

## **FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE**

### **Inquiry into the provision of supported accommodation for Victorians with a disability and/or mental illness**

Melbourne — 30 April 2009

#### Members

Mr B. Finn

Ms M. Kairouz

Mr W. Noonan

Mr J. Perera

Mrs E. J. Powell

Mr J. Scheffer

Ms M. Wooldridge

Chair: Mr J. Perera

Deputy Chair: Mrs E. J. Powell

#### Staff

Executive Officer: Dr J. Bush

Research Officer: Dr T. Caulfield

#### Witnesses

Mr T. Moore, senior policy officer, policy unit (affirmed), and

Ms N. Cassar, spiritual and emotional wellbeing coordinator (affirmed), Victorian Aboriginal Community Controlled Health Organisation.

**The DEPUTY CHAIR** — Thank you. I reopen our investigation. I thank our witnesses for being here. The committee is looking into issues such as the standard, range and adequacy of care and accommodation currently available, the appropriateness of the current service providers, how unmet need is managed in Victoria, accessibility and appropriateness of accommodation for rural communities, ethnically diverse communities and indigenous Victorians, and the impact of the current service provision on families and carers. The committee is an all-parliamentary investigatory committee of the Victorian Parliament and is due to report to Parliament by 30 June next year, after which the government has up to six months to reply to the committee's report and recommendations.

All evidence taken at these hearings is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments a witness makes outside the hearing may not be afforded such privilege. We are recording the evidence and will provide a proof version of the transcript to each witness at the earliest opportunity.

Are you both going to be giving verbal submissions this morning? I ask you to state your name and who are you representing today.

**Mr MOORE** — Yes, we will be co-presenting. Before I begin I would like to acknowledge the traditional owners of the land that we are meeting on today, the Wurundjeri people, and the other peoples of Victoria and to acknowledge their elders past who have built the organisations and the communities that we are here to represent.

I might distribute some papers of interest and information, which I might make referral to during the proceedings. There is a copy of the annual report of the Victorian Aboriginal Community Controlled Health Organisation. There is a brief on the specific issue that we are concerned with here today and some of our data set that we collect and distribute. This is a paper-based PowerPoint basically!

VACCHO is an Aboriginal community-controlled organisation. It represents 25 member organisations around the state. Each of those member organisations is an Aboriginal community-controlled health service provider. They are distributed widely across the state. There are four metro members, with the remainder in regional and rural Victoria.

The statistics, the health status, the conditions for Aboriginal people, as you will no doubt be aware, are something of a national disgrace. They are something of an international embarrassment. It is something the federal government has made a commitment to in a bipartisan approach. On 20 March last year the Prime Minister signed the statement of intent to close the gap in Aboriginal and Torres Strait Islander health inequality. That statement was followed up by the Victorian government signing the same statement, and also in Victoria it was a bipartisan commitment.

The statistics in Victoria are poor. Identification of the Aboriginal and Torres Strait Islander status of patients in the health system is not regularly carried out. That leads to some difficulty in providing as accurate a picture and as distinct a picture as we would want. However, the evidence that we do have, that we can be assured of, indicates that there are not significant differences between Victoria and other jurisdictions. The life expectancy in Fitzroy Crossing is approximately the same as the life expectancy in Fitzroy, Melbourne.

Many of the barriers to Aboriginal access to health and health services are not the tyranny of distance but the tyranny of an environment, the history, the geography and the tyranny of discrimination. A recent study by Fran Baum and partners from Adelaide University indicated that 93 per cent of the 3000 Aboriginal people they studied experienced racism on a weekly or more regular basis. This is a significant barrier to even approaching services. I suspect it was one of the drivers of the immense efforts put in by the Aboriginal community to build their own health services.

Those health services in the Victorian model have evolved into services which, in comparison to other states, provide a wide range of services. It is not just primary health care and access to a doctor but is

spiritual and emotional wellbeing services, in some places employment services, in some places cultural keeping places, and a wide range of programs — health promotion activities around mothers and babies from antenatal support through to early childhood development, health promotion and chronic care management to address the burden of chronic illness that exists within the community.

There is a wide range of services. Our members are integral parts of the communities in which they operate. Some of them also offer housing services, which is of relevance here.

Disability and mental illness affect Aboriginal people disproportionately. There are higher rates of those conditions experienced by Aboriginal people. The document headed 'Health and Aboriginal people in Victoria' is an excerpt from a 101-slide set that has been produced by Dr Robert Hall, who is a former chief medical officer of Victoria, for VACCHO. It came out last month. It is the most up-to-date and available data. In some places, because of the paucity of Victorian data, estimates have been based on the Productivity Commission reports. The Productivity Commission rejects Victorian data because of the failure to identify patients in many cases.

The history, situation and circumstance of Aboriginal people in Victoria is different. Settlement here occurred rapidly. It occurred in a particular style which developed the grazing lands, the access to timber and, fairly quickly after settlement, the access to gold. It meant that Melbourne became the centre of a regional development push that was quite aggressive. There are a number of slaughter sites in Victoria. Initially at settlement there were 250 Aboriginal languages recognised in Australia, which indicates that those societies had persisted in situ for a period sufficient to develop their own languages. In many cases their own associations with that are aspects of culture and aspects of spirituality.

The rapid settlement of Victoria led to many of those groups being pushed together, so that people were classified under a single category as Aboriginal, which was a cultural discontinuity to them. They were distinct in language and in spirituality and in learning. There may have been some commonalities, but certainly there were differences. I guess if we were to go to Europe and classify all people we saw there as Europeans, it would be as accurate an assumption. The Romanians are certainly different to the Swedes; they are certainly different to the Spaniards; and everyone is different to the English.

There is a background to the experience of dispossession, and there is a background to the experience of Victorian Aboriginal people which is distinct and has bearing on how communities, how society, how culture and how individuals and families persist just 10 generations later.

Do you have anything to add to that background?

