EDUCATION AND HEALTH
STANDING COMMITTEE

INQUIRY INTO ABORIGINAL YOUTH SUICIDES

TRANSCRIPT OF EVIDENCE
TAKEN AT KUNUNURRA
FRIDAY, 10 JUNE 2016

SESSION TWO

Members

Dr G.G. Jacobs (Chair)
Ms R. Saffioti (Deputy Chair)
Mr R.F. Johnson
Ms J.M. Freeman
Mr M.J. Cowper
Ms J. Farrer (co-opted member)

Hearing commenced at 11.28 am

Mr JOHN HADJIS
Deputy Chief Executive Officer, Boab Health Services, examined:

Dr NICOLE JEFFERY-DAWES
Psychologist, Boab Health Services, examined:

The CHAIR: I have a few procedural bits that I have to go through, so I might start. Thank you for coming before us today. We are the Education and Health Standing Committee. Do you mind if we call you Nicole and John?

Dr Jeffery-Dawes: No.

Mr Hadjis: Not at all.

The CHAIR: We do not mind if you call us by our first names, either. The purpose of this hearing is to discuss the inquiry into Aboriginal youth suicide. It was an issue that was brought to Parliament through Josie Farrer, the member for Kimberley. The Parliament commissioned us to do this inquiry. Let me begin by us acknowledging the traditional owners of this land and expressing our gratitude that we are able to meet here today. We would also like to pay our respects to the local elders, past, present and future. I am Graham Jacobs, the chair. On my left is Josie Farrer, on her left is Murray Cowper and on my right is Janine Freeman. We have Catie Parsons and Alison Sharpe, who are the secretariat who try to keep us in order. We also have Hansard recording—Geraldine and Melissa. This is a committee of the Legislative Assembly, which is the lower house of Parliament. The hearing is a formal procedure but we hope it is not too formal. It commands the same respect as the proceedings in the house itself. Even though the committee does not ask you to swear an oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. If you have any documents that you would like to refer to, if you could please provide the full title of that document for the record, it would be very helpful for us.

Before we commence, there are a number of procedural questions and forgive me for asking these: have you completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIR: Thank you, and forgive me again: do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes.

The CHAIR: Did you each receive and read an information for witnesses sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIR: Would each of you now state your full name and the capacity in which you appear before the committee today? Then I might ask Nicole to maybe set off and just give us a little bit of an overview of Boab Health Services.

Dr Jeffery-Dawes: I will hand over to the deputy CEO.

The CHAIR: Okay, whichever! Then maybe some of how it works administratively, because I saw that there is an office and my first reaction was, "How does that fit in with services that are provided by WA Country Health Service?" How do you fit in that space, what do you provide, and

what do you provide that they do not, or whatever? That would be good to start off with; just your full name and the capacity in which you appear. Then give us a bit of an overview, perhaps.

[11.30 am]

Mr Hadjis: I will start; just a little bit. I have been with Boab and in the Kimberley for seven months now. I cannot say I am as experienced as Nicole and she would probably provide far more relevant information, but it has been a steep learning curve for me.

The CHAIR: What were you doing before, John, just briefly?

Mr Hadjis: I come from the east coast, predominantly Sydney and Brisbane. My experience is predominantly in acute care. I was very fortunate to have commissioned hospitals, including mental health. My first training was in mental health so I have an obvious interest in it. I am very fortunate in that I was able to establish, some years ago, some very important mental health programs like the first private mother-and-infant care unit for postnatal disorders and the first private community services. That is what I bring to Boab.

A little bit about Boab: it has two offices—one in Broome and one here. We provide services to approximately 35 rural communities in the Kimberley. Our services include allied health and, in that, it is diabetes education, paediatric nutrition, dietetics and podiatry. In mental health we have a range of mental health professionals that include psychologists, mental health nurses, social workers and OTs. Our client base for mental health is mild to moderate, by definition. That is what we are supposed to. We are funded by the Department of Health via WAPHA. Do we need to explain?

The CHAIR: Yes, please.

Mr Hadjis: WAPHA stands for—I am learning all the acronyms in the Kimberley—the Western Australian Primary Health Alliance, which is the primary health network for Western Australia. There are three regions: two in Perth and then there is western —

The CHAIR: The recently convened ones?

Mr Hadjis: On 1 July they were formed. They are our primary funder. We also have a contract on agreement with the Prime Minister and Cabinet for the newly established youth rehab project, which is going to be managed by Nicole. We also have a direct Department of Health agreement and we will be in our second year of that for what is called the Katjungka program. I think I have covered them.

The CHAIR: Can you tell me about the magnitude of your funding? How much are we talking?

Mr Hadjis: All up, including allied health?

The CHAIR: Yes.

Mr Hadjis: It is $4.7 million. Sorry, the Closing the Gap team—do I need to explain what that means for you?

The CHAIR: You probably do not need to for Josie, but maybe you could just for the record, yes.

Mr Hadjis: Closing the Gap is basically a care coordination role for ATSIC clients. We facilitate their requirements as a result of some chronic condition that they may have. The guidelines for that change as of 1 July, and it is called the integrated team—I hate these acronyms. It has gone out of my head, but anyway. Integrated Team Care, I think is the correct term. It is an important point, I am assuming for you guys, because it is the first time they have included mental health.

The CHAIR: Okay.

Ms J.M. FREEMAN: Is it the case that Boab Health Services is like the old Aboriginal Medical Service, or is that not the case?

Mr Hadjis: No.

Ms J.M. FREEMAN: It is a different beast, is it?

Dr Jeffery-Dawes: Yes. The OVAHS—Ord Valley Aboriginal Health Service—is still working and going. We are just a separate, non-government organisation that provides those services. They have been around for 11 years—Boab Health.

Mr Hadjis: For 18 years.

Dr Jeffery-Dawes: Sorry, 18 years.

Mr Hadjis: Sorry, I should have said that.

Ms J.M. FREEMAN: When you say non-government, is it a not-for-profit non-government organisation?

Mr Hadjis: Yes.

Ms J.M. FREEMAN: It is not-for-profit.

Mr Hadjis: Not-for-profit.

Ms J.M. FREEMAN: So the board is made up of?

Mr Hadjis: The chairman of the board is Dr Sue Phillips and she is the senior medical officer at Broome hospital. Then we have the regional ambulance services fellow, whose name has gone straight out of my head. An accountant who lives in Kununurra is our company secretary, Dr Murray Chapman.

The CHAIR: He is a Geraldton doctor, is he?

Mr M.J. COWPER: No, CAMHS.

