EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO ABORIGINAL YOUTH SUICIDES

TRANSCRIPT OF EVIDENCE
TAKEN AT BROOME
TUESDAY, 7 JUNE 2016

SESSION ONE

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 9.08 am

Mrs RAINA WASHINGTON
Manager, headspace Broome, Kimberley Aboriginal Medical Services, examined:

Mr ROBERT McPHEE
Deputy Chief Executive Officer, Kimberley Aboriginal Medical Services, examined:

The CHAIR: On behalf of the Education and Health Standing Committee, I would like to thank you for your appearance before us today. The purpose of this hearing is to discuss our inquiry into Aboriginal youth suicide, and let me begin by acknowledging the traditional owners of this land and expressing my gratitude that we are able to meet here today. I would also like to pay my respects to the local elders past and present. I am Graham Jacobs, the chair of the committee. On my left is Janine Freeman; on her left is Murray Cowper. Josie Farrer is going to join us, hopefully shortly. On my right is the secretariat, Alison Sharpe and Katie Parsons. The Education and Health Standing Committee is a committee of the lower house, the Legislative Assembly of the Parliament of Western Australia. This hearing is a formal procedure of Parliament and therefore commands the same respect given to the proceedings of the house itself. Even though the committee is not asking witnesses to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. This is a public hearing and we have Hansard recording the proceedings. If you refer to any documents during your evidence, you could assist Hansard if you provide the full title for the record.

Before we commence, I have got a few questions for you. I am sorry; they are procedural questions. Have you each completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIR: Thank you. I am sorry about this. Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes.

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

The Witnesses: Yes.

The CHAIR: Would you please state the capacity in which you appear before the committee today? I might start with you, Rob, and then Raina. Then, Rob, maybe I could ask you to give us a bit of an overview of what you do and how you see your organisation, and then Raina.

Mr McPhee: Thanks. I am the deputy chief executive officer at the Kimberley Aboriginal Medical Services. I would just like to firstly provide apologies for Vicki O'Donnell, who would have liked to have been here. She is the CEO of KAMS and has been in Aboriginal health for over 30 years in the Kimberley, so would have been perfectly positioned to be—but, unfortunately, she had to fly to Kununurra; she had some other commitments there. My capacity as deputy CEO is going to be a little limited because I have only been in the role for a short amount of time, just under six months, so I do not have the breadth of experience as others and I hope you get to speak to other people while you are in Broome, but certainly Raina has a lot of experience in particularly mental health—youth mental health—and I might let you introduce yourself.

Mrs Washington: I am here in the capacity as the manager of headspace Broome, so I am also an employee of the Kimberley Aboriginal Medical Services and have been for eight years, so I have been the manager of the service for eight years in Broome.

The CHAIR: Maybe we could just start with you, Rob, and just give us a bit of an overview of how you see your organisation, your role and the role of the organisation.

Mr McPhee: The Kimberley Aboriginal Medical Services, or KAMS, as I will refer to it, is a peak organisation here in Broome, and it is a peak organisation representing the interests of the Aboriginal medical services sector in the Kimberley. Our members of our board include the Derby Aboriginal Health Service in Derby, the Broome Regional Aboriginal Medical Service here in Broome, the Yura Yungi Aboriginal Medical Service in Halls Creek and Ord Valley Aboriginal Health Service in Kununurra. They are our frontline Aboriginal medical services that deliver primary health care across the Kimberley, and we are the peak organisation that was established primarily around providing regional centralised support for those medical services in the areas of human resources, accounting, information and communication technology, advocacy, lobbying and kind of peak regional representation. We have grown from a fairly small organisation in 1986 to an organisation of around 250 employees. Even though it is not within our remit, we provide clinical services to the communities in the Kutjunka region, which is Balgo, Billiluna and Mulan. KAMS delivers the primary health care clinic out there. We also deliver the clinic in Bidyadanga community, which is about 200 kilometres from here. We also deliver the clinical services into Beagle Bay community, which is on the Dampier Peninsula, and we also provide GP services to One Arm Point in conjunction with WACHS. The clinical delivery side of KAMS is a fallback position, so our model is that where there is no existing community controlled health service available or in a position to deliver those clinical services, KAMS will deliver those services until we can empower the community to take them on themselves. It is always our intention to remain as a peak body, as opposed to a service delivery agency, but we also ensure that those services continue to be delivered if they cannot be by other organisations.

We also have established the Kimberley Renal Service, which is a dialysis acute service that is delivered across the Kimberley, and we have dialysis centres in Broome, which is located alongside BRAMS. We have them in Derby, which is also located alongside DAHS. We have also got services in Fitzroy Crossing and Kununurra, and that is it. That is quite a large organisation as well. About 100 to 150 of our staff are associated with dialysis. We are very much a primary health care organisation. We also work with other partners such as headspace; we are an auspice for headspace here in the Kimberley, and we have partnerships with the likes of Boab Health and others in terms of delivery of primary health care services. Within KAMS, we are made up of a kind of corporate services unit, which supports the organisation. We also have a registered training organisation, which delivers Aboriginal health worker training to the sector as a part of our support to the region. We also have a social and emotional wellbeing unit, which is the part of our organisation which is probably most relevant to this committee. We also have human resources, finance—that type of stuff. We have a formal partnership with the Rural Clinical School with UWA, and they have a place in our office and that is around Aboriginal health research in the Kimberley. We also chair the Kimberley Aboriginal Health Planning Forum, so KAMS is the chair of that regional body which brings together all health players in the Kimberley to deal with all kinds of health issues.

Ms J.M. FREEMAN: Is there a published plan?

Mr McPhee: Yes, there is a Kimberley Aboriginal health plan. That committee has just recently endorsed the Kimberley Aboriginal Health Planning Forum suicide position paper as well for the Kimberley. We can make that document available for you. It is a position on what we understand to be the key issues and gaps in relation to suicide in the Kimberley—not specifically youth focused, but much broader than that. I am happy to make that available. That is a bit about KAMS.

The CHAIR: Thank you, Rob. Before we ask you questions, can we maybe just go to Raina and if you can give a little bit of an overview about headspace and then we will come back to questions.

Mrs Washington: I prepared a PowerPoint presentation that has got about 13 slides and it will take about 15 to 20 minutes. I can go through that or you can ask me questions throughout if you like.

The CHAIR: Could you go through that and we will maybe ask a few questions perhaps through that if it is going to be 15 minutes?

