VICTORIAN ABORIGINAL HEALTH SERVICE CO-OPERATIVE LTD.

186 Nicholson Street Fitzroy 3065
P: 03 9419 3000 **E:** info@vahs.org.au **W:** www.vahs.org.au

To: Royal Commission Into Victoria's Mental Health System
Chairperson Penny Armytage;
Commissioners Dr. Alex Cockram;
Professor Allan Fels AO;
Professor Bernadette McSherry.

12 July 2019

Dear Commissioners,

Please find attached the Victorian Aboriginal Health Service's submission to the Royal Commission Into Mental Health.

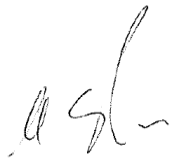
We welcome the opportunity to outline our commitment to improving the social, emotional and spiritual health and wellbeing of our community. With 46 years of experience in working to improve the health and wellbeing outcomes of our community, we are hopeful that this Royal Commission will achieve the level of change required to support those in our community who continue to suffer from SEWB and varying levels of compromised mental health.

We are cautiously optimistic that the recommendations you make will draw upon past work undertaken by the Commonwealth in addition to the recent priorities outlined in the Victorian Government's 10 Year Mental Health Plan and that collectively we will finally begin to turn around the legacy of colonisation, dispossession, disconnection and all that stems from our longstanding levels of disadvantage and discrimination which inhibit good mental health and wellbeing.

We are hopeful that we can continue and grow the many partnerships we have established since our service began in 1973, and that we can continue to advocate for cultural equality and work meaningfully to educate our mainstream colleagues developing a service system where holistic and trauma informed care from an Aboriginal perspective is truly understood and provided for as part of the necessary response to our communities.

For further information regarding the attached submission please contact either Salina Bernard (Office of the CEO) or Jeannie McIntyre (Clinical Coordinator) on 94033300.

Yours sincerely



Michael Graham
CE

Victorian Aboriginal Health Service Submission to the Royal Commission Into Victoria's Mental Health System

Preamble

We begin this submission by acknowledging that it was written on the lands of the Wurrundjeri people of the Kulin Nation and pay our respects to elders past, present and emerging. We also pay our respects to all those who have sadly lost their battle with mental health, and all those still struggling to survive despite their mental health. We implore this Royal Commission to not only hear their voices, but make culturally safe and considered recommendations to alleviate the concerns raised within this submission, and to ensure that governments implement recommendations made.

We acknowledge all previous Royal Commissions, (including but not limited to) the Royal Commission Into Aboriginal Deaths In Custody (1991); the Human Rights and Equal Opportunities Inquiry Into the Separation of Aboriginal Children from their Families (Bringing Them Home, 1997) and the Royal Commission Into Institutional Responses to Child Sexual Abuse (2017).

We acknowledge the courage of those who came forward and shared their pain, the numerous recommendations made but never implemented and reiterate that we know and are well aware of the issues – we should also already know what is required. There is a plethora of information and evidence accumulated through various inquiries that if implemented would by now have had a more positive and lasting impact for Aboriginal people with mental health and social and emotional wellbeing issues and placed service providers in a much stronger position to more effectively engage, support and treat them.

While we look forward to the findings of the Royal Commission, it also leaves us asking ourselves why is it so hard for governments to follow through? After numerous Royal Commissions into issues affecting Aboriginal people and communities without implementation of recommendations, it somehow becomes an insult to all the effort of all those who have shared their story, to those who have heard and made thoughtful and meaningful recommendations for Aboriginal people to once again dig deep and share our ongoing pain, trauma and sorrow with a lack of faith that there is no real commitment that things will change to improve the social, emotional, cultural and spiritual wellbeing of our communities in Victoria. Having said this, again we will expose our pain in the hope that we are heard and that the thoughts we share are transformed into action to support our communities and turn around the generations of loss and trauma.

Introduction

The Victorian Aboriginal Health Service is an Aboriginal community controlled health organisation established in 1973 specifically to address the specific medical and ancillary needs of Victorian Aboriginal communities. VAHS was established as a rights based organisation advocating for the sovereign and human rights of Aboriginal people to equality in access to health services through community control and self-determination. This is even more relevant for the mental health clients of VAHS and their carers in today's environment.

VAHS is AGPAL accredited and has expanded its service scope and operations over the past 45 years, currently providing a comprehensive suite of medical, allied health, oral health, clinical mental health, Social Emotional Well-Being and community support programs which include: aged care, women's and

children's, preventative health programs, nutrition and health promotion, alcohol and drug treatment services (counselling and pharmacotherapy), financial counselling and a range of visiting specialist services for Aboriginal communities across metropolitan Melbourne. VAHS is regarded as an innovator in health service design and delivery for Aboriginal people and has initiated many aspects of service delivery which are now the norm in mainstream services as well.

VAHS is committed to support the health and wellbeing of the Aboriginal community through leading, contributing to and delivering a number of community activities and health promotion campaigns which promote good health and healthy lifestyle choices using tried and tested preventative health campaigns which are based on successful community engagement in addressing chronic disease prevention and management.

VAHS' vision is focussed on *"Creating and inspiring healthy Aboriginal people and families through equality, effective community health services, education and training"*. VAHS seeks to realise this vision through an approach to health service delivery that is flexible, innovative and embraced by community to reinforce VAHS' standing as an international Centre of Excellence for Aboriginal Health.