**Ms CASSAR** — I guess more around the population, in that in Victoria around 50 per cent of our population is under 25 years of age. Opportunities are very different for our young people to those of non-indigenous young people, and hence the increase in their risk of developing mental illness and mental health problems and homelessness as well. Also, support and pathways to and through service systems are seen to be more difficult.

The number of Aboriginal children in out-of-home care services is around the 650 mark in Victoria. Of those children and young people only about 250 are actually in the care of Aboriginal carers. A high number of our young people continue to be at risk of losing their identity and their connection with their culture and family — things that were experienced similarly by the stolen generation. That is something that is of great concern to me, especially when you talk about mental health services and spiritual and emotional wellbeing.

**Mr MOORE** — The distinct history has a further influence, I guess. About 33 500 indigenous people have been identified by the ABS — that is, Aboriginal people in Victoria. That is a similar population to the Aboriginal population of South Australia, but the distribution of the population is distinctly different. There are very few locations with high concentrations of Aboriginal people. There are a few, but that history of opening land to grazing and moving people off their land and combining different peoples — different tribal, cultural and language groups — has changed the settlement structure in Victoria. Although there are a similar number of Aboriginal people in Victoria as there are in South Australia, in Victoria they

make up 0.6 per cent of the population, and by and large they do not live in concentrations. Just over 50 per cent of that Aboriginal population live in Melbourne, and because of the history that we have been through in many cases that population is invisible. It is certainly invisible in some statistical senses.

Even the *Melbourne Age*, when it talks about Aboriginal disadvantage, will feature a picture of a dark-skinned Aboriginal child in the central deserts of Australia playing on a broken vehicle on the side of the road or something like that. There is a collective cultural look-away relationship with Aboriginal people in Victoria, even though the issues for Aboriginal people in Victoria have more in common than in difference with other Aboriginal people.

We identified the life expectancy gap as about 17 years. On almost every health risk factor Aboriginal people do worse than their fellow citizens who are not Aboriginal. Some of the ones that relate to spiritual and emotional wellbeing, mental illness and disability are things like suicide, which is 2.5 times higher than the non-Aboriginal community; alcohol-related disease, which is 9 times higher; and violence, which is 10 times higher. Although we do not have figures on disability, national figures on disability also indicate a higher rate than non-Aboriginal Australians.

We have anxiety and depression at 1.5 per cent times higher; alcohol overuse at 4.5 per cent higher; schizophrenia at 1.7 per cent higher; heroine and polydrug dependence at 2.7 per cent higher; and other mental illness at a ratio of 1:0.9 and a total mental illness burden of 1.6:1.

The indigenous definition of health is a broad definition that includes the cycle of birth, life and death. It includes a relationship to the individual — their autonomy — and it includes relationships to community and relationships to land. It is not surprising that the health programs that were set up by a community with that view are wide-ranging and multifunctioned. It is very difficult to successfully address one element of a person's health without addressing a suite of factors.

There are some specific statistics on suicide. We have had to use national data because the Victorian data was not reliable. The Victorian Aboriginal Funeral Service, which is a community service established to assist families with the cost of funerals, reported that suicide is a factor in 20 per cent of the funerals they support. That is a service that people seek out on a voluntary basis. It is not representative, but it does indicate the burden of suicide on the community. There is some significant research that indicates that suicide in Aboriginal communities is of a different nature than the profile of suicide in the non-Aboriginal community. The minister responsible for mental health has established a task force to review Aboriginal suicide in Victoria. They are yet to have their first meeting, but we look forward to some further research in that area.

Housing is an area of acute shortage. As Nicole was alluding to earlier, we have a young and dynamic population, with 50 per cent under the age of 25. Households tend to be larger, family sizes tend to be larger, but access to reliable accommodation tends to be poorer. The whole housing stability structure of the community is very poor at the edges.

Child removal has an influence on the mental wellbeing of the individuals concerned and of the families. It is another indicator of things not being all right. About a third of the community can report that one of their relatives was not removed. Two thirds of the community are related to someone who is removed — it has an impact. Some of the mental health factors that we are looking at in Aboriginal communities are complicated by inter-generational trauma, grief and loss. It is a burden that someone carries their whole life, being removed as a child, and it can have downstream impacts even as they become a parent themselves. It can have an impact on things like educational achievement and educational outcomes.

The education system has by and large failed to successfully address the educational needs of Aboriginal people. Participation rates are low, and completion rates are significantly poorer. That has a lifelong impact.

**The DEPUTY CHAIR** — I wonder if we could ask some questions.

**Mr MOORE** — Certainly.

**The DEPUTY CHAIR** — What we are really interested in this inquiry is the provision of supported accommodation for Victorians with a disability or mental illness. Particularly what we would like from you is how that affects the Aboriginal community. Perhaps if we opened up to some questions, there might be something else you would like to put on the record and our questions may jog your memory.

**Mr NOONAN** — Thank you for your presentations and your attaching documents. They are very useful for this inquiry. I am looking at the third paragraph of the document that you have tabled for us this morning is this one — it has not got a marking, but I hope you can identify it. You have created a very big picture and, I might say, a bleak picture. One of the areas that this committee is charged with is, as the chair said, looking at supported accommodation specifically for people who have a physical disability or a mental illness. In some respects our terms are narrow in the context of the picture you paint. You have identified two key elements to the provision of supported accommodation. One is the support, and you talk about that needing to be effective or culturally appropriate. The other area you identify is accommodation. You talk about a number of elements: the size, the configuration and location. So I wonder whether you can expand on those two issues of support and accommodation specifically and, if possible, provide some examples for us, practical examples, because they will also be useful.

**Mr MOORE** — We were hoping that one of VACCHO's member organisations, which provides direct front-line services, would be able to attend to provide that side of the equation. My apologies if our presentation is a little biased towards the larger picture.

