

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

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

3
4 AUNTY DI: Thank you very much. I honour my ancestors and
5 my Elders and I pay homage to this sacred ground that we're
6 on. I wish to acknowledge Commissioners, Penny Armitage,
7 Allan Fels, Alex Cockram and Bernadette McSherry.

8
9 I wish to acknowledge my Elders of the year, in
10 particular Nellie Flagg and Aunty Lynette Austin. I
11 acknowledge all Aboriginal and Torres Strait Islander
12 peoples here. I acknowledge all of you and I pay my
13 respects to your ancestors and Elders.

14
15 I'm quite honoured to be here today in this building.
16 This is our mother organisation and it's an honour to be
17 able to welcome you to this building, but also to my
18 country. The area is part of the traditional country of my
19 grandmother, mother and family and I'm always very proud to
20 welcome people to my country on behalf of them.

21
22 I'm the eldest in my family line, I don't have any
23 generations above me, so it's my duty to be able to welcome
24 you here, and particularly with mental health, which is my
25 passion, and I always wonder why we suffer from mental
26 health and it is getting to a crisis level with our
27 community. We have young ones in primary school age
28 suffering from mental health at the moment.

29
30 Particularly we have a lot of young ones that are
31 committing suicide and it's really hard and it's hard as an
32 Elder because sometimes you feel that you're failing and,
33 it's not that we are, but we don't know what to do.

34
35 A few years back - I just want to tell a short story,
36 if that's okay. A few years back we had some of our girls
37 that were suffering with their mental health, and we call
38 it emotional health and wellbeing because we don't like the
39 word "mental health". We didn't know what to do, so we sat
40 around and spoke about it, and we wanted to know what was
41 missing in our lives. What was missing is our passage of
42 life because that was taken from us when our ancestors, my
43 grandmother, were on the missions. That was stopped, our
44 ceremonies.

45
46 So we decided to do ceremonies again for our girls and
47 we did coming of age ceremony, which is when they become a

1 woman. Because we had girls that were having anxiety,
2 depression, cutting themselves, were in the system but
3 weren't getting any better.
4

5 So, we had ceremony and they had to make their possum
6 skin belt which was across here (indicates), their
7 necklaces which are made from reeds from the creek, and the
8 story of those reeds is from a long time ago when the men
9 went out to hunt, the women put them around their necks
10 when they came home because they loved them. So, that was
11 in honour of our men. And, they engraved the possum skin
12 and they got their name, their traditional name.
13

14 Then they went through ceremony and that's about
15 honouring and obeying the laws of the land, about being
16 respectful, about being respectful to their parents,
17 respectful to each other, and respectful on country.
18

19 If they didn't do that their belts were taken off them
20 and they weren't allowed to participate in family
21 gatherings or dancing. That was the first time that
22 ceremony had happened in approximately 180 years.
23

24 Since then the girls have excelled. I'm not saying
25 that we fixed it all, but they have become very important
26 leaders, up and coming leaders, in our society.
27

28 They now look after each other. They watch on
29 Facebook if anybody's in trouble and they offer assistance.
30 They now have formed their own dance group, they want it
31 all the time. They dance with pride and they have formed
32 connection to country and other people want to dance with
33 them. Other people of other tribes want to participate in
34 ceremony with us.
35

36 And I'm very proud of them and they've taken their
37 roles and responsibilities themselves: we haven't given
38 them the roles, they have picked their roles.
39

40 Since then we've done baby naming ceremonies because
41 that stopped on the missions as well. Because, when you
42 were born, you were given your name which was about caring
43 for country. So, we started doing that about three years
44 ago. But those girls come to that ceremony and get all the
45 babies ready. We sit back now and they take that role and
46 responsibility.
47

1 After the ceremony with the babies, they do a welcome
2 country for the babies. So, I'm very proud of them. So,
3 what I'm saying is, when you think about what you need to
4 do with mental health with Aboriginal people, please think
5 about ceremony because that is what is missing in our
6 lives. It's very important that we do ceremony, it's
7 important that we connect to country, it's important that
8 we feel safe on country and, a lot of people aren't living
9 on their country, but they need to feel safe on the country
10 on where they live and that's what part of our welcome is,
11 about feeling safe on country.
12

13 So, thank you for letting me tell the tale, thank you
14 for allowing me to welcome you to country. And may bunjil,
15 our creators around you, keep you safe on country.
16 (Indigenous words spoken) Welcome to the traditional
17 country of the Wurundjeri people (Indigenous words spoken).
18 Thank you very much. Thank you.
19

20 CHAIR: Thank you very much, Aunty Di, and for those
21 reflections.
22

23 On behalf of the Commission I acknowledge the
24 traditional owners of the land on which we meet, the
25 Wurundjeri people of the Kulin Nation. I also pay respects
26 to their Elders past, present and emerging and extend that
27 to Elders joining us here today.
28

29 I am Penny Armitage, the Chair of the Royal Commission
30 into Victoria's Mental Health System. I am joined by my
31 fellow Commissioners, Professor Allan Fels, Professor
32 Bernadette McSherry and Dr Alex Cockram.
33

34 We feel privileged to be able to hold our 11th day of
35 public hearings at the Aborigines Advancement League in
36 Thornbury, a place with such meaning and significance. It
37 was incredibly moving for the Commissioners and I to see
38 the portraits of the Elders and the Board Members of the
39 Aborigines Advancement League looking over us as we
40 prepared for today. It is a really powerful reminder of
41 the importance of what we're doing here today and the
42 benefits we hope to realise both now and for future
43 generations
44

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

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

3
4 Aboriginal culture is founded on a strong social,
5 cultural and spiritual order that has been sustained for
6 more than 60,000 years and remains alive today. Its modern
7 history is one of resistance, reclamation of rights, as
8 well as community and personal resilience.

9
10 The heritage of Aboriginal communities throughout
11 Victoria is vibrant, rich and diverse. We value these
12 characteristics and consider them a great source of
13 strength and opportunity.

14
15 We recognise that the leadership of Aboriginal
16 communities and Elders in Victoria is crucial to improving
17 outcomes for Aboriginal people. Also to be acknowledged
18 are the devastating impacts and accumulation of trauma
19 resulting from colonisation, genocide, the dispossession of
20 land and children, discrimination and racism.

21
22 It is not lost on us that this Royal Commission is
23 occurring alongside renewed efforts to achieve
24 Constitutional recognition of Aboriginal communities and
25 Aboriginal Australians. We commit to build on this
26 momentum and to ensure our work is shaped by the voice of
27 Aboriginal people.

28
29 The work of this Royal Commission will be underpinned
30 by self-determination in recognition that Aboriginal-led
31 responses and leadership are central to better and more
32 enduring outcomes for Aboriginal people.

33
34 This was reiterated by a young Aboriginal man, Daniel.
35 He told us on our first day of our hearings how access to a
36 Koori Youth Health Service was a turning point in his
37 recovery and gave him, as he described, the building blocks
38 for the success he has had later in his life.

39
40 As we will explore further today, there is much to be
41 learned from Aboriginal responses and perceptions of health
42 encompassing, as they do, mental and physical health
43 alongside, with broader concepts of social and emotional
44 wellbeing in connection to land, community and traditions.

45
46 I note too how Pat Anderson, Chairperson of Lowitja
47 Institute, describes these concepts. She says:

1
2 "Those of us who have worked on the front
3 line of Aboriginal health for any length of
4 time know that beneath the surface the
5 reality of Aboriginal people's poor health
6 outcomes sits a deeper truth. It is about
7 the importance of social and emotional
8 wellbeing and how this flows from a sense
9 of control over one's life."

10
11 She says:

12
13 "Where this is lacking, as it is in so many
14 Aboriginal families and communities, there
15 is instead indifference and despair and a
16 descent into poor lifestyle choices and
17 self-destructive behaviours."

18
19 She says:

20
21 "Our medical professionals do a great job
22 of prescribing medicines and devising
23 treatment programs, but to fix the root
24 causes of ill-health we need something
25 more. As Aboriginal people we need to have
26 a sense of urgency in our lives, that we
27 are not stray leaves blowing about in the
28 wind. In a word, we need empowerment."

29
30 Empowerment through community ownership and
31 participation with Aboriginal Victorians is central to
32 addressing disconnection from culture and social and
33 emotional wellbeing.

34
35 Many Aboriginal people living in Victoria enjoy very
36 good social and emotional wellbeing, they are part of
37 thriving communities and have strong connections to culture
38 and country.

39
40 But for far too many others the impact of
41 intergenerational trauma, as well as social and economic
42 disadvantage at the individual, family and community level,
43 continues to profoundly affect wellbeing.

44
45 More than one-third of Aboriginal Victorians
46 experience depression and anxiety. This compares with just
47 under 20 per cent of the non-Aboriginal Victorians.

1 Compared with non-Aboriginal Victorians, Aboriginal and
2 Torres Strait Islander adults in Australia are almost three
3 times more likely to experience high or very high levels of
4 psychological distress; are almost twice as likely to be
5 hospitalised for mental health and behavioural challenges,
6 and are losing their life to suicide at twice the rate.
7

8 And we're not seeing improvements. The number of
9 Aboriginal mental health-related presentations to hospital
10 emergency departments in Victoria increased by more than
11 50 per cent in the three years between 2012-13 and 2015-16.
12

13 More, so much more, must be done to eliminate this
14 disparity. Our consultations so far have led to the
15 emergence of some compelling themes.
16

17 For example, we have been told about the direct impact
18 of the loss of land, culture, identity and self-worth on
19 the social and emotional wellbeing of Aboriginal
20 Victorians. How the high rates of family violence, poor
21 mental health, suicide, incarceration and homelessness are
22 linked to experiences of historical trauma and how these
23 instances can give rise to new instances of trauma leading
24 to cycles of multiple and compounding trauma.
25

26 Misunderstandings about culture and cultural safety on
27 the part of some services means Aboriginal people must
28 explain themselves and educate others about their lived
29 experience.
30

31 A lack of recognition of and respect for the positive
32 aspects of Aboriginal culture and culture's centrality in
33 creating a sense of meaning and purpose for Aboriginal
34 people. The importance of well supported, thriving
35 Aboriginal mental health workforce and building culturally
36 safe services and a holistic model of care.
37

38 Together, we have a challenge ahead, but it is a
39 challenge we commit to taking up alongside Aboriginal
40 Victorians. We must seize the opportunity afforded us
41 through this Royal Commission. We have a once in a
42 lifetime chance to work together with Aboriginal Victorians
43 to realise our shared hope for meaningful and lasting
44 change.
45

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

1 participation.

2
3 We are grateful to all who have contributed so
4 generously to the Commission's thinking so far. This
5 includes the many people and organisations who have
6 participated in our community consultation sessions or
7 contributed through our written submission process. In
8 particular, I extend my sincere thanks to those who are
9 appearing today as witnesses. We are so pleased that you
10 are here with us today.

11
12 I now ask Senior Counsel Assisting, Ms Lisa Nichols,
13 to say more about the structure and content of today's
14 hearings.

15
16 MS NICHOLS: On behalf of Counsel Assisting, I acknowledge
17 the Wurundjeri people of the Kulin Nation, the traditional
18 owners of the land on which we gather today, and pay my
19 respect to their Elders past, present and emerging, and
20 extend that to those present today. Thank you Aunty Di for
21 welcoming us to country.

22
23 The strong themes in the evidence we will hear today
24 have been already mentioned by the Chair but I will repeat
25 them. They are, first, that mental health in the context
26 for the indigenous community should embrace social and
27 emotional wellbeing and recognise the importance of
28 connection to land, culture, spirituality, ancestry, family
29 and community and how these things affect the individual.

30
31 Further, that social and emotional wellbeing problems
32 can result from unresolved grief and loss, trauma and
33 abuse, domestic violence, removal from family, family
34 breakdown, cultural dislocation, racism and discrimination
35 and social disadvantage.

36
37 We will also hear that the impacts of past, current
38 and intergenerational trauma, racism, discrimination,
39 marginalisation and cultural displacement have resulted in
40 poor outcomes of social and emotional wellbeing for
41 Aboriginal people.

42
43 The leadership of Aboriginal communities and Elders in
44 Victoria, we will hear, is critical for improving outcomes
45 for Aboriginal people, family and communities. We will
46 also hear that the resilience of previous generations has
47 ensured that Victorian Aboriginal communities remain

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

7
8 We will also hear that Aboriginal people, of course,
9 must be involved in the design of services and their
10 delivery, and in these respects and all respects have the
11 right to self-determination.

12
13 We will hear first from Aunty Nellie Flagg, who is a
14 respected Elder and a Taylor-Charles. Aunty Nellie's
15 traditional countries are Wemba Wemba and Dja Dja Wurrung
16 and Boon Wurrung. Aunty Nellie will tell the Commission
17 about her life and the work that she has done in providing
18 support for members of Aboriginal communities.

19
20 Helen Kennedy is a Trawlwoolway and the Chief
21 Operating Officer of the Victorian Aboriginal Community
22 Controlled Health Organisation. She will speak to a number
23 of things, including the meaning of social and emotional
24 health and wellbeing, the importance of early intervention,
25 the disparity in health outcomes between Aboriginal and
26 non-Aboriginal populations, barriers to trauma-informed
27 care, and the importance of providing trauma-informed care,
28 and how it is that culturally safe and appropriate
29 practices can be encouraged; also about the importance of
30 empowerment and self-determination in developing mental
31 health services.

32
33 Andrew Jackomos is a Yorta Yorta/Gunditjmara man. He
34 is also the Executive Director for Aboriginal Economic
35 Development and Inclusion in the Department of Jobs,
36 Precincts and Regions. He previously served as the
37 inaugural Commissioner for Aboriginal Children and Young
38 People. Mr Jackomos will share his views about the
39 importance of culture and cultural safety, and how we can
40 work better in ensuring that the big systems are more
41 culturally appropriate and responsive and how the Royal
42 Commission can make lasting generational change.

43
44 Adam Burns is a senior mental health clinician at
45 Wadamba Wilam. He will appear via video link to the
46 Northern Territory and will explain the services at Wadamba
47 Wilam, and the barriers people face in accessing

1 trauma-informed care.

2

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

15

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

20

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

28

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

35

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

37

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

41

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

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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.

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

3
4 I'm a Taylor-Charles and I'm very proud of that.
5 That's the first thing I wanna say. I grew up in Swan
6 Hill. I was born and bred there. Wemba Wemba is my
7 traditional country, it extends over to the Moonahcullah
8 mission over the outside of Deniliquin. I shared some of
9 my growing up over there as well.

10
11 One of the things that - growing up in Swan Hill, I
12 had a wonderful life. It was so rich with love and
13 connection and caring and sharing. As a child I loved my
14 life, I'd go and live it back in a heartbeat. Even though
15 we lived in old shacks and down dirt roads, and we didn't
16 have electricity, we didn't have water. We had dirt floors
17 in those huts, but they were good old times, and wonderful
18 memories for me to have and share with my family and my
19 kids.

20
21 And it wasn't until I went to school that I realised
22 there was a thing - now, I didn't know what it was called
23 then, and I still didn't know until I grew up and then this
24 word appeared: racism. When I first went to school one of
25 the things that I realised: people didn't like me, not
26 because I was Nellie, but because I was black. And,
27 because of that, they treated me differently. They called
28 us names, they threw stones at us. I nearly got kicked out
29 of school for standing up for my sisters.

30
31 And there's a lot of other things that happened to me
32 as a person and it's heartbreaking to think, you know, the
33 things that happened to me, me being a parent today, I'd be
34 heartbroken to know that happened to my children. And the
35 mental anguish you carry with you in regards to being
36 treated like that.

37
38 My mum, she was only a little woman, but she was an
39 incredible woman, just like so many Aboriginal mothers.
40 She cared for us, she looked after us in the best way that
41 she could, and that's all we needed.

42
43 The stories I have of walking and talking with mum and
44 dad will live with me forever. But when I tell these
45 stories to people - white people mainly - they look at me
46 as if to say, "Oh, what a terrible life you had." My life
47 wasn't terrible, it was a great life. I had riches that

1 they could not see.

