Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF LIN HATFIELD DODDS

I, Lin Hatfield Dodds, Associate Dean for the Australian and New Zealand School of Government, of the Crawford School at the Australian National University, say as follows:

1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Background

2 I am currently the Associate Dean for the Australian and New Zealand School of Government (**ANZSOG**). I have held this position since February 2019.

3 I have a Masters in Applied Psychology from the University of Canberra.

4 My background includes working as a counselling psychologist, with a particular interest in trauma and abuse.

5 Prior to my current role, I was:

(a) the Deputy Secretary for Social Policy in the Department of the Prime Minister and Cabinet between 2016 and 2019. In this role I led the provision of whole of government advice to the Prime Minister on health, education, social services and gender equality, advised the Prime Minister on the Council of Australian Governments and provided advice to the Minister for Women;

(b) the National Director of UnitingCare Australia between 2002 and 2016. UnitingCare is Australia's largest non-government provider of community services, providing social, health and aged care services across urban, regional and remote Australia;

(c) Chair of the Australian Social Inclusion Board between 2012 and 2013; and

(d) President of the Australian Council of Social Service between 2005 and 2009.

6 Attached to this statement and marked 'LHD-1' is a copy of my CV.

7 I confirm that I am giving evidence to the Royal Commission in my personal capacity and not on behalf of my employers or organisations that I am a member of.

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

Local communities and social inclusion

Defining 'local communities'

8 Communities may be experienced and defined by their members as:

(a) Place based geographic communities;

(b) Communities of interest; and

(c) Virtual communities where people connect online/by phone in ways that don't include face to face connection.

9 Communities are defined by identity and activity, and involve elements of scale, connecting, belonging, being valued, longevity and accountability.

10 Every community has a collectively curated culture and set of practices that holds it together. In formally constituted communities like sporting clubs, the culture and practices are more overt, while in informal communities like the local neighbourhood, the culture and shared practices are often unexamined. Whether examined or not, these elements of culture and practice frame how individuals relate and behave in a community.

11 Members of local communities usually define their community by place, and can clearly define the physical boundaries. If there is a secondary defining characteristic, its often about the quality of the relationships and experience, for example a member of a community member may say "I'm from XYZ, it's a really friendly place".

Differences between communities of connection or identity and geographic communities

12 Communities of connection or identity (for example, cultural and religious communities) differ from geographical communities in choice and key commonalities. While you can often choose, within constraints, where you live, you do not usually choose who else is in your geographical community. In general, however, you can usually choose to be part of a community of connection or identity because you share things in common with other members. In these communities, members often share a culture, worldview, history, set of practices, and long term connection and relationships, including across generations.

13 Intergenerational attachment is the first obvious exception to choice in communities of connection or identity, particularly in cultural or religious communities in which younger generations may experience significant pressure to belong and conform.

14 Communities of origin are the second important exception. In most cases you cannot choose whether you are born Indigenous, or with Greek immigrant parents, although you can choose the extent to which you embrace, accept, or reject your heritage and origins.

Defining 'social inclusion'

15 Social inclusion describes the experience of individuals when they are able to come together with others, face to face or virtually and:

(a) Connect,

(b) Contribute,

(c) Belong, and

(d) Be valued in a community.

16 Each of these elements matters. Social inclusion is both a collective construct and an individual experience. It is comparatively easier to connect and contribute as the agency to initiate doing so lies largely with individuals. Belonging and being valued are dependent on other members of the community. People need to know that they matter to other people: an individual acts by connecting and contributing, but others must include and appreciate them so they belong and are valued.

17 In public policy, social inclusion is a population or community level approach to not leaving anybody behind. If one of the goals of a social democracy is for every citizen to reach their potential at every point in their life – to develop, thrive, contribute, connect, belong and be valued – then a policy framework that enables and resources social inclusion is a way of achieving this at a community or population level. For 15 years or more Australian social policy has paid attention to social inclusion, seeking to optimize social and economic policy settings that will enable all citizens to thrive, reach their potential and connect in community.

Key features of socially inclusive communities

18 Key features of socially inclusive communities include a shared community identity and vision for future, and a culture that recognises and values the diversity of community members. My experience is that it's rare that a community is inclusive of all of its diversity. One of the markers of community is some clarity about who is 'in' and who is 'out'.

