Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF HELEN KENNEDY

I, Helen Kennedy, Chief Operations Officer, of 17-23 Sackville Street, Collingwood Victoria, say as follows:

Background

1 I am currently the Chief Operations Officer of the Victorian Aboriginal Community Controlled Health Organisation (**VACCHO**), which is the peak body for Aboriginal health and wellbeing in Victoria. In that role, I am responsible for overseeing VACCHO's operations across five units, all of which work to support 30 member organisations.

2 Previously, I have:

(a) held various senior management and leadership roles in the Aboriginal Community controlled sector and across government. This includes operational roles as the former Manager of the Family Counselling Service for seven years at the Victorian Aboriginal Health Service (**VAHS**) which encompassed four program areas, including Adult Mental Health, Koori Kids and Adolescent Mental Health and the now disbanded Minajalku Healing Centre.

(b) acted as a director for several organisations including Yappera Aboriginal Children's Centre, the Victorian Aboriginal Child Care Agency and the Indigenous Leadership Network of Victoria and was a former member of the National Aboriginal Mental Health and Suicide Prevention committee.

(c) worked as Principal Policy Advisor, Aboriginal Social Emotional Wellbeing for the Department of Health and Human Services (DHHS). There I played a leadership role in the development of key policies relating to Aboriginal people such as 'Balit Murrup: The Aboriginal Social Emotional Wellbeing Framework' (2017-2027).

3 Attached to this statement and marked **HK-1** is a copy of my Curriculum Vitae, which sets out further details of my education and career to date.

What is VACCHO?

4 VACCHO was established in 1996 as the peak body for Aboriginal health in Victoria. VACCHO's work is driven by the priorities of our members; Victoria's 30 Aboriginal Community Controlled Organisations (**ACCO**s) which are located across the state and

just over the border into New South Wales. By joining under VACCHO's umbrella, ACCOs gain strength, share knowledge and speak with a united voice.

5 VACCHO champions community control and health equality for Aboriginal communities. We are a centre of expertise, policy advice, training, innovation and leadership in Aboriginal health. VACCHO advocates for the optimum health and health equity of all Aboriginal people in Victoria. VACCHO recognises that it has a key leadership role in improving social and emotional wellbeing outcomes of Victorian Aboriginal people. We believe this role can be supported by working towards becoming a Centre of Excellence in Aboriginal social and emotional wellbeing, something that VACCHO has advocated for several years.

6 Underpinning our core functions is the work we do to systematically improve outcomes for Aboriginal people in Victoria so they can reach their aspirations in line with the Aboriginal definition of health. This includes creating systemic change to increase access to services, identifying and implementing evidence-based best practice models of service delivery and supporting workforce professional development and research.

7 About 52% of VACCHO's funding is from the state government – and DHHS funding is around 65% per cent of that component. VACCHO has been funded in the past by the state government to provide workforce support to a very small group of Koorie Mental Health Liaison Officers and a small group of ACCOs who delivery primary mental health care. VACCHO aspires to provide more comprehensive work in this area

From your perspective, what does that phrase "social and emotional wellbeing" mean to Aboriginal and Torres Strait Islander people and how does it affect the overall health gap experienced by many Aboriginal and Torres Strait Islander people?

8 Many Aboriginal people describe both their physical and mental health as having a foundation of social and emotional wellbeing (commonly referred to as **SEWB**), originating in strong and positive connections to family, culture and community and land and spirituality. This can be understood as a protective factor against high rates of stressors and negative social determinants that can lead to depression, anxiety, substance abuse and sometimes-severe mental illness. SEWB is a source of resilience that can help protect against the worst impacts of stressful life events for Aboriginal people and provide a buffer to mitigate risks of poor mental health. Understanding and building on this must then be at the heart of all efforts and responses to improve Aboriginal mental health and to reduce suicide. Supporting and strengthening social and emotional wellbeing is important for fostering preventative responses to mental health problems in Aboriginal communities.

9 An approach to Aboriginal mental health that accounts for SEWB is particularly important because there is a growing gap between the mental health of Aboriginal people and non-Aboriginal people. One example of the widening gap is that that the mental health-related hospitalisation rate of Aboriginal people from 2004 to 2015 increased by 22%, whereas the rate for non-Aboriginal individuals decreased by 24% over the same period.[1] Another example is that mental and health related conditions are estimated to account for as much as 22 per cent of the health gap (12 per cent mental health conditions, 6 per cent alcohol and substance abuse and 4 per cent suicide) between Aboriginal and non-Aboriginal people[2].

10 Understanding this also has implications at all levels, including for policy makers and practitioners, because it is not practical to separate mental health and social and emotional wellbeing. Social and emotional wellbeing must be addressed along with mental health across the broad spectrum of mental health interventions that include health promotion, early intervention and recovery.

Risk factors and Protective factors

What are the key factors that may protect social and emotional wellbeing?

11 For Aboriginal people, cultural concepts such as connection to land, culture, spirituality, ancestry, family and community are protective factors. These concepts serve as sources of resilience. They moderate the impact of stressful circumstances on SEWB at an individual, family and community level.

12 The SEWB model developed in recent years draws on seven overlapping domains. These domains are body, mind and emotions, family and kin, community, culture, country, spirituality and ancestors. The domains can be thought of as containing both protective and risk factors. Promoting SEWB is about maximising the benefits of the protective factors, whilst minimising the risk factors.

13 An example of how SEWB programs can improve Aboriginal mental health outcomes is through the recruitment of practitioners who provide SEWB services at ACCOs. Hepworth et al., (2015)[3] showed that Aboriginal people's access to mental health care increased by 34% (2012-13) at SQCE Primary Health Care when a SEWB model was implemented through the employment of psychologists and social workers who were capable of providing culturally safe services. This, and other studies, demonstrate the

[1] Australian Institute of Health and Welfare (2017). Aboriginal and Torres Strait Islander Health Performance Framework 2017 report: Victoria. Cat. no. IHW 183. Canberra: AIHW

[2] Department of Health and Human Services (2017). Balit Murrup: Aboriginal social and emotional wellbeing framework. State Government of Victoria, Melbourne.

[3] Hepworth J., Askew D., Foley W., Duthie D., Shuter P., Combo M., & Clements L. A., (2015). *How an urban Aboriginal and Torres Strait Islander primary health care service improved access to mental health care.* International Journal for Equity in Health.14:51.

positive impact SEWB services can have; we need to further develop our resources and evidence-base in Victoria to determine how we can best support services to implement SEWB services and service models as part of our service system.

What are the key risk factors that may detrimentally affect the social and emotional wellbeing of Aboriginal or Torres Strait Islander individuals?

14 Aboriginal people are disproportionately exposed to risk factors that negatively impact upon their social and emotional wellbeing. Sadly, the extent of this exposure is associated with increased suicide risk and ultimately suicide rates that are twice the national average (ABS, 2017)[4]. Significant risk factors that can negatively impact on the SEWB of Aboriginal people include:

(a) widespread grief and loss;

(b) impacts of the Stolen Generations and removal of children;

(c) unresolved trauma;

(d) separation from culture and associated identity issues;

(e) discrimination based on race or culture;

(f) economic and social disadvantage;

(g) physical health problems;

(h) incarceration;

(i) violence; and

(j) substance misuse.

Early intervention

Is early intervention important for the mental health of Victorian Aboriginal people? Are services in place to meet the mental health needs of Aboriginal Victorian youth?

15 The prevalence of childhood and family adversity experienced by Aboriginal community members is significantly higher than in non-Aboriginal Victorian communities. It is startling that young Victorian Aboriginal people experience the second highest rate of psychological distress in the nation at 39%.[5] Further, young people aged 0-24 make up 52.3% of the Victorian Aboriginal population and the population is growing rapidly, having increased by 16.7% since 2011. Exposure to adverse childhood experiences is

[4] Australian Bureau of Statistics (2017). Causes of Death, Australia, 2017. Intentional self-harm in Aboriginal and Torres Strait Islander People. Retrieved from: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm%20in%20Aboriginal%20and%20Torres%20Strait%20Islander%20people~10

[5] Australian Institute of Health and Welfare (2018). Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018. Cat. no. IHW 202. Canberra: AIHW.

associated with emotional and behavioural difficulties and mental health problems in childhood and adolescence. I believe that the impact of trauma on Aboriginal children and families is a major undetected, underestimated and misunderstood determinant of the poorer mental health outcomes seen in the adult Aboriginal population. Given the high prevalence of mental illness and a large, rapidly growing population, there is an urgent need to address this with new solutions and better, more accessible culturally responsive services and initiatives. In other words, we must prioritise and strengthen early intervention and prevention approaches for Aboriginal children.