**Ms CASSAR** — I was just going to say, I guess back in 2001, prior to me leaving, I actually worked for the Victorian Aboriginal Health Service in the mental health program. I worked there for six years, primarily with children, adolescents and families. I did a bit of relief work in its adult program, where it actually had a residential mental health rehabilitation kind of residential setting. It used to accommodate 10 patients at a time. During the duration of its existence, it actually housed, I guess, probably six people that were there for the entire time, and then you had various other patients that would come and go. But it was around supporting them to becoming independent, to be able to live out in the community in regular housing and sort of move them away from having to depend and rely upon their families to look after them.

It was culturally appropriate in the sense that the workers were Aboriginal, there was staff 24 hours a day, they had direct access, because they were all patients of the Aboriginal health service and the mental health program, and direct access to the doctors, the psychiatric nurse, the psychiatrist, as well as other support services that were needed. I guess something like that did work; it was closed down, however, some years ago now. The clients of that service actually ended up back with family. Some ended up in and out of family homes between there and just living on the streets and going from one house to another finding a place to stay wherever they could. Several of them became ill again, because they were not actually getting that consistent service, clinical service, that they were getting several times a week because of that direct contact and linkage.

While they were there they used to do things like art programs. That group was actually responsible for the mural that was on the wall in the outside garden at the St Vincent's mental health service.

I guess they all had their own personalities, but they were safe. A handful of them have now passed on. One of them in particular, one of the older clients there, he actually passed on two years ago now. He was severely ill; he had schizophrenia. He has had five children and four of the five children actually suffer schizophrenia as well. His son was also a resident within that service. There were several things — risks — that he presented with. One was actually that he had set his room on fire at one time, and because the residences were being staffed 24 hours, he was actually able to be found, procedures put in place and his safety was supported.

**Mr MOORE** — And the other residents.

**Ms CASSAR** — And the other residents, too. When this service closed down and he was placed back out into the community, he did not actually have somewhere to stay. He stayed with his daughter who is

also schizophrenic. She actually developed that through drug-induced psychosis after she got off track from what you would call living a normal kind of life. She worked for many years as a welfare service officer, and assisted people who were in similar positions to her today. She has since had children removed from her care. She has had more children and has maintained their care, unless she becomes sick and then her mum takes that on.

Her father basically would go from here to there. He was from the Shepparton area. He went back to Nagambie where he was staying with family. He actually took some sleeping tablets, set his bed alight and lay down in the fire and burnt to death. That is just an example where I guess the support and service system has failed a person and his family. Although there were some risk factors that he exposed himself to and others to within that residential service, it was there and it was something he had immediate access to. Workers were able to basically identify when people were becoming unwell, and were able to address those issues and admit them to the psychiatric ward up at St Vincent's, when need be, to one of the five Aboriginal beds which are allocated there.

I guess in more recent times I was privy to being a part of the mental health reform strategy consultations where VACCHO led the facilitation of those consultations with the Aboriginal community. One of the key issues or themes that arose within all of those was around respite care, particularly for carers that cared for a family with a mental illness or disability.

One of the more common things was knowing what services are available: lack of information about them, how to actually access the services, what services they were actually entitled to, I guess, when they were entitled to them and how they were entitled to them. All of those kinds of things were what was commonly raised. It was about not just support for them in the home but also support for the person they were caring for.

When intervention was required, generally CAT teams were called. Occasionally police officers would be called to the scene and people would be admitted involuntarily into psychiatric wards. Upon their release there was no discharge planning around it that was culturally sensitive to their needs. Many families were not part of the discussion in the development of that discharge planning and also ongoing treatment plan. One of the things identified was that the local Aboriginal health services were not informed of what was required for follow-up and stuff like that. They were some of the more common gaps in the consultations that took place.

I guess in saying that it is something that has been identified in the strategy that has now been released, that that was generically the case for a lot of the carers. We have also been involved in consultation around the Mental Health Act review. They are some of the things we have raised as well, that it is necessary that families are included. We understand about privacy laws and health records and things like that.

To ensure the safety of people and their families it is really important that families are included in those sorts of discussions and case planning meetings, as well as the local Aboriginal health services being engaged. What a lot of the families said was, 'We're given nothing. We're expected to take 24-hour care of these people, but we don't have support to do it ourselves'. In a lot of circumstances they actually have younger family or other members of the family living with them as well, so their time is fragmented and limited in what they can do with that particular person who is unwell.

Respite was definitely an area of great concern for us — and where they are able to get it. I guess there are places available, but it was around providing a place that was culturally safe for them. In saying that, that means where people understand their cultural needs and are sensitive to their culture and their practice and stuff like that. As Tim mentioned, our communities are very diverse. From here to Ballarat to Mildura, they are all very different. We all strive for similar goals but our needs are very different and our ways are very different as well. I guess it is about educating the people working in the service about how that is and what it means.

We have a Koori health liaison officer program similar to the hospital liaison officer program, where there is an Aboriginal person in the area of mental health service. We have only one in Melbourne; he is based at

the Royal Children's Hospital at Traralgon. Again his area of support is very limited, to children and young people and within the area that they actually service. We have actually been strongly advocating to get some of these positions in some of the bigger hospitals here that have a mental health service attached to them.

A lot of the Aboriginal people who are unwell are actually shipped down to St Vincent's, regardless of where they are from, just they feel that they have the five beds that have been allocated in the state for Aboriginal people, so they must go there. In doing that, it opens a Pandora's box around other issues it creates for them. They are isolated; they do not have family; they do not have the support networks in place. The family is definitely kept out of the loop in planning, treatment and things like that.

**Mr MOORE** — Even notification of release.

**Ms CASSAR** — Yes, even notification of release. So it is really difficult. I guess the concerns that we have been able to identify, having worked in that field for several years as well, include participation and the inappropriateness of cultural sensitivities to Aboriginal people who are accessing the services.

**The DEPUTY CHAIR** — Before I call the next person to ask a question, could I just say, Tim, that you do not have to apologise to this committee for talking about the overall health of Aboriginal people. One of the reasons we have called yourselves and other organisations is that we have a lack of evidence on our Aboriginal accommodation and some of those services. We are happy to hear whatever you have to say.

