ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Aborigines Advancement League
2 Watt Street, Thornbury
Victoria

On Tuesday, 16 July 2019 at 10.00am

(Day 11)

Before: Ms Penny Armytage (Chair)
Professor Allan Fels AO
Dr Alex Cockram
Professor Bernadette McSherry

Counsel Assisting:
Ms Lisa Nichols QC
Ms Georgina Coghlan
Ms Fiona Batten

CHAIR: Before we begin, I invite Aunty Di to offer a welcome to country.

AUNTY DI: Thank you very much. I honour my ancestors and my Elders and I pay homage to this sacred ground that we're on. I wish to acknowledge Commissioners, Penny Armitage, Allan Fels, Alex Cockram and Bernadette McSherry.

I wish to acknowledge my Elders of the year, in particular Nellie Flagg and Aunty Lynette Austin. I acknowledge all Aboriginal and Torres Strait Islander peoples here. I acknowledge all of you and I pay my respects to your ancestors and Elders.

I'm quite honoured to be here today in this building. This is our mother organisation and it's an honour to be able to welcome you to this building, but also to my country. The area is part of the traditional country of my grandmother, mother and family and I'm always very proud to welcome people to my country on behalf of them.

I'm the eldest in my family line, I don't have any generations above me, so it's my duty to be able to welcome you here, and particularly with mental health, which is my passion, and I always wonder why we suffer from mental health and it is getting to a crisis level with our community. We have young ones in primary school age suffering from mental health at the moment.

Particularly we have a lot of young ones that are committing suicide and it's really hard and it's hard as an Elder because sometimes you feel that you're failing and, it's not that we are, but we don't know what to do.

A few years back - I just want to tell a short story, if that's okay. A few years back we had some of our girls that were suffering with their mental health, and we call it emotional health and wellbeing because we don't like the word "mental health". We didn't know what to do, so we sat around and spoke about it, and we wanted to know what was missing in our lives. What was missing is our passage of life because that was taken from us when our ancestors, my grandmother, were on the missions. That was stopped, our ceremonies.

So we decided to do ceremonies again for our girls and we did coming of age ceremony, which is when they become a

woman. Because we had girls that were having anxiety, depression, cutting themselves, were in the system but weren't getting any better.

So, we had ceremony and they had to make their possum skin belt which was across here (indicates), their necklaces which are made from reeds from the creek, and the story of those reeds is from a long time ago when the men went out to hunt, the women put them around their necks when they came home because they loved them. So, that was in honour of our men. And, they engraved the possum skin and they got their name, their traditional name.

Then they went through ceremony and that's about honouring and obeying the laws of the land, about being respectful, about being respectful to their parents, respectful to each other, and respectful on country.

If they didn't do that their belts were taken off them and they weren't allowed to participate in family gatherings or dancing. That was the first time that ceremony had happened in approximately 180 years.

Since then the girls have excelled. I'm not saying that we fixed it all, but they have become very important leaders, up and coming leaders, in our society.

They now look after each other. They watch on Facebook if anybody's in trouble and they offer assistance. They now have formed their own dance group, they want it all the time. They dance with pride and they have formed connection to country and other people want to dance with them. Other people of other tribes want to participate in ceremony with us.

And I'm very proud of them and they've taken their roles and responsibilities themselves: we haven't given them the roles, they have picked their roles.

Since then we've done baby naming ceremonies because that stopped on the missions as well. Because, when you were born, you were given your name which was about caring for country. So, we started doing that about three years ago. But those girls come to that ceremony and get all the babies ready. We sit back now and they take that role and responsibility.

After the ceremony with the babies, they do a welcome country for the babies. So, I'm very proud of them. So, what I'm saying is, when you think about what you need to do with mental health with Aboriginal people, please think about ceremony because that is what is missing in our lives. It's very important that we do ceremony, it's important that we connect to country, it's important that we feel safe on country and, a lot of people aren't living on their country, but they need to feel safe on the country on where they live and that's what part of our welcome is, about feeling safe on country.

So, thank you for letting me tell the tale, thank you for allowing me to welcome you to country. And may bunjil, our creators around you, keep you safe on country. (Indigenous words spoken) Welcome to the traditional country of the Wurundjeri people (Indigenous words spoken). Thank you very much. Thank you.

CHAIR: Thank you very much, Aunty Di, and for those reflections.

On behalf of the Commission I acknowledge the traditional owners of the land on which we meet, the Wurundjeri people of the Kulin Nation. I also pay respects to their Elders past, present and emerging and extend that to Elders joining us here today.

I am Penny Armitage, the Chair of the Royal Commission into Victoria's Mental Health System. I am joined by my fellow Commissioners, Professor Allan Fels, Professor Bernadette McSherry and Dr Alex Cockram.

We feel privileged to be able to hold our 11th day of public hearings at the Aborigines Advancement League in Thornbury, a place with such meaning and significance. It was incredibly moving for the Commissioners and I to see the portraits of the Elders and the Board Members of the Aborigines Advancement League looking over us as we prepared for today. It is a really powerful reminder of the importance of what we're doing here today and the benefits we hope to realise both now and for future generations

As I said in my opening address on day one of these hearings, my fellow Commissioners and I are committed to continued and thoughtful engagement with Aboriginal

Victorians, to learn from their wisdom, build on existing knowledge and best practice and embrace self-determination.

Aboriginal culture is founded on a strong social, cultural and spiritual order that has been sustained for more than 60,000 years and remains alive today. Its modern history is one of resistance, reclamation of rights, as well as community and personal resilience.

The heritage of Aboriginal communities throughout Victoria is vibrant, rich and diverse. We value these characteristics and consider them a great source of strength and opportunity.

We recognise that the leadership of Aboriginal communities and Elders in Victoria is crucial to improving outcomes for Aboriginal people. Also to be acknowledged are the devastating impacts and accumulation of trauma resulting from colonisation, genocide, the dispossession of land and children, discrimination and racism.

It is not lost on us that this Royal Commission is occurring alongside renewed efforts to achieve Constitutional recognition of Aboriginal communities and Aboriginal Australians. We commit to build on this momentum and to ensure our work is shaped by the voice of Aboriginal people.

The work of this Royal Commission will be underpinned by self-determination in recognition that Aboriginal-led responses and leadership are central to better and more enduring outcomes for Aboriginal people.

This was reiterated by a young Aboriginal man, Daniel. He told us on our first day of our hearings how access to a Koori Youth Health Service was a turning point in his recovery and gave him, as he described, the building blocks for the success he has had later in his life.

As we will explore further today, there is much to be learned from Aboriginal responses and perceptions of health encompassing, as they do, mental and physical health alongside, with broader concepts of social and emotional wellbeing in connection to land, community and traditions.

I note too how Pat Anderson, Chairperson of Lowitja Institute, describes these concepts. She says:

"Those of us who have worked on the front line of Aboriginal health for any length of time know that beneath the surface the reality of Aboriginal people's poor health outcomes sits a deeper truth. It is about the importance of social and emotional wellbeing and how this flows from a sense of control over one's life."

She says:

"Where this is lacking, as it is in so many Aboriginal families and communities, there is instead indifference and despair and a descent into poor lifestyle choices and self-destructive behaviours."

She says:

"Our medical professionals do a great job of prescribing medicines and devising treatment programs, but to fix the root causes of ill-health we need something more. As Aboriginal people we need to have a sense of urgency in our lives, that we are not stray leaves blowing about in the wind. In a word, we need empowerment."

Empowerment through community ownership and participation with Aboriginal Victorians is central to addressing disconnection from culture and social and emotional wellbeing.

Many Aboriginal people living in Victoria enjoy very good social and emotional wellbeing, they are part of thriving communities and have strong connections to culture and country.

But for far too many others the impact of intergenerational trauma, as well as social and economic disadvantage at the individual, family and community level, continues to profoundly affect wellbeing.

More than one-third of Aboriginal Victorians experience depression and anxiety. This compares with just under 20 per cent of the non-Aboriginal Victorians.

Compared with non-Aboriginal Victorians, Aboriginal and Torres Strait Islander adults in Australia are almost three times more likely to experience high or very high levels of psychological distress; are almost twice as likely to be hospitalised for mental health and behavioural challenges, and are losing their life to suicide at twice the rate.

And we're not seeing improvements. The number of Aboriginal mental health-related presentations to hospital emergency departments in Victoria increased by more than 50 per cent in the three years between 2012-13 and 2015-16.

More, so much more, must be done to eliminate this disparity. Our consultations so far have led to the emergence of some compelling themes.

For example, we have been told about the direct impact of the loss of land, culture, identity and self-worth on the social and emotional wellbeing of Aboriginal Victorians. How the high rates of family violence, poor mental health, suicide, incarceration and homelessness are linked to experiences of historical trauma and how these instances can give rise to new instances of trauma leading to cycles of multiple and compounding trauma.

Misunderstandings about culture and cultural safety on the part of some services means Aboriginal people must explain themselves and educate others about their lived experience.

A lack of recognition of and respect for the positive aspects of Aboriginal culture and culture's centrality in creating a sense of meaning and purpose for Aboriginal people. The importance of well supported, thriving Aboriginal mental health workforce and building culturally safe services and a holistic model of care.

Together, we have a challenge ahead, but it is a challenge we commit to taking up alongside Aboriginal Victorians. We must seize the opportunity afforded us through this Royal Commission. We have a once in a lifetime chance to work together with Aboriginal Victorians to realise our shared hope for meaningful and lasting change.

By no means will this be easy, but we are very fortunate to have the community's support and

participation.

We are grateful to all who have contributed so generously to the Commission's thinking so far. This includes the many people and organisations who have participated in our community consultation sessions or contributed through our written submission process. In particular, I extend my sincere thanks to those who are appearing today as witnesses. We are so pleased that you are here with us today.

I now ask Senior Counsel Assisting, Ms Lisa Nichols, to say more about the structure and content of today's hearings.

MS NICHOLS: On behalf of Counsel Assisting, I acknowledge the Wurundjeri people of the Kulin Nation, the traditional owners of the land on which we gather today, and pay my respect to their Elders past, present and emerging, and extend that to those present today. Thank you Aunty Di for welcoming us to country.

The strong themes in the evidence we will hear today have been already mentioned by the Chair but I will repeat them. They are, first, that mental health in the context for the indigenous community should embrace social and emotional wellbeing and recognise the importance of connection to land, culture, spirituality, ancestry, family and community and how these things affect the individual.

Further, that social and emotional wellbeing problems can result from unresolved grief and loss, trauma and abuse, domestic violence, removal from family, family breakdown, cultural dislocation, racism and discrimination and social disadvantage.

We will also hear that the impacts of past, current and intergenerational trauma, racism, discrimination, marginalisation and cultural displacement have resulted in poor outcomes of social and emotional wellbeing for Aboriginal people.

The leadership of Aboriginal communities and Elders in Victoria, we will hear, is critical for improving outcomes for Aboriginal people, family and communities. We will also hear that the resilience of previous generations has ensured that Victorian Aboriginal communities remain

culturally diverse and rich histories are passed down. Factors such as connection to country, engagement in cultural practices and activities, connection to community and Elders, knowledge of history and community and personal resilience can be protected and can enhance social and emotional wellbeing.

We will also hear that Aboriginal people, of course, must be involved in the design of services and their delivery, and in these respects and all respects have the right to self-determination.

We will hear first from Aunty Nellie Flagg, who is a respected Elder and a Taylor-Charles. Aunty Nellie's traditional countries are Wemba Wemba and Dja Dja Wurrung and Boon Wurrung. Aunty Nellie will tell the Commission about her life and the work that she has done in providing support for members of Aboriginal communities.

Helen Kennedy is a Trawlwoolway and the Chief Operating Officer of the Victorian Aboriginal Community Controlled Health Organisation. She will speak to a number of things, including the meaning of social and emotional health and wellbeing, the importance of early intervention, the disparity in health outcomes between Aboriginal and non-Aboriginal populations, barriers to trauma-informed care, and the importance of providing trauma-informed care, and how it is that culturally safe and appropriate practices can be encouraged; also about the importance of empowerment and self-determination in developing mental health services.

Andrew Jackomos is a Yorta Yorta/Gunditjmara man. He is also the Executive Director for Aboriginal Economic Development and Inclusion in the Department of Jobs, Precincts and Regions. He previously served as the inaugural Commissioner for Aboriginal Children and Young People. Mr Jackomos will share his views about the importance of culture and cultural safety, and how we can work better in ensuring that the big systems are more culturally appropriate and responsive and how the Royal Commission can make lasting generational change.

Adam Burns is a senior mental health clinician at Wadamba Wilam. He will appear via video link to the Northern Territory and will explain the services at Wadamba Wilam, and the barriers people face in accessing

trauma-informed care.

Professor Helen Milroy is a descendant of the Palyku people of the Pilbara region. She is a Director of the Centre for Aboriginal Medical and Dental Health at the University of Western Australia, and a consultant child and adolescent psychiatrist with the specialist Aboriginal Mental Health Service. She will appear via video link to Perth. She is a Commissioner on the National Mental Health Commission and was a Commissioner appointed to the Royal Commission into institutional responses to child sexual abuse and she will share her knowledge on, amongst other things, child mental health and the application of indigenous knowledge.

Tamara Lovett is a Gunnai/Gunditjmara woman. She will share her experiences of trying to access culturally appropriate services in her work in the mental health system.

Dr Graham Gee will appear via video link from Norway. He is a clinical psychologist and researcher with Aboriginal, Chinese and Celtic heritage. He was born and raised in Darwin. His grandfather was born near Belyuen, an Aboriginal community just outside Darwin, and his great-grandmother was originally from the Barkly Tablelands.

As the Chair has noted in other contexts, the Commission will use a number of forums to listen to, understand and gain wisdom from members of the indigenous community. It will not be possible to address all of the issues relevant today, but we hope to make a very good start.

I'd like Ms Batten to call the first witness.

MS BATTEN: Thank you, Chair. I understand a restricted publication order has been made. Would you please read out the terms of the order.

CHAIR: Thank you. Pursuant to the Inquiries Act 2014, the Royal Commission has made an order in relation to the next witness, Aunty Nellie Flagg. That order prohibits the publication of the name or the identity of any child or niece of Aunty Nellie Flagg if she mentions them in her oral evidence to the Royal Commission today.

A copy of this order has been placed next to the door of the hearing room. Thank you.

MS BATTEN: Thank you, Chair. The next witness is Aunty Nellie Flagg. I call Aunty Nellie.

<AUNTY NELLIE AGNES FLAGG, affirmed and examined: [10.25am]

MS BATTEN: Q. Thank you, Aunty Nellie. We might just make sure we've got the microphone in the right place so that we can hear you properly. Thank you. Have you, with the help of the Royal Commission's lawyers, made a witness statement to the Commission?
A. Yes, I have.

Q. I tender that statement. [WIT.0001.0041.0001]

CHAIR: Thank you. Aunty Nellie, would you please tell the Commission your story.
A. The reason why I introduce myself as Nellie Taylor-Flagg Charles is because, as Aboriginal people, we have a connection and, as soon as you mention your mother's and your father's family, people can make that connection. To us, as Aboriginal people, that's so important.

One of the things that has happened in our community, is that, that has been taken away. I'm very emotional today. I'm not nervous, I'm emotional because I'm going to be talking about things that affect us deeply. They may have happened many years ago, but here we are today and we're talking about them and it's heartbreaking because we lived back then, but we've lived it all our lives.

The pain, the suffering, the rejection of who we are and where we come from, and our culture that lives within us. It's really difficult to talk about it in separation, and I honour and respect everyone for making sure that the inclusion of that as a whole. Our life was never different things, and we certainly didn't have a word for "mental health". It was never mentioned for me as a child growing up.

I'd also like to extend my sincere and honour to Aunty Di for giving us a welcome. I know she's not here now but - and I'd also like to acknowledge other Aboriginal people in this room with us today, Elders and people that I know.

Thank you for being here and supporting us and listening to our stories.

I'm a Taylor-Charles and I'm very proud of that. That's the first thing I wanna say. I grew up in Swan Hill. I was born and bred there. Wemba Wemba is my traditional country, it extends over to the Moonahcullah mission over the outside of Deniliquin. I shared some of my growing up over there as well.

One of the things that - growing up in Swan Hill, I had a wonderful life. It was so rich with love and connection and caring and sharing. As a child I loved my life, I'd go and live it back in a heartbeat. Even though we lived in old shacks and down dirt roads, and we didn't have electricity, we didn't have water. We had dirt floors in those huts, but they were good old times, and wonderful memories for me to have and share with my family and my kids.

And it wasn't until I went to school that I realised there was a thing - now, I didn't know what it was called then, and I still didn't know until I grew up and then this word appeared: racism. When I first went to school one of the things that I realised: people didn't like me, not because I was Nellie, but because I was black. And, because of that, they treated me differently. They called us names, they threw stones at us. I nearly got kicked out of school for standing up for my sisters.

And there's a lot of other things that happened to me as a person and it's heartbreaking to think, you know, the things that happened to me, me being a parent today, I'd be heartbroken to know that happened to my children. And the mental anguish you carry with you in regards to being treated like that.

My mum, she was only a little woman, but she was an incredible woman, just like so many Aboriginal mothers. She cared for us, she looked after us in the best way that she could, and that's all we needed.

The stories I have of walking and talking with mum and dad will live with me forever. But when I tell these stories to people - white people mainly - they look at me as if to say, "Oh, what a terrible life you had." My life wasn't terrible, it was a great life. I had riches that

they could not see.

My life was filled with love. I wasn't only loved by my family, I was loved by my community and wherever I went they knew who I was and where my connections was.

Over those years growing up, we seen children that were removed from their families because they used to come and stay with us off and on because their parent would go out and work. They'd come and stay with us at the old huts that we used to live at.

One of the things that they had, they came back to the community after they were removed and all grown, and they came back to our family because they were always a part of our family. It was sad that they had to leave us and not have the love and connection with their families and community each and every day like I did.

We grew up very poor, we had nothing. I mean, if you get a beach ball - and that's what I got for Christmas - I got a beach ball. I thought that was fantastic. I got a beach ball and a book from the Sunday School church. That's what I got. I was happy just to get that.

Growing up poor didn't matter to us, but how we were treated because we were poor did. Because that had an effect on us in thinking us: oh, we can't go and talk to them, they think we're just horrible people because, firstly because we're black, and secondly because we were poor.

