

2019 Submission - Royal Commission into Victoria's Mental Health System**Organisation Name:****Thirrili/National Indigenous Critical Response Service****About us**

Thirrili Ltd is a not for profit organisation, established to contribute to the broader social wellbeing of Aboriginal and Torres Strait Islander people and ultimately, to support Aboriginal and Torres Strait Islander people communities to stem suicide and trauma.

Thirrili Ltd has been funded by the Commonwealth Government of Australia through the Department of Prime Minister & Cabinet to deliver the National Indigenous Critical Response Service (NICRS) across Australia to:

1. Provide culturally responsive support for Aboriginal and Torres Strait Islander families affected by suicide-related or other trauma
2. Strengthen community capacity and resilience in communities where there have been high levels of suicide to better respond to critical incidents and strengthen service system coordination, and
3. Facilitate and contribute to broader systems change by working with State and Territory governments to understand and better respond to the needs of Aboriginal and Torres Strait Islander people who have been impacted by suicide and other trauma.

Established in 2017, the NICRS initially operated in the Northern Territory, South Australia and Western Australia. In 2018 the project expanded into Victoria and Queensland, and in 2019 the service has further expanded into New South Wales, Australian Capital Territory and Tasmania. Our Model of Care is attached.

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

There is no doubt that some good work has been done in Victoria in past years to improve understanding and reduce stigma, raise awareness and increase services and programs to respond to the mental health needs of individuals, families and communities in Victoria. However, the stigma of mental illness is still prevalent. This is particularly true in relation to Victorians of Aboriginal and Torres Strait islander descent. 'Invisible discrimination' remains a current issue for Aboriginal and Torres Strait Islander people.

While television and other media campaigns aimed at reducing the stigma of mental health have had some success, marketing professionals suggest messages are more effective when often repeated (Floyd n.d; Marx 2015; Pilcher 2019). Political campaigners tell us that by the time they are sick of delivering their message, the voting public are only just starting to hear the message. They argue that messages need to be heard between 6 and 20 times before they are embedded. Studies also show that repeated exposure to an opinion makes people believe the opinion is more prevalent, even if the source of that opinion is only a single person (Ernst et al. 2017). So not only do people remember a statement that gets repeated, they are more likely to believe it, and think it is the popular opinion.

Sadly, health services are not immune to institutional racism. A Victorian study of 755 aboriginal people, published in the Australian Medical Journal in 2014 (Kelaher et.al), found that nearly one-third of the study sample reported experiencing racism within health settings, within the previous 12 months. Regardless of whether this behaviour is intentional or not, it can have a profound effect on individuals and communities, including not accessing services when they are needed and leading to poorer health outcomes. Additionally, stereotyping of any kind can lead to assumptions which in a

health setting can lead to misdiagnosis and may even lead to death.

More recently in NSW there was an incident where death was the outcome for a 27-year-old Wiradjuri woman who was six months pregnant when she died in a NSW hospital on 1 January 2016. A coronial report showed the cause of death was a serious infection that is treatable with antibiotics. The deceased had attended the hospital 18 times in the seven months before her death complaining of pain, vomiting and nausea and had been discharged for the last time just 15 hours before her death (which was unrelated from the pain, vomiting and nausea). While this tragic death is out of jurisdiction for this Inquiry as it occurred in NSW, the Coroner's recommendations were instructive and readily generalisable to the Victorian public hospital system and systems in all States and Territories.

The Coroner in this case recommended that the Aboriginal liaison health worker program be strengthened so that they were available 24 hours a day, and making sure medical staff knew to notify liaison officers whenever an Aboriginal person presented to the emergency department, not just when they were admitted, as is the current practice at the hospital in question. Given Victorian Aboriginal Liaison Officers generally work an 8:30- 5pm shift or similar, the latter recommendation is not currently achievable 24/7.

She also recommended greater employment of Indigenous people as health workers and representation on the board of the local health district. Further, several other recommendations were made to improve implicit bias in the treatment of Aboriginal patients and to develop culturally safe healthcare for Indigenous people, including:

- that consideration is given to auditing the possibility of implicit bias by recording statistics for Indigenous and non-Indigenous patient triage categories, discharge against medical advice, triage times and referrals for drug and alcohol reviews for patients presenting to the that particular emergency department
- that consideration is given to identifying other assessment tools to measure the existence of implicit bias in the provision of health care and commit to making such tools available to that particular hospital.

Although the above mentioned example did not relate to mental health per se, it did highlight the fact that institutional discrimination exists and we would support each of these recommendations as the standard for the Victorian context while noting that some of these approaches may have already been implemented, at least in part, within the Victorian health system.