16 Significantly, when the national mental health secretariat undertook work to consider expert advice on specific challenges for Aboriginal people (2014),[6] they found that there was **no specific allocation of Commonwealth mental health program funds for Aboriginal early intervention and prevention programs**. The experts that contributed to this report supported the view that investment in early intervention programs for children and young people will provide the greatest return in investment.[7]

17 A lack of resources and joined-up approaches across the service system can mean that services such as early childhood, child mental health services and juvenile justice centres might fail to detect a child's distress or trauma or not know how to appropriately respond. Instead, they might be put in the too hard basket because of aggressive behaviour and low education rather than this being understood as distress.

18 The Royal Commission needs to undertake a deep-dive to ensure that we are able to precisely identify what the SEWB and mental health service needs and gaps are for young people. This will facilitate development of a long-term plan for delivering targeted services, partnerships and interventions across mental and physical health, education, housing, child welfare and the youth justice systems. As a starting point, an example of an ostensibly 'gap filling' early intervention model in practice is the Koori Kids and Adolescent Mental Health Program. This is run through the Family Counselling Services at the Victorian Aboriginal Health Service. In my experience participating in community consultations for the 10 Year Mental Health Plan and Balit Murrup, there is strong support for early intervention programs like this to be based in ACCOs and to be closely linked with maternal, childhood health and Children and Adolescent Mental Health Services (**CAMHS**).The program's success warrants exploration of opportunities to expand this model.

[6] National Mental Health Secretariat and Health Management Associates (2014). Expert Advice of Specific Challenges for Aboriginal and Torres Strait Islander Peoples Mental Heath. https://natsilmh.org.au/sites/default/files/National%20Mental%20Health%20Commission%20-%20Aboriginal%20and%20Torres%20Strait%20Islander%20Review%20Summary.pdf

[7] Ibid.

Trauma and recovery from trauma

6. From your perspective what do the terms 'historical trauma' and 'intergenerational trauma' insofar as they relate to Aboriginal and Torres Strait Islander people mean?

19 Historical trauma refers to the manifestation of emotions and actions that stem from the historical loss arising from the insidious and lasting impacts of colonisation, which include loss of land, cultural connections, language, assimilation and child removal. We know in Victoria that these impacts have been brutal. Our history of colonisation involved successive, sustained periods of interpersonal and structural violence on entire groups and communities. This level of traumatisation has resulted in what is often referred to as intergenerational, transgenerational or historical trauma - where for some individuals and families a transmission of trauma can occur via multiple pathways that include familial, biological and social mechanisms.

20 Intergenerational trauma continues to affect Aboriginal people in Victoria. This is not least due to the fact that over 47% of Victorian Aboriginal people have a relative who was forcibly removed from their family due to Stolen Generation policies[8]. It is an enduring trauma that is passed down through generations, and impacts the individual, family and community in numerous and compounding ways, including fracturing communities, identities and connection to culture. Intergenerational trauma is further perpetuated through systemic inequalities and structural racism, which often serve to blame the individual for their behaviours and experiences instead of understanding the impact that intergenerational trauma has on a person's mental and physical health and wellbeing. If people do not have the opportunity to heal, then they may "deal" with their pain in negative ways including physical or emotional violence, abuse or addiction.

In what ways can historical and intergenerational trauma impact on the social and emotional wellbeing of Aboriginal and Torres Strait Islander People?

21 Historical and intergenerational trauma impacts on the SEWB of Aboriginal and Torres Strait Islander people in numerous, compounding ways. The disproportionate number of Aboriginal children in out of home care, the high number of Aboriginal women who experience family violence, and the over-incarceration of Aboriginal people, are a few examples of the ways in which trauma has serious, deleterious impacts on individuals and compromises the actualisation of basic human rights in communities.

22 Aboriginal people experience higher rates of direct and indirect trauma than non-Aboriginal people.[9] Trauma leads to poorer mental and physical health outcomes.

[8] Department of Health and Human Services (2017). Balit Murrup: Aboriginal social and emotional wellbeing framework. State Government of Victoria, Melbourne.

[9] Department of Health and Human Services (2017). Balit Murrup: Aboriginal social and emotional wellbeing framework. State Government of Victoria, Melbourne.

Trauma engenders distrust in both governmental and non-governmental services due to the historical association with removal of Aboriginal children from their homes and communities, and experiences of racism.

23 Intergenerational trauma, in conjunction with institutionalized racism, impacts Victoria's Aboriginal people's engagement with the medical/mental health system and serve as two key barriers to accessing adequate health care in response to SEWB and racism. For example, Aboriginal Victorians are regularly subject to racism, with over 70% reporting eight or more racist incidents within the preceding 12 months[10]. This has a direct impact of mental health outcomes with 47.3% of Victorian Aboriginal people who self-reported instances of racism being over the threshold for high or very high psychological distress. Crucially, one study has shown that 62.4% of Aboriginal people reported experiencing racism in a healthcare setting[11]. This racism acts as a barrier to accessing services and seeing through healthcare services to completion.

What is 'trauma-informed care' or 'trauma recovery informed care'?

24 Trauma informed care is a framework for human service delivery that allows practitioners to better understand the ways in which trauma impacts the individual — leading to poor mental health, poor physical health outcomes and a range of SEWB issues.

25 Trauma informed care allows for a holistic understanding of trauma, and does so by situating trauma within a person's environment and experiences. This is a departure from medicalized models that understand trauma-related behaviours as a pathologised symptom rather than the result of larger societal inequalities and systems of oppression that impact the individual's health and wellbeing. Trauma informed care aims to reduce the trauma felt in an individual's life which manifests in numerous, differing ways.

In your experience, is trauma-informed care effective for improving mental health outcomes for Aboriginal and/or Torres Strait Islander people?

26 Trauma-informed and healing based care improves the mental health outcomes for Aboriginal people, as discussed below. As such, trauma-informed and healing based approaches should be the cornerstone of all care practices and for every service working in mental health and related areas for Aboriginal people. Trauma informed care allows for holistic approaches and service provision that recognises the individual experience of clients while, at the same time, addressing systemic historical and current injustices. Healing programs, for example, support people to articulate a range of issues

[10] Victorian Health Promotion Foundation (2012). Mental health impacts of racial discrimination in Victorian Aboriginal communities, Experiences of Racism survey: a summary. ISBN: 978-1-921822-74-2

[11] Kelaher, M. A., Ferdinand, A. S. and Paradies, Y. (2014), Experiencing racism in health care: the mental health impacts for Victorian Aboriginal communities. Medical Journal of Australia, 201: 44-47. doi:10.5694/mja13.10503

or problems they experience and allow for healing of individuals, families and communities through connection to culture and spirituality.

27 A good example of an effective, economically efficient healing program is the Murri Education program run in the greater Brisbane area. The Murri program is a holistic educational framework that consists of a range of activities such as counselling and healing camps, which are designed to address the intergenerational trauma experienced by Aboriginal children at a QLD school. Though the cost per individual student is slightly higher than the state average, the net benefit far outweighs the initial outlay. For every added dollar invested in the Murri Healing program, there was a return of $8.85. Kids had lower rates of mental illness, had less contact with the justice and child protection systems, and achieved a higher educational standard, all whilst saving an estimated 6.5 million.[12] This was for only 230 students, indicating the opportunity for significant saving.

28 Canada, who shares a similar history to Australia in terms of impacts of colonisation and child removal, has shown that one of the most effective investments they have made to prevent the negative health and well-being outcomes associated with intergenerational trauma experienced by Indigenous people has been through Healing Centres. Research has clearly linked cultural identity and renewal to reduced suicide rates amongst Indigenous youth.[13] [14]

29 Trauma informed services that are also healing based are demanded by Aboriginal people, are effective in improving mental health outcomes, and are economically more efficient.

30 I understand that, in 2015, DHHS commissioned Phoenix Australia to support the capability of mental health staff to provide trauma-informed treatments to people with refugee backgrounds seeking mental health care[15]. We need to do the same work for our first nation's people. We need to prioritise the commissioning of work that supports an Aboriginal trauma-informed and healing based framework and associated resources to be introduced across the mental health service system, including to ACCOs, in addition to healing centres and healing initiatives.

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[12] The Healing Foundation (2017). Cost Benefit Analysis of the Murri School Healing Program. Kingston, Australian Capital Territory. https://www.healingfoundation.org.au//app/uploads/2017/09/HF2017_Murri_School_Healing_Program_Report_V9_WEB.pdf

[13]The Healing Foundation (2012). Aboriginal and Torres Strait Islander Healing Programs: A Literature Review. Kingston, Australian Capital Territory. https://healingfoundation.org.au/app/uploads/2017/02/Aboriginal-and-Torres-Strait-Islander-Healing-Programs-A-Literature-Review.pdf at page 31

[14] Chandler, M. J., & Lalonde, C. (1998). Cultural Continuity as a Hedge against Suicide in Canada's First Nations. Transcultural Psychiatry, 35(2), 191–219. https://doi.org/10.1177/136346159803500202

[15] https://www.phoenixaustralia.org/wp-content/uploads/2019/03/PhoenixAustralia-2019-TrainingBrochure.pdf

Do Aboriginal and Torres Strait Islander people in Victoria face any barriers, at a systemic level, to accessing trauma informed care and mental health care? If so, what are the barriers?

