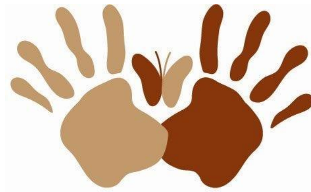

TRANSCRIPT OF PROCEEDINGS

April Lawrie, Commissioner for Aboriginal Children and Young People

Denise Rieniets, Counsel Assisting

Hearing for the Inquiry into the application of the Aboriginal and Torres Strait Islander Child Placement Principle in the removal and placement of Aboriginal children in South Australia

Thursday, 19 October 2023 at 2:00pm

Expert Witness:

- **Professor Katina D'Onise, , Executive Director, Prevention and Population Health, Wellbeing SA**

Denise Rieniets, Counsel Assisting:
Welcome, Dr D'Onise. We'll have the Commissioner give an Acknowledgement of Country before we start.

Commissioner April Lawrie (Chair):
Yes, I'd like to acknowledge that we are meeting on the lands of the Kaurna people. Pay my respect to Elders past and present, to all the children that are from our Aboriginal and Torres Strait Islander communities that make South Australia their home and acknowledgement of our Aboriginal and Torres Strait Islander people. This land never seeded, always was, always will be our country. So thank you.

Counsel Assisting:
Thank you. Dr D'Onise will ask you to affirm your evidence before we start, if that's all right.

Carla Ringvall, Assistant to Counsel Assisting:
So if I could just ask you to repeat after me please.

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Prof Katina D’Onise:
Sure.

Assistant to Counsel Assisting:
I solemnly affirm that the evidence I will give.

Prof Katina D’Onise:
I solemnly affirm that the evidence I will give.

Assistant to Counsel Assisting:
Will be the truth, the whole truth, and nothing but the truth.

Prof Katina D’Onise:
Will be the truth, the whole truth, and nothing but the truth.

Assistant to Counsel Assisting:
Thank you. And if you could please state your full name, address and occupation.

Prof Katina D’Onise:
Katina D'Onise. [address provided] and my occupation is a public health position and epidemiologist, currently Executive Director, Prevention and Population Health in Wellbeing SA.

Assistant to Counsel Assisting:
Thank you.

Counsel Assisting:
Thank you. Dr D'Onise, have we received a copy of your CV?

Prof Katina D’Onise:
No.

Counsel Assisting:
Would you mind forwarding that through to us when you get a moment, please, just so we can have that for reference as evidence.

Prof Katina D’Onise:
Sure.

Counsel Assisting:
I understand that you're working in the the area of public health and looking at public health and a public health approach to child protection, is that the case?

Prof Katina D’Onise:
Well, I'm working in the area of public health, not specifically in the public health approach to child protection.

Counsel Assisting:
Right. OK. Could you speak to the Inquiry about how that approach is different from what the child safety approach for child protection is please.

Prof Katina D’Onise:
Sure. I just really wanted to start as well by also acknowledging that I'm coming to you from the lands of the Kaurna people and I would like to pay my respects to the Kaurna people and their Elders

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and also, of course, to Commissioner April, with your cultural authority in this space. I also do want to acknowledge that is a difficult time for people.

Commissioner Lawrie:
Yes, thank you. Much appreciated.

Prof Katina D'Onise:
So public health approach, I have had a bit of a think about how to best describe this in a way that makes sense to people, and I hope it's OK, but what I've done is I've because we it's obviously generated out of the health discipline, is that I've taken what we all kind of have experience of and that is going to see a doctor for being unwell and given a parallel with what does a clinical world look like and how it and what's the direct parallel with public health. Kind of gives you a sense of how we how we look at things differently, and we use different skills, so if that's OK, I'll just start working through and please interrupt if you need.

Counsel Assisting:
Thank you.

Prof Katina D'Onise:
So from a clinical approach that's that, I guess you'd call that the child safety approach. It's a focus on the individual in front of you. Population health or public health focuses on the population as a whole and explicitly takes the approach of equity within that. So that's not necessarily an explicit approach of the individual way of working. When you go and see a doctor, the goal is to make a diagnosis, and that's gathering information from the patient themselves and also some tests. In, in public health on the other hand, what we're doing in that space is understanding what is the causal origin for what we're looking at. So we we talk about things like risk factors, but we also talk about protective factors. So, in a way, our evidence that we gather to make those decisions, that's epidemiology, so we would use quantitative data, qualitative where we're talking to people, but we also use the Community voice. So when I say data, I'm really talking about that full suite of information that we would gather as the intelligence, if you like, to help us to work out what's actually going on here, what's the cause. When we talk about clinical medicine, it tends to focus on proximal causes, that is the thing that directly caused what's in front of you. In public health we tend to think about distal, we go back in time and go what's the actual source of what we're seeing. And often that is not, you know, often that's years in advance and and when it comes to child protection, we when I say years, we could be talking generationally years. It's it's not really just the just before. So we do focus on those distal causes because they're the real cause, if you like. And when we do that, we're really talking, our focus tends to be on prevention. So by going back to those true causes, we're trying to prevent the progression well to disease in the in the medical world.