I remember the first brand new pair of shoes I got: they came from the tip. They were deadly shoes. They were in the box, still brand new, someone threw them away, and we, us as Aboriginal people, we didn't go to the tip to take things there, we went to the tip to see what we could take home. Back in those days we were frowned upon and thought as, you know, scroungers and dirty, but what's it called now? It's called recycling.

You know, life has certainly changed, but I'd walk that life again in a heartbeat. Because it made me the person I am. It gave me so much understanding of life and love, and I didn't realise that when I went out in the world that I was going to be treated badly. I was abused as a child, and that, back in those days, I couldn't, nor

could my parents, do anything about it. And I learnt to live with that, it's something that lingers within me, and it pops up every now and then.

But also over the many times throughout my employment I've walked many journeys with a lot of people who I've been honoured to share their story about abuse. They have the pains and scars that we cannot see because they hide them because it's too painful to live that life each and every day.

And, how they keep going and what is required of them to keep going, where do they go for help? I've had people who have gone to counselling: I do not like that word "counselling". And, as a person, I do counselling - counselling if you want to call it that, but I do not like it; I call it "a yarn". You know, they come and they want to talk to you about the pain that affects them all their lives and you sit and listen.

I've been honoured to listen to many, many stories from people, and those counsellors that they've gone and seen, mostly non-Aboriginal people, had no understanding of Aboriginal cultural, had no understanding of what really they were feeling, and so, it was difficult for them to talk to them about it.

Like I said, I was affected by racism quite deeply, because I lived in a small town, and it was a very racist town in Victoria. When I finally moved away, because I needed to move away because I could not grow up healthy there; I could not get a job other than picking fruit and vegetables, and I wanted more for myself and more for my family, and so, I moved away. But every fortnight all the kids would go home and, when we went home, we'd all want to catch up with our cousins and that and there was a pub in town that all the black fullas used to drink at - at the back bar, mind you, not the front bar.

It started happening, oh God, years ago that you'd go home and you'd have one black fulla play up during the week or within that two weeks that I hadn't been home, and you'd go and try and catch up with the mob, and you'd go out to the back bar and they'd walk up to you and say, "No, you can't come in"; we'd go, "Why can't we come in?" They turned around and said, "All you black fullas are barred." I said, "Barred, why?" "Because so and so played up."

We were all treated terribly, and all we wanted to do was continue our connection to each other and you're constantly - living in Swan Hill, and I'll name it, whether you take it out or not, I don't care - it was hard. I was very good at sport and one of the things - I was mostly captain on the teams - they would talk to me on the field but they would never talk to me off the field.

And so, you wonder why they would treat you like that. If I class someone as a friend or someone that I met and I thought they were nice, I would talk to them regardless of where it was. Again, I was with my husband and I walked into a hotel again to have lunch one day, and before I even - we hadn't got too far into the restaurant, a man approached me and said, "I'm sorry, you can't come in." I said, "Why can't I come in?" "Because the Aboriginal people are barred." I said, "But I haven't been here to be barred, how could I get barred?"

And so, that made you stop and think, as an adult, if I wanted to go out for dinner, or if I wanted to go and eat somewhere, would they treat me like this? And so, it stopped you from being you because you were worrying about how you were gonna be treated.

I stood in a shop in Swan Hill and not got served. Another day at school, we were learning folk dancing - whoopee, you know, that's the last thing that I'd wanna learn, but we were learning to do the folk dance. You had the boys lined up on one side, the girls lined up on the other side. My brother was down the other end, and when the music started you had to walk in and hold hands with the person opposite you. The music started, we walked in. The boy opposite me wouldn't reach out and touch my hands.

I didn't know what to do, I was a kid. The teachers didn't do anything, so I just stood out alone. The girl who was opposite my brother, she took his hands. When my brother saw that when I stepped away, he came up and he come and was my partner so we could be involved.

That had a severe impact on me because I thought, if I reach my hand out to shake someone's hand, introducing myself to them or saying "hello", will they take my hand? And I think about that now: I choose who I put my hand out to. This disease, racism, has impacted on many Aboriginal

people. It has stopped us from being who we truly are.

One of the things that I grew up knowing and understanding was that, you do not judge people for who they are. My parents taught us to accept people for who they are and what they bring, and accept that and be respectful. And so, when I found people didn't like me; again, not because I was just Nellie, it was because I was black. I learnt very quickly there are things I can do and there are things I can't do and places I don't wanna be.

Q. Thank you, Aunty Nellie. Just before we finish, you've said in your statement, you've talked about your fantasy of Aunty's place. I was wondering if you wouldn't mind telling the Commission a bit more about what you think Aunty's place could look like and how you think that might help people?

A. Aunty's place to me is a place, a place like I grew up in, a place where I knew I was safe and loved and cared for. Now I see a lot of our young people who were involved in DHHS, and a lot of our kids in foster care and out-of-home care, and what I'd like to see is those families reunited. When these families are breaking down, we will remove them, we separate them. How can they be strong if we do that?

What I wanna see or would like to see, places where we could take the whole family and work on them as a family. Not, you know, separate them, put the kids over in a non-Aboriginal foster care where some of these people have no understanding of our culture and do not connect with our communities to keep the children solid and strong.

For us as Aboriginal people, and especially our kids, they need to know who they are, where they belong. They need to understand they are loved by our community, even if their family is falling apart. If we could have a place where we could take them and show them that they are loved, and they matter and they're valued, and, you know, we can work on some of the problems that they're having in their lives, because that's what it is, it's problems. And some problems can be resolved. You just don't know, you know. Sometimes when they're young they don't know where to go and who to ask because they're ashamed and they're afraid.

I imagine what my parents lived - the fear that they lived with each day. And I think back, you know, mum -

used to think about how she reacted when a car used to come down towards the old huts. We knew, if we saw a car coming towards the old huts, that we had to go inside and be near mum and dad, or wherever mum and dad was.

The boys would just take off into the bush. I don't want our kids to grow up with that fear, the fear of not knowing or being scared of being taken away. I want them to be strong, I want them to know who they are. I want them to know who their cousins are and be a part of that.

I didn't play with other kids, especially white kids, until I went to school because, within our family we had 10 children - mum and dad had 12 children but two passed before I was born. Aunty down the road, she had eight, we had 18 kids. Would you want any more kids? There was a big mob of us, we always played together, and we cared about each other, we always watched out for each other and, you know, if we knew someone - they call it mental health issues now - had a problem, it wasn't a problem.

Everyone knew you had to look after them, everyone watched out for them, and that was a wonderful thing, that's how I grew up. I can't take my children back now and show them where the old huts and that were because they no longer exist, and the land is taken up now by orchards and things like that.

You know, there's so many stories that I have growing up and wonderful stories that I tell my boys about my life, and it's one thing telling them and it's another thing showing them, and I can't do that.

When I go home I take them up to - we go and visit the cemetery because that's where all my family, most of them are. Out of those 10 children I grew up with, there's only four of us left. One of the things in life that I wanted to do is reach 60, and I've done that. I'm over 60 now, and that was a milestone, because so many of my family didn't reach 60.

I've lost so many of my family at a young age, it breaks your heart. And, the passing of them didn't happen in isolation. The passing happened sort of in groups. I had a brother we lost at 27; I had a sister we lost at 37; I had two brothers die at 43. I had my sister, elder sister, die at 59. I had a brother a year older than me,

he died at 57. And these deaths just didn't happen, you know, one year and then five years later we lost someone else: it was one year, then not even six months later another death, and then another death.

That only didn't happen just with my brothers and sisters, it also was with my nieces and nephews. One particular niece, she passed away, she's only 26. I came home from the funeral because I was doing some work up in Sydney at the time, and then only two weeks later we had another niece who passed. She was 40, we buried her on her birthday. Her brother was 37, he went to her funeral and then five weeks later we were burying him. How do we cope with these sorts of things?

It's not an isolated situation. There's too many deaths in our community and a lot of them can be prevented through health.

Q. Thank you so much, Aunty Nellie. Chair, are there any further questions for Aunty Nellie?

CHAIR: No, I don't think so. Aunty Nellie, thank you so much for sharing with us your experiences. We didn't touch on all of the professional contribution you've made in your 40 years working in Aboriginal Health and Wellbeing, but we really do know that from your witness statement and thank you so very much for sharing your personal story with us here today. Thank you.

MS BATTEN: May Aunty Nellie please be excused?

CHAIR: Yes.

<**THE WITNESS WITHDREW**

MS NICHOLS: Commissioners, the next witness is Ms Helen Kennedy, I call her to give evidence now.

<**HELEN ELIZABETH KENNEDY, affirmed and examined: [10.53am]**

MS NICHOLS: Q. Ms Kennedy, have you, with the assistance of the Royal Commission, prepared a statement which sets out your experience in the mental health system and related matters and your opinions about the questions we've discussed with you?
A. Yes, I have.

Q. I tender that statement. [WIT.0001.0048.0001] Ms Kennedy, are you the Chief Operating Officer of the Victorian Aboriginal Community Controlled Health Organisation?
A. Yes, I am.

Q. Otherwise known as VACCHO?
A. Yes.

Q. Have you had many leadership and senior management roles within the Aboriginal Community Control Sector and Government including as a manager of the Family Counselling Service of the Victorian Aboriginal Health Service?
A. Yes, I have.

Q. Have you been a Director of various organisations and a member of the National Aboriginal Mental Health and Suicide Prevention Committee?
A. Yes, I have.

Q. Have you worked as Principal Policy Advisor for the Aboriginal Social and Emotional Wellbeing at DHHS, where you played a key role in developing Balit Murrup, the Aboriginal Social Emotional Wellbeing Framework?
A. Yes.

Q. Can I ask you to tell the Commissioners just a little bit about VACCHO and what it does and what its objectives are?
A. Victorian Aboriginal Community Control Organisation, otherwise known as VACCHO, is the peak Aboriginal health body for Victoria. It supports a number of member organisations which are adult community controlled organisations that have health as a key focus, currently numbering about 28. So, our role is to provide advocacy, policy support, research and over time we have aspirations to become a centre of excellence in Aboriginal social and emotional wellbeing.

Q. Is VACCHO a champion for improved mental health?
A. Absolutely.

Q. And does it get about half of its funding from the State Government?
A. Yes, roughly half.

Q. Can I ask you about social and emotional wellbeing, and it's right, isn't it, that many Aboriginal people describe both their physical and mental health as having a foundation of social and emotional wellbeing, originating in strong positive connections to family, culture, community, land and spirituality?
A. Yes, and I will answer that question, but before I do I also want to acknowledge that we are meeting here on the lands of the Wurundjeri people and thank Aunty Di for her amazing and warm, as always, welcome to country. I want to pay my respects to their Elders past and present and to Elders in the room and to all Aboriginal people and supporters that are here today.

Q. Thank you, Ms Kennedy.
A. There's obviously been lots of references about the importance of social and emotional wellbeing. We know that, to improve social and emotional wellbeing and mental health in Aboriginal Victorians, we really need to define health and wellbeing in terms of relevance and consistent with Aboriginal people's understandings and experience, both historically and in the context of colonisation and the contemporary experiences of Victorian Aboriginal families today.

I thought I'd just read out a definition that was actually written in one of the first landmark national reports on Aboriginal social and emotional wellbeing in 1995 and it still is relevant today:

> "The concept of mental health comes from an illness or a clinical perspective and its focus is much more on the individual and their level of functioning in their environment. For Aboriginal people the social and emotional wellbeing concept is broader than this and it recognises the importance to land, culture, spirituality, ancestry, family and community and how these affect the individual."

So critically it needs to be understood that, when the harmony of these interrelations is disrupted, Aboriginal ill-health will persist.

Q. Can you explain how it is that social and emotional wellbeing is understood as having both risk and protective

factors?
A. Yes. Many Aboriginal people can describe both their physical and mental health as having a foundation - social and emotion wellbeing, commonly known as SEWB, originating in strong and positive connections to family and culture, community and spirituality as per that definition. So, that has to 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.

Social and emotional wellbeing is a source of resilience and we heard from Aunty Nellie before how important it was for her to be connected to her culture and her spirituality that supports her and others to protect them against the worst impacts of stressful life events. Those stressful life events, and Aunty Nellie articulated them very well, sadly, is the number of deaths. Stressful life events are also around divorce, separation, family members being in incarceration, and the number of life events that Aboriginal people experience are way, way over-represented.

So, when we understand - I might just talk about the risk factors, if you don't mind?

Q. Yes, of course.
A. What we know is that Aboriginal people are disproportionately exposed to risk factors that negatively impact upon their social and emotional wellbeing, and sadly the extent of this exposure is associated with increased suicide risk and ultimately suicide rates are twice the average.

Significant risk factors: there's growing research that tells us more about these risk factors that negatively impact on social and emotional wellbeing of Aboriginal people which include widespread grief and loss, impacts of the Stolen Generation and removal of children, unresolved trauma, separation from culture and identity issues, discrimination, economic and social disadvantage, physical health problems, incarceration, violence and substance misuse.

As I said, there's growing research around risk and protection factors. Some researchers have identified very clearly that forced removal from family, systematic and

institutional discrimination and the presence of all of those multiple stressors, including things like death of family members, are common risk factors for Aboriginal people.

For those Aboriginal Victorians who don't experience strength in their identity and/or where those fundamental protective factors that contribute to resilience are not present in their lives, this can also lead to poor social and emotional wellbeing.

Q. Can I ask you about the protective factors, and does one model of social and emotional wellbeing draw on seven domains which are intended to and understood to protect, namely body, mind and emotions, family and kin, community, culture, country, and spirituality and ancestry?
A. Yeah, the social and emotional wellbeing model that's based on Aboriginal understandings of social and emotional wellbeing has been developed in recent years. Dr Graham Gee, who you will hear from later on, is one of the authors and architects of that model.

In one of the first government frameworks called Balit Murrup which was released two years ago, there's significant attention made around identifying that model, what the most specific risk factors are, protective factors are, and there is a fantastic case study that tells a story of an individual who's being supported to heal and improve her social and emotional wellbeing and mental health by focusing on all those protective domains, including connection to culture, focusing on improvements in mind, body and spirit, connection to family. Wadamba Wilam, who you will also hear from later on, who has prepared that case study, will give a really good detailed account of what that means in practice.

My concern is that there is a very poor understanding across the service system of social and emotional wellbeing and how that model can, by focusing on protective factors, can reduce the impacts of the risk factors and mitigate those risks.

And I just wanted to say one more comment that, at a practical level, there has to be a much greater understanding by service providers about Aboriginal concepts of social and emotional wellbeing to inform a development delivery of culturally and clinically

appropriate service responses right across every aspect of health and human service design and delivery approach for Aboriginal people.

I reinforce: there's a poor understanding of this model. Despite fantastic government reports such as this, there's a limit of resources available to support practitioners, policies, people working in social and emotional wellbeing in mental health to understand how to support people, Aboriginal people in the context of human services delivery.

Q. Has it been shown that, where a social and emotional wellbeing framework is actually implemented, that Aboriginal people will have much better access to services that express that framework?
A. Yeah. There's clearly a strong evidence base now that that social and emotional wellbeing model works, and I think that that will also over time support Aboriginal people to perhaps alleviate their distrust in mainstream services because they're able to be more culturally responsive and not just focusing on what is the immediate presenting factor and focusing on a biomedical approach.

I might actually just share a personal experience when I was working at the Victorian Aboriginal Health Service, and there was a community member who was waiting to see a doctor as it turned out. Had a yarn with that person and sat down, asked her how she was going. She said, "I'm really distressed. I've come to see the doctor. I have isolated myself, haven't left the house for weeks. I've lost contact with family and my only interaction with the world is through social media and what I'm seeing on social media is horrific and it's really distressing to me, so I thought I'd see the doctor. And, I don't know, maybe I need antidepressants."

So at that time, fortunately, the Victorian Aboriginal Health Service was running a Minajalku healing centre. So, we were able to encourage that community member to reconnect with community, to reduce her social isolation and be part of community and reconnect. At the time there were a number of women's healing groups, cultural activities, art therapy et cetera that she was able to reconnect with, and that supported her resilience.

So, in terms of those protective factors, connection

to country, family, identity, improving mental health, social and emotional wellbeing, that person was able to re-integrate and became a really significant member of many of those groups, and didn't have to be prescribed antidepressants.

Q. Thank you. Can I ask you about the importance of intervening early in life, and it's a fact, isn't it, that childhood and family adversity experience by Aboriginal community members is significantly higher than in the non-Aboriginal community?
A. Yes. I thought I actually might share some other research in addition to Penny providing - if I can call you Penny, Commissioner - in providing an overview of what we know about the entrenched mental health social and emotional wellbeing gap that exists in the context of young people.

Victoria has a very high youth population. From 0-24 our young people make up about 52 per cent of the population, and it's growing and our population is growing rapidly as well.

At the end of last year there was a major national review on Aboriginal young people's mental health that was released, and our young Victorian Aboriginal people experienced the second-highest rate of psychological distress in the nation, second to Western Australia, at 39 per cent. I think that's very, very telling and I think we need to start at that.

We know that exposure to adverse child experiences is associated with emotional and behavioural difficulties and mental health problems in children and adolescents.

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 that we see in the adult population. And given the high prevalence of mental illness of that 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 need to prioritise and strengthen early intervention and prevention approaches for our children and young people.

Interestingly, I've had an opportunity to look through

a lot of the National Mental Health Commission reports, background documents. The National Mental Health Secretary considered expert advice on specific challenges for Aboriginal people in 2014. 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 that report supported the view that investment and early intervention programs for children and young people will provide the greatest return in investment, and I think it would certainly, from my perspective, be very important for this Royal Commission to look at what investments this State Government are making in that area, what's working, what's not working well.

I think we need to do a deep dive to make sure that we can precisely identify what those social and emotional wellbeing mental health needs are and those gaps are for children and young people and have a long-term plan for delivering targeted services.

I know, when I was working at the Victorian Aboriginal Health Service, that it was relatively easy for me to attract funding to support adult mental health - I'm not saying it was really easy, it was always challenging - but whenever we made any attempts to find any funding and resources to support the work that we were doing as part of our Koori Kids and Adolescent Mental Health Unit there was absolutely nothing. There is a paucity of resources to support early intervention, social and emotional wellbeing mental health services for young people.

Q. Can you tell the Commission a bit about the Koori Kids and Adolescent Mental Health Service and why, though it has underfunding, it's a good example of an early intervention model?

