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**REPORT OF PROCEEDINGS BEFORE**

# STANDING COMMITTEE ON SOCIAL ISSUES

## INQUIRY INTO OVERCOMING INDIGENOUS DISADVANTAGE IN NEW SOUTH WALES

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**At Sydney on Wednesday 30 April 2008**

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**The Committee met at 9.00 a.m.**

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**PRESENT**

The Hon. I. W. West (Chair)

The Hon. G. J. Donnelly
The Hon. M. A. Ficarra
Dr J. Kaye
The Hon. T. J. Khan
The Hon. M. S. Veitch

**CHAIR:** I declare the Committee inquiry open. On behalf of the Committee I acknowledge that we are conducting our business today on the traditional country of the Gadigal people. Welcome to the eighth day of hearing of the inquiry by the Standing Committee on Social Issues into overcoming indigenous disadvantage. As I have noted previously, the inquiry will examine policies and programs aimed at addressing the lifetime expectancy gap between indigenous and non-indigenous Australians, the Federal Government intervention in the Northern Territory, opportunities for strengthening cultural resilience within indigenous communities and the outcomes of the COAG trial in Murdi Paaki, among other issues.

Today the Committee will hear from representatives of the Djirruwang Aboriginal and Torres Strait Island Mental Health Program at Charles Sturt University, Mission Australia and the University of Sydney School of Rural Health in Dubbo. This afternoon the Committee will travel to Redfern for further evidence from the Aboriginal Medical Service and the Babana Men's Cultural Group. I will make some comments about procedural matters relating to the broadcasting of proceedings. In accordance with Legislative Council guidelines for the broadcasting of proceedings, only Committee members and witnesses may be filmed and recorded. People in the public gallery should not be the primary focus of any filming or photographs. In reporting the proceedings of this Committee, members of the media must take responsibility for what they publish or what interpretation they place on anything that is said before the Committee. The guidelines for the broadcasting of proceedings are available on the table at the door or on request.

**WAYNE RIGBY,** Director, Djirruwang Aboriginal and Torres Strait Islander Mental Health Program, Charles Sturt University, sworn and examined:

**CHAIR:** I welcome Wayne Rigby of the Djirruwang Aboriginal and Torres Strait Islander Mental Health Program at Charles Sturt University to the eighth day of hearings of this inquiry. In what capacity are you appearing before the Committee?

**Mr RIGBY:** My purpose today is to talk with you about the Charles Sturt University's most unique mental health program. It has been in operation for about 15 years now. The issues around the program are that it is part of the self-determination and assistance to Aboriginal people and the Torres Strait Islander people. My heritage is Bunjellung. I am like many others whose heritage does not come out until some years down the track. Whilst I was growing up I found it very difficult to talk about my heritage because I did not know where I belonged. So my upbringing was interesting. But I always keep focused and determined on what I do. I have met the Hon. Mick Veitch. I pioneered the first rural mental health service in New South Wales, which was at Young. I was very privileged working at Young.

Prior to that I worked as a senior nurse in various hospitals. I was probably one of the very first registered nurses, if we want to track history, as an Aboriginal. A lot of famous Aboriginal people like Sally Gould claim that they were the first in 1972. I already had three major certificates by then and I was a nurse unit manager in Goulburn Base Hospital. I will show you a photograph of myself so it gives you a clear indication when students tell me that they have had a hard time adjusting to their role; just imagine what I went through in my role, especially being a male nurse. So I have had about 40 years' experience in mental health and I have worked both in and out of mainstream. I am salvaging credibility because it is really important; my history is very unique. I do not think too many people would have my history as an Aboriginal person.

**CHAIR:** It is important to hear it.

**Mr RIGBY:** Forty years of my life have been in mental health and I have really enjoyed it. Six years of my life I was a senior public servant. I was the senior staff counsellor for the Australian Bureau of Statistics. That is not too bad for a black fella to get that far. My skills are around negotiation and problem solving, which has been quite unique for this program I have been involved with on and off for years. My other roles have been cluster manager, especially at Manning, Queanbeyan and Cooma. As I said, I have pioneered a few health services in the past, like the one at Young—I will send a copy of that around—and Eurobodalla. I have also got a good sense of humour.

In my earlier days I did a lot of negotiating work with the police in siege situations. I said, "That is interesting. I have been promoted from a black tracker to now I am in control." That is just my sense of humour. I think working in mental health you have to have one. I do work in a very highly stressed job because it is hard to please all tribes. It is very, very difficult to come up with some interventions that are going to please people, particularly students. But that is the nature of the job and, of course, it is quite challenging.

The Djirruwang program itself is quite unique. It has a mainstream subject focus and it also has a traditional culture focus, which is quite unique in the world. I have done a lot of research and there is no other program in the world like it. What

complements it is that we have a skills competency rating in line with the program. Therefore, our graduates do graduate or go into their jobs with not only knowledge of both mainstream and traditional but also hands-on skills. Being an old health service manager myself, I want hands-on people to work for me and I want people who know their job. The reason why there is a big emphasis on skills competency building, it is about building resilience. I know the program is about building capacity, but capacity is not all that good if you do not build resilience to go with it.

A lot of our people who do go into the mental health game burn out very quickly. So if they have not got the resilience to cope with the issues around mental health, particularly in the mainstream—social, emotional, wellbeing and cultural issues—they get very disappointed and they do not go back, which is really sad. It is interesting too because when you work in mainstream and things go haywire they say it is the black coming out in you and if you are working in the black system and something goes haywire they say it is the white coming out in you. That is what our students, our graduates have to cope with.

**CHAIR:** You are a Bunjellung man?

**Mr RIGBY:** A Bunjellung man, yes. I am a Murri actually, just across the border at Warwick, Yangan, a little Aboriginal mission many years ago. I think one of my great-grandfathers must have been a convict. I have tracked him down and he has white skin and red hair, and I think that is the only reason he survived.

**CHAIR:** Is that centred around the Richmond River?

**Mr RIGBY:** Yes, Bunjellung is Coffs Harbour, Richmond River, right up into south-east Queensland across to Warwick and then back down to Casino, Kyogle.

**CHAIR:** Does that take in the Smoky Cape?

**Mr RIGBY:** I think it does, actually.

**CHAIR:** Where Captain Cook came down.

**Mr RIGBY:** That is it, yes.

**CHAIR:** John Ferguson, an attendant here, is a proud Bunjellung man. If the opportunity arises, you may meet him. That is another story. How prevalent are mental health issues in indigenous communities?

**Mr RIGBY:** When you talk about mental illness, and I am coming from the mainstream perspective, the classification systems and epidemiology, it is much the same as mainstream. So if you talk about schizophrenia it is about 1 per cent; if you talk about depression it is about 3 per cent. This is western classification. When you talk about anxiety disorders it is about 4 per cent. But when you look at mental disorders, Aboriginal and Torres Strait Islanders do not classify. What they do is tell a story and they try to get a cluster of experiences together. The western classification system does not reflect the real true accuracy of Aboriginal and Torres Strait Islanders having a mental health disorder. And that is why it is classified as not mental illness. It is all based

around colonisation and unresolved grief over the many years. So it comes out in what we call a transgenerational disorder.

The major issues that came out, and Professor Marie Bashir talked about it yesterday as well, are around depression. It is lifelong and many generations of depression. It is lifelong and many generations ago, three or four generations, of anxiety and post-traumatic stress disorders, and these problems have not been resolved all that well. The big issue, and what I found too with my upbringing, is being connected. That is really important for Aboriginal people that they feel that they are connected. As I said before, a lot of us have two families. We have a western family. My other side is Scottish, so it is very kinship orientated. I guess that blends in with Aboriginal and Torres Strait Islanders who are very kinship orientated as well. That is the road they have to tread. It is really awkward again for Aboriginal people and Torres Strait Islander people because most of us have another side to us.

**CHAIR:** Do you play the bagpipes?

**Mr RIGBY:** I do not play the bagpipes.

**CHAIR:** The didgeridoo?

**Mr RIGBY:** No, I do not play the didgeridoo either. I am not real good musically. So the major disorders in Aboriginal people are around depression, anxiety, post-traumatic stress disorder. Unfortunately, they usually are what we call comorbidity and they are associated with physical issues, particularly around cardiac or heart disease, renal disease and respiratory disease. Also there are other issues involved with being disadvantaged and unemployed and just racism in general. That is around domestic violence, substance misuse, and those things are becoming more and more evident. It is interesting too when you look at the bulk of age for Aboriginal people. The bulk is under 15 years of age. That is horrendous because as we go up, as we get older we die a lot earlier. I am hoping that my Scottish genes come out.

**CHAIR:** When you say the bulk are under 15, what do you mean percentage wise?

**Mr RIGBY:** You are looking at about 48 per cent of the Aboriginal population being under 15 years of age, and as the pyramid goes up it gets less and less. Very seldom do you see—probably up around 8 per cent—over the age of 65.

**The Hon. MICHAEL VEITCH:** I have a couple of questions about traditional treatment or practice with mental illness in Koori communities. What was the traditional approach to treating someone with depression or mental illness?

**Mr RIGBY:** It is interesting, my cousin Jenny Thompson is an Aboriginal healer, so I converse with her. Actually, she is the one that identified me. I was giving a lecture one day and she stood up and said, "You're my family. This is my heritage," which is interesting because they have great knowledge. Their way of treating people with, say, depression is very much support. The support not only comes from the family; it comes from the whole community at large. If you look at even mainstream interventions towards depression, probably about 20 per cent of people with depression receive medication. Eighty per cent of people who have depression are managed by

other types of counselling, cognitive behaviour or therapy, which is very similar to Aboriginal people as well. The majority are very much supported and that helps them cope with the depression. However, if the person who is depressed is being supported by people who are depressed, it just exacerbates the issue. It does not help the situation at all.

My experience in working with Aboriginal people is that a lot of what we call the psychotropic medication is not all that good for Aboriginal people, and the same with Asian people too. Somehow with the genes they do not go well with antipsychotics, for example. They cannot cope very well with antidepressant medications, particularly the tricyclates, one of the older groups of antidepressants. So, very much a lot of the intervention in traditional Aboriginal culture is based on support and activity, but the big issue there is around being connected. People need to feel connected to wherever they come from.

**The Hon. MICHAEL VEITCH:** So, things like regaining culture, such as language, for instance, in many ways would help the overall wellbeing of the Aboriginal population?

**Mr RIGBY:** Certainly. That is what we drive with the program. It is very hard because you are looking at 700-odd tribes. Ours is a national program. So we rely on the students that come in. So the skill is in the lecturers themselves being a facilitator to draw out that knowledge. It is interesting with a lot of our graduates, they can work in both and they have very good cultural knowledge and they are starting to become more experts in the knowledge of mainstream.

**The Hon. MICHAEL VEITCH:** From where do you source the students? How do you advise them of the program and identify who would make a good mental health worker in the Aboriginal community?

