We at Rumbalara Aboriginal Co-operative Ltd (RAC) through consultation with staff would like to highlight a number of items that we as an Organisation are identifying as gaps in services and possible solutions.

The Goulburn Valley area and surrounds has the largest population of Indigenous community members outside of Metropolitan Melbourne Victoria, the provision of Aboriginal and Torres Strait informed practice, is limited to a half dozen practitioners. In the regional area of the Goulburn Valley and other surrounding districts, there is inadequate access to suitably qualified professionals to respond to the multiple needs of the Aboriginal and Torres Strait Islander community member's complex needs. This is a barrier that requires action in order to create a holistic and culturally appropriate service response and to work towards closing the gap in health outcomes for our community.

The Triage Assessment in Main Stream services that is applied in contact with our community members is flawed, basically due to the fact that it is the mental health in most cases the trigger to alcohol and substance abuse and is not the primary trigger. Community members are judged on race and not by need of services. **The development of a Framework for services and Training programs led by VACCHO along with ACCHOS to Mainstream Services** would assist in working towards education of staff to be non-judgemental of clients who present regularly. Training staff to assess an individual clinically and non-judgementally and to be able to provide community culturally appropriate services before they are needing crisis intervention services.

Many of the supports provided to high risk community members is performed at the crisis intervention stage which does not allow medium or long term supports to be included in mental health care plans and professional meetings to decide treatment options. Contact can be fleeting and spasmodic which in turn leads to more "band aid" supports and therefore not working towards goals and solutions for better outcomes for community.

More supports and programs are required to allow meaningful connections to our high risk community members who have exhausted most other supports and housing options when they have not received the services that are required to gain quality of life and correct treatment processes. Community members can then spiral into deeper seeded mental health conditions and can then turn to self-medication. This then contributes to community commencing or continuing self-medication with illicit drugs/alcohol.

There are a many community members that have multiple complex issues such as homelessness, substance misuse and mental health issues that are unable to access existing supports due to the conflicting issues present. Some are unable to maintain contact with their supports programs/workers due to a lack of outreach support and the transit nature of their lives. With limited transitional/ emergency accommodation, some are using all their resources just to survive and making appointments and getting into treatment become secondary to this.

There has been little emphasis placed on the growth of mental health services with the ACCHOS, with RAC receiving reduced access of a mental Health Nurse, access to a psychiatrist on a fortnightly basis and also limited access to a psychologist. Community Members should have a choice in regards to referral and treatment pathways. Waiting times for clients seeking specialised Mental Health care (consultation with Psychiatrist) can be 3 monthly waiting periods. Waiting times for young clients referred to CAMHS and consult with Psychiatrist can be or the follow up appointment a 9 week waiting period.

Waiting times for clients referred to Head Space can be 9 weeks to 3 months. There is a lack of follow up for young community members who have been seen to be actively followed up for further appointments. Availability of appointments with a Psychiatrist in the Aboriginal Clinic requires extra funding support and the availability to suitably qualified professionals who can provide culturally appropriate care.. (Currently only three appointments available one afternoon per fortnight and if the visiting Psychiatrist is away we currently have no replacement from

Goulburn Valley Health provided which can mean community are waiting an extra month to be seen). There is also a need for increased availability of appointments with Psychologists (male and female) through the public system. Appointments that are provided under the current private system are unaffordable for most community members. Private run clinics in regional areas can most often charge astronomical prices for services which mean these are unreachable for community needing urgent help.

ACCHOs have the ability and resources to reconnect clients with their own country recognising cultural/spiritual beliefs to assist in recovery. Often traditional healing is only used as a last resort in mainstream services and more education and research is needed in this area.

Kind Regards

James Atkinson
Chief Executive Officer
Rumbalara Aboriginal Co-operative

Key outcomes needed for our Communities in line with VACCHOS Position

Social emotional wellbeing is important for us all. We all know the devastating impact that poor mental health, grief, trauma and particularly suicide has on our families and Communities. Intergenerational poor mental health, grief and trauma have its roots in colonisation that our Communities have experienced for over 200 years.