A. The Koori Kids Adolescent Mental Health Unit that's run through VAHS is the most unique service model of its kind in Victoria, and I will say that there are many other Aboriginal Community Control Organisations in Victoria that look at that program initiative and the positive outcomes that are being achieved and would love to adapt that model as part of their broader service model. Koori Kids and Adolescent Mental Health Unit are able to provide wrap-around integrated service responses to families. They

have a suite of mental health psychiatric professionals and Aboriginal health workers all working as one in collaboration.

I know - and I'm aware that Andrew Jackomos is going to be speaking later on. I had the privilege of being part of the Taskforce 1000 three years ago where I was part of a panel reviewing case, after case, after case, unpacking where that child was, what had happened to them, trying to identify systematic issues and improvements, and one of the common themes in the taskforce in the northern region for kids in out-of-home care who were doing well, was that they were supported by counsellors, staff, from the Koori Kids and Adolescent Mental Health Unit. It was quite startling.

Again, I think that there is opportunities for us to do a lot more research to really highlight and bring to bear and bring to life the evidence base of what works and how it works.

Q. Can I ask you to say something about historical trauma, sometimes referred to as intergenerational, transgenerational trauma, and how it can be transmitted by a number of pathways, including family, biological and social mechanisms?

A. Yes. It's clearly a central theme and in the context of historical trauma we know that refers to the manifestation of emotions and actions that arise from the historical loss from the insidious and lasting impacts of colonisation, which includes loss of land, cultural connections, language, assimilation and child removal.

And I do need to say in prefacing my comments that in Victoria 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's often referred to as the Stolen Generation - sorry, intergenerational, transgenerational and historical trauma.

Intergenerational trauma continues to affect Aboriginal people in Victoria today by being passed down from the first generation of survivors who directly experienced or witnessed these events, traumatic events to future generations.

I really do need to highlight that, within living

memory Aboriginal Victorians were forcibly removed from their families under Stolen Generation policies. We know that 47 per cent of Aboriginal Victorians have a relative that was removed under these policies. They have left a legacy of enduring trauma and loss that continues to affect Aboriginal communities, families and individuals in many compounding ways, including the fracturing of our communities, identities, connection to culture, one of the most important protective factors of social and emotional wellbeing.

I want to say that we know - and again I know we're hearing from Dr Helen Milroy who was the Commissioner for the Royal Commission into institutional abuse a bit later on - but we do know that many of the Stolen Generations were psychologically, physically and sexually abused while in care or with their adoptive families.

As Justice McClelland said:

"Their forced removal led to psychological and emotional damage which has been inherited by today's Aboriginal and Torres Strait Islander children. As a result, many remain highly vulnerable to sexual abuse."

I need to say, I find it astounding that Victoria, who is supposed to be one of the most progressive states, has been unable to come up with a reparation scheme for Stolen Generation survivors, unlike other states such as Tasmania, New South Wales and South Australia.

I think, for many Aboriginal people who were sexually abused in institutions, healing and seeking redress are not separate and should be addressed in parallel and considered as part of this Royal Commission process.

In answering the second part of your question, in terms of intergenerational trauma, that is passed down through parenting practices, it's passed down through behavioural problems, violence, substance abuse and mental health issues.

And of course, and this is something I really want to highlight, if people do not have the opportunity to heal, then they may deal with their pain in negative ways,

including self-destructive behaviour, development of lifestyle diseases, entering the justice system, physical and emotional violence abuse or addiction.

My plea is that we focus more on supporting our communities, individuals and families to address that underlying trauma and in the context of preventative responses. I am a big advocate for us to have a much greater focus on providing support services that focus on healing models.

Q. Can I ask you about the effect of racism. Is it the fact that Aboriginal Victorians, over 70 per cent report eight or more racist incidents within the preceding 12 months?
A. Yes, I think it's important to be aware that there is a connection between intergenerational trauma and institutionalised racism, and how that impacts on Aboriginal people's engagement with the medical mental health system. It serves as key barriers to accessing adequate health care.

One example is, Aboriginal Victorians are regularly subjected to racism, with over 70 per cent reporting eight or more racist incidents within the preceding 12 months. This has a direct impact on medical health outcomes with 47 per cent of Aboriginal people who self-reported instances of racism, being over the threshold for very high and high psychological distress.

One study has shown 62 per cent of Aboriginal people reporting experiencing racism in a health care setting.

Q. That was a study published in the Medical Journal of Australia?
A. Yes.

Q. In 2014?
A. Yes. And racism acts as a barrier to accessing services and seeing through health care Services to completion.

Q. Can I ask you to tell the Commissioners in brief, what is trauma-informed care?
A. Before I answer that question, I'd just like to share some other research that's important to understand because, if we are looking at bedding down trauma-informed models

and the importance of trauma-informed care, we need to understand the extent of trauma exposure. We've talked about intergenerational trauma, how that transmits from generation to generations.

Some research has been done, just five minutes down the road from here, by Dr Graham Gee over many years that looked at the extent of trauma exposure among Aboriginal clients attending family counselling services. The number of traumatic events clients reported experiencing in a lifetime was very high, at nearly 13.

Dr Gee, who you will be hearing from later, as I understand, by Skype noted that this level of trauma exposure was comparable to studies involving refugee populations who had experienced large-scale collective trauma. I don't think that people are anywhere aware enough of the extent of exposure to traumatic events in addition to the impacts of transgenerational trauma.

A further concern: 91 per cent of those clients report experiencing family violence; 40 per cent reported trauma symptoms severe enough to be consistent with post-traumatic stress disorder. So, a really important piece of research that I understand is not yet published, but no doubt Graham Gee will be talking about that.

So trauma-informed care is a framework that allows practitioners to better understand the ways in which trauma impacts on the individual. It allows for a holistic understanding of trauma by situating the person's experience within their environment and it's a departure from medicalised models to understand trauma-related behaviours as a pathological symptom, rather than as the result of larger inequalities.

Trauma-informed care aims to reduce the trauma felt in an individual's life which manifests itself in different ways. When I think of trauma-informed care, I don't stop at trauma-informed care, I say trauma-informed and healing-based care, if we are to be situating service models that are more responsive to the needs of Aboriginal people.

Trauma-informed and healing-based care improves the mental health outcomes of Aboriginal people and should be the cornerstone of all care practices and for every service

working in mental health and related areas. Again, it allows for holistic approaches and service provisions that recognise the individual experiences of clients.

I am aware that there has been some work done to support the capability of mental health staff across Victoria to provide trauma-informed treatments to people with refugee backgrounds seeking mental health care. We need to do the same work for our First Nations people and should prioritise commissioning of work that supports an Aboriginal trauma-informed and healing-based framework with associated resources to be introduced right across the mental health service system including our own organisations, our own ACCHOs, in addition to healing centres and healing initiatives.

Q. Can I ask you to explain briefly, what's the essential difference between trauma-informed and healing-based care and what you call medicalised models of care?
A. I think again, trauma-informed care is less of a biomedical model and ultimately has the same aim of reducing the trauma felt in an individual's life, which manifests itself in different ways. By adopting a social and emotional wellbeing framework in terms of supporting a person's social and emotional wellbeing, including their recovery/healing, recognises that, in an Aboriginal context, healing is a critical underpinning concept that sits across the entire social and emotional wellbeing model.

Q. Thank you. Can I ask you about the problem you've identified in your witness statement of many Aboriginal people in Victoria having a profound distrust of mainstream health services, and what do you think could be done to improve that position?
A. I'll start off by saying that Aboriginal people in Victoria have historically not accessed mental health services at levels appropriate to their needs. Aboriginal people are over-represented in terms of psychosocial problems compared to the general population and do not access mental health community support services and levels commensurate with their needs.

There are several reasons why I believe mainstream services often fail to meet the needs of Aboriginal people. One, there is an historical attitude of fear and distrust of mainstream health services, and this is due in part to

past associations with removal of children, experiences of discrimination and racism and negative staff attitudes.

Two, there's a lack of awareness amongst mental health service providers of the historical community and cultural factors relating to social and emotional wellbeing and mental health.

I believe there are inflexible models of service delivery, including the use of inappropriate assessment and diagnostic tools, and I have no doubt that some of the clinicians who will be speaking later on can provide some examples of where that occurs.

Critically, there are too few Aboriginal people actually working in the mental health service system. We know that Aboriginal people are more likely to access health services and return for following treatments if Aboriginal people are working in these services, and there's a lot of evidence for that and I'd be happy to talk more about that.

There are poor quality linkages for people, particularly - and we've been hearing this throughout this entire mental health Royal Commission, lack of integration, linkage between primary mental health, funded by the Commonwealth mainly, and our specialist clinical services which are delivered by the states.

The other challenge relates to the relative poverty and geographic location of many Aboriginal people with mental health problems and their carers, particularly Aboriginal people who live in regional locations which affects their capacity to access mainstream services.

Stigma: stigma of mental illness acts as a significant barrier to Aboriginal people seeking help when it's needed. I think we've got a lot of work to do to address stigma. It exists on a number of levels, including feelings of shame for individuals, and I think that there is still limited mental health literacy and awareness of social and emotional wellbeing problems in Aboriginal communities including early identification of needs.

Q. Can I ask you to say a little bit more about the workforce and the importance of developing the Aboriginal workforce in mental health and the challenges of doing

that?
A. It is very clear that there are major workforce gaps across all of our service systems, including our clinical mental health service systems, and within our ACCHOs, and if we are to seriously address improving mental health, social and emotional wellbeing outcomes we will prioritise the need to expand that workforce.

In our clinical mental health services alone, and we have 38 services I understand - 33 - which includes Child and Adolescent Mental Health Services as well as our Area Mental Health Services, there are only eight Koori Mental Health Liaison Officer positions. We know that there's a new traineeship program that's being rolled out to support a growing skilled mental health workforce, which is fantastic, but they're not located in all the services.

Those staff, a small number of the eight Koori Mental Health Liaison Officers, I believe feel under-supported, isolated, the lack of career paths, and a lack of clarity around the scope of practice, and I would suggest a major review of that initiative and how it fits in with the new traineeship program so that we can have a cohesive Victorian Aboriginal mental health workforce strategy that looks at the mental health service system and how we can grow and support that workforce, as well as within our Aboriginal Community Controlled Health Service.

I will say, I have looked a lot at the experiences of New South Wales who are at least 10 years ahead of us. They have a policy commitment that, for every 1,000 Aboriginal people living in New South Wales, there will be one Aboriginal mental health worker position employed. As I understand, they are well on target recognising that they have a much bigger population than we have in Victoria.

They have done extensive reviews and evaluations of their workforce program. Most of their mental health services have two Aboriginal mental health workers, an Aboriginal mental health clinician and an Aboriginal lead clinician, which reflects good practice as a general rule: you wouldn't put just one Aboriginal person working in, particularly a mental health service system with some of the complexities that are associated with that.

Q. Is it important to have a developed Aboriginal workforce in both ACCHO controlled services as well as in

mainstream services?
A. Absolutely. I do want to say, I really would just like to spend a few minutes reflecting on some of the issues and the needs within the Aboriginal community controlled sector. We know that our ACCHOs are often the preferred service of choice for Aboriginal Victorians and that they are effective in creating better outcomes, but they have limited primary mental health services. That in turn limits the ability to offer those in the community specific services.

With a few exceptions there is inadequate and inefficient funding. They're often recipients of very small parcels of funding that are short-term, non-recurrent, and they struggle to deliver real sustainable impacts on individuals, let alone families and whole communities across vast geographic areas where transport and a lack of outreach service remain barriers.

I would like to highlight that, despite those limited resources, two of the top presenting issues that are presented at ACCHOs are depression and second depression and anxiety. Our ACCHO CEOs have identified mental health as being their top priority and their top service gap. The Commonwealth Mental Health Commission identified as a priority, as a way to respond to growing mental health issues and the growing gap, that a solution is to support the development of Aboriginal social and emotional wellbeing teams that are integrated into every ACCHO and that's what we need to do.

I think Primary Health Networks have a key role to play in there, but I think that there is enormous frustration within ACCHOs that those resources to support those multidisciplinary teams to partner up with mainstream services are very, very slow to come. And there is some really good examples that I can highlight that are working really well where the State Government has invested in four ACCHOs to develop new treatment and service responses in mental health and an evaluation is still underway, and the outcomes are showing really positive impacts.

So, let's learn from that and grow that model across our ACCHOs.

Q. Because we're running reasonably short of time I'm going to ask you about a couple of things briefly. There's

much in your statement and you can be assured that the Commissioners have that and have read it and have considered it.

You have suggested in your statement that it's necessary for Victoria to develop an Aboriginal Suicide Prevention Framework. Can you say a few words about that briefly?

A. Very briefly, the last time there was an Aboriginal Suicide Prevention Framework was 2014. I'm really concerned that that suicide framework was developed in response to a spate of suicides right across Victoria; there was an enormous amount of community consultation that provided input into that strategy. I don't think it has ever been reviewed, evaluated, reported against, and I fear that we are now moving into another phase of far too many suicides, suicides that are under-reported.

We know that the Coronial Court is doing a deep dive into getting, for the first time ever, a register of Aboriginal suicides. Victoria's never been able to report on its Aboriginal suicides at a national level. I believe that we need to have a focused look at suicide prevention as part of this Royal Commission; it needs to be a specific piece of work that should review what has happened.

We know that there needs to be more research into what works, but there is a centre of best practice in Aboriginal suicide that we can look at, but I think we should not wait until we have crisis - which I think we probably already do - across Victoria to have a response.

Q. Thank you. In the remaining moments, is there anything that I haven't asked you about among the many things in your statement that you want to tell the Commissioners?

A. I will just say, from my experiences, being involved in community consultations leading up to the 10-year mental health plan, Balit Murrup, that a key area of focus that Aboriginal people and families were wanting to draw more attention on was a focus on healing, and healing services and support. We know they work, the evidence is compelling. Our own Aboriginal Healing Foundation has identified the benefits, including economic benefits of investing in healing centres.

The example that I provided before about the woman in

the waiting room at VAHS, who was then connected up to the Minajalku healing centre. That healing centre no longer exists. There are no dedicated resources whatsoever to support what we know works and what actually will reduce hospitalisations and support people to remain well and resilient and strong in their culture supporting those protective factors.

MS NICHOLS: Thank you very much, Ms Kennedy. Chair, are there any questions from the Commissioners?

CHAIR: Q. There's just one thing I'd like to examine a little bit. Thank you very much, it's a very comprehensive statement and we have, as Ms Nichols said, been able to go through that.

The importance of yarning, you used the word a fair bit, and in Aunty Nellie's statement she talked about the fact that when she worked at the CASA in her career a lot of the time no-one came into the centre, Aboriginal people weren't comfortable until she went out and was informally meeting with people having a coffee yarning and she said there was a tenfold increase in the number of people seeking assistance.

How important is us understanding yarning in the designing of Aboriginal-centred practice into the future? A. I think it's very important. I think that stigma of mental health, seeking help, is a real challenge. I know that even for people to rock up to family counselling services - again, that "counselling" - it's a big step and it's hard. I think that the Victorian Health Service have done incredibly well to break down some of that stigma because it's a trusted service.

You will see on ever door in any of the - you know, what's normally a "consult room" - it's called a yarning room: yarning room 1, yarning room 2, yarning room 3, yarning room 4 and it goes on and on. So, yes, I think it's important that that be recognised.

CHAIR: Thank you.

MS NICHOLS: May Ms Kennedy be excused?

CHAIR: Yes. Thank you very much for your evidence today.

MS NICHOLS: Is it convenient to rise for a 15 minute break?

CHAIR: Yes.

SHORT ADJOURNMENT

MS BATTEN: Commissioners, the next witness is Mr Adam Burns, who's appearing via video link to the Northern Territory. We'll just ask Mr Burns to take the affirmation.

<**ADAM JOHN BURNS, affirmed and examined: [12.02pm]**

MS BATTEN: Q. Thank you very much, Adam. Can you hear me okay?
A. Yeah, all good.

Q. Thank you. Have you, with the assistance of lawyers, prepared a witness statement for this Royal Commission?
A. I have.

Q. I tender that statement. [WIT.0002.0014.0001].
Adam, could you please start by telling us, what is Wadamba Wilam?
A. Okay, Wadamba Wilam's a program to work with Aboriginal and Torres Strait Islander people experiencing homelessness and mental illness, and it's been running for about five years and it's quite unique in that it has four organisations involved.

So, I represent the Northern Area Mental Health Services, and there's an Aboriginal mental health worker, there's a drug and alcohol worker, there's an NEAMI worker. There's also an NEAMI manager and a consultant psychiatrist. The idea being that we work as an inter-agency team, work collaboratively with 25 to 30 clients.

Q. Okay, thank you. Could I just ask you to speak just a fraction slower, please. Could you also tell us what's your role at Wadamba Wilam, what do you do there?
A. My role, I'm a senior mental health clinician, so I'm the psychiatric nurse on the team, so I guess I provide direct support case management and so forth to clients as well as some other roles within the team, like liaison and primary, secondary and tertiary consultations to other

parts of the Northern Area Mental Health Service, and essentially working with the other team members to provide holistic care based on the principles of social and emotional wellbeing.

Q. Can you tell us a bit more about that holistic care, what do the services that you provide look like?
A. So, it's all provided through intensive outreach, so we take the service to the person. So, it can be really varied. Like I said, the main criteria was homelessness and mental illness but that's normally just the tip of the iceberg for many of the people we work with. I think it should be acknowledged that underlying trauma drives a lot of this, but also that people have co-occurring addiction or other disabilities, and acquired brain injury and intellectual disability, and also I guess a lot of other issues in their life or, you know, they haven't had any connection with their culture or their people.

So, essentially it's about initially building trust and relationship and then working through the issues as we go. So, most of the people that I work with, the clients I've been working with for four or five years and seeing them at least once or twice a week in an outreach basis, so the work is varied. It certainly has a focus on trauma, but also navigating the many systems that people are involved with, and just, you know, also becoming empowered and engaging in meaningful activity, growing as individuals and becoming leaders in their community. So, I think it's about walking with and using all the skills that it takes to do that, but no two days are the same and the work is varied.

Q. You talked about building trust, does it take some time to build a trusting relationship?
A. Yeah, consistently when I've asked people how long has it taken to build trust, they inevitably say it's 12-18 months and, if you break that down to, I guess hours spent, it's probably around 100 hours, which is well in excess of most episodes of care for most parts of the mental health service sector. So, you know, that's the most important thing, I would say people say it takes 12-18 months to trust you.