Commissioner Lawrie:
Mm hmm.

Prof Katina D'Onise:
In the clinical world, it tends to involve people who are sick, so they've got a problem. In public health, we tend to work with people who are well. So our aim is to keep people well rather than having them progress through to being unwell. So in terms of like our intervention, if you like, in a clinical world, we're really focusing on treatments of an individual to change that individual's circumstances or their behaviour. But it's all about shifts in an individual. In public health, we are actually rather focused on whole population, so we look at universal, and our general aim is to, public health at its best, will do whatever it can to change the environment around a person that

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means that those, let's say, healthy decisions, in our context, are easy to make. So as an example of that, with the tobacco control work, which is, you know, it's basically changing all the laws and policies around people, giving them the education and support to make changes as well, but the education support without actually changing the environment around people isn't, is not effective at the population level. So rather than focusing on what does this one person have to do, we're focusing on what does society, how does society have to shift such that that problem becomes less of a problem as people kind of go down that path. The other thing about public health is that very small shifts in everybody's behaviour lead to very large population health gains. So it's kind of one of those things where if most people are, so when we talk about risk, you know in in the child protection context, we're talking about children at the at the very kind of significant end where they interact with child protection. But there's a continuum of risk, right. So there are people who are at that pointy, terrible end, but then there's a whole heap of people right next to them. Not quite so pointy and it and it goes on. The idea of population health is not just to focus in on those people who are at the pointy end, or even the ones just next to the pointy end, but rather to shift the entire curve. So everybody is in, has an improved opportunity, even those people who were in the middle, because those people in the middle still have risk. It's just not as great as those people who are at high risk. I hope I've explained, usually we do this with the white board, you know, show the shifting curve, but.

Counsel Assisting:
You've done a very good job of that, thank you.

Prof Katina D'Onise:
With the hands. So I guess another thing is when we talk about a clinical thing where you know the outcome being you either get better or you don't get better, but that's all at the individual level. In population health, we're explicitly evaluating. So we're looking, you know, how, did we achieve what we intended to achieve. Research as well can be part of that, and research is definitely a tool that's used in population health. And I guess the final thing that I wanted to say is that, you know, when you're treating someone clinically, you may identify that there are multiple other services that that person really needs to access. So multidisciplinary team or housing or whatever. The corollary in public health is who are the partners we need to work with? Because generally speaking, those causal drivers of wellbeing and lack of wellbeing, there is no one agency that holds all of those causes. So in public health, we must, working in true partnership is an absolute foundational thing. So I guess I would say, you know, we use data and evidence. We take a causal approach. We take a prevention and equity approach. We look at what, what, what legislation, policy, the big stuff, what are the big things we can change that are going to help support that environment to be healthier and then we measure how we're going and we do that with our partners. That's kind of I guess my version of public health. So I mean, I don't know if it it's kind of easy enough to slip that into the child protection, but I for me it is because you can just swap out the word sickness with you know at risk or have the, had harm done to people, it's really just that the negative, the bad thing being prevented.

Commissioner Lawrie:
Do you see at all though, in SA, like any aspects, if any, of public health approaches to supporting vulnerable children and their families? Without necessarily looking at the child safety sort of context in the child protection area.

Prof Katina D'Onise:
Well, look, I think we have pieces. I think that the, for example, the primary healthcare system, the

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Aboriginal community controlled health system, is a really critical piece that does do a lot of this very good work at the universal level and as well as they're family centred, you know that they're not services that just deal with one person in a family, a good, and and our Aboriginal community control sector is a strong sector, so I think that's good. I think there are aspects of the early childhood system that are supportive and I would call out call out Kura Yerlo here being an Aboriginal controlled early childhood system that you know, brings children together with Elders that has a real focus on culture. So you know, I think I think it's fair to say that we have, and also of course we have our Children's Youth Women's Health, we have Aboriginal birthing programs, they're very successful, I mean, I definitely think they're a critical and there's good evidence that they're very effective having Aboriginal control through the whole birthing process is absolutely necessary. So I, I think we have some fundamental pieces, but I guess what you know, we're kind of missing an overall understanding of how that's coming together.

Commissioner Lawrie:
Yep.

Prof Katina D'Onise:
And I think we also, you know, not every Aboriginal woman has the choice to access an Aboriginal birthing program, so we don't, also the scale, there's something about the scale that we, and there's not enough Kura Yerlo for, you know, it's in one part of the city, so I think, so in other words, I think people know what to do and know how to do it well, it's just it's not enough.