The inquiry is specifically on accommodation and mental health needs. Some of the issues you raise bring that forward very much, such as removing children — that would cause a mental problem — and some of the other issues. You do not need to apologise for that.

**Mr MOORE** — Just to round off Nicole's presentation, I might just engage her in a further conversation to explore some of those issues. Nicole, you said that you were working at the Victorian Aboriginal Health Service that was closed down. How many years did that run for?

**Ms CASSAR** — I think from memory it was between 6 and 10 years that it operated for.

**Mr MOORE** — You highlighted something in your talking about the mobility of the community — that people are in Nagambie, then they are in Melbourne and then they are in Shepparton; and that is something that happens a lot, especially when people are homeless or may be struggling with their own families?

**Ms CASSAR** — It does. Accommodation is scarce, and even more so today than it might have been 10 years ago. I guess one of the difficulties is that these people who are very transient between different areas will often go and stay at places — Aboriginal hostels and services similar to that which might be available. But they are at a high cost to them. The staff are not trained to be able to deal with their illness and the needs of their illness, so they are often evicted because of their presentation, and I guess some of the ways they act and behave and things like that.

There is generally within our society, not just within our community, a lot of stigma attached to mental illness and disability as well. A lot of people do not understand the disability of a mental illness, and that is broadly speaking. If somebody sees somebody in a wheelchair, they can immediately have empathy for that person, whereas if somebody is suffering severe depression, post traumatic stress disorder or something like that, they generally go unnoticed, although their behaviours or their actions are what are noticed and they are judged upon the way they present in that sense.

**Mr NOONAN** — If I can just clarify, in 2006 where was the centre?

**Ms CASSAR** — It was in Reservoir; it was based out in the suburbs.

**Mr NOONAN** — When it was closed, what options were people given? I suppose in asking that question I am trying to determine: in terms of supported accommodation, will that only work if it is an Aboriginal facility? Or in that centre closing and people being offered potentially other places, did they reject those because they were not Aboriginal-based services?

**Ms CASSAR** — Possibly, yes. I was not actually part of the adult team and so I am only able to answer that on behalf of some of the people I do know and have been close to their families. But some were offered alternative accommodation, and they were just sort of flats or units within part of the public housing system. There was concern from family members around their safety — you know, ‘What if they leave the stove on?’ or, ‘What if they do this and nobody is there?’. There were a lot of issues around that, and who was going to be able to support them in there to make sure that things were okay for them, that they were taking their medication and that sort of stuff because that is what the house was able to do.

The workers who were on from 9 to 5 would actually cook their dinner and do their lunches and distribute medication. All the workers would distribute their medication to ensure that they were well for most of the year. And where people were offered to be placed in other settings, they would have denied that, from the few I know that did deny — and that was because they were not seen as being culturally appropriate.

With be Aboriginal people it takes a lot to build the relationship, the trust, and therefore be able to successfully engage somebody in the service. That previous experience is something that many of them have had but has not actually been the case. The trust has never been at a level that it needs to be at to engage them properly and work with their recovery and treatment and keeping them well — so, yes.

**The DEPUTY CHAIR** — Can I follow on from that? Why was the centre closed? Was there a reason given?

**Ms CASSAR** — I could not say that because when it actually shut I was working for VACCA, the Aboriginal child-care agency. But I am close to a couple of the families who had family members placed there, and I just remember that they were put in either community housing — some were that unwell that they actually had to go back to family, which also became a bit of a burden on family as well. But I could not actually say why, definitively why it was shut down in the end.

**Mr SCHEFFER** — First of all I want to thank you for the presentation you gave and especially for reminding us again about the immediacy of history, the dispossession you talked about, and the pressing together of the very wide variety of indigenous communities into a mass of people who were confused and were not properly perceived by the non-indigenous community. The reason I mention that is that clearly what I am hearing you say is that that is part and parcel of every indigenous person present; it continues to live and be played out in people’s lives.

**Mr MOORE** — Yes.

**Mr SCHEFFER** — And in the case of people with mental health issues and physical disabilities, that then informs how they are treated and what kinds of treatments might be more or less effective, and that kind of thing. We have heard earlier today from other witnesses who have talked about how that is equally true of, for example, refugees and people who come from other countries where there are different regimes that then inform, qualify and change the way they react to what is happening here. It is a very complicated kind of picture.

What I want to ask you, and I do not know if you can reflect on this, is: how does all that relate to treatments and how you run an ideal organisation? Some of the things you have talked about are general — that for every person who finds themselves to be schizophrenic, for example, it follows a kind of clinical pattern that is very similar, no matter what culture you are in — but how that is treated, how that is overlaid, becomes culturally specific. Do you know what I am getting at?

**Mr MOORE** — Yes.

**Mr SCHEFFER** — Can you talk about that a bit?

**Mr MOORE** — One of the things that VACCHO has undertaken — and it can be complex because our 25 member organisations undertake many service areas, but there may be other organisations in the same district as our member organisations which undertake other community organisation roles, such as native title.

VACCHO supports the recommendations that were discussed in the media, because there has been little released publicly of the reform of the native title act, for instance, which looks at restructuring title, in a sense, from being a European lord of the manor — complete control of the individual — to a cooperative approach. So there can be something where indigenous title, or entitlement to access to land, can be recognised, without necessarily having to go through all of the loops.

Aboriginal people in Victoria are obviously disadvantaged in the national regulations and the state application and interpretation of those where it is unbroken, continuous attachment. Even the recognition of joint advisory entitlement to advise regional national parks on a group-by-group basis — the Gunditjmara people would be advising down in Warrnambool, the people would be advising in their local area and there would be supports to do that — may provide a person with a sense of belonging and attachment and continuity with 40 000 years or more of history. I think that sense of displacement can manifest itself in mental illness. Therefore it is unusual for a health organisation but we actually have a view on native title legislation because of the potential it has to provide people with a space.