**Mr RIGBY:** Typical black fella grapevine. The graduates are the ones who are our advertisers. The students are the ones. If they feel the course is worthwhile, the grapevine goes out. Also, we advertise in Koori mails, we advertise through conferences, we advertise through marketing the program. Last year I went to Queensland. It was interesting while I was travelling around Queensland because they identified my heritage. As soon as I walked into a medical service, an Aboriginal culture one, they said, "You're Queensland, you're Murray." I said, "How do you know" because I was born at Oberon. They said, "Because of your features." It is interesting. So they do identify. I am very good friends with an Aboriginal mental health worker in Wagga. He is from Fraser Island and has very similar features, you could see. Each tribe has its own uniqueness. And they have their own uniqueness and behaviour too. When you look at 700 tribes, the only time they had cross-fertilisation was when one tribe raided another tribe and stole the women. This is before colonisation. It is very important that we maintain our traditional culture. That is the emphasis on the program.

**Dr JOHN KAYE:** Could I ask a supplementary question? You did not mention schools? You do not promote your program to schools?

**Mr RIGBY:** Certainly. In the past we have not. It is a drive now and it is a requirement by the Commonwealth that we do enter schools. However, a lot of our graduates who go into mainstream medical services do have a role to play in schools. So,

I guess it is indirectly advertising in schools. But we do not get too many young people leaving, say, high school, for example, the secondary schools and entering our course.

**Dr JOHN KAYE:** Are they mostly older students?

**Mr RIGBY:** Mostly older, and this is why, and I will talk about the percentages of graduates, a lot of them tend to come in as a mature-aged student and they usually retire not so long afterwards, or they usually die. I know two or three very prominent and very successful Torres Strait Islanders who worked in the industry for about 10 years and then moved on.

**The Hon. MARIE FICARRA:** On that point, is it optimal that they are coming in at such a mature age? Perhaps you could recruit if there was awareness and knowledge earlier on?

**Mr RIGBY:** Yes. Definitely we have younger ones coming in. Again it is one of building resilience. In our student population we have the very innocent—it is just like school—and then we have the very experienced. I call them the streetwise ones. So, the innocent one might start talking about families, for example. One of my fortes is family counselling. So they might start talking about the good family of a certain family and there could be somebody more experienced and say, "Oh, so which part do you say you come from? The good part? Well, I'm from the bad part of the family." It causes a lot of problems. This is where a lot of young people do not cope all that well within the course because of the interplay between students themselves. Now they could belong to the same family, but there could be some conflict. So, again, it is the skill of the lecturer to make sure we intervene before that.

**The Hon. MARIE FICARRA:** This is something unique, is it not, to teach within the indigenous community?

**Mr RIGBY:** To be a lecturer in this course you have to not only have the knowledge of both mainstream and also traditional, but you have to be very good at group work, extremely good at group work.

**The Hon. MARIE FICARRA:** You talked about interventions and that there may not be acceptance of your suggestions of particular types of interventions. Can you explain that further?

**Mr RIGBY:** Yes. It is really important when you do any intervention with any indigenous person or groups of people that they have a collaborative process. They need to have a big say in what they do and where they want to head. If you do not, there is going to be resistance. In fact, you are not going to get it off the ground. So, the key is to make sure that there is collaboration and involvement and that they have ownership.

**The Hon. MARIE FICARRA:** Is the success of your program based in Wagga Wagga spreading? Your philosophy or approach and the success of getting proper outcomes in having indigenous people working within their own communities and assisting, is that spreading or are you sort of a one-school band?

**Mr RIGBY:** No, it is. It is starting to outreach. You are talking about partnerships with other courses? Yes, we are in partnership with the Aboriginal Health

College. We are in partnership with other subsidiary education programs and they could be just Aboriginal medical centres based. But there are credits given to students who can demonstrate that they are experienced or qualified in some sort of external course relating to this course I am director of. So, we do give credits.

**The Hon. MARIE FICARRA:** In treating mental health in indigenous or non-indigenous, the family support base is very important—the family and friends network. I imagine it is even more so in treating indigenous mental health problems?

**Mr RIGBY:** Certainly, more so. When you look at confidentiality, there are no issues there at all. It is very much based on family and community. So it has extended past the family with Aboriginal, particularly in child protection. For part of my career I worked in DOCS for a little while. So, being Aboriginal and working in DOCS, gee, that is talking about eggshells and you have to be involved, particularly if there are custody issues. Sometimes it might mean facilitating two tribes to come up with some sort of agreement about custody of a young person, and that can be quite volatile.

**The Hon. MARIE FICARRA:** How have you measured the success of your program's outcome? Quantitative is probably the easiest thing to measure, but has it been successful qualitatively?

**Mr RIGBY:** Quantitative, all I can give you are the figures of graduates. There are two that have graduated with a certificate, 41 that have graduated with a diploma and 55 that have graduated with a bachelor degree.

**The Hon. MARIE FICARRA:** Over what period of time is that?

**Mr RIGBY:** Over the 15 years. Eleven graduated this year with a bachelor degree and it is starting to increase. The thing is that once they graduate they are quickly sought after by mainstream services and medical services. So, when you look at ratio, you are probably looking at for every 10 people that graduate one will go into medical and social and emotional wellbeing—this is where we need emphasis—and nine will go into mainstream.

**The Hon. MARIE FICARRA:** When you say mainstream, that is not necessarily in indigenous communities?

**Mr RIGBY:** Yes, in indigenous communities, but they will go into mainstream mental health; they will go into mainstream health services. We have one graduate; she is coordinator for sexual health in the greater southern area. We have two graduates who hold statewide positions. One is a statewide coordinator in New South Wales for Aboriginal trainees. The other one is in Queensland and is a statewide manager for Aboriginal research. They are two of our graduates. We have many who occupy senior Aboriginal health worker positions. In fact, I met up with two last night from Dhurray, just to catch up with them. I think that is very important too because I have only just been back in the university for about the last 10 months. The university has neglected our graduates as well. It is very important to maintain contact with them and establish appropriate networks for them and keep them involved because they do burn out and they feel abandoned. I guess it is a little bit like being dislocated from their own country too. Aboriginal people and Torres Strait Islander people feel dislocated from the education where they once were.

**The Hon. MARIE FICARRA:** Have you found there is a problem with training and upskilling, but then after a period of time, maybe after burnout, people are not wanting to work any longer in indigenous communities and may be leaving?

**Mr RIGBY:** Certainly, yes. But my experience in mental health too, I have seen a lot of my mainstream colleagues come in, go back out, particularly around nursing. My background is nursing and social work.

**The Hon. MARIE FICARRA:** You mentioned the pharmaceutical treatment, the psychotropics and the old-style tricyclates. Has there been research of indigenous communities, not only in Australia but elsewhere? Is there any correlation with native communities in America or Canada having the same difficulties in responding to treatment?

**Mr RIGBY:** Some studies have been done in Canada and North America, but they are very scant. As Professor Marie Bashir said, it is an area in which appropriate research and outcomes are lacking. Aboriginal people are very well researched. The issue is the outcomes. I am attending the Australian Indigenous Health Conference run by the Aboriginal Health and Medical Research Centre at Cockle Bay.

**The Hon. MARIE FICARRA:** Are they responding to the newer types of psychotropics or the SRA inhibitors? What do you treat them with?

**Mr RIGBY:** They have many fewer side effects. The second generation is sinequan and doxepin, which has quite devastating side effects. Aboriginal people do respond to it, given in low dosages. Only about 1 per cent of the overall community is treated with anti-psychotics, but I do not know the percentage for Aboriginal people. The main issue is depression, anxiety and post-traumatic stress disorder. We need to look at tailored medication.

**The Hon. GREG DONNELLY:** We have obviously heard evidence from a number of people. I am struggling to comprehend whether there is scope to bring together or reconcile the approach we take in the European community to deal with health issues. The State identifies an issue and pushes out from a central point and raises the general standard across the community. It is our cultural modus operandi. It is about our governments, institutions and history. Over time, that is how we have dealt with major problems, particularly physical illnesses.

The Aboriginal culture is so different, and you have spoken about the tribes, their autonomy, cultural differences and so on, and the great need for them to be involved in consultation and discussion and, ultimately, in the decision making that leads to what we should do. Fundamentally that is at odds with the way in which Europeans deal with things. So the notion of setting targets, time lines and markers and things like that, which we would traditionally use to drive to resolve urgent health problems—and we have major health problems in the indigenous communities—seems to be on a completely different plane.

Much of what we have tried over decades to address the major issues, at least to this point, is not on any measurement proving to be successful. In your experience, is there any way to reconcile the fundamental cultural difference in dealing with something

like this, or are we forever almost trapped in the parallel approach and just trying different things and almost hoping they will work in the context of this community? Many witnesses have said that what works in this community may not work or be acceptable in another community. Ultimately there is a potential multiplicity of approaches to deal with a range of health issues—not only mental health issues but also general health issues. That has troubled me throughout the hearings and I do not know that I have explained it clearly. There is a fundamental difference in approach. Is there a capacity to create this understanding that to attack a fundamental issue we must launch a systematic or wholesale attack?

**Mr RIGBY:** You have explained it very clearly and highlighted the complexity of mental health or social and emotional wellbeing in Aboriginal communities. It is much more complex than people think. What works well for one nation does not necessarily work well for another. That is why it is important that consultation should be at a local level to enhance their needs. The complexity of mental health is all about health in general. It looks at the social determinants and biosocial determinants such as poverty, housing economics and raising health standards. As I said when you look at Aboriginal people with mental health issues, the other side is that you can bet your bottom dollar they will have a chronic health problem such as heart disease, diabetes or renal problems. That is the complexity.

It is very difficult to get a uniform agreement. Again, it is different horses for different courses. It is the big issue around getting some movement towards that. The Sorry Day was a big step towards resolving some of the complex issues around Aboriginal and Torres Strait Islander people, more so Aboriginal people. That is particularly the case in New South Wales. New South Wales is home to the largest population of Aboriginal people—28 per cent live here. I know our program is geared towards the bulk of our students, who are New South Wales employed. However, we also have a national responsibility. As you go out, particularly to the more remote and rural areas it becomes much more complex. Mention was made yesterday of the issue of supplying fresh vegies and fruit in remote areas. The surveys and abstracts discussed yesterday indicated that more than 50 per cent of Aboriginal people do not have access to fresh vegies and fruit. That is a big issue. Proportionally, only 6 per cent of Aboriginal people live remotely, probably 26 per cent live in rural or regional areas and the remainder are urban.

**CHAIR:** We are talking about gross disadvantage and dislocation. Are you saying that the treatment is the same or different regardless of whether I have grey hair or black hair, or green eyes or blue eyes?

**Mr RIGBY:** The treatment is much different. That is why we teach our students the traditional and cultural ways and the mainstream ways. How will our people have access to health services when the mental health worker or the health workers do not understand mainstream services? That is the key issue with our program. If they are going to have equal access to service delivery and to mainstream services they must have a facilitator who has the skills to ensure that that process occurs. Is that what you are hinting at? It is a big, complex issue and you have highlighted that.

**The Hon. GREG DONNELLY:** You have provided me with some food for thought. There seems to be a cultural clash—and I use that term advisedly—in dealing with a major health problem. What we are trying to do as part of our deliberations is

ultimately to produce recommendations that hopefully will make some contribution to addressing what has been revealed across a range of health indicators as significant disadvantage in indigenous communities in New South Wales. I am trying to establish whether there is an ability to bring the two closer together. Obviously, the way in which Europeans deal things would be seen as imposing our position, a methodology or an approach to deal with an issue that obviously receives push back from indigenous communities.