Mr Hadjis: No, CAMHS.

The CHAIR: That is the psychiatrist we talked to in Broome.

Mr Hadjis: That is him.

Ms J.M. FREEMAN: Sorry, did you want to talk about the service?

Dr Jeffery-Dawes: Yes. We provide focused psychological strategies for people 18 years and over as our main funding arm. We also have our suicide prevention arm for both Indigenous and non-Indigenous clients. We service Kalumburu, Wyndham, Kununurra and Warmun. We regularly service those other communities, normally once every fortnight.

Ms J.M. FREEMAN: How long have you been doing suicide prevention work?

Dr Jeffery-Dawes: Myself, or the —

Ms J.M. FREEMAN: No.

Dr Jeffery-Dawes: I would say since the mental health team has been around.

Mr Hadjis: It has been a while.

Dr Jeffery-Dawes: Sorry, I have only been with them 18 months—not only 18 months, but —

Mr Hadjis: It comes under the funding for ATAPS; there is a suicide prevention component. I am not sure if I am supposed to deviate like this.

Ms J.M. FREEMAN: You can do whatever you like.

Mr Hadjis: I am just conscious of the microphone. I was very fortunate in that I went to the ATSISPEP suicide prevention evaluation project conference in May. There were some serious punchlines, as I call them there. One of them is that the Kimberley suicides, sadly, over 90 per cent—I think the figure was actually 97 per cent—had not accessed a mental health service.

The CHAIR: We have heard that before as a theme.

Mr Hadjis: As a service provider, that is an important issue for us: how is it that this can happen? Sadly for me, I had only been in the community for a short time when that young girl had a successful suicide in Looma. I actually read the parliamentary debate stuff—is that what it is called?

Ms J.M. FREEMAN: Yes.

[11.40 am]

Mr Hadjis: Coming from the east coast, I found it very sad. To me it is a national issue. As an older person who has been around in health services for many, many years I think this is such a national issue that we need to deal with. I found the conference very helpful to me to get some clear perspective of what is actually happening out there now, and how we can improve what we are doing to capture anyone who is distressed. To me, that is a very important issue.

Dr Jeffery-Dawes: Obviously, with our suicide prevention program, we actually provide unlimited sessions for three months, which works in Kununurra—can work in Kununurra—but it is difficult in remote communities because of the travel. However, we do do telephone consultations, and it often takes 12 months to actually build up that trust with a client before actual work can happen. We are working on reduction of distress, coping strategies as we go, but it is not just a three-month fix. This is long-term intergenerational trauma that is affecting these people and it needs to be dealt with very gently and very slowly.

The CHAIR: John, from your ATSISPEP experience, did you have any thoughts around what was leading to the surge in the unfortunate statistics in Aboriginal youth suicide? And the second part is what views did you form about trying to cover, if you like, if there was a service provided, we are probably not meeting it; we are probably missing it in a lot of cases, because as you said these young people do not have a quantifiable or delineated mental illness as such and probably did not make contact with anybody previously? I wonder if you could just share your thoughts with us on that.

Mr Hadjis: I would love to say that out of it I have come away with some fairly strategic things that one should do, but I cannot. The reason I cannot do that is the one thing that became patently obvious to me—and certainly in the seven months I have been here—is that it is so complex. If I could create a pill to give people, I would be worth a fortune, but there is not one solution. I wrote down some things for my own sake. For example—and I am sure you have heard this—early intervention is obviously a key strategy; wraparound services, and by that I have taken that away to mean it is complex. It is not just one service provider doing one thing. It is housing. It is education. Where is their money coming from? Is there domestic violence? It is a whole suite of things that one needs to consider.

The CHAIR: Including employment.

Mr Hadjis: Absolutely; and having said that, it does need to be a culturally safe practice. I should say I was not born in Australia. I am actually an Egyptian-born Greek. It is just a complicated thing, so I am very aware of—when I came to Australia as a little fellow I did not speak English and I still remember children at school mocking me because I could not speak English. So, I am very sensitive to—and I was called a wog. That is not politically correct, I know. What I am alluding to is I am very conscious of the fact that the culture of the people you are trying to help is an important aspect of what you do. I cannot tell someone else—whether they are ATSI, Asian or whatever—that the Greek way is to do it or the Aussie way is to do it; you really need to consider what history that group of people have. To me that is a very important thing. The other thing I got from it was the significance of language. That has become more and more apparent. Actually, an example was given at the conference. Trauma as I understand it is very different to how an Indigenous person might understand it. So, being very aware of language issues will assist us in how we deal with people. The other thing is I do not believe you can apply the same principles everywhere because it

is more of a local response by the local community. How you manage this in Kununurra is going to be different to Wyndham, certainly to Halls Creek, and so on. I think you can have generic strategies but there need to be some fairly clear specific strategies that are established by the local community.

Ms J.M. FREEMAN: How are you working to do that?

Mr Hadjis: Boab is part of what is called KRAMHPF, which is the Kimberley Regional Aboriginal Mental Health Planning Forum.

The CHAIR: You did well!

Mr Hadjis: That is a subcommittee of KAPHF, and KAPHF is Kimberley Aboriginal Planning Health Forum—that is it, and that is the primary body for planning—and KRAMHPF is a subcommittee of that. It has representatives from all service providers, including WACHS, KAMS and Men's Outreach. I am more than happy to give you a list of people who attend that; it is public information.

The CHAIR: No; we have already got some information on that because we are speaking to some of these people.

Mr Hadjis: For me, that has been a very useful forum. We meet once a month, and I have to say I have been impressed with the commitment of all providers. In trying to address this we came up with a suicide prevention paper that was given to KAPHF. I cannot tell you where it is right this minute, because it has gone to KAPHF. And, yes, we do have a very committed group, and we are trying to find ways where—with the concept of a wraparound service, I always see a client's journey in life as a continuum of care, and we slot in at certain points. In the hospital, you slot in when they need surgery or admission or whatever, but what you really need to do is look at the total picture and work together on the before and after stuff. Like I say, housing is an issue and education is an issue. Boab or any other service provider should not be just slotting in with the client and not dealing with the other groups. I might get into trouble.

Dr Jeffery-Dawes: No, but that is what we do as clinicians on the ground—work those —

Mr M.J. COWPER: We have heard 70 per cent of people who have suicided have not sought; you are now saying 97. Either way it is a high number.

Mr Hadjis: It is a high number.

Mr M.J. COWPER: There appear to be some resources on the ground. Given that most people do not actually seek assistance, what are you doing to try to change your method of delivery of service? Obviously, you have got all these structures and acronyms and things.