2

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

6

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

12

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

19

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

25

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

32

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

41

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

1 could my parents, do anything about it. And I learnt to
2 live with that, it's something that lingers within me, and
3 it pops up every now and then.
4

5 But also over the many times throughout my employment
6 I've walked many journeys with a lot of people who I've
7 been honoured to share their story about abuse. They have
8 the pains and scars that we cannot see because they hide
9 them because it's too painful to live that life each and
10 every day.
11

12 And, how they keep going and what is required of them
13 to keep going, where do they go for help? I've had people
14 who have gone to counselling: I do not like that word
15 "counselling". And, as a person, I do counselling -
16 counselling if you want to call it that, but I do not like
17 it; I call it "a yarn". You know, they come and they want
18 to talk to you about the pain that affects them all their
19 lives and you sit and listen.
20

21 I've been honoured to listen to many, many stories
22 from people, and those counsellors that they've gone and
23 seen, mostly non-Aboriginal people, had no understanding of
24 Aboriginal cultural, had no understanding of what really
25 they were feeling, and so, it was difficult for them to
26 talk to them about it.
27

28 Like I said, I was affected by racism quite deeply,
29 because I lived in a small town, and it was a very racist
30 town in Victoria. When I finally moved away, because I
31 needed to move away because I could not grow up healthy
32 there; I could not get a job other than picking fruit and
33 vegetables, and I wanted more for myself and more for my
34 family, and so, I moved away. But every fortnight all the
35 kids would go home and, when we went home, we'd all want to
36 catch up with our cousins and that and there was a pub in
37 town that all the black fullas used to drink at - at the
38 back bar, mind you, not the front bar.
39

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

1
2 We were all treated terribly, and all we wanted to do
3 was continue our connection to each other and you're
4 constantly - living in Swan Hill, and I'll name it, whether
5 you take it out or not, I don't care - it was hard. I was
6 very good at sport and one of the things - I was mostly
7 captain on the teams - they would talk to me on the field
8 but they would never talk to me off the field.

9
10 And so, you wonder why they would treat you like that.
11 If I class someone as a friend or someone that I met and I
12 thought they were nice, I would talk to them regardless of
13 where it was. Again, I was with my husband and I walked
14 into a hotel again to have lunch one day, and before I
15 even - we hadn't got too far into the restaurant, a man
16 approached me and said, "I'm sorry, you can't come in." I
17 said, "Why can't I come in?" "Because the Aboriginal
18 people are barred." I said, "But I haven't been here to be
19 barred, how could I get barred?"

20
21 And so, that made you stop and think, as an adult, if
22 I wanted to go out for dinner, or if I wanted to go and eat
23 somewhere, would they treat me like this? And so, it
24 stopped you from being you because you were worrying about
25 how you were gonna be treated.

26
27 I stood in a shop in Swan Hill and not got served.
28 Another day at school, we were learning folk dancing -
29 whoopee, you know, that's the last thing that I'd wanna
30 learn, but we were learning to do the folk dance. You had
31 the boys lined up on one side, the girls lined up on the
32 other side. My brother was down the other end, and when
33 the music started you had to walk in and hold hands with
34 the person opposite you. The music started, we walked in.
35 The boy opposite me wouldn't reach out and touch my hands.

36
37 I didn't know what to do, I was a kid. The teachers
38 didn't do anything, so I just stood out alone. The girl
39 who was opposite my brother, she took his hands. When my
40 brother saw that when I stepped away, he came up and he
41 come and was my partner so we could be involved.

42
43 That had a severe impact on me because I thought, if I
44 reach my hand out to shake someone's hand, introducing
45 myself to them or saying "hello", will they take my hand?
46 And I think about that now: I choose who I put my hand out
47 to. This disease, racism, has impacted on many Aboriginal

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

2
3 One of the things that I grew up knowing and
4 understanding was that, you do not judge people for who
5 they are. My parents taught us to accept people for who
6 they are and what they bring, and accept that and be
7 respectful. And so, when I found people didn't like me;
8 again, not because I was just Nellie, it was because I was
9 black. I learnt very quickly there are things I can do and
10 there are things I can't do and places I don't wanna be.

11
12 Q. Thank you, Aunty Nellie. Just before we finish,
13 you've said in your statement, you've talked about your
14 fantasy of Aunty's place. I was wondering if you wouldn't
15 mind telling the Commission a bit more about what you think
16 Aunty's place could look like and how you think that might
17 help people?

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

26
27 What I wanna see or would like to see, places where we
28 could take the whole family and work on them as a family.
29 Not, you know, separate them, put the kids over in a
30 non-Aboriginal foster care where some of these people have
31 no understanding of our culture and do not connect with our
32 communities to keep the children solid and strong.

33
34 For us as Aboriginal people, and especially our kids,
35 they need to know who they are, where they belong. They
36 need to understand they are loved by our community, even if
37 their family is falling apart. If we could have a place
38 where we could take them and show them that they are loved,
39 and they matter and they're valued, and, you know, we can
40 work on some of the problems that they're having in their
41 lives, because that's what it is, it's problems. And some
42 problems can be resolved. You just don't know, you know.
43 Sometimes when they're young they don't know where to go
44 and who to ask because they're ashamed and they're afraid.

45
46 I imagine what my parents lived - the fear that they
47 lived with each day. And I think back, you know, mum -

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

5
6 The boys would just take off into the bush. I don't
7 want our kids to grow up with that fear, the fear of not
8 knowing or being scared of being taken away. I want them
9 to be strong, I want them to know who they are. I want
10 them to know who their cousins are and be a part of that.

11
12 I didn't play with other kids, especially white kids,
13 until I went to school because, within our family we had 10
14 children - mum and dad had 12 children but two passed
15 before I was born. Aunty down the road, she had eight, we
16 had 18 kids. Would you want any more kids? There was a
17 big mob of us, we always played together, and we cared
18 about each other, we always watched out for each other and,
19 you know, if we knew someone - they call it mental health
20 issues now - had a problem, it wasn't a problem.

21
22 Everyone knew you had to look after them, everyone
23 watched out for them, and that was a wonderful thing,
24 that's how I grew up. I can't take my children back now
25 and show them where the old huts and that were because they
26 no longer exist, and the land is taken up now by orchards
27 and things like that.

28
29 You know, there's so many stories that I have growing
30 up and wonderful stories that I tell my boys about my life,
31 and it's one thing telling them and it's another thing
32 showing them, and I can't do that.

33
34 When I go home I take them up to - we go and visit the
35 cemetery because that's where all my family, most of them
36 are. Out of those 10 children I grew up with, there's only
37 four of us left. One of the things in life that I wanted
38 to do is reach 60, and I've done that. I'm over 60 now,
39 and that was a milestone, because so many of my family
40 didn't reach 60.

41
42 I've lost so many of my family at a young age, it
43 breaks your heart. And, the passing of them didn't happen
44 in isolation. The passing happened sort of in groups. I
45 had a brother we lost at 27; I had a sister we lost at 37;
46 I had two brothers die at 43. I had my sister, elder
47 sister, die at 59. I had a brother a year older than me,

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

5
6 That only didn't happen just with my brothers and
7 sisters, it also was with my nieces and nephews. One
8 particular niece, she passed away, she's only 26. I came
9 home from the funeral because I was doing some work up in
10 Sydney at the time, and then only two weeks later we had
11 another niece who passed. She was 40, we buried her on her
12 birthday. Her brother was 37, he went to her funeral and
13 then five weeks later we were burying him. How do we cope
14 with these sorts of things?

15
16 It's not an isolated situation. There's too many
17 deaths in our community and a lot of them can be prevented
18 through health.

19
20 Q. Thank you so much, Aunty Nellie. Chair, are there any
21 further questions for Aunty Nellie?

22
23 CHAIR: No, I don't think so. Aunty Nellie, thank you so
24 much for sharing with us your experiences. We didn't touch
25 on all of the professional contribution you've made in your
26 40 years working in Aboriginal Health and Wellbeing, but we
27 really do know that from your witness statement and thank
28 you so very much for sharing your personal story with us
29 here today. Thank you.

30
31 MS BATTEN: May Aunty Nellie please be excused?

32
33 CHAIR: Yes.

34
35 <THE WITNESS WITHDREW

36
37 MS NICHOLS: Commissioners, the next witness is Ms Helen
38 Kennedy, I call her to give evidence now.

39
40 <HELEN ELIZABETH KENNEDY, affirmed and examined: [10.53am]

41
42 MS NICHOLS: Q. Ms Kennedy, have you, with the
43 assistance of the Royal Commission, prepared a statement
44 which sets out your experience in the mental health system
45 and related matters and your opinions about the questions
46 we've discussed with you?

47 A. Yes, I have.

1
2 Q. I tender that statement. [WIT.0001.0048.0001]
3 Ms Kennedy, are you the Chief Operating Officer of the
4 Victorian Aboriginal Community Controlled Health
5 Organisation?
6 A. Yes, I am.
7
8 Q. Otherwise known as VACCHO?
9 A. Yes.
10
11 Q. Have you had many leadership and senior management
12 roles within the Aboriginal Community Control Sector and
13 Government including as a manager of the Family Counselling
14 Service of the Victorian Aboriginal Health Service?
15 A. Yes, I have.
16
17 Q. Have you been a Director of various organisations and
18 a member of the National Aboriginal Mental Health and
19 Suicide Prevention Committee?
20 A. Yes, I have.
21
22 Q. Have you worked as Principal Policy Advisor for the
23 Aboriginal Social and Emotional Wellbeing at DHHS, where
24 you played a key role in developing Balit Murrup, the
25 Aboriginal Social Emotional Wellbeing Framework?
26 A. Yes.
27
28 Q. Can I ask you to tell the Commissioners just a little
29 bit about VACCHO and what it does and what its objectives
30 are?
31 A. Victorian Aboriginal Community Control Organisation,
32 otherwise known as VACCHO, is the peak Aboriginal health
33 body for Victoria. It supports a number of member
34 organisations which are adult community controlled
35 organisations that have health as a key focus, currently
36 numbering about 28. So, our role is to provide advocacy,
37 policy support, research and over time we have aspirations
38 to become a centre of excellence in Aboriginal social and
39 emotional wellbeing.
40
41 Q. Is VACCHO a champion for improved mental health?
42 A. Absolutely.
43
44 Q. And does it get about half of its funding from the
45 State Government?
46 A. Yes, roughly half.
47

1 Q. Can I ask you about social and emotional wellbeing,
2 and it's right, isn't it, that many Aboriginal people
3 describe both their physical and mental health as having a
4 foundation of social and emotional wellbeing, originating
5 in strong positive connections to family, culture,
6 community, land and spirituality?

7 A. Yes, and I will answer that question, but before I do
8 I also want to acknowledge that we are meeting here on the
9 lands of the Wurundjeri people and thank Auntie Di for her
10 amazing and warm, as always, welcome to country. I want to
11 pay my respects to their Elders past and present and to
12 Elders in the room and to all Aboriginal people and
13 supporters that are here today.

14
15 Q. Thank you, Ms Kennedy.

16 A. There's obviously been lots of references about the
17 importance of social and emotional wellbeing. We know
18 that, to improve social and emotional wellbeing and mental
19 health in Aboriginal Victorians, we really need to define
20 health and wellbeing in terms of relevance and consistent
21 with Aboriginal people's understandings and experience,
22 both historically and in the context of colonisation and
23 the contemporary experiences of Victorian Aboriginal
24 families today.

25
26 I thought I'd just read out a definition that was
27 actually written in one of the first landmark national
28 reports on Aboriginal social and emotional wellbeing in
29 1995 and it still is relevant today:

30
31 "The concept of mental health comes from an
32 illness or a clinical perspective and its
33 focus is much more on the individual and
34 their level of functioning in their
35 environment. For Aboriginal people the
36 social and emotional wellbeing concept is
37 broader than this and it recognises the
38 importance to land, culture, spirituality,
39 ancestry, family and community and how
40 these affect the individual."

41
42 So critically it needs to be understood that, when the
43 harmony of these interrelations is disrupted, Aboriginal
44 ill-health will persist.

45
46 Q. Can you explain how it is that social and emotional
47 wellbeing is understood as having both risk and protective

1 factors?

2 A. Yes. Many Aboriginal people can describe both their
3 physical and mental health as having a foundation - social
4 and emotion wellbeing, commonly known as SEWB, originating
5 in strong and positive connections to family and culture,
6 community and spirituality as per that definition. So,
7 that has to be understood as a protective factor against
8 high rates of stressors and negative social determinants
9 that can lead to depression, anxiety, substance abuse and
10 sometimes severe mental illness.

11
12 Social and emotional wellbeing is a source of
13 resilience and we heard from Aunty Nellie before how
14 important it was for her to be connected to her culture and
15 her spirituality that supports her and others to protect
16 them against the worst impacts of stressful life events.
17 Those stressful life events, and Aunty Nellie articulated
18 them very well, sadly, is the number of deaths. Stressful
19 life events are also around divorce, separation, family
20 members being in incarceration, and the number of life
21 events that Aboriginal people experience are way, way
22 over-represented.

23
24 So, when we understand - I might just talk about the
25 risk factors, if you don't mind?

26
27 Q. Yes, of course.

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

34
35 Significant risk factors: there's growing research
36 that tells us more about these risk factors that negatively
37 impact on social and emotional wellbeing of Aboriginal
38 people which include widespread grief and loss, impacts of
39 the Stolen Generation and removal of children, unresolved
40 trauma, separation from culture and identity issues,
41 discrimination, economic and social disadvantage, physical
42 health problems, incarceration, violence and substance
43 misuse.

44
45 As I said, there's growing research around risk and
46 protection factors. Some researchers have identified very
47 clearly that forced removal from family, systematic and

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

5
6 For those Aboriginal Victorians who don't experience
7 strength in their identity and/or where those fundamental
8 protective factors that contribute to resilience are not
9 present in their lives, this can also lead to poor social
10 and emotional wellbeing.

11
12 Q. Can I ask you about the protective factors, and does
13 one model of social and emotional wellbeing draw on seven
14 domains which are intended to and understood to protect,
15 namely body, mind and emotions, family and kin, community,
16 culture, country, and spirituality and ancestry?

17 A. Yeah, the social and emotional wellbeing model that's
18 based on Aboriginal understandings of social and emotional
19 wellbeing has been developed in recent years. Dr Graham
20 Gee, who you will hear from later on, is one of the authors
21 and architects of that model.

22
23 In one of the first government frameworks called Balit
24 Murrup which was released two years ago, there's
25 significant attention made around identifying that model,
26 what the most specific risk factors are, protective factors
27 are, and there is a fantastic case study that tells a story
28 of an individual who's being supported to heal and improve
29 her social and emotional wellbeing and mental health by
30 focusing on all those protective domains, including
31 connection to culture, focusing on improvements in mind,
32 body and spirit, connection to family. Wadamba Wilam, who
33 you will also hear from later on, who has prepared that
34 case study, will give a really good detailed account of
35 what that means in practice.

36
37 My concern is that there is a very poor understanding
38 across the service system of social and emotional wellbeing
39 and how that model can, by focusing on protective factors,
40 can reduce the impacts of the risk factors and mitigate
41 those risks.

42
43 And I just wanted to say one more comment that, at a
44 practical level, there has to be a much greater
45 understanding by service providers about Aboriginal
46 concepts of social and emotional wellbeing to inform a
47 development delivery of culturally and clinically

1 appropriate service responses right across every aspect of
2 health and human service design and delivery approach for
3 Aboriginal people.
4

5 I reinforce: there's a poor understanding of this
6 model. Despite fantastic government reports such as this,
7 there's a limit of resources available to support
8 practitioners, policies, people working in social and
9 emotional wellbeing in mental health to understand how to
10 support people, Aboriginal people in the context of human
11 services delivery.
12

13 Q. Has it been shown that, where a social and emotional
14 wellbeing framework is actually implemented, that
15 Aboriginal people will have much better access to services
16 that express that framework?

17 A. Yeah. There's clearly a strong evidence base now that
18 that social and emotional wellbeing model works, and I
19 think that that will also over time support Aboriginal
20 people to perhaps alleviate their distrust in mainstream
21 services because they're able to be more culturally
22 responsive and not just focusing on what is the immediate
23 presenting factor and focusing on a biomedical approach.
24

25 I might actually just share a personal experience when
26 I was working at the Victorian Aboriginal Health Service,
27 and there was a community member who was waiting to see a
28 doctor as it turned out. Had a yarn with that person and
29 sat down, asked her how she was going. She said, "I'm
30 really distressed. I've come to see the doctor. I have
31 isolated myself, haven't left the house for weeks. I've
32 lost contact with family and my only interaction with the
33 world is through social media and what I'm seeing on social
34 media is horrific and it's really distressing to me, so I
35 thought I'd see the doctor. And, I don't know, maybe I
36 need antidepressants."
37

38 So at that time, fortunately, the Victorian Aboriginal
39 Health Service was running a Minajalku healing centre. So,
40 we were able to encourage that community member to
41 reconnect with community, to reduce her social isolation
42 and be part of community and reconnect. At the time there
43 were a number of women's healing groups, cultural
44 activities, art therapy et cetera that she was able to
45 reconnect with, and that supported her resilience.
46

47 So, in terms of those protective factors, connection

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

6
7 Q. Thank you. Can I ask you about the importance of
8 intervening early in life, and it's a fact, isn't it, that
9 childhood and family adversity experience by Aboriginal
10 community members is significantly higher than in the
11 non-Aboriginal community?