We know our Communities are at a greater risk of poorer mental health and disproportionately experience poor mental health outcomes due to systemic discrimination and barriers to accessing services. It is unacceptable that Aboriginal peoples in Victoria are three times more likely than non-Aboriginal people to experience high or very high levels of psychological distress. New research identifies Victoria as having the second highest rate of high to very high levels of psychological distress in 39% of young Aboriginal people (AIHW, 2018).

The Royal Commission into Mental Health provides an opportunity to collect perspectives and experiences regarding mental health experiences in our Communities, and create a better understanding of large scale changes that are urgently needed.

Below is a list of positive outcomes we hope for our Communities from the Royal Commission:
• That all Aboriginal people in Victoria have the opportunity to thrive, enjoying optimal social and emotional wellbeing.
• 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.
• Address 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.
• The support of a holistic Aboriginal definition of social and emotional wellbeing, and healing.
• A sharper focus on efforts to reduce racism – recognising its significant effects on the mental health and wellbeing of Aboriginal people in Victoria.
• Recognition of the existing evidence of the significant need to expand investment in mental health services, including our Aboriginal Community controlled organisations (ACCOs).
• A substantial investment and re-investment in early intervention processes and programs that are in line with Community's priorities and evidence based solutions.
•An integrated mental health and social emotional wellbeing teams to be established and expanded in every ACCO.

• ACCOs are provided with long-term, sustainable funding to provide trauma-informed healing services as part of their service models and core business.
• That policies to prioritise government funding to ACCOS applies to all new mental health funding.
• That 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.
• The development of a Victorian Aboriginal mental health workforce strategy.
• That current capacity and future workforce needs to accelerate culturally responsive and accountable mental health services, including GP services are identified.
• That Community led solutions to suicide prevention be supported and resourced, and support the full implementation of self-determination.
• 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.
• 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.
• Supporting greater research capacity and development to consolidate and expand the evidence based approaches proven to be effective for mental health outcomes for Communities.

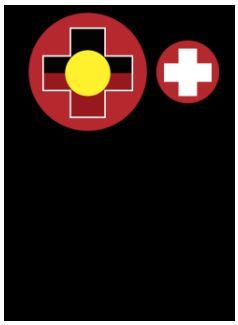
Below is a range of infographics and definitions

1. Aboriginal people experience poor mental health compared to non-Aboriginal Australians
    a. In 2014-15, 29.3% of Aboriginal people had a mental health condition compared to a national average of 17.5%[1] (ABS, 2016; ABS, 2015)

    b. 84% of Aboriginal people diagnosed with a mental health condition reported experiencing one or more stressors including serious illness (17%), AoD problems (19%), overcrowding at home (10%), and discrimination (9%) (ABS, 2016; McNamara et al., 2018)
    c. 29% of young Aboriginal people aged 15-24 have a long-term mental health condition compared to 16% of non-Aboriginal youths in 2014-15 (AIHW, 2018a)
    d. 39% of Victorian Aboriginal people aged 15-24 experienced high or very high psychological distress in 2014-15 (ibid.)

2. There is an overrepresentation of Aboriginal people utilising mental health services, yet their mental health needs are still not being met:
    a. Overrepresentation in rates of mental health service utilisation:
        i. The rate at which Aboriginal people sought community mental health services was 3.1 times higher than non-Aboriginal clients in 2014-15 (865 per 1,000 compared with 283 per 1,000) (AIHW, 2017a)
        ii. 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 (AIHW, 2017a)

[1] This rate has increased to 20.1% as of 2017-18



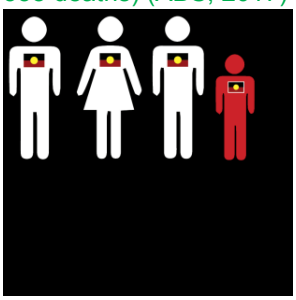
iii. In 2012-13 Aboriginal people aged 18–24 in Victoria (47% or 3,000) were more likely to use health services for mental health conditions than those in other states and territories (AIHW, 2018a)

b. Under-utilisation of services given the state of collective poor mental health:
   i. In 2013-14, Victorian Aboriginal people were less likely than non-Aboriginal individuals to have claimed for psychologist (108 compared with 172 per 1,000) or psychiatric care (48 compared with 94 per 1,000)(AIHW, 2017a)

   ii. Of all Indigenous people aged 18–24 who had experienced very high or high psychological distress, 77% (19,519) had not seen a health professional (AIHW 2017b).