One of our member organisations takes their adolescent community members on a tour of their Wathaurong country around Geelong. They go through the Otways and talk about the food types and materials and their use in culture. They visit the eel traps which are tens of thousands of years old — a form of aquaculture, the burial sites along the coast and so on.

People get a real sense of attachment to their country, the diverse ecosystems and how they were utilised, a sense of movement through time as well as the movement through space where an accusation of being Aboriginal, which is normally a racist taunt, can be turned around and adopted into something that is positive. People who might come under pressure from their school mates to deny their Aboriginality actually develop a sense of pride and ownership of that. I guess that is one example where that sort of attachment question comes into play.

**Mr SCHEFFER** — But in the set-ups that you were talking about, Nicole, the way you have been describing it you are dealing with people who are suffering from a range of dysfunctions and stresses. How does that larger story inform the kind of service you provide because when you were talking it sounded, with respect, as though it could have been any service that you were describing. Yet what you have talked about is specificities relating to the indigenous experience in Victoria that we need to sit up and take notice of — and that just does not mean here, that means on the ground when people are in pain.

**Ms CASSAR** — Yes. From my experience where I have worked in the mental health service and where I have worked with VACCA with kids in out-of-home care; I have also done a lot of voluntary work in establishing Aboriginal youth groups and things like that as well to help try to reduce some of the problems that a lot of kids are facing.

It varies per individual and is dependent on their family — what supports they have. In most extreme cases you cannot avoid medication; medication is a must. But on top of medication there are things like country, which Tim mentioned. If you talk to some of the older population, they will talk about what makes them well is to go back to country, and go out and spend time in the bush with their family, significant elders, significant people. That may not be part of their family but is somebody who has lived on that land for 70 years or something like that. They will actually talk about that being the kind of thing that heals them.

For some of the work I did, particularly with primary school-age children and preschool-age children and their families, it was around having an Aboriginal presence within the clinical setting with the non-Aboriginal clinicians. It was about my ability to be able to talk with the psychologist after the session and allow her to ask me why this is this way or how come this is like this for example, and my being able to explain the cultural significance of that particular way of living or value or belief of that family. That

helped their understanding in determining the outcomes for treatment, their overall assessments and that sort of thing.

**Mr SCHEFFER** — Can I just interrupt you? On the first example you gave, which is really interesting, it might be part of a person's 'treatment' that they go back to country. Could you budget that in? How would you get VACCHO to do that?

**Ms CASSAR** — It would be really difficult, because when it has been done, it has been expected to be done with existing resources, and you already have workers who are overworked and underresourced. It then means having to engage people from their local communities, finding that connection back. For example, if they were going up to Barmah Forest, finding someone locally up there who could be with that person because obviously the worker might be able to transport them there but they have still a job back down in Melbourne that they have to be at to service the other people. It is difficult but it is about engaging and utilising what is there to be able to do that.

It is not always able to be done because sometimes a person is seen to be too unwell to be able to be let loose, if that makes sense, and not have that support and guidance that they need from a clinical perspective. It is sometimes unfair to the members that you are sending these people to. They might not have the experience to deal with them if something goes wrong, where they might become very unwell and severely disturbed, that sort of thing. It is difficult. It has been done but it is done rarely. They try to do it for young adolescents who are placed in out-of-home care, more so with non-Aboriginal carers.

They might not be able to connect them to family but they will find a significant elder from the community that their family is from and maybe take them on a day trip and things like that, to help build their cultural awareness and rebuild their identity as well as their inner strength and spirit around what it is to be an Aboriginal person and allow them to get back in touch with that connection. So they can see what they are feeling is normal. It is a part of them, and this is why they feel like that.

Where that has not been able to happen, the young people have been in and out of placements, in and out of home care, in and out of the correctional services and facilities on many occasions as well, and generally end up with learning disabilities. They also end up with developmental delays, they end up with issues around education and employment, they end up with problems around accommodation and support, and often end up in and out of the justice system until late in their adult lives.

So it would vary from person to person, but it is really difficult for somebody to say, 'This is how we are going to implement our treatment plans for all of our clients', because there are not enough resources to do that. It is not just financial resources. It is about how you get a person from A to B, about who is up there who is trained and has experience in dealing with people who are unwell in these circumstances, and what they do when that person has an incident or a psychotic episode or threatens to injure themselves or somebody else.

They do not want to call the police but, like I said, that is sometimes a way that speeds up the response of the CAT team, for example. It is not something they like to do but it is something that for their own safety and the safety of others around they have to do sometimes.

**Mr MOORE** — Some of the elements that draw out a separation between an Aboriginal idealised model service and a non-Aboriginal service would be: the engagement of the concerned family members, which possibly might happen at a higher level than it would in a mainstream service; the meeting with and shared accommodation with other Aboriginal people — there is the client group and there is the staff group; the engagement in the elements of spirit and country that were referred to earlier; and having culturally competent carers and practitioners.

Nicole referred earlier in her opening remarks to the mental health liaison officers program. That was an attempt by regional mental health services to have a cultural broker, if you like, for the services. I think there were 12 positions — —

**Ms CASSAR** — Eleven.

**Mr MOORE** — Eleven positions — 1 metro and 10 regional. My understanding is that the metro one was completely insufficient to service 15 000 Aboriginal people in Melbourne and had taken a segment — bite off as much as you can and chew like hell — sort of approach. Of the 10 regional positions, I think on last report there were about eight vacancies.

**Ms CASSAR** — No, they have actually slowly been filled. We are up to having 2 vacancies left of the 11. Prior to that, though, there were some long-term vacancies. The Horsham position, for example, had been vacant for two and a half years; they were unable to recruit. The person they have recruited now is non-Aboriginal, because the local Aboriginal people who are there do not want to work in the mainstream service, especially in mental health, and be seen as the one person who gets handballed everything that is Aboriginal that walks through the door.