**Mr RIGBY:** That is a good point to make. As soon as they feel that, they have been disempowered.

**The Hon. GREG DONNELLY:** Of course.

**Mr RIGBY:** That is when we get resistance.

**The Hon. GREG DONNELLY:** The approach we are looking to take is one that will address some of these major health problems as quickly as possible. The approach is to try to push out and do it, and in a very organised fashion.

**Mr RIGBY:** Yes.

**The Hon. GREG DONNELLY:** It is a relatively inflexible approach. We mandate that this is the way it should be done and push out.

**CHAIR:** It is important that we understand. Correct me if I am wrong, but you are saying that it is not only a question of disadvantage, dislocation and DNA, the actual definition of healing is culturally different.

**Mr RIGBY:** Yes.

**CHAIR:** It is important that we comprehend that distinction.

**Mr RIGBY:** There are big issues. Each tribe is unique with regard to kinship. That is what creates the uniqueness of the culture of the tribe.

**CHAIR:** Are you suggesting that if my aunty is disadvantaged, dislocated or an adopted child that the cultural different will still be there?

**Mr RIGBY:** Certainly, yes. Many of our people do not understand their own culture. This is where the strangeness comes out. This is probably one of the major reasons that 22 per cent of our men are in the New South Wales prison system. It is a very high proportion. In addition, 8 per cent of our women are in the jail system. When we interview them it is all about being disempowered, racism and lacking recognition. In my experience in working in mental health and even with the Commonwealth I found that it is all about despair for the men. You look in the eyes of an eight-year-old who has been severely traumatised and sexually abused by his family and foster carers and he says, "I don't want you coming near me. I don't want you effing with my head." All you see is despair and anger and it goes up the scale. In a 15-year-old boy you see despair, but he has already made up his mind and a month later you read about him hanging in a park in the Australian Capital Territory. You might hear about a 34-year-old man in jail who is saying, "I'm angry, but I wish someone would listen to me."

**CHAIR:** And "I wish I knew why."

**Mr RIGBY:** Yes.

**CHAIR:** I refer to the retention rate in primary schools and high schools. There is a vast drop off. Does that relate to loss of innocence and going from the joy of life to the real world? Is there an element of that?

**Mr RIGBY:** There would be, but it is about being grounded. If you have good roots early in life you are better able to cope with life as it goes on. However, if it there has been upheaval and life has been dishevelled from the start, their ability to cope with life and their resilience is reduced. Therefore you will have antisocial problems, you will have domestic violence, alcoholism and depression. This is where the complexity is.

**Dr JOHN KAYE:** I have a lot of questions to ask, Mr Rigby. It has been a very informative session for me. I wanted to drill a bit into the issue of different mobs or different tribes in the one training program. First of all I want to get a sense from you of how important and how significant those issues are. I ask because we hear a lot about conflicts between different groups when they are put together. Can you talk a bit about that? Can you tell us what the cause of that is, and a bit about how you deal with that in the context of your course?

**Mr RIGBY:** That is a good point, too. My old saying is that just because you put a mob of blacks together it does not mean to say that there is agreement. Each tribe has its own uniqueness. What we teach is respect: We listen to what you have to say, but we have our own cultural differences. I think that is really the key issue within the course. But it is a very good question. That is what I always say, even when I go to conferences—we have to look at the realities of it. Just because there are different tribal groups together does not mean that they are the same: no, they are not. You have probably witnessed it.

I am very good friends with Matilda House, who is a very prominent elder. Yet when she goes to speak publicly she is knocked by other tribal people behind her back. There is that lack of uniformity. Often I will say to the males in the class, "Gee, you guys are all weak, you know. I don't see any of you coming up as true leaders. The women are the ones." That is history, too, because even in mainstream, women are the ones who got the welfare policies and everything else going, particularly for Aboriginal women. But they are saying then to me, "Oh, how can we, Wayne, when over 40 per cent of us spend our time in jail? We're in jail, so how can we be an identity model?"

**Dr JOHN KAYE:** Can we just go back to that issue of tribal interaction? I understand about the difference. What is it about the difference that leads to the conflict?

**Mr RIGBY:** The difference is in belonging to the land. It is all around belonging to the land. You might have the Badjalang tribe who occupy the north east of New South Wales and the south east of Queensland. You are looking at the Wiradjuri tribe. It is all about belonging to the land and that is where the emphasis is about tribal issues.

**Dr JOHN KAYE:** How much do those tribal differences undermine the ability to deliver health services?

**Mr RIGBY:** That is another good question. It is very difficult to come up with a common theme. Even right across the nation, you will not get common agreement.

**Dr JOHN KAYE:** It is about common agreement about the type of services being delivered or the nature of the services, yet what I find interesting about this is that your incredibly successful program is clearly incredibly successful in taking people from 18 different cultural backgrounds, putting them together, drawing out the commonality, and setting them back into a variety of communities where they are enormously successful. Clearly you have cracked something that needs to be promulgated.

**Mr RIGBY:** It is quite unique. Like I said, I have looked at it internationally, and I think we have a goldmine program. Of course, all programs are a bit short of money, though, and with all programs, particularly in education and health, it is the poor workers. You see, I have about two or three roles. My role is just not only Dijrruwang. I am the Director of Indigenous Health overall for the university. There are only three Aboriginal academics within the Charles Sturt University—me, Gary Shipp and Wendy Nolan. Of course we occupy a lot of other roles, but it is like that in Health. When you are a senior clinician you deal with multiple other issues. When you are a health service manager, you are a clinician, a manager, a negotiator and a public relations person. That is the nature of the job.

**Dr JOHN KAYE:** Can I take you possibly a little bit out of your normal area? Can we talk about delivery of mental health services for Aboriginal people in the New South Wales jail system? We understand that in the New South Wales jail system, or in any jail system, you have a massive overrepresentation of people with mental health issues. We understand also that among Aboriginal people it is an even higher proportion of the Aboriginal inmates in New South Wales. We hear conflicting stories about how good mental health services are. Do you have an opinion on that?

**Mr RIGBY:** Within the jail system?

**Dr JOHN KAYE:** Yes.

**Mr RIGBY:** Even from mainstream, it is very, very difficult because they may have a reasonably good service within the jail system. It is the follow-up program after they are discharged from the jail system, and that has been highlighted in the Tracking Tragedy reports. Even in mainstream, if there is not appropriate follow-up services once they are discharged or let out of prisons, there is a big chance of either their mental illness becoming greatly exacerbated and they could suicide, or it is a revolving-door syndrome and they go back. When you look at, say, Aboriginal men, for example, when they are discharged or let out of jail 70 per cent of them have no home to go to. Even leading up to before they go to jail, you are looking at over 30 per cent of them who have been homeless, and that is why they go to jail.

When you look at the deinstitutionalisation—I have lived right through the institutionalisation from the 1970s right through and I have seen what happens here—if you have not got an appropriate infrastructure to maintain the discharge of people, of course you will have other services, like non-government services, picking up the bag or

the jail system picking up the bag. When you look at, say, mental illness overall, it is probably 30 to 40 per cent of people in jail systems who have a full-blown mental illness as well. Of those Aboriginal people who are in jail, you have a much higher percentage. You are looking at about 60 per cent.

**Dr JOHN KAYE:** I wanted to ask one more question but we do not have time. I appreciate that, but I will be writing and asking you about the issue. I think it is important to know how much of this is about treatment and how much of it is about prevention.

**Mr RIGBY:** Yes.

**Dr JOHN KAYE:** And what can be done for community programs and intervention programs to improve matters.

**Mr RIGBY:** Certainly.

**Dr JOHN KAYE:** We do not have time now.

**CHAIR:** We do not have time right now. We apologise for that. We will be pestering you in the hope that you will assist us further in our ongoing inquiries. As you know we have an interim report that is due in June and then a final report that is due at the end of the year. Your assistance will greatly enhance the quality of our work.

**Mr RIGBY:** Thank you very much for giving me the opportunity. My background is primary health care, so I am into prevention.

**(The witness withdrew)**

**ROGER JOSEPH KENNEDY**, National Program Manager, Mission Australia, GPO Box 3515, Sydney, 2001, affirmed and examined:

**CHAIR:** Thank you very much for being with us this morning. Will you please state the capacity in which to appear before the Committee this morning?

**Mr KENNEDY:** I have been the National Program Manager for Mission Australia for the last five years. I started work with Mission Australia in a different role at the end of 1998. If you do not mind, I will open my remarks with an address and provide answers to questions that you have sent me. Mission Australia welcomes the opportunity to make a brief submission to the inquiry into overcoming indigenous disadvantage in New South Wales by the Standing Committee on Social Issues. Mission Australia is a non-denominational national Christian organisation that delivers community employment and training services in communities across Australia. In 2007 we supported over 250,000 Australians through over 300 services across Australia.

Our goal is to make a positive contribution to the wellbeing of Australians, especially those who are disadvantaged and on low incomes. There is considerable diversity in the living situations, cultural values, social expectations and service delivery needs of indigenous individuals, families and communities. Mission Australia provides assistance through both its mainstream services, targeting the general Australian community and indigenous-specific services. This enables us to tailor services and their delivery to suit particular needs and circumstances. Nationally, Mission Australia has over 60 community services. Approximately half of those have 10 per cent or more of clients who identify as Aboriginal and Torres Strait Islanders. In employment, we deliver services from over 180 sites across Australia. Our caseloads are approximately 4 per cent indigenous, which equates to approximately 15,000 to 20,000 indigenous clients.

Mission Australia's current suite of indigenous employment and community services includes running structured training and employment projects in New South Wales, Queensland and South Australia; specialist indigenous job placement employment and training [JPET] in Darwin, Katherine and Dubbo; providing indigenous youth employment consultants through our job network programs across Australia; job networking with approximately 15,000 clients; a breakaway post-release program in Taree; pathways to prevention program in Inala in Brisbane; youth withdrawal and respite services in Western Australia; Youth Beat and night patrol and sobering-up shelter in Darwin, of which 90 per cent of the clients are indigenous; and the Dubbo leadership and cultural development program. We have been involved with Boys from the Bush with Noel Pearson in Cape York. We also deliver remote services to 51 communities across the top end and we have been part of the Northern Territory emergency response. My responsibility is basically to look after employment programs on a national basis. I am happy to answer any questions going forward.

**CHAIR:** What type and level of employment and training opportunities are selected for targeting?

**Mr KENNEDY:** They are predominantly Federal-type programs. The ones that we deliver include the job placement, employment and training [JPET] program. It is targeted to 15 to 21-year-olds and it is generally looking at clients who are homeless or at risk of being homeless. Also we do specialist job placement, employment and training

programs at Dubbo and in Darwin. We provide indigenous youth employment consultants, and we have six of those around Australia. But, once again, that is a Federal Government program. We are working with indigenous youth by mentoring them, training them and placing them into employment. We run what is known as the indigenous youth mobility program [IYMP], operated through the Department of Education, Employment Workplace Relations [DEEWR], as are most of the programs. That is looking at indigenous youth mobility programs. It is looking at moving indigenous people around to help with traineeships and putting them into work.