31 Yes, there are clearly systemic barriers to accessing trauma informed and mental health care. First, there is a fundamental inefficiency in the provision of mental health services for Aboriginal people who have high levels of underlying mental health need. This is not matched by appropriate levels of investment in primary mental health care. This contributes to the higher levels of expenditure on inpatient care than for non-Aboriginal people.

32 Second, for the reasons discussed below, the mental health service system's responses to the high rates of psychological distress and trauma experienced within communities have been ineffective or culturally inappropriate. Largely, they do not (or are unable to) embrace Aboriginal concepts of health and wellbeing and/or have failed to understand the pervasiveness of racial oppression and disadvantage. Not surprisingly, there is increasing support for new Aboriginal led approaches to healing and recovery from trauma responses.

33 Third, systemic issues relating to racism (partially due to the lack of cultural competency and knowledge of Aboriginal history and the impact of colonisation) can mean that trauma-informed care poses the risk of creating further trauma in clients.

34 Finally, many Aboriginal people in Victoria have a profound distrust in mainstream health services, pointing to the need for trauma-informed and healing based care models, across all services including ACCOs, that are culturally safe and respond to the individualised needs of clients

What is the role of the mainstream mental health services in supporting the social and emotional wellbeing needs of Aboriginal and Torres Strait Islander people? In your experience, to what extent are mainstream health services fulfilling this role?

35 Aboriginal people have historically not accessed mental health services at levels appropriate to the need that exists. Aboriginal people are overrepresented in terms of psycho-social problems compared to the general population and they do not access to Mental Health Community Support Services at a level commensurate with their need. For example, the rate at which Aboriginal people sought community mental health services was 3.1 times higher than non-Aboriginal people in 2014-15[16] but of all Aboriginal people aged 18–24 who had experienced very high or high psychological

[16] Australian Institute of Health and Welfare (2017). Aboriginal and Torres Strait Islander Health Performance Framework 2017 report: Victoria. Cat. no. IHW 183. Canberra: AIHW

distress, 77% (19,519) had not seen a health professional[17]. This infrequent contact with mental health services and results in contact that is mostly limited to acute episodes of illness. We know that for many Aboriginal people, this late contact leads to poorer health outcomes and major disruption to themselves and their families.

36 There are several reasons why mainstream services often fail to meet the needs of Aboriginal people:

(a) There is a historical attitude of fear and distrust of mainstream health services and government. This is due to past associations with the removal of children, discrimination and racism and negative staff attitudes.

(b) A lack of awareness amongst mental health service providers of the historical, community and cultural factors related to social emotional wellbeing and mental health.

(c) Inflexible models of service delivery, including the use of inappropriate assessment and diagnostic tools.[18]

(d) There are relatively few Aboriginal people working in the mental health system. We know that Aboriginal people are more likely to access health services and "return" for follow-up treatments if Aboriginal people are working in these services.

(e) Poor quality linkages for patients/clients, particularly between primary mental health components (mainly funded by the Commonwealth) and specialist clinical services components (mainly delivered by the States and Territories).

(f) Relatively limited resources and service development work, reflecting the need to further develop Aboriginal mental health services to make sure that Aboriginal people are able to obtain services.

(g) The relative poverty and geographic location of many of Aboriginal people with mental health problems and their carers affects their capacity to access mainstream services.

(h) The stigma of mental illness acts as a significant barrier to Aboriginal people seeking help when needed. Stigma exists on a number of levels including feelings of "shame" for individuals living with mental illness.

(i) Limited 'mental health literacy' and awareness of social emotional wellbeing problems in Aboriginal communities, including early identification of needs.

[17] Australian Institute of Health and Welfare (2017). Aboriginal and Torres Strait Islander health performance framework 2017: supplementary online tables. Cat. no. WEB 170. Canberra: AIHW.

[18] Department of Health and Human Services (2017). Balit Murrup: Aboriginal social and emotional wellbeing framework. State Government of Victoria, Melbourne.

(j) The relative lack of recognition of, and investment in, contemporary healing programs that focus on promoting and strengthening connection to culture as a way to deal with trauma

37 Despite these issues, general mainstream health services are important. A significant proportion of Aboriginal people do not use an ACCO for their primary health. This is often because they may simply prefer mainstream services and/or there may be no ACCO in their immediate geographic area.

38 As discussed, the causal factors underpinning mental illness in Aboriginal people are generally multifactorial and interrelated (e.g. poor housing, childhood trauma, substance misuse). Different healthcare organisations can have different roles to play in the prevention, identification and treatment of mental health conditions, and in the effective delivery of primary mental health care and SEWB services. The boundaries between organisations and lack of coordination can negatively impact mental health treatment outcomes because:

(a) Administrative navigation between organisations is an obstacle to participation in health services; and

(b) Separation of services may prevent identification of salient casual factors in the individual's mental illness.

What is the role of Aboriginal mental health services? Please provide an example of an Aboriginal mental health service.

39 There is only one specialist Aboriginal mental health service in the Aboriginal community-controlled sector provided by Victorian Aboriginal Health Services. Most other ACCOS would not identify themselves as providing an Aboriginal mental health service because they are not funded to provide mental health services or even psycho-social support in many instances. This does not mean that several ACCOs are not providing a limited suite of social, emotional, and mental health services to their community as part of an integrated service model.

40 I do not know of any other services that describe themselves as an Aboriginal mental health service, with the exception of Wadamba Wilam, a mainstream service supported by a consortium approach including the Victorian Aboriginal Health Service.

41 An example of a mainstream Aboriginal mental health initiative is the Koori Mental Health Liaison Officer (**KMHLO**) program run in Victoria. Whilst these roles are only based in approximately 8 services, their work includes supporting Aboriginal patients, building links between Aboriginal mental health service (**AMHSs**) and ACCOs, providing culturally sensitive practice advice to clinicians and other mental health workers,

participating in health promotion activities, and providing cross-cultural training in collaboration with ACCOs.

42 Research has shown that KMHLOs improve mental health outcomes for Aboriginal people. For example, research undertaken by Adams et al. (2014)[19] shows that when KMHLO work in collaboration with GPs who had completed mental health training, the rate at which Aboriginal people received mental health care plans, MCP reviews and diagnosis of anxiety and depression, increased. This shows that KMHLOs work leads to better treatment options and outcomes.

What factors influence or determine when an Aboriginal mental health services is required in a community?

43 There are multiple factors that determine when mental health services are required in a community. As a fundamental principle, Aboriginal mental health services should be made readily accessible to any Aboriginal person in Victoria as a basic human right. As such, a major factor for determining where services are required is community need. Some communities show evidence of higher rates of distress, which are exemplified by higher suicide rates, hospital admissions and/or contacts with mental health services. Another related factor is population demographics and projected growth. Finally, there needs to be community demand and organisational readiness. In sum, resources such as funding, infrastructure and an Aboriginal workforce and good planning are all considerations for extended services.

What are some of the challenges when designing and delivering a viable and responsive Aboriginal mental health service?

44 There are currently only 8 recurrently funded Koori Mental Health Liaison Officers employed in a total of 33 mainstream Adult Area Mental health services and Child and Adolescent Mental health Services, as I understand.

45 We need to invest in a strong Aboriginal workforce because we know that the presence of Aboriginal health workers leads to improved health outcomes for Aboriginal people. For example, implementation of Maga Bardi mental health service in a WA ACCO increased access to mental health services and psychiatric admissions for Aboriginal patients by 58%.[20] Other studies have also shown that Aboriginal people are more likely

[19] Adams K., Halacas C., Cincotta M., Pesich C., (2014). Mental health and Victorian Aboriginal people: what can data mining tell us?. Australian Journal of Primary Health 20, 350-355.

[20] Laugharne J, Glennen M, & Austin J. (2002). The 'Maga Barndi' mental haelth service for Aboriginal people in Western Australia. Australasian Psychiatry, 10(1), 13-17.

to visit an Aboriginal mental health worker, particularly those who are highly visible in the community.[21,22]

46 One of the major challenges for delivering a viable Aboriginal mental health service is the recruitment and retention of an Aboriginal workforce that is capable of meeting demand. Currently, there is shortage of Aboriginal people working in primary health care professions. For example, in 2011, about 3.4% of the non-Aboriginal population were employed in health-related occupations, yet only 1.6% of the Aboriginal were employed in these occupations indicating underrepresentation.[23] Supplying enough mental health workers is vital given the high prevalence of mental illness.