The Ballarat position was similar. It was vacant for around one and a half years before it got filled, again with a non-Aboriginal person. The Geelong one has just been filled. That was vacant for about 15 months. A young Aboriginal lady has taken that but she is from Darwin, so part of her need will be to build up a relationship with the local community, because she is unknown and is seen as an outsider, and therefore she is not going to be able to engage quickly, as a local person would be able to.

But in saying that, I have only just met with her the other day in Geelong, and her role has actually been changed significantly in that she is only there now to provide cultural awareness training to the clinicians and will have no contact with clients whatsoever. She talked about case management, and I explained that the positions were not set up to do case management but they were set up to engage Aboriginal people into that service and to be a familiar face and someone that is seen to be culturally safe to help bring them through and assist in explaining things. That role has now been changed, though, and she will be unable to do that either.

**Ms KAIROUZ** — You mentioned the mental health reform strategy and said it was good. One of the things you mentioned was the themes and knowing how you access the services, and when, where, how and what people are entitled to. That is really good, but how do people access your service? How do the clients come to you? Do you go out looking for them, or do they come to you and get referred to you? How is that done? I am interested in that.

**Ms CASSAR** — Our particular organisation is non-service delivery. We are the peak body for Aboriginal health so we do a lot of the policy and planning, but, for example, for the health service in Victoria where I used to work, for people who are new to the area, who might have moved down here from another state and things like that, it is probably word of mouth.

**Ms KAIROUZ** — Within the community?

**Ms CASSAR** — Yes, within the Aboriginal community. They will actually meet other Aboriginal people, who will say, ‘Go here for this service’ or, ‘Go there’. People who have lived in Victoria all their lives or for a very long time are aware of the Aboriginal co-ops and health services around the state. They may not know exactly what services they provide, unless they access them and ask, but generally for most Aboriginal people they are the starting point for any service-related relationships they have or service that they receive — for example, the health service is a starting point for somebody who goes in and has been evicted from their house. They may not know how to access the Aboriginal Housing Board, for example, or Aboriginal Hostels Ltd, or things like that, so they will actually go into the health service to see a doctor and they will be in there for quite a while explaining all their issues. Then the doctor will actually inform them that, ‘You need to come back out and we will make an appointment with this person for you’ or ‘Come and talk to this person’.

It depends on what their need is. It is generally from a community level; it starts from within our own community because particular people do not know. The majority of the families that are born and bred within Victoria are actually brought up within these services, if that makes sense. Clients will be serviced from birth, so they are more than well aware of them, but it is more the people that are not from that area or not from this state that are not aware of them. They know services exist, but where and how?

It is a little bit hypocritical in the sense that we are able to say these things about all the mainstream services, but sometimes we do not have the ability to do some of the things that they do not do as well. But that is not at a conscious level; it is more because the ratio of clients to the worker is sometimes 30 or 40 to 1. I know where I was with my previous case load there were two Koori-kids mental health workers, and our case loads were somewhere between 20 and 30 in any one year.

**Ms KAIROUZ** — But then the problem with that is also that you want somebody who understands so you just cannot get an outsider, can you?

**Ms CASSAR** — No.

**Ms KAIROUZ** — They are quite selective as well in who they want to deal with.

**Ms CASSAR** — Yes, very much. When I was first employed in that — I am a local from Melbourne — my family is from Warrnambool and Dimboola, but I was born and bred in Melbourne all my life. My mum worked at the health services 25 years ago so I have been brought up in that.

**Ms KAIROUZ** — This is just a hypothetical: if there were five people, and five of us worked on this and there were Aboriginal youth and you were the indigenous worker, would they come to me, even though that service was available to them?

**Ms CASSAR** — They would go to you if they did not know that there was an Aboriginal worker there.

**Ms KAIROUZ** — Right.

**Ms CASSAR** — If there was an Aboriginal worker there, chances are they would ask for that person. That would be, in most cases, the first point of contact. They actually might not go to reception and say, 'I am here, I have got an appointment with Dr Smith', for example. They might go there and say, 'I have got an appointment, could you please call the Aboriginal health worker' or the Aboriginal worker or whatever.

**Ms KAIROUZ** — They would expect it to be an indigenous worker.

**Mr MOORE** — By definition.

**Ms KAIROUZ** — Yes, okay.

**Ms CASSAR** — Yes. Although some of the positions out in services are identified as Aboriginal positions, I guess, or to work with Aboriginal people and communities, they are not always Aboriginal people who are employed in those positions.

**The DEPUTY CHAIR** — Tim, could I ask you to clarify something. You said that 93 per cent of the 3000 Aboriginals surveyed said that they had experienced racism. Was that racism in the community or was that racism in the services that were provided to them?

**Mr MOORE** — No, my understanding was that it was in the community.

**The DEPUTY CHAIR** — Okay. And a second one: we have heard from the ethnic group who talk about accommodation and say that we cannot lump them all into the same ethnic group because they all have different needs, and Nicole was talking about the different ways of Aboriginal communities. We understand that there are many different clans in Victoria; some may not even get on. Is there a need for specific accommodation, or if we had accommodation would that be culturally aware for all of the Aboriginal people in that area, or would you need to be very careful who you select as carers?

**Ms CASSAR** — From a personal opinion I do not think it needs to be, say, a service for Yorta Yorta people, a service for Gunditjmara people, a service for Wathaurong people. I do not think that needs to be the case. I think an Aboriginal service as a whole is what is needed, but the people that work within that setting need to be aware of the diversity of different families, different groups, people from different areas and that sort of thing. Most Aboriginal people are aware of that. It is generally the clinicians who are

non-Aboriginal and who may not have had that direct work experience with those particular clients before. They are not aware of that.

My personal opinion is that I do not think it would matter if it is not specific to a particular group. I think that is not an issue, but I do know for certain that it is an issue if the people are not sensitive or even educated around the differences between each family, each group and each clan, and stuff like that as well. I really think that when you are with other Aboriginal people it can be good, it can be bad. It is similar to the general community. That is not really the issue, I do not think. I think it is more about people being sensitive to their needs and their issues.