Mrs Washington: Yes, absolutely. Headspace, Broome, is one of almost 100 headspace centres across Australia. We have been open since July 2008. Broadly, the aim of headspace is to improve the mental, social and emotional wellbeing of young people aged 12 to 25. The concept is about having an enhanced primary care service where young people with mild to moderate mental health concerns are able to access a broad range of services that are connected, or we refer them to complementary services that we have partnerships with. We work across four key domains, and they are: mental health, physical health, drug and alcohol, and social and vocational participation. That is our core work that we support young people with those issues. This kind of holistic approach to young people's health is informed by the expertise of our lead agency, which we have identified as KAMS, and our consortium partners. To give just a little bit of an overview about the governance of our organisation and of our service, KAMS is the lead agency and we are very much embedded in that service. I am a member of the senior management team and we sit in on all of their clinical services meetings, management meetings and planning, so we are very much bound by those principles of Aboriginal community control, whilst still being bound also by the headspace national model.

In Broome, it is a requirement that we have a consortium of partners. In Broome, we have the Kimberley Mental Health and Drug Service team, Boab Health Services, Broome Youth and Families Hub, Nyamba Buru Yawuru, and Kimberley Population Health Unit, which is another WACHS organisation. It is chaired by an independent chair, Mr Emmett McKenna, and we have a youth representative from our youth advisory committee, Trent Caldwell. This consortium has been in place for the duration of the service, so, eight years, with meetings occurring every two months. Their role is to guide, support and have input into the way that the service operates and refer and support young people in need. Really key to the headspace model is having youth input, so we have a youth advisory committee.

[9.20 am]

The CHAIR: Sorry Raina, can people self-refer?

Mrs Washington: Yes, absolutely. Our youth advisory committee is a group of young people that voluntarily support our service. At the moment, we have eight formal members aged between 15 and 23. We have a closed social media Facebook page with 23 young people that we liaise with and consult with, run ideas past and talk with regularly. That is so they have input into the day-to-day operations of the service. They assist us in setting priorities. I guess it is all based on that premise that young people are the experts of their own health and, as such, we need to listen to them about how we work.

The configuration of headspace financially, in terms of resources, is that our core funding comes through headspace national, which is through the national Department of Health, essentially. As of 1 July, we will transition over to the WA Primary Health Network. They will become our contract managers. We also have a smaller bucket of money, through WACHS, to deliver the Footprints to Better Health program.

The CHAIR: Sorry, what is the core funding bucket of money?

Mrs Washington: The dollar amount?

The CHAIR: Yes.

Mrs Washington: It is $795 000 per year. The WACHS money is shared between headspace and KAMS. So we have, in the headspace component, a Dampier Peninsula position and a Broome-based position to deliver healthy lifestyle activities, which I will talk about that a little bit later but we also share—the same program sees an extra two or three FTEs over at KAMS delivering the Footprints to Better Health program. Then we have really meaningful and important co-contributions from our consortium partners. KAMS provides us with four GP sessions per week, so, afternoon appointments and full primary health care service in the service. They are free half-hour appointments for young people. The mental health service provides a consultant psychiatrist and his registrar for four appointments per month. Boab Health Services provide us with psychologists and dieticians, again, for two appointments per fortnight. Then, through our partnership with the Broome Youth and Families Hub, we have two healthy lifestyle activities per week.

In Broome, we have an independent shopfront. It has three counselling rooms, an AGPAL-accredited GP treatment room, so we follow the RACGP standards of delivering a fully functional, almost private practice but which is much more accessible. We have seven full-time staff based in the centre. That is myself, the centre manager, admin, three full-time equivalent youth mental health professionals—at the moment, they are mental health nurses and social workers—a youth engagement project officer, and two youth social and emotional wellbeing workers; they are the Footprints to Better Health positions. One of those is based in Ardyaloon/One Arm Point, which is a Dampier Peninsula community.

The CHAIR: Can I just ask you—I will put this in a very crude way, perhaps—but how many youths are on your books?

Mrs Washington: I have a section later about data that talks about access rates over the past nine months. I can go through that.

The CHAIR: I will wait for that, thank you.

Mrs Washington: These things are really the objectives set by the national office. They are important to talk about in terms of what headspace is about and the way that we work. It is very much a young person–centred service so we want to make sure we are engaged with our community, that the community knows who we are, and how to access us. Ease of access is really important so we do not have complicated referral pathways in. A young person can walk in the door and say, "I'd like to see somebody", and we will endeavour to make that happen. They do not require GP referrals or referrals from a third party.

Integration: we need to be connected with our partners and with other key service providers. We need to be cost effective and long term. There is a very big emphasis on evidence-based high-quality service. That comes through headspace national who came out of the University of Melbourne Orygen Brain and Mind Research Institute, so there is a lot of evidence behind the way that we work and deliver those evidence-based services. In addition, the Footprints to Better Health program is specifically funded to increase Aboriginal and Torres Strait Islander young people's knowledge and practice of healthy lifestyle behaviours. In this instance, we are talking about physical activity, diet, healthy relationships, connecting with culture and community, and help-seeking. They are the big picture objectives about what we do.

We deliver clinical services in Broome only and then, on the peninsula, we deliver our healthy lifestyle activities. We will do health promotion and community awareness–raising activities across the West Kimberley, where we are invited and where we have capacity. I have already touched on those principles, but I think it is important to emphasise I think the headspace Broome model is particularly strong in the Kimberley, given our connection with KAMS and that focus on making sure that we work in culturally secure ways, that we are informed by our SEWB team, that they sit in on our clinical review meetings and our intake and they assist in oversight. Any documents that we develop, we seek their advice regularly. Some of those other things are about us being an early intervention service; so for young people with mild to moderate mental health concerns. We are not

an acute mental health service or a crisis service. Our funding agreement currently talks to us about providing short to medium-term solutions—brief interventions. There are limitations to that when we are talking about working with Aboriginal young people, and a lot of young people, but as we move to a new kind of outcome-based world I think that there needs to be some ability to not be bound by the six sessions of Medicare interventions because it takes longer to build relationships, particularly for young people who are most at risk.