Mr Hadjis: Education.

Mr M.J. COWPER: But who is at the coalface? The police officers on the night who work the shifts —

Mr Hadjis: StandBy.

Mr M.J. COWPER: — and probably the nursing staff at the local hospitals or the clinics in the remote areas would be the ones who are first on ground. What sort of a relationship do you have with those people and is there an interaction of information? Is there trying to get out there and market—"market" is not the right word—but trying to get out there and deliver —

Mr Hadjis: Education.

Mr M.J. COWPER: — where it is needed?

[11.50 am]

Dr Jeffery-Dawes: There are two things. Firstly, we can only service 18 and over. Currently, in the East Kimberley, there is no youth early intervention service here, and I am extremely passionate

and get upset about that—that there is nowhere for these children to go to other than child and adolescent mental health.

The CHAIR: That is a gap, is it not? It is huge.

Dr Jeffery-Dawes: We have excellent relationships with all the clinics. Because I am actually servicing all the communities in the East Kimberley from Warmun to Kalumburu, whenever I go in, I say hello to the police and say hello to the nurses. We discuss things, but it is often after a crisis has happened and we are not a 24-hour service, unfortunately. I cannot be on call because I need to be sustainable as a clinician as well. That is where there are these gaps in the service. We go out into the community. We run talks with the community. We assist if somebody is coming in or the community is running, say, like a Deadly Thinking program. They will ask us to come in and assist and help so we get to know the community members. We can have those discussions. It is very difficult trying to do an in-service in a community, say, with the police or the nurses, because everyone is just so busy and understaffed, I think. We exchange information, but it is often sort of an opportunistic time. If they say someone is coming in distressed, I will often debrief the nurse and go, "Okay; how can we work with this? What can we do next time better?"

Mr M.J. COWPER: Let us say for the sake of argument there is a critical incident—a couple of people go missing and perish or something like that. Is there some sort of support network for the people involved?

Mr Hadjis: Yes; StandBy. Is that what we are meaning? Is StandBy Anglicare?

Dr Jeffery-Dawes: Yes, the StandBy suicide response. Is that what you are talking about, or just a critical incident in general?

The CHAIR: It is in relation to suicide would you think?

Mr M.J. COWPER: Yes.

Dr Jeffery-Dawes: There is the StandBy suicide response team. I will often debrief with the staff, or certainly the nursing staff. There is the CRANAplus Bush Support Services, which is a 1800 number that they can call. It is 24/7 for remote health workers, but often they do not feel comfortable doing that and people do not understand where they are working. So they will often debrief with me. The next in community will give me a phone call to do that.

Mr Hadjis: You know there is a critical response team established at the University of Western Australia? Okay.

The CHAIR: Nicole, I am just trying to see whether there is any potential for overlap and the other service providers. You provide services in 35 communities in allied health, diabetes health education and paediatric nutrition. How do you engage and how do you engage with the other services that are maybe providing some of those services as well, so that you know that you are not obviously replicating what they are doing and you are actually providing a service that they are not?

Dr Jeffery-Dawes: Because we all talk.

The CHAIR: So how do you do that, and from the programs that you have got in those areas, has that come out of a discussion with what the Western Australian Country Health Service, the mental health services and health services as such provide?

Dr Jeffery-Dawes: There is actually no overlap between ourselves and WACHS. As far as mental health, OVAHS have the social and emotional wellbeing unit and they provide that group generalist counselling, but we will also get referrals from OVAHS for the focused psychological strategies. So there is actually no overlap between services.

Mr Hadjis: There are memorandums of understanding in most service providers where we clearly articulate what each one is doing.

The CHAIR: So in the mental health space, what clearly do you do that they are not doing?

Dr Jeffery-Dawes: WACHS will provide assistance to those low prevalence disorders—things like schizophrenia, active bipolar —

Ms J.M. FREEMAN: Psychosis.

Dr Jeffery-Dawes: — psychosis.

The CHAIR: So they are dealing there with the more acute.

Dr Jeffery-Dawes: Absolutely acute.

The CHAIR: You have the mild and moderate spectrum.

Dr Jeffery-Dawes: Allegedly!

Mr Hadjis: And they are getting more acute.

The CHAIR: That is an interesting line to draw that line and see what is the definition of "moderate" and "mild" and who is dealing with what.

Dr Jeffery-Dawes: And they are supposed to be high-prevalence disorders, so we get anxiety and depression. Often there will be a huge history of trauma that does not come under the acute setting, but there is sort of that gap in that service so we will end up having to provide services to those people as well, because other than that, there is Anglicare, who provide the generalist counselling rather than that focused psychological strategy.

Ms J.M. FREEMAN: So if you go to Anglicare and you are just going for general and then they say to you, "You seem depressed", they then refer that person through to you?

Dr Jeffery-Dawes: Through the GP mental health care plan.

Ms J.M. FREEMAN: So they come to you on a mental health care plan?

Mr Hadjis: Yes.

Dr Jeffery-Dawes: Yes, in Kununurra. However, out in communities, there might only be a doctor there one or two days a week, so we do take referrals from the remote area nurses out there. We also let people self-refer in community and we will assess them.

Ms J.M. FREEMAN: How often do you deliver services into the communities?

Dr Jeffery-Dawes: Fortnightly, and I see people fortnightly in Kununurra as well. But say they need more for, like, the suicide prevention, then we can organise a telehealth VC, which has not been successful in community, or telephone.

Ms J.M. FREEMAN: Is there not a capacity to have a nurse in a community who is skilled up to be able to do what Anglicare does, what you do and a bit of crisis care and do paediatrics and do all of those other things and be in the community?

Dr Jeffery-Dawes: The nurses are so overloaded as it is just trying to deal with the day-to-day stuff. They also have portfolios, so they will have a mental health portfolio, but often that only covers the acute mental health clients. They have to do the school kids; they have to do all sorts of things and they are just swamped.

Ms J.M. FREEMAN: And what about Aboriginal health workers? Do you employ Aboriginal health workers?

Dr Jeffery-Dawes: Yes, through the Closing the Gap.

Mr Hadjis: Yes, through the Closing the Gap.

Ms J.M. FREEMAN: And are those Aboriginal health workers in the communities as well?

Dr Jeffery-Dawes: They are based in Kununurra and they come out to communities with us.

Ms J.M. FREEMAN: Are the nurses based there all the time —

Dr Jeffery-Dawes: Yes.

Ms J.M. FREEMAN: — in the communities that you go to?

Dr Jeffery-Dawes: Yes.