We also run Youth Beat in the Northern Territory. What we have there is like a small bus or a van that goes around the streets of Darwin. Basically we are conversing with indigenous people at night, trying to see what the issues are with them, and we try to refer them to some of our services. What we found in that particular service is that it is very important to involve the family as well. We will get into some of those matters a bit further down the track. We are also involved in the Northern Territory emergency response where we are delivering services in over 51 communities across the top end, from Darwin down to Katherine, out to Nhulunbuy and out to Borroloola.

**CHAIR:** That is 51, but what is the percentage—51 out of 300, for example?

**Mr KENNEDY:** That would be in the order of 200 communities. We have the largest market share in delivering employment services as part of the Northern Territory emergency response and also on behalf of the Department of Education, Employment Workplace Relations.

**CHAIR:** The word "mission" is a bit unfortunate in many ways, is it not? The mission mentality does not really go down that well with many. Do you have difficulty with that?

**Mr KENNEDY:** Not necessarily so. It can create a bit of a problem from the old days when the indigenous were on the mission. However, we develop relationships, try to develop relationships, at the local level to get over those circumstances.

**The Hon. MICHAEL VEITCH:** I spent 15 years running an employment provider as well, so I understand a lot of the programs. With most State and Federal funded programs there are reporting obligations you have to meet. Does Mission undertake its own internal reporting away from just reporting on the outcomes of the funding from the Government?

**Mr KENNEDY:** We do. We would do so more on other programs and more so in community services. That would be where we are generating funds through corporate partnerships, that would be the banks or some of the resource companies who want to get involved in helping indigenous issues. They would be basically supporting us in some of those projects. We would be reporting to them, not necessarily back to the Government. We also do youth surveys. There is a national youth survey that we run which is independent of any funding, where we basically try to assess—there are about 30,000 a year we assess of which 7,000 are indigenous—statistics on suicide rates and mental health issues. I can always direct you to that report. I do not have the figures currently to hand.

We also do investment, seed capital for projects. One of the ones we have done is Pathways to Prevention in Inala, which is in the western suburbs of Brisbane, a very socially disadvantaged area. This is where we put our own money into running a program specifically targeting zero to 12-year-olds and it was looking at how can we work with the families and the youth at a very young age, how to support the families and support the youth through training, through education, through counselling and through housing to make an impact on the youth at a very young age which, as the gentleman before me said, is a critical stage. That is where we did investment ourselves and what happened with that program was it was so successful, we piloted it and the Government came in—FaHCSIA at the time—and saw it and said this is a great program and it cut and pasted it basically around Australia.

**The Hon. MICHAEL VEITCH:** What happens with a lot of the not-for-profit employment providers is that you tend to set aside funds or you obtain funds from private donors and you use those for seed programs. Does Mission act as a conduit for corporations who wish to donate, so you become a collection point and then you run specific programs in Aboriginal communities?

**Mr KENNEDY:** Yes, we do. It is limited at this stage. It is interesting because there is a big demand out there in the communities and there is a big request from organisations to do that so we are trying to broker that as much as we can. Some of the struggles around that are the funding can sometimes be limited in terms of the length and commitment. It is all about corporate social responsibility. It is a win-win situation. They get some good kudos and they can also help the indigenous in some of the communities. The challenge is the length of the funding. Communities really need a long-term commitment. They need three, five, 10 years in order to make a significant difference and sometimes funding may only be one year or two years—at most several years—so that is one of the issues. But that is something we are definitely looking at at the moment and that is quite high on the radar for corporates to be involved in indigenous areas.

**The Hon. MICHAEL VEITCH:** I think you have partly answered my next question. This Committee has heard on a number of occasions now that the indigenous community is pretty much sick and tired of pilot projects, short-term funded projects. There is a plethora of these things.

**Mr KENNEDY:** Yes.

**The Hon. MICHAEL VEITCH:** And that longer-term funding of projects important. Have you measured the success of these short-term projects that you run with corporate dollars?

**Mr KENNEDY:** Short-term success would be—very simple things would be—the number of pilots engaged, whether or not you have spent the money and then whatever sort of KPIs they would be requesting. They may be something along the lines of how many you have trained, how many you have commenced in terms of the whole community, how many you placed in employment and how many you may have referred to detox—so, things around those sorts of KPIs.

**The Hon. MICHAEL VEITCH:** I want to move on to two other areas now—disabilities and people with disabilities within the Aboriginal communities who

are engaged in your programs. Do you know what percentage of your program participants would have a disability?

**Mr KENNEDY:** Disabilities in general would be probably between 4 per cent and 6 per cent of our caseloads, and indigenous make up around 4 per cent. So, you are looking at a small percentage of indigenous who have disabilities. I could not give you an exact figure on that, but naturally it would make up quite a bit of our caseload.

**The Hon. MICHAEL VEITCH:** Earlier, in response to one of the chair's questions, you were talking about mentoring and leadership arrangements. Do you engage with the elders as a part of your program delivery?

**Mr KENNEDY:** Yes, it is essential. It does not matter whether we are operating in Bega or operating in Borroloola in the Northern Territory, we have to have people making a pathway for us by engaging the elders. That is a critical success factor. It is really slowly, slowly. Things cannot move fast in indigenous communities. Engaging the elders, engaging the CEOs of the local councils and getting them on side and then being able to deliver. The key thing is in a lot of communities, as you said, there have been a lot of pilots and everyone wants to help, however, what are you going to do for me and how can you involve me in that decision? A lot of things are talking about social inclusion at the moment. One of the key things is getting the buy-in of the local people, getting them engaged in the solution, what is the solution, involving elders, involving the CEOs. Sometimes the CEOs can be transient but they are pretty switched on people.

Quite a few of the communities we have gone to have business plans. Up on the Tiwi Islands they have a business plan for 34 different types of businesses. How can we get involved in that to try to help start some of their businesses rather than just go in and go out? So, engagement with the elders and engagement with the key stakeholders is paramount. Basically it is slowly, slowly. It is not going to happen overnight and that is the issue regarding funding. Two years, three years, five years, a long-term funding is the answer.

**The Hon. MICHAEL VEITCH:** Can I go back to the corporate donations? Do you think there is a role for government to play in focusing where those corporate dollars go rather than have them wasted on a whole range of short-term programs that will complete in the short term?

**Mr KENNEDY:** I think the role of government would be to try to facilitate shared responsibility agreements. What the New South Wales Government has at the moment is these things called job compacts. I do not know whether you have heard of those. We are running one in the Hunter. This is where you get the job network providers, the local councils, the indigenous organisations and business involved and they all sign a compact saying how can we work together to try to improve indigenous outcomes in employment or how can we look at reducing the gap between normal people into work, as in white, compared to indigenous, or how can we narrow the gap on life expectancy, and getting agreement between all those facilitators.

I think where Government can come in is how can it facilitate that. How can it have a solutions broker to bring it all together? It is not an easy task. Who can organise the committees, who can get the people together and organise the meetings? That

involves the corporates as well. It may not be national because usually large organisations want to deal with a national provider. That is where one of our strengths is. Say we have Westpac, who wants to work with us, or ANZ typically. That is where I can see the Government can help. A typical example is how ANZ wants to work with us as a national provider. It has a scheme where it wants to educate people in the finances. It is as simple as opening a bank account, doing a budget, how to manage a credit card, and it is working through us to train disadvantage people throughout Australia and it is paying us for it.

**The Hon. TREVOR KHAN:** Because we are a New South Wales Committee, how much of the overall budget of Mission Australia is spent in New South Wales?

**Mr KENNEDY:** I could not give you an exact figure off the top of my head but the two biggest States are New South Wales and Queensland. We turnover in the order of $280 million, $300 million in revenue a year. At least $100 million or $120 million would be in New South Wales. So, a significant portion of our turnover is in New South Wales. A fair bit of that would be in employment-related services but the majority would be in community services. The history of the organisation is that it was once the Sydney City Mission and it basically joined with the Brisbane City Mission, Hunter City Mission, Wollongong City Mission, South Australia City Mission, and the big hub is New South Wales. So in terms of community services, my main focus and my role is employment services, but our largest community services is in New South Wales. We have relationships now with the Department of Community Services, the Department of Housing and the Department of Juvenile Justice. So, we have quite a lot of relationships with the New South Wales Government.

**The Hon. TREVOR KHAN:** Of the $100 million, $120 million, are you able to indicate how much of that would be directed to services for the benefit of Aboriginal people or Aboriginal communities?

**Mr KENNEDY:** Yes. All of the funding is used to help the disadvantaged, of which a small portion in almost every service would have a component of indigenous clients. The ones that are specifically for indigenous I could not say off the top of my head but I could get that figure, but it would probably be in the order of 5 per cent or 10 per cent. The indigenous population is in the order of 2 per cent, but we find we are spending in general double or triple that on indigenous.

**The Hon. TREVOR KHAN:** Of the moneys you receive from governments, if we talk in terms of New South Wales, how much of your funding comes from the Federal Government, for New South Wales?

**Mr KENNEDY:** For employment services it would be almost 100 per cent. For community services, what comes from Federal, in New South Wales we say it would probably be somewhere between 40 per cent and 50 per cent.

**The Hon. TREVOR KHAN:** Do I therefore assume that for community services something in the order of half then comes from the State Government?

**Mr KENNEDY:** Yes, that would be right. From DOCS, the Department of Housing, the Department of Juvenile Justice, et cetera.

**The Hon. TREVOR KHAN:** What sort of amount of money is that?

**Mr KENNEDY:** I suppose in the order of $40 million or $50 million. I can get some exact figures for you if I can come back to you on that as well.

**The Hon. TREVOR KHAN:** I would appreciate that. If we can just talk about the provision of employment services, and we will talk about Aboriginal people in New South Wales. What programs are run, and where, related to indigenous employment?

**Mr KENNEDY:** The overriding one would be Job Network, which is a Federal Government program. We have in the order of 30 sites around New South Wales, anywhere from upper Hunter near Newcastle, out to as far west as Orange, as far south as Bega. So, Job Network would be the predominant one. We also run personal support programs, and 75 per cent of those on PSPs have mental health issues. So there would be a fair proportion of indigenous clients in that area as well. We run that at 30 sites around New South Wales. JPET we run in about 12 sites around New South Wales and we run an indigenous specialist out in Dubbo. We run a few indigenous specialist programs out in Dubbo.

There are also apprenticeship programs we run in various locations in New South Wales. They are the predominant programs we run in employment. We run large numbers of Work for the Dole programs in New South Wales in 13 locations. Work for the Dole is a big component of what we deliver. In terms of how it links with indigenous, we have memorandums of understanding with local indigenous communities in Bega. The number of outcomes we have achieved in Bega with indigenous is quite high. We are in the process of getting in contact with Job Compact up in the Hunter region out of some of our job network sites.

**The Hon. MARIE FICARRA:** From your experience and that of Mission Australia with helping indigenous employment and welfare, what is really working well? Have you been able to take a helicopter view and say, "This is really working well. This is an area we don't want to revisit." Is there a clear distinction coming through where you tend to operate effectively?

**Mr KENNEDY:** Yes. The success factors are basically that it is really important to have indigenous staff. It is critical. In Charlestown we were ranked 17 out of 18 for job network providers in terms of achieving indigenous outcomes but once we employed indigenous staff to work with indigenous clients our ranking went up to five out of 18. It is critical to engage indigenous staff to work in new programs. They can be challenging, not only in New South Wales but particularly in the Northern Territory when you are dealing with sorry time, when people pass away, when they have their own cultural issues that are going on. It is the essential to have cultural training not only for the indigenous person working in our environment but also for the whole office in how to cope with that.