19 The more inclusive a community is, the more positive the correlation is with health outcomes, including mental health outcomes. If a socially inclusive community is defined as one in which we all take responsibility for ensuring that everyone can reach their potential, individually and collectively, and feels that they belong and are valued, experience and evidence from around the world suggests this will optimise physiological health, mental health and emotional wellbeing of its members.

People and communities in Victoria at greater risk of poor health and mental health outcomes

20 We know that people are more likely to experience poor physical and mental health outcomes if they live in a low socioeconomic status location, if they grew up in an unemployed or underemployed household, if their housing is precarious, if they've moved around a lot, if their family members have been in and out of prison, if they have been in the foster care system, if they have experienced family violence or are living in poverty. People are also more likely to experience poor physical and mental health if they are old and live alone, if they live with complex physical or intellectual impairment, and if they are chronically ill. If you think about it, none of this should be a surprise: life is harder with any one of these factors, and many Australians live with many of them.

21 What we don't really have a handle on is how the interactions of the risk factors above play out in people's lives. For example, over the past 20 years, evidence has shown that 20% of Australian children consistently do not do well as compared to their peers on developmental indicators. These 20% of children's lives are often characterised by the risk factors above, and despite program after program, inventions and policy shifts, 20% of Australian children remain locked out of thriving from early childhood. We have not yet been successful in shifting that dial.

22 The opportunity through this Royal Commission is to consider what things Victoria could do at scale over a long enough time period with appropriate resources and properly established base line data to identify what works and rule out what doesn't work, no matter its popularity. We need to stick with the evidence, keep explaining it to and engaging the community, and proceed on that basis.

The impact of socioeconomic status and disadvantage on mental health

23 Australians can and do experience mental ill health in any socioeconomic decile, but more people in lower deciles experience mental ill health without adequate supports and often with physical health and other comorbidities. These comorbidities in people's lives amplify each other, make the challenges of living with mental ill health in a disadvantaged context more challenging, and too often trapping people in disadvantage. Severe and episodic mental ill health can lead to unemployment, then to poor physical health and insecure housing or homelessness, in a cycle that is very difficult to escape.

Enabling communities

The role inclusive communities can play in supporting good mental health

24 Inclusive communities are healthy, open communities, where residents have the opportunity for regular and meaningful social interaction, ranging from a hello when

walking in the park, to participating in community events and regular groups. They are communities that tend to be open and welcoming. These are characteristics that support good mental health.

25 In Canberra where I live, people are organising by street and local community to deliver food to older residents at greater risk during the coronavirus lock down. This is a great example of supportive community at work.

26 Governments, non-government organisations and health professionals could develop and support leaders in inclusive communities to lead good practice around promoting and protecting good mental health, including destigmatising mental ill health, and promoting community awareness and engagement.

Opportunities and potential collaborations to prevent mental ill health and better meet the mental health needs of vulnerable people

27 A practical collaborative relationship with people living with mental ill health in which they have the agency to shape the policy agenda that impacts on them is probably the most effective vehicle for better outcomes. I would love to see vulnerable people invited to share their needs and aspirations, and invited to co-design prevention and support strategies through carefully designed processes that meet their needs. This would need to be a long and iterative process – which doesn't fit well with the ways we currently develop and deliver social policy responses. But imagine if a longer and inclusive process were part of the response, and imagine if the outcomes delivered were stickier than the ones we develop in our clean offices and meeting rooms.

28 Opportunities and potential collaboration in the mental health space are most effective if they are demand led. That is, putting the citizen at the centre – requiring direct engagement with them – and bringing an awareness that the person living with mental ill health is likely to be the expert on their life and what they need.

29 One opportunity that I see is resourcing expert organisations to build a basic level of expertise about good mental health and the signs of mental ill health in community organisations focussed on vulnerable people and generalist NGOs, a bit like what we have done across Australia about heart attack awareness. I imagine this in two streams: understanding and implementing the basic organisational characteristics that promote good mental health, and enough organisational competence to identify when someone is struggling with their mental health, deliver an initial response, and refer through an identified pathway to specialist support.

Collaboration between the Commonwealth and State governments

30 In the current circumstances concerning our response to COVID-19, we have seen that Australian governments can work collaboratively across jurisdictions. A national cabinet has formed with first ministers making decisions informed by experts.