12 A. Yes. I thought I actually might share some other
13 research in addition to Penny providing - if I can call you
14 Penny, Commissioner - in providing an overview of what we
15 know about the entrenched mental health social and
16 emotional wellbeing gap that exists in the context of young
17 people.

18
19 Victoria has a very high youth population. From 0-24
20 our young people make up about 52 per cent of the
21 population, and it's growing and our population is growing
22 rapidly as well.

23
24 At the end of last year there was a major national
25 review on Aboriginal young people's mental health that was
26 released, and our young Victorian Aboriginal people
27 experienced the second-highest rate of psychological
28 distress in the nation, second to Western Australia, at
29 39 per cent. I think that's very, very telling and I think
30 we need to start at that.

31
32 We know that exposure to adverse child experiences is
33 associated with emotional and behavioural difficulties and
34 mental health problems in children and adolescents.

35
36 I believe that the impact of trauma on Aboriginal
37 children and families is a major undetected, underestimated
38 and misunderstood determinant of the poorer mental health
39 outcomes that we see in the adult population. And given
40 the high prevalence of mental illness of that large rapidly
41 growing population, there is an urgent need to address this
42 with new solutions and better, more accessible culturally
43 responsive services and initiatives. In other words, we
44 need to prioritise and strengthen early intervention and
45 prevention approaches for our children and young people.

46
47 Interestingly, I've had an opportunity to look through

1 a lot of the National Mental Health Commission reports,
2 background documents. The National Mental Health Secretary
3 considered expert advice on specific challenges for
4 Aboriginal people in 2014. They found that there was no
5 specific allocation of Commonwealth mental health program
6 funds for Aboriginal early intervention and prevention
7 programs.

8
9 The experts that contributed to that report supported
10 the view that investment and early intervention programs
11 for children and young people will provide the greatest
12 return in investment, and I think it would certainly, from
13 my perspective, be very important for this Royal Commission
14 to look at what investments this State Government are
15 making in that area, what's working, what's not working
16 well.

17
18 I think we need to do a deep dive to make sure that we
19 can precisely identify what those social and emotional
20 wellbeing mental health needs are and those gaps are for
21 children and young people and have a long-term plan for
22 delivering targeted services.

23
24 I know, when I was working at the Victorian Aboriginal
25 Health Service, that it was relatively easy for me to
26 attract funding to support adult mental health - I'm not
27 saying it was really easy, it was always challenging - but
28 whenever we made any attempts to find any funding and
29 resources to support the work that we were doing as part of
30 our Koori Kids and Adolescent Mental Health Unit there was
31 absolutely nothing. There is a paucity of resources to
32 support early intervention, social and emotional wellbeing
33 mental health services for young people.

34
35 Q. Can you tell the Commission a bit about the Koori Kids
36 and Adolescent Mental Health Service and why, though it has
37 underfunding, it's a good example of an early intervention
38 model?

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

1 have a suite of mental health psychiatric professionals and
2 Aboriginal health workers all working as one in
3 collaboration.
4

5 I know - and I'm aware that Andrew Jackomos is going
6 to be speaking later on. I had the privilege of being part
7 of the Taskforce 1000 three years ago where I was part of a
8 panel reviewing case, after case, after case, unpacking
9 where that child was, what had happened to them, trying to
10 identify systematic issues and improvements, and one of the
11 common themes in the taskforce in the northern region for
12 kids in out-of-home care who were doing well, was that they
13 were supported by counsellors, staff, from the Koori Kids
14 and Adolescent Mental Health Unit. It was quite startling.
15

16 Again, I think that there is opportunities for us to
17 do a lot more research to really highlight and bring to
18 bear and bring to life the evidence base of what works and
19 how it works.
20

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

26 A. Yes. It's clearly a central theme and in the context
27 of historical trauma we know that refers to the
28 manifestation of emotions and actions that arise from the
29 historical loss from the insidious and lasting impacts of
30 colonisation, which includes loss of land, cultural
31 connections, language, assimilation and child removal.
32

33 And I do need to say in prefacing my comments that in
34 Victoria these impacts have been brutal. Our history of
35 colonisation involved successive, sustained periods of
36 interpersonal and structural violence on entire groups and
37 communities. This level of traumatisation has resulted in
38 what's often referred to as the Stolen Generation - sorry,
39 intergenerational, transgenerational and historical trauma.
40

41 Intergenerational trauma continues to affect
42 Aboriginal people in Victoria today by being passed down
43 from the first generation of survivors who directly
44 experienced or witnessed these events, traumatic events to
45 future generations.
46

47 I really do need to highlight that, within living

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

11
12 I want to say that we know - and again I know we're
13 hearing from Dr Helen Milroy who was the Commissioner for
14 the Royal Commission into institutional abuse a bit later
15 on - but we do know that many of the Stolen Generations
16 were psychologically, physically and sexually abused while
17 in care or with their adoptive families.

18
19 As Justice McClelland said:

20
21 "Their forced removal led to psychological
22 and emotional damage which has been
23 inherited by today's Aboriginal and Torres
24 Strait Islander children. As a result,
25 many remain highly vulnerable to sexual
26 abuse."

27
28 I need to say, I find it astounding that Victoria, who
29 is supposed to be one of the most progressive states, has
30 been unable to come up with a reparation scheme for Stolen
31 Generation survivors, unlike other states such as Tasmania,
32 New South Wales and South Australia.

33
34 I think, for many Aboriginal people who were sexually
35 abused in institutions, healing and seeking redress are not
36 separate and should be addressed in parallel and considered
37 as part of this Royal Commission process.

38
39 In answering the second part of your question, in
40 terms of intergenerational trauma, that is passed down
41 through parenting practices, it's passed down through
42 behavioural problems, violence, substance abuse and mental
43 health issues.

44
45 And of course, and this is something I really want to
46 highlight, if people do not have the opportunity to heal,
47 then they may deal with their pain in negative ways,

1 including self-destructive behaviour, development of
2 lifestyle diseases, entering the justice system, physical
3 and emotional violence abuse or addiction.
4

5 My plea is that we focus more on supporting our
6 communities, individuals and families to address that
7 underlying trauma and in the context of preventative
8 responses. I am a big advocate for us to have a much
9 greater focus on providing support services that focus on
10 healing models.
11

12 Q. Can I ask you about the effect of racism. Is it the
13 fact that Aboriginal Victorians, over 70 per cent report
14 eight or more racist incidents within the preceding
15 12 months?

16 A. Yes, I think it's important to be aware that there is
17 a connection between intergenerational trauma and
18 institutionalised racism, and how that impacts on
19 Aboriginal people's engagement with the medical mental
20 health system. It serves as key barriers to accessing
21 adequate health care.
22

23 One example is, Aboriginal Victorians are regularly
24 subjected to racism, with over 70 per cent reporting eight
25 or more racist incidents within the preceding 12 months.
26 This has a direct impact on medical health outcomes with
27 47 per cent of Aboriginal people who self-reported
28 instances of racism, being over the threshold for very high
29 and high psychological distress.
30

31 One study has shown 62 per cent of Aboriginal people
32 reporting experiencing racism in a health care setting.
33

34 Q. That was a study published in the Medical Journal of
35 Australia?

36 A. Yes.
37

38 Q. In 2014?

39 A. Yes. And racism acts as a barrier to accessing
40 services and seeing through health care Services to
41 completion.
42

43 Q. Can I ask you to tell the Commissioners in brief, what
44 is trauma-informed care?

45 A. Before I answer that question, I'd just like to share
46 some other research that's important to understand because,
47 if we are looking at bedding down trauma-informed models

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

5
6 Some research has been done, just five minutes down
7 the road from here, by Dr Graham Gee over many years that
8 looked at the extent of trauma exposure among Aboriginal
9 clients attending family counselling services. The number
10 of traumatic events clients reported experiencing in a
11 lifetime was very high, at nearly 13.

12
13 Dr Gee, who you will be hearing from later, as I
14 understand, by Skype noted that this level of trauma
15 exposure was comparable to studies involving refugee
16 populations who had experienced large-scale collective
17 trauma. I don't think that people are anywhere aware
18 enough of the extent of exposure to traumatic events in
19 addition to the impacts of transgenerational trauma.

20
21 A further concern: 91 per cent of those clients report
22 experiencing family violence; 40 per cent reported trauma
23 symptoms severe enough to be consistent with post-traumatic
24 stress disorder. So, a really important piece of research
25 that I understand is not yet published, but no doubt Graham
26 Gee will be talking about that.

27
28 So trauma-informed care is a framework that allows
29 practitioners to better understand the ways in which trauma
30 impacts on the individual. It allows for a holistic
31 understanding of trauma by situating the person's
32 experience within their environment and it's a departure
33 from medicalised models to understand trauma-related
34 behaviours as a pathological symptom, rather than as the
35 result of larger inequalities.

36
37 Trauma-informed care aims to reduce the trauma felt in
38 an individual's life which manifests itself in different
39 ways. When I think of trauma-informed care, I don't stop
40 at trauma-informed care, I say trauma-informed and
41 healing-based care, if we are to be situating service
42 models that are more responsive to the needs of Aboriginal
43 people.

44
45 Trauma-informed and healing-based care improves the
46 mental health outcomes of Aboriginal people and should be
47 the cornerstone of all care practices and for every service

1 working in mental health and related areas. Again, it
2 allows for holistic approaches and service provisions that
3 recognise the individual experiences of clients.
4

5 I am aware that there has been some work done to
6 support the capability of mental health staff across
7 Victoria to provide trauma-informed treatments to people
8 with refugee backgrounds seeking mental health care. We
9 need to do the same work for our First Nations people and
10 should prioritise commissioning of work that supports an
11 Aboriginal trauma-informed and healing-based framework with
12 associated resources to be introduced right across the
13 mental health service system including our own
14 organisations, our own ACCHOs, in addition to healing
15 centres and healing initiatives.
16

17 Q. Can I ask you to explain briefly, what's the essential
18 difference between trauma-informed and healing-based care
19 and what you call medicalised models of care?

20 A. I think again, trauma-informed care is less of a
21 biomedical model and ultimately has the same aim of
22 reducing the trauma felt in an individual's life, which
23 manifests itself in different ways. By adopting a social
24 and emotional wellbeing framework in terms of supporting a
25 person's social and emotional wellbeing, including their
26 recovery/healing, recognises that, in an Aboriginal
27 context, healing is a critical underpinning concept that
28 sits across the entire social and emotional wellbeing
29 model.
30

31 Q. Thank you. Can I ask you about the problem you've
32 identified in your witness statement of many Aboriginal
33 people in Victoria having a profound distrust of mainstream
34 health services, and what do you think could be done to
35 improve that position?

36 A. I'll start off by saying that Aboriginal people in
37 Victoria have historically not accessed mental health
38 services at levels appropriate to their needs. Aboriginal
39 people are over-represented in terms of psychosocial
40 problems compared to the general population and do not
41 access mental health community support services and levels
42 commensurate with their needs.
43

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

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

3
4 Two, there's a lack of awareness amongst mental health
5 service providers of the historical community and cultural
6 factors relating to social and emotional wellbeing and
7 mental health.

8
9 I believe there are inflexible models of service
10 delivery, including the use of inappropriate assessment and
11 diagnostic tools, and I have no doubt that some of the
12 clinicians who will be speaking later on can provide some
13 examples of where that occurs.

14
15 Critically, there are too few Aboriginal people
16 actually working in the mental health service system. We
17 know that Aboriginal people are more likely to access
18 health services and return for following treatments if
19 Aboriginal people are working in these services, and
20 there's a lot of evidence for that and I'd be happy to talk
21 more about that.

22
23 There are poor quality linkages for people,
24 particularly - and we've been hearing this throughout this
25 entire mental health Royal Commission, lack of integration,
26 linkage between primary mental health, funded by the
27 Commonwealth mainly, and our specialist clinical services
28 which are delivered by the states.

29
30 The other challenge relates to the relative poverty
31 and geographic location of many Aboriginal people with
32 mental health problems and their carers, particularly
33 Aboriginal people who live in regional locations which
34 affects their capacity to access mainstream services.

35
36 Stigma: stigma of mental illness acts as a significant
37 barrier to Aboriginal people seeking help when it's needed.
38 I think we've got a lot of work to do to address stigma.
39 It exists on a number of levels, including feelings of
40 shame for individuals, and I think that there is still
41 limited mental health literacy and awareness of social and
42 emotional wellbeing problems in Aboriginal communities
43 including early identification of needs.

44
45 Q. Can I ask you to say a little bit more about the
46 workforce and the importance of developing the Aboriginal
47 workforce in mental health and the challenges of doing

1 that?

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

8
9 In our clinical mental health services alone, and we
10 have 38 services I understand - 33 - which includes Child
11 and Adolescent Mental Health Services as well as our Area
12 Mental Health Services, there are only eight Koori Mental
13 Health Liaison Officer positions. We know that there's a
14 new traineeship program that's being rolled out to support
15 a growing skilled mental health workforce, which is
16 fantastic, but they're not located in all the services.

17
18 Those staff, a small number of the eight Koori Mental
19 Health Liaison Officers, I believe feel under-supported,
20 isolated, the lack of career paths, and a lack of clarity
21 around the scope of practice, and I would suggest a major
22 review of that initiative and how it fits in with the new
23 traineeship program so that we can have a cohesive
24 Victorian Aboriginal mental health workforce strategy that
25 looks at the mental health service system and how we can
26 grow and support that workforce, as well as within our
27 Aboriginal Community Controlled Health Service.

28
29 I will say, I have looked a lot at the experiences of
30 New South Wales who are at least 10 years ahead of us.
31 They have a policy commitment that, for every 1,000
32 Aboriginal people living in New South Wales, there will be
33 one Aboriginal mental health worker position employed. As
34 I understand, they are well on target recognising that they
35 have a much bigger population than we have in Victoria.

36
37 They have done extensive reviews and evaluations of
38 their workforce program. Most of their mental health
39 services have two Aboriginal mental health workers, an
40 Aboriginal mental health clinician and an Aboriginal lead
41 clinician, which reflects good practice as a general rule:
42 you wouldn't put just one Aboriginal person working in,
43 particularly a mental health service system with some of
44 the complexities that are associated with that.

45
46 Q. Is it important to have a developed Aboriginal
47 workforce in both ACCHO controlled services as well as in

1 mainstream services?

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

11
12 With a few exceptions there is inadequate and
13 inefficient funding. They're often recipients of very
14 small parcels of funding that are short-term,
15 non-recurrent, and they struggle to deliver real
16 sustainable impacts on individuals, let alone families and
17 whole communities across vast geographic areas where
18 transport and a lack of outreach service remain barriers.

19
20 I would like to highlight that, despite those limited
21 resources, two of the top presenting issues that are
22 presented at ACCHOs are depression and second depression
23 and anxiety. Our ACCHO CEOs have identified mental health
24 as being their top priority and their top service gap. The
25 Commonwealth Mental Health Commission identified as a
26 priority, as a way to respond to growing mental health
27 issues and the growing gap, that a solution is to support
28 the development of Aboriginal social and emotional
29 wellbeing teams that are integrated into every ACCHO and
30 that's what we need to do.

31
32 I think Primary Health Networks have a key role to
33 play in there, but I think that there is enormous
34 frustration within ACCHOs that those resources to support
35 those multidisciplinary teams to partner up with mainstream
36 services are very, very slow to come. And there is some
37 really good examples that I can highlight that are working
38 really well where the State Government has invested in four
39 ACCHOs to develop new treatment and service responses in
40 mental health and an evaluation is still underway, and the
41 outcomes are showing really positive impacts.

42
43 So, let's learn from that and grow that model across
44 our ACCHOs.

45
46 Q. Because we're running reasonably short of time I'm
47 going to ask you about a couple of things briefly. There's

1 much in your statement and you can be assured that the
2 Commissioners have that and have read it and have
3 considered it.
4

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

9 A. Very briefly, the last time there was an Aboriginal
10 Suicide Prevention Framework was 2014. I'm really
11 concerned that that suicide framework was developed in
12 response to a spate of suicides right across Victoria;
13 there was an enormous amount of community consultation that
14 provided input into that strategy. I don't think it has
15 ever been reviewed, evaluated, reported against, and I fear
16 that we are now moving into another phase of far too many
17 suicides, suicides that are under-reported.
18

19 We know that the Coronial Court is doing a deep dive
20 into getting, for the first time ever, a register of
21 Aboriginal suicides. Victoria's never been able to report
22 on its Aboriginal suicides at a national level. I believe
23 that we need to have a focused look at suicide prevention
24 as part of this Royal Commission; it needs to be a specific
25 piece of work that should review what has happened.
26

27 We know that there needs to be more research into what
28 works, but there is a centre of best practice in Aboriginal
29 suicide that we can look at, but I think we should not wait
30 until we have crisis - which I think we probably already
31 do - across Victoria to have a response.
32

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

37 A. I will just say, from my experiences, being involved
38 in community consultations leading up to the 10-year mental
39 health plan, Balit Murrup, that a key area of focus that
40 Aboriginal people and families were wanting to draw more
41 attention on was a focus on healing, and healing services
42 and support. We know they work, the evidence is
43 compelling. Our own Aboriginal Healing Foundation has
44 identified the benefits, including economic benefits of
45 investing in healing centres.
46

47 The example that I provided before about the woman in

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

8
9 MS NICHOLS: Thank you very much, Ms Kennedy. Chair, are
10 there any questions from the Commissioners?