Based on our understanding of the issues, we would suggest several other strategies to assist in reducing stigma and discrimination against Aboriginal and Torres Strait Islander people who seek treatment for a mental illness, as below:

1. Continue to promote and deliver— with frequency— broad media campaigns aimed at reducing stigma that:
 - are simple (and thus easy to remember)
 - are relevant to Aboriginal and Torres Strait Islander peoples
 - include the faces of Aboriginal and Torres Strait Islander people; and,
 - challenge the rest of the community to be more tolerant of those with mental health issues.
2. Consider ensuring Aboriginal Mental Health Liaison Officer positions become standard across Victorian hospital networks and are available 24/7 —if that is not already the case
3. Government to direct some funding to provide free or subsidised cultural awareness training to health workers that is:
 - codesigned and presented by Aboriginal and Torres Strait Islander people
 - aimed at creating understanding in order to reduce stigma and discrimination; and
 make such training mandatory for all health workers, much the same as workplace health and

safety is mandatory for all staff in many organisations.
2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
<p>In understanding that you will receive submissions canvassing a wide range of issues of which we will concentrate on a small number of matters throughout the submission These are:</p> <ul style="list-style-type: none"> • The need for appropriate services to operate where suicides (and attempts) among Aboriginal and Torres Strait islander people are occurring, • Understanding the centrality of social and emotional wellbeing in the lives of Aboriginal and Torres Strait Islander peoples, • The need for services to adopt a trauma centred practice approach in working with communities and survivors of suicide, and • The importance of understanding the risk and protective factors which impact on the social and emotional wellbeing of Aboriginal and Torres Strait Islander people and communities. <p>Providing appropriate services where they're needed most</p> <p>Suicide death rates for Aboriginal and Torres Strait Islander people are almost double that of other Australians (AIHW 2015). Further, in the period 2011-15, the Indigenous suicide rate for those aged 15–24 years was almost four times that of their non-Indigenous peers (Australian Health Ministers' Advisory Council, 2017). In Victoria, the number of Aboriginal mental health related presentations to Hospital Emergency departments increased by 55 percent between 2012-13 and 2015-16 (DHHS 2017). 34.8 percent of Aboriginal Victorians experience medically diagnosed depression and anxiety compared with 19.6 per cent of non-Aboriginal Victorians and over 47 per cent of Aboriginal people have a relative who was forcibly removed from their family due to stolen generations policies in Victoria meaning that transgenerational trauma continues to affect Aboriginal people in Victoria (DHHS 2015).</p> <p>We know that that there are fewer GPs, specialists and other health professionals in remote and rural areas, and while Aboriginal and Torres Strait Islanders experience a greater prevalence of multiple stresses that will impact their social and emotional wellbeing (SEWB), for those with mental illness, there may be a performance gap in terms of the provision of those services (Parker and Milroy 2014). Further, Aboriginal and Torres Strait Islander people may be reluctant to access mainstream services due to a lack of cultural appropriateness (Schultz et al. 2014, citing Reibel and Walker 2010).</p> <p>Dudgeon and Ugle (2014) note the work of Mark Sheldon, an influential psychiatrist who worked in remote Aboriginal communities. Sheldon contended that a western model of psychiatric assessment and examination was not culturally appropriate to meet the needs of Aboriginal people with mental health issues living in remote communities. After working with the Ngangkari (traditional healers), he advocates that the best outcomes were often obtained when both traditional healing approaches and western clinical methods were used together (Dudgeon and Ugle 2014).</p>
3. What is already working well and what can be done better to prevent suicide?
<p>Given the overrepresentation of Aboriginal and Torres Strait Islander people in suicide statistics and our role in working with those who are bereaved by suicide, we welcome the attention of the Commission on suicide in Aboriginal and Torres Strait Islander communities that this inquiry may bring, through its broad focus on mental health.</p> <p>It is important to note also, that there is both anecdotal and empirical evidence that the numbers of deaths of Aboriginal and Torres Strait Islander people attributed to suicide are underreported. Silburn</p>

and others cite sources which attribute this underreporting to a number of factors: misclassification of Aboriginal status on death certificates and other data systems; differences between jurisdictions in their coronial processes; the procedures around reportable deaths (i.e. deaths which must be reported to a coroner); and the strictness with which the legal criteria are applied in arriving at the official determination of the death being suicide (2014). Unpublished analysis of National Coronial Information System (NCIS) suicide data from 2003-2018, compared to other available sources including from the Australian Bureau of Statistics also suggest considerable underreporting (Healthcare Management Advisors 2018). Anecdotally we are hearing from families and communities across the country that this seems to be the case in their view as well.

The 2016 ATSIPEP report, *Solutions that work: what the evidence and our people tell us*, recommended that governments should explore mechanisms for encouraging partnerships between Indigenous communities and providers and mainstream providers to develop new, or adapt existing, suicide prevention programs for use in Indigenous communities. Further, promising programs with strong community engagement and/or leadership are not evenly geographically distributed, meaning large populations of Aboriginal and Torres Strait Islander people in New South Wales, Victoria, South Australia and Tasmania are less likely to be able to access them (Dudgeon et.al 2016). According to Dudgeon and Walker et al.:

'...programs that show promising results for Indigenous social and emotional wellbeing are those that encourage self-determination and community governance, reconnection and community life, and restoration and community resilience' (2014a).

The need for culturally competent and flexible services, particularly in rural and remote areas, has been highlighted by the Western Australian Coroner in his report into the deaths of 13 children and young people in the Kimberley region:

'The considerable services already being provided to the region are not enough. They are still being provided from the perspective of mainstream services, that are adapted in an endeavour to fit into a culturally relevant paradigm. It may be time to consider whether the services themselves need to be co-designed in a completely different way, that recognises at a foundational level, the need for a more collective and inclusive approach towards cultural healing for Aboriginal communities' (Coroner of Western Australia 2019).