I guess I will say that, if the family vouches for you, that process can be a lot quicker because that family member you're working with immediately trusts you because

the family trusts you, so it can be quicker, but as a rule 12-18 months. I should also say that I'm working with a population of people that have fallen through the gaps in traditional service provision and probably have quite significant mental illnesses and other barriers, so I'm kind of working at the hidden population, I would say. Many of the people I work with haven't had - I might be, you know, the only contact they've had with a health care professional for a long time. Other people might be, you know, they're in and out of crisis and have contact with lots of healthcare professionals, but I think they don't have an opportunity to build that trusting relationship.

Q. I do want to ask you about barriers in a moment, but before we get to that, how do people come to you? How do they find your service and how do they get referred to you?
A. Initially it was agency referrals, so any agency can refer to us if the client meets the criteria. But more recently, we've been getting referrals straight from community and family members, which is a good thing, so I think anyone can refer to us essentially.

Q. And you said that you think that's a result of the community growing an acceptance of you; is that right?
A. Yeah, definitely so, yeah, that's a result of that vouching process which has taken two or three years I would say. All our initial referrals were - or actually, you could say that most of our initial referrals were from mainstream services, so I guess we get vouched for within Aboriginal services as well. So, now I would say that there's consistent referrals from community Aboriginal services and mainstream services.

Q. Can you tell us from your experience, how does trauma-informed care contribute to the mental health outcomes of Aboriginal and Torres Strait Islander people?
A. Oh, it's central. I think that, I guess a lot of the issues that we're seeing are outcomes of trauma, so to be trauma-informed is essential and needs to be part of the whole agency, the individual, the paperwork, everything needs to be trauma-informed, and I think unfortunately the time constraints can make that difficult to achieve, so trauma-informed is central to what we do, I guess --

Q. You finish and then I'll ask you a question.
A. You go.

Q. Can you clarify what you mean by the time constraints? What are the time constraints?
A. For instance, like, if someone's say, going to an Emergency Department or accessing other parts of the service, the person's got to gather that information in 60 minutes in an interview or whatever, and sometimes people will share their trauma and other times they won't, but I think sometimes it takes 12 or 18 months after that trust-sharing period for people to start to share some of their experiences. So, I think, you know, it's important to give the space and the time and the skill to allow that to happen in a safe manner.

But also, I think as a clinician to be aware of that in the background, that trauma is driving a lot of this and you need to be aware of that.

Q. Have you seen outcomes where there has been trauma-informed care, has that resulted in more positive health outcomes for Aboriginal people?
A. Oh, definitely. That's one of the privileges of working with Wadamba Wilam, I can draw on 30 amazing stories of people that have turned their life around, and I think it comes from not having to tell their story over and over, or having their story held in a safe way.

Unfortunately, I think the service systems are so fragmented that people get re-traumatised over and over and over when they have to tell their story and they don't get any healing. So, I've had the privilege of being part of some amazing healing journeys, and people who have gone from homelessness with significant mental illness, to working full-time, to being parts of community and to taking ownership and control of their own health, being a big part of their family and community, so I think that all comes from having those principles of social, emotional wellbeing and trauma, using the trauma lens at all times.

Q. Did you want to refer to some case studies at this point? Were there some case studies of the work that you've done that you wanted to share with the Commission?
A. Yeah, look, there's a couple of people that come to mind. A couple of single males that were in their 50s and had been homeless for 30-plus years, haven't had any support from any services, and had a lifelong of post-traumatic stress but not diagnosed or recognised, and also, as a result of that, a lifelong addiction; heavy

substance use, homelessness, and also extensive involvement with the justice system.

Both of these gentlemen made their first disclosures of significant interpersonal trauma from a young age and they kept that secret for their whole life. Both disclosed that at about the 18-month mark and over that next two or three-year period we worked on skills together about how to manage that distress; when you're triggered how to do different coping strategies, how to not turn to addiction.

Both those men now are doing really, really well, no longer using drugs, and have also re-engaged with their family and been a part of their grandchildren's lives and so forth. Most importantly, I think connected with their culture on a positive level, so come to the mens camps and other things where, they in some ways felt too threatened to do that in the early stages or too traumatised, but now they've got a sense of pride and so forth and so they can access all the things that are healing for them.

I think that's one of the privileges of the work. I've been part of many healing journeys and, yeah, that's just one of many stories.

Q. Thank you. You've mentioned earlier the barriers. Could you tell us about the barriers at a system level that Aboriginal and Torres Strait Islander people face in trying to access trauma-informed care?

A. I think the fragmentation is such an issue, and I guess I should say that, for any service there needs to be an alignment between concept, process and instrumentation.

I think Helen Kennedy touched on it earlier, is that, the mainstream services come from a biomedical model, so there's immediately a clash there with cultural understandings of health and wellbeing.

I think the process is so rigid because of the time constraints and also the instrumentation as well; the language barriers, all the instrumentations used are based on mainstream populations, so I think on many levels there are barriers, but I think it plays out mostly in those three areas and just having a safe space.

I would say that the biggest success of Wadamba Wilam is the outreach, so taking the service to the people rather

than the people coming to the service, but not only that, fitting the service to the individual, not the individual fitting to the service and that's how you break down barriers.

Q. You highlighted some of the key features of the Wadamba Wilam model. Were there any other elements of the model that you haven't spoken about that you wanted to cover?

A. Yeah. So, definitely having care coordination as part of direct service provision. Because the work is so nuanced it's imperative to have the care coordination with the people that spend the most time with the client, because they can adjust the care needs in a more dynamic, opportunistic and realistic fashion, so I think that's imperative.

Also having the inter-agency thing, so we can manage most people's needs within the team, so that is another way of reducing trauma because you know that it's covered within the team.

The other thing is working with multiple family members at one time; I think that's been a thing that has developed over the last couple of years and that has been one of the major factors. I've been working with, say, someone's son for two or three years in an intensive capacity and have had some contact with the mother as a carer for that time. At that point she asked for some help for herself, so then we pick up her as well and working with multiple family members at one time can help break some of these transgenerational cycles of trauma and working with the families together.

I think Aunty Nellie earlier said that she wants families and stuff to be able to go to a service together; maybe it's the services need to go to the families and that's when you can work with that, because there's such a richness of information, but also a richness of resources strengths and resilience that you can tap into to promote that healing.

Other things like early interventions, things like that that the family will contact us straight away, and so, you can manage a situation before it even becomes a crisis because the family have been proactive in managing that, so I think that's an important one.

Low case numbers is imperative. As I mentioned, 25-30 clients between four workers, that gives you that time, flexibility and really your focus is to build that relationship; that's a bit of a different focus to other parts of the mental health system. So, it's about, you're already changing the way you're approaching things, but understanding that it's going to take three, four, five years to go on a journey with someone and that you're going to have to use different skills and resources at different times, but that having those low case numbers gives that opportunity for that responsiveness, which gives people opportunities to do dynamic healing, so having people call up when they're triggered and traumatised and going to sit with them in that moment is such a powerful opportunity, so then you can start to build in some coping strategies and even just some basic knowledge around trauma and how it affects their body.

The other really important component is considering trauma recovery and considering when someone is on that trauma cycle. So, there's three main stages of trauma recovery and that needs to be the focus of treatment. So, phase 1, we talk about safety and stability and security, and that's the phase where engagement happens, where maybe some medication happens, where people are learning about what trauma is and how it's affected them, there's a lot of education, there's a lot of resources and so forth.

Phase 2 is like a reprocessing phase, so not reliving, but sort of processing and gaining a different understanding, a relationship with trauma, and sort of phase 3 is going on to a meaningful life, employment and community and so forth. But it's not a linear journey, so people can easily go back to phase 1 and that's really important to recognise where people are on that trauma journey.

Another really important component is continuity of care. So, when a Wadamba Wilam client goes to another part of the service, a Secure Extended Care Unit, a Community Care Unit, or they go to Justice or anywhere, that we remain involved as a key member of that care and work with that person while they're in that institution, and that's important for a number of reasons, in that, we hold a lot of the knowledge of their story and what works and what doesn't work, but also to inform the treatment in wherever

they are, and more importantly be part of discharge coordination and really reinforce what has happened in those parts of the service.

So, that's invaluable, that is, and from what I've noticed in my previous roles, that usually when a client goes to another part of the service, then you no longer have a role and you pick them up and they come out the other end, but being a key part of that journey is important. They're the main elements of the model that I think, you know, what works.

MS BATTEN: Thank you very much, Adam. Chair, are there any questions from the Commissioners for Adam?

COMMISSIONER McSHERRY: Thank you very much for your statement. One question: you mention co-design as being an important or valuable way of involving communities as well as carer and consumer consultation and peer support. I'm just wondering whether you might tell us what your ideal situation would be in that regard?
A. So, at Wadamba Wilam we face the same troubles, in that we didn't have the instrumentation or process when we started, and I think the co-design part would be developing the instrumentation or checking the language with the clients and getting their feedback and modelling it, but also having the carer and consumer involvement I think would be a great part.

On a broader level, I think it's paramount that people need to be involved in defining what the services are and how they work. So, I think my vision would be having them involved in all parts and, from a Wadamba Wilam perspective, we've had a number of peer support workers on our team and they're invaluable in the knowledge and skills and so forth that they bring.

COMMISSIONER McSHERRY: Thank you.

CHAIR: Professor Fels.

COMMISSIONER FELS: Q. Thank you for your excellent evidence. Could you comment briefly on the question of homelessness and poor accommodation, their impact on mental illness and their role in the recovery approach?
A. Oh, of course, yeah. I think that's the other part of the engagement phase, in that, you need to sort of go back

to Maslow's Hierarchy, in that people need to have somewhere safe to live, food in their belly and so forth, so we're working with a lot of people that don't have those things so quite often the engagement phase can be part of that.

Housing and homelessness is a major barrier that we face, in that there's just very little access to appropriate housing. So, I would say that, you know, people often think we're a housing service, but I would say we're a homelessness support service, and unfortunately there's a major crisis in access to housing.

What I will also say is that we immediately increase our support when someone does get housing. Because all those needs are all of a sudden taken care of, there can be a massive influx of trauma because otherwise the person's been living day-to-day, so we can almost set our watch to four to six weeks after someone moves into a house, they have a major re-traumatising thing and we increase our support at that point.

So, I think a lot of the work can go into helping people maintain their accommodation, and thankfully at Wadamba Wilam I don't think anyone has lost their accommodation after they've got accommodation, so a lot of work goes into maintaining that accommodation.

But, yeah, I think it's just the elephant in the room, I think. There's no housing out there, and I think it has such a huge impact on mental illness, so yeah, it's massive.

Also, I think, on the other side of the coin, that unfortunately in many ways having homelessness as a criteria for Wadamba Wilam is a barrier for some people, because there are some people that are housed that require the type of support that Wadamba Wilam can provide, you know, in an outreach model and so forth and to help them maintain their housing and prevent that housing breakdown. So, I think, if I had an opportunity, that I would probably in some ways remove the homelessness criteria for Wadamba Wilam, yeah.

COMMISSIONER FELS: Thank you.

CHAIR: Thank you, Mr Burn, there's just one other

question I'd like to ask you and it goes to the issue of continuity of care. Throughout this Royal Commission we've heard about the mental health system being very episodic and people even with ongoing need being discharged from service, and so, it was very pleasing to hear that you can work with people for four to five years, but how do you manage the flow of new demand and planning? Do you discharge people from your service, or how are you managing that?

A. Of course we do. I guess I think that's probably one of the challenges though as well. As we develop this model, I think throughput's one of the major challenges because it's become clear that this is what's required to get the healing journey through.

I guess there is some throughput because there are a proportion of people that don't engage, so we'll give it a good go for six to 12 months and then, if it's not working, then other people can come through.

We've also been flexible with managing our numbers because, when someone's at the four, five year mark there, their needs aren't as acute as someone who's coming into an intensive engagement phase.

Also, we reduced the episodes of care, so a number of the people at Wadamba Wilam have had 20-plus hospital admissions and multiple ED presentations and so forth prior to coming to Wadamba Wilam and haven't had an admission for four years with this wrap-around support, and I think they were traditionally on community treatment orders and notoriously difficult to follow up in the traditional sense, now taking ownership and control of their own treatment in their lives, and so, I think it's a great model and that's such an important thing, an important part of it.

Q. Can I just ask in relation to that: was an evaluation built into this model? Is it going to be possible to access that sort of data and information about the effectiveness of your responses.

A. Yeah, so I think there was a general evaluation done into the breaking the cycles, but that was in the first two years of practice. We've done some in-house evaluations and most of the data shows a significant reduction in the amount of inpatient hospital admissions for instance, but

also more importantly reductions in substance use, contact with the justice system, people who have had significant forensic histories that are no longer part of the justice system. People that have accessed primary health care now and have cured their Hep C for instance, and they haven't seen a doctor for 20 years. There are any number of amazing outcomes, but also more importantly I think that the cultural connection side of things as well: mapping what people's connection is to culture, country and family.

I think also at Wadamba Wilam we have an opportunity to do more cultural interventions like taking people back to country and going on camps and stuff, and there's some amazing healing opportunities at those events.

CHAIR: Thank you very much, Mr Burns.

MS BATTEN: Thank you. May Mr Burns please be excused?

CHAIR: Yes, thank you very much for your evidence and making the time to be engaged with us from Darwin today.

MS BATTEN: Thank you very much. We'll cut the link.

<**THE WITNESS WITHDREW**

MS NICHOLS: Commissioners, the next witness is Mr Andrew Jackomos. I call him now to give evidence.

<**ANDREW MORGAN JACKOMOS, affirmed and examined: [12.31pm]**

MS NICHOLS: Q. Mr Jackomos, are you the Executive Director, Aboriginal Economic Development, at the Department of Jobs, Precincts and Regions?
A. Yes, I am. But first, can I acknowledge --

Q. Sorry, yes.
A. -- country. I respectfully acknowledge traditional owners and the welcome that Aunty Di gave us earlier. I'd like also to acknowledge the support and commentary from Helen and Nellie.

I'd also like to acknowledge that the last time I was here on this dance floor was eight weeks ago when my mother was buried, and last time I saw her was in front of me. I'd just like to thank you for the opportunity.

Q. Mr Jackomos, thank you for coming to give evidence today at the Royal Commission, we really do appreciate it. Can I ask you before I forget, have you, with the assistance of the Victorian Government Solicitor, prepared a witness statement in relation to the questions the Royal Commission has asked you to address?
A. Yes, I have, and I do want to thank them.

Q. I tender the statement. [WIT.0003.0003.0001] Mr Jackomos, just a few questions about yourself, if I may. From 1999-2013, were you an Executive Officer in the Victorian Department of Justice, and in that role, among other things, did you lead the development of the Victorian Aboriginal Justice Agreement?
A. Yes, I did.

Q. From 2013 for about five years, were you the inaugural Commissioner for Aboriginal Children and Young People in Victoria?
A. Yes, I was.

Q. During that appointment, did you lead two important inquiries: first, "Always was, always will be Koori children", an inquiry into the Victorian protection system and its interaction with close to 1,000 Koori children across Victoria?
A. Yes, I did.

Q. And, "In the child's best interests", an inquiry into the Victorian child protection system's compliance with Aboriginal child placement principles?
A. Yes, I did.

Q. In 2018, were you appointed the special advisor for Aboriginal Self-Determination in the Department of Premier and Cabinet, where you worked with the Koori community to lead the development of the Victorian government's 11 guiding principles for Aboriginal self-determination?
A. Yes, I did.

Q. Can I ask you, in your working life, what have you observed about the connection between unresolved mental health issues and socio-economic disadvantage and an over-representation of Aboriginal people in the criminal justice system with family violence and child protection issues?
A. So, what I've seen is that intergenerational trauma

and the history of colonisation and invasion are at the centre of Aboriginal disadvantage today.

For me, whether it's in the child protection system, whether it's in youth justice, whether it's in family violence, whether it's in the adult criminal justice system, the history of this country is ever present.

Q. Can I ask you a very basic question, and that is, what does the term "culture" mean for Aboriginal and Torres Strait Island people?
A. "Culture" for me means the parameters in which I exist: they set the values, they set my obligations to my family, my children, my community. They give us - for me, culture is the greatest resilience factor we can give our children.

I've seen, where there is strong culture, we have strong children. I've seen, in the Youth Justice system, I've seen in child death reviews where there's an absence of culture and there's a direct linkage between strong culture and strong children.

Q. What happens when a person's connections to culture break down?
A. For me it's, you lose your sense of belonging, you lose your parameters in which you live, you can lose pride and self-esteem. And, where you have strong culture, you have strong self-esteem. Where you have poor culture, you see those mental health issues.

When I undertook Taskforce 1000, looking at 1,000 children and child protection, you actually saw the absence of culture and the negative power it plays with our children.

Q. Perhaps looking at it from the other side, in your witness statement you've given an example of how community and connection to culture can be very empowering. You've given the example of a young Aboriginal man you met in a Youth Justice facility who was then placed on country in the protective company of an Elder. Can you tell the Commission about that?
A. So, I met this young man, 17 years of age, in a Youth Justice facility. When I saw him, he had fresh cuts on his arms, his neck, and his arms and his legs were just a pattern of scars. A beautiful young man, very intelligent,

very smart, but just absolutely didn't see the purpose of living. In some work we did with the Youth Parole Board, youth justice, child protection, and a local Aboriginal community organisation were able to have him be transferred from the youth justice out to country where he stayed on the river - I won't tell you which river, but he was on the river - where he spent time with an Elder, and he was just a changed person. He was absolutely changed from spending time with probably the first positive role model he's had in his life, where he actually had a vision and he told me of his vision, that he wanted to become a youth trainer and fitness health trainer. And, I just saw the power of taking a kid out of a concrete box and putting them on land underneath a gum tree next to water and spending time with an Elder who he respected and who the Elder respected him.

Q. Amongst Aboriginal and Torres Strait Islander communities, are there differences in terms of what's meant by culture and community connection?
A. I'm sure there are. There are so many nations and communities across, and they will have different aspects than individuals will have, but that's common. You might have different dance moves and different words, but it's a common, for me having an experience lived across Australia, there are common concepts of what culture is.