Culturally competent and culturally safe service delivery

What is meant by "culturally competent" and "culturally safe" service delivery?

47 Cultural competency in a service delivery context requires recognition and acknowledgement of the factors that contribute to an Aboriginal person's health and wellbeing. Recognition and acknowledgement then amounts to a set of behaviours that actively contribute to addressing the causes that underlie a person's SEWB that is strengths based. Cultural competency occurs on a continuum of education and improvement; competency can shift due to staff turnover, organisational change and due to cultural growth. At this stage, many mainstream organisations are not culturally competent; as such, recommendations of the Royal Commission should focus on addressing attitudes, improving knowledge and changing behaviour at both individual and institutional/systemic levels that result in effective care for Aboriginal People as a right.

48 Cultural safety is an environment that is safe for people— where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning, living and working together.

What roles can cultural safety and community play in the prevention and recovery of trauma-related mental illness? What other strategies would you recommend to prevent mental illness for Aboriginal and Torres Strait Islander peoples?

49 Cultural safety and community both play important, but play different roles in supporting the social and emotional welling of Aboriginal people. Cultural safety functions as a

[21] Fielke K., Cord-Udy N., Buckskin J., Lattanzio A., (2009). The development of an 'Indigenous team' in a mainstream mental health service in South Australia. Australas Psychiatry.15(Suppl):S75–8.

[22] Whiteside M, Tsey K, Cadet-James Y. A theoretical empowerment framework for transdisciplinary team building. Aust Soc Work. 2011;642:228–32.

[23] Australian Health Ministers' Advisory Council, (2015). Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report, AHMAC, Canberra.

protective factor for re-traumatisation when seeking mental health services. As such, it increases service accessibility (because people know they will be helped when they seek out services) and promotes service completion. Cultural safety amounts to a holistic understanding of the contextual factors surrounding an individual's request for mental healthcare and the application of appropriate treatment measures accordingly. As follows from my earlier definition of SEWB, community health plays an obvious role in the prevention of mental illness.

50 As discussed above, prevention is a critical factor in improving the overall mental health of the Victorian Aboriginal community. It is more than simply the application of cultural safety in a limited range of contexts.

51 **Prevention means** addressing and supporting the social and emotional wellbeing needs of Aboriginal people before they reach a crisis point where they are a health risk to themselves and/or others. Prevention means reducing rates of hospitalisation and/or contact with the justice system by enhancing the support able to be provided by ACCOs across the spectrum of prevention, early intervention, detection and treatment through the establishment of multi-disciplinary integrated Social and Emotional Well-being teams in every service, in partnership with relevant mainstream services wherever appropriate.

52 These teams, supported by a more integrated mental health and community service system broadly can support people to stay well, strong and resilient, ensuring that when a community member is are becoming unwell, there is timely access to community based appropriate clinical and cultural support in the community to support their care and recovery in their local community, wherever possible.

53 Building on this overarching approach, a key outcome is to develop a set of specific strategies that facilitate risk management and the early detection of individual mental illness. Strategies could include actions such as:

(a) Supporting Aboriginal community crises response teams to support Aboriginal Victorians who may be in a crisis to avoid hospitalisation wherever possible. This could also include much needed suicide postvention supports, to support families impacted by suicide and reduce potential suicide clusters.

(b) Implementing service provider mental health literacy and trauma sensitivity training e.g. provide the Aboriginal Mental Health First Aid course to the broader workforce as well as across all communities including to Aboriginal families.

(c) Providing culturally appropriate screening for emotional and behavioural difficulties in children and mental health problems and trauma (particularly

psychological distress) at child and adolescent mental health services, Head Space and ACCO's.

(d) Providing broader support for culturally appropriate treatment pathways within a SEWB framework e.g. referral pathways from mainstream services to ACCOs, including discharge planning

(e) Rolling out evidence-based healing and cultural strengthening programs that promote culture and community connectedness. An example of a successful program is the former Minajalku healing service.

54 I provide more details on prevention below in this statement, in the sections on trauma-informed care, reform and further recommendations.

55 **Supporting self-determination.** There is an opportunity to support real self-determination as part of implementing the recommendations of the Royal Commission. This can be achieved by learning from the experiences of ACCO's and DHHS as part of how we support the expanded role of ACCO's in delivering enhanced social emotional well-being and mental health support services that are responsive to the local needs of their communities. Two examples provide a model for what the implementation of self-determination in practice looks like:

(a) Aboriginal children and young people were placed under the authority, care and case management of ACCOs as opposed to mainstream services. This allowed ACCOs to build the capacity of Aboriginal families, communities and the sector to care for their children and to reduce the number of children in out of home care.

(b) 1448 properties were transferred to Aboriginal Housing Victoria (an Aboriginal not for profit registered housing provider) and designated for Aboriginal people.

56 Ultimately, lessons can be learnt from these reformist policies and operational changes, including co-design processes, to advance self-determination and community control in mental health and support better health outcomes

In your view, what skills, knowledge or initiatives could help mental health service providers deliver culturally safe and culturally competent service delivery for Aboriginal and Torres Strait Islander people?

57 The National Framework for Recovery-Oriented Mental Health Services (**NFROMHS**)[24] Guide for Practitioners and Providers is an example of a knowledge and skill building framework that can assist service providers deliver culturally safe/competent healthcare.

[24] And other frameworks such as the Naanggabun Yarning culturally appropriate clinical supervision framework or the Collaborative Recovery Model' (CRM), developed by NEAMI with support from Wollongong University

Endorsed by the Commonwealth Government in 2013, it sets out the capabilities for a recovery-oriented mental health service that is 'responsive to Aboriginal and Torres Strait Islander people, families and communities. Resources allotted to mainstream service providers to implement this framework would facilitate culturally safe and competent service delivery. To deliver services in accordance with this framework, the non-indigenous mainstream mental health services workforce requires ongoing access to cultural competency training. This training needs to be co-designed and delivered by Aboriginal mental health clinicians, educators and co-facilitators across the mainstream mental health jurisdictions wherever possible.

58 Additionally, any 'recovery oriented' training packages must also be considered alongside Indigenous Mental Health Cultural Training. The Australian Indigenous Psychological Society (**APS**) has developed this training that has been successfully delivered to the previous Medicare Locals in the northern suburbs of Melbourne, as well as to a number of staff across Mental Health and AOD services in both service delivery and senior management levels.

59 As stated earlier, creating a strong Aboriginal mental health workforce is another mechanism by which service providers can build cultural competence and safety into their services.

60 In addition to the employment of Aboriginal staff, cultural understanding and culturally safe practices are primary ways to combat otherwise undetected institutional racism and ensure services for Aboriginal people are person-centred. This includes cultural safety training for all staff, organisational cultural safety policies, practices and procedures including data collection, identification and patient follow up care and outreach services.

61 Additionally, Victoria should look to NSW and learn from their experiences, policies, frameworks and experiences given their strong and long history of many decades in supporting a robust culturally responsive Aboriginal mental health workforce. For example, the NSW Aboriginal Mental Health Workforce program Funded under the NSW Aboriginal Mental Health and Wellbeing Policy 2006-2010 sought to 'Expand the Aboriginal mental health workforce in AMHSs until there is one Aboriginal Mental Health Worker HW for every 1000 Aboriginal people.' Crucially, funding for and roll out of this program occurred 10 years before the Victorian Aboriginal Mental Health Traineeship program. So NSW is 10 years ahead of Victoria in terms of Aboriginal mental health workforce development. Importantly an external evaluation of the program showed that it works. It demonstrated that Local Health Districts (**LHD**) highly valued trainees because they increased staff knowledge and understanding of Aboriginal mental health and cultural issues; they also improved the capacity of LHDs to provide accessible and relevant services to local Aboriginal people; finally, they provided a unique opportunity

for Aboriginal people to gain valuable skills and a tertiary qualification to work as mental health professionals, support their communities, and be role models for others.

62 Another example is the NSW Government Local Decision Making (**LDM**) initiative. Local Decision Making is the NSW Government's plan to 'fundamentally and positively change the relationship between Aboriginal communities and government, and enable Aboriginal communities. LDM seeks to put planning, decision-making, service-design, and service delivery into the hands of Aboriginal community-based regional decision-making groups (regional alliances). LDM lays the foundation for a SEWB service model through locally deployed Aboriginal workforces. Thus, in relation to the provision of mental health services, LDM represents a potential model for rolling out services that could improve Aboriginal mental health outcomes.

In your experience, what are some examples of best practice models of care and services that ensure cultural safety for Aboriginal and Torres Strait Islander people?