Mr M.J. COWPER: Typically, when you go to a community—let us say Kalumburu or Warmun—how many people would you see on a given visit?

Dr Jeffery-Dawes: It could go between zero and 12 in a day, depending on what is going on, and sometimes that might be a family intervention with someone they are worried about who has expressed suicidal ideation. Sometimes I go there and people are out or there is a meeting on or anything. But I would say easily four to six.

Mr M.J. COWPER: There has been an attempt by the former police superintendent to try to map or document some of the information. Are you aware of that and have you been a participant in trying to identify those people who are showing ideations? Are you aware of that at all?

Mr Hadjis: In Kununurra?

Mr M.J. COWPER: In the Kimberley.

Mr Hadjis: In the Kimberley. There is a police rep on the land and we discuss statistics, like how many self-harms et cetera.

Mr M.J. COWPER: I am a bit perplexed here. Why do you only deal with 18 and above?

Dr Jeffery-Dawes: Because that is all we are funded for.

Mr Hadjis: Our agreements are fairly strict as to what we are allowed to do. I do not know if you have interviewed WAPHA, but WAPHA will dictate what you can and cannot do. We are not allowed to act outside of that because if that is not what you are funded to do, you risk some serious problems occurring.

Mr M.J. COWPER: What is a serious problem? What is potentially the problem?

Mr Hadjis: The potential is that WAPHA says you were not contracted to provide this service.

Mr M.J. COWPER: That is a process. What about the outcome?

Mr Hadjis: The outcome is —

Dr Jeffery-Dawes: You lose your job.

Mr Hadjis: You lose your funding.

The CHAIR: You spend your money and they want to know where you spend your money and you find it.

Mr Hadjis: I understand what you are saying, but we cannot act outside of that because potentially we —

Mr M.J. COWPER: I have spent some time in remote areas. How do you know they are 18? They do not have birth certificates.

[12 noon]

Mr Hadjis: If you do not quote me, I am very happy to say that we —

Ms J.M. FREEMAN: If we are not going to quote you, then —

Mr Hadjis: I had better stop. Through the referral process—they should not come to you from a referral point of view, as everyone knows. Having said that, we do address issues case by case.

Dr Jeffery-Dawes: If it is a month or two off the eighteenth birthday or whatever, they will be. For example, if there is a 15-year-old that people come to me saying they are worried about, we will try to connect them into child and adolescent management health or I will go and talk to the adult

and the family and have them as clients so we can work that way. It is frustrating. I have worked in the Tanami Desert, in Balgo and Billiluna with young people down there on suicide prevention. It frustrates me. We try to work with families. We work with families anyway.

Ms J.M. FREEMAN: Is it only KAMS that has funding for counselling with adolescents in this region?

Dr Jeffery-Dawes: Yes, in the East Kimberley.

Mr Hadjis: Unless we have a point five for child mental health services, so up to 12.

Ms J.M. FREEMAN: So you can do up to 12 and then gap.

Mr Hadjis: Yes, and then there is a gap. I need to stress for you guys that me and the chief have clinical backgrounds and learnt a long time ago that you do not knock back anyone. If you are not allowed to proceed in a certain way because of external matters, you facilitate what needs to happen. There is no way we will just drop someone but I cannot say exactly.

Ms J. FARRER: You just turn your back on them, do you?

Dr Jeffery-Dawes: No. We work with the families and adults and all the rest of it.

Mr Hadjis: We do not just say no. That is what I was trying to stress—it is case by case. I am actually involved in one myself at the moment that I am discussing with the GP who made the referral because this client does not fit our criteria. I am trying to find a way that we can address these issues going forward. Clinicians do not just drop—you just do not.

Ms J. FARRER: Just on that, you people come into this area. Are you made culturally aware? Is there any training involved and who provides that?

Dr Jeffery-Dawes: Here, it is the Miriuwung language centre. We all have to go through cultural training there. I will always connect in with people in each community and basically have a champion who is a liaison officer. You learn from the elders. I have been out to the Gidja women's law camp last year. There have been some beautiful people who will help me. I do not just walk out into the community and go, "Right, let's give services." It is working with the community, walking around the community, learning from people. I am here to stay. I love Kununurra and I love the people in the East Kimberley. I also think there needs to be a youth-specific service—a youth-friendly service that is culturally appropriate in the east.

Ms J. FARRER: Do you have any Aboriginal people who are trained in mental health care who are working with you people?

Dr Jeffery-Dawes: Russell from the Closing the Gap team has previously worked in mental health as part of this funding from Prime Minister and Cabinet and this new project. We hate the word "youth rehab project"; we are going to get the kids to come up with a new name. But part of that funding is put away for Aboriginal liaison officers to pay them to guide me through Kununurra and Wyndham to help me negotiate. The community families teach me what I need to know. The women from Waringarri Aboriginal Arts have been absolutely beautiful in helping me to do that as well.

Mr M.J. COWPER: Is churn a bit of a problem in your industry.

Dr Jeffery-Dawes: Sorry?

Mr M.J. COWPER: Churn—changing of personnel. You are just going into all this wonderful experience and understanding and then there is burnout and then someone else moves in and has to learn the whole thing.

Mr Hadjis: Recruitment and retention is a serious issue for any service provider in the Kimberley. This is public knowledge. It makes it very difficult for us as service providers when you have three,

six, nine and 12-month contracts starting from 1 July to secure highly skilled health professionals. That is the environment and the uncertainty that we work in.

Ms J. FARRER: Just in the Balgo area, I have heard some really good outcomes regarding the person who was working there with the men's issues. There have been some excellent records in the way that it has been able to help some of those men change their lives. We have heard all this about the homelessness of people who come from Balgo who are sleeping on the oval in Broome and their high numbers. A lot of those services that people should be having out on their own community, it is not provided for—it is not given to them. Their next port of call is Broome. We have heard about the homelessness and how it is affecting a lot of the people from the desert. The Katjungka region is a pretty big area. It looks after the four different communities that are set up out there. Katjungka means one. Why is there not this sort of service? Why has it not been provided to Katjungka as one region instead of these people having to travel to places like Broome where they can get some of these services?

Dr Jeffery-Dawes: It is actually provided down there by one of our clinicians.

Ms J. FARRER: But the funding was cut last year for this person who was working with the men.

Dr Jeffery-Dawes: I know who you are talking about—the men's health service. I think that was under KAMS.

Ms J. FARRER: Why has it been cut? A lot of these men are now moving all over the place. Why has there not been any support for that to be looked at? I brought it up in Parliament but there was no answer to it. A lot of these men have now moved and they are all over the place; they are in Broome. I guess that has created a lot of homelessness for them because if they move, they take the family with them.