**Mr MOORE** — VACCHO as a state peak body provides a regional centre funded by the commonwealth for spiritual and emotional wellbeing and we provide networks of professional development, planning and support for the workforce that operates in our membership. Over 40 per cent of that workforce are Aboriginal health workers and they may be generic Aboriginal health workers and carry out a range of roles from patient transport, to triage, health assessments and so on.

We provide mental health first aid training to the general workforce. We also prepared a suicide prevention toolkit to assist Aboriginal health workers and related workers to, hopefully, identify and intervene in situations where there is a suicide risk. We provide a support network for the mental health liaison officers and try to provide better links and training to those, and the Bringing Them Home workers who work with the stolen generations group. There is another workforce that I am missing, I think. There are the BTH workers and, yes, in some places there is are targeted spiritual emotional wellbeing workers that we provide support to. So although we do not provide direct service provision to clients, we provide some of the essential and necessary supports for the workforce that do that.

**Ms KAIROUZ** — Yes.

**The DEPUTY CHAIR** — Thank you for that information.

**Mr SCHEFFER** — There are some really interesting things embedded in what you have been saying. Maybe what I am going to ask you is a bit unfair. We have to put recommendations to government. You might want to comment on this as well. The government has a mental health strategy out there, which is being worked on around disability. We know there is a long way to go; everybody understands that. What would you recommend that we should put to government that would make a difference?

**Ms CASSAR** — This is from my own experience, but also in recent times from the consultations, as part of my role is to support the Koori mental health liaison officer network as well. One of the key things that comes up is that, obviously, everybody would love to have Aboriginal-specific accommodation services for people suffering mental illness and disability, but that is not always going to be the case.

**Mr SCHEFFER** — What do you mean by that, that that is not always the case?

**Ms CASSAR** — From what we have tried to do; we have actually tried to have some of those services set up in different areas. Regardless of how successful or not they are, they always seem to wind down for some reason or another or be taken away. Like I said with Worrin Yan House, I am not sure why it closed, but it was closed down, and those clients were expected to be a part of the mainstream services, I guess, which did not necessarily work in the way that it thought it would work. Ideally you would love to have a service similar to that set up in every region — that is, Aboriginal specific.

State Trustees generally manage their affairs, so a portion of their money was taken to cover their accommodation, but it was not as high as it would be in hostel or even just in public housing, for example. In saying that, if that were not a possibility — and this is something we and a lot of the workers have tried to advocate for — instead of having five designated beds at St Vincent's Hospital for Aboriginal people, why not spread them across the state so there are Aboriginal-identified beds within the area of mental health services and psychiatric wards? They could be identified for Aboriginal people when they do present instead of having to say to them, 'We don't have any beds available here, but St Vincent's have

five that are allocated for Aboriginal people, so how about we send you down there?'. It might be 800 kilometres away in some instances.

That has been one of the things, and that has not just come from workers; it has also come from the families that these workers work with. For example, in Wodonga people have been sent down to St Vincent's. They have gone to Wangaratta, for example, and they have not found that service to be appropriate. Workers have tried to work with that service. They might not have enough beds because it is a smaller service compared to something like St Vincent's but they service a large area. They have basically said, 'Even if we can have one or two allocated beds per mental health ward or psychiatric unit, that would be sufficient for us'. It would mean that they could actually work and visit this person, and they can provide transport to family to do the same.

I guess the difficult thing is that when they come to St Vincent's there is nowhere — and family want to come with them — for family to stay. A set-up something like Ronald McDonald House, which provides for the families of children who are at the children's hospital, is something that they have always said they would really like to have, even if there is just one, two-bedroom unit or something that is available so that the patient can get well.

It is not just the medication that has maybe created the episode, but having that disconnection and being isolated just adds more to the problem than not, I guess. That is one of the things workers have said, having allocated beds within regions so that the travel is not as far. In saying that, they have also said that if that is to happen, they actually need to be culturally appropriate, as in the staff need to be aware and have that education around obviously the mental health liaison officer positions but also other Aboriginal health services and mental health workers also located within that area, and they should be liaising with and working together to ensure that the patient is engaged and feeling comfortable and things like that.

**Mr NOONAN** — Can I just expand on your recommendation? You talk about the clinical side, which is the bed in the unit, if you like, at St Vincent's. What about recommendations around the transition back into the community broadly?

**Ms CASSAR** — I guess that was one of the strengths that that program had. It was about building up the independence for independent living. It was about walking those clients. Like I said, probably about five or six people did not leave there until it closed down, but there were a number of other people who came in there for shorter stays.

**Mr NOONAN** — Is this the — —

**The DEPUTY CHAIR** — The centre at Reservoir.

**Mr NOONAN** — This is Reservoir?

**Ms CASSAR** — Yes, and basically while they were there, housing or accommodation was sought and found for them. They were basically linked in — if they needed to be — with Centrelink, for example, to ensure that their payments were coming. They were linked in with financial counsellors to help them be able to budget and make sure that they had money for food and that sort of stuff. They were actually assisted with getting Met tickets and things like that to make sure that they could get on trams, buses and trains to get to and from a point and see if support services were needed.

**Mr NOONAN** — So in terms of a recommendation, how long did people generally stay for? How do you avoid it being another form of housing availability as opposed to a transitional service from a clinical environment to essentially get people back into community, whatever community they choose? You have outlined a range of services that were provided as part of that, but can you be perhaps more specific about the transition length that you saw and just make a comment on that?

**Ms CASSAR** — I think a short-term stay is the best. When I say 'short term' I am probably talking about a couple of months. Like Tim said, maybe six being the kind of maximum, because I think they need to get their mental health and their physical health in control first. Once they are seen to be able to manage

that, it is about having them engage with the right people who can ensure that their independent living is sustained once they are out there. Again, it is about not just the service support; it is also about the peer support and their family support as well. They might not have family around but in that time they can identify people who do support them and who they do trust and that sort of thing. When kids go to primary school and they do their safety network, they draw their handprint and they write the five people who they could find safety with if something was to go wrong. It is something similar to that in their identifying 'These are the people who always help me, these are people I can rely on', but they are outside of the service support network.