Can you provide any examples of mainstream mental health services that are delivering culturally safe care?

63 NEAMI National is a mainstream service who has developed an innovative service model called 'Wadamba Wilam' that has demonstrated improvement in SEWB, mental health and housing stability. The success of this model relates to the development of a multi-disciplinary team across a range of mainstream services, including the Victorian Aboriginal Health Services. In my experience, this service has literally saved lives.

64 It is also my experience that during community consultations as part of the Ten-Year Mental Health Plan and Balit Murrup, that there was a consistent message around "not reinventing the wheel, but build on what works". Wadamba Wilam is a great innovative example of an exemplar program that has the potential to be extended and adapted in other regional areas.

Can you provide any examples of workforce training or other initiatives that are successfully building cultural competence?

65 The Australian Psychological Society auspices the highly successful model of 'Cultural Competence Training' for the mental health workforce. This is an example of a positive workforce training program.[25]

[25] See https://www.psychology.org.au/About-Us/who-we-are/reconciliation-and-the-APS/reconciliation-action-plan/APS-Apology and http://www.indigenouspsychology.com.au/

How would you describe the 'criteria' or 'indicators' for monitoring and understanding the responsiveness of services to Aboriginal and Torres Strait Islander people?

66 Accountability of leadership for the delivery of quality mental health services to Aboriginal people, and the development of appropriate targets and indicators, needs consideration at three levels:

(1) services in the community;

(2) mainstream mental health services; and

(3) policy, programme design and implementation review.

67 There must be additional obligations placed on mainstream services funded to provide mental health to report on their levels of engagement with Aboriginal people and the cultural responsiveness of their services. Mainstream services also should be accountable for the quality of the care they deliver through performance reporting, including discharge planning.

68 This is an important area of consideration that should become a piece of dedicated work commissioned to make sure that we are able to measure and monitor the responsiveness of services to Aboriginal people. This should be achieved through collaboration with Aboriginal stakeholders and mainstream services. The Gayaa Dhuwi (Proud Spirit) Declaration should be used as a guide to support this work.

Partnership and community involvement

How could Victoria better embed self-determination for Aboriginal and Torres Strait Islander people into the design and delivery of mental health services to improve the delivery of those services?

69 Given the legacy of institutional injustice, how governments work with Aboriginal communities is just as important as what actions governments take to improve mental health outcomes for Aboriginal people and communities.

70 The release of the 5th Mental Health Plan and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Emotional and Social Well-Being (2017-2023) provides an opportunity for the State Government to collaborate to simultaneously strengthen and improve:

(a) the capacity of the primary healthcare sector, particularly ACCOs to deliver social and emotional well-being programs, preventative strategies, early identification of mental health problems and appropriate referrals, and linking patients with social support services that can alleviate stressors;

(b) the accessibility, effectiveness and cultural capability of mainstream mental health services in working with Aboriginal and Torres Strait Islander patients with severe mental illness, including models of care (Aboriginal-led, recovery oriented, family centred and trauma informed);

(c) the Aboriginal mental health workforce and to develop the skills and behaviours of individual non-Indigenous clinicians and staff; and

(d) integration of the pathways between primary and acute care sectors; the intensive case management of clients across the primary/acute care interface, effective referrals and discharge planning.

How can Aboriginal and Torres Strait Islander communities be empowered to become more involved in the design and delivery of mental health services?

71 Empowering communities to be involved in the design and delivery of services can occur through co-design. 'Co-design' means involving Aboriginal consumers and communities in generating ideas, testing them and making decisions about how these ideas could shape responses to SEWB. Critically, co-design involves a shift in power, responsibility and control so that Aboriginal consumers and communities become *active* partners in designing, shaping and resourcing services, programs, and activities rather than being passive recipients of those things.

72 Implementation of co-design ought to occur in line with the principles outlined in The Gayaa Dhuwi (Proud Spirit) Declaration[26]. VACCHO can potentially support the process

[26] Gayaa Dhuwi was developed and launched by the Aboriginal and Torres Strait Islander Leadership group in Mental Health in 2015, and has since been endorsed by the Victorian 10-Year Mental Health Taskforce. The declaration sets out principles for governments, professional bodies and services to support a new paradigm for shaping mental health system responses to Aboriginal mental health problems. It provides a platform for governments to work collaboratively to embed culturally safe services within the mental health system that are adaptable and accountable to Aboriginal and Torres Strait Islander people. This includes supporting Aboriginal leadership in mental health and suicide prevention as the foundation upon which to address the high rates of mental health conditions and suicide through both culturally and clinically based approaches.

The Gayaa Dhuwi (Proud Spirit) Declaration Guiding Principles are:

1. Aboriginal and Torres Strait Islander health is viewed in a holistic context, that encompasses mental health and physical, cultural and spiritual health. Land and sea is central to wellbeing. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal and Torres Strait Islander ill-health will persist.
2. Self-determination is central to the provision of Aboriginal and Torres Strait Islander health services through ACCOs
3. Culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal and Torres Strait Islander peoples' health problems generally, and mental health problems, in particular.
4. It must be recognised that the experiences of trauma and loss, present since European invasion, are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continues to have inter-generational effects.
5. The human rights of Aboriginal and Torres Strait Islander peoples must be recognised and respected. Failure to respect these human rights constitutes continuous disruption to mental health, (versus mental ill-health). Human rights relevant to mental illness must be specifically addressed.
6. Racism, stigma, environmental adversity and social disadvantage constitute ongoing stressors and have negative impacts on Aboriginal and Torres Strait Islander peoples' mental health and wellbeing. 7. The centrality of Aboriginal and Torres Strait Islander family and kinship must be recognised as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and sharing.

of co-design by maximising community engagement through coordinated actions of its member ACCOs

How can mental health service providers ensure sustained engagement with Aboriginal and Torres Strait Islander communities?

73 They can achieve this through the development of an Aboriginal workforce supporting SEWB and mental health services, through embedding cultural competence and safety in mainstream services and by interconnected services with streamlined, efficient referral pathways and formal partnership agreements.

74 On behalf of VACCHO, we need to stress the urgent need to invest in and support the expansion of the current Aboriginal workforce. A strong Aboriginal workforce is a central element of the mental health service system if we want to see improved service access and positive Aboriginal mental health/SEWB outcomes. VACCHO advocates that every ACCO should be supported to enable the delivery of a comprehensive suite of mental health/SEWB services through integrated mental health and social emotional wellbeing teams. As part of any broader investment to expand the Aboriginal workforce, the addition of Koori Mental Health Liaison Officer positions in every clinical mental health service would lead to significant benefit.

75 VACCHO is confident that Aboriginal workforce expansion alone would go a long way to increasing access to locally delivered mental health and SEWB services. Team care/approaches will ensure improved care co-ordination and higher levels of prevention, early detection and supported referrals and access to treatment services.

Reform

What reforms and innovations would you recommend to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people in Victoria now and in the future?

76 Currently, there are major gaps in the provision of SEWB services in both mainstream mental health services as well as ACCO's. As has been stated, this is due in part to the significant Aboriginal workforce gaps in the mainstream clinical mental health system with a limited number of KMHLO positions attached to services and only a small number

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7. There is no single Aboriginal or Torres Strait Islander culture or group, but numerous groupings, languages, kinships, and tribes, as well as ways of living. Furthermore, Aboriginal and Torres Strait Islander peoples may currently live in urban, rural or remote settings, in traditional or other lifestyles, and frequently move between these ways of living.

8. It must be recognised that Aboriginal and Torres Strait Islander peoples have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment.

National Aboriginal and Torres Strait Islander Leadership (NATSILMH) in Mental Health 2015, Gayaa Dhuwi (Proud Spirit) Declaration, NATSILMH, Canberra. Available at: https://natsilmh.org.au/sites/default/files/gayaa_dhuwi_declaration_A4.pdf

of ACCO's funded to provide primary mental healthcare to Aboriginal. A significant investment is needed to develop the mental health workforce supporting the SEWB and mental health needs of Aboriginal and Torres Strait Islander people.

77 Victoria should adopt the same policy as NSW Health who, as I understand, are on track with implementing a clear policy directive under its *NSW Mental Health and Wellbeing Policy* that requires at least one Aboriginal mental health worker to be employed per 1,000 Indigenous people in the catchment area. I would expect that this Royal Commission will support every single area mental health service and CAMHS service to employ a minimum of one — ideally two — Aboriginal mental health clinicians as part of a dedicated Aboriginal Mental Health Workforce Strategy.