Dr Jeffery-Dawes: I was shocked when I heard that that funding had been cut, and it was also for the sexual health nurse, who I worked closely with, with the young women and men in the community too. I cannot say why because that was KAMS and they were doing amazing —

Ms J. FARRER: This is not KAMS; this is the state. People are saying it is a combination of funding that was supposed to provide the service out there. People have asked if I could ask to make sure that the service is reinstated. I do not know how many health services are working out there that provides a lot of this care.

Ms J.M. FREEMAN: You do not work at Balgo, though, do you?

Dr Jeffery-Dawes: No, I used to. I did work with the young people as the social and emotional wellbeing crisis and suicide prevention practitioner, I think it was—it was a very long title—but basically working with the young people. It came out of the coroner's report a number of years ago into the cluster of suicides they had down there, so they funded a youth position and also an adult position. The youth position is held by Anglicare. They have got the funding for that but Boab has the funding for the adult, and she is down there two weeks in, one week out, so that service is there. I cannot say why that funding has been cut.

Mr Hadjis: We cannot speak for—because we do not know why they withdrew that.

Dr Jeffery-Dawes: But I saw the results down there and we connected in, worked in and it was amazing.

Ms J. FARRER: But somebody has to provide that information, because it is not—no?

Ms J.M. FREEMAN: Can you just give us some details about the youth rehab project and what that entails and where it is going to be delivered? You just recently got the funding—when did you get the funding?

Dr Jeffery-Dawes: Yes, like about two weeks ago.

Ms J.M. FREEMAN: And who is the funding through?

Mr Hadjis: Prime Minister and Cabinet.

Dr Jeffery-Dawes: Their idea was to provide services to young people aged 12 to 15, because after the age of 16 they can be picked up by adult community drug and alcohol services, to address the young people's drug and alcohol issues, to get them back into school. There are supposed to be 20 in Kununurra and 20 in Wyndham; that is the target number.

[12.10 pm]

The CHAIR: It sounds easy, eh?

Dr Jeffery-Dawes: For one person and an Aboriginal liaison officer, no. But it is sort of on a case management basis to link them in to other services. But there are no other services and there are these underlying issues. Drug and alcohol is not the issue. What is happening underneath? What are the people struggling with? In our proposal to them, we said, "No, we need to actually address those." It is probably going to work differently in Wyndham to Kununurra because of what the community has requested, but basically we are going to be providing—the young person and an adult will be assessed, and we need an adult from the family involved in that. We will be looking at things such as emotional self-regulation, distress tolerance, how do we deal with our emotions, what are they, obviously the education about drug and alcohol on the body, but linking them into other community groups and community people to provide that extra support. Waringarri want to do some art therapy, so they are actually doing a week on art therapy group that we are linking into. They have given us space; the people in Wyndham are looking at space for us. It has not actually been mapped out yet, because I am actually trying to wind down our clinical load. We are trying to bring on a new clinician and I am still in a community consultation about how they actually want this to work properly and how we can get some good outcomes from it. But it is not diversionary activities, which is what a lot of the other service providers provide.

The CHAIR: This is a case from top up, top down, is it not, rather than bottom up? Maybe that is where we have gone wrong in the past in a lot of cases. We say, "Here's a program, here's the money, here's your youth project. Go to it", instead of, as you said, that critical bit you said—got to find out what the community wants and how they want it to look.

Dr Jeffery-Dawes: Yes.

The CHAIR: And what they think is going to be effective, really.

Dr Jeffery-Dawes: Yes.

Mr M.J. COWPER: Nicole, I asked a question yesterday in one of the communities we visited and the question revolved around what has changed. Thirty years ago—more than 30 years ago now; 37 years ago—when I first came to the Kimberley, suicide in the Aboriginal population was really low, and then it sort of started to manifest in police lockups and there were royal commissions and things, and now it seems to have spilled out over into the wider community to such an extent that it is now six to seven times more prevalent here in the Kimberley than anywhere else in the rest of the country. In a period of 30-something years we have gone from one of the lowest rates to exponentially high, and I put it to some people yesterday—senior people in the Aboriginal community—what has changed, and they were perplexed as to what is different now. Given your experiences, have you got any insight that you might have as to how —

Dr Jeffery-Dawes: Me personally, I have been here four years, so I cannot speak for that.

Mr M.J. COWPER: What has changed? What has changed in that period?

Dr Jeffery-Dawes: No, but from talking to people in community, what they are sort of saying to me is that we need to go backwards to go forwards. We need to reconnect with culture; we need to reconnect with country. We need to be able to work together, Indigenous and non-Indigenous, learn from each other—that two-way learning—to move forward and to get over this and to get those kids to be proud of who they are and where they come from.

Mr M.J. COWPER: I think we all agree on that one, but I actually then put it back to them and said, "When was the last time you took this young fellow over here to country?" and they kind of sort of all looked sideways. It is almost as though we have now got a generation within our Aboriginal people who are lost, and now we have other groups like Winun Ngari and the Yiriman program—the program from Fitzroy Crossing—taking them out. That was traditionally done by the—I use the example at Fitzroy Crossing; we had Jock Shandley and Reggie Ford just take their families out, and they used to take the biggest mob out. But they do not seem to have that anymore. Another thing I found interesting, and it might only be anecdotal, was I went down to the power station with some men; we had a bit of a chat and walked around and spent a bit of time together. Each house now has got an air conditioner in it, and when it is hot they stay inside in the air-conditioning in some of those communities. When do they actually go out on country? I found it really interesting that they do not see it as their role, and that is now being provided by an external provider. They say this, but have you got any insight as to how do we motivate the people to take their young people out?

Dr Jeffery-Dawes: Often, what I have heard is transport is an issue to get out. However, I know certainly as a part of this program, I will facilitate and connect with other people, but that young person, there will be other people—I am not just going to take young people out. That is a diversionary activity, not a therapeutic one.

Ms J.M. FREEMAN: I would assume that transport is an issue, because in the old days they could throw 20 people in a car and now if they did that, they would get picked up by the coppers. Also, I would assume that—do you know whether it is an issue with Centrelink if they go out to country for any lengthy time? Do they have problems with their Centrelink payments?

Dr Jeffery-Dawes: Because they have not turned up to their CDP programs and those sorts of things, yes.