   iii. Fear of shaming one's self or family, racism, and a lack of awareness or available mental health services were barriers to accessing mental health services for Aboriginal youths aged 10-24 years (Brown et. al, 2016)

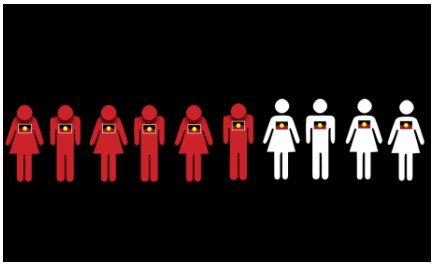
3. There is a pressing need to implement multifactorial measures to reduce suicide among Aboriginal people, but more data is needed determine which preventative measures are most effective
   a. The suicide rate for Aboriginal people is double the national average at 24.9 persons per 100,000 vs. 12.08 persons per 100,000 for the years 2013-2017 (ABS, 2017)
   b. 26% of suicide deaths of Aboriginal people were children and young persons aged 5-17 years (93 of 358 deaths) (ABS, 2017)



   c. Suicide rates in Aboriginal men were 4 times higher than the national average (2013-17) (ibid.)
   d. Social disadvantage is associated with higher rates of suicide (Dudgeon et. al. 2016). Example of social disadvantage experienced by Victorian Aboriginal people:
      i. In 2011, 39% of the total Aboriginal population lived in the most disadvantaged areas and 5% lived in areas of most advantage compared to 17% and 18% for non-Aboriginal individuals respectively (AIHW, 2017a)

e. Aboriginal Australians are disproportionately exposed to risk factors, such as grief, trauma, and loss, which is associated with an increased suicide risk (Chalmers et al. 2014; Gee, 2017)
f. Aboriginal designed prevention activities focusing on cultural resilience factors such as connectedness to community are associated with lower rates of suicide and suicidal ideation (Gee G., 2017)
g. However, a systematic review of national and international studies on Indigenous suicide prevention and intervention revealed that *"there is not sufficient evidence to identify the key factors that determine successful Indigenous suicide prevention programs and activities, and experimental evaluation designs were urgently required to systematically investigate program outcomes."* (Gee, 2017)

4. Poor family mental health is associated with placement of children in out of home care (OOHC); placement in OOHC compromises the mental health of Aboriginal youth which may be associated with subsequent overrepresentation in the justice system
    a. Victorian Aboriginal children are 12.9 times more likely to be in out of home care (OOHC) than non-Aboriginal youth (CCYP, 2016)
    b. 60% of Aboriginal children in OOHC[2] came to the attention of child protection as a result of parental mental health issues in combination with other risk factors. (CCYP, 2016)



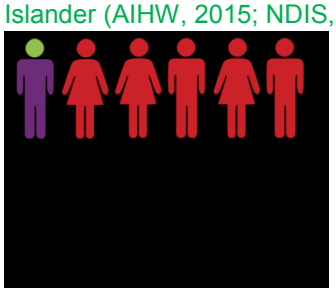
    c. From 2014-2016, 22% of Aboriginal children aged 0-18 in OOHC had a mental illness (ibid.)
    d. Young Aboriginal people placed in out-of-home care are 16 times more likely than the equivalent general population to be under youth justice supervision within the same year (AIHW, 2017c)
    e. In a 2011 study, 89% of Aboriginal youths in juvenile justice detention had a psychological disorder (Indig et. al)
    f. 90% of Aboriginal and Torres Strait Islander youths who appeared in a children's court went on to appear in an adult court within eight years—with 36% of these receiving a prison sentence later in life (Senate select committee, 2010)