Silburn and others (2014) note the growing concern of high rates of bereavement suffered by Aboriginal families in some parts of Australia. They argue that families and communities can be in a constant state of mourning when suicides follow one another. The evaluation of StandBy's Support After Suicide program suggests that postvention support is effective in reducing the risk of suicide:

'...those receiving support from StandBy had a significantly lower risk of suicidality, mental health concerns and social isolation following the loss of a loved one' (Gehrmann et al. 2018). This finding is encouraging and is consistent with what Advocates within Thirrili's Critical Incident Response Service are reporting.

Trauma informed care

When working with Aboriginal and Torres Strait Islanders it is crucial to consider working with a trauma informed lens. The Trauma Centre of Australia defines trauma as *'a psychological wound that has occurred due to a person's perception of a stressful event'* (Trauma Centre of Australia 2019). The stressful event involves an actual or perceived threat to the person's physical or emotional wellbeing (AIHW 2013). These events can include physical, emotional or sexual abuse (Commonwealth of Australia 2017). Further, responses to the stressful event may include intense fear, helplessness, horror or disordered behaviour (particularly in children) (AIHW 2013).

In a 2018 literature review, Thirili noted that Aboriginal and Torres Strait Islander children are at particular risk of experiencing trauma. They included a key finding that Aboriginal and Torres Strait Islander people are at an increased risk of experiencing prolonged, multiple exposures to traumatic events (complex trauma) and that exposure to trauma is significantly associated with suicide risk (Thirili 2018). Along with greater risk of suicide, other negative outcomes from serious psychological distress include anger and aggression; problem gambling; and smoking (Kelly et al. 2009).

Aboriginal and Torres Strait Islander children may experience trauma differently due to traumatic histories of colonisation and marginalisation and current contemporary living disparities (Swanson and Saus 2013). Atkinson (2008; cited in Atkinson et al. 2014) suggests that trauma can be passed through generations (intergenerational trauma), whereby abuse incurred during childhood increases the likelihood of perpetuating abuse and destructive behaviours as an adult. Trauma-informed care and practice recognises the prevalence of trauma and its impact on the emotional, psychological and social wellbeing of people and communities (Gee et al. 2014).

Traumatic events that have occurred from colonisation, including dispossession of land, forcible removal practices and oppressive legislative policies “...continue to impact significantly on Aboriginal Australian peoples in the form of complex trauma” (Haythornthwaite and Hirovnen 2015). Further, the literature states that ***‘familial transmission of suicide risk, particularly involving parental and sibling suicide, along with early experiences of trauma and substance abuse within communities, was strongly linked to suicide attempts in children and young people’*** (Robinson, Silburn, & Leckning, 2012; Mitchell & Gooda, 2015).

The continued impact of past events is such that it is critical that services working with Aboriginal and Torres Strait Islander peoples recognise, understand and respond appropriately to trauma (Haythornthwaite and Hirovnen 2015). Trauma-informed practice directly deal with trauma and its effects and is underpinned by the following principles:

- understanding trauma and its impact on individuals, families and communal groups,
- ensuring a safe environment for healing: individuals and families (especially children) who have experienced trauma require spaces in which they feel physically and emotionally safe,
- ensuring cultural competence in service delivery,
- supporting client’s control and choice to actively participate in decisions that affect them,
- sharing power and governance across all aspects of the organisation including opportunities for client participation in design and evaluation of programs and practices,
- Integrating care: bringing together all the services and supports needed to assist individuals, families and communities to enhance their physical, emotional, social, spiritual and cultural wellbeing,
- supporting relationship building: positive relationships assist in recovery, including peer to peer models, and
- enabling recovery: by empowering individuals, families and communities to take control of their own healing and recovery through the adoption of a strengths-based approach, which focuses on individuals own strengths and capacities (Atkinson 2015).

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

Social and Emotional Wellbeing (SEWB) is the foundation for physical and mental health for Aboriginal and Torres Strait Islander peoples. A holistic concept, SEWB results from a network of relationships

between individuals, family, kin and community. It also recognises the importance of connection to land, culture, spirituality and ancestry, and how these affect the individual (Gee et al. 2014). Similarly, Dudgeon et al. (2016) suggest that:

'For Indigenous peoples, health itself is not understood as the concept often assumed by non-Indigenous people, rather it is a culturally informed concept, conceived of as 'social and emotional wellbeing' – a term that is increasingly used in health policy but in this context carries a culturally distinct meaning: it connects the health of an Indigenous individual to the health of their family, kin, community, and their connection to country, culture, spirituality and ancestry. It is a deep-rooted, more collective and holistic concept of health than that used in Western medicine' (Dudgeon et al. 2016).