Ms J.M. FREEMAN: Okay. So, in terms of how you would have to deal with it then, you are going to have and deal with Centrelink so they do not come off Centrelink payments in that period of time that they are going and getting that —

Dr Jeffery-Dawes: Yes. And, also, I have spoken to EKJP certainly in Wyndham about this, and actually being able to have those people have it as an activity —

Ms J.M. FREEMAN: The job providers, you are saying?

Dr Jeffery-Dawes: Sorry, yes. As an activity, because it would not just be going out; there would be learning both from things that I am teaching as well as traditionally.

Ms J.M. FREEMAN: This morning when we had the drug and alcohol services, they particularly noted that there was not rehab for young people in this state. They were not aware of your funding. How do you work with the alcohol and drug services?

Dr Jeffery-Dawes: Normally excellently for adults. We work very closely together and we will often travel to community together if need be. Like I said, this last two weeks is really quite a transition phase for me. I have got clients that I cannot just drop. I have to wind down and then wind this up. Whilst I have been talking to communities—and it is interesting, because I have talked to someone from drug and alcohol about this, but needing to have the time to be able to now discuss it with other services—that is going to be starting from 1 July; I will be full-time on this.

Ms J.M. FREEMAN: You are employed full-time, and will you employ an Aboriginal worker with you on this?

Dr Jeffery-Dawes: Yes.

Mr M.J. COWPER: Nicole, the other thing that came to light during conversation was that we have got a group of Aboriginal people there who are the best trained unemployed people going

around. They have got certificates, they said, that they can wallpaper the wall with, but no job. Any comment in and around the importance of self-worth and employment?

Dr Jeffery-Dawes: Generally?

Mr M.J. COWPER: Yes.

Dr Jeffery-Dawes: We all need something to get up for in the morning, whether that be a job, family, volunteering, whatever; we all need something to keep us going each day. I think employment is certainly important for self-worth.

The CHAIR: How many of your clients would be employed, or how many would be unemployed?

Dr Jeffery-Dawes: Is that including things like the job programs, because a lot of them are involved in that or they are employed in a shop. The problem is in community, there are only so many jobs at the moment. You either work at the store or you work at the clinic or you work at the job program.

Mr M.J. COWPER: Or you do not work.

Dr Jeffery-Dawes: Or you do not work. There are just not these employment opportunities for people. They are just not there.

Ms J.M. FREEMAN: Can you give any sort of commentary about FASD and whether that has an impact on people's wellbeing and personal health in terms of the people you are dealing with?

Dr Jeffery-Dawes: I can think of probably one client I have worked with as an adult that you could sort of recognise FASD. I see more of it in younger people now. It certainly affects wellbeing. The cognitive processing takes time and the way we need to speak to people, the way they learn. Mainstream programs and education are just completely—they are not geared up for it, to be able to have that time for that processing to happen. There are also the behavioural issues, so then they are marginalised because of not being able to manage their own behaviour or not being taught how to do that.

[12.20 pm]

The CHAIR: It is an emerging issue, is it not? What is your feeling anecdotally about the prevalence or the incidence of that in your clients?

Ms J.M. FREEMAN: She said only one.

Dr Jeffery-Dawes: One that I know of.

The CHAIR: Only one?

Dr Jeffery-Dawes: That I know of as an adult. The other thing is I am not testing for that either.

The CHAIR: Did you want to say something, John?

Mr Hadjis: I wanted to maybe add some comments for Murray's sake and these are dot points for you. I would suggest—and this is not peculiar to the Kimberley—that we are data rich but information poor. I think there are some serious research opportunities because a lot of information is anecdotal or picking one b it. Like, it is very easy for me to say, "Over 90 per cent didn't access mental health services", but there is so much around that.

Mr M.J. COWPER: How do you know, you know?

Mr Hadjis: Exactly. I think there is an opportunity for us or someone to do some—actually for us. I am hoping to undertake a master of philosophy that involves research on this very subject, because I am trying to—and purely to assist us as an organisation as well, but trying to get some very clear research data is very difficult. The other thing—I may sound critical when I say this and please forgive me, because I am at the coalface, so to speak—is I think leadership is a serious issue. I mean that in a general political environment, state, federal, whatever. There seems to be the right

intention by most of us, but it gets confused because there are so many people playing at it, for want of a better way of describing it, and I find it frustrating. For example, I raise the issue of our funding. To me, there are so many contradictions because there are so many players. We get three, six, nine-month contracts and are told that recruitment and retention is a serious issue in the Kimberley. I do not think I have got "idiot" tattooed on my forehead. It just does not make sense to me how these decisions can be being made by people who are not even at the coalface.

Ms J.M. FREEMAN: Your core funding is Health, and how long is that for?

Mr Hadjis: Three, six, nine months. Within our group of services, we have got to give contracts to our staff from 1 July for three months.

Ms J.M. FREEMAN: Your core Department of Health funding is for three, six or nine months?

Mr Hadjis: Correct.

Ms J.M. FREEMAN: How long has that been the case?

Mr Hadjis: Previously it was 12 months—that was max—and even that, I can say as an experienced operator, you are going to attract someone to a rural, move home. I came here because I wanted to. I am hoping that my background will allow me to contribute in some fashion. But there are a lot of young people who are not going to come here with those—they want the experience; you know you are going to have them for two years et cetera. You offer someone a 12-month contract even, that is difficult. But to go to three months —

Ms J.M. FREEMAN: Can I say something controversial? Maybe you could find people who live here already in terms of—there are a few people out there.

Mr Hadjis: Absolutely. No, that is not controversial. I would suggest that that is what you need to do. When I say I come from the east coast, it is not that I am great. In fact, I think I have missed out on a lot over many, many years. I can tell you from Sydney and Brisbane, I know more about Kim Kardashian's butt than I do about what Aboriginals are going through, and that is why I came. I know that is an awful thing to say, but it is the truth. I came here because I have a very strong clinical background. I did general midwifery and mental health and I have run acute care sector environments, and I came here for a specific reason. But I think if you are trying to recruit people, certainly local is the best, because you get longer tenure and they understand. But it does not help providers trying to achieve that with these sorts of decisions being made. Then you get the threat of open tender. Our staff are very aware of the environment. As people who live in the Kimberley, are we happy to lose skilled health professionals because of some administrative leadership that, to me, has gone wrong? That is just one of the worst decisions anyone could make, and I am not having a go at anyone. I am just saying somewhere someone has not recognised that leadership in this very sensitive area is very important; that you have a number of players who do not seem to have got their act together—I was about to say something else. I feel for you guys; I really do. I feel for you guys because it reflects on you, I assume, as the politicians. I would be looking for someone, please, stand up and say, "This is what's going to happen". Am I sounding political here, am I?