The mental health challenges for Aboriginal people over several generations is well documented, yet successful healing outcomes are limited. In part that is due to a mismatch between the mainstream understanding of mental health issues and their determinants and the actual social and cultural determinants for Aboriginal people. Some basic understandings need to be acknowledged if we are to have a meaningful and informed conversation about the mental health of the Victorian Aboriginal community. The basic premise which needs to be acknowledged includes the following:

- Prior to colonisation, Aboriginal communities lived and shared this country now known as Australia for over 60,000 years or more
- Colonisation led to massacres, disease, disconnection, dislocation, attempted genocide through the removal of children (Stolen Generations), assimilation policy and processes and discriminatory government policy including the White Australia policy
- Colonisation resulted in intergenerational trauma, community trauma, dispossession, self medication through drug and alcohol misuse, isolation, disconnection and continued discrimination and victimisation, these impacts are as real today as they were a century ago
- Colonisation brought disease, changes to diet via a ration system and decimation to country, a silencing of language and cultural practices that had previously enabled sustainable and healthy food procurement and medicines from the land
- Much of the social disadvantage for many Aboriginal people in Victoria stems from the above and it is very challenging to adequately support someone's mental health when they are homeless, experiencing food insecurity, without an income or are Centrelink dependent (for some this is generational) and their mental health often coincides with other health comorbidities leaving them unable to seek out meaningful employment, engage in studies (poor numeracy and literacy) or physically capable to engage in the workforce so they are further disadvantaged by the system. Often this leads to people with mental health conditions being cut off entirely including socially, emotionally and financially. These kinds of situations leaves you asking what chance is there to address their mental health, intergenerational and ongoing personal life trauma's and setbacks including dealing with a constant stream of grief and loss?

- These results have led to many in our community living with poor mental health and issues such as violence (against self and others), stigma, and a lack of connection and understanding between why a person feels the way they feel, and the feelings they are experiencing
- Couple this with the high rates of institutionalisation of Aboriginal children in the child protection and youth justice systems, and criminal justice arenas and the unrecognized, unacknowledged but very apparent systemic racism faced by our communities on a daily basis, the picture appears to be incredibly bleak.

Alongside the above, we want to recognize and celebrate that there is a strong history of resistance and resilience within our community. We know we have many ideas to effectively support our community members. What is needed from governments is the recognition that our approaches are valid and are that resourcing is available to be able to implement the programs and activities we know will work. We need governments to listen and empower us to care for those in our communities who are struggling with compromised mental health or who are vulnerable.

We need governments to review the implementation of recommendations of previous Royal Commissions that have considered the issues presented by and that specifically concern Aboriginal people because most often therein lies the answers to addressing the historical and long standing underlying issues that need to be addressed along with the very recommendations for reforming many service systems that continually deny equity of access and poor service experiences for Aboriginal people and communities resulting in disengagement and further complexity and diversity of need and service demand.

While VAHS has responded to a number of the questions posed by the Royal Commission below, we believe it is critical that serious consideration is given to truly supporting and enabling us and other Aboriginal community controlled health services to provide the holistic healing service to our communities that consists of the following components/activities:

Preventative:

- Community awareness
- Building resilience early - SEWB and Cultural supports in schools and Kindergartens
- Cultural land based Healing spaces/centers (in bushland across Victoria) – opportunities to run groups and engage in cultural connections for men, women, boys and girls.
- Nutrition promotion via cooking programs that connect people socially, that develop food skills for healthy eating, provide a meal and that facilitate the sharing of cultural knowledge and practices around food

Early Intervention:

- Supported respite – Units where community members can have time out from their usual routine as they feel their capacity to cope begins to deteriorate
- Men's and women's Support Groups
- Family Support Groups
- SEWB Family Group Conferencing
- Dietitian assessment and review as part of a mental health care plan

- Nutrition promotion via cooking programs that connect people socially, that develop food skills for healthy eating, provide a meal and that facilitate the sharing of cultural knowledge and practices around food

Tertiary:

- Culturally informed and safe
- Trauma informed from an Aboriginal cultural/spiritual and community perspective
- Individualized healing responses
- Family and community healing responses
- Dietitian assessment and review as part of a mental health care plan
- Culturally informed assessment protocols

Partnerships:

- Support and facilitate the development of meaningful partnerships between Aboriginal community controlled social and emotional wellbeing services and mainstream community based and tertiary mental health service providers

Workforce Development

- Support the expansion of the Aboriginal SEWB and clinical mental health workforce
- Support the cultural and spiritual understandings of mainstream health care workforce treating and working with Aboriginal people including GP's and other health practitioners
- Validating Aboriginal cultural and spiritual knowledge and raising the profile and validity of Aboriginal workforce advice on assessment and treatment options

In response to the questions posed by the Royal Commission VAHS offers the following:

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

For the Victorian Aboriginal Community's ensuring our clients mental health is understood through a Social Emotional Wellbeing lens, which is that the determinants of their "mental health" are viewed in a holistic manner that looks beyond the presenting symptomology. If all services had even the most basic understanding of the range of issues facing Aboriginal Victorians as outlined above, then the way supports were offered would change significantly and preventative or early intervention opportunities would see our community engage with services before their mental health was at the point of requiring significant tertiary intervention and/or hospitalisation.

There is a dire need for improved access to preventative and early intervention supports after hours which would ensure support/assessment is available as and when needed and allow or support the client to better engage and have more choice in their care and what will work best for them.