The first National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009 (Social Health Reference Group 2004) detailed nine guiding principles that emphasise the holistic and whole-of-life view of health held by Aboriginal and Torres Strait Islander People. In the 2017-23 edition of the framework these guiding principles have been retained. Reproduced below, these principles succinctly describe the relationship between social and emotional wellbeing and both mental and physical health for Aboriginal and Torres Strait islander peoples:

1. Aboriginal and Torres Strait Islander health is viewed in a holistic context, that encompasses mental health and physical, cultural and spiritual health. Land 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.
3. Culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal and Torres Strait Islander people's 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 continue(s)¹ to have inter-generational effects.
5. The human rights of Aboriginal and Torres Strait Islander people must be recognised and respected. Failure to respect these human rights constitutes continuous disruption to mental 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.
8. 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 people may currently live in urban, rural or remote settings, in traditional or other lifestyles, and frequently move between these ways of living.
9. It must be recognised that Aboriginal and Torres Strait Islander people have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment (Commonwealth of Australia 2017).

Each of these principles need to be considered in the development, delivery and evaluation of programs for Aboriginal and Torres Strait Islander peoples. The *Elder's Report into Preventing*

¹ The 2009 edition used 'continue' while the 2017-23 edition uses 'continues'

Indigenous Self-harm and Youth Suicide strongly emphasised the need for self-determination and cultural connectedness and continuity for suicide prevention in Aboriginal and Torres Strait Islander communities (Culture is Life 2014). Similarly, the Healing Foundation brought together Aboriginal and Torres Strait Islander young people from diverse nations and language groups to discuss cultural identity, safety and wellbeing and how to address the impact of intergenerational trauma on their lives. The report developed by the forum suggested guiding principles for Aboriginal and Torres Strait Islander youth healing as follows:

1. Include young people in co-design of policy and programs
2. Establish local level ownership
3. Develop better ways of measuring success that look beyond short-term funding cycles
4. Build strong community governance that ensures appropriate oversight, administration and management (Healing Foundation 2017).

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

In summary, several key drivers contributing to Aboriginal and Torres Strait Islander communities experiencing poorer health outcomes include:

- **A discriminatory mental health system:** We have a system that discriminates against Aboriginal and Torres Strait Islander people. Institutionalised racism continues to exist and there is still a lack of cultural appropriateness when working with communities.
- **Mental health literacy:** There are some community members who do not know how to access the services they require. There have been anecdotes of community members expressing that they do not know how or where to get help.
- **Risk and protective factors:** Risk and protective factors are those aspects, including the environment or past personal experiences that make it more likely (*risk factors*) or less likely (*protective factors*) that people will experience a particular outcome.
- **Social and economic disadvantage:** Social and economic advantage impacts on individual's ability to access the services that they may need.
- **An under-resourced mental health sector:** There is a need for acknowledgement that the mental health sector is under-resourced and that investment into a stronger and skilled workforce needs to take priority in order to service the community. Delayed response times and processes can deter individuals from reaching out or following through their treatment.
- **A need to localise services:** Services need to be relevant to the community that they are targeting.
- **Lack of outreach:** As an outreach service we have heard that there is a lack of outreach for families and that it is very much needed and valued.
- **Lack of coordination between service providers:** An improvement of coordination between service providers is required to ensure that there is no duplication of services and to ensure that individuals do not need to re-tell their stories needlessly.

A few of these will be elaborated on below:

Discrimination and institutionalised racism

In Australia we have a health system that discriminates Aboriginal and Torres Strait Islander people. Institutionalised racism is a reality and cannot be ignored when discussing the improvement of health outcomes. In the 2014 *Elders' Report into Preventing Indigenous Self-Harm and Youth Suicide*, Professor Pat Dudgeon, a Bardi woman from WA describes the key drivers behind the high rates of self-harm and suicidal behaviour among Aboriginal and Torres Strait Islander children and young people; ***'the brutal history of colonisation, the inter-generational trauma left by Stolen Generations policy, and ongoing racism, combined with the everyday realities in many Aboriginal communities, such as unemployment, poverty, overcrowding, social marginalisation, and higher access to alcohol and drugs'***. Although this refers to children and young people, this 'ongoing racism' affects all Aboriginal and Torres Strait Islander people and this racism permeates into our healthcare system.

Mental health literacy

The community is continually sharing that there is a lack of outreach for those experiencing mental health issues. There needs to be an acknowledgement that the sector is heavily under-resourced and that existing resources need to be trained in Aboriginal specific cultural competence programs. For those that try to seek help response times and processes can be slow and inappropriate, deterring people from further seeking the help they need. Moreover, there are pockets of the community that do not know where to go or who to approach when they or a family member are suffering from a mental health issue or are experiencing suicidal thoughts. This brings to light the issue of mental health literacy – we have experienced that many Aboriginal and Torres Strait Islander community members do not possess strong mental health literacy.

Risk and protective factors

Put simply, risk and protective factors are those aspects— including the environment or past personal experiences that make it more likely (*risk factors*) or less likely (*protective factors*) that people will experience a particular outcome. In terms of suicide, they are the things in a person's life that increase (risk factor) or decrease the likelihood (protective factor) of them acting on suicidal thoughts. In relation to children and young people, it is important to understand how they establish a sense of identity, how they view the world and develop coping strategies and life skills, and how they adapt across the life span. All of these issues can be affected by a number of risk and protective factors that are well known and include genetic predisposition, family history, life stress events and experiences, as well as personal attributes such as gender, perceived intelligence, appearance and temperament (Milroy 2014).

