KIMBERLEY SUICIDES

Grievance

MS J. FARRER (Kimberley) [9.25 am]: My grievance today is to the Minister for Mental Health and concerns the number of suicides that have occurred and continue to occur in the Kimberley. I would like to ask the following questions: Over the years, how many people have committed suicide in the Kimberley? How many were male? How many were female? How many were children? How many were Indigenous? How many were non-Indigenous? Coroners' reports have been done into the rate of suicide in the Kimberley, but despite these reports, what has changed? The latest report released in February this year was the "Inquest into the 13 Deaths of Children and Young Persons in the Kimberley Region". Many of the interviews with the persons mentioned in that report took place in a courthouse—a place where many of those people were not comfortable and which did not hold good memories. This was the place that they attended to hear the finding that their loved one's death had been ruled as suicide. To have to sit in that same courtroom and relive the trauma of losing their loved one was emotionally distressing.

This is a seriously distressing issue. For too long alcohol and drugs have been blamed as the perpetrators causing these people to commit suicide. As we know, alcohol restrictions are not the answer. Many issues need to be dealt with and collaboration between departments is paramount. Police who are called out to domestic violence situations need to take into consideration the effect it has on the children in that household. I would like to make it very clear that family violence can have a long-lasting effect on children who finally suicide. What happens in homes is often behind closed doors and no-one sees it. Money may build infrastructure and set up services, but it is how these services are implemented and how they integrate and collaborate with other services and departments that can make the difference. The exchange of information between departments is vital so that children and young persons who are victims, in many cases not physically but psychologically, of domestic violence in their family or environment get the support they need. It is only through this collaborative approach that many children can then get the psychological support that they need to ensure that they know there is a better life, someone does care, there is help and a safe place, and, most importantly, that suicide is not the answer. It seems that not much has changed as a result of the findings of any of these reports, and the rate of suicide in the Kimberley remains one of the highest in the country. Are departments collaborating and exchanging information that enables children, and children at risk, to be protected and supported? What new services have been implemented to help avert the problem instead of trying to treat it? How much funding is being put in for the prevention of suicide? How much is from the state government and how much is from the federal government? As we say, there does not seem to have been any changes that I know of. I would like to put this on the record, because these are the concerns that my people have.

MR R.H. COOK (Kwinana — Minister for Mental Health) [9.30 am]: I thank the member for Kimberley for bringing forward this grievance today and I acknowledge the work the member has done to raise the issue of suicide prevention in her community. She spearheaded the work done by this Parliament through the report "Learnings from the message stick: The report of the Inquiry into Aboriginal youth suicide in remote areas". Subsequent to that report was the coroner's report, which she observed was brought down early this year. Both reports were very instructive and the government is obviously resolute, but also morally bound, to respond to those reports fully, and we are attempting to do so.

I will endeavour to provide more written information to the member in the future to answer her specific questions, but today I will provide a sense of what is going on in the community. In 2018, Western Australia had the third highest rate of suicide across Australian states, with 14.7 deaths per 100 000, which was higher than the national average of 12.1 deaths per 100 000. There was a decrease in the number of registered suicides to 383—285 males and 98 females—compared with 409 in 2017. The rate of suicide deaths per 100 000 people has decreased to 14.7 deaths per 100 000 compared with 15.8 deaths in 2017.

Western Australia had the highest age-standardised rate of suicide among Aboriginal and Torres Strait Islander people of 37.9 deaths per 100 000 people. This was considerably higher than the national average of 23.7 deaths per 100 000 people. The state also has the second highest age-standardised rate of suicide among children aged five to 17, at the rate of 3.1 deaths per 100 000 people. This was higher than the national average for children aged five to 17 over that period, which was 2.4 deaths per 100 000.

The significant number of suicides in the Kimberley region gave the coroner cause to raise this issue. As the member for Dawesville rightly pointed out, recently the midwest also had high suicide rates among the Yamatji community, so we have much work to do. Indeed, we are attempting to respond to the coroner and the message stick report in an appropriate way. In doing so, in May this year we brought down our statement of intent on Aboriginal youth suicide.

This is a significant issue and I probably will not do it justice in the seven minutes I have available to me today. I want to assure the member that the Premier is absolutely focused on this issue and his department is leading the cross-departmental agency final response, which is a follow-up to our statement of intent. We look forward to

producing that response later this year. That will be informed by a range of things, including the two workshops that were held this year, in the Kimberley in August and in Kununurra in October. Although the reports from those workshops are still being compiled, overall the message from the community has been emphatic: first, to stress that the situation is urgent, but also that fundamental changes are needed in how the government works with and for Aboriginal people in the Kimberley and across the state. As I have said in the past, we are determined to make sure that this is not simply an exercise in co-design but in co-production and co-delivery of services.

I have been greatly encouraged by the work of the federal government in the trial sites that are currently running in conjunction with Kimberley Aboriginal Medical Services. These are the national suicide prevention trials. I think the member would agree that the work that KAMS is doing with the WA Primary Health Alliance has been impressive. The member and I recently attended that workshop in Broome—I forget when it was; it might have been in September—at which a number of people working out in the field gave detailed descriptions of what they are doing in the communities now, particularly in the engagement of social and cultural wellbeing officers, who are able to anticipate and observe changes in community behaviour which may of themselves be a precursor or indication that things may not be all right and that we need to be proactive in stepping in.

I have worked closely with Hon Ken Wyatt on this issue. As the member for Kimberley has observed on a number of occasions, this goes beyond political parties and political governance. This is something that we need to work on. We need to work on it with a sense of urgency but we also need to ensure that what we do does not get in the way of the good work that has already been done. Let us not kid ourselves: this will be a long-term project.

The member asked about a range of initiatives that the government is taking on. I draw her attention to one in particular: under the Suicide Prevention 2020 plan, the Mental Health Commission funds the Aboriginal Health Council of Western Australia to deliver the Aboriginal family wellbeing project, which focuses on addressing the social and emotional wellbeing of Aboriginal people to prevent suicides. Importantly, it involves the delivery of an adapted accredited six-month certificate II in family wellbeing to Aboriginal medical services across the state, which will then co-facilitate with AHCWA individualised family wellbeing workshops for communities, based on community need and local priorities. Delivery of the family wellbeing program commenced in the Kimberley in July 2019. The member would be aware that we also have suicide prevention coordinators working throughout the state, including one who is based in Kununurra. As I said, I cannot do justice to this issue in the time I have available. I will endeavour to provide written material to the member to answer more fulsomely the important questions she has raised today.