Q. And what are the important common concepts?
A. For me, the important concepts are: connection to country, it's connection to other Aboriginal peoples. It's your obligations - for me, one of the most important things about culture is obligations to your children, to your siblings, to your family, parents, Elders, obligations to country, obligations are fundamental, it's about how you relate to each other.

I noted in my statement I mentioned that, when one Aboriginal person meets another Aboriginal person for the first time, it's about identifying connections, about who's your mob rather than, you know, where do you work. It's who are your mob, it's about drawing those connections.

Q. Can you tell the Commission what you understand by the term "cultural safety"?
A. Cultural safety is how I feel, how other Aboriginal people feel in their environment. So, as opposed to cultural competence, it's how we feel entering into an environment.

Q. In the context of cultural safety, how important is it to develop an Aboriginal workforce?
A. For me, it's critical to success, to sustainable success. But when we're talking about an Aboriginal workforce, we're not just talking about people at the frontline. What we're talking about is having a workforce where your policy - the people driving policy are Aboriginal people; it's where people setting the budgets are Aboriginal; it's where people developing the programs and implementing them are Aboriginal; it's where you have evaluation are Aboriginal. So, it's not just a tokenistic about having people at the frontline, it's about having Aboriginal people throughout the whole system, prioritising the policy, prioritising the resources and prioritising how we respond.

Q. Can you tell the Commission what you understand by cultural competence as distinct from cultural safety?
A. For me cultural competence is in respect of non-Aboriginal people and having an understanding and being able to relate. Cultural competent need service is ensuring that a service sends the right messages. A cultural competent service is having Aboriginal people there at all levels and all areas of the service. Cultural competency is about white people getting their act together; cultural safety is about how I feel about how that culturally competent person has acted.

Q. Can cultural competence be achieved where there's a lack of self-determination?
A. No. You need self-determination to have sustainable cultural competence. So, we're not after cultural competence for a day or a week, we're after cultural competency for the long-term.

And self-determination is about our involvement, it's about our directing the services, it's about us developing services that meet our needs, and you can't have a cultural competence where Aboriginal people are excluded. You can't have a totally cultural competence where actual people are excluded at parts of the service delivery.

So a culturally competent service is where Aboriginal people, as I mention again, are just at the front counter. A culturally competent service is where Aboriginal people are throughout the service delivery: its design,

development, monitoring and evaluation.

Q. You've given an example of a culturally competent service delivery in the Department of Corrections Victoria called Wulgunggo Ngalu. Can you tell the Commissioners something about that?
A. So, the Aboriginal Justice Agreement, first established in 2000, was about reducing recidivism of Aboriginal people in the criminal justice system, and one of the ways Aboriginal people were breaching orders at a much higher rate than non-Aboriginal people. So, Aboriginal people, in partnership with non-Aboriginal people through the Department of Justice, developed a community-based, a land-based, Wulgunggo Ngalu which is down in South Gippsland, and it's where Aboriginal men, predominantly young men, voluntarily go there and spend the time.

The program was designed by Aboriginal people. It's staffed and managed by Aboriginal people, it's on country. It's where Aboriginal men come and they spend time with Aboriginal Elders who come and rotate. For many Aboriginal people it's a strong cultural experience where they haven't had that.

It's managed by Shaun Braybrook, fantastic fulla. Sometimes you have to ask men to go home. For me, it's the best corrections program that you could have.

Q. And that's been running successfully for over a decade?
A. Yes, yes, 10 years last year.

Q. Does the extent to which a service is delivered in a culturally competent way affect the extent to which Aboriginal and Torres Strait Islander people will use that service?
A. Yes. Nobody's going to go to a racist service. You know, I'm a serial attendee at the Victorian Aboriginal Health Service. I go there not just for my health needs, but I go there to have a positive cultural experience with my friends and relatives.

I go there and I'm served by young Aboriginal people, great young Aboriginal people. I see Aboriginal art. It's not just - you know, a culturally competent service isn't just photos on your wall or paint, it's how you feel, it's

how people connect with you when you're there, and that's what a cultural competent service is.

Q. In your witness statement you've said that you agree with this statement which is from the DHHS report, Balit Murrup, that:

> "Overall the mental health and primary health service systems have been largely ineffective in responding to the high rates of psychological distress experienced with Aboriginal communities. Much of the service system has been unable to embrace Aboriginal concepts of health and wellbeing and has failed to understand the historical context and pervasiveness of racial oppression and social disadvantage."

A. Yes.

Q. What are the main reasons you think that that is an accurate description of the state of affairs?
A. Because it's what I know, it's what I see, but more so when I was Commissioner for Aboriginal Children, and where I had the great honour of listening to the stories of 1,000 Aboriginal children over a short period of time, where I saw the lack of culturally appropriate Koori-friendly mental health services provided to our children. I saw that.

Now, things may have changed in the last couple of years, I don't know, but that's what I saw across the state. Absolutely there were some good examples, but I saw consistently a lack of Koori-friendly mental health services being provided to our children in a timely manner.

If you think that 9 out of 10 of our kids in child protection are there because they are victims of family violence, that goes with the trauma, and where you don't have - every one of those kids is carrying trauma, and where you hear of kids not having counselling or appropriate counselling in a timely manner, then that has repercussions for the future.

Q. Does the Victorian Aboriginal Affairs Framework set out some self-determination enablers that should be embodied in services, namely prioritised culture, address

trauma and support healing, address racism and promote cultural safety, and transfer the power and resources to communities?
A. Yes, and they are fundamental. Those four enablers that were identified by Aboriginal communities across the state, they are fundamental before you can achieve self-determination.

We can't - you know, when you've got, for me, trauma, the lack of resources, they are fundamental for undermining progress of our community. What we've got to be careful of is where people pay lip service to those enablers. They are critical to us moving forward.

Q. We've asked you to consider the foundations and principles for designing and delivering major reform to deliver better outcomes for Aboriginal communities in Victoria, and you've identified a number of principles in your statement. I'd like you to elaborate on them if you could, please.

You'll find them at paragraph 87. The first is the need for service and program initiatives that are identified by the community or equally owned by the community. Can you say what you mean by that?
A. What I'm saying is that, government recognises, our community recognises that design and delivery of programs that are most effective need to come from our community. Unless you know where we've come from, you can't design the programs. You can assist in the design of the programs, but the programs need to be owned by our community.

We have to be involved from the very start. You know, there's a practice where you may have some people design programs, then they invite us to come in and say, "What do you think about this?" That doesn't go the distance any more.

The timelines for the development and decision-making need to be consistent with Aboriginal decision-making processes. The resources for the service provision need to be transferred to the community and they need to be long-term and sustainable. The services, the principals, should be about Aboriginal people managing the program and working at all stages.

Q. Can I just get you to elaborate on what you mean by

"transfer to community"?
A. Yes. So, self-determination just isn't about decision-making, it's also about the transfer of resources. It's where we prioritise the needs of the service; it's where we prioritise where we make the decisions about what the service should look like. I know that services for our community are better delivered and more effective when they come from our community. For me, that's about a transfer of decision-making and transfer of resources.

Q. What's the importance of long-term as opposed to short-term funding in that regard?
A. There's a saying in the Koori community, national community, about "We have a lot of airports around", and that's because there's a lot of pilot projects that come in and go, you know, for 12 months. A lot of times they set up communities for failure unless there's long-term funding.

One of my projects that I've got at the moment is to work with the Latrobe Valley Aboriginal community to develop an economic strategy for the community.

Some comments I've made in government is that I don't want to go to the community in Latrobe Valley and make promises that aren't kept; that we work with them to develop responses and there's only funding for the next six months, then after that we're back to the airport, and that's - you can do more damage in short-term funding where you build up the expectations and the hope and relationships. Short-term funding, government people going in and promising the world, then not delivering is more harmful in the long-term.

Q. How important is it that once responsibilities and resources have been transferred, that people are allowed to make mistakes along the way?
A. White fullas make mistakes all the time. When an Aboriginal person makes a mistake, you know, it's - all Aboriginal people make mistakes.

For me, it's a part of the learning process, it's a part of - for me, it's part of maturing. Yes, mistakes will be made, but we need to work together in those. I've seen examples where plenty of mistakes had been made, but you don't throw out the department because a mistake's been made, and with mistakes also can I talk about

accountability and transparency and honesty. So, relationships between government and community must be based on accountability, transparency and respect; that's the basis of a good relationship.

And part of that is, coming back to making mistakes, it's about all people being accountable. It's not just about Aboriginal community being accountable, it's about government being accountable as well and, where you share that accountability and responsibility, that's when you get better outcomes.

Q. And, where services are provided by non-Aboriginal organisations, what do you say about the governance of those organisations and whether it should have Aboriginal representation on the Governance Board?
A. So, my view is that no programs for the Aboriginal community should be provided to non-Aboriginal community providers unless there are Aboriginal people involved in the governance, are on the Board of Directors, that when there is sizeable programs, there needs to be Aboriginal people recruited in the organisation.

I know many times within - while I was commissioned to do Taskforce 1000 I would ask many times the question whether they're - and the majority of Aboriginal children in care are placed with non-Aboriginal providers, and many did a great job, and some didn't - and I would always ask the question, what Aboriginal people are involved in the service, in the committee, in the working; not just in the child protection, not just the workers themselves, but in the management behind the scenes?

Q. Can I ask you a little bit about the process of reform. What do you say about the difficulties caused by isolated reforms to parts of the system?
A. So, I was listening earlier to Helen. It has to be holistic, the responses working with our community need to be holistic. So, you can't - working with vulnerable families, children, it's not just about a certain vulnerable - it's about how they're feeling, it's about, do they have a good house, is the home safe and is it warm and is it nurturing; is the education where the kids are going, is it good, are the kids getting good education?

For me we've got to work with Aboriginal families and community in a holistic manner rather than piecemeal, and

that is what you potentially can see as you look around in different responses, piecemeal, that's done by different areas of government. We need holistic responses that are developed and led by Aboriginal people and community organisations in partnership.

Q. You give an example in your witness statement of something that wasn't done particularly well and that was the handing back of the land to the Lake Tyers Aboriginal community in the 1960s, and that's something that you describe as a "dump and run" approach to empowerment. What are the lessons to be learned out of that situation?
A. The lessons from Lake Tyers, is that, back in the early 60s the Victorian Government was seeking to move the Aboriginal community from Lake Tyers to the Latrobe Valley, and there was a successful campaign led by the Aboriginal Leaders and Elders from Lake Tyers against the government's disposal/selling of that and moving the people on.

In the end, with the 67 referendum and the transfer of responsibility from the states to the Commonwealth, the government basically pulled up stumps and said, we're gonna hand the title back to the shareholders, to the residents, which was all good, but for the previous 100 years the Victorian Government had kept - the then Victorian Governments - had kept the Aboriginal community on rations, had controlled their everyday life, they controlled the gate, who could come in, who couldn't. Then all of a sudden the administration of the place was handed back to the community without the necessary capability and capacity built into the community, and that had significant results on that community, but there's other examples across the state.

You know, you have to work with communities. For me, that was a classic dump and run.

Q. We've asked you the question, what is needed to ensure reforms that this Commission recommends are sustainable? What do you say about the importance of reforms having bipartisan support?
A. It goes back to the airport. We need - for me, it's critical that there's bipartisan support for work by the Aboriginal community and work. There's nothing worse than having programs in place, albeit suicide strategies, that are promises made to the community, great work 's done by community and government together, and there's a change of

government and that is no longer a priority and is off the table. Well, it might be off the table for some; for people in the community it's not off the table, but it undermines the relationship going forward. It pulls a rug out from underneath Aboriginal communities.

Wherever we can have bipartisan support, then we have to strive, we have to struggle to get that.

Q. What's the important of community and government leadership being engaged on a sustainable basis and not delegating that engagement?
A. So, having the leadership at the table on a consistent basis and a regular basis is where, it doesn't just show commitment with the Aboriginal community, it shows commitment within the department and it's where you have sustainability of effort.

Our problem is where, the shine wears off the brochure and senior heads of different agencies no longer attend meetings - I'm trying to think of the right words here - the meetings, and that sends a message to everyone that there's a lack of interest. Along with that lack of interest will be support from government funding. Having the most senior leadership, whether they're from the Aboriginal community or government or other sectors is critical to longevity of programs.

Q. How importantly do you rate regular monitoring and reviews and reporting back on the outcomes of recommendations?
A. I think accountability and transparency are critical to good outcomes, to continuing parties being at the table. One of the things I saw as Children's Commissioner was about Aboriginal child placement principles. Great legislation, absolutely fantastic legislation, but unless there's accountability, unless people are held to be accountable, whether they're in government or whether they're in the community, things go wrong and the worst outcomes in this case was for children who - true to the example under the child placement principle - should have been, and should have been and could have been connected with family and they weren't because there was a lack of monitoring and a lack of accountability in what was happening. Now, that was three years ago, hopefully it's changed.

Q. What do you think are some key ways to ensure better accountability?
A. I think open and regular reporting is for a start. I think Aboriginal people need to be at the table in designing what the performance indicators are. Aboriginal people need to be involved in setting the terms of reference for the reviews rather than as clients, you know, we're there directing the traffic, so Aboriginal people need to be there.

There needs to be a regular and thorough reporting by agencies, whether they're government or community, to community stakeholders on a quarterly basis, regular basis.

Q. Mr Jackomos, thank you very much. Is there anything that I haven't asked you about that you want to say in closing?
A. What I witnessed as Commissioner was the lack of appropriate Koori-friendly mental health services for our children. I saw kids who have been sexually abused, not one or two, but many who hadn't received timely support. Yarning: we need a strong Aboriginal mental health workforce across state in every community, not in this community and not that community. There is a great need across the state.

There needs to be significant investment in the provision of tertiary scholarships for our people to undertake the skills that they need to take up positions at all levels and all places of the mental health system, whether it's community or non-community.

There needs to be long-term funding, not short-term. Aboriginal people need to be involved in designing the programs that are delivered in our community. Non-Aboriginal community providers and clinicians and workers have to be culturally competent or get out, and that needs to be sustainable. Not just, the fad for this year and next year, but it needs to be an ongoing service improvement.

MS NICHOLS: Thank you, Mr Jackomos. Chair, do the Commissioners have any questions?

CHAIR: No. Thank you very much for coming and giving evidence today, Mr Jackomos. As always, it's given us a very strong overview and thank you very much for your

statement.

MS NICHOLS: May Mr Jackomos be excused, and is it a convenient time to rise for lunch until 2 o'clock?

<**THE WITNESS WITHDREW**

CHAIR: Thanks. I'm told it should be 1.45, is that acceptable?

MS NICHOLS: Yes, thank you, 1.45.

CHAIR: Yes.

LUNCHEON ADJOURNMENT

UPON RESUMING AFTER LUNCH:

MS BATTEN: Thank you, Commissioners. The next witness is Helen Milroy who is appearing via video link from Perth. Hi Helen, can you hear me?

MS MILROY: Yes, yes, I can, thank you.

MS BATTEN: Thank you. We'll just ask you to make an affirmation.

<**HELEN MARY MILROY, affirmed and examined:** [1.49pm]

MS BATTEN: Q. Thank you, Professor Milroy. Have you with the assistance of the Royal Commission's lawyers made a witness statement to the Commission?
A. Yes.

Q. I tender that statement. [WIT.0001.0049.0001]

THE CHAIR: Thank you.

MS BATTEN: Q. Professor Milroy, do your roles include Professor of Child and Adolescent Psychiatry at the University of Western Australia?
A. Yes.

Q. Honorary Research Fellow with the Telethon Institute for Child Health Research in Perth?
A. Yes.

Q. Commissioner on the National Mental Health Commission?
A. Yes.

Q. Chief investigator on the Million Minds Mission Grant, Generating Indigenous Patient-Centred, Clinically and Cultural Capable Models of Mental Health Care?
A. Yes.

Q. And Co-chair of the Million Minds Mission Advisory Group?
A. Yes.

Q. From 2013-2017 were you one of the Commissioners appointed to the Royal Commission into Institutional Responses to Child Sexual Abuse?
A. Yes.

Q. Professor Milroy, in your experience what are the key determinants of mental illness for Aboriginal and Torres Strait Islander people?
A. If you look at determinants in general, so there's a lot of biological, psychological and social factors that impact on the development of good mental health for the entire population, and therefore for the Aboriginal and Torres Strait Islander population as well. But in particular for the Aboriginal and Torres Strait Islander population historical legacy and the ongoing impact of trauma, racism and discrimination play a much bigger role and have quite a devastating impact going forward in terms of mental health and mental health outcomes.

So I'm referring here to past incidents of trauma that have been experienced by indigenous communities and the types of harm that have been suffered in the past and the legacy can manifest today in the form of intergenerational trauma, the ongoing experience of loss and grief and ill-health and as well disadvantage and racism and all of these factors have an ongoing impact.

The other issue that needs to be understood in regard to such a historical legacy of trauma as well is that this also impacts on children in the form of a vicarious type of traumatisation. The children are exposed to traumatic stories and understanding actually what happened to their ancestors as well and trying to understand what that means for them.

Q. Thank you. May I just ask you to slow down a fraction when you're speaking, just so that we can capture everything that you say. Thank you. You have said in your statement:

> "It is important to note that there are differences in the way indigenous people experience mental health issues to Western populations."

Can you just elaborate on that and explain what those differences are, please?

A. So, if you look at the way culture can impact on a group, then culture isn't just a set of belief systems or a way of behaving; it also can influence how an illness is developed or experienced by that particular cultural group. So, for Aboriginal and Torres Strait Islander people, they tend to have a cultural life that's very rich and may involve a certain way of them understanding the world which may include things like hearing ancestors, seeing ancestors, other forms of understanding which relate to things like spiritual or cultural healing and the role that traditional healers are normal as part of normal cultural life.

So when you take the next step further, it also then impacts on the way a person may experience illness. For example, if you take something like depression, in a sort of a western context depression may be experienced as a sadness, a loss of hope, a desire to die and other sorts of more cognitive type of features. But for Aboriginal and Torres Strait Islander those depressive features may be experienced in the form of seeing and hearing relatives who are deceased and other sorts of experience in a visual auditory realm.

So you have to understand that the phenomenology is fundamentally different. If you don't understand the differences in the cultural aspects of symptoms and the way it develops, then you don't know what you're assessing. So, one of the really important factors when dealing with Aboriginal and Torres Strait Islander communities in regard to mental health is understanding how that plays out for them so that we don't get mislabelling or misdiagnosis.