Risks factors for suicide experienced by Aboriginal and Torres Strait Islander people are complex, highly variable by community and distinct from non-Indigenous Australians' notions of suicide (ATSIPEP 2017). Further, many of the mainstream social risk factors for suicide cannot be broadly applied to Indigenous populations (ATSIPEP 2017 citing Hunter & Harvey, 2002). According to Walker et al. (2014):

'It is now recognised that there are suicidal risk factors that are uniquely Aboriginal; these include the transgenerational grief and loss resulting from colonisation, disruption to cultural identity, forced removal, substance misuse, social isolation and racism' (cited in Dudgeon et al. 2014).

The current national policy framework for suicide prevention has an emphasis on 'whole-of-

population' and strengths-based approaches to prevent individuals from becoming at risk in the first place (Silburn et al. 2014). This is consistent with a focus on protective factors that build resilience. Dudgeon et al. suggest that:

'Identifying the protective factors that enhance the SEWB of Aboriginal communities, as well as those factors that contribute to community distress and suicide, is paramount. It requires an in-depth knowledge of the historic, social, cultural and economic risk factors at play in each community, which are best known and understood by community residents' themselves' (Dudgeon et al. 2014).

According to Zubrick et al. (2014), there exist a '*... unique set of protective factors contained within Indigenous cultures and communities that serve as sources of strength and resilience*' (Zubrick et al. 2014). For Aboriginal and Torres Strait Islander people, protective factors include physical and mental wellbeing; connection to community; and connection to land, culture, spirituality and ancestry. (Commonwealth of Australia 2017; Culture is Life 2014; Kelly et al. 2014). The importance of connection to culture was succinctly highlighted by one Elder in the Elders report: '*if they lose language and connection to culture they become a nobody inside and that's enough to put them over the edge*' (Culture is Life 2014).

The ATSIPEP report, *Solutions that work: what the evidence and our people tell us*, identified a range of success factors for reducing suicide in Aboriginal and Torres Strait Islander communities. Factors. That report recommended that Indigenous suicide prevention activity should reflect, among other considerations, the following:

- Community specific and community led upstream programs focused on healing and strengthening social and emotional wellbeing,
- Justice reinvestment towards upstream programs that divert Indigenous young people away from the criminal justice system,
- Training, hiring and retention of Aboriginal and Torres Strait Islander people as mental health workers, peer workers in suicide prevention,
- Initiatives that ensure that non- Indigenous workers in SEWB and suicide prevention are culturally competent,
- Ensuring representation of Indigenous people identifying as LGBTQI on all Australian Government and other Indigenous mental health and suicide prevention advisory forums (ATSIPEP 2017).

6. What are the needs of family members and carers and what can be done better to support them?

Since 2017, the National Indigenous Critical Response Service (NICRS) has been supporting families following a suicide or other traumatic event. Drawing on the experience of our service and from feedback provided to us by families, we know that direct outreach following an incident is critical. Additionally, having a key contact person, which, in the case of our service is one of our Aboriginal advocates/support workers, that is continually supporting the family, has been a game changer for our families. Advocates are assigned to cases and stay on those cases until families feel supported enough to be independent. Further, the duties which our workers fulfil to support families has assisted them in moving forward. These duties include and are not limited to: advocating on the family's behalf to Department of Housing for relocation due to a suicide occurring at their place of residence; securing income support from Centrelink if any family members are not employed; and working with schools to ensure that children and young people feel safe and supported in the classroom. In addition to this advocacy type work, our advocates are also most importantly being with

families without time limits and talking/yarning with them, sharing their grief and supporting them through their difficult time.

One recent and ongoing example of our work occurred last month in Victoria when a young Aboriginal woman aged 27 years completed suicide. Our support workers established contact with the family at their request and made their first home visit last week. Family members that require support include the woman's mother, her two children [REDACTED], and the deceased's siblings who lost their sister.

In another example, one of our workers shared how they supported a family after the suicide of one of their family members:

'I think of one particular case which was actually my first family when I started working as a advocate/support worker. When I first met this client, she refused to engage with any other services and it was really difficult for her to open up and articulate how she was feeling, and it was coming out in very negative ways. So, through my engagement with her which started off on a weekly basis, and it wasn't a formal setting, it could have been done in a park, just getting to know one another, she started to open up a bit more, and I started to talk to her about the services she could receive. I said to her that she had the power to choose which ones she would want to engage with and that it was perfectly okay if she didn't to, and over a matter of three or four months, she really started to open up and wanted to engage with services because she realised that it's not as scary when you've got someone by your side supporting you along the way. It was that consistent approach that helped as well – she knew that if we had a meeting at nine o'clock on Friday, I was going to be there. Letting them know that it's an informed decision, that if they are going to engage with the service, what do they provide, that they are able to ask questions, and that if they don't have the confidence to ask questions I'm there to advocate on their behalf.'

These examples where families have a key contact point who support their social and emotional wellbeing, and who advocate on their behalf to relevant services highlights the need for and the impact this can have on their wellbeing.

Lastly, as mentioned in the previous question, there are pockets of the community that do not know where to go or who to approach when they or a family member are suffering from a mental health issue or are experiencing suicidal thoughts. This brings to light the issue of mental health literacy – we have experienced that many Aboriginal and Torres Strait Islander community members do not possess strong mental health literacy. This highlights the need for ongoing support for families to assist them in the process of help-seeking and accessing treatment.