5. Addressing poor mental health during the perinatal period represents a vital opportunity to interrupt the transfer of intergenerational trauma and improve the health and wellbeing of Victorian Aboriginal women, children, families and communities
    a. From 2010-2015, 49.5% of Aboriginal mothers (n = 215) who gave birth at the Melbourne Royal Women's hospital were diagnosed with a mental illness compared to 18.8% of non-Aboriginal mothers (n = 38,264) (Ford et al., 2018)
    b. From 2011-13, 35.6% of South Australian Aboriginal mothers (n = 319) who reported three or more social health issues during pregnancy experienced high to very high postpartum psychological distress indicating an association between trauma and postpartum mental illness (Weetra et al., 2016)
    c. 98% of healthcare workers surveyed (n = 82) across Australia stated that trauma, stress and grief were primary factors in the poorer health outcomes for Aboriginal women during the perinatal period (Highet & Goddard, 2014)
    d. Compared with women attending mainstream public antenatal care, women attending metropolitan and regional Aboriginal Family Birthing Program services had a higher likelihood of reporting positive experiences of pregnancy care (adj OR 3.4 vs. adj OR 2.4). Women attending Aboriginal Health Services were also more likely to report positive experiences of care (adj OR 3.5) (Brown et al., 2015)

[2] reviewed in the Taskforce1000 study (n = 588)

6. Access to NDIS mental health supports remains a challenge for Victorian Aboriginal people
    a. In 2012-13, approximately 36% Aboriginal people were assessed as being disabled. 34.7% of this cohort had a psychosocial disability (AIHW, 2015)

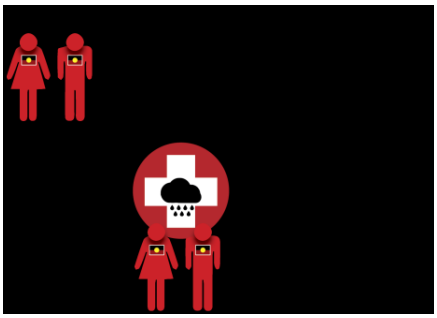
    b. The prevalence of Aboriginal disability indicates that Aboriginal people should constitute 12.5% of all NDIS participants, yet they make up only 5%. (NDIS, 2017)
        i. Aboriginal people, who make up 3% of the Australian population, should constitute 12.5% of all NDIS participants, however, only 5% of participants are Aboriginal and/or Torres Strait Islander (AIHW, 2015; NDIS, 2017)



    c. Section of 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 (VMIAC, 2018)
    d. Given points 8.a,b. below, Aboriginal healthcare workers may be best positioned to assist Aboriginal people access the NDIS.

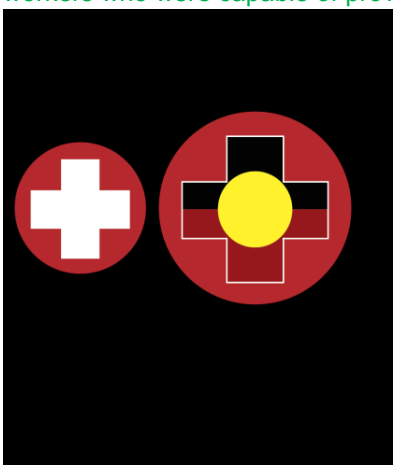
7. Racism is a significant causal factor in the poorer mental health of Aboriginal Victorians, but there is no consensus on cultural safety education to reduce racism within mainstream healthcare
    a. Individuals exposed to weekly episodes of overt and covert racism are 5 times more likely to have poor mental health and 2.5 more likely to experience poor physical health (DHHS, 2017)
    b. Aboriginal Victorians are regularly subject to racism, with over 70% reporting eight or more racist incidents within the preceding 12 months (VHP, 2012)
    c. 47.3% of Victorian Aboriginal people who self-reported instances of racism were over the threshold for high or very high psychological distress.[3] This rate increased to 62.4% in a healthcare setting (Kelaher et. al., 2014)