31 It would be great to see governments across Australia collaborating in a focussed way across different issues for specific outcomes. For example, if governments could agree on a set of mental health outcomes across identified population groups with clear goals and targets, activity could be aligned across the federation with different jurisdictions taking the lead for specific outcome delivery. Getting the initial settings right matters: too much ambition is the biggest challenge to cross-jurisdictional collaboration, while too little ambition doesn't inspire anyone to act. It is best to start in a focussed way and build on successes.

32 The final piece in the collaboration puzzle is for governments to work collaboratively with other sectors and mental health consumers themselves. Determining what institutional arrangements, governance arrangements, policy and practice is required to do this effectively is the first collaborative task.

33 When I was on the Australian Social Inclusion Board, we visited the ten trial site communities that had been established across Australia in low socio-economic areas. The Australian government, the relevant state or territory government, and a range of non-government organisations coordinated their efforts in each community around what research indicated was best practice: identifying and resourcing a community leadership group that worked with the wider community to develop community owned goals and targets for social inclusion and economic growth; and having government and community action leaders out in the community listening, feeding back to agencies, and building community leadership. The aim was to coordinate government and NGO inputs into these communities, advised by community leadership, to enable and equip activity resulting in social inclusion.

Collaboration within the mental health sector, including community organisations

32. It would be terrific to see more practical collaboration on the ground across the mental health sector, across levels of government, NGOs, and community organisations. Where that happens, usually due to generous leadership, outcomes on the ground improve. For collaboration to become normed, attention will need to be paid to federation barriers, funding disincentives, and ignorance of other entities and people active in the same community.

33. I would love to see workers and volunteers given the opportunity at every level to experience life in another organisation based in their community – perhaps through three

to six month exchanges. It would be great to see multi-sector gatherings of leaders in communities meetings to discuss how to bring better collaboration into being in their place. Perhaps public funding to support this kind of activity would spur it on.

Collaboration within the community

34 The ten trial sites of the Australian Social Inclusion Board are an example of opportunities within communities to better meet the mental ill health needs of vulnerable people. There was a complex – but very effective – set of governance arrangements around the ten trial sites. There were two different agents based in each community. One was a was a Community Action Leader (**CAL**) appointed by the community, paid for by the Commonwealth and managed by community leadership, and the other was a Government Action Leader (**GAL**) paid for the Commonwealth and managed by the Department of Human Services. Both the CAL and GAL were to be out in the community as opposed to in an office – the idea was that they should be literally wearing out shoe leather.

35 This approach of being "live" in communities was effective. For example, in one of the communities in regional Australia, the GAL and CAL discovered a cohort of young women who were single parents living from couch to couch, who had no idea they were eligible for any support or government payments. These young women were connected with their entitlements and supports.

Supporting mental health in communities

Types of local organisations, groups or institutions that are well placed to support good mental health in communities

36 There are two main types of specialist groups well placed to provide mental health support in communities. The first are the professional organisations or institutions with a clear good mental health purpose, who take the needs, aspirations and experiences of the people they support seriously. Longevity matters as without it, supports and programs chop and change and that can be very disruptive for those accessing services.

37 The other type of effective group is consumer led organisations populated with people living with mental ill health and their families and friends at service and governance level. While there are effective regional and national consumer led advocacy groups, consumer led support and service delivery groups tend to be locally based. These small, hyper local groups are able to connect with the community and its culture in ways that multi-site larger organisations cannot. They can be support groups, and/or deliver funded supports and services and are an essential part of the good mental health ecosystem.

38 At a different level, any local – or locally based – organisation or group is well placed to support good mental health in communities if they invest in developing their understanding and expertise around supporting good mental health, and develop an inclusive culture. Indeed, promoting and supporting good mental health is something that must be undertaken by more than specialist organisations. At the community level, good mental health is everybody's business. Sporting organisations, schools, religious institutions: every civil society organisation is able to support good mental health.

39 Ideally in communities, all three types of group are flourishing. There is perhaps a role for government in mapping what types of groups are active across which communities. This information, cross checked against mental health data, would enable consideration of where to invest first to enable a mutually reinforcing good mental health ecosystem in every community.