Other things that are important are things like memorandums of understanding with local indigenous organisations, such as the Community Development Employment Program [CDEP] provider for the local council. Having long-term relationships with the indigenous is very important. Things do not happen overnight. If you get a new service or a new provider, all of a sudden they want to change the world and most people in a

non-profit area want to do that but it does not happen overnight and you need to gain their trust and respect.

It is about getting them involved in the decision-making process. Ability to identify employers who are willing to take on indigenous and getting mentoring for them and also cultural training with them and an open-door arrangement with indigenous and looking at subsidising accommodation, uniforms, transport, particularly when they are linked into work, mediating when issues come up are some of the things that basically need to be looked at. Also, looking at place-based solutions, that is, looking at the community and saying, "What is the solution for that community?" And it is just like the gentleman said before, it may not necessarily be the solution for what is occurring in the next community. It is what we are realising with the Northern Territory because the model we are delivering there is the uniform model but it does not necessarily work everywhere.

**The Hon. MICHAEL VEITCH:** You did not mention literacy. Do you do anything with literacy?

**Mr KENNEDY:** Yes, we do literacy but just bear with me because I look after employment services; literacy is looked after by training services. We do literacy up in Katherine and we do language, literacy and numeracy program [LLNP] in New South Wales as well. That was another program that was previously looked after by DEST but it is all part of DEEWR now. In terms of the training programs we are involved in, literacy tutoring programs in Katherine, Macarthur River, harvesting for the future, so we are linking with mining companies in the Northern Territory—we have not as yet in New South Wales—certificate in business in Meekatharra in Western Australia; language, literacy and numeracy programs across Katherine and Arnhem Land; indeed, we deliver across the country. They are some of the examples that we do in training.

**The Hon. MARIE FICARRA:** It was heartening to hear that you are involving and employing indigenous people in the rollout of your programs. Can you quantify that? How are you going about growing it?

**Mr KENNEDY:** In the Northern Territory the number of indigenous would be about 70 per cent. It is very high. A lot of the time it is by word of mouth. We advertise and we get some indigenous apply and then we say, "Have you got any brothers or sisters or relatives? And they say, "Yes, I've got some, or friends who want to join", so a lot of it is by word-of-mouth. A lot is how we have inducted that person into the organisation. If they have had a good experience in terms of the induction, they tell their friends. A lot is getting some key people and then spreading the word through family, friends, et cetera.

**The Hon. MARIE FICARRA:** Has the retention rate been good using that method and induction training?

**Mr KENNEDY:** The retention rate is much better when we have a very ordered induction that involves cultural training as well. If it is a very fast pace environment and things are changing all the time, there is too much to take in and we find that retention is not very high. I keep on going to the Northern Territory but that is a lot of my experience in terms of delivering programs. Retention has been a challenge. With the volume of information in delivering programs it is a challenge to train people

in the amount of information they need to have. We are trying to have hubs of expertise in Darwin and Katherine so that our workers do not necessarily have to be experienced in everything. They will be experts in just this little part so they can go out to the community, engage clients and try and work with them to get them into Work for the Dole or getting work experience or trying to find some work in that community of which there is limited, usually.

**The Hon. MARIE FICARRA:** You mentioned earlier that it was important that all the parties were involved in your memorandums of understanding in service delivery. Can you explain what that means?

**Mr KENNEDY:** In Bega we had a memorandum of understanding with the CDEP provider, which is basically indigenous work for the dole. That memorandum of understanding was what we were going to do for them and what they are going to do for us. They will refer clients to us from their CDEP program but we are going to be helping with mentoring, updating resumes, placing them into work, and mentoring them once they are placed in that work.

**The Hon. MARIE FICARRA:** So it is a clear delineation of responsibilities, reporting outcomes and measurements?

**Mr KENNEDY:** Yes, and that can be expanded in these job compacts. To my mind, 11 are occurring at the moment in New South Wales. There is the question of what government can do and you have already asked that. Their role can be to broker it, to bring things together as much as possible. I have some other suggestions as well.

**The Hon. MARIE FICARRA:** I would like to put that on record. From Mission Australia, what would you like this Committee to look at, recommend or investigate?

**Mr KENNEDY:** You may have already, but State governments do have targets on recruiting indigenous in public service roles. I do not know what that is and whether or not you are tracking on that key performance indicator, but it is important to be walking the talk. I think the outcome would be to link in with Federal programs. The challenge with all the agenda at the moment with the Federal Government and social inclusion, and how they are going forward, the idea is that they really want to focus on particular areas of disadvantage, so that in New South Wales it could be Dubbo, Bega, Taree or Redfern, and how does the State link in with Federal programs because they have job network, JPET, IYAC, IYMP, language, literacy and numeracy.

How can they fit in with all those programs to bring it together because they operate in isolation sometimes and even we—and we are a large organisation; we employ 3,500 people—struggle sometimes with the isolation, trying to make sure that we refer to community services or we know what our training colleagues are doing. Your level could try to do that. I also recommend having more job compacts or shared responsibility agreements, which brings all that together. They are some recommendations from Mission Australia.

State Government development indigenous employment—I know there are limitations on what you can do in terms of employment policy because the New South Wales Government probably has fewer employment programs than other State

governments, compared to Queensland and Victoria. I know that when the previous Treasurer removed the mature workers program and the specialist migrant placement program there was a big uproar but the idea was that it was the Federal Government's responsibility. New South Wales is lagging the other States in what they are doing.

The State Government development indigenous employment policy for local government to implement is compulsory. We talked about that in terms of recruiting internally. I have here indigenous car licence program. That could be one that comes out. Funding provided to schools for indigenous career counsellors and teachers aides. You do have a links-to-learning program, but that is generic. Can you be more specific? Training programs for career counsellors for indigenous job seekers; that would be linking predominantly into the education system—and incentives for elders to become involved in active job seeking participation for job seekers.

The other ones are more around Federal issues that relate to how a job network could be improved but we also have literacy and numeracy mentor support on-the-job. We have realised in the remote communities that for all the implications of the old mission days, when the Catholic organisations went into the old communities they really taught people their language, literacy and numeracy and a lot of that is disappearing. In the remote communities the level of literacy and numeracy is very low, so that is a real issue.

**The Hon. MARIE FICARRA:** Would you like those programs established, expanded or enhanced?

**Mr KENNEDY:** I do not think the indigenous car licence program is available but language, literacy and numeracy can be expanded. Training programs through DET can be expanded and career counsellors for indigenous jobseekers can be expanded.

**The Hon. MARIE FICARRA:** Can you go back to the employment programs? You compare New South Wales to the other States. Can you give us more information where you believe we could improve?

**Mr KENNEDY:** For instance, in Victoria they have employment strategies around working with job networks. They have one program called workforce participation, working in specific areas of disadvantage, working with job network members to try to get people into work. It is not in competition. They are all usually grant-based funding. It is not as if organisations come in and make a profit because you only get paid what you expend. Similarly in Queensland there is a program called community jobs program, which is working in collaboration with job network providers to provide support to get people into work. Some clients may not be eligible for job network because with immigration most migrants are not necessarily eligible for job network. It is not what we are talking about today in terms of indigenous because it is migrants. I can always provide some more information. I have a nice spreadsheet that we have put together recently on the other programs that are provided in other States.

**CHAIR:** Currently the State Government has a vision and an objective which incorporates the State Plan and Two Ways Together. Part of that is developing these shared responsibility agreements. It has a framework which involves going down from the Director General of the Premier's Department and Cabinet, through the CEOs of the various agencies, through the Department of Aboriginal Affairs, and through

regional and local community working parties, and land councils, et cetera, in developing the local communities.

With memorandums of agreement we find that there is usually a very nice launch, with a cup of tea and some biscuits, and then it tends to gather a little bit of dust on a shelf somewhere and the initial enthusiasm wanes—a little bit like the finger in the bowl of water. One issue I gathered when you were talking was about the question of facilitation of local shared responsibility agreements. Given that there is a need for a catalyst, a driver, and bringing out the enthusiasm that is obviously there in the local communities, and getting them to the point where they can take some equal partnership and control of those local community working parties-land council relationships in these shared responsibility agreements, do you see that it would be of great benefit, or any benefit, for organisations like Mission Australia to be involved in facilitating that process of finding those local gems, those local drivers and activists?

**Mr KENNEDY:** Yes, we could definitely get involved in that. We have a wealth of expertise of working in different indigenous areas, working collaboratively with different organisations, and particularly working to key performance indicators. I think the key to getting those shared responsibility agreements working is: What is in it for me? As you say, sometimes it gathers dust. For the job network provider, if you get more indigenous clients into work it will increase your star ratings. I will talk about star ratings a little more in a moment. If you are an employer and you take on an indigenous worker, there are fees for a traineeship, there is $4,000 there, if they stay for 13 or 26 weeks there is more money there federally. If you are a corporate, if you get involved in this process and donate some dollars, you can put it in your annual report and we can basically go to your AGM and we will have someone there to talk about the great things you are doing. We have to try to do it so that the key performance indicators are not clashing but there is a benefit in it for everyone.

**CHAIR:** May I put the question another way. The vision of Two Ways Together in the State Plan is to have jointly owned outcomes, jointly owned accountability. In ensuring that the indigenous community has in some way the ability to come to grips with accountability and control, and equal partnership in this vision, what do you think can be done to ensure that local communities are able to participate, in a meaningful way, in those shared responsibility agreements? We are getting a lot of feedback that there is disconnection.

**Mr KENNEDY:** I think the primary thing there is to really get the elders, the CEOs or the parents involved. One of the programs we are just about to embark on—or a program we have heard about and we are just about to help out—is in Cape York, where they are basically working in the individual communities to work with young adults, to say, "We have some job opportunities for you but they are not in your community, they are way down in Victoria." Most of them are in the abattoirs. It is usually with the boys. The reason it is very successful is that young men sometimes have penknives and that sort of stuff. They have usually been involved in a kill, in terms of kangaroos or beef, or whatever. The third one is that their parents have been stockmen. They say to them, "That's a good job, boy. You go down there and it will be a good outcome for you." They go down there, and sometimes they never come back because they settle themselves down. Or, they do come back in two or three years time and everyone sees the changes.

It is important to get the buy-in of the senior people and say to them, "What this can lead to is an increase in job opportunities and an increase in social engagement." It may not necessarily work straight off. It may be that we get that barbecue going, or we get that shed built, or we get that community area built. It is about what is in it for them. You say to them, "If you get involved and we achieve these outcomes, what would you like to see?" It may be that the pool gets opened, it may be that there is a community centre, it may be that a cultural activity gets run every six months. It has to be linked into them, where the elders or the parents have buy-in, so that all of a sudden it is driven by them as well. Then you say, "Okay kids, you've got to get involved in that", in order to get an outcome.