[3] As measured using the Kessler Psychological Distress Scale



d. Preliminary evidence suggests that embedding culturally safe practices into the provision of healthcare through health practitioner education reduces experiences of racism (Durey, 2010)
e. Currently, there is no national consensus on what cultural safety standards are and the associated incorporation of cultural safety education in the health care sector (Laverty, McDermott, & Calma, 2017)

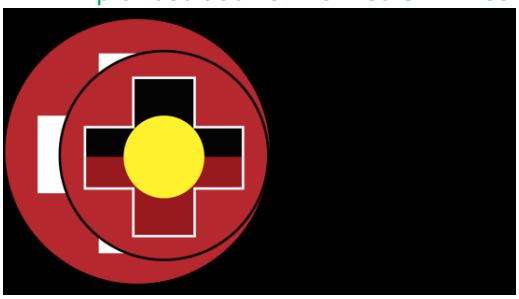
8. Recruitment of Aboriginal mental health workers increases accessibility of mental health services, but Aboriginal people remain underrepresented in the healthcare workforce
    a. Aboriginal people are more likely to visit an Aboriginal mental health worker, particularly those who are highly visible in the community (Fielke et al., 2009; Whiteside et al., 2011)
    b. Aboriginal people's access to mental health care increased by 34% (2012-13) at SQCE Primary Health Care when a SEWB model was affected through the employment of psychologists and social workers who were capable of providing culturally safe services (Hepworth et al., 2015)



    c. 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% (Laugharne, et al., 2002)
    d. In 2011, 1.6% of Aboriginal people were employed in health-related occupations compared to 3.4% of non-Aboriginal Australians indicating a shortage of Aboriginal health workers (AHMAC, 2014)
    e. The Aboriginal Mental Health Traineeship program launched 2019 may help to alleviate this shortage

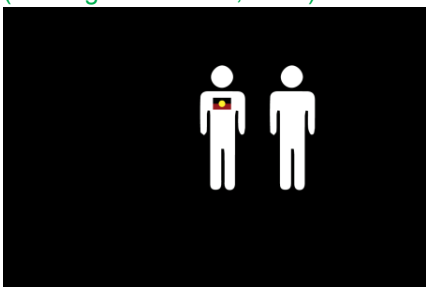
9. Despite a mandate to implement trauma-informed social and emotional well-being (SEWB) services, mainstream services have been slow to adopt this model of care
    a. Trauma-informed, SEWB health services are accepted as the primary mechanism by which health service providers can positively intervene in the health and wellbeing of Aboriginal people (Atkinson, 2013; DHHS, 2017a; DHHS, 2017b)
    b. The Royal Commission into Child Sexual Abuse represents a model for Government acknowledging the importance of trauma-informed care in improving the health and wellbeing outcomes for vulnerable individuals (Quadara & Hunter, 2016).
    c. Policy frameworks such as the Victorian Aboriginal Affairs Framework 2018-2023 mandate the delivery of SEWB services to Victorian Aboriginal people (DPC, 2018)
    d. Nationally, only 33% of organisations (88 of 196) providing health care to Aboriginal people provided trauma-informed SEWB services (AIHW, 2018b)

e. 77 (88%) of the organisations providing SEWB services were ACCHOs (ibid.)
    i. Nationally, 33% of organisations (88 of 196) providing healthcare to Aboriginal people provided trauma-informed SEWB services. ACCOs make up 88% of this group.



10. ACCOs are well used by Aboriginal people seeking mental health support, yet ACCOs do not have the financial capacity to meet the need
    a. 50% of the Victorian Aboriginal population regularly accessed ACCHOs (VACCHO, 2019)
    b. SEWB services are utilised when they are offered with 16,300 clients seeing 189 counsellors an average of 5 times over 2016-17 (AIHW, 2018b)
    c. The combination of GP's who had completed mental health training and the presence of a Koori Mental Health Liaison Officer increased the rate at which Aboriginal peoples received mental health care plans (MCP), MCP reviews and diagnosis of anxiety and depression. This indicates that ACCO staff are able to guide Aboriginal peoples to more successful treatment options and outcomes. (Adams et. Al, 2014)
    d. 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 (AIHW, 2018b).