This is our service activity. You will understand from what I have said that there are multiple pathways in and multiple services happening. Our two main, key streams are our primary health care service and our counselling service. At the moment our data collection tool is a system that has been created by headspace national called the minimum data set. For us to be able to demonstrate our activity and our effectiveness, the current tool requires young people to complete a survey each time they access the service and for the service provider to also complete that survey. That system was introduced in 2012 and it has been a really challenging data collection tool. Young people are pretty reluctant to complete that when they walk into a service to seek help. They would rather talk to somebody than complete a survey, our experience tells us. For the period —

The CHAIR: So you can help them while you are talking to them.

Mrs Washington: Yes, they can be helped.

The CHAIR: You could help them fill out the form, could you not?

Mrs Washington: Yes, of course.

The CHAIR: What is that time frame there—July?

Mrs Washington: That is a nine-month period.

The CHAIR: That is July 2015 to March?

[9.30 am]

Mrs Washington: Yes.

There were 804 occasions of service. That is 255 new young people seen and 109 new young people. The average number of visits for young people is 3.2. Fifty-four per cent of those young people presented with mental health concerns and 31 per cent with physical or sexual health. The Indigenous access rates are low in this one. Our experience over the years has been that it is usually much closer to 30 per cent, but this is what the data is showing in this instance. You will also see that most of the people are in that kind of 17–25 age range, so we do not see a lot of younger young people here. I think that is because we are one of the few services that works with the 18–25 age range. A lot of the other youth services in Broome tend to work the 10–18 kind of age range.

The CHAIR: Can we just go back to that? I could just ask you anyway—can I?

Mrs Washington: Sorry; you could, yes.

The CHAIR: The 20 per cent Aboriginal from that data, the engagement of Aboriginal youth in the community—this is a Broome-based service really.

Mrs Washington: Yes.

The CHAIR: And there is no really significant outreach into communities.

Mrs Washington: No.

The CHAIR: When youth engage in your service, if a young person walks in to your service, can you just walk us through what happens with that? I understand whether they have a mental health issue or whether they have a physical or sexual health issue or whatever it is, who is available there at the time and how do you walk them through that? When they say they want to see someone, who

is there to see them? Do you see them straightaway or is an appointment made for them? How does it work?

Mrs Washington: If a young person walks through the door and wants to see a counsellor, we will endeavour to link them with one of the youth mental health professionals, but they might be in an appointment seeing another young person. In the case where there is a mental health professional available, they will sit with the young person and go through kind of an intake form—collect some information about what is going on and what help they would like. They will do a risk assessment, make sure they are safe and that there is some support, because we do a weekly intake and allocation meeting. That initial access is managed fairly briefly and then that goes to an intake meeting. If a young person walks in or calls and there is no-one available, the person on the end of the phone will take some information, some contact details, and they call the young person back and get some more details about what they are after and then again that will go to the intake and allocation meeting. That is the point at which they are allocated to one of those mental health professionals or a SEWB worker.

The CHAIR: Raina, what if someone comes in and says, "I feel pretty low and I want to take my own life"? You said you do not deal with necessarily the acute situation, but what if that certain acute situation presented—how would you manage that?

Mrs Washington: It definitely happens. It again depends on who is in the building, but there is —

The CHAIR: Who could you likely have in the building? Just run me through that again, could you?

Mrs Washington: It would be myself, our admin person, an SEWB worker —

The CHAIR: What is that?

Mrs Washington: A social and emotional wellbeing worker—and one of the youth mental health professionals. If they are around, one of those guys is able to sit with the young person and do a more thorough risk assessment and then explore: is the risk that high that they need to be taken to the mental health service? Are there family or other supports that can be accessed to support that young person? If it is possible, we always try to link them with a GP, if there is an appointment available that day, so it is around kind of safety planning.

The CHAIR: Do you have a GP in-house doing sessions in the —

Mrs Washington: Yes. Four afternoons a week.

The CHAIR: Four afternoons a week?

Mrs Washington: Yes.

Mr M.J. COWPER: This is a great snapshot from July to March. One of the reasons we are here is because of an apparent increase in the number of people who have been successful in suicide, particularly in the Kimberley but also it seems to be a phenomenon, as we have just discovered, not only in Western Australia but Australia and internationally —

Ms J.M. FREEMAN: For Indigenous communities.

Mr M.J. COWPER: No, not just Indigenous —

Mr McPhee: Higher rates.

Mr M.J. COWPER: This is being reflected—what was your other periods preceding that? Is what you have been dealing with fairly consistent or are we seeing a spike?

Mrs Washington: In access or in?

Mr M.J. COWPER: In everything. Are we facing what appears to be an epidemic?

Mrs Washington: From our experience—and this is one of the limitations of the headspace model—we are not seeing young people that are taking their lives, so they are not walking through our service door. We are not connecting with those young people for whatever reason. My experience in the youth sector in Broome is that the numbers of young people in Broome taking their lives are not spiking, are not higher than they have been previously. If anything, there was a previous spike, I think, in 2010 when there were lots of high rates across the region but, if anything, the numbers are still high but there are no spikes at the moment and they tend not to be in Broome.

Mr M.J. COWPER: That is just in Broome?

Mrs Washington: Yes.

Mr M.J. COWPER: The statistics will show—I hate using statistics, because these are actually human beings—that there were something on average of 30 in the Kimberley region on an annual basis. So far, until the time we started this inquiry, there have been 19, so at that current trajectory, we are going to see almost a doubling in the numbers. It is concerning to start with, but it is doubly concerning.

Mr McPhee: We find from our research that suicide tends to occur more often in the Kimberley around particular periods of time. October and the wet season are the highest periods of suicide. It is often a very difficult time anyway in terms of the oppressive weather. It can be called all sorts of names like banana season or loopy season because it does tend to —

Mr M.J. COWPER: Cicadas—those cicadas, they are noisy!

Mr McPhee: I am not sure whether, if you look at the statistics over a period of time, there is necessarily a spike or whether we have come through a season where it is traditionally quite high. But certainly suicide is increasing. It is disproportionately high for Aboriginal people in the Kimberley. We found that 70 per cent of people who have suicided in the Kimberley have never accessed a mental health service. They are not the sort of people who are presenting to GPs, psychologists or counsellors. These are people who have never been seen by the mental health services in the Kimberley?

Mrs Washington: Yes and I think the big challenge is that suicide is a mental health issue. Because people do not have mental illnesses, it is a symptom of greater community despair I think. It is —

Mr McPhee: Dysfunction, social —

Mrs Washington: Yes; it is not about services missing people; it is the fact that the services are not being accessed for whatever reason. We are not being seen as an option for people to come and talk to and in some cases where those suicides are occurring, the services are not on the ground.