The broader community has little understanding of mental illness, and there is much stigma and discrimination toward those who experience compromised mental health. This discrimination and stigma for Aboriginal people is coupled with racial discrimination which has reportedly been experienced by 97% of those surveyed in a Vic Health survey conducted in 2012.
There would be merit in national Media campaigns to destigmatise mental illness that is inclusive of all cultural backgrounds along with media campaigns as a means to reduce racial discrimination. Effectively placing these issues into people's lounge rooms will have two complimentary impacts:

1. Increasing the general community's understanding and awareness of mental illness and discrimination
2. Decreasing the isolation experienced by those experiencing mental health by seeing that there are almost as many people who experience some form of compromised mental health as those who do not.

These campaigns need to include how stigma and discrimination adversely impact a person's mental health and how understanding, kindness and empathy enhance mental health. Public health campaigns focussed on mental health need to challenge the myths and destigmatise the negatives connected with mental health, for example that those with schizophrenia are more violent or those of different cultural backgrounds are more violent.

We also suggest that in looking at this question, the Mental Health Royal Commission look more broadly and acknowledge discrimination more widely within our community - beyond towards those with mental illness - as the literature shows that discrimination can have a negative impact on mental wellbeing. This includes discrimination and racism towards Aboriginal Australians and people of colour; and discrimination and transphobia towards Trans and non-binary individuals. Not only do such negative behaviors occur in the broader community but also within services providing mental health support, including the public mental health system. It occurs from when clients first approach the service (e.g. negative attitudes towards Aboriginal people, or being misgendered by reception staff) and actions by clinicians (e.g. sharing racist views or voicing misinformed assumptions with the client on race related issues/presumptions/opinions; writing notes and letters with the client's incorrect gender).

For professionals across every industry that encounter those experiencing mental health challenges, there needs to be workplace training to ensure all interactions with clients are non-stigmatising and non-discriminatory and that staff understand the considerably mythology that exists in relation to mental illness and often a person's cultural identity. Of particular concern here are Centrelink, DHHS, Corrective Services, Schools, TAFE's, Universities, General Practice Clinics, Police, Ambulance, all emergency services, all community service organisations, hospitals (not just the mental health and Emergency departments) and clearly the lists continue.

For services that are set up specifically for those experiencing mental health challenges, there needs to be additional specialised training. Our experience includes the following:

Case Study
Clients of our Family Counselling Service present to ED seeking mental health support following engaging in self harm and experiencing high distress. They have felt they have been judged negatively by hospital staff and viewed as attention seeking and wasting hospital time and resources. Consequently, their experience at hospitals has been negative and unsupportive - the exact opposite of what they were seeking (i.e. support and safety, assessment and treatment). This is a common experience. It is my opinion that there are widely held negative views about people who engage in self harm (e.g. as being attention seekers) and those with Borderline Personality Disorder.

RECOMMENDATION

1. A well resourced and researched advertising campaign that includes increasing awareness and understanding of mental health and how the range of discriminatory views adversely impacts an individual's mental health. Discrimination includes: cultural identity, religious/spiritual identity, gender identity etc.

2. Resources are allocated to ensure all professionals across every human service category are provided with professional education and training with regard to mental illness and discrimination.

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

Our experience of what is working well is unfortunately quite limited but includes the following:

1. VAHS as the largest Aboriginal community based Aboriginal specific mental health/SEWB program in the state has a longstanding partnership with St Vincent's Hospital Mental Health. This arrangement sees five dedicated Social Emotional Wellbeing beds allocated (when the ward has capacity) for Aboriginal clients. This arrangement has room for improvement but has been known to work relatively well for some clients and their families. There is also an arrangement with Northern Mental Health which supports Aboriginal patient access and treatment which, while there is also room for improvement, again is viewed as good practice. These arrangements are being developed through the recently state government funded Aboriginal Mental Health Demonstration Projects as part of the Victorian Government's 10 Year Mental Health Plan.
2. VAHS Koori Kids team works with families by partnering the clinical expertise of psychologists and other clinicians with Aboriginal Health workers to ensure families are provided with clinical expertise and cultural expertise and understanding of the presenting issues. The Aboriginal Health worker provides the cultural lens for the clinician and acts as a cultural translator to ensure suggested interventions and understandings by the families are accurate.
3. There is an understanding of the importance of early intervention within the community.
4. While there are Aboriginal Health Liaison positions available within most hospitals through Improving Care for Aboriginal Patients (ICAP) program, there is not specific access to these positions by the mental health ward and none or extremely limited access within community teams or services outside hospitals to assist Aboriginal clients to stay connected.
5. Child and Adolescent specific services exist (CAHMS, Early Youth Psychosis Programs) but are not supported by formal partnership arrangements to support service access and referral pathways
6. Some early intervention programs occurring in schools.
7. VAHS has been granted funding in the past and had some extremely successful outcomes with Health promotion activities (see case study) but this has been dependent on sourcing external funding
8. The colocation of AOD and mental health programs in a single location has its benefits in supporting clients with dual diagnosis issues, however service system responses to responding and providing necessary therapeutic treatment options to address dual diagnosis is challenging, particularly for Aboriginal communities

9. The introduction of the NDIS and supporting people with required psychosocial support needs attention and review. This reform is not something that has been well thought through as it relates to Aboriginal people with severe and enduring mental health conditions who would benefit from ongoing support and unlikely to recover
10. Much work has been done to develop Aboriginal specific assessment tools and approaches. Opportunity exists to review and implement these as they consider the cultural and social determinants which are at play for Aboriginal people with SEWB/mental health conditions. Implementation of these could certainly go a long way to contributing to building capacity of mainstream and tertiary providers in their response to Aboriginal people.