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

A response to this question has two parts for us as an Aboriginal and Torres Strait Islander organisation. The first part relates to the Aboriginal and Torres Strait islander workforce. It is important that Aboriginal and Torres Strait Islander workers are not so few and far between that they

feel isolated and unsupported. The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* provides guidance as to needs-based population workforce ratios for psychologists, psychiatrists and ACCHS-based SEWB teams for a community of 1500 people (Commonwealth of Australia 2017). We also understand there has been evidence given to this current inquiry (from Helen Kennedy from Victorian Aboriginal Community Controlled Health Organisation) that there are only eight Aboriginal and Torres Strait Islander mental health workers across the whole state of Victoria. We would therefore contend that along with recruitment policies and practices that give appropriately qualified and experienced Aboriginal people opportunities to be obtain roles within the sector, there needs to be a training and employment strategy that achieves the following objectives:

1. encouragement of Aboriginal people to apply for roles within the mental health workforce
2. realistic pathways to ensure that Aboriginal people are able to obtain the qualifications required for the role/s; and
3. a focus on employment satisfaction and retention of Aboriginal workers once they are employed.

Cultural safety and diversity training is needed across the system. Some people receive the training and understand and act on it, while others either don't receive the training or don't 'sign on' when they do. As stated in response to Question (1) earlier, institutional racism still occurs. We need a system that ensures that from the CEO to the cleaner and everyone in between, they both understand and practice tolerance and inclusivity. Removing institutional racism would assist in supporting and retaining Aboriginal and Torres Strait Islander workers, as well as other workers from diverse backgrounds. It is important that there is understanding of family commitments, an understanding of racism that Aboriginal people have experienced, in order to produce a culture where there is trust, communication and respect for the Aboriginal workforce.

In focusing on the broader mental health workforce, we would suggest that the system be redesigned as required, to support mental health workers ensure the policies and practices including eligibility for services are based on client need. Currently it appears that service users need to fit the system, rather than the system fitting the needs of the service user. There is nothing more frustrating and 'a downer' for workers to have to refuse people a service based on inflexible systems. Current gaps in the system can be heartbreaking for workers who cannot find a service that fits the circumstances of the client.

Further, and as mentioned earlier in response to Question (1), it would be good to see state government sponsored, state-wide professional development for mental health workers. Such training would provide opportunities for peer learning, sharing of best practice and peer support. Even occasional forums would be useful in building peer networks of workers in the sector.

8. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

Inclusiveness is key here too. While much has been done to de-stigmatise mental illness, there will be people, including employers, who continue to focus on the illness rather than the person. If an employer is to focus on the illness, the candidate will likely not get a chance to demonstrate the positive aspects that they can bring to the role. While anti-discrimination legislation is in place, is

there a role for government to assist, particularly those smaller providers, to ensure appropriate policies and practices are in place that will ensure their compliance with anti-discrimination legislation?

Perhaps there are opportunities for incentives to employ workers with mental health issues, like past programs for the long term unemployed? Of course, proprietors would need to be vetted to ensure they are responsible employers.

One approach already suggested to this Inquiry is the creation of trauma-informed community "healing centres" aimed at helping individuals build stronger connections to culture, community, family, spirituality, their mind and emotions. Such centres would support protective factors and contribute to social and emotional wellbeing. We would support such an approach.

Community outreach for indigenous and non-indigenous Australians with mental health issues would go some way to improving social and economic participation. This would be particularly so amongst those who were either not aware of programs and projects which they could connect with in their communities, or could not easily negotiate the service system/s.

9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

As well-meaning as current service providers, funders and practitioners are, services are still failing Aboriginal and Torres Strait Islander people. To be effective, programs must be designed with communities, led by communities and focussed on culture. One elder put it simply: *'...to bring our kids back from a suicidal way of thinking, we need to be self-managing our healing and strengthening our culture for those kids'* (Culture is Life, 2014).

Recommendation 1

Mental health services to Aboriginal and Torres Strait Islander peoples must be provided within a framework that recognises that many Aboriginal and Torres Strait Islander people have suffered trauma through their lives.

Recommendation 2

Delivery of Mental Health services to Aboriginal and Torres Strait Islander peoples must be delivered consistent with the nine guiding principles that emphasise the holistic and whole-of-life view of health held by Aboriginal and Torres Strait Islander People, as detailed in the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well 2017-23.

Recommendation 3

Community based programs must be developed in consultation with Elders to ensure cultural appropriateness.

Recommendation 4

Suicide prevention and postvention programs must look beyond the short term, be flexible and designed and delivered as a result of consultation, engagement and partnership with the community and the Aboriginal Community Controlled Health Service sector.

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

We recommend and suggest that the opportunity provided by the Royal Commission to listen to and take on board considerations about what needs to be done to reflect, change, introduce and implement various programs, initiatives and services needs to be taken seriously. As a sector we have a real opportunity to lead and change the way mental health is viewed and responded.

11. Is there anything else you would like to share with the Royal Commission?

References

Aboriginal and Torres Strait Islander Healing Foundation (2017) ***Our Healing Our Way: Leading and Shaping our Future***. National Youth Healing Forum Report. Canberra ACT. Authors.