Mr M.J. COWPER: So, just to home in on that a bit, is it a case that the services are not available to them, or they just choose not to?

Ms J.M. FREEMAN: They do not see themselves as mentally ill.

Mrs Washington: There is a lot of stigma around a service like headspace particularly. Young people have told us that since we have been open, “I don’t want to go there, I’m not crazy.” There is a really strong history in the Kimberley about fear of what happens if you access mental health service. Before we had the acute mental health unit here, people would go to hospital if they were really unwell and get sent on a plane to Perth and mysterious things would happen there and then they would come back and be different. There is a lot of stigma around what it means will happen to them, so I think it is a combination of both: sometimes services, and not just mental health services but I think all these kinds of places that people interact with community services.

[9.40 am]

Mr M.J. COWPER: Raina, how long have you been working in the service?

Mrs Washington: Eight years with KAMS and four years running the Broome Reconnect service, which provides support to young people who are homeless or at risk of homelessness.

Mr M.J. COWPER: Whilst I am aware that there are contributing factors to it and every case is different, is social media an issue? Is that a way that young people can now communicate and change the landscape a bit?

Mrs Washington: Yes; I think it is. Young people have a lot of knowledge about how social media service provider staff do not necessarily have that and I think the way that young people communicate in the access to information. It is certainly different.

Ms J.M. FREEMAN: Is headspace working in that area so that they can do positive stuff through social media, because they were talking about that at the conference in New Zealand?

Mr M.J. COWPER: Can they be contemporary, yes?

Mrs Washington: Yes; absolutely, so at the moment at a national level, they are about to launch a campaign called "The Big Stigma." It has an online component through their Facebook page. Young people engage very well through a Facebook page. I think you have to work at it consistently. I have seen over the eight years that our service has been open, it has improved. We have worked really hard with some of those hard-to-reach groups of young people through the PCYC alternative education program and the drop-in centre to get young Aboriginal men who are prolific priority offenders walking the streets at night—you know, drug and alcohol use, coming in and seeing a GP once a term. It has been a huge piece of work to get that happening. For two years before they would not speak to our staff. They would not walk in the door, telling local Aboriginal staff, "I am not going there; I am not crazy." Now, they will come in the back; they will see the GPs. I think they are small steps but they are indicative of the work that it takes and the real kind of outreach approach you have to have in working with the most at-risk young people.

Mr M.J. COWPER: On this chart you have here, 24.27 per cent Indigenous, so we are assuming that 79.8 per cent are non-Indigenous, which is surprising. When you think of the population of the Kimberley, it is about 50 per cent Indigenous.

Mr McPhee: Broome is probably around 30. Given headspace is Broome based, it is a bit different from the rest of the community.

The CHAIR: Raina, one could say that perhaps there may be a gap. Would you share with us how you think we could overcome that gap and try to improve the engagement?

Mrs Washington: Yes. I do intend to go over that. I did do a slide about some of the gaps.

The CHAIR: How can we engage more of the Indigenous community with the 20 per cent? I am sure that headspace in some of the areas I have seen did tend to bridge the gap, because you would come to headspace not because you had a mental illness necessarily; you might have a social issue; you are not nuts, you are just wanting support in some way, even support in how to get a job?

Mrs Washington: Yes, absolutely; it is a really important part of wellbeing; having a purpose and income stream. So some of the gaps that I see in the considerations for maybe solutions are around youth, alcohol and other drug services; family inclusive ways of working, which facilitate healing in past trauma and loss. So when you are looking at an Aboriginal context, headspace is very much about being young-person centred on that individual. There are huge limitations of that, particularly for Aboriginal people. From a family, their community is key and we are really limited in how much we can work with the family, so there needs to be investment in that, whether it is through other services or through the headspace model. The impact of trauma and loss cannot be underestimated and those big things like intergenerational trauma, stolen gen—these things are continually talked about but they impact our young people because, like I said, suicide is a symptom of an unwell community. They are impacted by their family being distressed. I think there needs to

be culturally informed ways of working so we look in mainstream services. The headspace model is a mainstream medical model but to engage with people who are really distressed, living remotely, have not attended school, major drug and alcohol issues, family violence, you need to be working with our elders; our social, emotional, wellbeing staff; Aboriginal health workers to be able to engage with them. There needs to be culturally validated evidence-based risk-assessment screening tools. They need to be embedded in hospitals, in health services and housing services, not just in mental health services.

Ms J.M. FREEMAN: My understanding is that if you go into a hospital in South Australia, there is a cultural worker in South Australian hospitals. Are you aware of that? If you go in as an Aboriginal person, there is someone who can work with you—the cultural appropriateness of fee for service.

Mrs Washington: We have an Aboriginal liaison officer role with the hospital.

Mr McPhee: But it is really about integrating people into the hospital and making sure that everything is okay.

Ms J.M. FREEMAN: It is about getting them to adapt to the medical system.

Mr McPhee: Yes; this is what they mean when they are telling you this is wrong with you.

Mrs Washington: You can tape up the self-harm, but did you ask about it? What is the plan for when you leave here? What are the referral pathways that have been discussed? How are the nurses working with that stuff? There are tools. Tracy Westerman is one example of a culturally validated risk assessment tool for Aboriginal young people around preventing suicide. It is evidence based, it is expensive but it is something that is out there that is a possibility. I think there needs to be more education and training about identifying and managing suicide risk for community members and young people, not service providers. A lot of suicide prevention training comes to the region and ends up being delivered to service providers. We have no after-hours services in Broome basically other than hospital and police. Families and friends are the people who are sitting with people when they are feeling suicidal. They need to be equipped to support them through that.

Ms J.M. FREEMAN: That was one of the questions I wanted to ask you—whether your Aboriginal health workers are trained in that and do you do training around suicide prevention?

Mr McPhee: Not specifically. Mental health is one of the areas that they look at but not in any detail. The Aboriginal health worker curriculum is largely a nationally accredited curriculum. We adapt and we modify for the region. We talk about the issues facing Aboriginal people in the region in relation to suicide. There are not a lot of resources around teaching specifically.

Ms J.M. FREEMAN: I gather that is accredited by the health department and the training providers.

Mr McPhee: APPRA.

Ms J.M. FREEMAN: So it would be appropriate to talk to them about the fact that there is a necessity that they have suicide prevention training. Is that an appropriate thing for them to have?