11. Older Aboriginal people, in particular stolen generation survivors, require aged care supports that do not re-traumatise them
    a. 100% of stolen generation survivors will be eligible for aged care by 2023 (CDH, 2019)
    b. Nationally, approximately 1 in 7 Aboriginal people aged over 50 were removed from their families (AIHW, 2018c)
    c. Childhood trauma is a risk factor for the development of dementia in later life (Radford et. al, 2018)
    d. 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+ (Healing Foundation, 2018)



    e. The prevalence of dementia in Aboriginal people is three to five times higher than non-Aboriginal people (e.g. 26.8% vs. ~10%)(AIHW 2016; Smith et al., 2008; Radford et. al, 2018)
    f. 52% of permanent aged care residents score highly on the Cornell Scale for Depression suggesting that entering and staying in aged-care traumatises residents (AIHW, 2013)

Reference list:

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.

Atkinson J., (2013). Trauma-informed services and trauma-specific care for Indigenous Australian children. Resource sheet no. 21. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies.

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

Australian Bureau of Statistics (2016). 4714.0 - National Aboriginal and Torres Strait Islander Social Survey, 2014-15. (n.d.). Retrieved from: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4714.0~2014-15~Feature%20Article~Aboriginal%20and%20Torres%20Strait%20Islander%20people%20with%20a%20mental%20health%20condition%20(Feature%20Article)~10

Australian Bureau of Statistics (2015). 4364.0.55.001 - National Health Survey: First Results, 2014-15. Retrieved from https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2014-15~Main%20Features~Mental%20and%20behavioural%20conditions~32

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

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

Australian Institute of Health and Welfare (2018b). Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2016–17. Aboriginal and Torres Strait Islander health services report no. 9. Cat. no. IHW 196. Canberra: AIHW

Australian Institute of Health and Welfare (2018c). Aboriginal and Torres Strait Islander Stolen Generations aged 50 and over. Cat. no: IHW 199. Canberra: AIHW

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

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

Australian Institute of Health and Welfare (2017c). Young people in child protection and under youth justice supervision 2015–16. Data linkage series no. 23. Cat. no. CSI 25. Canberra: AIHW.

Australian Institute of Health and Welfare (2016). Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW

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.

Australian Institute of Health and Welfare (2013). Depression in residential aged care 2008–2012. Aged care statistics series No. 39. Cat. no. AGE 73. Canberra: AIHW.

Beaver, C., and Zhao, Y. (2004). Investment analysis of the Aboriginal and Torres Strait Islander Primary Health Care Program in the Northern Territory. Commonwealth of Australia. ISBN 0 642 82496 7

Brown, S. J., Weetra, D., Glover, K., Bucksin, M., Ah Kit, J., Leane, C., Mitchell, A., Stuart-Butler, D., Turner, M., & Gartland, D. (2015) Improving Aboriginal Women's Experiences of Antenatal Care: Findings from the Aboriginal Families Study in South Australia. Birth, 42, 27–37.

Chalmers K., Bond K. S., Jorm, A. F., Kelly C. M., Kitchener B., & Williams-Tchen, A. (2014). Providing culturally appropriate mental health first aid to an Aboriginal or Torres Strait Islander adolescent: development of expert consensus guidelines. International Journal of Mental Health Systems 2014 8:6.

Commission for Children and Young People (2016). 'Always was, always will be Koori children': Systemic inquiry into services provided to Aboriginal children and young people in out of home care in Victoria Melbourne: Commission for Children and Young People. Melbourne.

Commonwealth Department of Health (2019). Actions to support older Aboriginal and Torres Strait Islander people - A guide for aged care providers. Publications Number: 12164, Canberra, ACT.

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

Department of Health and Human Services (2017b). Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027. State Government of Victoria, Melbourne.

Department of Health and Human Services (2017c). Racism in Victoria and what it means for the health of Victorians. State Government of Victoria, Melbourne.