The other thing that can happen in a cross-cultural context is everything can be put down as cultural and so

it's dismissed and it's not understood as part of illness, or it's all mythologised into illness and the cultural aspects aren't understood and that tends to happen, rather than some middle of the road where we get a cultural understanding and we understand the person's symptoms and their behaviour and their illness in the context of their culture and cultural belief systems.

Q. Just another question to establish the context, can you please explain the altered population structure in indigenous communities?
A. So, if you look at the latest ABS data, we can see that in the Aboriginal population we have a lot of children, which is fabulous because they're our future. However, we have less adults in the middle part of the population and then we have very, very few Elders. If you compare that to the non-indigenous population in Australia: the non-indigenous population has lots of adults and Elders around and less children, so there's the capacity to buffer families and support children in their development. But our population structure has been decimated over some generations, and so, we haven't rebuilt the population structure to be a well-buffered family system.

It does mean that what happens to children is that sometimes the burden of care will fall onto children because there are less adults available and less adults who are well, because of the burden of chronic disease and other factors that can contribute to stress in communities.

Q. I want to ask you about children. How does the mental health of Aboriginal and Torres Strait Islander infants and children compare to the mental health of non-indigenous infants and children?
A. It's very hard to have community-wide surveys, and I'll just make one point of caution about data in general. There's no pan-indigeneity, so all of the communities to some degree have differences, and so what you might find as a whole set of risks and difficulties in one community may not be the same for the next community.

So, a lot of incidences exists on a national level. For example, if you look at something like suicide in young people. You can have an averaging out of the suicide data, but if you look at it in specific communities it can be extremely high for that small population compared to another community where the suicide rate might actually be

relatively low. So, it's very important to understand that national data doesn't really tell you the full story at the local community level, and that's particularly so for our Aboriginal community groups, because our data gets a little bit washed out because of the larger population and our now relatively small size.

But if you look at general data, then it would suggest that Aboriginal and Torres Strait Islander children have far more risk and a greater level of mental health complexity as they're growing up. If you look at the AIHW data around children in out-of-home care, Aboriginal and Torres Strait Islander children are grossly over-represented there: something like 10 times the non-Aboriginal Australian for being on care and protection orders.

If you also look at the rates of Aboriginal children in the juvenile justice system, also extremely high and grossly over-represented, so clearly those sorts of risks for children are much, much higher. Then if you look at things like exposure to violence and other sorts of issues, then that's all going to impact and make it a much more difficult life for children to grow up in.

If you look at the Western Australian Aboriginal Child Health survey which was done some years ago now, it's probably still one of the most comprehensive datasets and it was able to show some of the social and emotional difficulties that Aboriginal and Torres Strait Islander children had. And one of the biggest risk factors for why children were experiencing difficulty was exposure stressful life events: so experiencing too much too soon, too much trauma, not enough support, not enough avenues of treatment.

Q. Can I ask you about early intervention. What's meant by early intervention in the context of mental health and why is it important?

A. Early intervention has been around for a long time and it's important for all populations whether it be health or mental health. The idea is that, if you can pick up symptoms and signs early, then you can either prevent before the development of the course of illness or you can prevent complications from arising out of adult presentation.

It's a little bit more difficult in mental health compared to health because there's a lot of other sorts of factors that impact on mental health, particularly in children. So, for example in development, in child development, if development isn't on course, for example the development of language, then that will later impact on mental health. But in mental health specifically, if you've got early signs of something like depression or anxiety in a child, if that's treated early then you're likely to have quicker recovery, less likely to have relapse.

A lot of the early intervention work in mental health has been done in regard to psychosis, and what we know for something like psychosis which can be a very severe and disabling disorder: if you intervene early you prevent relapse and you have a much, much better outcome long term, so it's a very important concept.

I also just add an extra issue here around children. We often emphasise the need for early intervention in childhood which I think is absolutely right. But we haven't actually even developed intervention services, clinical mental health services for children at a level that is sufficient to meet the current need, let alone add additional resourcing for the early intervention space.

Q. For the resources that do exist, what are some of the barriers that prevent Aboriginal children from obtaining effective early intervention?

A. From my experience, and certainly my recent experience having returned to look at some of the clinical services here in Western Australia, there's a real lack of capacity in the mental health system to deal with the level of needs there for children. I know Victoria doesn't have quite the remote communities that WA has, but there's a real lack of even available child mental health services in some of the more rural and remote locations.

The other issue I think in regard to Aboriginal and Torres Strait Islander children, if you consider the historical legacy and the generations of forced removal of children into institutions, one of the biggest fears that Aboriginal families have if they seek help from a mental health service is that their children might be removed. So, there's a lot of trust issues, which are clearly understandable from the historical legacy and the present

levels of removal, that make it really difficult for Aboriginal families to seek help, particularly if it's in regard to a child's behaviour or distress within the family. It makes it very, very tricky and very precarious for that family to seek help.

Q. In terms of diagnosing, you've said that picking up early warning signs can be difficult in children and more so within a cross-cultural context. Can you expand on what you mean by that?
A. I'll just pick up the cross-cultural context first. As I said earlier, behaviour can be different in a different cultural context, and I'll give one example for children.

Children from an average perspective often grow up with a different style of parenting model which was a very, very good model historically. So, children are brought up with more autonomy and more ability to make decisions and be self-reliant. That can present as defiance in a school setting or in another context. Whereas, in a cultural context it may be the child expressing their own degree of independence and autonomy. So, if they're not understood in a cultural context then the approach that child may actually increase a sort of adversarial conversation or outcome as opposed to if it was done within a cultural context where it would be understood and dealt with differently.

Sorry I've just forgotten the first part of the question.

Q. No, that's all right, that really covered it, was the diagnosing and the cultural context that needs to be taken into account. Also in relation --
A. Sorry, if I could just add to the other part, I remember now. Picking up mental health illness difficulties in children is difficult anyway because children are not necessarily forthcoming about their internal world as an adult might be.

So, you have to use different techniques when you're assessing - particularly younger children, and I'm talking about primary school and younger, because they either don't have the verbal skills or the sophistication to understand what's going on. So they are really telling you what's happened by their behaviour and behaviour can be easily

misunderstood, particularly aggression in boys which can be diagnosed as either some sort of oppositional disorder or ADHD when it can actually be part of the trauma if you understood the context and the history of the child and you understood what the behaviour represents. We don't have enough child mental health expertise generally to provide that level of expertise to the general community.

Q. You referred earlier to intergeneration trauma. Can you explain how that can manifest particularly through families? You gave an example of a woman who was pregnant and how the trauma can transcend through the generations.
A. So intergenerational trauma can be transferred via a number of different mechanisms, it can be biological, psychological, social, cultural or spiritual depending on the particular trauma that's being experienced.

Historically for our families, because there was many generations of trauma that was sustained over a long period of time, a lot of people affected. So, when you look at family systems there's the fragmentation of family and the loss of cultural parenting, which then also impacts on the parent-child relationship.

If you look at a biological mechanism for example, a woman who was traumatised during her pregnancy is potentially going to have her infant or foetus bathed in stress hormones, that's going to impact on the development of the infant. The baby may be born with a low birth weight or prematurely, then that means that the child then has not a good start to life. That trauma can also impact on the way that infant and the mother attach, and we know that early attachment is one of the many detractors in terms of how relationships develop over time in the development of resilience and the infant's resiliency, so then that's impacted. So then, you can see that that child is put at risk throughout life, which means that the next generation is then put at risk.

We also know that the impact of high levels of stress in pregnancy don't just have an impact on that foetus but also on the next generation subsequent to that because of the impact on the genetics.

Q. You have put in your statement, "The key of trauma-informed care" and you have said:

"The key of trauma-informed care is to ensure that it is compassionate and can accommodate the needs of the person based on the trauma a person has experienced throughout their life."

Can you just elaborate on how that care needs to be delivered?

A. So trauma-informed care has been around for some time now and the idea behind is that for a lot of people trying to either receive services or get assistance or help, but regardless of what the issue is, they often ended up with an adverse outcome because there was no accommodation or understanding of what they've been through, and so, the trauma-informed care approach was aimed to try and produce better outcomes for everyone within the system by having a much more nuanced understanding of the way people come to services, how they need to be catered for, how they need to be cared for in a way that's compassionate. In a way the difference is between asking, "What's wrong with you", to asking them what has happened and let us understand that and that way we can then work out how we sort out all of these issues.

So compassion is one of the key responses but also having very good understanding and training around what trauma is, how it impacts on a person's life and their behaviour, what's required in order to accommodate that. One of the other hallmarks as well is making sure that when a person comes into care they're not re-traumatised by the system, which is often the case unfortunately through some of our mental health systems and in systems generally. We make things worse for people while we're trying to help them at the same time.

There's one other aspect of trauma-informed care that doesn't always get mentioned either and that is that working in the mental health system can be very difficult for staff, it can be very emotional and very distressing for staff, and so, if we're going to expect the system to be much better at responding in an appropriate way, we also have to make sure we have a really resilient and resourced staff support system as well so that we keep the staff healthy in order to keep a much better system flow.

When they looked at some work in Canada around staff support systems they found that, if they supported staff

better, they actually got better health outcomes.

Q. That's in terms of supporting staff who are able to provide the culturally competent care. Can you comment on the importance of cultural safety training, so ensuring people deliver that kind of training in care in the first place?
A. So, again, cultural competency or cultural safety training is an important issue for everybody in terms of a cross-cultural context, but for Aboriginal and Torres Strait Islander people within the Australian context it's vital because of the historical legacy and the issues around mistrust and what happened to people coming into systems of care.

So cultural safety training is really important because it allows a person to feel safe when they come into a service system, that their identity will not be challenged, their culture will be protected, that they will have a safe passage to services. So, in some respects it's a little bit aligned with trauma-informed care as well, because the idea is to give safe passage and an improved outcome for people coming into the system.

In terms of cultural competencies, we also again need to understand, what are the different ways and different skill sets that we need in order to understand how we best assess and manage and provide treatment or services or healing programs for people of a different cultural context.

As I said earlier, Aboriginal and Torres Strait Islander people can present very differently in terms of how they experience illness or distress or what they see as the right outcome or what they want in terms of a healing treatment. So, you must have those sorts of understandings and educational training around what might be required, what's different in assessment, how do you understand the cultural influences on symptoms and recovery, how do you get a second opinion, for example, from an Elder or a traditional healer or from the Aboriginal community. Sometimes even things like language translation and simple understandings around English can make a huge difference in an assessment interview, so all of those things need to be factored into cultural competency and cultural safety training.

Q. Thank you. You've referred in your statement to the Specialist Aboriginal Mental Health Service in Western Australia: can you briefly outline for us the key elements of that service in terms of delivering culturally safe and competent care?
A. So the service was developed out of an absolute need and recognition that Aboriginal and Torres Strait Islander people are not experiencing the same levels of care and then outcomes as the rest of the population, that they were falling through the cracks, that a lot of the outcomes data was pretty poor, so people were present much later, not engaging with services, getting very poor outcomes.

So, there was a statewide consultation that led to the development of a culturally informed model of care which included a lot more emphasis on Aboriginal staff and also developing the Aboriginal health workforce, the role of traditional healers in mental health care, a cultural model of practice in terms of how to engage and assess people presenting with mental health issues. And also, because mental health issues in one person can affect the whole family or kinship system, it was a much more holistic model derived around looking at the whole family and the complexity of needs of the whole family system rather than just an individualised approach.

So the service has been running now for eight or so years, it has had very good outcomes in terms of improving outcomes generally for Aboriginal and Torres Strait Islander families, but also for improving engagement with mainstream systems. So, the model operates in a few ways: it can manage families within its own system structure, it can provide a cultural bridge or a cultural brokerage model so that people can be assisted in getting those good connections in the mainstream service that may be within their area, and it also provides education and training to upskill the mental health system.

The workforce model that's also aligned with the service provides an opportunity for Aboriginal and Torres Strait Islander people to come into the service, initially at a level of something like a liaison worker or a mental health worker. They get an education throughout that process, they get a university degree at the end of the three year training program, and then they're qualified to work within the mental health system.

One of the issues we've had in terms of cultural safety is not having enough Aboriginal people within the system to provide that cultural safety help and brokerage for the communities.

Q. Just finally, Professor Milroy, based on your experience and the work that you've done, what do you think needs to be done to improve the mental health outcomes of Aboriginal and Torres Strait Islander people?
A. That's a really big question, we could be here all day.

Q. We don't have long, I'm afraid.
A. I think that first of all, we have to understand the historic legacy and I don't think we've understood that in terms of the magnitude of what actually happened and the ongoing impacts today: it wasn't something that just happened a couple of hundred years ago, it's very present in the current populations that we are seeing and particularly in the impact of children today and some of their outcomes, so we haven't done very well, and understanding what was needed to address that historical legacy.

So, instead of just throwing money at the problem or putting in the same programs over and over again, we have to take a step back and have a look at what's actually required for that community. Some communities, they're doing really, really well and they've managed to provide their own healing pathways, which is fantastic, but other communities are really struggling.

And if there's not good community governance and if we haven't strengthened that self-determination, then what are we putting the number of programs into? We're putting them into a void and, of course, you're not going to go get the same response.

So first of all I think we need to step back and have a look at what's actually required, so we need to address the programs, and not just in terms of single purpose programs, but a more holistic approach in understanding community governance, healing programs around grief and loss and healing programs around interpersonal trauma, and those three elements all need to be combined to get a more realistic and robust approach to mental health.

You then need to address all of the other social requirements around disadvantage, racism, discrimination, poor education, unemployment, all of those sorts of issues.

Then we need to have mental health systems that are really robust, that are culturally competent and safe, that people can feel welcome when they come into the service and know that they're going to be well cared for and that they're going to get the appropriate treatments and services that they require based on a cultural awareness and a cultural framework that recognises the importance of those belief systems and the role that us as humans have kept as well for many thousands of years.

Mental health is not just a mental health systems problem, it is everybody's business, and so we need all of those other collaborations with housing, education, employment, child protection, juvenile justice, all of the other issues need to be brought on line as well.

In terms of the mental health system itself, when you look at some of the remote communities, we just don't have enough service provision for the younger age groups. We've had a lot of investment in adult services, a bit less in older adult, quite a lot of recent investment in youth which is fantastic, but we actually know that the origins or the risk factors for most mental health problems will start in childhood and we haven't seen the resources go into early childhood as it should.

MS BATTEN: Thank you very much, Professor Milroy. Chair, are there any questions from the Commissioners for Professor Milroy?

CHAIR: Q. Thank you very much, Professor Milroy, I just have one question, because it was very important you raised the issue of spirituality and the fact that it's not well understood and sometimes can lead to misdiagnosis.

I noted earlier today we had a witness statement from Aunty Nellie and in that she said that she didn't think that the system, the mental health system, did understand Aboriginal spirituality and that we didn't appreciate that it's still very present in today's life and that the presence of spirits and the understanding and how often the mental health system just doesn't appreciate that and might mean that's indicative of poor mental health.

In terms of how you think we go about raising awareness in terms of all of the dimensions around cultural safety, how important do you think that element of spirituality is?

A. I think it's absolutely vital. It's really spirituality and the cultural aspects of Aboriginal and Torres Strait Islander communities, because the focus obviously needs - because it's part of a whole belief system and the way you're experiencing the world.

I remember one Elder said to me once, that if he really told the GP what he actually experienced in terms of his spirituality, they'd probably lock him up. So, I think that there is this fear that if you also disclose to a mental health practitioner what you experience, then it will be misunderstood and mislabelled, so people don't talk about it. They don't talk about, you know, talking to their deceased relatives or the experiences that they have in regard to healing or traditional healing.

We've had more acceptance, I think, in recent years of traditional healing models, but not quite enough yet, and yet, when you actually talk to community members, they've often gone and had their traditional treatments anyway without any knowledge of the mental health system. So, it's happening any way, we should embrace it and incorporate it into a collaborative model rather than seeing this us and them sort of divide that we have currently.

So we've made great strides, I think, in regards to some aspects of training and education but probably not enough emphasis on some of those more spiritual and cultural sides of education and training. We could go a lot further I think.

We also need to try and increase the Aboriginal and Torres Strait Islander workforce, that they bring that culture naturally into systems. Always training from the outside doesn't always have the same impact as people who are also in the system that can develop and enhance some of those skills within the system itself. They're absolutely vital.

Q. The other point that you made which I think is very important about the future Aboriginal workforce in mental

health is, it can be very stressful. I think we heard earlier today about how many Aboriginal people will feel they have an obligation to just not only their own family and its wellbeing but to the broader community and that translates for people in their professional lives as well.

How do you think we are best to support Aboriginal workers who are involved in mental health so they're not overwhelmed by that sense of obligation

A. I think that's right because, remember, a lot of our Aboriginal workers also have issues of trauma within their own family systems, so they're carrying their own burden as well as the burden in the families and the communities that they're working with, so it's doubly difficult I think for some of our workers.

I've also observed and tried to assist where sometimes, if it's an Aboriginal system of care, which may be fantastic, if they're not getting supervised or buffered and supported by external agencies, they can implode because the levels of distress and the levels of re-traumatisation that occur can just keep going round and round in circles, and so, there's not enough external support. And I wonder whether we need to look at the system very differently and not have such isolated service systems working but a much more well-buffered system that can be then supervised and supported by other agencies that help those frontline workers.

If you're the frontline worker and it's not an Aboriginal agency, the trauma just gets recirculated and it becomes more traumatising for the workers as well. I also think we are unfairly burdening some of our frontline workers, who are working in remote communities where they are probably seeing some of the most complex and complicated mental health problems with the least amount of expertise, training and support, and I think that's just a fundamentally unfair system and it's not right to place a worker in that position.

The other issue of course that you also need to be aware of is, for some Aboriginal workers in communities, they may well be at risk themselves if something goes wrong, because they're seen as providing the treatment and, if something goes wrong, they may be held responsible by the community. So, if that's not well understood and that worker's not well supported, they may just have to leave.

So, I think we have some complexities around confidentiality and outcomes and responsibility for our frontline workers as well.

CHAIR: Thank you.

MS BATTEN: Thank you very much, Chair. May Professor Milroy please be excused?

CHAIR: Yes, thank you very much, Professor Milroy, for making the effort to be involved with us from Western Australia and for your very comprehensive witness statement and evidence today, thank you.

<**THE WITNESS WITHDREW**

MS BATTEN: Chair, I understand a restricted publication order has been made in relation to the next witness.