Mr McPhee: You can certainly do additional training. That is one of the things we have been talking about to WAPHA, the primary health network up here—how do we equip Aboriginal health workers with other skill sets such as suicide specific skills?

Ms J.M. FREEMAN: I would have thought if they are Aboriginal health workers, people would come to them after hours and stuff like that.

Mrs Washington: The Aboriginal health workers are not in WACHS services so they are not in hospitals. I think that is probably the first step—to have Aboriginal health workers with those skills in hospitals because they are in the Aboriginal medical service that closes at 4.30.

Mr McPhee: That is right and we only see people who walk through the door to see a doctor or who have come there by themselves to take some sort of action around their health. That is the

clinical model that we deliver as well through medical services. A patient comes in to see somebody, we do some triage and the health worker will do an assessment but it is usually health related.

Ms J.M. FREEMAN: It is all over by 4.30 and they close the door. Those workers would live in the community. They might walk away from the job at 4.30 but —

Mrs Washington: They do not really.

[9.50 am]

Mr M.J. COWPER: What do the police do if they find themselves in need of support? Are they on their own? Are they committed to the hospital or is there a callout service or some sort of arrangement?

Mrs Washington: There is a good relationship between the police and the hospital and the mental health service. I chair that mental health planning forum and there is a group within that that police, the standby suicide prevention service, the hospital and the mental health service all collect and share data and then respond so that the police department big boss collects data around self-harm. They have a policy where they —

Mr M.J. COWPER: That was Superintendent Mike Sutherland.

Mrs Washington: He had a really clear process of making sure —

Mr McPhee: We have a new one now.

Mrs Washington: Yes; he has gone. He would make sure that, even mentioning the word "suicide" or "self-harm" would be shared and a referral made to the mental health service. They do the best they can, I think—the police in Broome.

Mr M.J. COWPER: Has that been successful?

Mrs Washington: There are limitations to the data. It is above and beyond the role of the police and they have tried to collect it but then the qualitative stuff is not there. These are the numbers of callouts, this is where they happened but there is no context. The issue around a resource to analyse and make sense of what that data is and then work with other services to respond to, if we can see peaks in times or days in certain communities, if it is starting to be clusters. That is the hope; that was Mick Sutherland's idea, I think, to be able to get all this raw data and then be able to use it.

Mr M.J. COWPER: Are you aware of any patterns emerging out of that?

Mrs Washington: There has been over the past, yes.

Mr M.J. COWPER: What were they?

Mrs Washington: I think we saw spikes in places like Derby at certain times of the year. Sorry, that was in Kununurra, probably 18 months ago. Key services sat down and said, "Okay, we need to take some resource from the service in Broome and took that up to Kununurra to respond to that need, which was a good example of having timely access.

Mr M.J. COWPER: I suppose there is no real way of measuring how successful that would be.

Mrs Washington: It is really difficult. I think that was one of the things I said. How do we measure success and health and a life saved? I can say we have seen these many young people and I could say in one breath Headspace is in the business of suicide prevention but everything we do every day is about preventing suicide and maintaining health and wellbeing but you cannot measure it.

Mr M.J. COWPER: The other question is: once there is a spike somewhere else and those resources are pushed somewhere else, does that mean that that person is saved forever or are they going to reappear or re-emerge?

The CHAIR: In the social and emotional health and wellbeing and support, you did talk about a potential gap in the service because it is nine o'clock to 4.30 pm and after that, we know that things often happen after hours or on the weekend. Do you see your role as trying to perhaps fulfil that role in emotional health and wellbeing or do you believe that it is probably the Kimberley mental health service?

Mrs Washington: For after-hours service?

The CHAIR: For after-hours support, yes.

Mrs Washington: After-hours crisis would be better placed in an acute kind of setting.

The CHAIR: And of course the after-hours events would more likely be crisis.

Mrs Washington: Yes, but I think the key is managing those crises. That is what the hospital does now—makes sure that there are really supportive, clear, established referral pathways so you can manage the crisis after hours but you are keeping that person alive and say what you need to do to prevent it happening again is to have a good plan post —

The CHAIR: When they go home.

Mrs Washington: Yes. How are we going to go when you are back at home?

The CHAIR: How does that happen now? If a youth is taken to the hospital and they are sent home or treated and sent home, do they engage the Kimberley mental health service or you guys? What is the pathway?

Mrs Washington: At the moment they make a decision depending on the level of risk of the young person. We occasionally get referrals from the hospital for someone who has presented overnight and is distressed and they will be then referred to our service for ongoing counselling and monitoring. If they are more acute and their level of risk is too high, they may stay with the mental health service. They may spend some time in the inpatient unit or they might be referred to other services as well.

Ms J.M. FREEMAN: You said two really important things. One was that the suicide prevention training tends to go to service providers, not families, and families are the ones who are dealing with it. My first question is about how you envisage that happening. That was a key out of some of the New Zealand stuff, which was, you know, families had to be involved in that process and other young people. The second is I just want to ask you about the role of Aboriginal health workers—you said they are not in general hospitals; they are with KAMS—and where you see whether they are a good tool or resource in this space.

Mrs Washington: If you are asking me, I think to deliver training like this to Aboriginal people, you need to engage and empower your Aboriginal staff to talk with people about this because there is a lot of fear around being trained in this as well. What happens, if I have this knowledge now and somebody still goes and completes suicide, I am responsible, so that is really real. The only reason we have success with the Aboriginal communities through our connection with KAMS and our Aboriginal staff who are trusted, you cannot do this alone, and I think from a headspace perspective, I would really see the role of Aboriginal health workers in mainstream medical services as a no-brainer.

Mr M.J. COWPER: It also throws up a parallel situation. Whilst the Kimberley is a big place, it is also a small place. It is big in land, but small in that everyone knows each other. Most often, people are related, so if someone was to emerge from an Indigenous background and came and sought services, the drums beat, if you know what I am saying, so I suppose that all comes back down to the breakdown or education that needs to continue in that area. I just realised when you were speaking that that would add to the uniqueness of this basic problem.