Supporting local organisations, groups and institutions to develop and implement plans and strategies to support good mental health and prevent mental illness

40 Supporting local groups and NGOs in their development and implementation of effective plans and strategies will require investment in them through funding, training, and organisational development. It is not about investing in everything, rather there needs to be thought around what is required at a whole of state level, what coverage is needed where and how resources can be efficiently and effectively marshalled and deployed. This thinking will be best done *with* local entities. Large NGOs are capable of developing their own people, but small, local NGOs generally don't have the scale or capability to develop their people or skills on their own.

41 Resourcing for good governance to help organisations become sustainable, and characterised by good practice is an investment that would deliver community returns over many years. There is a lot of ordinary practice out there, because leaders have never had the opportunity to develop.

42 It should not need to be said but it is not okay for community organisations to have cultures or practices that exclude individuals or groups of people. Human service organisations need to be inclusive in a diverse society. This is critical in the area of mental health where so many highly vulnerable groups have been discriminated against, for example the LGBTIQA+ community.

43 Resourcing a larger organisation in a community to act as a big sibling to a group of smaller ones can be quite effective. Or funding the creation of networks of smaller organisations to come together regularly to share information and experiences, with expert practitioner teaching and learning at those gatherings. Small organisations don't

have the capacity to develop these kinds of support and development opportunities on their own.

44 The Australia New Zealand School of Government (ANZSOG) has developed a detailed plan for a trans-Tasman School of NGO Leadership. If funded, this school would be a great resource for building leadership capability in community based organisations.

Supporting organisations and institutions to develop collaborative and innovative approaches to shared community problems

45 Organisations and institutions need to want to develop collaborative and innovative approaches to share community problems. I have never seen forced collaboration be particularly effective. Inspiration and a shared vision are good drivers for collaboration. Identifying an inspiring leader, leadership cohort, or organisation and equipping/supporting them to act as a catalyst to bring key leaders together to collaborate with a very specific focus and clear agreed outcomes is a tried and tested way to incubate collaboration. Understanding the drivers of every organisation in scope is important. Explicit governance arrangements must be worked out early on and be robust enough to deal with the inevitable highs and lows of collaborative activity.

46 Resourcing sector specific leadership development, attention to organisational capability, and access to relevant data and evidence are powerful tools for assisting organisations to be ready to collaborate. There is much data that community level leaders never see because it's held in academic or government systems. A mediated case library or portal containing stories of local successes, and putting local practitioners in contact with each other are also effective strategies.

47 Collaboration is hard, grinding, and resource intensive. If it were easy, our federation would work more efficiently and consistently deliver seamless service systems for citizens. When properly resourced, collaboration across types of organisations and levels of government is generally highly effective in delivering outcomes and value for communities.

48 During the crisis period for coronavirus, ANZSOG is taking the lessons learned about responding well to crises from international papers and best practice public policy and practice and condensing it into two page know-how summaries. In the past, the Australian Social Inclusion Board and the Department of Social Services were great at doing this. If this existed in the mental health space it could promote good informed decision making in a complex environment.

Population groups requiring a dedicated focus in relation to the prevention of poor mental health

49 Population groups requiring a dedicated focus in poor mental health prevention are those will high vulnerability and/or co-morbidities. Adolescents because of the high onset rate for them; children; isolated older people; LGBTIQA+, culturally and linguistically diverse and Indigenous communities; those with poor social support, prolonged periods of stress or who are unemployed; people with a family history. Trauma is also a predictor of poor mental health.

Community level approaches to support good mental health for population groups requiring a dedicated focus

50 Population groups identified as requiring a dedicated focus in relation to the prevention of poor mental health include children and young people; older people; women and men; Aboriginal communities; culturally and linguistically diverse communities; rural communities; people with a disability; LGBTIQA+. Based on my experience, approaches at the community level that support good mental health for these population groups are all based around a deep understanding of each group; listening carefully, respectfully and iteratively to understand each group's context and culture; checking draft proposals with representatives; and seeking to include members of each group in the delivery of each community level approach

Providing support at the community level for different groups

51 It is useful to think about the provision of support at the community level for different groups in two streams. One stream is those groups that require a dedicated focus and approach, like the groups above. Appropriate supports for a group of older Indigenous women might look quite different to supports for a group of young trans people. For this stream, my comments above cover how you might develop a community level approach to good mental health.