11
12 CHAIR: Q. There's just one thing I'd like to examine a
13 little bit. Thank you very much, it's a very comprehensive
14 statement and we have, as Ms Nichols said, been able to go
15 through that.

16
17 The importance of yarning, you used the word a fair
18 bit, and in Auntie Nellie's statement she talked about the
19 fact that when she worked at the CASA in her career a lot
20 of the time no-one came into the centre, Aboriginal people
21 weren't comfortable until she went out and was informally
22 meeting with people having a coffee yarning and she said
23 there was a tenfold increase in the number of people
24 seeking assistance.

25
26 How important is us understanding yarning in the
27 designing of Aboriginal-centred practice into the future?
28 A. I think it's very important. I think that stigma of
29 mental health, seeking help, is a real challenge. I know
30 that even for people to rock up to family counselling
31 services - again, that "counselling" - it's a big step and
32 it's hard. I think that the Victorian Health Service have
33 done incredibly well to break down some of that stigma
34 because it's a trusted service.

35
36 You will see on ever door in any of the - you know,
37 what's normally a "consult room" - it's called a yarning
38 room: yarning room 1, yarning room 2, yarning room 3,
39 yarning room 4 and it goes on and on. So, yes, I think
40 it's important that that be recognised.

41
42 CHAIR: Thank you.

43
44 MS NICHOLS: May Ms Kennedy be excused?

45
46 CHAIR: Yes. Thank you very much for your evidence today.

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

3
4 CHAIR: Yes.

5
6 **SHORT ADJOURNMENT**

7
8 MS BATTEN: Commissioners, the next witness is Mr Adam
9 Burns, who's appearing via video link to the Northern
10 Territory. We'll just ask Mr Burns to take the
11 affirmation.

12
13 **<ADAM JOHN BURNS, affirmed and examined: [12.02pm]**

14
15 MS BATTEN: Q. Thank you very much, Adam. Can you hear
16 me okay?

17 A. Yeah, all good.

18
19 Q. Thank you. Have you, with the assistance of lawyers,
20 prepared a witness statement for this Royal Commission?

21 A. I have.

22
23 Q. I tender that statement. [WIT.0002.0014.0001].

24 Adam, could you please start by telling us, what is
25 Wadamba Wilam?

26 A. Okay, Wadamba Wilam's a program to work with
27 Aboriginal and Torres Strait Islander people experiencing
28 homelessness and mental illness, and it's been running for
29 about five years and it's quite unique in that it has four
30 organisations involved.

31
32 So, I represent the Northern Area Mental Health
33 Services, and there's an Aboriginal mental health worker,
34 there's a drug and alcohol worker, there's an NEAMI worker.
35 There's also an NEAMI manager and a consultant
36 psychiatrist. The idea being that we work as an
37 inter-agency team, work collaboratively with 25 to 30
38 clients.

39
40 Q. Okay, thank you. Could I just ask you to speak just a
41 fraction slower, please. Could you also tell us what's
42 your role at Wadamba Wilam, what do you do there?

43 A. My role, I'm a senior mental health clinician, so I'm
44 the psychiatric nurse on the team, so I guess I provide
45 direct support case management and so forth to clients as
46 well as some other roles within the team, like liaison and
47 primary, secondary and tertiary consultations to other

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

5
6 Q. Can you tell us a bit more about that holistic care,
7 what do the services that you provide look like?

8 A. So, it's all provided through intensive outreach, so
9 we take the service to the person. So, it can be really
10 varied. Like I said, the main criteria was homelessness
11 and mental illness but that's normally just the tip of the
12 iceberg for many of the people we work with. I think it
13 should be acknowledged that underlying trauma drives a lot
14 of this, but also that people have co-occurring addiction
15 or other disabilities, and acquired brain injury and
16 intellectual disability, and also I guess a lot of other
17 issues in their life or, you know, they haven't had any
18 connection with their culture or their people.

19
20 So, essentially it's about initially building trust
21 and relationship and then working through the issues as we
22 go. So, most of the people that I work with, the clients
23 I've been working with for four or five years and seeing
24 them at least once or twice a week in an outreach basis, so
25 the work is varied. It certainly has a focus on trauma,
26 but also navigating the many systems that people are
27 involved with, and just, you know, also becoming empowered
28 and engaging in meaningful activity, growing as individuals
29 and becoming leaders in their community. So, I think it's
30 about walking with and using all the skills that it takes
31 to do that, but no two days are the same and the work is
32 varied.

33
34 Q. You talked about building trust, does it take some
35 time to build a trusting relationship?

36 A. Yeah, consistently when I've asked people how long has
37 it taken to build trust, they inevitably say it's
38 12-18 months and, if you break that down to, I guess hours
39 spent, it's probably around 100 hours, which is well in
40 excess of most episodes of care for most parts of the
41 mental health service sector. So, you know, that's the
42 most important thing, I would say people say it takes
43 12-18 months to trust you.

44
45 I guess I will say that, if the family vouches for
46 you, that process can be a lot quicker because that family
47 member you're working with immediately trusts you because

1 the family trusts you, so it can be quicker, but as a
2 rule 12-18 months. I should also say that I'm working with
3 a population of people that have fallen through the gaps in
4 traditional service provision and probably have quite
5 significant mental illnesses and other barriers, so I'm
6 kind of working at the hidden population, I would say.
7 Many of the people I work with haven't had - I might be,
8 you know, the only contact they've had with a health care
9 professional for a long time. Other people might be, you
10 know, they're in and out of crisis and have contact with
11 lots of healthcare professionals, but I think they don't
12 have an opportunity to build that trusting relationship.
13

14 Q. I do want to ask you about barriers in a moment, but
15 before we get to that, how do people come to you? How do
16 they find your service and how do they get referred to you?

17 A. Initially it was agency referrals, so any agency can
18 refer to us if the client meets the criteria. But more
19 recently, we've been getting referrals straight from
20 community and family members, which is a good thing, so I
21 think anyone can refer to us essentially.
22

23 Q. And you said that you think that's a result of the
24 community growing an acceptance of you; is that right?

25 A. Yeah, definitely so, yeah, that's a result of that
26 vouching process which has taken two or three years I would
27 say. All our initial referrals were - or actually, you
28 could say that most of our initial referrals were from
29 mainstream services, so I guess we get vouched for within
30 Aboriginal services as well. So, now I would say that
31 there's consistent referrals from community Aboriginal
32 services and mainstream services.
33

34 Q. Can you tell us from your experience, how does
35 trauma-informed care contribute to the mental health
36 outcomes of Aboriginal and Torres Strait Islander people?

37 A. Oh, it's central. I think that, I guess a lot of the
38 issues that we're seeing are outcomes of trauma, so to be
39 trauma-informed is essential and needs to be part of the
40 whole agency, the individual, the paperwork, everything
41 needs to be trauma-informed, and I think unfortunately the
42 time constraints can make that difficult to achieve, so
43 trauma-informed is central to what we do, I guess --
44

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

46 A. You go.
47

1 Q. Can you clarify what you mean by the time constraints?
2 What are the time constraints?

3 A. For instance, like, if someone's say, going to an
4 Emergency Department or accessing other parts of the
5 service, the person's got to gather that information in 60
6 minutes in an interview or whatever, and sometimes people
7 will share their trauma and other times they won't, but I
8 think sometimes it takes 12 or 18 months after that
9 trust-sharing period for people to start to share some of
10 their experiences. So, I think, you know, it's important
11 to give the space and the time and the skill to allow that
12 to happen in a safe manner.

13

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

17

18 Q. Have you seen outcomes where there has been
19 trauma-informed care, has that resulted in more positive
20 health outcomes for Aboriginal people?

21 A. Oh, definitely. That's one of the privileges of
22 working with Wadamba Wilam, I can draw on 30 amazing
23 stories of people that have turned their life around, and I
24 think it comes from not having to tell their story over and
25 over, or having their story held in a safe way.

26

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

38

39 Q. Did you want to refer to some case studies at this
40 point? Were there some case studies of the work that
41 you've done that you wanted to share with the Commission?

42 A. Yeah, look, there's a couple of people that come to
43 mind. A couple of single males that were in their 50s and
44 had been homeless for 30-plus years, haven't had any
45 support from any services, and had a lifelong of
46 post-traumatic stress but not diagnosed or recognised, and
47 also, as a result of that, a lifelong addiction; heavy

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

3
4 Both of these gentlemen made their first disclosures
5 of significant interpersonal trauma from a young age and
6 they kept that secret for their whole life. Both disclosed
7 that at about the 18-month mark and over that next two or
8 three-year period we worked on skills together about how to
9 manage that distress; when you're triggered how to do
10 different coping strategies, how to not turn to addiction.

11
12 Both those men now are doing really, really well, no
13 longer using drugs, and have also re-engaged with their
14 family and been a part of their grandchildren's lives and
15 so forth. Most importantly, I think connected with their
16 culture on a positive level, so come to the mens camps and
17 other things where, they in some ways felt too threatened
18 to do that in the early stages or too traumatised, but now
19 they've got a sense of pride and so forth and so they can
20 access all the things that are healing for them.

21
22 I think that's one of the privileges of the work.
23 I've been part of many healing journeys and, yeah, that's
24 just one of many stories.

25
26 Q. Thank you. You've mentioned earlier the barriers.
27 Could you tell us about the barriers at a system level that
28 Aboriginal and Torres Strait Islander people face in trying
29 to access trauma-informed care?

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

33
34 I think Helen Kennedy touched on it earlier, is that,
35 the mainstream services come from a biomedical model, so
36 there's immediately a clash there with cultural
37 understandings of health and wellbeing.

38
39 I think the process is so rigid because of the time
40 constraints and also the instrumentation as well; the
41 language barriers, all the instrumentations used are based
42 on mainstream populations, so I think on many levels there
43 are barriers, but I think it plays out mostly in those
44 three areas and just having a safe space.

45
46 I would say that the biggest success of Wadamba Wilam
47 is the outreach, so taking the service to the people rather

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

5
6 Q. You highlighted some of the key features of the
7 Wadamba Wilam model. Were there any other elements of the
8 model that you haven't spoken about that you wanted to
9 cover?

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

17
18 Also having the inter-agency thing, so we can manage
19 most people's needs within the team, so that is another way
20 of reducing trauma because you know that it's covered
21 within the team.

22
23 The other thing is working with multiple family
24 members at one time; I think that's been a thing that has
25 developed over the last couple of years and that has been
26 one of the major factors. I've been working with, say,
27 someone's son for two or three years in an intensive
28 capacity and have had some contact with the mother as a
29 carer for that time. At that point she asked for some help
30 for herself, so then we pick up her as well and working
31 with multiple family members at one time can help break
32 some of these transgenerational cycles of trauma and
33 working with the families together.

34
35 I think Aunty Nellie earlier said that she wants
36 families and stuff to be able to go to a service together;
37 maybe it's the services need to go to the families and
38 that's when you can work with that, because there's such a
39 richness of information, but also a richness of resources
40 strengths and resilience that you can tap into to promote
41 that healing.

42
43 Other things like early interventions, things like
44 that that the family will contact us straight away, and so,
45 you can manage a situation before it even becomes a crisis
46 because the family have been proactive in managing that, so
47 I think that's an important one.

1
2 Low case numbers is imperative. As I mentioned, 25-30
3 clients between four workers, that gives you that time,
4 flexibility and really your focus is to build that
5 relationship; that's a bit of a different focus to other
6 parts of the mental health system. So, it's about, you're
7 already changing the way you're approaching things, but
8 understanding that it's going to take three, four, five
9 years to go on a journey with someone and that you're going
10 to have to use different skills and resources at different
11 times, but that having those low case numbers gives that
12 opportunity for that responsiveness, which gives people
13 opportunities to do dynamic healing, so having people call
14 up when they're triggered and traumatised and going to sit
15 with them in that moment is such a powerful opportunity, so
16 then you can start to build in some coping strategies and
17 even just some basic knowledge around trauma and how it
18 affects their body.

19
20 The other really important component is considering
21 trauma recovery and considering when someone is on that
22 trauma cycle. So, there's three main stages of trauma
23 recovery and that needs to be the focus of treatment. So,
24 phase 1, we talk about safety and stability and security,
25 and that's the phase where engagement happens, where maybe
26 some medication happens, where people are learning about
27 what trauma is and how it's affected them, there's a lot of
28 education, there's a lot of resources and so forth.

29
30 Phase 2 is like a reprocessing phase, so not reliving,
31 but sort of processing and gaining a different
32 understanding, a relationship with trauma, and sort of
33 phase 3 is going on to a meaningful life, employment and
34 community and so forth. But it's not a linear journey, so
35 people can easily go back to phase 1 and that's really
36 important to recognise where people are on that trauma
37 journey.

38
39 Another really important component is continuity of
40 care. So, when a Wadamba Wilam client goes to another part
41 of the service, a Secure Extended Care Unit, a Community
42 Care Unit, or they go to Justice or anywhere, that we
43 remain involved as a key member of that care and work with
44 that person while they're in that institution, and that's
45 important for a number of reasons, in that, we hold a lot
46 of the knowledge of their story and what works and what
47 doesn't work, but also to inform the treatment in wherever

1 they are, and more importantly be part of discharge
2 coordination and really reinforce what has happened in
3 those parts of the service.
4

5 So, that's invaluable, that is, and from what I've
6 noticed in my previous roles, that usually when a client
7 goes to another part of the service, then you no longer
8 have a role and you pick them up and they come out the
9 other end, but being a key part of that journey is
10 important. They're the main elements of the model that I
11 think, you know, what works.
12

13 MS BATTEN: Thank you very much, Adam. Chair, are there
14 any questions from the Commissioners for Adam?
15

16 COMMISSIONER McSHERRY: Thank you very much for your
17 statement. One question: you mention co-design as being an
18 important or valuable way of involving communities as well
19 as carer and consumer consultation and peer support. I'm
20 just wondering whether you might tell us what your ideal
21 situation would be in that regard?

22 A. So, at Wadamba Wilam we face the same troubles, in
23 that we didn't have the instrumentation or process when we
24 started, and I think the co-design part would be developing
25 the instrumentation or checking the language with the
26 clients and getting their feedback and modelling it, but
27 also having the carer and consumer involvement I think
28 would be a great part.
29

30 On a broader level, I think it's paramount that people
31 need to be involved in defining what the services are and
32 how they work. So, I think my vision would be having them
33 involved in all parts and, from a Wadamba Wilam
34 perspective, we've had a number of peer support workers on
35 our team and they're invaluable in the knowledge and skills
36 and so forth that they bring.
37

38 COMMISSIONER McSHERRY: Thank you.
39

40 CHAIR: Professor Fels.
41

42 COMMISSIONER FELS: Q. Thank you for your excellent
43 evidence. Could you comment briefly on the question of
44 homelessness and poor accommodation, their impact on mental
45 illness and their role in the recovery approach?

46 A. Oh, of course, yeah. I think that's the other part of
47 the engagement phase, in that, you need to sort of go back

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

6

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

13

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

22

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

28

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

33

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

44

45 COMMISSIONER FELLS: Thank you.

46

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

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

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

15
16 I guess there is some throughput because there are a
17 proportion of people that don't engage, so we'll give it a
18 good go for six to 12 months and then, if it's not working,
19 then other people can come through.

20
21 We've also been flexible with managing our numbers
22 because, when someone's at the four, five year mark there,
23 their needs aren't as acute as someone who's coming into an
24 intensive engagement phase.

25
26 Also, we reduced the episodes of care, so a number of
27 the people at Wadamba Wilam have had 20-plus hospital
28 admissions and multiple ED presentations and so forth prior
29 to coming to Wadamba Wilam and haven't had an admission for
30 four years with this wrap-around support, and I think they
31 were traditionally on community treatment orders and
32 notoriously difficult to follow up in the traditional
33 sense, now taking ownership and control of their own
34 treatment in their lives, and so, I think it's a great
35 model and that's such an important thing, an important part
36 of it.

37
38 Q. Can I just ask in relation to that: was an evaluation
39 built into this model? Is it going to be possible to
40 access that sort of data and information about the
41 effectiveness of your responses.

42
43 A. Yeah, so I think there was a general evaluation done
44 into the breaking the cycles, but that was in the first two
45 years of practice. We've done some in-house evaluations
46 and most of the data shows a significant reduction in the
47 amount of inpatient hospital admissions for instance, but

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

10
11 I think also at Wadamba Wilam we have an opportunity
12 to do more cultural interventions like taking people back
13 to country and going on camps and stuff, and there's some
14 amazing healing opportunities at those events.