Mrs Washington: I think that we mentioned before about the concept of health and wellbeing from an Aboriginal perspective and the article I referred to was written by Eunice Yu and Mandy Yap. It is called Yawuru ways of wellbeing or something; I will find out the correct name of the article. It is an amazing article about how white mainstream services really need to reframe how we think about wellness and health, and give a lot of that power back to Aboriginal people to say, "Hey, you know what? My health and wellbeing is about how often I can be on country, speak language, share my fish with my family." It talks very clearly about things like that, rather than—you know, they referenced the Closing the Gap program, and we measure success in terms of how many people are now in employment or have finished years 7 or 10 or whatever at school, so I think that has to shift before we can start seeing success as well, and I think that is a really important thing because we talk so much about deficit, but there is a lot of health and wellbeing and strength and positivity in the Aboriginal community here. But, yes, that is one thing.

Mr M.J. COWPER: Do you spend much time in Derby?

Mrs Washington: We go there and do a little bit of health promotion when we are invited, and we do get people call us from Derby. I get calls from the East Kimberley regularly around, "Will you guys come here? What services are there for young people?"

Mr M.J. COWPER: Do they come from Kununurra?

Mrs Washington: Kununurra, yes, and occasionally from Fitzroy. Derby is quite well resourced, but we do get calls from young people. Sometimes kids travel from Derby to access our service.

Mr M.J. COWPER: Just on drug issues, they would be different in towns to the remotes, alcohol being probably the one that is of concern in the remotes, and probably other stuff in the bigger towns.

[10.00 am]

Mr McPhee: Again, I think from our perspective alcohol is a symptom of other issues. It is certainly a contributing factor to people's mental health, but it is around the kind of social indicators that are the issues that underlie suicide, from our perspective. The reason people are drinking is because of intergenerational trauma, because of no job opportunities, because they have no money and just do not have a very good life. It has been like this for a long time, my grandparents have experienced it, and alcohol becomes a symptom of those sorts of issues that are not resolved, and I think that is what a lot of the international evidence is showing as well. It is about colonisation, it is about dispossession, it is about loss of language and connection to country, and that is what this paper is about—in order to get healthy, in order to stop thinking about killing yourself, you have got to feel good about yourself.

Mrs Washington: It talks about the wellness measure—the Yawuru —

The CHAIR: Have you got that document's specific detail there?

Mr McPhee: Yes. It is called "Operationalising the capability approach: developing culturally relevant indicators of indigenous wellbeing—an Australian example". I forgive Raina for not knowing it!

The CHAIR: Is that the short title?

Mr McPhee: It is in *Oxford Development Studies*, so they needed to have a pretty flash title!

Ms J.M. FREEMAN: Yes, that is right—those titles are always amazing, are they not?

Mr McPhee: Yes.

Ms J.M. FREEMAN: There are some people who say that FASD has an impact on suicide. Have you come across any information around that that you have heard? I get what you are saying and I want to acknowledge what you said, which was that we are talking about deaths and there is so more strength and capacity and a celebration of culture in the communities, but, unfortunately,

we are here to talk about deaths, so that is a sad thing and I acknowledge what you say, which is that alcohol is a symptom; it is not the cause. But has KAMS seen an increase in FASD or any matters around that?

Mr McPhee: We do not have any data around FASD; FASD is fairly new in terms of being recognised as a genuine health issue and mental health issue because it does affect people's brain development and behaviour, but there is not a lot of data around connecting people who have FASD with other incidents around suicide or other health issues. There is a real lack of data; it is a bit of a void. I know that in Fitzroy Crossing they have really spoken loudly and said, "This is a major issue; we're underestimating the impact of FASD", and I would have to completely agree with that. We do not have the resources, we do not have the data, we do not really know what the issue is and how that is impacting on whether or not some of the increases are related to some of those issues around brain development in early years. It is certainly an area that needs more attention. There is some research that has been done, I think —

Mrs Washington: Through the Telethon Institute.

Mr McPhee: Yes, the other guy, James —

Mrs Washington: Fitzpatrick.

The CHAIR: Under the Yiriman Project in Fitzroy.

Mr McPhee: Yes; so there is some research being done, but certainly not enough in terms of giving us any insights into how FASD is having a broader impact across the community.

The CHAIR: Can I ask you a sort of generic question, and you do not have to answer the question if you do not wish to. From where you sit, does a gap really appear to you in funding allocation, particularly from the state government's point of view, in delivering your health service? Can you say that there is a significant gap here, and that if we had more money, we had some allocation of funds, we could do this better —

Mr McPhee: Absolutely.

The CHAIR: — recognising, of course, that money does not fix everything?

Mr McPhee: Yes. I think one of the key outcomes for us is replicating the model that we have with headspace here in Broome. This is only in Broome, and ideally we would have this model delivered across the Kimberley. It is only available to young people who live in Broome; there is no such service anywhere else in the Kimberley. That is a real issue, having that kind of mental health direct support, otherwise the system could be quite difficult to navigate, whereas the model that headspace has is very approachable, and even then you struggle sometimes because of the issues around people's perceptions around mental health.

The CHAIR: Because the engagement, Rob, is still fairly low there—20 per cent—for Indigenous people.

Mr McPhee: Yes, absolutely—20 per cent, you know —

The CHAIR: But do you think, maybe—sorry to butt in, but do you think the allocation of funds to provide the headspace model out into communities, because you have not got the capacity to do much outreach into communities, have you?

Mrs Washington: Not with the current model and the current service agreement with the national office, but, yes, there is a lot of unmet need out there, and I think what makes the headspace model strong is that it is led by community needs, so if we were to develop a service in Fitzroy, you would create a model based on what the community there needs, and what the resources are, and it would look different to the Broome model. You know, there would be a greater focus on engaging with Aboriginal people, and with this change of national office not being our contract manager and WAPHA being—there is great opportunity for models to develop based on need and have some of

those elements of the headspace model that are strong, and then further grow to incorporate things like family-focused work.

Ms J.M. FREEMAN: Because the family-focused work you are saying is really quite important.

Mrs Washington: Yes.

Mr McPhee: Yes; it is key. It is where you are dealing with a lot of the trauma and dysfunction, and if you are not addressing that—like we said, 70 per cent of the people who have suicided in the Kimberley have not seen a mental health service provider, so, you know —

The CHAIR: Have they seen anybody? They have not seen you guys either.

Mrs Washington: No.

Mr McPhee: No. We are considered a non–mental health service provider, so I think —

Mrs Washington: We are not, yes.

Ms J.M. FREEMAN: They are not accessing the GP even.

Mrs Washington: No.

Mr McPhee: That is right.

Ms J.M. FREEMAN: But they may go and talk to their family, and there may be someone who can talk to the family. So you might not want to do stuff around—if you do something culturally appropriate, and you use Aboriginal health workers, for example, you might not call it Aboriginal training in suicide prevention; you might call it strengthening families.