Case Study

VAHS #HerTribe Aboriginal Women's Health and Empowerment Program was a finalist for the Vic Health - Health Promotion Awards 2017

#HerTribe was a holistic healthy lifestyle and self-empowerment program, targeting Aboriginal women and their families in Victoria.

It began as an innovative program to improve the health and wellbeing of Aboriginal women by creating a culture of action, reflection and experimentation incorporating a wide variety of activities, including weekly empowerment and education sessions, weekly fitness sessions, and quarterly data collection and fitness testing. It achieved over 1000 points of contact with 121 Aboriginal women.

#HerTribe also developed into an Aboriginal Community led research project that engaged 88 Aboriginal women. The objectives of #HerTribe were to:

- improve the health and wellbeing of Aboriginal women
- increase Aboriginal women's capacity to take action and control of their own lives (self-efficacy)
- create a support network of Aboriginal women and
- acknowledge achievements and create Aboriginal Health Community champions.

Analysis of results from baseline to week 16 of the #HerTribe program revealed some significant results including; a decrease in psychological distress; an increase in multiple resilience-related strengths(including personal strength and relational-cultural strength); significant increases of self-care, self-esteem, community connection, social support, access to role-models, safety, cultural practices and spirituality; as well as an increase in cardio-vascular fitness.

The list for what is required or what is not working well includes the following:

1. Lack of funding of culturally informed services - there is a need for more funding for Aboriginal community controlled services, not only to be direct service providers to the community but to enhance our capacity to improve communication with external services to ensure more timely responses to clients.
2. There is a need for more cultural support for mainstream services to reduce the need for Mental Health Assessment Orders and to empower clients and their families to have more say over their care.
3. Long waitlists and referrals not being accepted due to "not being severe enough" even if the young person has had multiple suicide attempts.
4. Few inpatient units for only young people.
5. More support required in schools. (education and early intervention)
6. Whilst early intervention is important, still need just as much focus on intervention in adulthood. The reasons are that not all young people are able to access services available either because 1) they do not meet the criteria 2) long waitlists 3) location 4) parents unable to support the young person engaging 5) opening hours make it hard. Additionally, not all young people will be ready or willing to engage for a range of reasons and may present later in adulthood. Furthermore, not all mental health issues present in childhood/adolescents and often people may only first engage in services following experiencing some type of crisis.
7. Lack of holistic services and funding for these e.g. acknowledgement and support for the role of nutrition and traditional medicine and cultural practices for addressing mental health challenges.

RECOMMENDATION:

1. Fund early intervention and community based services that enable the Aboriginal community to provide much needed early support for their family members and community members.

2. Expand the VAHS/St Vincent's arrangement whereby a number of beds are available for Aboriginal people to access to support their social emotional wellbeing.

3. Enable the expansion of the Koori Kids model where an Aboriginal Health worker and mental health clinician work in tandem with children and their families to ensure the cultural understandings of the situation are considered.

4. Expand the Aboriginal Hospital Liaison Officers to ensure there is coverage in all emergency and mental health wards.

5. Fund health promotion and traditional healing as a core function of community controlled health Organisations

3. What is already working well and what can be done better to prevent suicide?

In our view there is much that can be done to better prevent suicide in our communities.

The Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention has outline three principles that demonstrate best practice in this area. These principles are:

1. Cultural and Community Focus
2. Strengthening and Indigenous Governance
3. Cultural Respect

We would like to see resourcing to enable us to provide the Mental Health First Aide and other culturally informed training programs delivered to both community members and the Aboriginal workforce to assist them to identify risk factors and be empowered to know how to support their loved ones when they may be at risk of suicide or self-harm. We know the "mental health sector" will never have the resources it requires to respond to all those who require their support BUT we see an untapped resource within families and communities who are desperate to identify risk and know what to do and how to support their loved ones who are experiencing suicidal ideation or have attempted suicide and are at risk or trying again.

This training alone will not be sufficient, but coupled with 24/7 phone support and improved access to counselling, cultural healing and other supports, we estimate will make a dent in the alarming over representation of deaths by suicide in the Aboriginal community.

In addition we recommend resourcing agencies like VAHS to be able to provide the following:

- Community based programs that take people away from their everyday struggles and provide time out – groups – therapeutic – trips/country/activities – build pride in self and identity and orientation – connection to culture/community/family and social networks and resilience building. Understanding that culture and opportunities to practice culture is healing, preventative and increases resilience.
- Crisis lines – include an Aboriginal free call 24 hour crisis line – trained Aboriginal psychological support/response and established referral pathways to Aboriginal community and mainstream services. Cultural, community and family contexts are critical knowledge to providing informed crisis responses.

In respect to the current mental health system and support we think suicide will be better prevented through:

1. The public mental health system providing support to people to prevent a suicidal crisis. Whilst there are short-term (often case management) supports available for those who have engaged in suicidal behavior, few supports are available to prevent suicidal behaviour in the first instance. Currently the system operates to mainly put out fires (postvention for suicide attempts) rather than preventing fires (addressing issues that contribute to suicide).
2. Invest in expanding levels of psychological therapy available to address psychological issues contributing to suicidal ideation and behaviour. Current Medicare restrictions means that only 10 psychological sessions are funded to work through often very significant mental health

challenges and traumas which in fact usually will require more longer term therapy and/or psychiatric treatment.