Department of Premier and Cabinet, Victorian Government, (2018). Victorian Aboriginal Affairs Framework 2018-2023. Melbourne ISBN 978-1-925789-12-6.

Dudgeon, P., Milroy, J., Calma, T., Luxford, Y., Ring, I., Walker, R., Cox, A., Georgatos G., and Holland, C. (2016). Solutions that Work: What the evidence and our people tell us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report. University of Western Australia. Perth.

Durey A. Reducing racism in Aboriginal health care in Australia: where does cultural education fit?. Aust NZ Public Health 2010; 34: 587-592.

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.

Ford E., Cade T., Doyle L.W., & Umstad M.P. (2018). Pregnancy risk factors associated with birthweight of infants born to Australian Aboriginal women in an urban setting - a retrospective cohort study. BMC Pregnancy Childbirth 8 (1):382. doi: 10.1186/s12884-018-1946-3.

Gee, G., (2017). Indigenous Suicide Prevention Scoping Paper. Unpublished

Healing Foundation (2018). Submission to developing an Action Plan for Aboriginal and Torres Strait Islanders under the Aged Care Diversity Framework. Unpublished

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.

Highet, N. J. and Goddard, A. K . (2014). Aboriginal and Torres Strait Islander Perinatal Mental Health Mapping Project: A scoping of current practice surrounding the screening, assessment and management of perinatal mental health across Australia's New Directions: Mothers and Baby Service program. Centre of Perinatal Excellence (COPE). June 2014

Indig, D., Vecchiato, C., Haysom, L., Beilby, R., Carter, J., Champion, U. et al. (2011). 2009 NSW Young People in Custody Health Survey: Full report. Sydney: Justice Health and Juvenile Justice.

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

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.

Laverty, McDermott, & Calma, (2017). Embedding cultural safety in Australia's main health care standards. Med J Aust 2017; 207 (1): 15-16. || doi: 10.5694/mja17.00328

McNamara B. J., Banks E., Gubhaju L., Joshy G., Williamson A., Raphael B., & Eades S., (2018). Factors relating to high psychological distress in Indigenous Australians and their contribution to Indigenous-non-Indigenous disparities. Australian and New Zealand Journal Of Public Health. 2018;42(2):145-152. doi:10.1111/1753-6405.12766.

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

Radford K., Lavrencic L. M., Delbaere K., Draper B., Cumming R., Daylight G., Mack H. A., Chalkley S., Bennett H., Garvey G., Hill T. Y., Lasschuit D., & Broe G.A.(2018). Factors Associated with the High Prevalence of Dementia in Older Aboriginal Australians. J Alzheimers Dis. 2018 Nov 27. doi: 10.3233/JAD-180573

Senate Select Committee (2010). Discussion Paper 32 Regional and Remote Indigenous Communities., Indigenous Australians, Incarceration and the Criminal Justice System. Parliament of Australia

Smith K., Flicker L., Lautenschlager N. T., Almeida O. P., Atkinson D., Dwyer A., LoGiudice D. (2008) High prevalence of dementia and cognitive impairment in Indigenous Australians. Neurology 71, 1470-1473.

Quadara, A. and Hunter, C. (2016). Principles of Trauma-informed approaches to child sexual abuse: A discussion paper, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney.

Victorian Aboriginal Community Controlled Health Organisation (2019). Unpublished.

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

Victorian Mental Illness Awareness Council, Davis, D. (2018). Coercive accessibility requirements by the NDIA for psychosocial disability. Unpublished

Victorian Population Health Survey (2008). Supplementary report, Health Intelligence Unit, Prevention and Population Health Branch, Wellbeing, Integrated Care and Ageing. Victorian Government.

Weetra D., Glover K., Buckskin M., Kit J.A., Leane C., Mitchell A., Stuart-Butler D., Turner M., Yelland J., Gartland D., & Brown S.J. (2016). Stressful events, social health issues and psychological distress in Aboriginal women having a baby in South Australia: implications for antenatal care. BMC Pregnancy Childbirth. 2016 Apr 26;16:88. doi: 10.1186/s12884-016-0867-2.

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