78 Government should invest in resources and further research into community-led responses to suicide, and trauma informed healing because there are some evidence gaps. In addition to further research, there should be establishment of Aboriginal mental health crises response teams in metropolitan Melbourne and all regional areas to support people and families in crises. To date, I know of no Victorian Aboriginal postvention support services that have been made available to family members of individuals who have committed suicide. This is particularly important. I know, for example, in recent days that family members and those connected to an individual who has recently committed suicide have then presented to hospital having self-harmed.

79 There needs to be an independent review of the Koori Mental Health Liaison Officer Program to identify what is and isn't working. This is long overdue, and I think would it be strongly supported by the KMHLO's themselves and the sector more broadly.

80 VACCHO would support a major Aboriginal SEWB conference for all parts of the service system to come together, including ACCOs. This will provide an opportunity for relationship development through networking which will support further collaboration. It could showcase emerging models of what works, the latest evidence and practice-based research and provide an opportunity for information and resource exchange and address the challenges facing the sector.

81 VACCHO would like to see prioritising of funding for ACCOs to deliver SEWB and mental health services. ACCOs are well used by Aboriginal people seeking mental health support. VACCO's internal data team have told me that 50% of Aboriginal community have used ACCOs at least 3 times in the year from May 2018 to May 2019. 56% of these ACCOs report that depression is the most prevalent issue they come across, followed by anxiety. They report that this consumes a large proportion of their time without adequate resources. This is commensurate with reporting that 34.5% of Victorian Aboriginal people have diagnosed with depression or anxiety at some point in their lives. Importantly, it has been shown nationally that SEWB services are used when

they are offered with 16,300 clients seeing 189 counsellors an average of 5 times over 2016-17. Yet ACCOs do not have the financial capacity to meet the demand for these services. We know that 63% of organisations funded to provide primary health care services for Aboriginal people identified the provision of mental health and social and emotional well-being services as a major service gap which is primarily due to resource constraints. In a nutshell, most ACCOs have limited resources to provide an appropriate service response to the huge demand for SEWB services.

82 The next reform initiative required is to invest in healing centres and programs. Healing is an important concept and practice for Aboriginal Victorians, and has emerged during consultations across many Aboriginal communities and workforce and stakeholder groups as being a significant issue and one where resource investment should be prioritized. Healing is a critical concept of supporting social emotional well-being. The release of the 'Bringing them home" report in 1997 led to recognition of the Stolen Generations and continuing negative impacts on individuals and whole communities of government policies. It is now broadly recognised, as described by the Healing Foundation, that unresolved trauma is directly related to the policies of past governments, resulting in the legacy of the stolen generations. Many of the problems prevalent today, such as substance abuse, mental illness and family violence are themselves rooted in a cycle of trauma. As described by the National Healing Foundation, healing involves the application of existing cultural knowledge, as well as the development of new ways to practice this in a contemporary context, in order to address trauma stemming from colonisation. Healing needs to be an intricate part of the processes of prevention as well as the treatment of mental health issues, supporting recovery and improving social and emotional well-being. No amount of conventional Western mental health approaches will be enough without concurrent investment and focus on traditional and contemporary healing.

83 Finally, there is acute need for investment in acute psychiatric care for Aboriginal people. Hospitals are currently not capable of meeting demand for psychiatric beds in Victoria. An example of the overwhelming demand is that, during the first week of July 2019, there are 5 of 50 beds currently filled by Aboriginal people, but there are 14 Aboriginal individuals waiting for a bed, unable to receive the acute care they need. These individuals cannot be referred onto other hospitals (e.g. St. Vincent's) because they are also at capacity. To compound the matter, there is only one mental health liaison officer to provide support to these individuals. Thus, funding is needed to provide more beds for acute needs patients, there needs to be adequate case management to support discharge planning, and there needs to be culturally safe support programs within hospitals which include healing places.

84 In addition to funding for the provision of beds, there needs to be culturally safe services for people to transition to out of the acute setting and an investment in a facilitated referral process. At present there is insufficient funding to provide basic supports for people being discharged from psychiatric care e.g. they are discharged with a plastic bag of medication and left to fend for themselves, often escorted to temporary stay facilities by policy. It often the case that there aren't enough community-based beds to refer discharged individuals into

85 In addition to supports for psychiatric patients there needs to be support for Aboriginal health workers. Many support workers are isolated and experience vicarious trauma due to the continuous high pressure they are subject to.

How can mental health services and other government agencies monitor and respond to changing needs of Aboriginal and Torres Strait Islander people?

86 There are two key areas of promising innovation that I would like to highlight that are working well and have the potential to be replicated across Victoria, particularly in regional areas. They clearly demonstrate the benefits of investing in multidisciplinary Aboriginal mental health and social emotional wellbeing teams in ACCO's and the importance of strong partnerships with mainstream mental health services.

87 Over the last two years, funding has been allocated, and recently extended to support four Balit Murrup demonstration sites across ACCO's to test new service models for Aboriginal people with moderate to severe mental illness, trauma and other complex health and social support needs.

88 Each site provides culturally responsive mental health care, treatment and care coordination in strong partnership with local mainstream mental health services with the aim of streamlining pathways for clients requiring acute mental health care. All of the ACCOs are making progress towards the development of strong partnerships with mainstream mental health services, and delivering unique local programs supporting and empowering their clients.

89 The four ACCO's involved include the Victorian Aboriginal Health Service (**VAHS**), Wauthrong Cooperative in Geelong, Ballarat and District Aboriginal Coop and MDAS (Mildura). A major independent evaluation is currently being undertaken by Social Compass, which is already showing emerging signs of strong and significant positive outcomes.

90 Early findings from the evaluation are indicating that all four projects are on positive and effective paths. From a consumer of client perspective, this approach is already showing signs of success such as:

(a) Clients are remaining engaged with their ACCO over a period of time (are not "falling out" of the system);

(b) Clients are accessing a wider range of supports;

(c) Clients are supported to move into more stable housing;

(d) Clients have reduced stress and chaos in their lives; and

(e) Clients have increased ability to make decisions about their lives.

91 Some more specific outcomes are being achieved in different sites. For example, in Ballarat the new service model has a focus on clients with Aboriginal children in the child protection system and where there have been a reported 16 family reunifications achieved.

92 While each site is different and the service models are operating in varying contexts, there are some consistent factors contributing to their success including:

(a) Effective ACCO team leadership;

(b) Healthy team environments; and

(c) Positive collaborative relationships between ACCO and area mental health and hospital staff.

93 One of the key success factors identified has been the opportunity to establish larger multi-disciplinary teams with a mix of both clinical and non-clinical workers and Aboriginal and non-Aboriginal staff working in roles such as Aboriginal mental health and community support workers, Mental Health practitioners, psychologists and psychiatrists. This has meant that clients receive culturally responsive, coordinated clinical and practical supports in the one place. Staff are able to share client information and exchange cultural and clinical skills.

94 At MDAS, there are reports of a very successful partnership with the Mental Health Unit at Mildura Base Hospital, with some strong learnings and lessons, examples of good practice emerging on what a positive and successful partnership may look like between an ACCO and an area mental health service.

Are there any other key changes that you would recommend?

95 Recommendation 1: Develop a Victorian Aboriginal suicide prevention strategy.

(a) There has not been a cohesive focus on supporting Aboriginal suicide prevention since the Victorian Aboriginal Suicide Prevention and Response Action Plan. We also need to urgently ensure that we are able to access emerging quality and accurate information on preventable deaths that may be

suicide related from the Coroners Court. I understand that there is significant under reporting of Aboriginal suicide. We must have more accurate data to understand the full depth of this suicide crisis.

96 Recommendation 2: roll out the National Empowerment Program in Victoria.

(a) The National Empowerment Project has been identified at a national level as an innovative Aboriginal led pilot project working directly with communities to address their cultural, SEWB. Victoria has not been part of the national roll out of this commonwealth-funded initiative, despite MDAS in Mildura previously expressing their strong interest and readiness in being Victoria's only trial site.

(b) The National Empowerment Project aims to:

(1) strengthen cultural SEWB;

(2) increase resilience;

(3) reduce psychological and community distress; and

(4) reduce high rates of suicide in Aboriginal and Torres Strait Islander communities.

(c) Research consultations led by the University of Western Australia identified that empowerment, healing and leadership programs are an effective way for Aboriginal and Torres Strait Islander people. This provides us with an opening to adopt this model in Victoria.

97 Recommendation 4: Improve access to the NDIS.

(a) In 2012-13, approximately 36% of Aboriginal people were assessed as being disabled. 34.7% of this cohort had a psychosocial disability[27]. The prevalence of Aboriginal disability indicates that Aboriginal people should constitute 12.5% of all NDIS participants, yet they make up only 5%[28]. Aboriginal people, who make up 3% of the Australian population, should constitute 12.5% of all NDIS participants, however, only 5% of participants are Aboriginal and/or Torres Strait Islander[29]. Thus, there is a drastic underrepresentation of Aboriginal people participating in the NDIS. Section 24 of the NDIS Act 2013 may be responsible for the underrepresentation of Aboriginal people participating in the NDIS for psychological disability, because of the difficulty associated with proving that their mental illness significantly reduces their functional capacity. Aboriginal

[27] Australian Institute of Health and Welfare (2015). The health and welfare of Australia's Aboriginal and Torres Strait Islander people 2015. Cat. no. IHW 147. Canberra: AIHW.