3. Invest in expending the level of out of hour's services. There are very few out of our services. Hospital emergency departments are often the only option for clients after hours. The call out to governments to invest in the establishment of an Aboriginal specific CAT response has been a longstanding issue that would benefit from review in terms of responding to those needing intervention and assessment after hours. Again, this would need to be supported by culturally informed or Aboriginal people being made part of this workforce to ensure that family, community and cultural contexts are understood and form part of the assessment process.
4. Increase/expand outreach services - many people who suicide do not have contact with mental health services and are often isolated from family, friends and community
5. Expand the number of allocated inpatient beds supported by trauma-informed care including gender based only units as well as adolescents' only units.
6. Increased investment and development of mental health responses and services for transgender people - current waitlist for hormone treatment is up-to 12 months. This is highly distressing for transgender people and there is a need for more timely support.
7. Improved understanding and workforce development and training around dual diagnosis and the funding of dedicated specialist service responses to meet this need.
8. Greater recognition of the role Aboriginal staff (i.e. Aboriginal liaison officers and Aboriginal Health Workers) play in engaging and providing culturally sensitive support to those who may be at risk of suicide.
9. Redevelopment of Aboriginal developed culturally informed suicide risk assessment tools/checklists
10. There is an ongoing need to address/understand racism within the mental health service system. Many Aboriginal people are reluctant to engage in the mental health system and this is in part due to challenges in navigating the system, poor experiences of the system and its response to access required services, the negative stigma associated with mental health and racism and discrimination (including overt and covert from staff and the system). This is compounded by a sometimes overly clinical approach to addressing mental health and suicidal risk. There is a need for all mental health practitioners to be aware of and recognise already developed Social and Emotional Wellbeing frameworks on Aboriginal health and mental health/SEWB.
11. The importance of continuity of care and the need for improved communication across and between services to support smooth and supported transition in and across the mental health service system continuum.

RECOMMENDATION:

1. Fund VAHS to provide the Mental Health First Aide Training and any other culturally informed training opportunities to the broader Aboriginal community so family members are empowered to identify, support and prevent the suicide of their loved ones.
2. Fund cultural healing programs to enable those experiencing challenges in their social and emotional wellbeing to reconnect to country and cultural ways and build their sense of self, pride in identity and build personal resilience through this culturally founded healing.
3. Support initiatives that consider the wellbeing of the workforce who are working with very challenging behaviours and addressing vicarious trauma in both clients and their families as well as the workforce responding to suicide. This is of particular significance given the extended familial and community relationship/network contexts that exists in Victoria's Aboriginal community and the stretch of grief and loss that is felt when dealing with suicide in our community.

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

It is not surprising that for Aboriginal people, families and communities, the history of colonisation, introduction of disease and alcohol, dislocation (missions and mixing of the clans), assimilation processes and loss of language and punitive approaches to cultural practice together with the imposition of foreign belief systems, transgenerational grief and loss, stolen generations, including high numbers who have experienced institutional child sexual abuse and other abuses (physical, psychological and cultural) past, current and ongoing life trauma, constantly dealing with grief and loss, racism and victimisation, community and family stress and high levels of social disadvantage, lack of access to services, food insecurity and inadequate nutrition, housing and financial insecurity and a lack of awareness of one's own mental health including denial, drug and alcohol misuse (self-medication), and lack of or connection to family, community, or social support networks all contribute to many community members experiencing less than optimal mental health.

Many of the above issues can be as prevalent in the Aboriginal workforce as they are in our client group. Working in an environment of high pressure, sadness and sorrow and uncertainty (funding and employment security never a certainty) can make workforce wellbeing difficult. There is a need for supports within the Aboriginal workforce to assist those dealing daily with their own family and community health and wellbeing challenges, poor mental health/SEWB as well as experiencing continuous grief and loss and associated trauma. Vicarious trauma in Aboriginal people and communities is an ongoing issue and a particularly relevant issue for the Aboriginal workforce who are not only working with and responding to Aboriginal ill health but living and working with it all day every day. The availability of more support in the way of more manageable workforce/client ratios and access to clinical supervision

and/or cultural supervision and support would go a long way to 'heal the healers' who are working with our often most vulnerable community members.

Food insecurity and unhealthy dietary patterns impact on mental health. Good quality diets are consistently associated with reduced depression risk whilst unhealthy dietary patterns – higher in processed foods which are associated with increased depression and often anxiety, for example. Inadequate nutrition is also associated with five of the seven leading risk factors contributing to the health gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians - obesity, high blood cholesterol, alcohol, high blood pressure, and low fruit and vegetable intake. Access to healthy food and knowledge about how to prepare food is fundamental to enabling healthy dietary patterns.

As previously mentioned above there are insufficient services or informed understandings of the complex needs of our clients. Our experience indicates that many clients are unaware of the mental health supports that do exist, or if they are aware they are fearful of using them without Aboriginal workers being available to walk them through the processes as they experience misinformed assumptions, negative judgement, overt and covert racism and a total lack of cultural understanding from mainstream services that are available. This contributes to additional distress being experienced by individuals and families to self-manage conditions that need therapeutic responses. It can mean that people do not access supports until a crisis occurs. Additionally, if a family member or friend is concerned about a loved one's mental wellbeing, they can feel helpless due to not knowing how to support the person in need or know how/where to refer them for support. Even if they are able to identify an appropriate service, often long waitlists prevent timely support and results in disengagement.

Information about mental health services and supports needs to be accessible, including a guide of who and what kinds of services the provider delivers and how as a way to increase engagement for those seeking/requiring support. Having said this the support needs to be available as and when needed. There also needs to be greater communication between services. Often when VAHS clients are referred to or self-present to hospitals experiencing psychological distress (which may include suicidal risk), this information is not shared with VAHS. Additionally, hospitals often include VAHS clinician's names in discharge planning and discharge reports, however the clinician is often unaware that the client is in hospital and/or are not contacted regarding the discharge plan. This negatively impacts continuity of care upon discharge and interrupts therapeutic interventions and community supports being available to reduce relapse.