Mrs Washington: Well, you know, like, I think KAMS needs to be given credit for the Kimberley empowerment, healing and leadership program. I do not know if you guys have heard about that, but that is a program that has come out of Aboriginal suicide, and that is suicide prevention, but it is not called suicide prevention, and I have had Aboriginal staff who have done that. It is incredibly powerful, because it looks at all those things.

Ms J.M. FREEMAN: Where do you get the funding for that?

Mr McPhee: We are funded by the federal government—IAS funding. We are provided, I think, about $500 000 a year to deliver a range of social and emotional wellbeing training courses, but one of those is the Kimberley empowerment, healing and leadership program. But, again, in an ideal world, we would be delivering that to more places around the region. It is a highly resource intensive course. It is for two and a half days a week for five weeks. It is about engaging ordinary community people and putting them through a self-awareness and self-development program that helps them heal, and helps them deal with issues themselves, but also then helps them to identify other people at risk and provide them with just basic intervention support, or being the right person at the right time to just kind of calm things down. It is a program that, if we had more resources, we could be delivering it a lot more. There is a lot of demand on us to deliver it. There is a lot of opportunity. We are going to Beagle Bay, working with headspace to try and trial, you know, the delivery of the program in a discrete community. So you have got all of these trained people in the community who are then capable of responding to issues as they arise. Then, the idea is that they do additional training with us and they become trainers themselves. We do not hold it; we pass it on to people who are interested to deliver it.

Ms J.M. FREEMAN: One of the things that came out in one of the breakout groups that I went to in New Zealand was that they kept on talking about all this positive stuff that people were doing in their community—in this one particular community—and then someone from the audience asked about violence and sexual assault. I am just going to bring the elephant into the room here now that the ABC has left. Does the empowerment project—what is happening in that space around talking to people about sexual assault and violence in the community? Is it a problem? It is a problem in my community.

[10.10 am]

Mr McPhee: I think it is a problem everywhere. It is a problem, if it is occurring, absolutely. I think the challenge you have got with casting issues like that in communities is that it can be very divisive and it can be very debilitating too, because the community, unless they are ready to resolve issues that are going on—and I know, again, part of the reason why we are looking to take the KEHLP program to Beagle Bay is that they have come together and have said "We are not tolerating violence; we are not tolerating child sexual abuse; we are not going to stand for this anymore. We need to take control as a community." I do not think it is necessarily any different to any other community where you have got that social dysfunction, where you have got a history of violence, you have got a history of sexual abuse. It is about how you respond to it, and it needs to be responded to at a community level, and people need to be empowered to be able to take control. That is very difficult when you have got a history of people covering things up and protecting family members. But I think there is a swing; I think there really is. People are starting to say it is not okay, you know. People are standing up.

Mrs Washington: We have young men coming into our service, saying, "I'm starting to see myself behaving in this way, and I don't want to do that. Help me to learn what is a healthy relationship." That is an amazing presentation, and you really want to harness that. My clinicians would say, "I'm not really sure how to work with this." There are specific skills as well, and then there is the cultural layer on top of that around keeping people safe. It is an area that needs probably a little bit more investment and resources as well around perpetrator support.

Ms J.M. FREEMAN: Yes. The perpetrator support is the strongest aspect of changing behaviour, is it not? In your suicide position paper that you are going to send us, was there any information around whether there were links between sexual assault and suicide or violence?

Mrs Washington: We talk about relationships a little bit, do we not?

Mr McPhee: Yes, there is a little bit about relationships, but, again, I think the paper itself is really about bringing light to the issues around the causal factors, so that suicide, alcohol abuse and child sexual abuse are all issues that are bubbling above it, but the causal factors are really what needs to be addressed.

Ms J.M. FREEMAN: So it is culture and language?

Mr McPhee: Yes, connection to culture. It is about healing trauma. It is about economic opportunities. It is about creating education, and creating a change in people's lives that is positive. Until you do that, and heal the past, you are going to continue to have that kind of level of dysfunction.

Ms J.M. FREEMAN: That is a bit of a long-term strategy —

Mr McPhee: Absolutely. If we had started 50 years ago, we would be in a much better place today.

Ms J.M. FREEMAN: I was born 50 years ago. So the Kimberley empowerment—that is what that tries to do.

Mr McPhee: Absolutely.

The CHAIR: So KEHLP is delivered in how many places, Rob?

Mr McPhee: We are funded to deliver two per year—two sessions per year through IAS, and then we deliver around 28 other training programs, which include mental health first aid, ASIST suicide prevention, protective behaviours. Youth mental first aid, I think, is another one that we deliver.

Ms J.M. FREEMAN: And there is an Aboriginal first aid —

Mr McPhee: Yes, Aboriginal mental health first aid, red dust healing, sexual health awareness. There is a whole range of different training that we are funded to deliver, and KEHLP is one of

them, but KEHLP is really one that is targeting the kind of healing component of trauma and past issues that have gone on in people's lives. The others are kind of specifically around suicide.

Ms J.M. FREEMAN: What you are saying is that the others tend to be for the service providers, not for people.

Mrs Washington: While they tend to be accessed by them, they can definitely be delivered to communities but —

Mr M.J. COWPER: Rob, if you can take a step back and have a look at the big picture and not just from a KAMS perspective, I understand that some very well intended organisations have been doing some volunteer work in that area, and in some cases there have been people working across each other and there has been a lot of duplication of some services. How can they be better coordinated, do you think, or is there a need for better coordination? Are there areas in which we are wasting money for instance, that can be better utilised?

Mr McPhee: I am probably not in a position to know where the wastage is.

The CHAIR: Rob, excuse me; we are not overlapping here, are we? Headspace, you guys and mental health service, are you all coordinated on the same page in delivering services to communities and you are not actually overlapping and you know exactly what everybody is doing?

Mr McPhee: Absolutely.

Mrs Washington: I believe, between those three services, there is a lot of clarity, yes.

Mr McPhee: Those three, yes; we have strong relationships between those. We are strong partners.

The CHAIR: In your KEHLP program, for instance, what does it mean for an Aboriginal community? You see two per year; what do they get—two sessions or forums run per year? I do not understand. What is the spread?

Mr McPhee: The course runs for five weeks.

The CHAIR: Who gets it and how often?