[28] National Disability Insurance Scheme (2017) COAG Disability Reform Council Quarterly Report, 30 September 2017 pp24.

[29] Ibid.

healthcare workers may be best positioned to assist Aboriginal people access the NDIS. They can assist community members with a disability to navigate through the bureaucratically challenging system. Another issue with accessing NDIS supports is the cost of verifying disability through medical assessments. Due to socioeconomic disadvantage of some Aboriginal community members, this precludes them from participating in the NDIS because they cannot afford assessments. Thus, the Royal Commission ought to investigate solution for improving Aboriginal people's access to the NDIS.

98 Recommendation 5: Provide supports for Stolen Generation Survivors entering aged care.

(a) 100% of stolen generation survivors will be eligible for aged care by 2023. We know that there is a significantly higher prevalence of dementia in this group and that trauma has played a significant role in predisposing them to dementia. On top of this, 40% of Stolen Generation Aboriginal people aged 50+ have poor mental health due to the trauma of removal and are 1.3 X more likely to have poor mental health than non-Aboriginal people aged 50. We also know that entering care is associated with re-traumatisation. As such the Royal Commission ought to investigate the delivery of mental health and SEWB care in an aged care setting to this particularly vulnerable group of people and plan to expand the number of Aboriginal aged care facilities.

Summary of the desired outcomes of the Royal Commission

99 All Aboriginal people in Victoria have the opportunity to thrive, enjoying optimal SEWB.

100 A tangible reduction in the rates of suicide, mental illness and psychological distress can be measured over time with government reporting to promote greater accountability for delivering better mental health outcomes.

101 The critical need for our Communities to heal from intergenerational trauma, loss and grief, with a greater focus on culture as an underlying protective factor, is addressed.

102 A holistic Aboriginal definition of SEWB, and healing, is supported.

103 There is a sharper focus on efforts to reduce racism – recognising its significant effects on the mental health and wellbeing of Aboriginal people in Victoria.

104 There is recognition of the existing evidence relating to the significant need to expand investment in mental health services, including our ACCOs.

105 A substantial investment and re-investment in early intervention processes and programs that are in line with Community's priorities and evidence-based solutions.

106 Integrated mental health and social emotional wellbeing teams to be established and expanded in every ACCO.

107 ACCOs are provided with long-term, sustainable funding to provide trauma-informed healing services as part of their service models and core business.

108 Victorian State Government policies to prioritise government funding to ACCOS apply to all new mental health funding.

109 Aboriginal children and young people have access to culturally safe, therapeutic family strengthening services and early intervention, and have priority access to mainstream mental health services.

110 The development of a Victorian Aboriginal mental health workforce strategy.

111 Current capacity and future workforce need to accelerate culturally responsive and accountable mental health services, including GP services, are identified.

112 Community led solutions to suicide prevention be supported and resourced, and support the full implementation of self-determination.

113 The improvement and strengthening of mental health service access, referrals and integrated pathways between all parts of the mental health service system and related areas E.g. justice, family violence, education and alcohol and other drugs.

114 The need for mainstream services to be culturally responsive, including specialist mental health services, and the development of accountability mechanisms to ensure the culturally safe delivery of mental health outcomes.

115 Supporting greater research capacity and development to consolidate and expand the evidence-based approaches proven to be effective for mental health outcomes for Communities.

sign here ►

print name Helen Kennedy

date 12/07/2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT HK-1

This is the attachment marked 'HI-1' referred to in the witness statement of Helen Kennedy dated 12 July 2019.

HELEN KENNEDY
SUMMARY OF EDUCATION AND EMPLOYMENT EXPERIENCE

EDUCATION

2009	**Master of Education (RMIT)** (Exegesis and Project: Promoting and investing in Aboriginal Leadership)
2001	**Master of Business Administration (MBA) RMIT** • Completed two subjects with Distinction: '*Leadership and Management*' and '*Managing Relationships'*
1998	**Williamson Community Leadership Program** (known as '*Leadership Victoria'*)
1990-1991	**Graduate Diploma in Community Development (RMIT)** • Successfully completed all units except 1 module due to University discontinuing course
1982-1987	**Bachelor of Arts Degree (Swinburne University)** • Majoring in Psychology and Australian Politics

Training and professional development

2014-2018	Various VPS tailored PD courses: procurement and financial delegation training
2014	Certificate in Corporate Governance (VUT)
2014	Change Agent Network (existing and emerging AOD service Managers) – intensive leadership development (Leadership Victoria/Turning Point)
2002	Certificate in Workplace Training and Assessment Level 1V (VECCHI)

EMPLOYMENT

2019 **Chief Operations Officer, Victorian Aboriginal Community Controlled Health Organisations (VACCHO)**

Responsibilities and Achievements

VACCHO is the peak body for Aboriginal health and wellbeing in Victoria. Oversee VACCHO's operations across five units – who

work to support VACCHO 30 Aboriginal Community Controlled Member Organisations. Leading organisational restructure, oversee business planning across VACCHO, and proved critical representation and expertise to government and stakeholders.

2015 **Principal Policy Adviser, Aboriginal Social Emotional Well Being**

Responsibilities and Achievements

Co-ordination of all stages of development of new 10 year Aboriginal social emotional wellbeing framework, Balit Murrup Leadership, strategic input and coordination of successful 2016 Budget ($7.2 million) and additional investment to support 4 new Aboriginal mental health demonstration sites located in ACCO's.

February, 2018 (current DHHS **Assistant Director, Aboriginal Health and Well Being Branch,**

Responsibilities and Achievements

Establishment of newly created position; responsible for management of senior staff and key reform initiative's including implementation of Korin Kori, Balit Murrup and Aboriginal Governance and Accountability Framework and input into key cross government policy reform (VAFF, Family Violence, AJF#4, Wungerwil Gap Gap Duir).

2009-2015 **Manager, Family Counselling Services, Victorian Aboriginal Health Service**

Responsibilities and Achievements

Responsible for the management of over 45 staff – including a range of allied health professionals providing acute mental health and social emotional well-being support, counselling, therapeutic intervention, such as psycho- social support as well as group recovery and healing programs. Supported relocation of services from small site to two new sites in the north/western region.

Services include (AOD) drug and alcohol support, problem gambling and financial counselling, additional clinical as well as psychiatric disability rehabilitation support, family therapy, Koori Kids and Adolescent Mental Health service.

Key achievements over this time have included:

- Sourcing an additional funding of over 2.2 million dollars to support major service expansion across all programs and new Healing Service

- Overseeing program specific reviews and organisational restructure – resulting in greater devolution of authority to cross functional teams

- Initiating and implementing recommendations arising from three independent reviews of program areas i.e. 'Financial Well Being – including problem gambling;'; 'Evaluation of Koori Kids and Adolescent program'; 'FCS Service Improvement Project' and most recently 'Minajalku Review.'

- Establishing two successful pilot programs 'Empowering Men' and 'Healing program for Women' (clients in abusive/violent relationships'. This provided the evidence base for successful CTG/Koolin Balit investment in unique healing/recovery model and suite of services i.e. art therapy etc.

Description of most recent service expansion (last two years)

- Two Partners in Recovery Positions (PIR) : VAHS part of new consortium with Inner NWM Medicare Local, NEAMI and MIND

- New Detox support position in partnership with R-Gen (subjected to recent successful independent review/to be published) – negotiated position as part of two designated beds at Regen Detox facilities

- New Wadamba Wilam Service as part of a consortium with NAMHS, NEAMI and ReGen (subjected to current highly successful independent review by KPMG)

- Department of Justice 'Community Safety Project' developing a pool of skilled mediators, expanding group healing and recovery programs and a new VAHS 'Restorative Justice Model

- New 'trauma education project' increasing awareness of trauma resulting in new professional development opportunities offered to VAHS and other staff and new 'community lead' resources to support parents who have experienced their own trauma 'break the cycle.' The successful launch of these products and growing VAHS experience in trauma and parenting support lead to securing a Koolin Balit contract to support new parenting programs- responses to which have been overwhelming

This position has required significant leadership as well as high level managerial skills.