Below is a case example that recently occurred for one of our young people which highlights some of our issues.

Case Study

17 year old female client, BPD diagnosis.

VAHS took her to ED for acute assessment as her behaviour and presentation was nothing like we have seen or experienced with her in almost 2 years of working with her. Heightened emotions, unable to regulate, some bizarre thoughts, attempting to jump out of a moving car.

The worker had to insist at ED that she receive a Mental Health assessment, they were prepared to discharge her after giving her prn medication without an assessment. As a mental health clinician who has known the clients mental status for over 2 years the worker was not asked about what she was concerned about or the changes in her presentation that prompted the need for a crisis assessment by either ED doctor or the MH CATT clinician.

She was discharged from ED on the same day (Thursday) then presented to [redacted] ED the following Tuesday and admitted to [redacted] for a couple days with suspected drug induced psychosis. After a few days she was released having settled, [redacted] were going to refer her to the [redacted] for follow up in agreement with VAHS but the client didn't agree.

Following her discharge she went to family in [redacted] and then was readmitted to CAMHS inpatient with acute psychotic episode and overdoses. 2 psychiatric admissions and 1 ED admission while there (in about 2 week time frame)

She left [redacted] 24/06/19 and was referred to the local CAMHS. Within 24 hours CAMHS was phoning VAHS to essentially refer her back to our service. We explained that we don't have acute / crises or inpatient services that the client needed and is entitled to.

After pushing back and getting numerous excuses about why they couldn't take her, the response was that she essentially doesn't meet the criteria for their service because she's not currently saying that she's suicidal and she was denying experiencing any psychotic phenomena and the client wanted a service that can see her from now to adulthood. She's turning 18 soon and therefore they would need to transfer her, they have a 6-8 week wait list so by the time they see her they would have to transfer her and the client wanted a service that can see her from now to adulthood.

VAHS is very concerned that a young person with 3 inpatient admissions and 2 overdoses in a space of 3 weeks did not meet the criteria for a mainstream service. We don't believe that this is a unique experience for Aboriginal young people and have concerns about CAHMS and their preparedness to work with us and our clients in a more proactive and collaborative way.

RECOMMENDATION:

1. Services should value the understanding we have of our clients and pay us a bit more professional respect than we often receive.
2. There is a need as recommended above to address broader issues of discrimination and racism in the broader community.
3. Specific cultural healing programs to assist in healing the intergenerational and community trauma that exists in our community should be funded and seen as integral to improving our people's mental health.
4. Funding under a mental health care plan for allied health visits as well as for group activities that promote health e.g. cultural groups, self-awareness and self-care activities, cooking groups, etc

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

The Aboriginal People and Communities 10 Year Mental Health Plan Technical Paper developed to inform the Victorian Government's 10 Year Mental Health Plan details a range of statistics that acknowledges that Victoria's Aboriginal community experiences worse mental health than their non-Aboriginal counterparts. This is for the most part due to the range of issues outlined earlier in this submission. Suffice to say that discrimination, institutionalised racism, continued over representation in the criminal justice and child protections systems conjoined with intergenerational and community trauma, stolen generations, disconnection from country, dislocation, grief and loss and the high levels of social disadvantage that many Aboriginal Victorians suffer demonstrate there is a lot of work to be done.

In order to address these issues, a beginning point could be ensuring that mainstream health services are supported to require to have a more comprehensive understanding of the above issues and an informed understanding of what is meant by Aboriginal mental health and social and emotional wellbeing and social and cultural determinants. As previously stated, VAHS have some arrangements and partnerships with mainstream mental health services in place. Having said this, the advice and cultural lens provided by Aboriginal staff could be better acknowledged, respected and validated. At this stage we have not achieved a level of professional equity in this space. Once we do, we are hopeful that the outcomes and service experience for Aboriginal people will be greatly improved.

RECOMMENDATION:

1. Funding to Aboriginal Community Controlled Organisations to enable them to provide the culturally supports required to enhance the community's social and emotional wellbeing.

2. Work towards reducing the removal of Aboriginal children, reconsider the implementation of the Deaths in Custody recommendations to reduce the high levels of incarceration of Aboriginal people and instead fund healing programs to break the cycle of generational trauma and improve the overall social emotional wellbeing of our community.

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

Our families are an underutilised resource for those in our community experiencing compromised mental health. As outlined in question 3, we believe that with appropriate resourcing, we can train and support family members to identify and support their loved ones, where suicide and other mental health concerns are known to be a risk. Providing and sharing food is a way many show their love and care within families, so support for programs that enable access to healthy food and that develop skills around cooking, could enable families to contribute in a practical way, where they may otherwise feel powerless to help. Our families need culturally focussed community based supports to be able to continue to provide the supports to their loved ones as and when required. Time out opportunities for carers and respite facilities for individuals living with ongoing mental health challenges are urgently needed. Many placements breakdown due to families not getting the respite or supports they require. Healing Centre's for families are also strongly encouraged to support family wellbeing and healing processes.

There is evidence that when parents are better able to meet the emotional needs of children, their children demonstrate better outcomes in areas such as education, relationships, and mental health. The provision of parenting support and education better equips parents with the capacity to accommodate these needs, and group programs are an effective medium for imparting the required knowledge and skills. A number of parenting programs exist in the mainstream community, however, these are often not culturally appropriate and/or do not adequately meet the needs of vulnerable Aboriginal parents and carers.