52 The second stream is comprised of groups for whom a generalised approach to good mental health will be effective. Some of these groups may prefer a dedicated experience of this generalised approach for example, Men's Sheds, but the approaches themselves will be the same. Men's Sheds are functionally the same as book clubs in respect of good mental health – both provide purposeful spaces for people to come together regularly and form relationships and interpersonal support networks.

Examples of effective place-based approaches to promoting good health or social outcomes at the community level

53 An example of an effective place-based approach in promoting good health and social outcomes is UnitingCare's program called New Parent and Infant Network (**Newpin**), which focuses on the developmental needs of children up to the compulsory school age. The kids are kids from vulnerable single parents who often live with mental ill health. The program involves parents and their children meeting either in a home like environment three or four times a week with trained professionals and volunteers. At the meetings they learn how to parent through watching, modelling and talking to people. While many people are able to get this through their extended family or friendship groups, these are people who are socially isolated in a way that is hard for others to understand. The program has been massively successful and was the subject of Australia's first social financing model.

54 Another example relates to approaching the problem of people with mental ill health issues who also have dementia. Wesley Mission Queensland has embraced the internationally recognised Eden Alternative for its philosophy of residential aged care for some of its sites, which focuses on changing residential care from a bio-medical operation to a person centred operation. Instead of the residential aged care looking and feeling like a hospital wing, they have included things like shops on site, short-term accommodation and childcare. All the signage is small and up high and its designed and fitted to feel like a home. One whole wall of everyone's rooms is glass and looks onto outside activities for example children playing, making them part of a visual community even if they are too frail to participate in the activity itself. There are animals who live onsite and who have the run of the place, usually cats and dogs. Residents can bring their own pets with them. Ten years ago it was ground breaking to have couples stay together, for gay couples to be with their partners, and for pets to be included in a facility. This program has been hugely successful.

55 Another example in the aged care space, is Blue Care in Brisbane, which developed the first Chinese-focussed residential aged care about fifteen years ago. There are red walls, arched doorways, the staff are Chinese Australians and speak Mandarin, the food is curated to be what residents are used to eating. These things all promote good mental health, and improved care outcomes.

56 Other examples include Prahran Mission in Melbourne and UnitingCare Wesley Port Adelaide, both of which are non-government organisations that are part of the UnitingCare network. These two organisations provide employment services for people living with mental ill health. When I worked with them some years ago, Port Adelaide had a car cleaning service, a lawn mowing service, a house cleaning service and a curtain

sewing service for hotels, all staffed and led by people who were the mission's mental health clients in other programs.

57 Both Wesley Port Adelaide and Prahran Mission used the same models, where there were four teams and every week or two they would select team leaders, who were scaffolded and assisted by professional staff but otherwise were actually in charge of running that area. This gave them agency, control (not just a sense of control) and developed their confidence and capability, which is important for vulnerable people living with mental ill health as too often their sense of themselves as capable people has been eroded. These programs have been very successful, to the point where some people graduated from them and no longer needed to access mental health services.

Service coordination and integration

The importance of effective co-ordination between mental health services and other social services, and the impacts of fragmentation

58 In the reality of people's lives fragmentation translates to a significant time constraint as well as lost opportunities for better outcomes. It is a huge impost on people. Typically, in order to pay rent or eat or go to appointments (for example, the dentist, the doctor, a youth worker) people who need mental health and other social services need to go to different places. Those places are open at different times, sometimes different days. People need to do it all on public transport, but don't have enough money or energy for all the trekking around, particularly as they are usually required to be looking for fulltime employment. And these services can't deliver on their potential because they are fragmented rather than set up in a coordinated way that optimises the outcome for the person accessing them.

59 In my experience, fragmentation exhausts people. It's like running on a treadmill using all your energy just to keep going.

Supporting people to access the breadth of services required to support their mental health and wellbeing

60 An example of what can be done to support people to access services required to support their mental health and wellbeing, is that of Auckland City Mission, New Zealand's Family 100 Project. In this project 100 families were identified that were regular users of Auckland City Mission's services and they mapped what their family looked like and all the services they were accessing. There were families between 2 and 12 people and some of these families had 50 or 60 inputs in their lives from different NGOs, government agencies, education organisations and hospitals.