Available at:

https://healingfoundation.org.au//app/uploads/2017/12/HF_National_Youth_Healing_Forum_Report_Nov2017_V7_WEB.pdf

Atkinson, C. (2008) ***The Violence Continuum: Australian Aboriginal Male Violence and Generational Post-Traumatic Stress*** [Unpublished PhD thesis]: Darwin: Charles Darwin University. Available at: https://espace.cdu.edu.au/eserv/cdu:44891/Thesis_CDU_44891_Atkinson_C.pdf

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. Available at: <https://www.aihw.gov.au/getmedia/e322914f-ac63-44f1-8c2f-4d84938fcd41/ctg-rs21.pdf.aspx?inline=true>

Atkinson, J., Nelson, J., Brooks, C., Atkinson, & Ryan, K. (2014) Addressing individual and community transgenerational trauma. Chapter 17 in Dudgeon, P., Milroy, M., & Walker, R. (eds.), ***Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice – Revised Edition***, pp 289-305. Canberra: Commonwealth of Australia.

ATSIPEP (2017a) ***Suicide Prevention in Aboriginal and Torres Strait Islander Communities: Learnings from a meta-evaluation of community-led Aboriginal and Torres Strait Islander suicide prevention program***. Perth: University of Western Australia.

ATSIPEP (2017b) ***Suicide prevention in Indigenous communities***. Literature review. Perth: University of Western Australia.

Australian Health Ministers' Advisory Council (2017) ***Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report***, Canberra, AHMAC.

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

Bath, H (2008) The Three Pillars of trauma-informed care. ***Reclaiming Children and Youth***, vol. 17, no. 3, pp. 1721. Available at: <https://s3-us-west-2.amazonaws.com/cxl/backup/prod/cxl/gklugiewicz/media/507188fa-30b7-8fd4-aa5f-ca6bb629a442.pdf>.

Commonwealth of Australia (2017) ***National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023***. Canberra: Department of the Prime Minister and Cabinet.

Coroner of Western Australia (2019) ***Inquest into the deaths of: Thirteen Children and Young Persons in the Kimberley region of Western Australia***. Government of Western Australia: Perth. Available at: https://www.coronerscourt.wa.gov.au/_files/inquest-2019/13-Children-and-Young-Persons-in-the-Kimberley-Region-Finding.pdf

Culture is Life (2014) ***Elder's Report into Preventing Indigenous Self-harm and Youth Suicide***. Melbourne: authors. Available at: <https://apo.org.au/sites/default/files/resource-files/2014/04/apo-nid40060-1209076.pdf>

Department of Health and Human Services. (2015) ***Mental Health and Aboriginal people and Communities, 10 Year Mental Health Plan Technical Paper***, Victorian Government: Melbourne. Available at:

https://www.mhvic.org.au/images/documents/10_year_plan_for_mental_health/Mental_health_and_Aboriginal_people_and_communities_technical_paper_mental_health_plan.doc

- Department of Health and Human Services. (2017) **Balit Murup: Aboriginal Social and Emotional Wellbeing Framework 2017-2027**, Victorian Government: Melbourne. Available at: <https://dhhs.vic.gov.au/publications/balitmurrupaboriginal-social-and-emotional-wellbeing-framework>
- Dudgeon, P., Ugle, K. (2014) Communicating and Engaging with Diverse Communities. Chapter 15 in Dudgeon, P., Milroy, M., and Walker, R. (eds.), **Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice – Revised Edition pp 257-267**. Canberra: Commonwealth of Australia.
- Dudgeon, P., Darwin, L., McPhee, R., Holland, C., Von Helle, S. & Halliday, L. (2018) **Implementing Integrated Suicide Prevention in Aboriginal and Torres Strait Islander Communities: A Guide for Primary Health Networks**. Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, Poche Centre for Indigenous Health and Wellbeing, University of Western Australia & Black Dog Institute. Sydney: Black Dog Institute.
- Dudgeon, P., Walker, R., Scrine, J., Carrington, S., Calma, T., and Ring, I. (2014a) **Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people** Issues paper no. 12. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies.
- Dudgeon, P., Milroy, J., Calma, T., Luxford, Y., Ring, I., Walker, R., Cox, A., Georgatos, G., & Holland, C. (2016). **Solutions That Work – What the Evidence and Our People Tell Us**. The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report. Perth: University of Western Australia.
- Dudgeon, P., Wright, M., Paradies, Y., Garvey, D., & Walker, I. (2014). Aboriginal social, cultural and historical contexts. Chapter 1 in Dudgeon, P., Milroy, M., and Walker, R. (eds.), **Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice – Revised Edition**, pp 3-24. Canberra: Commonwealth of Australia.
- Dudgeon, P., Walker, R., Scrine, C., Cox, K., D’Anna, D., Dunkley, C., Kelly, K., Hams, K. (2014b). Enhancing Wellbeing, Empowerment, Healing and Leadership. Chapter 25 in Dudgeon, P., Milroy, M., and Walker, R. (eds.), **Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice – Revised Edition**, pp 437-447. Canberra: Commonwealth of Australia.
- Ernst, N., Kühne, R., Wirth, W. (2017). Effects of Message Repetition and Negativity on Credibility Judgments and Political Attitudes. *International Journal of Communication*. **11**. 3265-3285.
- Floyd, B.(n.d) **The Importance of Repetition and Consistency for Political Campaigns**. The Campaign School. Available at: <http://thecampaignschool.com/>
- Gee, G., Dudgeon, P., Schultz, C., Hart, A., and Kelly, K. (2014). Social and Emotional Wellbeing and Mental Health: An Aboriginal Perspective. Chapter 4, in Dudgeon P, Milroy M, and Walker R(eds.), **Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice – Revised Edition**, pp 55-67. Canberra: Commonwealth of Australia.
- Gehrmann, M., Dixon, S., Visser, V., & Griffin, M. (2018). **StandBy National Client Outcomes Project – Final Report**, The Science of Knowing, Buddina, QLD, Australia.
- Hazell, T., Dalton, H., Caton, T., & Perkins, D. (2017). **Rural Suicide and its Prevention: a CRRMH position paper**. Centre for Rural and Remote Mental Health, University of Newcastle, Australia.
- Haythornthwaite, S., & Hirvonen, T. (2015). **The relevance of trauma informed care to Aboriginal primary health care services**. Presentation to the 13th National Rural Health Conference, Darwin. Available at: http://www.ruralhealth.org.au/13nrhc/images/paper_Haythornthwaite%2C%20Sara_Hirvonen%2C%20Tanja.pdf
- Healthcare Management Advisers (2018) **Suicide Data Analysis: unpublished data from Coronial Information Records**, State and Territories of Australia.
- Kelaher, M.A., Ferdinand, A.S., & Paradies, Y. (2014) Experiencing racism in health care: the mental health impacts for Victorian Aboriginal communities. *Medical Journal of Australia*; 201 (1): 44-47.