15
16 CHAIR: Thank you very much, Mr Burns.

17
18 MS BATTEN: Thank you. May Mr Burns please be excused?

19
20 CHAIR: Yes, thank you very much for your evidence and
21 making the time to be engaged with us from Darwin today.

22
23 MS BATTEN: Thank you very much. We'll cut the link.

24
25 **<THE WITNESS WITHDREW**

26
27 MS NICHOLS: Commissioners, the next witness is Mr Andrew
28 Jackomos. I call him now to give evidence.

29
30 **<ANDREW MORGAN JACKOMOS, affirmed and examined: [12.31pm]**

31
32 MS NICHOLS: Q. Mr Jackomos, are you the Executive
33 Director, Aboriginal Economic Development, at the
34 Department of Jobs, Precincts and Regions?

35 A. Yes, I am. But first, can I acknowledge --

36
37 Q. Sorry, yes.

38 A. -- country. I respectfully acknowledge traditional
39 owners and the welcome that Aunty Di gave us earlier. I'd
40 like also to acknowledge the support and commentary from
41 Helen and Nellie.

42
43 I'd also like to acknowledge that the last time I was
44 here on this dance floor was eight weeks ago when my mother
45 was buried, and last time I saw her was in front of me.
46 I'd just like to thank you for the opportunity.

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

7 A. Yes, I have, and I do want to thank them.

8

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

15 A. Yes, I did.

16

17 Q. From 2013 for about five years, were you the inaugural
18 Commissioner for Aboriginal Children and Young People in
19 Victoria?

20 A. Yes, I was.

21

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

27 A. Yes, I did.

28

29 Q. And, "In the child's best interests", an inquiry into
30 the Victorian child protection system's compliance with
31 Aboriginal child placement principles?

32 A. Yes, I did.

33

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

39 A. Yes, I did.

40

41 Q. Can I ask you, in your working life, what have you
42 observed about the connection between unresolved mental
43 health issues and socio-economic disadvantage and an
44 over-representation of Aboriginal people in the criminal
45 justice system with family violence and child protection
46 issues?

47 A. So, what I've seen is that intergenerational trauma

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

3
4 For me, whether it's in the child protection system,
5 whether it's in youth justice, whether it's in family
6 violence, whether it's in the adult criminal justice
7 system, the history of this country is ever present.

8
9 Q. Can I ask you a very basic question, and that is, what
10 does the term "culture" mean for Aboriginal and Torres
11 Strait Island people?

12 A. "Culture" for me means the parameters in which I
13 exist: they set the values, they set my obligations to my
14 family, my children, my community. They give us - for me,
15 culture is the greatest resilience factor we can give our
16 children.

17
18 I've seen, where there is strong culture, we have
19 strong children. I've seen, in the Youth Justice system,
20 I've seen in child death reviews where there's an absence
21 of culture and there's a direct linkage between strong
22 culture and strong children.

23
24 Q. What happens when a person's connections to culture
25 break down?

26 A. For me it's, you lose your sense of belonging, you
27 lose your parameters in which you live, you can lose pride
28 and self-esteem. And, where you have strong culture, you
29 have strong self-esteem. Where you have poor culture, you
30 see those mental health issues.

31
32 When I undertook Taskforce 1000, looking at 1,000
33 children and child protection, you actually saw the absence
34 of culture and the negative power it plays with our
35 children.

36
37 Q. Perhaps looking at it from the other side, in your
38 witness statement you've given an example of how community
39 and connection to culture can be very empowering. You've
40 given the example of a young Aboriginal man you met in a
41 Youth Justice facility who was then placed on country in
42 the protective company of an Elder. Can you tell the
43 Commission about that?

44 A. So, I met this young man, 17 years of age, in a Youth
45 Justice facility. When I saw him, he had fresh cuts on his
46 arms, his neck, and his arms and his legs were just a
47 pattern of scars. A beautiful young man, very intelligent,

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

16
17 Q. Amongst Aboriginal and Torres Strait Islander
18 communities, are there differences in terms of what's meant
19 by culture and community connection?

20 A. I'm sure there are. There are so many nations and
21 communities across, and they will have different aspects
22 than individuals will have, but that's common. You might
23 have different dance moves and different words, but it's a
24 common, for me having an experience lived across Australia,
25 there are common concepts of what culture is.

26
27 Q. And what are the important common concepts?

28 A. For me, the important concepts are: connection to
29 country, it's connection to other Aboriginal peoples. It's
30 your obligations - for me, one of the most important things
31 about culture is obligations to your children, to your
32 siblings, to your family, parents, Elders, obligations to
33 country, obligations are fundamental, it's about how you
34 relate to each other.

35
36 I noted in my statement I mentioned that, when one
37 Aboriginal person meets another Aboriginal person for the
38 first time, it's about identifying connections, about who's
39 your mob rather than, you know, where do you work. It's
40 who are your mob, it's about drawing those connections.

41
42 Q. Can you tell the Commission what you understand by the
43 term "cultural safety"?

44 A. Cultural safety is how I feel, how other Aboriginal
45 people feel in their environment. So, as opposed to
46 cultural competence, it's how we feel entering into an
47 environment.

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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,

1 development, monitoring and evaluation.

2

3 Q. You've given an example of a culturally competent
4 service delivery in the Department of Corrections Victoria
5 called Wulgunggo Ngalu. Can you tell the Commissioners
6 something about that?

7 A. So, the Aboriginal Justice Agreement, first
8 established in 2000, was about reducing recidivism of
9 Aboriginal people in the criminal justice system, and one
10 of the ways Aboriginal people were breaching orders at a
11 much higher rate than non-Aboriginal people. So,
12 Aboriginal people, in partnership with non-Aboriginal
13 people through the Department of Justice, developed a
14 community-based, a land-based, Wulgunggo Ngalu which is
15 down in South Gippsland, and it's where Aboriginal men,
16 predominantly young men, voluntarily go there and spend the
17 time.

18

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

25

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

29

30 Q. And that's been running successfully for over a
31 decade?

32 A. Yes, yes, 10 years last year.

33

34 Q. Does the extent to which a service is delivered in a
35 culturally competent way affect the extent to which
36 Aboriginal and Torres Strait Islander people will use that
37 service?

38 A. Yes. Nobody's going to go to a racist service. You
39 know, I'm a serial attendee at the Victorian Aboriginal
40 Health Service. I go there not just for my health needs,
41 but I go there to have a positive cultural experience with
42 my friends and relatives.

43

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

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

3
4 Q. In your witness statement you've said that you agree
5 with this statement which is from the DHHS report, Balit
6 Murrup, that:

7
8 "Overall the mental health and primary
9 health service systems have been largely
10 ineffective in responding to the high rates
11 of psychological distress experienced with
12 Aboriginal communities. Much of the
13 service system has been unable to embrace
14 Aboriginal concepts of health and wellbeing
15 and has failed to understand the historical
16 context and pervasiveness of racial
17 oppression and social disadvantage."
18

19 A. Yes.

20
21 Q. What are the main reasons you think that that is an
22 accurate description of the state of affairs?

23 A. Because it's what I know, it's what I see, but more so
24 when I was Commissioner for Aboriginal Children, and where
25 I had the great honour of listening to the stories of 1,000
26 Aboriginal children over a short period of time, where I
27 saw the lack of culturally appropriate Koori-friendly
28 mental health services provided to our children. I saw
29 that.

30
31 Now, things may have changed in the last couple
32 of years, I don't know, but that's what I saw across the
33 state. Absolutely there were some good examples, but I saw
34 consistently a lack of Koori-friendly mental health
35 services being provided to our children in a timely manner.
36

37 If you think that 9 out of 10 of our kids in child
38 protection are there because they are victims of family
39 violence, that goes with the trauma, and where you don't
40 have - every one of those kids is carrying trauma, and
41 where you hear of kids not having counselling or
42 appropriate counselling in a timely manner, then that has
43 repercussions for the future.
44

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

1 trauma and support healing, address racism and promote
2 cultural safety, and transfer the power and resources to
3 communities?

4 A. Yes, and they are fundamental. Those four enablers
5 that were identified by Aboriginal communities across the
6 state, they are fundamental before you can achieve
7 self-determination.

8

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

14

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

21

22 You'll find them at paragraph 87. The first is the
23 need for service and program initiatives that are
24 identified by the community or equally owned by the
25 community. Can you say what you mean by that?

26 A. What I'm saying is that, government recognises, our
27 community recognises that design and delivery of programs
28 that are most effective need to come from our community.
29 Unless you know where we've come from, you can't design the
30 programs. You can assist in the design of the programs,
31 but the programs need to be owned by our community.

32

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

38

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

46

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

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

10

11 Q. What's the importance of long-term as opposed to
12 short-term funding in that regard?

13 A. There's a saying in the Koori community, national
14 community, about "We have a lot of airports around", and
15 that's because there's a lot of pilot projects that come in
16 and go, you know, for 12 months. A lot of times they set
17 up communities for failure unless there's long-term
18 funding.

19

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

23

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

34

35 Q. How important is it that once responsibilities and
36 resources have been transferred, that people are allowed to
37 make mistakes along the way?

38 A. White fullas make mistakes all the time. When an
39 Aboriginal person makes a mistake, you know, it's - all
40 Aboriginal people make mistakes.

41

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

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

5
6 And part of that is, coming back to making mistakes,
7 it's about all people being accountable. It's not just
8 about Aboriginal community being accountable, it's about
9 government being accountable as well and, where you share
10 that accountability and responsibility, that's when you get
11 better outcomes.

12
13 Q. And, where services are provided by non-Aboriginal
14 organisations, what do you say about the governance of
15 those organisations and whether it should have Aboriginal
16 representation on the Governance Board?

17 A. So, my view is that no programs for the Aboriginal
18 community should be provided to non-Aboriginal community
19 providers unless there are Aboriginal people involved in
20 the governance, are on the Board of Directors, that when
21 there is sizeable programs, there needs to be Aboriginal
22 people recruited in the organisation.

23
24 I know many times within - while I was commissioned to
25 do Taskforce 1000 I would ask many times the question
26 whether they're - and the majority of Aboriginal children
27 in care are placed with non-Aboriginal providers, and many
28 did a great job, and some didn't - and I would always ask
29 the question, what Aboriginal people are involved in the
30 service, in the committee, in the working; not just in the
31 child protection, not just the workers themselves, but in
32 the management behind the scenes?

33
34 Q. Can I ask you a little bit about the process of
35 reform. What do you say about the difficulties caused by
36 isolated reforms to parts of the system?

37 A. So, I was listening earlier to Helen. It has to be
38 holistic, the responses working with our community need to
39 be holistic. So, you can't - working with vulnerable
40 families, children, it's not just about a certain
41 vulnerable - it's about how they're feeling, it's about, do
42 they have a good house, is the home safe and is it warm and
43 is it nurturing; is the education where the kids are going,
44 is it good, are the kids getting good education?

45
46 For me we've got to work with Aboriginal families and
47 community in a holistic manner rather than piecemeal, and

1 that is what you potentially can see as you look around in
2 different responses, piecemeal, that's done by different
3 areas of government. We need holistic responses that are
4 developed and led by Aboriginal people and community
5 organisations in partnership.
6

7 Q. You give an example in your witness statement of
8 something that wasn't done particularly well and that was
9 the handing back of the land to the Lake Tyers Aboriginal
10 community in the 1960s, and that's something that you
11 describe as a "dump and run" approach to empowerment. What
12 are the lessons to be learned out of that situation?

13 A. The lessons from Lake Tyers, is that, back in the
14 early 60s the Victorian Government was seeking to move the
15 Aboriginal community from Lake Tyers to the Latrobe Valley,
16 and there was a successful campaign led by the Aboriginal
17 Leaders and Elders from Lake Tyers against the government's
18 disposal/selling of that and moving the people on.
19

20 In the end, with the 67 referendum and the transfer of
21 responsibility from the states to the Commonwealth, the
22 government basically pulled up stumps and said, we're gonna
23 hand the title back to the shareholders, to the residents,
24 which was all good, but for the previous 100 years the
25 Victorian Government had kept - the then Victorian
26 Governments - had kept the Aboriginal community on rations,
27 had controlled their everyday life, they controlled the
28 gate, who could come in, who couldn't. Then all of a
29 sudden the administration of the place was handed back to
30 the community without the necessary capability and capacity
31 built into the community, and that had significant results
32 on that community, but there's other examples across the
33 state.
34

35 You know, you have to work with communities. For me,
36 that was a classic dump and run.
37

38 Q. We've asked you the question, what is needed to ensure
39 reforms that this Commission recommends are sustainable?
40 What do you say about the importance of reforms having
41 bipartisan support?

42 A. It goes back to the airport. We need - for me, it's
43 critical that there's bipartisan support for work by the
44 Aboriginal community and work. There's nothing worse than
45 having programs in place, albeit suicide strategies, that
46 are promises made to the community, great work 's done by
47 community and government together, and there's a change of

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

6
7 Wherever we can have bipartisan support, then we have
8 to strive, we have to struggle to get that.

9
10 Q. What's the important of community and government
11 leadership being engaged on a sustainable basis and not
12 delegating that engagement?

13 A. So, having the leadership at the table on a consistent
14 basis and a regular basis is where, it doesn't just show
15 commitment with the Aboriginal community, it shows
16 commitment within the department and it's where you have
17 sustainability of effort.

18
19 Our problem is where, the shine wears off the brochure
20 and senior heads of different agencies no longer attend
21 meetings - I'm trying to think of the right words here -
22 the meetings, and that sends a message to everyone that
23 there's a lack of interest. Along with that lack of
24 interest will be support from government funding. Having
25 the most senior leadership, whether they're from the
26 Aboriginal community or government or other sectors is
27 critical to longevity of programs.

28
29 Q. How importantly do you rate regular monitoring and
30 reviews and reporting back on the outcomes of
31 recommendations?

32 A. I think accountability and transparency are critical
33 to good outcomes, to continuing parties being at the table.
34 One of the things I saw as Children's Commissioner was
35 about Aboriginal child placement principles. Great
36 legislation, absolutely fantastic legislation, but unless
37 there's accountability, unless people are held to be
38 accountable, whether they're in government or whether
39 they're in the community, things go wrong and the worst
40 outcomes in this case was for children who - true to the
41 example under the child placement principle - should have
42 been, and should have been and could have been connected
43 with family and they weren't because there was a lack of
44 monitoring and a lack of accountability in what was
45 happening. Now, that was three years ago, hopefully it's
46 changed.

1 Q. What do you think are some key ways to ensure better
2 accountability?

3 A. I think open and regular reporting is for a start. I
4 think Aboriginal people need to be at the table in
5 designing what the performance indicators are. Aboriginal
6 people need to be involved in setting the terms of
7 reference for the reviews rather than as clients, you know,
8 we're there directing the traffic, so Aboriginal people
9 need to be there.

10

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

14

15 Q. Mr Jackomos, thank you very much. Is there anything
16 that I haven't asked you about that you want to say in
17 closing?

18 A. What I witnessed as Commissioner was the lack of
19 appropriate Koori-friendly mental health services for our
20 children. I saw kids who have been sexually abused, not
21 one or two, but many who hadn't received timely support.
22 Yarning: we need a strong Aboriginal mental health
23 workforce across state in every community, not in this
24 community and not that community. There is a great need
25 across the state.

26

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

32

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

41

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

44

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

1 statement.

2

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

5

6 <THE WITNESS WITHDREW

7

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

10

11 MS NICHOLS: Yes, thank you, 1.45.

12

13 CHAIR: Yes.

14

15 **LUNCHEON ADJOURNMENT**

16

17 **UPON RESUMING AFTER LUNCH:**

18

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

22

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

24

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

27

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

29

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

33

34 A. Yes.

35

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

37

38 THE CHAIR: Thank you.

39

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

43

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

47

1 Q. Commissioner on the National Mental Health Commission?

2 A. Yes.

3

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

7 A. Yes.

8

9 Q. And Co-chair of the Million Minds Mission Advisory
10 Group?

11 A. Yes.

12

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

16 A. Yes.

17

18 Q. Professor Milroy, in your experience what are the key
19 determinants of mental illness for Aboriginal and Torres
20 Strait Islander people?

21 A. If you look at determinants in general, so there's a
22 lot of biological, psychological and social factors that
23 impact on the development of good mental health for the
24 entire population, and therefore for the Aboriginal and
25 Torres Strait Islander population as well. But in
26 particular for the Aboriginal and Torres Strait Islander
27 population historical legacy and the ongoing impact of
28 trauma, racism and discrimination play a much bigger role
29 and have quite a devastating impact going forward in terms
30 of mental health and mental health outcomes.