We found particularly in the Northern Territory, with Youth Beat and with JPET there, that just working with kids alone will not work. That is when we run mums' groups, getting the mums in as well. We work the mums and say, "This is the great thing that is happening there." Then all of a sudden, the mum lets the boy or the girl out every day to come to our service because they get an idea of it. I think that is where you can get something involved in shared responsibility agreements. That is not easy. What is it that can be the key performance indicator, the driver, that will drive the indigenous community but also will achieve the outcome for that community as well?

**CHAIR:** I am thinking more in terms of physical human beings, as opposed to key performance indicators. Unless you have drivers in the community who are people, who are driving an outcome, it does not happen. The Director General of the Department of Premier and Cabinet, with due respect to her talents, who has a role of driving outcomes for the vision—unless we are able to somehow come up with local people in local communities that are driving the outcomes, I cannot see how it could possibly happen.

**Mr KENNEDY:** Yes. And that is the challenge: getting the right person hired.

**CHAIR:** When we look at the issue of the message stick and the word of mouth, that can tend to be a great way of communicating but also it can engender certain groups of people, families or whatever, having perhaps more say than what they necessarily should have in terms of the community working parties, the land council, the committees, or whatever. There needs to be some way of facilitating the governance of how those structures take place. Is there any thought on the part of organisations like yourselves about that being an outcome of our inquiry?

**Mr KENNEDY:** From what you are saying, that sounds like it would be a good outcome, in terms of organising the government structure, what is the local community, and what is the driver. As you say, what we are trying to say is: How could we mandate that this needs to occur? You need someone who is very persuasive and very good at negotiating, so you can achieve the maximum outcomes for the indigenous community, but also so that the drivers, who are in there for business, get an outcome as well.

**CHAIR:** The driver has the best wishes of their passengers in mind too and maybe not just an outcome for themselves?

**Mr KENNEDY:** No, that is right. Getting the right staff in the community is a real challenge, the right people, with unemployment at 4 per cent at the moment.

**The Hon. GREG DONNELLY:** My question relates to the employment programs that Mission Australia runs in indigenous communities in terms of what is sometimes called the "churn" factor: people going into employment but only being there for a relatively short period of time, as opposed to a reasonably long period of time which hopefully leads to a career and full-time employment. Do you measure the length of service that people stay in the employment they are found through Mission Australia?

**Mr KENNEDY:** We do not specifically measure that but we are rewarded by the Federal Government on the length of employment, in terms of how long they keep in work.

**The Hon. GREG DONNELLY:** Can you enlighten us about that framework for the reward you get? Is it for 6 months, 12 months or two years?

**Mr KENNEDY:** That links to what I said about the stars. The reward system at the moment is that once you place someone into a job you basically get rewarded financially. Once they last 13 weeks in a job you get rewarded more financially. Once they last 26 weeks in the job you get rewarded financially as well. The secret to success to a lot of it is that almost 80 per cent or 90 per cent of the clients who reach three months go to 26 weeks—they go from 13 weeks to 26 weeks. Once they get over the first barrier and get to 26 weeks they will be on the cycle and will probably stay there for a long period of time.

**The Hon. GREG DONNELLY:** You are saying that the reward arrangement goes to the 26-week mark but what about beyond that?

**Mr KENNEDY:** At this stage in the major project that we deliver: Job Network, there is nothing beyond that. However, there is another program: STEP ERS.

**The Hon. GREG DONNELLY:** Let us just talk about Job Network for a moment. With respect to beyond the 26 weeks, does Mission Australia audit or keep records on the ongoing employment of those individuals in the jobs they have been placed in?

**Mr KENNEDY:** No, We do not.

**The Hon. GREG DONNELLY:** So you have no idea, for example, how long term some of those arrangements are with respect to those people's employment?

**Mr KENNEDY:** That would be right. Once they have reached 26 weeks the clients usually disappear from our system caseload. It is not until they actually go back on unemployment benefits that they would be re-referred to us. We could approximately make some assumptions looking at those who achieved 26-week outcomes of all that subset who many have come back within a certain time frame and you are then assuming how long that has lasted.

**The Hon. GREG DONNELLY:** That is hypothetical and I am not asking you to go and do that work. Various witnesses to these proceedings over the various days who have spoken about the employment issues with respect to indigenous people have spoken about the real challenges in being able to not just get them into employment and

overcome a range of issues associated with getting them into the employment, but the support, the nurturing and the encouragement which goes on for some period of time to enable them to continue long-term. By long-term I mean over a significant period of time well beyond 26 weeks. I am talking about getting established in hopefully a full-time job as opposed to a casual or part-time job and that full-time job leading to a career. A number of witnesses before this hearing have given that similar type of evidence.

I am wondering how geared, if at all, is Mission Australia to that long-term approach of ensuring that the people that you did get in stay in. It seems to me there could be the real possibility that your KPI of getting people in and the box being ticked through to the 26 weeks might meet the very maxim or high star rating but the reality may well be that people are not in jobs or do not remain in jobs for any significant time beyond the 26 weeks. Surely if we are looking to get Aboriginal people into employment, and full-time employment and careers, that is what is going to raise their standard of living, raise their ability to support their family and be part of their community, the champions in the community and be a good example to others, as opposed to what is short-term possibilities. Would you like to comment on that?

**Mr KENNEDY:** Yes. One of the programs that the Government has started recently is called STEP ERS. STEP means Structured Training Employment Program and ERS is employment related services. That is what has replaced the old CDEP generally in the metro areas because CDP's disappeared from Sydney. What that program has is longer-term outcomes. They are individually negotiated with a provider, but they are looking at 52-week outcomes in that particular program. How they have structured it is that you are basically rewarded financially to play someone into a job, you are rewarded to engage someone initially and you are then rewarded to mentor. The ongoing mentoring on a regular basis, up to those 52 weeks and/or beyond, is part of the overall program. It may be that this month we have done four hours with James or six hours with Harry and we would just put in an invoice for those six hours. That is where they are starting to move to—long-term outcomes and sustainability is important. We have got a very limited number of those programs that we are delivering. We are only delivering a couple of them in north Cape York and Cairns-Townsville and then down in Victoria.

We have tried to get a few going in New South Wales but there has been pretty fierce competition and there are only limited funds that they have. We have recommended to the Federal Government along those lines about more sustainability in jobs and how is that going to be funded? I think it is a good model that they have, as there is a mentoring component. That mentoring is not only necessary for the jobseeker or employee, in terms of how you are going in that job, but it is also for the employer. We can go down there and do some cultural awareness training or mediation or is there anyway that we can work to try and sustain that outcome? I think that is a very pertinent point because 26 weeks can be short-sighted. STEP ERS is looking at longer-term outcomes but it is not necessarily mandated for every contract that they do. Sometimes it is 26 weeks, sometimes it is 42 weeks and sometimes it is 52 weeks.

**CHAIR:** Unfortunately we have run out of time. Thank you for your attendance and your important contribution. Our interim report is due at the end of June and the final report at the end of year. With your assistance we may wish to call upon you again for your advice.

**Mr KENNEDY:** It has been my pleasure and I welcome the opportunity to present.

**(The witness withdrew)**

**(Short adjournment)**

**JOSEPH CANALESE,** Associate Professor, School of Rural Health, University of Sydney, P.O. Box 1043, Dubbo, 2830, sworn and examined:

**CHAIR:** Thank you for your attendance, Professor Canalese. In what capacity are you appearing before us today?

**Associate Professor CANALESE:** I am Associate Dean and Head of the School of Rural Health, which is part of the University of Sydney, Faculty of Medicine. I have been asked to attend this Committee.

**CHAIR:** That is greatly appreciated. Would you like to make some opening remarks as to your role?

**Associate Professor CANALESE:** Certainly. Because I am not certain in what context I am representing here, whether it is educational, health, social or otherwise, it might be worthwhile for the Committee members to know my background and also, importantly, where the School of Rural Health sits in the educational structure of the University of Sydney. My background is that I grew up in Italy until the age of 11, came to Australia and lived in Sydney. I graduated from the University of Sydney and specialising in general medicine at North Shore Hospital.

**CHAIR:** I am having difficulty hearing.

**Associate Professor CANALESE:** I will start again. I grew up in Sydney, was educated in Sydney and graduated from the University of Sydney. From North Shore Hospital I went to London and then in 1980 I came back as a specialist and went into a locum in Dubbo and I am there 28 years later, so I have a long rural background. There I was one of three clinic physicians, so it is a very large sort of clinical burden. In terms of Aboriginal exposure, we have a large indigenous population both in Dubbo and also for 18 years in clinics in Brewarrina, Bourke and Wellington. Our population there varies from 10 to 15 to 30 per cent in each of those towns. A large number of my patients were indigenous. In the context of education, I was asked to be the Associate Dean of the School of Rural Health three years ago, and that is where I am at.

Just to give you a context for the School of Rural Health, in 2000 the Commonwealth Government through its Rural Clinical Schools program, thinking that by exposing medical students to the rural and remote setting it might encourage some or hopefully many to go and practise in those areas, asked various universities to bid for a sum of money in the context of setting up rural clinical schools. Nine universities bid and Sydney was one of them. Sydney decided to place its rural clinical school at Dubbo and also at the campus in Orange. So our main campus is at Dubbo-Orange and we also send our students to Broken Hill, Bourke and smaller areas. The contract is that in order to get the funding you have to have a quarter of the Australian students spend at least one year in a rural setting. This is where we come in. So we get our students come from the Faculty of Medicine of the University of Sydney. We get a quarter of each year that will spend one full year with us. The curriculum that we deliver is the same curriculum as the University of Sydney, but it is in a rural setting and obviously with a rural flavour. We go out of our way to expose our students to rural and indigenous health. It really is not very difficult because that is what the health there is. That is our focus.

In terms of indigenous recruitment to the University of Sydney, that has some problems. The reason is that the University of Sydney medical program is a post-graduate medical program. What that means is that in order to come to us you must have a prior degree. That can be in any format at all. It can be in Arts or Humanity, but most of our students come from a background of medical science. It is almost a direct pathway. That is not our choice; that is their choice. Then in order to even get to first base you have to have a credit average pass. You then have to sit a general exam called a GAMSAT, which examines scientific knowledge as well as personality, but mainly scientific. You have to get a fairly high, good pass. If you fulfil both those criteria you then get an interview. From those we choose.

There are other universities, of course, where there is direct entry from year 12, namely places like the University of Newcastle, the University of New South Wales and the University of Western Sydney. In terms of direct entry for students, especially indigenous students, it is easier to do that. I am sure I will be fired when this gets out, I encourage my indigenous students who have the idea to do medicine and they have a reasonable score to apply there, because they are guaranteed. For us, they have to do another degree and then potentially the other hurdles. However, if we can identify a graduate we encourage them and we facilitate it, if we can. But getting a graduate to then go into medicine, it is not quite as easy at the moment. Hopefully it will change. At the moment if I have indigenous promising students who wish to do medicine I ask them to consider the possibilities which are much more direct and straightforward and have less hurdles. That is one of the reasons.

**The Hon. TREVOR KHAN:** Professor, a lot of your experience is clinical experience, is that right?

**Associate Professor CANALESE:** Certainly.

**The Hon. TREVOR KHAN:** Am I right in saying in a town like Dubbo there is a limited number of general practitioners?

**Associate Professor CANALESE:** The numbers have decreased, unfortunately, although in Dubbo itself we have stabilised over the last two or three years. The crisis is in the smaller towns. The smaller towns are really struggling to maintain their workforce.