CHAIR: Pursuant to the Inquiries Act 2014 the Royal Commission has made an order in relation to the next witness, Tamara Lovett. That order prohibits the publication of the name or the identity of the mother or any brother of Tamara Lovett if she mentions them in her oral evidence to the Royal Commission today.

A copy of the order has been placed next to the door of this hearing room.

MS BATTEN: Chair, may we just wait for one minute. Thank you. Thank you. The next witness is Tamara Lovett. I call Tamara.

<**TAMARA LOVETT, affirmed and examined:** **[2.23pm]**

MS BATTEN: Q. Thanks, Tamara. Do you want to adjust the microphone so it's at a good level for you? Great, thank you. Have you, with the assistance of the Royal Commission's lawyers, prepared a witness statement for the Royal Commission?
A. Yes, I have.

Q. I tender that statement. [WIT.0001.0050.0001]

THE CHAIR: Thank you.

MS BATTEN: Q. Tamara, you're a Gunai and a Gunditjmara

woman. Is that right?
A. Yep.

Q. And you were raised in Melbourne?
A. Yep.

Q. You've been living with mental illness since you were a young girl?
A. Yes.

Q. You've said in your statement that making your statement is part of your mental health journey.
A. Yep.

Q. Can you please tell the Commission your story?
A. Alright. I'm a little bit nervous, so sorry.

Q. It's okay.
A. Okay. So, my - actually, first I'd like to acknowledge the traditional owners of the land on which we meet today, and I just wanted to say that I don't speak for everybody, this is just my personal journey.

It sort of starts with my grandfather being a member of the Stolen Generation as well as my mother, and it sort of stems back from my mother suffering from post-traumatic stress, anxiety and depression from abuse within the system. This sort of led me from a young age to experience mental illness quite strongly, dealing with my mother's panic attacks, and stress, and the way she would - how do I explain that? - I guess, how she wouldn't manage at times.

So, I was sort of in a position where I had to step up at a young age, and at that point I had realised that I had something different going on in my head and wasn't really sure how to explain it, also didn't really have the space to talk about it, dealing with my mum's stuff.

At a young age I was also in a position where I was responsible for three of my younger brothers due to, I suppose, mum being emotionally unavailable at the time. I guess this is just putting a little bit into context of where I've come from, the traumas that I've experienced leading into until now.

From a young age, I witnessed trauma from a very, very young age, in terms of witnessing family violence,

witnessing physical violence [redacted]. Have lived through physical violence of my own, lived through sexual abuse of my own.

Q. You're doing really well, Tamara.
A. And, most of the time dealing with these issues, it wasn't an option to ask for help due to, when you - sorry. Most of my grandfather's children were removed and it wasn't an option to ask for help from the fear of the department coming in and removing children.

Sorry, I didn't think this would be this difficult.

Q. Take your time, you're doing really well.
A. All up, through my younger years, before I could understand what was going on, my mother fought nine court cases to keep her children, to keep us together, due to her not being able to - in the words of the department - adequately care for her children. She didn't have the parenting capabilities, she was never taught those growing up in the system. She had never had those role models to show her what real emotional support or parenting looked like.

This stemmed to a fear of me asking for help for a long time. It wasn't until later in high school that, or even after I finished high school and I was pregnant with my first child, that I decided that I would try and break the cycle, that I would try and put - actually it was before my pregnancy - I decided I'd had enough, I needed some support, I needed someone to talk to to get a lot of the things I'd seen and things I'd experienced off my shoulders.

And so, I saw a GP, and that GP I saw until I was pregnant with my first child. She had a very good understanding of me and the things that I would experience in my head with my mental health.

Throughout my pregnancy I avoided the closest hospital to me through family fear of child removal from mental health issues. I was also warned off of the hospital that I chose for the same reason, because there was fears around mental health assessments being done and being reported.

I chose to stick with my doctor at the point of my first pregnancy, but I did ask for a psychologist or a

psychiatric referral because I knew at that point, when I am dealing with a lot of stress, I tend to not sleep; I experience psychosis, is what they were telling me - you know, my doctor was sort of saying or the previous people who I'd spoken to.

And so, we made a plan to do shared care which is where, through my pregnancy I would go to the hospital for the important appointments, but then I would see my GP for every other appointment. It was just a little bit more of a comfortable process that I was happy with.

I remember my referral going through to the hospital, and my GP at the time had said that the psychiatrist was away, but when she came back she would get in contact with me to make an appointment. Before that psychiatrist came back from leave, another lady that wasn't part of my care picked up my referral, read it, and decided that I needed, without permission from anybody to do with my treating team or my care team, whatever you wanna call it, decided that I needed a CAT Team referral, and so, without my permission and without my knowledge I received a call from the CAT Team asking me to come in for an appointment, and I've never heard a great thing about the CAT Team, so was already kind of stressed out. I was - I can't remember - maybe halfway through my pregnancy.

I went in, sat down, and was just, like, smashed with questions on what my experiences were, what the voices were that I was hearing, what the hallucinations were that I was having, what was going on for me and why wasn't I taking medication, and I should be taking medication regardless of the fact that I had said that medication wasn't what I wanted to do, regardless of the fact that my GP had written a full support letter outlining how I self-managed my mental illness, how I didn't need medication, I was just needing support should I feel stressed out at any point throughout my pregnancy. It was more proactive care than it was because I was needing it at the time.

I remember leaving from that appointment quite stressed out, quite angry, and saying, "I don't wanna be here any more", and I walked out, and I felt like the worst I had ever felt. I felt like I wasn't listened to, I felt uncomfortable, I felt forced into treatment options that I didn't even want.

And then, within a week or two I think - I don't remember how I read it, but I either received a letter or I was back - oh sorry, I should say that the hospital at that time had decided to suspend my shared care. They said that I wasn't eligible because of my mental illness, so that I was only allowed to see the hospital for care, which I didn't agree to.

I went back to my GP and I said, "This is too much. I can't - like, I don't want to just go through the hospital, I want to stay with you", and then after I received a letter, or she received a letter saying that I was non-compliant, and it was a very negative letter about me and about how I wasn't open to treatment, and I was very frustrated because it, (a) wasn't the plan that I had in place for my care, it wasn't the plan that my GP had in place.

They disregarded all of my experience, they disregarded all of my GP's support letters, and I was very - at that point I wanted to run away and be like, I don't want to deal with the hospital any more, I don't want to deal with - like, I don't wanna go there. I was nervous, I was scared, and that's not how people should feel when they're pregnant and just needing a little bit of extra help.

After my first child was born, I continued with the same GP that I had for a while. I ended up stopping seeing that GP out of living too far away, and I think it was about 18 months after my first son was born - no, it would have been a little bit longer than that - I received from a family member who worked in a facility - a childcare centre - came to me and told me that there had been a welfare check done on my son, after I had taken him to hospital for an illness, due to my mental health: no prompting, like, no real reason as to why there should have been a notification put in from the hospital. Nobody had contacted me.

At this point I decided I didn't care, I decided to continue trying to seek help wherever I needed it because, at least if I was seeking help when those notifications, if they go in, or if things like that happen, they've got no - no-one's got a leg to stand on because I'm doing all the right things.

But that is a stressful way to live: knowing that you constantly have to have your crap together just to avoid somebody putting in a notification against you because you may be feeling a bit stressed out and reaching out for help or because you have a day where you're not managing. Fearing that, if you even show one little bit of emotion or struggle, that you're constantly being watched, or like, people are constantly waiting for you to mess it up.

This led me, I guess, to a long time of, I access services, either I get support and I can't tell the full story, and I can't talk about when I'm struggling too much, I go into very surface details, on the surfaces. I instantly get defensive when anyone tries to dig any deeper, because I fear that my children, or at that time my child, would be taken away from me.

After my second pregnancy a year ago, I had another son, I went for my first or second appointment with the maternal child health nurse, and I did a postnatal depression scale, and I rated "severe" on that scale. I was sent home with no support.

A couple of weeks later I had another maternal child health nurse come out on outreach, and she spoke to me about postnatal depression. I told her about the first maternal child health nurse scale that I had done. She offered to put in a referral for me to speak to somebody about postnatal depression. Six months later, still no help or support, and I never saw that lady again.

I had another support worker who tried to follow up, with no response. And then the last response that was given was that, that service wasn't adequate, it wasn't the right service and they didn't accept my referral, and that was the end of that.

It's taken me over 12 months to find another counsellor to talk to them about the postnatal depression. It took for me to be at crisis point. I contacted my support worker, I sent her a text and said I wasn't coping, I needed to get some immediate support or, if she could please just text me a phone number of somebody I could call - this was a Friday afternoon, so I was understanding that, you know, services finish at 5, it's the weekend, there's not really a lot people could do, so just a phone number for someone I could talk to. I didn't receive a

response to that.

I called two numbers that I found online for - let's just call them depression services. The first one I called answered but the response was fairly cold, which is like, "What can we do for you today?" And I hung up because I was, like, kind of needed some more compassion, needed somebody to - it wasn't just a normal phone call. It wasn't just like a catch-up, hey, how are you? I was really struggling.

The second number I called, I was on hold for 20 minutes, then nobody answered. And at this point I had to pick up my youngest son from childcare, so I basically just had to tell myself to suck it up, go in and pick him up and just try again on Monday.

Q. Tamara, do you want to tell the Commissioners about some of the problems that you see with the mental health system?

A. Some of the issues or some of the problems I find is that people are too quick to just want to give you a diagnosis. They don't want to hear, or they don't take the time to hear the story, like where you've come from, if there's any trauma that you've experienced in your life that could potentially - it's not: you don't just sort of wake up one day and say, yep, okay, I've got all this stuff going on.

Generally for me it's been a build-up, so to get to the bottom of that would give them a very good idea of why my mind works the way that it does, why it defends itself the way that it does, why I sort of do the - sort of, why I'm very shut off, why I don't go into depth on things or why I get frustrated. As soon as I sit down, I'm angry because I know that they're going to ask me the same questions, or I'm going to have to traumatise myself. If I've come from a doctor with a support letter, they will want to ask the same questions that are already there.

I feel there is not enough Aboriginal people within services; generally that's somebody who I would look for, because I feel like I don't have to explain myself.

I feel like, when there are really great services that are really supportive and do really great work, they struggle for funding. They either have to re-apply yearly

or they may not get re-funded again because there may be a pilot program, and that leaves a lot of people who have accessed that service with either nothing or with uncertainty, and it doesn't allow you to build up enough trust with somebody to really start to work on that healing to start moving forward, or to start to trust a service, or a worker, or anything like that.

Q. Thank you so much, Tamara. Is there anything that we haven't covered that you want to say? I think you've done very, very well.
A. No, that's it.

MS BATTEN: Thank you. Chair, are there any further questions from the Commissioners?

CHAIR: Q. No, I'd just like to very much acknowledge you and thank you very much for coming, Tamara, today and sharing your reflections with us. I do note in your witness statement that you've worked a lot in the mental health sector and had some very useful suggestions also that you've made in your witness statement about how to improve things. But we very much appreciate you being so brave and coming in to share with us today. Thank you very much.

MS BATTEN: Thank you, Chair. May Tamara please be excused?

CHAIR: Yes.

MS BATTEN: And we just need to have a short break to arrange the next video conference, for 10 minutes, please, Chair.

SHORT ADJOURNMENT

MS NICHOLS: Commissioners, the next witness is Dr Graham Gee and he'll be joining us via video link from Norway.

Dr Gee, can you hear me?

DR GEE: Yeah.

MS NICHOLS: Thank you for joining us.

<**GRAHAM JOHN GEE, affirmed and examined:** **[3.01pm]**

MS NICHOLS: Q. Dr Gee, with the assistance of the Royal Commission, have you prepared a witness statement which sets out your opinion on the questions we have asked you?
A. I have.

Q. I tender the statement. [WIT.0001.0045.0001] Just a few questions about your professional background, if I may. Are you a clinical psychologist and researcher with over a decade's experience working in the Aboriginal Community Controlled Health sector?
A. Yes.

Q. What's been your area of work in clinical practice?
A. I worked at the Victorian Aboriginal Health Service for just a little over 10 years and have worked primarily with adult help-seeking community members and their families within the area of social, emotional wellbeing and mental health. I was a senior psychologist there and clinical coordinator last year, so I worked in a range of areas: cultural, issues and cultural support for Stolen Generation members and people working with cultural connection, as well as high prevalence mental health issues, such as depression and anxiety, as well as more severe end work around things like psychoses.

Q. Are you a Senior Research Fellow of the Murdoch Children's Research Institute?
A. Yes. Currently I've got a four-year national Research Fellowship to continue doing work with Aboriginal mental health and social and emotional wellbeing at the Murdoch Research Children's Institute.

Q. Dr Gee, can I ask you about the concept of social and emotional wellbeing, we've heard quite a lot about that today. Could you explain to us how it is that that concept links the health of individuals and families to the health and wellbeing of whole community?
A. Yes, certainly. Before I do start I just want to pay my respects to the traditional owners of the land on which the hearing is, the Wurundjeri people and their Elders past and present and emerging, and also pay my respects to the Kulin Nations and the Victorian Aboriginal community.

Social and emotional wellbeing, as is used for the Aboriginal and Torres Strait Islander people in Australia, and I'll respectfully use the term "Aboriginal" throughout

this testimony to refer to the diversity of Aboriginal and Torres Strait Islander people and cultures in Australia.

We've used that term for going on three decades now, and it really refers to a more holistic view of health than the conventional understandings of mental health. It includes mental wellbeing and mental health disorders, but importantly it's also much more than just physical, emotional and wellbeing. So, social and emotional wellbeing also refers to the wellbeing of families and communities, and it also recognises that mental health is shaped by connections to culture, to land, to kinship and ancestors and spirituality.

In recent years, as we've explored that concept more in our cultures we've also recognised that social and emotional wellbeing also extends to more than just connections to social determinants which we know are really important, things such as education and employment, as they are connected to mental health. But in this social and emotional wellbeing context we also recognise the importance of historical and political and cultural determinants and how these cultural factors shape the presentation and meaning of distress and how mental health symptoms are understood for actual clients in lots of different ways.

Just as two examples, historical determinants refers to the impact of past government policies that's been experienced by whole cultural groups or communities, in terms of the impact on the community, or conversely the way in which communities have resisted the impacts of colonisation and maintained their cultural continuity.

Political determinants is about sovereignty and unresolved issues of land rights and uncontrolled resources and self-determination, and again, historical and political determinants as it impacts mental health within an Aboriginal context, they're not abstract - they literally shape the environment and circumstances in which Aboriginal children are born into: they influence the type of coping skills and knowledge or resources that children and families can draw upon, including the community and the relationship networks that are so important for recovery in mental health.

Q. We've asked you to consider the key risk factors that

may detrimentally impact upon the social and emotional wellbeing of Aboriginal and Torres Strait Islander people, and you've made the observation in your witness statement that there's a very significant gap in research on this question. Can you say something about that and why there's such a significant gap in the research?
A. Well, research historically has not been done well at all in Aboriginal communities; it's been done pretty poorly, but we are making headway into changing that, and the way to change that is to have Aboriginal communities themselves co-design and drive the research and design the research, but the reality is that it has been done poorly in the past and there hasn't been enough good research done.

So, that's part of the reasons why there's a big gap in research, and I really think it's really just in recent years that we're really starting to see well designed research that comes from Aboriginal organisations themselves, basically.

Q. Thank you. That said, what do we learn from recent Aboriginal and Torres Strait Islander national health surveys published by the Australian Bureau of Statistics about factors contributing to poorer social and emotional wellbeing outcomes?
A. In the past at least three national surveys, we're starting to get a good picture of a range of risk and protective factors for social and emotional wellbeing more broadly.

I just want to say one caveat which is that, our challenge now is to really - risk and protective factors are always relative to the type of outcome that we're looking for, so we do need to map some of these protective factors and risk factors to specific mental health issues and what have you, but broadly we're starting to see some really consistent evidence across, yeah, as I said, the last three national surveys.

The first thing is that we know that Aboriginal people report higher psychological distress, so across the country Aboriginal people are nearly three times more likely to report high to very high psychological distress in comparison to other Australians, and we know that this is a predictor of suicide and mental health difficulties. It's not the only one, but it's certainly a key predictor and

it's probably our best indicator of levels of distress in the communities. We also know that - excuse me?

Q. Sorry, I interrupted you. I was just going to ask you about the rates in Victoria, and have Aboriginal Victorians reported the highest rates of emotional distress, or sorry, psychological distress in comparison with populations in other parts of Australia?
A. Yep, that is correct. In 2012 and 2013, Aboriginal Victorians reported the highest rate of distress at 32 per cent in comparison to other Aboriginal people in other jurisdictions, yeah.

Q. Sorry, you continue.
A. Just a couple of other factors that are really important, is that, the Aboriginal people who report being removed as children from their natural families also report higher levels of psychological distress than Aboriginal people who were not removed from their families. So, this is a really important factor to consider because it's also associated with higher psychological distress, and again, Aboriginal Victorians actually report the highest rates of removal from family. I think it was something like 12 per cent in comparison to other Aboriginal Australians, where the national rate is something like 10 per cent.

So, the effects of removal are absolutely critical to consider.

The other thing that we should factor in is the rate of children in out-of-home care across Victoria for Aboriginal children has absolutely reached crisis proportions in my opinion. Between 2010 and 2015, Aboriginal children in out-of-home care was approximately 12 times the rate of non-Aboriginal children, and Aboriginal children in out-of-home care in Victoria, again, was higher than other jurisdictions in Australia.

So, I really can't stress enough for the Royal Commission that, if recommendations are going be to implemented to reform the mental health system, we need to have focused efforts on reducing the rates of out-of-home care and supporting Aboriginal children in out-of-home care in the child protection system.

Q. What about the exposure of Aboriginal Victorians to social inequality?

A. So, like other Aboriginal Australians, Aboriginal Victorians report inequalities across most social determinants in comparison to other Australians and other non-Aboriginal Victorians. We've got clear evidence that those social determinants, like lower employment and education and what have you, are associated with higher rates of psychological distress and other mental health problems in Victoria, and that's really consistent internationally with the understanding that poverty and lack of access to education and what have you is associated with higher rates of mental health difficulties.