61 Accepting that the Auckland Mission was unlikely to have the power of government to align these inputs, they considered how this could be navigated and prepared navigation guides for each of these families. The family were partnered with one agency and one person from that agency would act with and for that family as their navigation guide to the multiplicity of agencies touching their lives. It wasn't perfect but it was a huge leap forward and highly successful in reducing the burden of system navigation for vulnerable households.

62 Subsequent to this the Western Australian Council of Social Service (**WACOSS**) brought Auckland Mission's CEO to Western Australia. She had run the Family 100 Project in Auckland, and worked with WACOSS to shape their work with Western Australian NGOs. WACOSS is the peak body for social service NGOs in Western Australia. I am not sure how much practice changed on the ground as a result of this intervention.

63 It is critical that service systems involve persons who are experienced in the governance of programs and organisations on the ground. A governance mindset can be applied to problems to consider questions like what roles are required, how risk should be mitigated and how to deliver on the desired outcome. To me the brilliance of Auckland City Mission's navigation approach is that the roles, authority and what they are trying to achieve is really clear - it is focussed and not over-ambitious.

Supporting recovery from trauma

Defining 'trauma'

64 My professional trauma experience is mostly around child sexual abuse and domestic violence. To understand trauma, I recommend the work of Professor Judith Herman, a Professor of Psychiatry at the Harvard Medical School. In her book, *Trauma and Recovery,* Professor Herman discusses child sexual abuse within the context of a family. Professor Herman writes:

"Social judgment of chronically traumatised people tends to be extremely harsh. The chronically abused person's apparent helplessness and passivity, her entrapment in her past, her intractable depression and somatic complaints, and her smouldering anger, often frustrate the people closest to her."

65 Herman says that those who have never experienced this have no understanding.[1] I'd add, and precious little empathy. These sentiments too often apply to people with mental illness, many of whom are chronically traumatised. The judgment of those who don't know

[1] Judith Herman, Trauma and Recovery: The Aftermath of Violence--From Domestic Abuse to Political Terror.

manifests in the imposed isolation on people who are living with mental ill health, and the stigmatisation of people with mental ill health.

66 Trauma is a fundamental disruption to someone's sense of themselves. It can be emotional, psychological or physiological. People can be traumatised emotionally and psychologically by being ignored, dismissed or trivialised. In our culture today, we tend to characterise emotional abuse as something that happens between two people but trauma can also arise from emotional abuse from a culture or community towards individuals or groups of people.

67 In writings from black Americans, Latinos, Indigenous Australians and Maori, people talk about growing up with a sense of alienation and fundamentally not mattering. When a person is trivialised, dismissed, ignored, or subjected to racist or homophobic behaviour, their sense of themselves is taken away and disrupted in fundamental ways. It is so hard to recover from because most treatment approaches and developments focus on the behaviours and the cognitive effects of trauma, and don't go to that very deep sense of identity that is aggrieved.

68 I think that unconditional positive regard (love in everyday language) is important. I remember my first time in Fremantle running 12 week treatment programs with child sex offenders, in the time before mandatory reporting in Western Australia. The program consisted of individual psychological therapy for each offender and group work. We heard stories of the abuse the guys had perpetrated, but also stories of the childhood abuse they had been subjected to. Part of program was them going to the authorities to own up to what they had done.

69 I was auditing the program, so sitting in the group as a silent observer. At the end of one of the 12 week programs one of the men came over, pulled me up out of my chair and gave me this enormous hug. He had tears in his eyes and said "*You've just been sitting there for 12 weeks loving us*". What he had observed was me behaving differently from most people hearing about child sexual abuse from an offender – not recoiling but listening respectfully to the men's own childhood stories of survival. This is in no way condoning offending behaviour, but is the only way to get into people's stories and start to change the script with them.

70 Not every therapeutic approach will suit every person, and part of the reason why the Freemantle child sex abusers program was so successful (it had a re-offending rate of under 5% compared with the standard rate of around 10 times higher) was because it triaged people to determine whether the program would suit them before accepting them.

71 Part of our challenge is to reclaim some of the humanity when we engage with traumatised people. The question is how do we welcome them into the community and

how do we provide them with the support they need to thrive? It is not easy. If we are serious about supporting recovery from trauma, we have got to be serious about journeying therapeutically with people over time. Recovering from trauma isn't something that happens in a matter of months, there has to be a commitment for at least a year from people who are qualified in dealing with trauma. In my view, an economic analysis of the cost to our economy of having part of population disabled by mental ill health, would show it would be well worth investing in supporting the recovery of traumatised people.