**The Hon. TREVOR KHAN:** I will talk in terms of Dubbo, but I welcome any comments about your experience in Bourke, Brewarrina and elsewhere. How many of the general practitioners in those towns bulk bill? Do you have a knowledge or understanding of how many how many doctors bulk-bill?

**Associate Professor CANALESE:** I cannot say. We have one major clinic that bulk-bills, and probably one or two others also do it. That is one of the problems with indigenous patients. If they are not bulk-billed they are less likely to go there. At the moment one major clinic is bulk-billing and possibly two or three others, and they would do that selectively rather than globally.

**The Hon. TREVOR KHAN:** I take it from what you are saying that the opportunity to access bulk-billing in Dubbo is not great. It throws many Aboriginal patients back on to the accident and emergency department, does it not?

**Associate Professor CANALESE:** Yes. We also have the Thubbo Aboriginal Medical Service, which provides an excellent service. It is not limited to indigenous patients; it is really for the disadvantaged and people in financial difficulty. Our casualty and outpatient demand has skyrocketed.

**The Hon. TREVOR KHAN:** Let us talk about the doctors who work in casualty, and I may use the wrong terms. You obviously have young interns who are in their second, third or fourth year. Is that right?

**Associate Professor CANALESE:** Yes.

**The Hon. TREVOR KHAN:** You operate essentially a similar program to that offered by the University Department of Rural Health in Tamworth. I think they pull their students out of Newcastle.

**Associate Professor CANALESE:** Yes. However, we have ours for a whole year and they do a whole program. If they come in third or fourth year, they will do the same as they would do at Prince Alfred. The educational content is the same but in a different setting with a different slant. They take the same path. The curriculum does not alter from that offered by the University of Sydney. Be it Prince Alfred, North Shore or wherever, the clinical schools are the same.

**The Hon. TREVOR KHAN:** I am not being critical of any young interns, but I take it that their life experience is in a city environment.

**Associate Professor CANALESE:** Yes. Each year some staff and I go to the city to recruit students to the country. We do a survey and it astounds me that of these graduate students, who are about 22 or 23 years old, only 30 per cent to 35 per cent have been past Bathurst, and some have never been past Penrith.

**The Hon. TREVOR KHAN:** Not only do they have limited life experience west of the range, but most would be either middle class or upper middle class in background.

**Associate Professor CANALESE:** Yes, but that is changing.

**The Hon. TREVOR KHAN:** What training in social awareness and sensitivity is provided by either your medical school or the university?

**Associate Professor CANALESE:** We have lectures in indigenous culture and sensitivity. In fact, we have just written a web-based learning program on both rural and indigenous cultural matters. We want to help in that. A lot of them have very little awareness at the beginning, but their mindset changes. It is interesting. In the future that program will bear fruit, but this only the start. We have some people who bought boxes of noodles thinking they could not buy them in Dubbo. That gives an idea of how closed some people's minds are. In terms of the indigenous context, some have very little knowledge. Of course, when you are there you cannot help but be exposed because 35 per cent to 50 per cent of the inpatients and outpatients are indigenous. They suddenly realise the need and that people are people.

**The Hon. TREVOR KHAN:** Taking into account my name—

**Associate Professor CANALESE:** Yes.

**The Hon. TREVOR KHAN:** I am the son of a general practitioner. In terms of those students who, for example, go looking for their noodles, do the patients interact with the young intern in those circumstances? Does a social barrier exist both ways?

**Associate Professor CANALESE:** At the beginning it does. You can see that both the patient and students are fending off and sizing up each other. Fortunately, many of our students are socially and culturally aware and driven and it does not take long for that to break down. Some of our students end up running little clinics of their own and helping as volunteers. In fact, one of our students had a clinic with one of the general practitioners in West Dubbo for a year purely to help indigenous people. Obviously, that student will end up being involved in indigenous health because she is very driven by that. By the end of six months, many of the students are very comfortable and have much better interaction with indigenous people. I am very comfortable that we are succeeding in that regard.

**The Hon. TREVOR KHAN:** How long has the program been operating?

**Associate Professor CANALESE:** It started in 2001 and by 2004 it was in full flight. We have now had four graduations. In that time, we have had people coming back. Two of our former students are now practicing in Orange and one will be practising in Dubbo. We are we are beginning to see the fruits. I cannot say how many are working in smaller towns, but we will be tracking that soon. I am not sure how many will end up working in Aboriginal health or related areas. It would not surprise me if we see more in the next four or five years.

It is important to note that the student who graduates today will not be working in the community for at least four years. It could be eight or nine years if they go overseas. The routine is that they graduate and spend two years in a hospital. The majority take a year off to travel overseas. They might have a good social or educational reason to have a break. They then decide whether they will specialise. If they want to become a general practitioner, that will take another two years. If they decide to do surgery or medicine, it will take another four or five years. In reality, the pathway is 12 years. Obviously I have thought a lot about this because of this discussion. We will see fruits in 2012 to 2015. That is when the fruit will ripen.

**The Hon. TREVOR KHAN:** You pre-empted the balance of my questions.

**The Hon. GREG DONNELLY:** We had some questions on notice.

**Associate Professor CANALESE:** I have received them.

**The Hon. GREG DONNELLY:** I take you to question number five. Does the school provide assistance for indigenous students on campus?

**Associate Professor CANALESE:** We do not have any indigenous students. However, the faculty at the University of Sydney has some. We have the Koori centre,

which is very specifically helping at the University of Sydney. Dr Lilon Bandler is well known in the indigenous community. She helps any indigenous students. Our school has a program called A Will and A Way. It is run by one of our lecturers who works for the Department of Education and Training at the main school in Dubbo. Her task is to assist students, not only indigenous students. However, because a large percentage are indigenous students she is very engaged with them. She supports them in pledging and helping them to do one of three things: to stay at school until year 12; if they really want to leave at year 10, to do a trade or TAFE; or to get a job.

Initially it was funded by a scholarship from the Sir Russell Drysdale funding—there was a particular scholarship for that—but now the value has been seen and the Commonwealth Government is now funding it for three years. It has now been extended to other centres. The aim of that is to get indigenous students early and help them to the next step and encourage them and maybe foster them and mentor them. For example, if Louise finds that somebody can get a job but they need a pair of shoes for that job, sometimes we find some of that either within the school or in surreptitious ways to help them. At the main faculty level, Lilon Baulla is very involved in that, and with a limited number of students she helps there. You might have read of late that a very generous benefactor has granted $10 million to the University of Sydney and we have the Aboriginal and Torres Strait Islander Health Centre. The consequence of that is that we will have a professor of indigenous health who will drive both research and teaching.

We have had extensive visits to Dubbo, Bourke, Brewarrina, Broken Hill, the Northern Territory, Broome and now the Torres Strait Islands asking them exactly what are the real needs of the local indigenous communities and the Torres Strait Island communities, rather than us going in and saying this is what we think you should do. The Dean and other members of the faculty at a high level have been going around and doing that. I was privy to some of those meetings with the indigenous leaders to see what is needed. That is what the faculty does, and what we do. Unfortunately, we do not have the number of students at the moment. If I found a student from an indigenous background who wished to do medicine, you can be sure it would be facilitated and he would be helped in every way possible. We have 10 places each year reserved for indigenous students but we cannot fill them. When the time comes that we can get candidates, they will be fast tracked.

**The Hon. GREG DONNELLY:** Which leads me on to the next question, which, in part, you have answered about your thoughts on how to encourage them?

**Associate Professor CANALESE:** I thought about this. I think the way I would like to do it is at high school level. If we have students who show a promise—the major problem is that we have students who show a promise in year 10 but at year 12 a lot of them drop out for a variety of reasons. Unfortunately for some students higher education is not in the mindset. Their peer group likes to do other things and occasionally very promising students would drop by the wayside. If we could just mentor them, help them, support them so that they get to the next step, at university—and perhaps I will lose my job over this—if they might go to another university—

**The Hon. GREG DONNELLY:** That is the second time this morning.

**Associate Professor CANALESE:** If I can encourage them to go to a school, for example the University of Newcastle, which has a good setup, including some indigenous support. Also, for some of the students I have spoken to Sydney is a frightening place. They have lived in smaller communities. Dubbo is not such a small community but for them it is. Suddenly they have to go to the sandstone, 15,000 students running everywhere—the enrolment at the University of Sydney is now 46,000—and some of these young people do understand that many. It is a bit frightening, a bit daunting, whereas a place like Newcastle, although it is fairly large, and some of the smaller places like Armidale or certainly a place like James Cook University in Queensland, which, because of its nature is a bit more welcoming.

**CHAIR:** Charles Sturt University.

**Associate Professor CANALESE:** Charles Sturt does not have the medical faculty although we have an agreement with Charles Sturt University that we would accept, both in the dental and medical faculty, some of the students who have done their primary degree there, and we were hoping specifically along these lines that we would have some indigenous students who grew up in, say, Bathurst or Wagga or Dubbo, if we could track them through that and then bring them in, that was part of our hope, and there is a facilitated entry—10 for medicine and 10 for dentistry—in that scope. So, the goodwill is there, it is just a matter of taking that step.

**The Hon. GREG DONNELLY:** Question No. 7 goes to the issue of—

**Associate Professor CANALESE:** Any indigenous?

**The Hon. GREG DONNELLY:** On the teaching staff at the moment, are there any?

**Associate Professor CANALESE:** At the moment we have none, however this is part of the program I mentioned before. This is the indigenous health, and we were going to have a professor of Indigenous health.

**The Hon. GREG DONNELLY:** When is that to start?

**Associate Professor CANALESE:** However, Lilon Baulla is at the faculty. When is that starting?

**The Hon. GREG DONNELLY:** Yes.

**Associate Professor CANALESE:** It is in the process now. They had advertised for a professor, so it is at that level. I think the interviews will be held in the next month or so.

**The Hon. GREG DONNELLY:** Just finally, on question No. 8, about the schools funding—

**Associate Professor CANALESE:** The funding comes from the Department of Health and Ageing, through its rural clinical schools program. Up to now it has been a three-year constant funding but I understand the program has gone from lapsing to a non-lapsing program.

**Dr JOHN KAYE:** Can you tell us how many Aboriginal doctors there are in New South Wales?

**Associate Professor CANALESE:** No, I cannot. I think it is about 25 or thereabouts. But the number is increasing. We have had some come through our schools in the early days. At Dubbo we used to have students from the University of New South Wales and the University of Newcastle. We had them on secondment. This is before the clinical school as we are now. I remember two students, one from Gulargambone who is now practising.

**Dr JOHN KAYE:** In a rural context or in a city context?

**Associate Professor CANALESE:** I think it is in a city context. That is always the problem.

**Dr JOHN KAYE:** So, the majority of those 25 would be in the city?

**Associate Professor CANALESE:** In the city or in the health department or indigenous departments.

**Dr JOHN KAYE:** Is there a phenomenon in which people of Aboriginal background who get jobs and get qualifications in things like education, medicine, and so on, end up being taken out of front-line services and promoted through into managerial services?