The CHAIR: Not chopping and changing either. This is the course long term.

Dr Jeffery-Dawes: Janine, just what you were saying about employing local people or people living in the area, what we actually provide, certainly from our perspective, is that evidence-based mental health—it is often four to seven years of university training and we just do not have it here to be able to provide that service.

Ms J.M. FREEMAN: I get that you think and that people think that the only people who need that is university trained, but if it is an issue around community and culture and things like that, then is it possible that we could actually branch out from the clinical model and think about healing in a much more —

Mr M.J. COWPER: Contemporary —

Ms J.M. FREEMAN: Well, not even contemporary—in an old-style sense of going back to culture and saying, "Actually, how did you heal and can we tap into your knowledge and your community and employ your people to heal your people?"

Mr Hadjis: Absolutely.

Dr Jeffery-Dawes: Yes, sorry. I am going back to that sort of clinical model. That is what we are trying to do with this, but it is 12 months of funding. What is going to happen after that?

Mr Hadjis: What relationships will you set up within three months? But it is a very valid point. One of the presentations at the conference was—and forgive me; I am not really good with names —

Ms J.M. FREEMAN: Nindilingarri healers.

Mr Hadjis: The ladies?

Ms J.M. FREEMAN: Yes.

Mr Hadjis: I was so impressed. I was just so impressed with these people, just gorgeous ladies as well. They had it together. They did not separate themselves from the visiting psychiatrist, but what they did was, they became a team, and that is what it is about! We are a team. We all should have the same goal: that I am here because of a client, not because of myself. If you put your client first, you will work out, "Okay; we need those ladies because what they're doing with those young men and women is fantastic!"

Ms J.M. FREEMAN: But they are Central Desert healers. What you need to do is find the healers in these communities.

Mr Hadjis: Absolutely. I am not saying that applies to —

Ms J.M. FREEMAN: How long has Boab Health Services been operating? I have taken into account that you have been here for a short period of time!

Mr Hadjis: Eighteen years.

[12.30 pm]

Ms J.M. FREEMAN: And they have not identified any traditional healers in that 18 years? Do you know, I have to say, apart from anything else, you could get a few traditional healers and employ them, and you could probably make a mint out of the white people who want to come in and get some healing as well. I do not know if that is particularly culturally appropriate, but it seems to me that there is almost an opportunity for self-funding there, and it would enable them to work in their communities. But, hey, I am a white politician from down south. But you have been here 18 years and we are only talking about that sort of stuff now.

Mr Hadjis: Are you familiar with the primary health network agreements? They actually specify what you must have.

Ms J.M. FREEMAN: Yes. That is from the Department of Health again.

Mr Hadjis: Yes. And I take your point, but, again, we have legal responsibilities. If you want me to change that, you are talking to the wrong guy. If you want that change, you have to talk to the Department of Health and to the primary health networks and say to them, "Get your act together and allow these people the resources to appoint." We have been talking with again another group whose name escapes me, but they have a particular seed; it is south of Broome and I have forgotten their name. But, anyway, there is this seed that apparently cures lots of things, so we have actually been trying to network outside our remit with a professor of dermatology to see how we could use this.

Ms J. FARRER: Gubinge seed?

Mr Hadjis: That is it—and see how we can help that community, but also establish those really positive relationships. I stress that I take your point, but please recognise that your providers are ruled by those who give them the money. It is not that we do not want to. I am going to be in trouble by saying that sometimes we act out of that because our primary responsibility are our clients, always—whoever comes to your door. Can I just add, the other thing is that it is important to also recognise that service providers provide services to both Indigenous and non-Indigenous; we do that, obviously. One of the things that I think would be invaluable going forward is the sharing of those methodologies within the group. I bought some of the cream and whatever, but I learnt a lot—and I am an experienced health operator—I learnt a lot from those ladies from—sorry, I have forgotten their name again.

Ms J.M. FREEMAN: Nindilingarri healers.

Ms J. FARRER: Nindilingarri.

Mr Hadjis: Thank you. I learnt a lot from what models they are using. I think that that is not peculiar. It is like suggesting that ATSI people or Indigenous people are very different to the rest of us. We are all human beings. If we can learn from each other, surely that is a good thing and, dare I say, I am one for alternative-type approaches. I come from the acute sector, but I firmly believe there are other ways to do things.

Ms J.M. FREEMAN: This is my last question. This morning we had the team leader or one of those from the Kimberley Mental Health and Drug Service, Terry Howe, and he said in his evidence that people present to the hospital either saying that they will self-harm or having self-harmed under the influence of drugs and alcohol and then, when they sober up in the morning, there is not an acute mental health issue that they can deal with. He did not say that there was a moderate or mild-to-moderate mental health issue either; he just said, "That's what often happens and we'll refer them to drug and alcohol, but if they do not want to go, there's nothing we can do." In terms of the work that you do, unless they get referred to you, you cannot deal with them either; is that the case? If someone is there and they have those issues where they go into suicide ideation under the influence, how can Boab Health help?

Dr Jeffery-Dawes: Well, we do not know about them; we do not hear about them. That is what I am saying. Kimberley Mental Health gets called in; they do an assessment and do whatever they do and make that referral, but we would not even know that that person was in the hospital unless we were advised by someone, and we cannot keep tabs on 20 000 people or so.

Ms J.M. FREEMAN: No, obviously.

Dr Jeffery-Dawes: In community, though, that is where it will often happen because I have those relationships. People come up and say, "We're really worried about this one." "Would they be okay with me going and talking to them?" Yes." So I will go and then talk to them. Most likely, they will not be under the influence because the crisis might have been the previous night or two nights before. I have actually seen people who have been under the influence and we are not actually supposed to, but —

Ms J.M. FREEMAN: I am not expecting you to do it when they are under the influence of any substance; I am saying post.

Dr Jeffery-Dawes: No, but we can talk about keeping them safe. We can get family and community involved and keep them safe at that time. But mostly it will happen afterwards, and yes, then we go in and put them under our suicide prevention program and see them for as long as necessary.

Mr Hadjis: We do get referrals from Kimberley mental health services. Predominantly, that is where our referrals will come from. In Broome, I have a very close relationship with Adam Vincent and Bob Goodie and those sorts of people. We meet to discuss, firstly, triaging and, secondly, what

they call their pending list. We try and assist with them with that list so they do not blow out because then they stay on their books, as they say, which is not a good call for the client.

Ms J.M. FREEMAN: I did say that was my last question, but my last question is about post-incident counselling. You do stuff for suicide prevention but what about for people and the families who are suffering with the grief and the trauma of suicide?