But I think the transition, similar to prison release transition, is different for every person. Some people can walk out the gate and have a family that is ready to provide them with housing, accommodation, support, meals, that sort of stuff, and others do not. They end up back on the street or wishing that 'Maybe jail was better for me' kind of thing. You do not want that to happen with people with mental illness and disability.

**Mr NOONAN** — Finally, because we have spent almost all the time talking about mental illness and virtually no time talking about physical disability — this might be limited by your experience, and that is fair enough; we might have to research in other areas — essentially do you have anything that you want to add in terms of the cultural nuances of Aboriginal people living in Victoria with physical disabilities and their needs in terms of supported accommodation, whether they are in your experience better to be supported in a family environment or whether in terms of the experience you have had Reservoir is an appropriate environment. I know you can never have a one size fits all. If you do not have the experience, that is fine, but if there is something that you would like to offer the committee in terms of a view or recommendation, we would be happy to hear.

**Ms CASSAR** — I guess it has been a program that has had more of a focus on our elders or people who actually have a disability. It is programs like home and community care and KAP, which is the Koori aged-care package program where they provide that in-home support, particularly if they do not have family who are able to do that. It is things like taking people out and assisting them to do their shopping, for example, or going in and helping them clean their house. I guess from a carer's perspective it is about respite, so how do they get respite? That is on both scales, whether it is somebody suffering mental illness or a physical disability. As strong as they are and as willing as they are to care for these people, they often need time out and support. It is not always around removing the person who is suffering from the home, but maybe bringing somebody in to stay in their house for a weekend, for example, so they can take a break and go somewhere else. I guess it is just having those services available, but their knowing how to access them as well has been really important just in my experience of working in some of that field.

**Mr MOORE** — The unpaid and unsung heroes are the families and communities, but by and large it is families who support people both with mental illness and with disability. I am thinking about some of our staff at VACCHO and the extended relationships they have with family members with a mental illness and the support structures that go in there. At the other end of the scale I think prison does play a role in the continuum of treatment. It is very expensive, and in fact there will be some people who require a level of support and accommodation on an ongoing basis and who in the current system are selected by the prison system as their model of end-point care, inappropriately and unjustly, but I think it is a confluence of circumstances that lead them there.

I think we could include in the accreditation of mental health services an Aboriginal cultural competence standard that would ensure there was at least a process of engagement. We have mental health liaison officers within the mental health system, but the breadth of scope of engagement that is required of those workers often far exceeds the demand. I think there could also be community-based, in the Aboriginal community controlled sector, mental health officers who can broker access to mainstream services. Although many of the clients will continue to seek those services specifically from an Aboriginal community-controlled organisation, where they need to be brokered outside that service, there could be a role played by mental health brokers so the person would have an advocate, a friend and someone who could assist in that pathway.

**The DEPUTY CHAIR** — Just on that, when you talk about accreditation, do you think it would be appropriate in accommodation places or where services are being provided to Aboriginal people that non-Aboriginal people could be given the accreditation and the training to be culturally sensitive and acceptable to the Aboriginal people, or do you think they would only use the services and the accommodation where Aboriginal people themselves are running it? I guess what I am saying is, do we also have enough Aboriginal people who are skilled purely because they are Aboriginal, or do you think we could actually have a cohort of people who are trained to be culturally sensitive and meet all the needs of the Aboriginal people without actually being Aboriginal people?

**Ms CASSAR** — I guess in my experience there have been a lot of non-Aboriginal people I have worked with who, like I said, have worked in Aboriginal community organisations and with Aboriginal people for very, very long times. They have actually been accepted; they have been able to develop trust and be seen as somebody who understands and is willing to help and is not one to judge them or their story, their history, their family and that sort of stuff.

I wish there were enough Aboriginal people who could fill positions and things like that, but it is not always the case. I wish that with the employment — say — of the two non-Aboriginal people in the professions in Ballarat and Horsham, they were able to engage with their HR staff and say, ‘Look, I do not really have an issue with this, but I think you need to engage the local Aboriginal health service right from the start before you even interview this person’, so that they can then ask questions and feed in information and develop that relationship right at the start, which they have done. Now they have negotiated that the people work between the area mental health service and the Aboriginal health service. They separate their hours to help build that relationship. I think it can be done with non-Aboriginal people.

The palliative care program is another example. There are no Aboriginal-specific palliative care workers out there. There may be Aboriginal people who are employed in the service, but they are not specific jobs for Aboriginal people. The palliative care program we have at VACCHO is around teaching them about the cultural wellbeing of an Aboriginal person, and helping to build their knowledge and education around the family so that when somebody is on their last legs — for example with cancer — and you have 30 people in the hospital saying, ‘Only one at a time’, it is not going to work. They are working with them to get them to understand the depth of what it means for that family and for that person and everything else. Also, it is about getting them to understand if somebody says, ‘Look, if I am going to die, it is going to be with my family in my own home’, or, ‘It is going to be back here in my own country. I am not going to do it in the hospital’. A lot of people in hospitals are not prepared to die there. It is getting them to understand that, and understand that yes, there will be 30 people up here for the next week.

If somebody has an accident and ends up in a coma, for example, the whole family is going to be in and out. Some will be there for days and days and others will come and go, but it is about helping them to understand and be respectful about it and about the beliefs and values behind it. It does work, especially when people are open and willing to learn and understand the reasoning behind some of our ways.

**The DEPUTY CHAIR** — Thank you very much. Sadly, we are going to have to finish because you have given us enough of your time. Thank you both very much for your insights; it has been absolutely fascinating. You will get a copy of the transcript. You will be able to make some changes to any minor mistakes. Once again, thank you for coming before the committee.

**Ms CASSAR** — Thank you.

**Witnesses withdrew.**