**Associate Professor CANALESE:** Yes, I think there is an element of positive discrimination. I think that is a good thing but the problem with that is it removes them from the coalface. That is always a problem. You want to promote people but by doing that you take them from where they are often most effective at a one-to-one level. I think the other important thing is to have them as peer examples for the younger people. It would be lovely if we could get one or two indigenous doctors back in Dubbo for the local young indigenous people. Many years ago, before I was involved in any educational context, I proposed to the high schools that I would sponsor two students who are now doctors at the University of New South Wales to come and talk to all the schools. Me talking to a group of indigenous students at years 10 and 11 about higher education and the benefits of medicine—a middle-class, old male—does not quite resonate like having somebody still at university who has the same life experience as them, saying you can do it.

**Dr JOHN KAYE:** There are many barriers there, right? There is the barrier of perception, that this is just beyond me?

**Associate Professor CANALESE:** Yes.

**Dr JOHN KAYE:** As you say, it is 12 years from higher school certificate to being in a job, which is a long time in anybody's view of the world, and there is the barrier also of the unknown. How do you overcome those three barriers?

**Associate Professor CANALESE:** I think one of the ways is to show them, by the people who have done it, that it can be done. For them to say, "I was in your shoes

12 years ago and this is where I am now." You cannot do it with everybody but you can with a lot of them. Just bring them to the university and show them that the university is not a frightening place.

**Dr JOHN KAYE:** I taught at one for 25 years; it is frightening.

**Associate Professor CANALESE:** Surprisingly, I never found it too frightening. I came from a family that fortunately soon after I went to Dubbo a lot of my nephews were coming on stream and a lot of them were graduates. Every time I came to a graduation I would take two Dubbo young people to graduation, in the context that if you are not enthused by the graduation nothing will enthuse you. Every one of those kids has now gone to university. They might have gone anyway, but that experience of seeing it as just another place and talking to them about it—and then if you have somebody who is really very promising maybe you concentrate a bit more effort. If you want to call it cherry picking, you know this person has a lot of talent.

**Dr JOHN KAYE:** I understand the University of Melbourne has moved to a system where medicine is entirely postgraduate?

**Associate Professor CANALESE:** As is ours.

**Dr JOHN KAYE:** As yours is also?

**Associate Professor CANALESE:** Yes.

**Dr JOHN KAYE:** Do you think that is alleviating the barriers in that it breaks the process down into separate degree steps?

**Associate Professor CANALESE:** I think it makes it a bit more difficult for some people who find the thought of a medical degree daunting. I think this makes it even more daunting because then you have to go another step to get there. So, if you are in a group of people for whom just the thought of going to a medical school is frightening, going to a medical school at a place like Sydney University, not so much the degree but the process of getting there is more burdensome on the way. This is why in my opening remarks I was saying there are other places where indigenous people are more likely to attend.

**Dr JOHN KAYE:** To that extent, is the postgraduate medical structure not a positive thing in that a young person can enrol and get a science degree from a less intimidating institution and then make the choice to go on and do a medical degree?

**Associate Professor CANALESE:** Sure, except to say that it lengthens time. Financially it is a bit more daunting and if you are the sort of person who was driven to do medicine and there is an option to do it earlier, you will do it. However, the benefits of a postgraduate degree are that the students are a bit more mature. Teaching our students now is very different to teaching students straight out of high school. They are three years more mature, they have had experience of doing another degree.

**Dr JOHN KAYE:** Do you think that HECS is a barrier to Aboriginal children making decisions to go to university and, in particular, because of the length of medicine, making the decision to study medicine?

**Associate Professor CANALESE:** Possibly, but I do not think it is a real one. I will tell you why. If you are an indigenous student wanting to do medicine, you will be guaranteed a scholarship. If today you came to me with an indigenous student who wants to do medicine, I guarantee you that I will find not only scholarships but other support measures. I do not think that is a particular problem. That is current. If we get flooded with them, that might alter, but the number of scholarships we can give at the moment far outweigh the number of applicants. Our problem is the applicants, not the scholarships.

**The Hon. MICHAEL VEITCH:** Following on from one of the questions that Dr Kaye asked about which you may or may not be aware, but Charles Sturt University had a week here at Parliament House a couple of weeks ago where they showcased the university and a member of their alumni was showcased as well, that being the Hon. Linda Burney, who is the first indigenous student through Charles Sturt University. It follows on from what John was saying about champions within communities also being prepared to be that champion and that example of what can be done. In a conversation I had with Linda about getting more indigenous students into university, she made the comment that indigenous people's learning structures are often different to the way the universities' conduct their learning. Do you have a view about that?

**Associate Professor CANALESE:** To be fair, I do not have great experience about that, except to say that I was at university at the same time as Charlie Perkins and I remember him away studying by himself. It must have been daunting for him whereas now all that is changing. I am really not aware of the different learning styles except to say that a lot of the young people in the year 12 say that they feel what is taught is irrelevant to their perceptions of life, so that is the educational context at that level.

In terms of my experience of teaching indigenous students, at times we had to be more supportive because they are a little bit more reticent in asking questions and in coming forward. If I had a group of five students, more often than not the indigenous students would hold back. I have to be conscious of that and ask the questions specifically and say, "Would you like to comment on that?" because if I said, "Does anybody want to comment on that", you could be sure they would be much more aggressive in that social context.

**The Hon. MICHAEL VEITCH:** If I can ask you about something that is broader than your role here today. In your opinion, what is the key issue affecting indigenous people in New South Wales right now?

**Associate Professor CANALESE:** There have been huge meetings about this. This is a personal and possibly biased view. At the moment there is a lot of support for indigenous people but it is not always accessed by the people who need it. There is a lot of goodwill and some of the support is not directed or structured. I am a great believer that if you want a program, you support people and ask them what it is, and then make sure they are getting engaged in it, but that they are responsible for it as well and if it does not work, they are responsible for what they do. While occasionally the young people that I interact with do not have that sense of personal responsibility and there is a feeling with disadvantage that "somebody owes us something", society or Australia but there is nothing I can do about it, whereas you can do a lot about it. Get engaged, access

what is available, do the next step and contribute and then you will change things. That is part of it.

From a health point of view, there are some major problems. I have actually sat down and thought of some of the things that need to be done and hopefully a little bit will be addressed by the programs that the university will do. Nutrition is a problem and it is not so much the calories but what is eaten. This is not purely an indigenous problem but a society problem, but it is a little bit more noticeable in indigenous communities.

**Dr JOHN KAYE:** Do you mean what is eaten or what is not eaten?

**Associate Professor CANALESE:** It is both. You can have a thousand calories in carbohydrates and sugar or you can have something with nutritious meat, et cetera. Dental problems are huge. If you see patients for medical reasons, dental problems are something we really have to address. Since you mentioned CSU, I am hoping to have cooperation between Sydney University, the CSU and Greater Western Area Health Service to pull resources and have a dental clinic for Dubbo because that would be a place where indigenous people could go for free. We have a lot a problem with middle ear infections, and teenage pregnancy at the moment is a problem.

A lot of indigenous people come when the problem is well and truly there. Preventative medicine is not strong and they come in crisis management instead of when things start to go wrong. Somehow we have to have programs to access and encourage that. Then you have problems the same as the rest of society with alcohol and drugs. That is not isolated to that section of the community; it is slightly marginalised though.

**The Hon. MICHAEL VEITCH:** This is a wish question, if you could outline one thing that the Committee should recommend that would increase the number of indigenous students at university, what would it be?

**Associate Professor CANALESE:** It would be to have young indigenous people who show promise to be identified and then encouraged, mentored and supported to allay a lot of the anxiety. Once we get a critical mass it will be self-sufficient. At the moment we are starting from such a low base that it is difficult. If we can get a number that we can support and by all means fast-track them and do not worry about people saying, "This is not fair. My son Johnny missed out." That is another matter. We should have dedicated places for indigenous people and identify 10 indigenous students in the whole of New South Wales and support them because the money spent will be a pittance compared to the benefits, and then mentor them, either by other indigenous or non-indigenous students or whatever means help them along. When they come to university there are measures there to help them. It is a matter of showing them where they are. If we had a group of people we knew were coming, we would put measures in place to make sure that they would be helped. At the moment the real problem is getting them there, getting them to the first step.

**The Hon. MARIE FICARRA:** If you look at prenatal-paediatric-adolescent health, particularly prenatal, to ensure that our birth rates are going up in the indigenous communities, the importance of prenatal adolescent health and the birth of the baby,

the status of the baby and nutrition, has the teaching of rural health changed to better equip us to realise these key areas?

**Associate Professor CANALESE:** We show students what the problems are. Again indigenous health varies. Access is very different in Dubbo to Brewarrina to the very remote. If we take a centre like Dubbo because numerically it is fairly large, they have access like any other member of the community to services like anybody else. It is not as though they are limited to that. The obstetrician and gynaecologist there bulk-bill so it is not a problem. The clinics are available. The problem is getting them there early on, especially teenagers where there is a moderately floating population between the areas. Continuing care at that level is a little difficult. Maybe one day, when we have universal medical records, patients will be able to take them with them, although there will be issues with confidentiality. That day will come; it is a matter of when, not if. That will help. We point out to the students what the problems are and how to redress them. The practical problem is when the patients present.

**The Hon. MARIE FICARRA:** There has been a lot of talk in the media on sanitation, water supply and inadequacies in some of the rural communities and a 218 per cent increase in hospital admissions for gastroenteritis, respiratory problems and skin conditions. Are you taking this into account?

**Associate Professor CANALESE:** Yes, we are very aware of that, although fortunately in Dubbo this is not a major problem because it is a metropolitan town. It is interesting that the increase in dental care may well be due to the fact that some of the patients live in places where fluoridation is not available or, as you are probably aware, the new fashion of having bottled water, which does not have fluoridation, is beginning to show up, has the potential for an increase in dental care because a lot of people no longer drink fluoridated water, but bottled water.

**The Hon. MARIE FICARRA:** And the cultural sensitivity of getting healthcare workers in these rural communities doing healthcare checks. Earlier I was talking to you about cervical cancer screening and difficulties in the training of medical practitioners who work in these communities.

**Associate Professor CANALESE:** We try to give them cultural sensitivity but the problem is that in hospitals you get some people who are bit of a drongo and you have to make them aware of all of the issues and the way they interact. Even taking the history is difficult. You have to be sensitive also. If you have an indigenous patient who is very sick in hospital, you will have half the town camped outside. You could say it is a nuisance having to trample over people sleeping or you can say, "It is a caring community and that is the way they react. Maybe we should have a few more chairs."

**The Hon. MARIE FICARRA:** Should we have more mobile vans or travelling communities with culturally sensitive healthcare workers doing healthcare checks?

**Associate Professor CANALESE:** It is changing. In the past I used to cringe at some of my colleagues.

**CHAIR:** Unfortunately we have run out of time. Thank you for your assistance.

**Associate Professor CANALESE:** Thank you for the opportunity. I was not sure what was expected.

**CHAIR:** Our interim report will be handed down in June and the final report at the end of the year. We may seek further assistance from you.

**Associate Professor CANALESE:** One person who would be very useful in providing a submission or talking to is Louise Lawler from the "A will and a Way" program, which has great potential. The Commonwealth Government has seen that and it has funded to extend it. Its aim is to encourage students, especially indigenous students, to stay on and further their education.

**(The witness withdrew)**

**(The Committee adjourned at 11.55 a.m.)**