31

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

39

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

47

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

5
6 "It is important to note that there are
7 differences in the way indigenous people
8 experience mental health issues to Western
9 populations."

10
11 Can you just elaborate on that and explain what those
12 differences are, please?

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

25
26 So when you take the next step further, it also then
27 impacts on the way a person may experience illness. For
28 example, if you take something like depression, in a sort
29 of a western context depression may be experienced as a
30 sadness, a loss of hope, a desire to die and other sorts of
31 more cognitive type of features. But for Aboriginal and
32 Torres Strait Islander those depressive features may be
33 experienced in the form of seeing and hearing relatives who
34 are deceased and other sorts of experience in a visual
35 auditory realm.

36
37 So you have to understand that the phenomenology is
38 fundamentally different. If you don't understand the
39 differences in the cultural aspects of symptoms and the way
40 it develops, then you don't know what you're assessing.
41 So, one of the really important factors when dealing with
42 Aboriginal and Torres Strait Islander communities in regard
43 to mental health is understanding how that plays out for
44 them so that we don't get mislabelling or misdiagnosis.

45
46 The other thing that can happen in a cross-cultural
47 context is everything can be put down as cultural and so

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

8
9 Q. Just another question to establish the context, can
10 you please explain the altered population structure in
11 indigenous communities?

12 A. So, if you look at the latest ABS data, we can see
13 that in the Aboriginal population we have a lot of
14 children, which is fabulous because they're our future.
15 However, we have less adults in the middle part of the
16 population and then we have very, very few Elders. If you
17 compare that to the non-indigenous population in Australia:
18 the non-indigenous population has lots of adults and Elders
19 around and less children, so there's the capacity to buffer
20 families and support children in their development. But
21 our population structure has been decimated over some
22 generations, and so, we haven't rebuilt the population
23 structure to be a well-buffered family system.

24
25 It does mean that what happens to children is that
26 sometimes the burden of care will fall onto children
27 because there are less adults available and less adults who
28 are well, because of the burden of chronic disease and
29 other factors that can contribute to stress in communities.

30
31 Q. I want to ask you about children. How does the mental
32 health of Aboriginal and Torres Strait Islander infants and
33 children compare to the mental health of non-indigenous
34 infants and children?

35 A. It's very hard to have community-wide surveys, and
36 I'll just make one point of caution about data in general.
37 There's no pan-indigeneity, so all of the communities to
38 some degree have differences, and so what you might find as
39 a whole set of risks and difficulties in one community may
40 not be the same for the next community.

41
42 So, a lot of incidences exists on a national level.
43 For example, if you look at something like suicide in young
44 people. You can have an averaging out of the suicide data,
45 but if you look at it in specific communities it can be
46 extremely high for that small population compared to
47 another community where the suicide rate might actually be

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

7
8 But if you look at general data, then it would suggest
9 that Aboriginal and Torres Strait Islander children have
10 far more risk and a greater level of mental health
11 complexity as they're growing up. If you look at the AIHW
12 data around children in out-of-home care, Aboriginal and
13 Torres Strait Islander children are grossly
14 over-represented there: something like 10 times the
15 non-Aboriginal Australian for being on care and protection
16 orders.

17
18 If you also look at the rates of Aboriginal children
19 in the juvenile justice system, also extremely high and
20 grossly over-represented, so clearly those sorts of risks
21 for children are much, much higher. Then if you look at
22 things like exposure to violence and other sorts of issues,
23 then that's all going to impact and make it a much more
24 difficult life for children to grow up in.

25
26 If you look at the Western Australian Aboriginal Child
27 Health survey which was done some years ago now, it's
28 probably still one of the most comprehensive datasets and
29 it was able to show some of the social and emotional
30 difficulties that Aboriginal and Torres Strait Islander
31 children had. And one of the biggest risk factors for why
32 children were experiencing difficulty was exposure
33 stressful life events: so experiencing too much too soon,
34 too much trauma, not enough support, not enough avenues of
35 treatment.

36
37 Q. Can I ask you about early intervention. What's meant
38 by early intervention in the context of mental health and
39 why is it important?

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

47

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

12
13 A lot of the early intervention work in mental health
14 has been done in regard to psychosis, and what we know for
15 something like psychosis which can be a very severe and
16 disabling disorder: if you intervene early you prevent
17 relapse and you have a much, much better outcome long term,
18 so it's a very important concept.

19
20 I also just add an extra issue here around children.
21 We often emphasise the need for early intervention in
22 childhood which I think is absolutely right. But we
23 haven't actually even developed intervention services,
24 clinical mental health services for children at a level
25 that is sufficient to meet the current need, let alone add
26 additional resourcing for the early intervention space.

27
28 Q. For the resources that do exist, what are some of the
29 barriers that prevent Aboriginal children from obtaining
30 effective early intervention?

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

39
40 The other issue I think in regard to Aboriginal and
41 Torres Strait Islander children, if you consider the
42 historical legacy and the generations of forced removal of
43 children into institutions, one of the biggest fears that
44 Aboriginal families have if they seek help from a mental
45 health service is that their children might be removed.
46 So, there's a lot of trust issues, which are clearly
47 understandable from the historical legacy and the present

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

6
7 Q. In terms of diagnosing, you've said that picking up
8 early warning signs can be difficult in children and more
9 so within a cross-cultural context. Can you expand on what
10 you mean by that?

11 A. I'll just pick up the cross-cultural context first.
12 As I said earlier, behaviour can be different in a
13 different cultural context, and I'll give one example for
14 children.

15
16 Children from an average perspective often grow up
17 with a different style of parenting model which was a very,
18 very good model historically. So, children are brought up
19 with more autonomy and more ability to make decisions and
20 be self-reliant. That can present as defiance in a school
21 setting or in another context. Whereas, in a cultural
22 context it may be the child expressing their own degree of
23 independence and autonomy. So, if they're not understood
24 in a cultural context then the approach that child may
25 actually increase a sort of adversarial conversation or
26 outcome as opposed to if it was done within a cultural
27 context where it would be understood and dealt with
28 differently.

29
30 Sorry I've just forgotten the first part of the
31 question.

32
33 Q. No, that's all right, that really covered it, was the
34 diagnosing and the cultural context that needs to be taken
35 into account. Also in relation --

36 A. Sorry, if I could just add to the other part, I
37 remember now. Picking up mental health illness
38 difficulties in children is difficult anyway because
39 children are not necessarily forthcoming about their
40 internal world as an adult might be.

41
42 So, you have to use different techniques when you're
43 assessing - particularly younger children, and I'm talking
44 about primary school and younger, because they either don't
45 have the verbal skills or the sophistication to understand
46 what's going on. So they are really telling you what's
47 happened by their behaviour and behaviour can be easily

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

8
9 Q. You referred earlier to intergeneration trauma. Can
10 you explain how that can manifest particularly through
11 families? You gave an example of a woman who was pregnant
12 and how the trauma can transcend through the generations.

13 A. So intergenerational trauma can be transferred via a
14 number of different mechanisms, it can be biological,
15 psychological, social, cultural or spiritual depending on
16 the particular trauma that's being experienced.

17
18 Historically for our families, because there was many
19 generations of trauma that was sustained over a long period
20 of time, a lot of people affected. So, when you look at
21 family systems there's the fragmentation of family and the
22 loss of cultural parenting, which then also impacts on the
23 parent-child relationship.

24
25 If you look at a biological mechanism for example, a
26 woman who was traumatised during her pregnancy is
27 potentially going to have her infant or foetus bathed in
28 stress hormones, that's going to impact on the development
29 of the infant. The baby may be born with a low birth
30 weight or prematurely, then that means that the child then
31 has not a good start to life. That trauma can also impact
32 on the way that infant and the mother attach, and we know
33 that early attachment is one of the many detractors in
34 terms of how relationships develop over time in the
35 development of resilience and the infant's resiliency, so
36 then that's impacted. So then, you can see that that child
37 is put at risk throughout life, which means that the next
38 generation is then put at risk.

39
40 We also know that the impact of high levels of stress
41 in pregnancy don't just have an impact on that foetus but
42 also on the next generation subsequent to that because of
43 the impact on the genetics.

44
45 Q. You have put in your statement, "The key of
46 trauma-informed care" and you have said:

1 "The key of trauma-informed care is to
2 ensure that it is compassionate and can
3 accommodate the needs of the person based
4 on the trauma a person has experienced
5 throughout their life."
6

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

9 A. So trauma-informed care has been around for some time
10 now and the idea behind is that for a lot of people trying
11 to either receive services or get assistance or help, but
12 regardless of what the issue is, they often ended up with
13 an adverse outcome because there was no accommodation or
14 understanding of what they've been through, and so, the
15 trauma-informed care approach was aimed to try and produce
16 better outcomes for everyone within the system by having a
17 much more nuanced understanding of the way people come to
18 services, how they need to be catered for, how they need to
19 be cared for in a way that's compassionate. In a way the
20 difference is between asking, "What's wrong with you", to
21 asking them what has happened and let us understand that
22 and that way we can then work out how we sort out all of
23 these issues.
24

25 So compassion is one of the key responses but also
26 having very good understanding and training around what
27 trauma is, how it impacts on a person's life and their
28 behaviour, what's required in order to accommodate that.
29 One of the other hallmarks as well is making sure that when
30 a person comes into care they're not re-traumatised by the
31 system, which is often the case unfortunately through some
32 of our mental health systems and in systems generally. We
33 make things worse for people while we're trying to help
34 them at the same time.
35

36 There's one other aspect of trauma-informed care that
37 doesn't always get mentioned either and that is that
38 working in the mental health system can be very difficult
39 for staff, it can be very emotional and very distressing
40 for staff, and so, if we're going to expect the system to
41 be much better at responding in an appropriate way, we also
42 have to make sure we have a really resilient and resourced
43 staff support system as well so that we keep the staff
44 healthy in order to keep a much better system flow.
45

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

1 better, they actually got better health outcomes.

2
3 Q. That's in terms of supporting staff who are able to
4 provide the culturally competent care. Can you comment on
5 the importance of cultural safety training, so ensuring
6 people deliver that kind of training in care in the first
7 place?

8 A. So, again, cultural competency or cultural safety
9 training is an important issue for everybody in terms of a
10 cross-cultural context, but for Aboriginal and Torres
11 Strait Islander people within the Australian context it's
12 vital because of the historical legacy and the issues
13 around mistrust and what happened to people coming into
14 systems of care.

15
16 So cultural safety training is really important
17 because it allows a person to feel safe when they come into
18 a service system, that their identity will not be
19 challenged, their culture will be protected, that they will
20 have a safe passage to services. So, in some respects it's
21 a little bit aligned with trauma-informed care as well,
22 because the idea is to give safe passage and an improved
23 outcome for people coming into the system.

24
25 In terms of cultural competencies, we also again need
26 to understand, what are the different ways and different
27 skill sets that we need in order to understand how we best
28 assess and manage and provide treatment or services or
29 healing programs for people of a different cultural
30 context.

31
32 As I said earlier, Aboriginal and Torres Strait
33 Islander people can present very differently in terms of
34 how they experience illness or distress or what they see as
35 the right outcome or what they want in terms of a healing
36 treatment. So, you must have those sorts of understandings
37 and educational training around what might be required,
38 what's different in assessment, how do you understand the
39 cultural influences on symptoms and recovery, how do you
40 get a second opinion, for example, from an Elder or a
41 traditional healer or from the Aboriginal community.
42 Sometimes even things like language translation and simple
43 understandings around English can make a huge difference in
44 an assessment interview, so all of those things need to be
45 factored into cultural competency and cultural safety
46 training.

1 Q. Thank you. You've referred in your statement to the
2 Specialist Aboriginal Mental Health Service in Western
3 Australia: can you briefly outline for us the key elements
4 of that service in terms of delivering culturally safe and
5 competent care?

6 A. So the service was developed out of an absolute need
7 and recognition that Aboriginal and Torres Strait Islander
8 people are not experiencing the same levels of care and
9 then outcomes as the rest of the population, that they were
10 falling through the cracks, that a lot of the outcomes data
11 was pretty poor, so people were present much later, not
12 engaging with services, getting very poor outcomes.
13

14 So, there was a statewide consultation that led to the
15 development of a culturally informed model of care which
16 included a lot more emphasis on Aboriginal staff and also
17 developing the Aboriginal health workforce, the role of
18 traditional healers in mental health care, a cultural model
19 of practice in terms of how to engage and assess people
20 presenting with mental health issues. And also, because
21 mental health issues in one person can affect the whole
22 family or kinship system, it was a much more holistic model
23 derived around looking at the whole family and the
24 complexity of needs of the whole family system rather than
25 just an individualised approach.
26

27 So the service has been running now for eight or
28 so years, it has had very good outcomes in terms of
29 improving outcomes generally for Aboriginal and Torres
30 Strait Islander families, but also for improving engagement
31 with mainstream systems. So, the model operates in a few
32 ways: it can manage families within its own system
33 structure, it can provide a cultural bridge or a cultural
34 brokerage model so that people can be assisted in getting
35 those good connections in the mainstream service that may
36 be within their area, and it also provides education and
37 training to upskill the mental health system.
38

39 The workforce model that's also aligned with the
40 service provides an opportunity for Aboriginal and Torres
41 Strait Islander people to come into the service, initially
42 at a level of something like a liaison worker or a mental
43 health worker. They get an education throughout that
44 process, they get a university degree at the end of the
45 three year training program, and then they're qualified to
46 work within the mental health system.
47

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

5
6 Q. Just finally, Professor Milroy, based on your
7 experience and the work that you've done, what do you think
8 needs to be done to improve the mental health outcomes of
9 Aboriginal and Torres Strait Islander people?

10 A. That's a really big question, we could be here all
11 day.

12
13 Q. We don't have long, I'm afraid.

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

24
25 So, instead of just throwing money at the problem or
26 putting in the same programs over and over again, we have
27 to take a step back and have a look at what's actually
28 required for that community. Some communities, they're
29 doing really, really well and they've managed to provide
30 their own healing pathways, which is fantastic, but other
31 communities are really struggling.

32
33 And if there's not good community governance and if we
34 haven't strengthened that self-determination, then what are
35 we putting the number of programs into? We're putting them
36 into a void and, of course, you're not going to go get the
37 same response.

38
39 So first of all I think we need to step back and have
40 a look at what's actually required, so we need to address
41 the programs, and not just in terms of single purpose
42 programs, but a more holistic approach in understanding
43 community governance, healing programs around grief and
44 loss and healing programs around interpersonal trauma, and
45 those three elements all need to be combined to get a more
46 realistic and robust approach to mental health.

1 You then need to address all of the other social
2 requirements around disadvantage, racism, discrimination,
3 poor education, unemployment, all of those sorts of issues.
4

5 Then we need to have mental health systems that are
6 really robust, that are culturally competent and safe, that
7 people can feel welcome when they come into the service and
8 know that they're going to be well cared for and that
9 they're going to get the appropriate treatments and
10 services that they require based on a cultural awareness
11 and a cultural framework that recognises the importance of
12 those belief systems and the role that us as humans have
13 kept as well for many thousands of years.
14

15 Mental health is not just a mental health systems
16 problem, it is everybody's business, and so we need all of
17 those other collaborations with housing, education,
18 employment, child protection, juvenile justice, all of the
19 other issues need to be brought on line as well.
20

21 In terms of the mental health system itself, when you
22 look at some of the remote communities, we just don't have
23 enough service provision for the younger age groups. We've
24 had a lot of investment in adult services, a bit less in
25 older adult, quite a lot of recent investment in youth
26 which is fantastic, but we actually know that the origins
27 or the risk factors for most mental health problems will
28 start in childhood and we haven't seen the resources go
29 into early childhood as it should.
30

31 MS BATTEN: Thank you very much, Professor Milroy. Chair,
32 are there any questions from the Commissioners for
33 Professor Milroy?
34

35 CHAIR: Q. Thank you very much, Professor Milroy, I just
36 have one question, because it was very important you raised
37 the issue of spirituality and the fact that it's not well
38 understood and sometimes can lead to misdiagnosis.
39

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

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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

1 health is, it can be very stressful. I think we heard
2 earlier today about how many Aboriginal people will feel
3 they have an obligation to just not only their own family
4 and its wellbeing but to the broader community and that
5 translates for people in their professional lives as well.
6

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

10 A. I think that's right because, remember, a lot of our
11 Aboriginal workers also have issues of trauma within their
12 own family systems, so they're carrying their own burden as
13 well as the burden in the families and the communities that
14 they're working with, so it's doubly difficult I think for
15 some of our workers.
16

17 I've also observed and tried to assist where
18 sometimes, if it's an Aboriginal system of care, which may
19 be fantastic, if they're not getting supervised or buffered
20 and supported by external agencies, they can implode
21 because the levels of distress and the levels of
22 re-traumatisation that occur can just keep going round and
23 round in circles, and so, there's not enough external
24 support. And I wonder whether we need to look at the
25 system very differently and not have such isolated service
26 systems working but a much more well-buffered system that
27 can be then supervised and supported by other agencies that
28 help those frontline workers.
29

30 If you're the frontline worker and it's not an
31 Aboriginal agency, the trauma just gets recirculated and it
32 becomes more traumatising for the workers as well. I also
33 think we are unfairly burdening some of our frontline
34 workers, who are working in remote communities where they
35 are probably seeing some of the most complex and
36 complicated mental health problems with the least amount of
37 expertise, training and support, and I think that's just a
38 fundamentally unfair system and it's not right to place a
39 worker in that position.
40

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

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

4
5 CHAIR: Thank you.