2007 – 2009 **Victorian Aboriginal Community Controlled Health Organisation (VACCHO) – Health Programs Manager**

Establishment of newly created senior Management role across eight disparate Health programs and policy initiatives and key change management role during a major organisational re structure

Responsible for providing effective operational and management support to eight Health program areas (ICAP 0 Improving Care for Aboriginal Patient); Palliative Care; Sexual Health, Koori Maternity Program (KMS); Social and Emotional Well Being Program; Diabetes, Nutrition and Physical Activity and Mental Health.

Management of up to 11 staff and development of new human resource management systems

Successful implementation of a new streamlined and 'team based' approach to improve a range of integrated workforce supported initiatives. This includes health promotion and professional development and other initiatives aimed at improving the capacity of Aboriginal Community Controlled health organisations to deliver holistic health services

As a particular area of interest, provision of leadership on a range of mental health related initiatives including:

- Support for successful roll out of State Government Indigenous Mental Health Review leading to recognition of major reforms required
- Successful advocacy for whole of Government and whole of community support to better prevent and respond to suicide in Aboriginal communities
- Innovative response to Commonwealth review of Social Emotional and Well Being Program – focusing on better ways of providing broader based workforce support in mental health
- Management of community consultations for the State Governments Koori Alcohol Plan
- Presentations at numerous International, National and State forums

Responsible for deputising the CEO and representing VACCHO at numerous meetings, forums and conference in different capacities including regular presentations and public speaking

2005 – 2006 **Victorian Aboriginal Community Services Association (VACSAL)**

Problem Gambling Service

Responsible for establishment of an Indigenous *'Problem Gambling Service'* (based on a preventative/health promotion model). This includes:

- Reviewing relevant literature, mapping and scoping current and new services, employing/coaching new staff and working in collaboration with Centre for Ethnicity and Health, VACCHO, VAHS and Dept. of Justice

Responsible for ensuring the effective development and implementation of new Strategic Directions and Operational planning framework – based on evidence based framework

Cultural Awareness Training

Secured major tenders with Department of Justice and three Local Government Councils and community agencies to design and deliver Cultural Awareness Training.

Responsibilities included:

Development/design and customisation of course materials; some facilitation, evaluation of all sessions and on-going customisation where required. Community agencies who have participated in 2 day training sessions include the Aborigines Advancement League (AAL), Victorian Aboriginal Child Care Agency (VACCA) and VACSAL.

Victorian Aboriginal Education Association (VAEAI)

Provision of consultancy services including:

- Reviewing all internal reporting/management systems to ensure improved reporting compliance; provide training to staff on new reporting systems and templates
- Preparing all end of year and mid year reports to OTTE and the Victorian Learning and Skills Formation Council (VLESC)
- Provision of training to all TAFE Wurreker Brokers on reporting requirements – including report writing skills and individual mentoring.

Sept – December 2004

Senior Project Officer (Department of Education and Employment)

Responsible for development of strategic directions across all levels of the Victorian Adult Community Education Sector to implement new 'Ministerial Directions in ACE' and 'Wurreker Strategy' for Koorie Communities and management of stakeholder relationships.

This included identifying potential new opportunities for the sector to align with other Government Departments in the context of a 'whole of government approach to Aboriginal Affairs.'

2001-2004 **Koorie Community Leadership Program (VACSAL) in partnership with RMIT**

Major architect of multi-award winning Leadership program that now has over 60 graduates from a range of Koorie communities and educational/employment backgrounds.

Responsible for all planning and management systems as well as program design and some facilitation and teaching.

Responsible for on-going liaison with employers; management of information systems/annual program launches and presentation night. Importantly, provided significant on-going mentoring to Leadership participants and graduates.

Partnership management with RMIT University and preparation of all written materials and coordination of formal presentations associated with Award nominations. Nominations culminating in the following community, State and National achievements and recognition:

- **Most Innovative Training Program** (State Training Award 2003)
- **Excellence in Teaching Award** (RMIT Faculty of Business) 2003
- **Excellence in Mental Health Promotion Award** (Vic Health) 2003
- **Australian Training Initiative Award** (ANTA) 2003
- **Special Recognition for outstanding achievement** (inaugural Wurreker Awards: VAEAI) 2004

Other achievements while at VACSAL

Responsible for participating in and (in some instances) coordinating, a range of community consultations and concurrent planning requirements and documentation on a range of community issues

Involvement in a major review and re-structure of VACSAL management systems

Initial involvement in successful tender of the first Koorie Job Network in eastern Australia

Preparation of a range of successful funding/tender submissions on behalf of several Koorie community organisations (AAL; Gurwidj Neighbourhood House, VACSAL; KDSV)

Preparation of a range of major **planning** documents including:

- Completion of a major planning document identifying **capacity building needs** of VASCAL
- Planning and scoping for a new Drug and Alcohol Healing Service in partnership with Berry St
- Development of Strategic Plan for the Victorian Aboriginal Funeral Service (2004)
- Planning for various Cross Cultural Awareness programs (and involvement in delivery)
- Proposal for a Victorian Youth Strategy (2004)
- Assistance with planning for an State wide Women's Forum and Aboriginal Men's Group

Responsibilities and Achievements

2001 -2002 **Koorie Diabetes Service (2001 – 2003)**

Responsible for re-establishment of a State wide service including undertaking necessary planning and development of operational systems and auspicing arrangements.

Responsible for recruitment and management of staff under the direction of the KDSV Board.

2000-2001 **Senior Project Officer** (Office of Training and Further Education)

Responsibilities and Achievements

- Key architect of Wurreker Strategy

Responsible for working with a team to develop initial scoping; planning; resource and consultative arrangements to implement a new and large scale initiative aimed to improve TAFE and employment outcomes for Koories across the State through rolling out the 'Wurreker Strategy' across TAFE Institutes, the community sector and Industry groups.

1994 - 2001 **State-wide Koorie Programs Coordinator (Adult Community and Further Education Board)**

Responsibilities and achievements

Developed Koorie ACE strategic planning documents aligned to mainstream ACE planning and policy imperatives.

Development of performance measures and monitoring systems alongside the nine Regional ACE Councils for their respective Koorie Regional Plans.

Provided leadership and advice to the ACFE Board on funding priorities and **all** areas relating to policy, planning and resource requirements in Koorie ACE education.

Responsible for a range of **major new initiatives** that lead to improved education opportunities and outcomes for Koorie youth at risk particularly.

This included securing and managing significant Commonwealth funds and necessary implementation delivery plans i.e. professional development strategy for providers and development of associated curriculum support materials

General

Major project and multiple contract management; responsibility for Commonwealth IESIP reporting and monitoring arrangements; annual reporting arrangements required for monitoring implementation of major policy imperatives (i.e. Black Deaths in Custody Inquiry; Stolen Generation Report). Ministerial briefings and speeches as required and coordination of several Ministerial launches.

Management of six Commonwealth funded staff (until 1996)

Jan –Sept 1996 **Manager – Koorie Services Unit (Northern Melbourne Institute of TAFE)** ***Secondment***

Broad ranging responsibilities including management of several teaching programs and associated staff as well as coordination and participation in several consultancy projects including:

'Acquired Brain Injury Illnesses' resources for carers; 'Cultural Awareness Program for AFL Umpire's; 'ATSIC Women's Economic Development Conference'

1993-1994 **Education Research Officer – RMIT Student Union**

Responsible for undertaking a wider range of research projects (i.e. '*Impact of proposed changes to AUSTUDY and ABSTUDY'* and '*Fees and Charges in TAFE*'

1992- 1993	**Equal Opportunity Manager** Responsible for managing the University's Access and Equity Strategy/Equal Opportunity Plan and all associated planning, support and monitoring arrangements Conducted for the first time at RMIT a 'Koorie Awareness Day'
1996-1997	**Education Research Officer – Box Hill College of TAFE** Responsible for initial establishment of the new Student Association at the College
1984	Acting President of the Swinburne Student Union
1982	Vice President Swinburne Student Union

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Other:	Employed part time from 1982 – 1987 as a 'Kitchen Hand' at Cotham Private Hospital to support undergraduate studies
Training Programs	Advanced Microsoft Word; Project Management Incident Reporting and Incident Investigation (VHIA) 2010 Performance Management (VHIA) 2011 Igniting Leadership (Leadership Victoria) 2010

Committees and Membership

National Aboriginal Mental Health and Suicide Prevention committee (2018)

Victorian Aboriginal Child Care Agency	(Director 1998- 2003; 2013 – current)
Yappera Aboriginal Child Care Agency	(Director 2003 – 2006)
Dulin Mentoring Association	(November 2005 – January 2006)
NAIDOC Committee	(Treasurer/2005)
Leadership Victoria	(current 'Fellow')
Victorian Indigenous Leadership Network	(former Director 2008-2013)
Melbourne Stars Basketball	(former committee member)

*Current extensive membership on a range of health and wellbeing related advisory committees and groups: too numerous to mention but available on request