Mr Hadjis: The immediate response comes from StandBy. That is understood by all of us. Then providers slot in as necessary after that immediate period.

Dr Jeffery-Dawes: StandBy will then go, “Okay, this person —

Mr Hadjis: They are very good, I have to say.

Dr Jeffery-Dawes: Yes, and we liaise all the time. Then we will provide that postvention.

The CHAIR: Nicole, you might have said this, but how many clinicians like yourself are in Boab Health Services?

Dr Jeffery-Dawes: Two.

The CHAIR: Two. My last question is: what did you do your doctorate in?

Dr Jeffery-Dawes: Health psychology.

The CHAIR: Anything more specific than that?

Dr Jeffery-Dawes: It was a professional doctorate, so we did coursework and a thesis and placements.

The CHAIR: What was your thesis on?

Dr Jeffery-Dawes: Depression, anxiety and metabolic syndrome in farm men and women, so very passionate about rural and remote mental health, and the gaps in services. That is sort of what brought me remotely, because there is just such a huge gap. I think it is 0.8 per cent of psychologists are in rural and remote areas, and often 45 per cent of those are new clinicians. I am passionate about providing health out here, but also supporting clinicians to be sustainable so that we can build up those relationships and maintain them and stay.

Mr Hadjis: Did we mention most suicides occur between 5.00 and 6.00? Okay; there is one.

Dr Jeffery-Dawes: Between 5.00 pm and 6.00 am?

Mr Hadjis: Okay, between 5.00 pm and 6.00 am—because I made notes, obviously. Why I raise this is that—and I am not suggesting we be the ones to do this, though Margie, our chief, knows I want us to do this—after hours, there is not funding there. I mean, how do we capture 5.00 pm to 6.00 am, for goodness sake, you know? Your doors are closed. I do not think we should have our doors closed. That is because I come from hospital life.

The CHAIR: And the weekends.

Mr Hadjis: Exactly; and, you know, Christmas, Boxing Day even, someone’s birthday, blah, blah, blah.

The CHAIR: So, in an ideal world, John, what service could you provide in those hours?

[12.40 pm]

Mr Hadjis: I have to say, if you are going to venture out after hours, the clinicians probably should be nurses with trained Aboriginal liaison—whatever. I cannot imagine me trying to address an issue, although sometimes people think I have an Indigenous background—and I am actually quite flattered when people say that—and I am an experienced clinician, I would not go to after hours, because I need the cultural aspect addressed by a colleague. So, I would say you would need both, hand in hand. There is nothing worse than a psychologist being confronted with a serious medical

emergency. So, if something does go wrong, I think a nurse is the most appropriate person. And I did not mean that disrespectfully.

The CHAIR: Any more questions? Thank you very much.

Dr Jeffery-Dawes: Can I just say that what I think would be lovely up here as well would be a youth early intervention, youth-appropriate, culturally appropriate service.

Ms J.M. FREEMAN: Is there not one?

Dr Jeffery-Dawes: No. There are diversionary activities. We have people like —

The CHAIR: Nothing for that particular age group?

Dr Jeffery-Dawes: No; the 12 to 25—something like a headspace—you know, that sort of model—is so desperately needed over here. It breaks my heart when I cannot work one-on-one with a young person. I try and do the best I can, but sometimes that young person just needs to talk to someone by themselves as well.

Mr Hadjis: Are you aware how they actually form these age ranges? It seems to me to be —

The CHAIR: Something like 12 and then a gap between 12 and —

Mr Hadjis: It is arbitrary to me. It is just nonsense to say it is 12 years old, but if they are 12 years and one month, no, you cannot touch them. Like, seriously, give me a break!

Mr M.J. COWPER: And that headspace—of course, in Broome, we heard from Alive and Kicking Goals They are grassroots initiatives, and they are successful because they are grassroots. I hear what you are saying, but the last thing I would like to see is a cookie-cutter type somewhere to Kununurra. What I would say in response to that is that—I understand where you are coming from and the frustration, but I would be looking very seriously at what you have got here and what could be found generic here locally.

Dr Jeffery-Dawes: But that is what we are saying; there is just not that early intervention —

Ms J.M. FREEMAN: Is there not a youth centre?

Dr Jeffery-Dawes: — the diversionary activities like basketball, Save the Children —

Mr M.J. COWPER: There is no PCYC or anything like that, no.

Ms J.M. FREEMAN: That is diversionary as well, is it not, the PCYC?

Dr Jeffery-Dawes: Yes; so, there is nothing actually addressing these mental health issues for young people. There is child and adolescent mental health, but other than that there is nothing. You know in mapping this new program, I am going, "I'm here!" You know, it is a huge gap up here.

Ms J.M. FREEMAN: Does headspace come up here?

Dr Jeffery-Dawes: No.

Ms J.M. FREEMAN: At all?

Dr Jeffery-Dawes: No.

Mr Hadjis: May I add one more thing, sorry: are you aware of the reform services unit?

Ms J.M. FREEMAN: Yes.

The CHAIR: We have heard about it.

Ms J.M. FREEMAN: What impact does that have on you?

Mr Hadjis: Personally, zip-a-dee-doo-dah! What I appreciate is that—Grahame Searle, I think was the gentleman—someone is looking at how we can do things better, but there is a sense that it has existed now for a few months, and service providers get very nervous if you have got someone who

is checking you out in the background, but you are not sure why and where they are leading to. Again, we come from backgrounds that are very familiar with terms like outcomes and KPIs and whatever, but can we do this together as a group and not miss out things like cultural awareness et cetera, because it is fundamental to your going forward strategies? It is not just 10 occasions of service and they each cost $100, you know. Anyone who says it is that simple should not be in the job; it is not that simple. But you want outcomes. You do not want to be pouring out money to people who do not give you the results that you guys, as politicians, are responsible for.

Mr M.J. COWPER: The point that you make about leadership is a very important one, but leadership runs at all levels.

Mr Hadjis: Oh, yes; yes.

The CHAIR: I just have to give you this little bit of closing statement. Thank you very much for your evidence today and, of course, the work you do. The committee is grateful for that. A transcript of this hearing will be forwarded to you for your correction if you see some minor errors. Any such corrections must be made and the transcript returned to us. I have got 10 days down here, but we give you more time than that—tyranny of distance and all that.

Mr Hadjis: Thank you.

The CHAIR: If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on any particular point, we are very happy for that, and please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. Thank you again and thank you for your frankness.

The Witnesses: Thank you.

Hearing concluded at 12.46 pm