6
7 MS BATTEN: Thank you very much, Chair. May Professor
8 Milroy please be excused?

9
10 CHAIR: Yes, thank you very much, Professor Milroy, for
11 making the effort to be involved with us from Western
12 Australia and for your very comprehensive witness statement
13 and evidence today, thank you.

14
15 <THE WITNESS WITHDREW

16
17 MS BATTEN: Chair, I understand a restricted publication
18 order has been made in relation to the next witness.

19
20 CHAIR: Pursuant to the Inquiries Act 2014 the Royal
21 Commission has made an order in relation to the next
22 witness, Tamara Lovett. That order prohibits the
23 publication of the name or the identity of the mother or
24 any brother of Tamara Lovett if she mentions them in her
25 oral evidence to the Royal Commission today.

26
27 A copy of the order has been placed next to the door
28 of this hearing room.

29
30 MS BATTEN: Chair, may we just wait for one minute. Thank
31 you. Thank you. The next witness is Tamara Lovett. I
32 call Tamara.

33
34 <TAMARA LOVETT, affirmed and examined: [2.23pm]

35
36 MS BATTEN: Q. Thanks, Tamara. Do you want to adjust
37 the microphone so it's at a good level for you? Great,
38 thank you. Have you, with the assistance of the Royal
39 Commission's lawyers, prepared a witness statement for the
40 Royal Commission?

41 A. Yes, I have.

42
43 Q. I tender that statement. [WIT.0001.0050.0001]

44
45 THE CHAIR: Thank you.

46
47 MS BATTEN: Q. Tamara, you're a Gunai and a Gunditjmara

1 woman. Is that right?

2 A. Yep.

3

4 Q. And you were raised in Melbourne?

5 A. Yep.

6

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

9 A. Yes.

10

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

13 A. Yep.

14

15 Q. Can you please tell the Commission your story?

16 A. Alright. I'm a little bit nervous, so sorry.

17

18 Q. It's okay.

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

23

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

32

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

38

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

45

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

1 witnessing physical violence [REDACTED]
2 [REDACTED]. Have lived through physical violence of
3 my own, lived through sexual abuse of my own.
4

5 Q. You're doing really well, Tamara.

6 A. And, most of the time dealing with these issues, it
7 wasn't an option to ask for help due to, when you - sorry.
8 Most of my grandfather's children were removed and it
9 wasn't an option to ask for help from the fear of the
10 department coming in and removing children.
11

12 Sorry, I didn't think this would be this difficult.
13

14 Q. Take your time, you're doing really well.

15 A. All up, through my younger years, before I could
16 understand what was going on, my mother fought nine court
17 cases to keep her children, to keep us together, due to her
18 not being able to - in the words of the department -
19 adequately care for her children. She didn't have the
20 parenting capabilities, she was never taught those growing
21 up in the system. She had never had those role models to
22 show her what real emotional support or parenting looked
23 like.
24

25 This stemmed to a fear of me asking for help for a
26 long time. It wasn't until later in high school that, or
27 even after I finished high school and I was pregnant with
28 my first child, that I decided that I would try and break
29 the cycle, that I would try and put - actually it was
30 before my pregnancy - I decided I'd had enough, I needed
31 some support, I needed someone to talk to to get a lot of
32 the things I'd seen and things I'd experienced off my
33 shoulders.
34

35 And so, I saw a GP, and that GP I saw until I was
36 pregnant with my first child. She had a very good
37 understanding of me and the things that I would experience
38 in my head with my mental health.
39

40 Throughout my pregnancy I avoided the closest hospital
41 to me through family fear of child removal from mental
42 health issues. I was also warned off of the hospital that
43 I chose for the same reason, because there was fears around
44 mental health assessments being done and being reported.
45

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

1 psychiatric referral because I knew at that point, when I
2 am dealing with a lot of stress, I tend to not sleep; I
3 experience psychosis, is what they were telling me - you
4 know, my doctor was sort of saying or the previous people
5 who I'd spoken to.
6

7 And so, we made a plan to do shared care which is
8 where, through my pregnancy I would go to the hospital for
9 the important appointments, but then I would see my GP for
10 every other appointment. It was just a little bit more of
11 a comfortable process that I was happy with.
12

13 I remember my referral going through to the hospital,
14 and my GP at the time had said that the psychiatrist was
15 away, but when she came back she would get in contact with
16 me to make an appointment. Before that psychiatrist came
17 back from leave, another lady that wasn't part of my care
18 picked up my referral, read it, and decided that I needed,
19 without permission from anybody to do with my treating team
20 or my care team, whatever you wanna call it, decided that I
21 needed a CAT Team referral, and so, without my permission
22 and without my knowledge I received a call from the CAT
23 Team asking me to come in for an appointment, and I've
24 never heard a great thing about the CAT Team, so was
25 already kind of stressed out. I was - I can't remember -
26 maybe halfway through my pregnancy.
27

28 I went in, sat down, and was just, like, smashed with
29 questions on what my experiences were, what the voices were
30 that I was hearing, what the hallucinations were that I was
31 having, what was going on for me and why wasn't I taking
32 medication, and I should be taking medication regardless of
33 the fact that I had said that medication wasn't what I
34 wanted to do, regardless of the fact that my GP had written
35 a full support letter outlining how I self-managed my
36 mental illness, how I didn't need medication, I was just
37 needing support should I feel stressed out at any
38 point throughout my pregnancy. It was more proactive care
39 than it was because I was needing it at the time.
40

41 I remember leaving from that appointment quite
42 stressed out, quite angry, and saying, "I don't wanna be
43 here any more", and I walked out, and I felt like the worst
44 I had ever felt. I felt like I wasn't listened to, I felt
45 uncomfortable, I felt forced into treatment options that I
46 didn't even want.
47

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

8
9 I went back to my GP and I said, "This is too much. I
10 can't - like, I don't want to just go through the hospital,
11 I want to stay with you", and then after I received a
12 letter, or she received a letter saying that I was
13 non-compliant, and it was a very negative letter about me
14 and about how I wasn't open to treatment, and I was very
15 frustrated because it, (a) wasn't the plan that I had in
16 place for my care, it wasn't the plan that my GP had in
17 place.

18
19 They disregarded all of my experience, they
20 disregarded all of my GP's support letters, and I was
21 very - at that point I wanted to run away and be like, I
22 don't want to deal with the hospital any more, I don't want
23 to deal with - like, I don't wanna go there. I was
24 nervous, I was scared, and that's not how people should
25 feel when they're pregnant and just needing a little bit of
26 extra help.

27
28 After my first child was born, I continued with the
29 same GP that I had for a while. I ended up stopping seeing
30 that GP out of living too far away, and I think it was
31 about 18 months after my first son was born - no, it would
32 have been a little bit longer than that - I received from a
33 family member who worked in a facility - a childcare
34 centre - came to me and told me that there had been a
35 welfare check done on my son, after I had taken him to
36 hospital for an illness, due to my mental health: no
37 prompting, like, no real reason as to why there should have
38 been a notification put in from the hospital. Nobody had
39 contacted me.

40
41 At this point I decided I didn't care, I decided to
42 continue trying to seek help wherever I needed it because,
43 at least if I was seeking help when those notifications, if
44 they go in, or if things like that happen, they've got no -
45 no-one's got a leg to stand on because I'm doing all the
46 right things.

47

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

9
10 This led me, I guess, to a long time of, I access
11 services, either I get support and I can't tell the full
12 story, and I can't talk about when I'm struggling too much,
13 I go into very surface details, on the surfaces. I
14 instantly get defensive when anyone tries to dig any
15 deeper, because I fear that my children, or at that time my
16 child, would be taken away from me.

17
18 After my second pregnancy a year ago, I had another
19 son, I went for my first or second appointment with the
20 maternal child health nurse, and I did a postnatal
21 depression scale, and I rated "severe" on that scale. I
22 was sent home with no support.

23
24 A couple of weeks later I had another maternal child
25 health nurse come out on outreach, and she spoke to me
26 about postnatal depression. I told her about the first
27 maternal child health nurse scale that I had done. She
28 offered to put in a referral for me to speak to somebody
29 about postnatal depression. Six months later, still no
30 help or support, and I never saw that lady again.

31
32 I had another support worker who tried to follow up,
33 with no response. And then the last response that was
34 given was that, that service wasn't adequate, it wasn't the
35 right service and they didn't accept my referral, and that
36 was the end of that.

37
38 It's taken me over 12 months to find another
39 counsellor to talk to them about the postnatal depression.
40 It took for me to be at crisis point. I contacted my
41 support worker, I sent her a text and said I wasn't coping,
42 I needed to get some immediate support or, if she could
43 please just text me a phone number of somebody I could
44 call - this was a Friday afternoon, so I was understanding
45 that, you know, services finish at 5, it's the weekend,
46 there's not really a lot people could do, so just a phone
47 number for someone I could talk to. I didn't receive a

1 response to that.

2

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

11

12 The second number I called, I was on hold for
13 20 minutes, then nobody answered. And at this point I had
14 to pick up my youngest son from childcare, so I basically
15 just had to tell myself to suck it up, go in and pick him
16 up and just try again on Monday.

17

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

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

29

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

40

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

44

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

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

8
9 Q. Thank you so much, Tamara. Is there anything that we
10 haven't covered that you want to say? I think you've done
11 very, very well.

12 A. No, that's it.

13
14 MS BATTEN: Thank you. Chair, are there any further
15 questions from the Commissioners?

16
17 CHAIR: Q. No, I'd just like to very much acknowledge
18 you and thank you very much for coming, Tamara, today and
19 sharing your reflections with us. I do note in your
20 witness statement that you've worked a lot in the mental
21 health sector and had some very useful suggestions also
22 that you've made in your witness statement about how to
23 improve things. But we very much appreciate you being so
24 brave and coming in to share with us today. Thank you very
25 much.

26
27 MS BATTEN: Thank you, Chair. May Tamara please be
28 excused?

29
30 CHAIR: Yes.

31
32 MS BATTEN: And we just need to have a short break to
33 arrange the next video conference, for 10 minutes, please,
34 Chair.

35
36 **SHORT ADJOURNMENT**

37
38 MS NICHOLS: Commissioners, the next witness is Dr Graham
39 Gee and he'll be joining us via video link from Norway.

40
41 Dr Gee, can you hear me?

42
43 DR GEE: Yeah.

44
45 MS NICHOLS: Thank you for joining us.

46
47 **<GRAHAM JOHN GEE, affirmed and examined: [3.01pm]**

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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

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

3
4 We've used that term for going on three decades now,
5 and it really refers to a more holistic view of health than
6 the conventional understandings of mental health. It
7 includes mental wellbeing and mental health disorders, but
8 importantly it's also much more than just physical,
9 emotional and wellbeing. So, social and emotional
10 wellbeing also refers to the wellbeing of families and
11 communities, and it also recognises that mental health is
12 shaped by connections to culture, to land, to kinship and
13 ancestors and spirituality.

14
15 In recent years, as we've explored that concept more
16 in our cultures we've also recognised that social and
17 emotional wellbeing also extends to more than just
18 connections to social determinants which we know are really
19 important, things such as education and employment, as they
20 are connected to mental health. But in this social and
21 emotional wellbeing context we also recognise the
22 importance of historical and political and cultural
23 determinants and how these cultural factors shape the
24 presentation and meaning of distress and how mental health
25 symptoms are understood for actual clients in lots of
26 different ways.

27
28 Just as two examples, historical determinants refers
29 to the impact of past government policies that's been
30 experienced by whole cultural groups or communities, in
31 terms of the impact on the community, or conversely the way
32 in which communities have resisted the impacts of
33 colonisation and maintained their cultural continuity.

34
35 Political determinants is about sovereignty and
36 unresolved issues of land rights and uncontrolled resources
37 and self-determination, and again, historical and political
38 determinants as it impacts mental health within an
39 Aboriginal context, they're not abstract - they literally
40 shape the environment and circumstances in which Aboriginal
41 children are born into: they influence the type of coping
42 skills and knowledge or resources that children and
43 families can draw upon, including the community and the
44 relationship networks that are so important for recovery in
45 mental health.

46
47 Q. We've asked you to consider the key risk factors that

1 may detrimentally impact upon the social and emotional
2 wellbeing of Aboriginal and Torres Strait Islander people,
3 and you've made the observation in your witness statement
4 that there's a very significant gap in research on this
5 question. Can you say something about that and why there's
6 such a significant gap in the research?

7 A. Well, research historically has not been done well at
8 all in Aboriginal communities; it's been done pretty
9 poorly, but we are making headway into changing that, and
10 the way to change that is to have Aboriginal communities
11 themselves co-design and drive the research and design the
12 research, but the reality is that it has been done poorly
13 in the past and there hasn't been enough good research
14 done.

15
16 So, that's part of the reasons why there's a big gap
17 in research, and I really think it's really just in
18 recent years that we're really starting to see well
19 designed research that comes from Aboriginal organisations
20 themselves, basically.

21
22 Q. Thank you. That said, what do we learn from recent
23 Aboriginal and Torres Strait Islander national health
24 surveys published by the Australian Bureau of Statistics
25 about factors contributing to poorer social and emotional
26 wellbeing outcomes?

27 A. In the past at least three national surveys, we're
28 starting to get a good picture of a range of risk and
29 protective factors for social and emotional wellbeing more
30 broadly.

31
32 I just want to say one caveat which is that, our
33 challenge now is to really - risk and protective factors
34 are always relative to the type of outcome that we're
35 looking for, so we do need to map some of these protective
36 factors and risk factors to specific mental health issues
37 and what have you, but broadly we're starting to see some
38 really consistent evidence across, yeah, as I said, the
39 last three national surveys.

40
41 The first thing is that we know that Aboriginal people
42 report higher psychological distress, so across the country
43 Aboriginal people are nearly three times more likely to
44 report high to very high psychological distress in
45 comparison to other Australians, and we know that this is a
46 predictor of suicide and mental health difficulties. It's
47 not the only one, but it's certainly a key predictor and

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

3
4 Q. Sorry, I interrupted you. I was just going to ask you
5 about the rates in Victoria, and have Aboriginal Victorians
6 reported the highest rates of emotional distress, or sorry,
7 psychological distress in comparison with populations in
8 other parts of Australia?

9 A. Yep, that is correct. In 2012 and 2013, Aboriginal
10 Victorians reported the highest rate of distress at
11 32 per cent in comparison to other Aboriginal people in
12 other jurisdictions, yeah.

13
14 Q. Sorry, you continue.

15 A. Just a couple of other factors that are really
16 important, is that, the Aboriginal people who report being
17 removed as children from their natural families also report
18 higher levels of psychological distress than Aboriginal
19 people who were not removed from their families. So, this
20 is a really important factor to consider because it's also
21 associated with higher psychological distress, and again,
22 Aboriginal Victorians actually report the highest rates of
23 removal from family. I think it was something like
24 12 per cent in comparison to other Aboriginal Australians,
25 where the national rate is something like 10 per cent.

26
27 So, the effects of removal are absolutely critical to
28 consider.

29
30 The other thing that we should factor in is the rate
31 of children in out-of-home care across Victoria for
32 Aboriginal children has absolutely reached crisis
33 proportions in my opinion. Between 2010 and 2015,
34 Aboriginal children in out-of-home care was approximately
35 12 times the rate of non-Aboriginal children, and
36 Aboriginal children in out-of-home care in Victoria, again,
37 was higher than other jurisdictions in Australia.

38
39 So, I really can't stress enough for the Royal
40 Commission that, if recommendations are going to be
41 implemented to reform the mental health system, we need to
42 have focused efforts on reducing the rates of out-of-home
43 care and supporting Aboriginal children in out-of-home care
44 in the child protection system.

45
46 Q. What about the exposure of Aboriginal Victorians to
47 social inequality?

1 A. So, like other Aboriginal Australians, Aboriginal
2 Victorians report inequalities across most social
3 determinants in comparison to other Australians and other
4 non-Aboriginal Victorians. We've got clear evidence that
5 those social determinants, like lower employment and
6 education and what have you, are associated with higher
7 rates of psychological distress and other mental health
8 problems in Victoria, and that's really consistent
9 internationally with the understanding that poverty and
10 lack of access to education and what have you is associated
11 with higher rates of mental health difficulties.
12

13 Q. And what's the - no, you go ahead.

14 A. Yeah?

15
16 Q. You go ahead.