Aboriginal Community Health Services are in a stronger position to provide trauma-informed and culturally sensitive parenting programs which are more appropriate for clients with a background of inter-generational trauma and disconnection. The Aboriginal service environment has the additional benefit of indirectly promoting engagement with Elders, other available programs and relevant health and community services as well as knowledge of community and cultural events, thereby strengthening connections to family, culture and community.

The Victorian Aboriginal Health Service (VAHS) has been running a Parenting Project for a number of years, providing group programs and information sessions for parents and/or their workers. Participants in the VAHS programs have reporting feeling supported in the groups, and have found the sessions to be

beneficial for themselves and their children. VAHS has also developed partnerships with mainstream Organisations in presenting and developing the programs, thereby raising these services' awareness of the needs of the Aboriginal community.

In 2018, VAHS developed "Deadly Dads", an eight module Parenting Program for incarcerated Aboriginal fathers. The program was presented at Ravenhall prison three times between May and December and produced positive outcomes, with participants reporting an increase in their parenting knowledge and skills; and feeling more empowered and relaxed about parenting.

RECOMMENDATION:

1. Continuing support for Aboriginal-specific parenting programs in the community and prisons and provision of funding to provide individual parenting education for parents where this additional support is needed.

2. Dedicated group activity funding needs to be specifically allocated to cover all costs of developing and running activities including the provision of a healthy feed.

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

For the Aboriginal workforce there is a need for greater investment in the training and supervision of the staff in services such as VAHS. The impact of a client taking their life has a different impact to our workers. As outlined above, our workers experience "Vicarious trauma" as do other workers in mental health settings. However, there is a difference for Aboriginal staff. For Aboriginal staff it is personal. More often than not, the client/person is connected to us in a way that is not the same in a mainstream service including through direct and extended family networks, clansman and country or simply long standing friendships or long term clients who become part of our lives. It is difficult in an Aboriginal community context to draw the line of separation. Our workers therefore need accessible and culturally informed clinical supervision and more informal yarning time would benefit the workforce while acknowledging the complexity of issues, clients and community context they are working with and within. This work is difficult at the best of times and results in high burn out rates where there are limited supports and flexibility available. Better support for the workforce, not just supervision but down time when need with less pressure on performance and throughput and excessive reporting and reporting requirements. Workforce/client ratios is something that is also worthy of consideration. This applies in the mainstream but due to resourcing is not currently an option in an Aboriginal community service setting.

Supporting provision of high level training and scholarships for those Aboriginal workers wanting to further develop their skills and qualifications and career aspirations in the field of mental health is encouraged. The professional development budgets of our service are extremely low and despite the desire to further develop the workforce and retain well trained staff, current funding levels do not enable this to occur.

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

Acknowledging and valuing that those with mental illness can contribute to society is a start. While levels of functionality is acknowledged, funding employers as an incentive to employ those with compromised mental health and supporting those workers to access the treatment and time out they might need to be able to engage in meaningful and manageable employment opportunities could see benefits for the broader community. If provided with the opportunity, those experiencing mental health challenges could contribute where they are able, this would build their sense of self-worth and value and this in turn will build their resilience while addressing a number of social determinants. The per workforce approach is an initiative that VAHS highly recommends.

Social enterprise that enables the sale of artwork or other products made as part of group/cultural and land based activities would also be of benefit supporting and mentoring people into business or earning money while recognising their artistic, cultural or other gifts and values – i.e. music, painting, cultural tours, cultural healing ways and making of traditional health/healing products, growing traditional foods, Koori catering etc.

Participation in education/Adult education to build literacy/numeracy/confidence/self-pride and confidence to engage in employment opportunities and even attend groups/activities are also encouraged. Mentoring within an Aboriginal organisation such as VAHS, for example employees or trainees being mentored by experienced health service employees to gain skills in specific areas eg. psychology, dietetics, practice management, administration and peer advocates and support workers.

It is well known that group activities are places of healing within the Aboriginal community. A group environment creates opportunities for sharing stories and reducing social isolation as well as for promoting health and wellbeing and self-care and awareness.

Case Study

VAHS Deadly Elders Circus

This is a weekly Elders group in partnership with Circus Oz where an Aboriginal Health worker and Dietitian or Physiotherapist attends Circus Oz in Collingwood for a 1.5 hour circus workshop followed by lunch. This group has provided opportunity for participants to be more socially connected than they were previously, form friendships which have developed outside of the group, share a meal, share stories about culture, trauma, health challenges. Stolen generation participants now feel more connected to their mob and culture and many have had improved mental health outcomes. Please watch to hear from the participants.

https://www.youtube.com/watch?v=jyDGtW-bL0M

Every 6 months this program is under threat due to having to scrounge for minimal funds via council grants etc and these funds don't cover specialist and Aboriginal Health Worker time, this is given in kind by VAHS.

RECOMMENDATION:

1. Dedicated funding needs to be specifically allocated to cover all costs of developing and running group activities including the provision of a healthy feed.

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

In addition to Aboriginal Mental Health being a priority in the Victorian Mental Health Plan, government needs to invest in Aboriginal Community Controlled Organisations to better respond to clinical and social and emotional wellbeing programs and services more generally including those focused at children and adolescents.