Mr McPhee: It is individuals in communities. I think it is up to 10 people.

Mrs Washington: Yes, up to 10—fairly small numbers.

Mr McPhee: They are small groups of people that come together and we promote it in a community and they let us know that they are interested. Once we get enough numbers, we will go in and deliver that course. Then we follow it up once a week for five weeks. During that time, they have got to go away and do some thinking and do some planning. It is delivered based on demand. Also, because of the amount of time it takes to deliver it, we do not have enough people to be able to it more often than what we are doing now. We are funded to run it twice a year. We do it probably four or five times a year.

The CHAIR: What did it mean to communities like Fitzroy Crossing, Halls Creek and Warmun? What does it mean? Where was the last service provided and for how much?

Mrs Washington: We ran that in Broome.

Mr McPhee: Yes, we were in Broome.

Mrs Washington: There was one in Balgo, so that was maybe 12 months ago, but I am not sure of any other.

Mr McPhee: Look, I can get those details. I just do not have them now.

The CHAIR: Yes; I was just wondering about penetration and the spread of that to make a difference, that is all.

Mr McPhee: Yes. We certainly would like to deliver it more often than what we are. We are unable to keep up with the demand based on —

The CHAIR: And the communities put their hands up for that, do they?

Mr McPhee: Yes, so individuals; and once we have got individuals who are interested, we get others engaged and we deliver the program.

The CHAIR: Can you reiterate? There is the KEHLP program and Mental Health First Aid. Can you provide us with a list of those?

Mr McPhee: I can provide you with a list.

The CHAIR: Thanks; that would be great.

Mr McPhee: I will send them through to you.

The CHAIR: You will get a transcript of this and then you could send it back with the transcript.

Mr McPhee: Great. Back to your question about —

The CHAIR: Sorry about that.

Mr McPhee: — the ideal world. For me, I think part of what we need to do is—suicide is not a youth issue; it is an issue across ages. I hope I am not speaking out of turn. For me, it is about, from a youth perspective—I think the district leadership group, through the regional reform stuff, is focusing on youth in the Kimberley at the moment. They are doing a piece of work where they are looking at all funding coming into the Kimberley that has a youth focus.

Ms J.M. FREEMAN: Who is doing that?

Mr McPhee: The regional reform unit through Terry Redman's—what do they call them? Yes, the regional reform services. They have got district leadership groups. The West Kimberley currently is looking at all of the youth funding that is coming into the region in order to understand whether there are any gaps or whether there is bad coordination. Certainly, I think coordination is critical, particularly around referrals and around trying to keep people engaged once they have become known to a service provider. Having coordination so that you have got that kind of care pathway is really important but, also, it is about understanding or mapping what are the issues and then looking at what programs you have got that are currently addressing those issues and then where are the gaps. We operate, unfortunately, a lot on the basis of what funding is available. Our service delivery model is the result of opportunistic funding rather than a complete comprehensive strategy on the primary healthcare needs of Aboriginal people in the Kimberley and this is the service that we need to deliver and let us track it and see whether it works. We do not work like that. We have got various government departments that provide various funding at various times on various topics, and so we try to grab what we can to deliver a service. But, in all reality, it is not a comprehensive service; it is a service that is made up of what we could get at the time and do the best job with what we have got. I think that is a common issue across government. That coordination needs to be evidence based; it needs to be an integrated comprehensive strategy that you then commit to for 10, 15 or 20 years, because we know these issues are here. We know that you need to heal and deal with these issues, and we know it is going to be a long-term prospect. If we do not commit to that long-term prospect and we only commit to an election term or to a particular political party —

[10.20 am]

Mr M.J. COWPER: Just on what you have said, how does the Department for Child Protection and Family Support fit into all that? I have heard you work very well with headspace and the health department and so on. I have not heard how that is integrating with the DCP.

Mr McPhee: We have got an MOU with the Department for Child Protection and Family Support, so we will provide support to kids who are in care who have health-related issues and also where there is pregnancy for young people. We have an MOU which allows us to come in and support young people in care.

Mr M.J. COWPER: What I am leaning to is that whilst every life lost is tragic, one in particular that comes to most people's minds—to all Australians—is the tragic loss recently in Looma. I understand that she came from a different location—I will not mention any names here. She came from another location to there. Did she fall through the cracks? Was there someone monitoring her? I am just interested to know.

Mr McPhee: I do not know much about that particular story. Do you, Raina? No, I do not.

Mr M.J. COWPER: I heard there was some trouble previously.

Mr McPhee: Look, I have heard things as well, but I do not have any firsthand knowledge.

Mr M.J. COWPER: Fair enough.

The CHAIR: We might have to wrap up.

Ms J.M. FREEMAN: I have one last question. Culture and language is very important. At KAMS and headspace, when people walk in, do you say hello to them in—when we were in New Zealand, it was "Kia ora" and the whole aspect of speaking language in the workplace, and the expectation that the pakeha would at least attempt to acknowledge and use language. Can you practise that in your own organisation?

Mr McPhee: Not as much as we should. There is certainly a trend where people are signing off on their emails with "galiya" and there are Yawuru words being used and that kind of stuff, but as an organisation, we have not adopted those sorts of things.

Ms J.M. FREEMAN: You have not got a policy or a mission that you would —

Mr M.J. COWPER: It is informal.

Mr McPhee: Yes, it is informal. As I said, there is a bit of a trend. The board has just approved a plaque to recognise Yawuru people at the building, so there is a bit of momentum building around that kind of reclamation of language and culture and then embedding it into systems. I think New Zealand has been very fortunate because there is a common language across the whole country, whereas in Australia it has been a bit slower because there are some different dialects and language groups. Certainly, Yawuru, I think for a long time, were quite busy going through native title processes. Now there is a resurgence coming from Yawuru, which is about let us get the language out there, let us speak Yawuru, so organisations are responding. We are certainly open to it.

The CHAIR: Thank you, Rob. Thanks, Raina. We have run out of time, but thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. 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, but I would love you to provide any additional information or elaborate on any particular points and provide those documents that you have undertaken to give us as a supplementary submission to the return of your transcript. Thank you very much again for your time and for giving us an insight into very important issues.

Ms J.M. FREEMAN: And could we have that paper?

Mr McPhee: Yes, the position paper.

Ms J.M. FREEMAN: Yes, the one that you spoke about that you read out.

Mrs Washington: I will email it to you.

Hearing concluded at 10.24 am

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