Kelly, K., Dudgeon, P., Gee, G. & Glaskin, B. (2009). ***Living on the Edge: Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People***. Discussion Paper No. 10, Darwin. Cooperative Research Centre for Aboriginal Health.

Marx, W. (2015). ***The Importance of Repetition in Marketing***. Available at: <https://www.linkedin.com/pulse/importance-repetition-marketing-wendy-marx>

Milroy, H. (2014). Understanding the Lives of Aboriginal Children and Families. Chapter 21 in Dudgeon, P., Milroy, M., & Walker, R. (eds.), ***Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice – Revised Edition***, pp 373-381. Canberra: Commonwealth of Australia.

Parker, R., & Milroy H. (2014). Aboriginal and Torres Strait Islander Mental Health: An Overview. Chapter 2 in Dudgeon, P., Milroy, H., & Walker, R. (Eds) ***Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice***. Office of Aboriginal and Torres Strait Islander Health, Department of Ageing: Canberra.

Pilcher, J (2019). ***Say It Again: Messages Are More Effective When Repeated***. Available at: <https://thefinancialbrand.com/42323/advertising-marketing-messages-effective-frequency/>

Reibel, T., & Walker, R. (2010). Antenatal Services for Aboriginal Women: the relevance of cultural competence. ***Quality in Primary Care***. 2010; 18(1):65-74.

Select Committee into Youth Suicide (2012). ***Gone Too Soon: a report into youth suicide in the Northern Territory***. Committee Report. Darwin. Legislative Assembly of the Northern Territory

SHRG (Social Health Reference Group) (2004). ***National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009***. Canberra: National Aboriginal and Torres Strait Islander Health Council and National Mental Health.

Silburn, S., Robinson, G., Leckning, B., Henry, D., D., Cox, A., & Kickett, D. (2014). Preventing Suicide Among Aboriginal Australians. Chapter 9 in Dudgeon P, Milroy M, and Walker R(eds.), ***Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice – Revised Edition***, pp 147-164. Canberra: Commonwealth of Australia.

Tatz, C. (2001) ***Aboriginal Suicide is Different: A Portrait of Life and Self-destruction***. Canberra: Aboriginal Studies Press.

Thirrili Ltd (2018). ***Defining and addressing Aboriginal and Torres Strait Islander trauma, grief and postvention. Literature review***. Melbourne. Thirrili Ltd.

Trauma Centre of Australia (2019). ***What is Trauma*** Webpage. Available at: www.traumacentre.com.au/what-is-trauma/

van der Kolk, B. (2005) *Developmental Trauma Disorder: Towards a rational diagnosis for children with complex trauma histories*. ***Psychiatric Annals***, 33(5), pp401-408.

Wexler, L., White, J. & Trainor, B., (2015) Why an alternative to suicide prevention gatekeeper training is needed for rural Indigenous communities: presenting an empowering community storytelling approach. ***Critical Public Health***, 25(2), pp. 205–217.

World Health Organisation (2014). ***Preventing suicide: A global imperative***. World Health Organisation. Geneva.

Zubrick, S., Carrington, C., Shepherd, C., Dudgeon., Gee, G., Paradies, Y., Scrine, C., & Walker, R. Social Determinants of Social and Emotional Wellbeing. Chapter 6 in Dudgeon, P., Milroy M, & Walker, R (eds.), ***Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice – Revised Edition***, pp 93-112. Canberra: Commonwealth of Australia.