Understanding that for an Aboriginal person, cultural healing opportunities are as important to their social and emotional wellbeing as are clinical/ therapeutic interventions. There is insufficient acceptance or understanding of this, and consequently a dearth of funds available to provide these types of programs within the community. For example every community controlled health service and their community would benefit from the employment of traditional healers as is being done in South Australia https://www.abc.net.au/news/2018-03-28/aboriginal-healers-complementary-medicine-finds-its-place/9586972

The implementation of the Commonwealth Governments Contributing Lives Report recommendations (review of the Mental Health System undertaken by the National Mental Health Commission) is worthy of review. Essentially the recommendations consider the service system, funding and service delivery context of the national mental health system and makes a number of recommendations for reform to better respond to Aboriginal mental health. The first sections of recommendations are focused on understanding which part of government is responsible for which part of the mental health system and identifying where opportunities exist to better organize funding allocations and how this could be done in parallel to support broader service system reform to better cater for the specific needs of Aboriginal and Torres Strait Islander communities. This report provides a blueprint from which to start planning for a better mental health system response to Aboriginal people with mental health conditions.

The above report and supporting documents focused on Aboriginal mental health provides yet another example of work that has been undertaken and recommendations made which have not yet been implemented.

Other considerations include Aboriginal population data across the state. Recent Census data indicates that around half the Aboriginal population lives in metropolitan Melbourne while the remaining 50% live in rural Victoria. There are over 20 Aboriginal community controlled health Organisations across the state with only 2 located in metropolitan Melbourne servicing half of our Aboriginal and Torres Strait Islander population. While we acknowledge that not all Aboriginal people in metropolitan Melbourne we would suggest that we are the service of choice, particularly when it comes to providing culturally relevant and trauma informed SEWB and mental health services. Consequently, VAHS is overwhelmed with client demand and expectations and this will only grow with the recent establishment of a satellite clinic in the

outer northern LGA of Whittlesea where there is likely to be expectation that there will be access to clinical mental health and SEWB services available.

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

While we fully support client say, there may be some merit in reviewing the current Mental Health Act as it relates to voluntary/involuntary patients and family and community based advice around when involuntary admission is required to ensure the safety and wellbeing of the client.

There is also a need to consider service system response to dual diagnosis and drug induced psychosis and NDIS reforms around mental health and access to required psychosocial disability support which has presented its challenges.

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

If we accept that the mental health status of the Victorian Aboriginal community is primarily due to unresolved intergenerational, communal and complex trauma, then it follows that recovery from this trauma requires long term relational and cultural healing opportunities, everything that the current mental health system is not. There is an ongoing and longstanding need for trauma informed and culturally informed and relational opportunities for clients experiencing compromised mental health. Arguably this can only be provided by the Aboriginal community. At a minimum there needs to be respectful, equitable partnerships between the current mainstream mental health providers and agencies like VAHS. In the absence of these partnership arrangements and mainstream services having a comprehensive understanding of the range of social emotional wellbeing issues experienced by Aboriginal people due to the legacy of the last 240 years, there is always a risk that further harm could be done and further distrust in the system occur.

VAHS is disheartened to see that despite all the work that has occurred at the national and state levels recently on refreshing the Aboriginal Close the Gap targets that specific Mental Health and Social and Emotional Wellbeing targets have not been established. We are of the view that while mental health and SEWB continue to be absent from key Aboriginal health policy frameworks that are specific to Aboriginal Affairs that they will not attract the necessary level of attention needed to support dedicated and concerted efforts to address the issues. We are concerned that we will again be left wondering why there has been little or no progression made in the mental health arena while mental health and wellbeing issues and suicide rates continue to escalate. We strongly advocate that government consider Aboriginal mental health as a key priority health indicator in its own right in future Aboriginal health policy and planning mechanisms including current and future Health related Close the Gap targets.

Conclusion

The Victorian Aboriginal Health Service is committed to working towards significantly improving the social, emotional and spiritual wellbeing of individuals, families and communities we serve. We know that many in our communities suffer the impacts of intergenerational trauma, discrimination, injustice, institutional racism as well as homelessness, poverty and a number of other social disadvantages. We also know that given the opportunities and resources our service can deliver so much more to support healing and alleviate these impacts and improve the wellbeing of our communities. We are unable to do this without adequate resources and equitable partnerships. We need to have respectful and equal partnerships with a range of mainstream services who acknowledge and value the role we do and can play in providing a cultural understanding of the client's mental health challenges and ensuring that alongside a clinical intervention there is also the provision of cultural healing programs like those referred to above. With significant additional resourcing (not only for expanded service delivery but to support partnership development and back of house functions), we believe there is much we can do that would make an enormous difference in providing the type of programming and response that is needed to support a reduction in the current high rates of Aboriginal suicide in our community, as well as the over representation of Aboriginal people experiencing poor mental health and high levels social and emotional distress. Having said this, we cannot shift systemic racism, discrimination, and social disadvantage and injustice. This is a role for governments and the broader community to embark upon with our support.

It is also worth noting that while much work has been done at the national level and more recently at the state level on Aboriginal mental health, our communities have been let down so many times. We are hopeful that the outcomes of this Royal Commission will not lead to further disappointment but see the beginning of real healing through improved and more accessible and informed responses to our most vulnerable community members.

We look forward to this Royal Commission making bold and meaningful recommendations given the government of the day has already committed to implementing in full the recommendations made.

REFERENCES:

1. Mental Health and Aboriginal people and Communities – 10 year mental health plan technical paper. (DHHS.)
2. Best Practice Programs and Services (The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention)
3. Contributing Lives, Thriving Communities Nov 2014 (Australian Government.)
4. Stability within the Chaos – (VAHS Conference paper)