17 A. I think that's one of the biggest challenges that we
18 face from clinicians and the service point of view, is this
19 combination of inequalities and social determinants such as
20 housing and employment and education. When you combine
21 that with the other factors that I've been speaking about,
22 like high rates of childhood removal and children in
23 out-of-home care, incarceration rates and what have you,
24 and the damage to the cultural continuity for some
25 communities in terms of loss of language and dispossession
26 of land: basically, these are multiple co-occurring risk
27 factors that are legacies of colonisation. The people that
28 we're generally seeing in our community health services are
29 those who experience co-occurring risk factors, not just
30 one but accumulation of all of these. They are the
31 families and adults and children that present to our
32 services with really serious mental health difficulties and
33 are experiencing multiple crises, and it's near impossible
34 to address mental health difficulties unless there's
35 coordinated efforts to deal with all of the other things
36 that they're experiencing.
37

38 I think that's one of the biggest challenges that the
39 Commission needs to think really carefully about, is that
40 in some instances we're not even reaching those most in
41 need because they're so unwell sometimes with so many
42 layers of adversity that they're actually unable to get the
43 right services.
44

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

1 vulnerable in the community.

2

3 Q. And thinking about the factors that may protect social
4 and emotional wellbeing, what are those factors that are
5 unique to Aboriginal and Torres Strait Islander
6 communities?

7 A. I'll just start, but before I talk about those that
8 are really specific and important for our community, I just
9 want to say that, there's also a whole bunch of common
10 resilience and protective factors that are similar for
11 populations worldwide which we should also be considering.
12 So things like self-worth or self-esteem, supporting people
13 and families to have a sense of control over their lives,
14 participation in sport and family cohesion, social support,
15 they're all really, really important protective factors,
16 you know, regardless of what culture you come from.

17

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

22

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

31

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

42

43 Q. Have you also found that community-designed healthy
44 lifestyle programs are very helpful?

45 A. Yeah, absolutely. I'm increasingly, over the years
46 I'm becoming more and more convinced that, after working in
47 the counsel rooms for so many years, the last five years my

1 big learning lesson as a clinician has been how important
2 community programs are in terms of building some of the
3 cultural and community factors that we're talking about.
4

5 We've run programs where we've found that, despite
6 bringing community together in programs that may focus on
7 healthy lifestyles, physical activity, chronic disease that
8 don't even necessarily have a mental health focus per se,
9 we're finding that levels of safety, having a safe place to
10 heal and these types of things, connection to the
11 community, a sense of connection, those things are being
12 strengthened, and we've also found reductions in
13 psychological distress in these programs, while not even
14 necessarily having a specific mental health component.
15

16 So, these cultural or these community programs build
17 kind of social and cultural community networks that
18 essentially I think provide the means for recovery. We
19 need individual and family counselling as well - don't get
20 me wrong, but more and more I'm seeing the power of these
21 programs.
22

23 Q. Can I turn to the question of intergenerational
24 issues. Do poor social and emotional wellbeing outcomes
25 and mental illness outcomes cause you to reflect on the
26 role of collective trauma?

27 A. Absolutely. Again, within the context of the legacies
28 of colonisation it's really important to recognise that
29 we've got to look beyond, not only personal traumatic
30 experiences, but collective trauma refers to trauma that
31 has far wider reaching impacts than just individual
32 experiences.
33

34 So, it talks about the ripple effect through
35 communities where there's a breakdown of social norms and
36 cultural practices, and the collective knowledge and values
37 of entire communities is threatened and it's fragmented as
38 a result of, generally speaking, structural violence such
39 as colonisation, and we see this in vulnerable groups
40 across the world that have been structurally impacted by
41 violence.
42

43 Intergenerational trauma on the other hand refers to
44 the effects of traumatic experiences being transmitted to
45 subsequent generations from nana and pop, down to mum and
46 dad, down to children.
47

1 Q. What happens when you layer the effects of cultural
2 trauma, intergenerational trauma and particular
3 environmental factors specific to the individual?

4 A. So, in my clinical or therapeutic experience working
5 as a clinician at VAHS, essentially it's when people and
6 families experience all of those types of layers of risk
7 factors that we've been speaking about: essentially that
8 creates a really, you know, toxic combination of risk
9 factors that creates environments where re-traumatisation
10 among the younger generations is much more likely.

11
12 So, you know, risk factors like being members of the
13 Stolen Generation, intergeneration cultural loss,
14 disposition of lands, loss of language, ceremony and other
15 practices. When you combine that with intergenerational
16 poverty or social disadvantage, and you throw in drug and
17 alcohol misuse, especially ice at this time, you know, and
18 family violence or neglect, all of this creates a recipe or
19 contributes to re-traumatisation. As well as experiences
20 of racism which we know from our national surveys is,
21 unfortunately, alive and well in this country.

22
23 So, all of those things create really, really
24 difficult environments for our younger people and,
25 unfortunately, we see the absolutely unacceptable suicide
26 rates among our younger generations and, when you have all
27 of those layers of adversity, the young people just don't
28 see a future for themselves, in my opinion. They don't see
29 themselves represented in the future.

30
31 So, that's what intergenerational trauma looks like in
32 our social and emotional wellbeing mental health services.
33 I just want to be clear that resilience is an important
34 part of the picture, and I'm not suggesting that all
35 Aboriginal Victorians are victims of trauma: rather, that a
36 proportion of the community is at higher risk because of
37 those intergenerational legacies that I've mentioned, and
38 those are the families that we're most likely to be seeing
39 in our services.

40
41 Q. Is there a concept of "intergenerational resilience"?

42 A. Absolutely, and I mean, the Koori people of Victoria
43 are testimony really to resilience and intergenerational
44 resilience. Given the impacts of colonisation and how
45 brutal it was in the southern parts of Australia,
46 intergenerational resilience is absolutely critical. And
47 not surprisingly, as I mentioned in the health survey

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

7
8 So it's really a combination of cultural, family and
9 personal factors that contribute to intergenerational
10 resilience in my opinion, as well as political factors like
11 restoration of land and what have you.

12
13 Q. Do you think that in the mental health arena enough
14 emphasis is placed on putting resources into building
15 cultural connections?

16 A. Not at all, no. We need much more, much, much more.
17 Cultural determinants of health really haven't been
18 recognised well enough at all in the mental health space in
19 Australia and probably a lot of other countries. I think
20 that the mainstream mental health system is really catching
21 up in terms of that, but the thing is, we're starting to
22 get good evidence now, especially those national health
23 surveys. There's got to be a much greater emphasis on
24 resourcing communities to rebuild the cultural and
25 community networks.

26
27 You know, they really are - when you get that holding
28 space from those kind of programs, that creates
29 environments and stability where recovery is possible.

30
31 Q. What do you say about the necessity of assertive
32 outreach, particularly to those who have moderate and
33 severe mental health issues?

34 A. I think that that's, and I've said this in my
35 statement, that besides things like cultural diversity, I
36 think that assertive outreach is something that's been
37 missing from the picture, there hasn't been enough of it.

38
39 I've mentioned already that those who are most
40 vulnerable and experiencing severe mental health and social
41 and emotional wellbeing issues, often they're too unwell to
42 actually make it into our services. We're actually missing
43 the most unwell parts of the community.

44
45 Assertive outreach to my mind has been the best model
46 of practice so far that I've seen that supports the most
47 vulnerable people in community. There's just not enough of

1 it.

2

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

10

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

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

22

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

30

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

47

1 Q. Dr Gee, we've asked you to think about examples of
2 best practice in Aboriginal mental health in Victoria and
3 elsewhere, and I think your response in your statement is
4 that the evidence base for that is very thin. Having made
5 that observation, are there some examples of best practice,
6 apart from the one we've just discussed, that you think the
7 Commission should be particularly mindful of?

8 A. Yeah, I think we're building an evidence base, but it
9 is slow, but for a start I think the Commission would be
10 really well placed to look at the kind of programs and
11 evaluations that are happening with the National Aboriginal
12 and Torres Strait Islander Healing Foundation, as well as
13 the Canadian First Nations Healing Foundation. I was
14 involved in helping to establish our National Healing
15 Foundation and we really took the lead from the Canadian
16 First Nations research.

17
18 Essentially, both our foundation and theirs have found
19 three common elements to many of our Hidden programs. Many
20 programs focus on reclaiming culture and history, on
21 strengthening culture and also providing family and
22 individual counselling. So, this mix of looking at history
23 and strengthening culture, combined with therapeutic
24 services are common elements to many programs.

25
26 We've got a limited evidence base here in Victoria,
27 primarily because there's such little money gone into
28 community-driven research and evaluations. I know at the
29 moment VAHS is working with three other ACCHOs and the DHHS
30 on what we call a demonstration site, where we're trying to
31 map exactly what's working across different services which
32 I think is really important.

33
34 Nationally, there's successful programs, examples are
35 the Marumali training by Aunty Lorraine Peeters who's a
36 member of the Stolen Generation and she has a great model
37 of healing with how to work with the Stolen Generation
38 members.

39
40 The We al-li program by Professor Judy Atkinson.
41 Professor Pat Dudgeon's suicide prevention work is also
42 really important examples.

43
44 In terms of Victoria, we've spoken about Wadamba as -
45 that's probably the best non-Aboriginal service model that
46 I've seen personally. Alan Thorpe's Dardi Munwurrowl, a
47 family violence program run for men, I think is another

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

9
10 Q. Thank you, Dr Gee. How do you think Victoria can do
11 better identifying and assisting those Aboriginal and
12 Torres Strait Islander people who are at risk of developing
13 trauma-related mental illnesses who are not currently in
14 contact with service providers?

15 A. Yeah, I'm not gonna lie, that's a complex area when
16 you say "better identification". I'm involved in a
17 national project that we're trying to understand how to
18 better support families with histories of complex trauma
19 and what we're learning is, it's a very sensitive area,
20 this idea of how you safely identify or work with families
21 to support and to identify whether they have been impacted
22 by trauma.

23
24 Safety is the number one word that I would say where
25 we're working with parents and families to look at what's
26 the most safe way to speak to people within services. Our
27 learning so far is that we actually have to work with the
28 services on the ground, like, maternal services and
29 perinatal services. We actually have to work with each
30 local service to co-design safe approaches to talking about
31 complex trauma.

32
33 There's a lot of worry or fear from parents that
34 speaking about complex trauma will lead to child
35 notifications or child protection issues. So, they're
36 identifying the first thing is that we've got to work with
37 organisations to co-design safe ways and safe recognition
38 and assessment processes.

39
40 Q. Can I just ask you to elaborate on that aspect of
41 safety, with that particular fear about children being
42 removed?

43 A. So, it may be that there's less focus on, in the
44 identification, trying to identify complex trauma. What
45 we're finding is that it's better to talk, to hopefully
46 create an education component where we can talk about the
47 impacts of trauma rather than speaking to families about,

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

5
6 So, it's more to speak about the impacts of trauma in
7 an education focus so that parents, for example, can think
8 about complex trauma rather than, you know, telling their
9 story, for example, which is what we don't want.

10
11 But we do want to talk about and find ways to talk
12 about depression and complex trauma or post-traumatic
13 stress disorder with parents in case some of those
14 experiences will - they'll recognise those things
15 basically.

16
17 Q. One of the things you draw attention to in your
18 witness statement is that there are no Aboriginal designed
19 services to deal with childhood sexual abuse. Why do you
20 say this is particularly important?

21 A. Well, I say that because, out of all the types of
22 interpersonal trauma that someone can experience - and I
23 looked at some of this in my PhD - we know that experiences
24 of childhood sexual abuse is a huge key driver of long-term
25 mental health and social and emotional difficulties
26 irrespective of what culture you come from. It's huge and
27 there's just unacceptable rates of childhood sexual abuse,
28 for adults and children, and we don't have any
29 Aboriginal-specific services to work in this area.

30
31 I just think it's such a key driver, not the only one
32 of course, but it's such a huge factor implicated in
33 long-term mental health difficulties that it's time that we
34 get a community-led process where we can design safe
35 healing spaces for people who have experienced childhood
36 sexual abuse. But there are no Aboriginal-specific
37 services yet.

38
39 Q. More generally speaking, do we need a much greater
40 focus on early childhood?

41 A. In terms of building resilience, I think that,
42 especially after 10 years of working with adults, I'm
43 definitely convinced that we need to focus much more on
44 early childhood and adolescent resilience programs.

45
46 We know that Aboriginal children aged 10-14 years are
47 eight times more likely to commit suicide than

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

5
6 We need to start earlier at Aboriginal daycare centres, for
7 example, like Wadamba Wilam in the northern suburbs. We
8 have to start working with our young ones in building that
9 resilience early, in my opinion.

10
11 Q. Can I ask you about your views about the most
12 significant impediments to being able to intervene in
13 mental illness amongst Aboriginal communities in Victoria?

14 A. I think one of the biggest impediments, and the
15 reality is that this goes for everyone in Victoria really,
16 is that the current mental health system is fragmented.
17 It's really difficult for families and adults and children,
18 it's really difficult to understand how to navigate the
19 system as it is, because it's so siloed and fragmented.

20
21 Even for clinicians and practitioners, it's just,
22 there's so much disconnect between services. So, I think
23 the first thing we have to do is think about an integrated
24 care and better coordination across primary, secondary and
25 tertiary services.

26
27 Better links between ACCHOs that work with families
28 across a life-span, so the Victorian Aboriginal Health
29 Service and VACCHO, for example. There needs to be better
30 communication with hospitals, Emergency Departments and
31 psychiatric units.

32
33 I think we actually need funding for a dedicated
34 workforce that assists families to navigate these
35 transitions between services, because at the moment I don't
36 feel like the client pathways, they're getting this
37 continuous pathway, it's services are not connected and we
38 need to connect them up and we need resources and people to
39 do that so that families can be supported to navigate the
40 mental health system.

41
42 Another thing we've got to do is work on improving the
43 quality of care within our current services. I think we
44 need workforce training for staff. As organisations we've
45 got to look at trauma-informed care, for example. What
46 else?
47

1 Q. One of the things --

2 A. We need --

3

4 Q. No, you go ahead.

5 A. We don't have enough Aboriginal design tools to
6 support our workers on the ground, and that's something
7 that, you know, there's a huge need for real world
8 translatable research where community services that are
9 actually co-designing tools around, you know, depression
10 and posttraumatic stress disorder and what have you, that
11 are co-designed by Aboriginal people and clients themselves
12 and staff, because there's just not enough of them. We've
13 got some, but we need to have more of that.

14

15 Q. What's an example of a co-designed tool, for example,
16 to deal with depression?

17 A. Well, what I mean by co-design is, basically, you work
18 with community members on the ground to explore a concept
19 like depression, or resilience, or post-traumatic stress
20 disorder, and you work with the community on the ground so
21 that is, people who may have lived experience of depression
22 for example, and you work with staff, Aboriginal staff who
23 work with clients and who are familiar and work everyday
24 with depression or anxiety for example, and you explore
25 those concepts and you build questions or assessment tools
26 based on cultural understandings of those concepts.

27

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

36

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

44

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

1 conventional understandings of mental health.

2

3 Q. Finally, Dr Gee, can I ask you about the really
4 striking fact that we've heard a bit about today, and that
5 is the youth of the Victorian Aboriginal population.
6 You've said in your statement that one-third of the
7 Aboriginal and Torres Strait Islander population is between
8 15-29. Do you mean in Victoria or Australia-wide?

9 A. Australia-wide.

10

11 Q. Do you know the Victorian figure?

12 A. I don't. I couldn't tell you that, sorry.

13

14 Q. I couldn't tell you either actually as I stand here,
15 but it's still a very high proportion of the population is
16 young; is that right?

17 A. Definitely, yes. I mean, nationally and state-wide,
18 we have a younger population, that's really well documented
19 and we're going to suspect, if you refer to the appropriate
20 stats, you'll find that our youth, there's a much bigger
21 population compared to the older population.

22

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

32

33 Q. Do you think we've grappled with the fact of the
34 demographic in terms of the importance of continuing to
35 strengthen culture?

36 A. Look, my gut instinct is, no, we haven't. I haven't
37 specialised in the area of working with children and youth,
38 so I need to qualify that statement. I think you'll need
39 to talk to people who work more with the young people. But
40 certainly I have done some focus groups with the Koori
41 Youth Council around social and emotional wellbeing, and
42 judging by the young people's responses in those focus
43 groups, we've got a hell of a lot more work to do to
44 understand how to support them better with their
45 experiences of mental health at their age.

46

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

1 questions from the Commissioners to Dr Gee?

2

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

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

13

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

16

17 CHAIR: Thank you very much.

18

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

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