Key features of best practice models that support the recovery of individuals from trauma

72 In my experience, the key features that support the recovery of individuals from trauma are being able to see the person, identify the disruption and then heal that disruption. This attention to underlying causes is radically different to approaches that only aim to treat or suppress the symptoms of trauma. Seeing a person involves skills and commitment to listen to a person and draw out what has happened to shape them, rather than just seeing the person in the manner they currently present, which is often adapted to how they have compartmentalised their issue to cope in public.

Improving the accessibility, experience and care in the mainstream mental health system for people who have experienced trauma

73 Improving the accessibility, experience and care for people who have experience trauma would require basic trauma training for mainstream frontline staff and investment in skilled trauma specialists to provide system oversight and specialist trauma interventions and supports. Conceptualising trauma as tractable would be helpful too.

Features of system design needed to make specialist mental health expertise available to support and advise other service providers

74 The system design must begin with an analysis of the current mental health and generalist support systems to determine where resources could most effectively be deployed as these systems shift to being supported by specialist mental health expertise.

75 One model could involve senior specialist mental health practitioners being available to step into a generalist system when required, or to act as coaches in emergencies, or have people referred to them for direct specialist support.

76 Technology could be incorporated into system design to allow for specialist mental health expertise to be made available right across Victoria. In the physical health world it is not uncommon for surgeons in one place to direct less experienced surgeons in another place using technology.

77 I'd also want to consider the current training and skills development of the full range of practitioners on the ground in communities; it's likely that skills upgrades would be required.

78 Considering what part of the services ecosystem is funded by whom, and reports to whom on what outcomes is necessary to understand what's happening in communities. Doing a bit of a "Families 100" analysis form the perspective of the community could be enlightening in terms of overlaps and over/under servicing in particular locations or for particular population groups.

79 Serious system design wouldn't just bolt specialists on to what is already on the ground. Best practice design would redesign the services system and training for all practitioners in it, around a model with specialist practitioners at its core, being utilised in more efficient and effective ways. Trade offs are inevitable, which must be acknowledged at the outset of the system redesign. Drawing on the analysis of the current systems, design work could be done to determine optimal ratios of the full range of generalist and other staff on the ground to a range of specialist workers (if you were going for a full system redesign you'd want more than specialists in mental health).

80 I would also pay attention to system governance and seek to develop an overarching governance umbrella by place that is able to create an environment in which role and responsibilities are clear across program owners and program funders, that is across the three levels of government, NGOs, businesses providing services, and communities themselves.

sign here ▶ 

print name Lin Hatfield Dodds

date 15 June 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT LHD-1

This is the attachment marked 'LHD-1' referred to in the witness statement of Lin Hatfield Dodds dated 15 June 2020.

Lin Hatfield Dodds

Associate Dean
Australia & New Zealand School of Government

Lin joined the Australian and New Zealand School of Government (ANZSOG) on secondment from the Department of the Prime Minister and Cabinet in 2019. She is an Associate Dean, leading work across a range of social policy and industry areas.

Lin was Deputy Secretary, Social Policy, Department of the Prime Minister and Cabinet from 2016 to 2019, where her responsibilities included health, education, social services and gender equality, support for the Council of Australian Governments, and advice on policy and international engagement to the Minister for Women.

From 2002-2016 she was the National Director of UnitingCare Australia, the national body for Australia's largest non-government network of social, health and aged care services.

Lin has served on a wide range of boards and government advisory bodies, including as President of the Australian Council of Social Service and Chair of the Australian Social Inclusion Board. She was a member of the the Community Response Task Force advising the Deputy Prime Minister during the global financial crisis and the Aged Care Sector Committee advising the Minister for Health and Aged Care.

Her background includes working as a counselling psychologist with families and young people at risk, with a particular interest in trauma and abuse.

Lin holds a Masters in Applied Psychology from the University of Canberra. She is a member of the Australian Institute of Company Directors, was ACT Australian of the Year in 2008, received a Churchill Fellowship in 2003, and was awarded a Chief Minister's International Women's Day Award in 2002.

March 2020