Q. And what's the - no, you go ahead.
A. Yeah?

Q. You go ahead.
A. I think that's one of the biggest challenges that we face from clinicians and the service point of view, is this combination of inequalities and social determinants such as housing and employment and education. When you combine that with the other factors that I've been speaking about, like high rates of childhood removal and children in out-of-home care, incarceration rates and what have you, and the damage to the cultural continuity for some communities in terms of loss of language and dispossession of land: basically, these are multiple co-occurring risk factors that are legacies of colonisation. The people that we're generally seeing in our community health services are those who experience co-occurring risk factors, not just one but accumulation of all of these. They are the families and adults and children that present to our services with really serious mental health difficulties and are experiencing multiple crises, and it's near impossible to address mental health difficulties unless there's coordinated efforts to deal with all of the other things that they're experiencing.

I think that's one of the biggest challenges that the Commission needs to think really carefully about, is that in some instances we're not even reaching those most in need because they're so unwell sometimes with so many layers of adversity that they're actually unable to get the right services.

So the real challenge is thinking about what kind of resources and what kind of more coordinated or integrated mental health system is going to reach those who are most

vulnerable in the community.

Q. And thinking about the factors that may protect social and emotional wellbeing, what are those factors that are unique to Aboriginal and Torres Strait Islander communities?
A. I'll just start, but before I talk about those that are really specific and important for our community, I just want to say that, there's also a whole bunch of common resilience and protective factors that are similar for populations worldwide which we should also be considering. So things like self-worth or self-esteem, supporting people and families to have a sense of control over their lives, participation in sport and family cohesion, social support, they're all really, really important protective factors, you know, regardless of what culture you come from.

We've also got three decades though now of research in Victoria and across Australia which also shows some cultural factors that we're consistently seeing associated with high social and emotional wellbeing.

Essentially, if I kind of summarise them, we're seeing that there are protective effects for connection to country, engagement in cultural practices, connection to Elders, connection to community, having a knowledge of history we've found is important for adolescents, Aboriginal adolescents. Increasingly we're calling these cultural determinants of health and actually we're seeing that these types of factors are really, really important.

So, those national health surveys that you mentioned are our biggest studies or surveys that are involving 7,000 to 10,000 Aboriginal people from around the country, and what we've found is that stronger levels of cultural connection naturally associated with higher wellbeing, self-reported wellbeing; it's associated with higher socioeconomic status, it's associated with higher rates of employment, lower rates of drug and alcohol use and what have you. So, connection to culture is incredibly important.

Q. Have you also found that community-designed healthy lifestyle programs are very helpful?
A. Yeah, absolutely. I'm increasingly, over the years I'm becoming more and more convinced that, after working in the counsel rooms for so many years, the last five years my

big learning lesson as a clinician has been how important community programs are in terms of building some of the cultural and community factors that we're talking about.

We've run programs where we've found that, despite bringing community together in programs that may focus on healthy lifestyles, physical activity, chronic disease that don't even necessarily have a mental health focus per se, we're finding that levels of safety, having a safe place to heal and these types of things, connection to the community, a sense of connection, those things are being strengthened, and we've also found reductions in psychological distress in these programs, while not even necessarily having a specific mental health component.

So, these cultural or these community programs build kind of social and cultural community networks that essentially I think provide the means for recovery. We need individual and family counselling as well - don't get me wrong, but more and more I'm seeing the power of these programs.

Q. Can I turn to the question of intergenerational issues. Do poor social and emotional wellbeing outcomes and mental illness outcomes cause you to reflect on the role of collective trauma?
A. Absolutely. Again, within the context of the legacies of colonisation it's really important to recognise that we've got to look beyond, not only personal traumatic experiences, but collective trauma refers to trauma that has far wider reaching impacts than just individual experiences.

So, it talks about the ripple effect through communities where there's a breakdown of social norms and cultural practices, and the collective knowledge and values of entire communities is threatened and it's fragmented as a result of, generally speaking, structural violence such as colonisation, and we see this in vulnerable groups across the world that have been structurally impacted by violence.

Intergenerational trauma on the other hand refers to the effects of traumatic experiences being transmitted to subsequent generations from nana and pop, down to mum and dad, down to children.

Q. What happens when you layer the effects of cultural trauma, intergenerational trauma and particular environmental factors specific to the individual?
A. So, in my clinical or therapeutic experience working as a clinician at VAHS, essentially it's when people and families experience all of those types of layers of risk factors that we've been speaking about: essentially that creates a really, you know, toxic combination of risk factors that creates environments where re-traumatisation among the younger generations is much more likely.

So, you know, risk factors like being members of the Stolen Generation, intergeneration cultural loss, disposition of lands, loss of language, ceremony and other practices. When you combine that with intergenerational poverty or social disadvantage, and you throw in drug and alcohol misuse, especially ice at this time, you know, and family violence or neglect, all of this creates a recipe or contributes to re-traumatisation. As well as experiences of racism which we know from our national surveys is, unfortunately, alive and well in this country.

So, all of those things create really, really difficult environments for our younger people and, unfortunately, we see the absolutely unacceptable suicide rates among our younger generations and, when you have all of those layers of adversity, the young people just don't see a future for themselves, in my opinion. They don't see themselves represented in the future.

So, that's what intergenerational trauma looks like in our social and emotional wellbeing mental health services. I just want to be clear that resilience is an important part of the picture, and I'm not suggesting that all Aboriginal Victorians are victims of trauma: rather, that a proportion of the community is at higher risk because of those intergenerational legacies that I've mentioned, and those are the families that we're most likely to be seeing in our services.

Q. Is there a concept of "intergenerational resilience"?
A. Absolutely, and I mean, the Koori people of Victoria are testimony really to resilience and intergenerational resilience. Given the impacts of colonisation and how brutal it was in the southern parts of Australia, intergenerational resilience is absolutely critical. And not surprisingly, as I mentioned in the health survey

stuff, we're finding that protective factors are the cultural strengths that were the very things that were fragmented because of colonisation, but families that have managed to sustain those connections, we're seeing nationally that that's associated with better outcomes in terms of less drug and alcohol use and what have you.

So it's really a combination of cultural, family and personal factors that contribute to intergenerational resilience in my opinion, as well as political factors like restoration of land and what have you.

Q. Do you think that in the mental health arena enough emphasis is placed on putting resources into building cultural connections?
A. Not at all, no. We need much more, much, much more. Cultural determinants of health really haven't been recognised well enough at all in the mental health space in Australia and probably a lot of other countries. I think that the mainstream mental health system is really catching up in terms of that, but the thing is, we're starting to get good evidence now, especially those national health surveys. There's got to be a much greater emphasis on resourcing communities to rebuild the cultural and community networks.

You know, they really are - when you get that holding space from those kind of programs, that creates environments and stability where recovery is possible.

Q. What do you say about the necessity of assertive outreach, particularly to those who have moderate and severe mental health issues?
A. I think that that's, and I've said this in my statement, that besides things like cultural diversity, I think that assertive outreach is something that's been missing from the picture, there hasn't been enough of it.

I've mentioned already that those who are most vulnerable and experiencing severe mental health and social and emotional wellbeing issues, often they're too unwell to actually make it into our services. We're actually missing the most unwell parts of the community.

Assertive outreach to my mind has been the best model of practice so far that I've seen that supports the most vulnerable people in community. There's just not enough of

it.

Wadamba Wilam is a really great example of a service that's doing that, but they've only got limited resources. So we need assertive outreach, combined with some of these community programs that I mentioned - this is my way of thinking - to actually get out in communities and engage with those families that we're not engaging at the moment due to a lack of outreach services.

Q. Are there any features about assertive outreach that you'd like to raise? We have heard from Wadamba Wilam earlier this afternoon and that's, as you've said, an extremely good example of assertive outreach, but what are the features that you think the Commission should be mindful of?

A. Look, to be honest, I'm probably not the most qualified to talk about assertive outreach because most of my work's primarily been done in community programs and in the counsel rooms. I suspect Wadamba Wilam's probably named some of those things.

What I would say, having worked with Wadamba Wilam, is that one of the most important factors is that they are seeing vulnerable clients over the long-term. So, you know, this is the thing about the assertive outreach, is that the 10 session mental health model just does not fit a family or an individual who is suffering from really the severe end or moderate mental health difficulties.

So, what assertive outreach when it's done well, which I think Wadamba Wilam does well, is they engage with a client over a number of years. They may go through phases of support and recovery and cycles, it's not a linear process. You can't work with a family who's vulnerable like that without having a long-term engagement with the families over a number of years: that's really, really important; I think that that's what a successful outreach model looks like. It has someone helping that family navigate the mental health system over a number of years as they get stable, because the reality is that really significant and more severe end mental health difficulties and adversity takes years to overcome: it's just not a short-term, 10 session solution, and we need staff, a skilled workforce, who can work with families over a longer period and that's what for me makes it such a good model.

Q. Dr Gee, we've asked you to think about examples of best practice in Aboriginal mental health in Victoria and elsewhere, and I think your response in your statement is that the evidence base for that is very thin. Having made that observation, are there some examples of best practice, apart from the one we've just discussed, that you think the Commission should be particularly mindful of?
A. Yeah, I think we're building an evidence base, but it is slow, but for a start I think the Commission would be really well placed to look at the kind of programs and evaluations that are happening with the National Aboriginal and Torres Strait Islander Healing Foundation, as well as the Canadian First Nations Healing Foundation. I was involved in helping to establish our National Healing Foundation and we really took the lead from the Canadian First Nations research.

Essentially, both our foundation and theirs have found three common elements to many of our Hidden programs. Many programs focus on reclaiming culture and history, on strengthening culture and also providing family and individual counselling. So, this mix of looking at history and strengthening culture, combined with therapeutic services are common elements to many programs.

We've got a limited evidence base here in Victoria, primarily because there's such little money gone into community-driven research and evaluations. I know at the moment VAHS is working with three other ACCHOs and the DHHS on what we call a demonstration site, where we're trying to map exactly what's working across different services which I think is really important.

Nationally, there's successful programs, examples are the Marumali training by Aunty Lorraine Peeters who's a member of the Stolen Generation and she has a great model of healing with how to work with the Stolen Generation members.

The We al-li program by Professor Judy Atkinson. Professor Pat Dudgeon's suicide prevention work is also really important examples.

In terms of Victoria, we've spoken about Wadamba as - that's probably the best non-Aboriginal service model that I've seen personally. Alan Thorpe's Dardi Munwurrow1, a family violence program run for men, I think is another

really good example of a local program. I've already kind of mentioned the healthy lifestyle programs, which in this case I'm thinking about Laura Thompson, a Gunditjmara woman at Spark Health, and she also worked at VAHS. They're also running these types of programs that I've already spoken about that have shown reductions in distress, in building cultural determinants of health, you know, in relatively short programs.

Q. Thank you, Dr Gee. How do you think Victoria can do better identifying and assisting those Aboriginal and Torres Strait Islander people who are at risk of developing trauma-related mental illnesses who are not currently in contact with service providers?
A. Yeah, I'm not gonna lie, that's a complex area when you say "better identification". I'm involved in a national project that we're trying to understand how to better support families with histories of complex trauma and what we're learning is, it's a very sensitive area, this idea of how you safely identify or work with families to support and to identify whether they have been impacted by trauma.

Safety is the number one word that I would say where we're working with parents and families to look at what's the most safe way to speak to people within services. Our learning so far is that we actually have to work with the services on the ground, like, maternal services and perinatal services. We actually have to work with each local service to co-design safe approaches to talking about complex trauma.

There's a lot of worry or fear from parents that speaking about complex trauma will lead to child notifications or child protection issues. So, they're identifying the first thing is that we've got to work with organisations to co-design safe ways and safe recognition and assessment processes.

Q. Can I just ask you to elaborate on that aspect of safety, with that particular fear about children being removed?
A. So, it may be that there's less focus on, in the identification, trying to identify complex trauma. What we're finding is that it's better to talk, to hopefully create an education component where we can talk about the impacts of trauma rather than speaking to families about,

you know, how much trauma they've been exposed to, which is just generally speaking in a service, unless there's so much trust already established, that's not necessarily a safe approach to talking about trauma.

So, it's more to speak about the impacts of trauma in an education focus so that parents, for example, can think about complex trauma rather than, you know, telling their story, for example, which is what we don't want.

But we do want to talk about and find ways to talk about depression and complex trauma or post-traumatic stress disorder with parents in case some of those experiences will - they'll recognise those things basically.

Q. One of the things you draw attention to in your witness statement is that there are no Aboriginal designed services to deal with childhood sexual abuse. Why do you say this is particularly important?
A. Well, I say that because, out of all the types of interpersonal trauma that someone can experience - and I looked at some of this in my PhD - we know that experiences of childhood sexual abuse is a huge key driver of long-term mental health and social and emotional difficulties irrespective of what culture you come from. It's huge and there's just unacceptable rates of childhood sexual abuse, for adults and children, and we don't have any Aboriginal-specific services to work in this area.

I just think it's such a key driver, not the only one of course, but it's such a huge factor implicated in long-term mental health difficulties that it's time that we get a community-led process where we can design safe healing spaces for people who have experienced childhood sexual abuse. But there are no Aboriginal-specific services yet.

Q. More generally speaking, do we need a much greater focus on early childhood?
A. In terms of building resilience, I think that, especially after 10 years of working with adults, I'm definitely convinced that we need to focus much more on early childhood and adolescent resilience programs.

We know that Aboriginal children aged 10-14 years are eight times more likely to commit suicide than

non-indigenous children, and the solutions lie earlier: we need prevention and early intervention programs and mental health promotion and building resilience coping skills and cultural strengthening.

We need to start earlier at Aboriginal daycare centres, for example, like Wadamba Wilam in the northern suburbs. We have to start working with our young ones in building that resilience early, in my opinion.

Q. Can I ask you about your views about the most significant impediments to being able to intervene in mental illness amongst Aboriginal communities in Victoria?
A. I think one of the biggest impediments, and the reality is that this goes for everyone in Victoria really, is that the current mental health system is fragmented. It's really difficult for families and adults and children, it's really difficult to understand how to navigate the system as it is, because it's so siloed and fragmented.

Even for clinicians and practitioners, it's just, there's so much disconnect between services. So, I think the first thing we have to do is think about an integrated care and better coordination across primary, secondary and tertiary services.

Better links between ACCHOs that work with families across a life-span, so the Victorian Aboriginal Health Service and VACCHO, for example. There needs to be better communication with hospitals, Emergency Departments and psychiatric units.

I think we actually need funding for a dedicated workforce that assists families to navigate these transitions between services, because at the moment I don't feel like the client pathways, they're getting this continuous pathway, it's services are not connected and we need to connect them up and we need resources and people to do that so that families can be supported to navigate the mental health system.

Another thing we've got to do is work on improving the quality of care within our current services. I think we need workforce training for staff. As organisations we've got to look at trauma-informed care, for example. What else?

Q. One of the things --
A. We need --

Q. No, you go ahead.
A. We don't have enough Aboriginal design tools to support our workers on the ground, and that's something that, you know, there's a huge need for real world translatable research where community services that are actually co-designing tools around, you know, depression and posttraumatic stress disorder and what have you, that are co-designed by Aboriginal people and clients themselves and staff, because there's just not enough of them. We've got some, but we need to have more of that.

Q. What's an example of a co-designed tool, for example, to deal with depression?
A. Well, what I mean by co-design is, basically, you work with community members on the ground to explore a concept like depression, or resilience, or post-traumatic stress disorder, and you work with the community on the ground so that is, people who may have lived experience of depression for example, and you work with staff, Aboriginal staff who work with clients and who are familiar and work everyday with depression or anxiety for example, and you explore those concepts and you build questions or assessment tools based on cultural understandings of those concepts.

And so, you build it from the ground up rather than, you know, primarily for most of the time we're having to rely on measures that haven't had Aboriginal involvement in exploring concepts of distress and resilience. So, you work with community at the local level to design those tools and then you test them in community to see where they're effective in predicting changes in levels of depression and what have you.

You know, we're already doing that in some respects. There's a resilience measure that VAHS and myself, for example, have developed that work with Aboriginal staff on what they see as resilience: it includes cultural resilience and we're testing that at Wadamba Wilam and at our services, and we've found that in those programs I spoke about there are increases in resilience, for example.

So, we just need to get a whole suite of measures that can assess things like social and emotional wellbeing, Aboriginal understandings of that, rather than just

conventional understandings of mental health.

Q. Finally, Dr Gee, can I ask you about the really striking fact that we've heard a bit about today, and that is the youth of the Victorian Aboriginal population. You've said in your statement that one-third of the Aboriginal and Torres Strait Islander population is between 15-29. Do you mean in Victoria or Australia-wide?
A. Australia-wide.

Q. Do you know the Victorian figure?
A. I don't. I couldn't tell you that, sorry.

Q. I couldn't tell you either actually as I stand here, but it's still a very high proportion of the population is young; is that right?
A. Definitely, yes. I mean, nationally and state-wide, we have a younger population, that's really well documented and we're going to suspect, if you refer to the appropriate stats, you'll find that our youth, there's a much bigger population compared to the older population.

And, of course, they're the ones that we need to talk about, you know, how do services look for those young people, because their views of course are very different than middle-aged farts like myself, you know, or Elders: the young have got their own views and they're the ones who are going to be using our systems in the future, so I think that we need to really think about how we engage the young people and ask them what's going to work in terms of services that will support them.

Q. Do you think we've grappled with the fact of the demographic in terms of the importance of continuing to strengthen culture?
A. Look, my gut instinct is, no, we haven't. I haven't specialised in the area of working with children and youth, so I need to qualify that statement. I think you'll need to talk to people who work more with the young people. But certainly I have done some focus groups with the Koori Youth Council around social and emotional wellbeing, and judging by the young people's responses in those focus groups, we've got a hell of a lot more work to do to understand how to support them better with their experiences of mental health at their age.

MS NICHOLS: Thank you, Dr Gee. Chair, are there any

questions from the Commissioners to Dr Gee?

CHAIR: No, I don't think there is any further questions, Dr Gee, but thank you very much for your very comprehensive statement and evidence you've given us. I did note in your CV that you were awarded the 2018 National Health and Medical Research Council rising star award, and we would encourage your continuing interest in this very important research, and thank you very much for making yourself available, particularly from Norway, so thank you very much.

A. Thank you for giving me the opportunity. Thank you.

MS NICHOLS: Commissioners, that concludes the evidence for today.

CHAIR: Thank you very much.

AT 3.45PM THE ARBITRATION WAS ADJOURNED TO WEDNESDAY, 17 JULY 2019 AT 10.00AM

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