Commissioner Lawrie:
Mm hmm, thank you.

Prof Katina D'Onise:
Yeah.

Counsel Assisting:
And Dr D'Onise, can I ask, is that an issue of funding? Or is it an issue.

Prof Katina D'Onise:
Well, I mean, I think everything, let's, let's face it probably, I mean not that I would know, but I think it's more than funding. I think we also struggle with you know recruitment appropriately skilled people. You know, and you need to have, from a community control perspective, obviously you need to have a community that has the energy and focus to create a community controlled organisation and it's not going to pop up, just that's not, that's not something that can pop up anyway. So I think there's probably lots of factors, but obviously funding is a supportive, supportive to building these systems.

Counsel Assisting:
From a public health perspective, can you tell us what, what are the main causal drivers that result in in what's going on with our Indigenous children being highly represented, overrepresented in the care and protection system?

Prof Katina D'Onise:
Yes. So I mean they're they're very, very, very large drivers and they're kind of societal drivers. So, you know, socioeconomic factors are absolutely critical. So that is, you know, people having access to enough money to for that not to be stress in their lives, but just the basic needs, people having access to high quality work environments where they feel enriched as an individual, life skills and that and and parenting skills, which can happen from an intergenerational perspective where there's

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been child removal over generations, and of course, there is the stolen generation, which was a profound kind of line in the sand for people where cultural rearing practices by definition were just taken. So people didn't kind of grow up in a in culture and how parenting works in in their own culture. So there's also accessibility of services. That's a really important thing. I think the really important bit here is that all of these factors I've talked about directly impact on people's mental wellbeing. And so if you're a person who is not really sure how you're going to eat because you don't have any money, you might even be homeless, you're living on someone's couch, you might have children. There's a whole lot of things going on in your life, and even just kind of staying afloat as an individual is is pretty tough. It's pretty hard for people, especially if they don't have the life skills, they didn't have that experience themselves, they've got no work respite for themselves to get out of the house, to have something else to do with their brain for a period of time. That is like a pressure cooker, and it's really hard for people to look outside themselves. So once you start combining these kind of major societal drivers in one family and that's how that is how it goes, it's not one of those things, it's usually all of them, the pressure on people and their mental health is just too great and it is just too hard to look after self, let alone looking after others. And that's where issues of neglect can become quite prominent when people just really, I mean, they're neglecting themself as well. So I think it's really important to say quite clearly, though, that for Aboriginal people, I mean, I've already referred to the stolen generation, but impacts of colonisation over time and intergenerational trauma can't, can't imagine that that's separate from this conversation. So while we have those socio economic drivers which are pretty well universal, those drivers will have the same outcome no matter your culture. Yeah, if you've also been effectively marginalised by society, which I think is the other side, so there's the intergenerational trauma and the stolen generation but there's absolutely marginalisation of Aboriginal people and Aboriginal culture. I think there's only pockets where that's probably not the case. And I think there are ongoing impacts of racism, and I think that that really does impact on people's mental health, so that's just another load once you've got all those other drivers in place. People, racism is really important because yes, there's institutional racism, yes, there's interpersonal like person to person, but people who experience racism are known to internalise and so people, it's it's an people can develop an internal conflict, an internal and this is not just the case with racism, this is the case with all forms of discrimination, this internalised voice, because people are part of society.

Commissioner Lawrie:
Mm hmm.

Prof Katina D'Onise:
So it's really hard to escape. I mean, we all know when you don't teach your kids certain things and they come home from school with saying that thing you're like, wow, how did that happen? Well, society, you can't actually isolate yourself off of it. So I really think those factors coming together, and that's just the internal racism that's not even going to the racism of the institutions that people need to use, need to rely on. Which I think plays a role in, well, in accessing the child safety system or being in it.

Counsel Assisting:
Thank you. And so what are the answers?

Prof Katina D'Onise:
Mmm. Sorry, it's not a flippant thing. But no it's a big question. So look, I think if we I do think a public health approach is an important component, now it's not to deny that there needs to be a service system as well of course. So it's not a or it's an and. I think that, you know, I I would be

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thinking about this in the in the way of primary prevention, secondary prevention and then tertiary prevention, so I might just start, and I'll talk through what I mean by that, because different people have different interpretations of those words. But by primary prevention, that's where we go to, you know, what are those systems that what does society need to look like so that children are generally brought up in safe environments, right. So that's that's not just the norm, but just about everybody. So I think, you know, we talked about the some of the health systems and education systems, they're critical because they're universal. So I think that they have a role, but just like, I just as an a specific example. So we know we can kind of, you know things like mental wellbeing of youth, so youth, you know, they're the ones that become parents pretty quickly and certainly people who end up as part of the child protection system tend to have children younger, that's not exclusive, but you know, that is definitely a risk group. So you know, we could focus on youth. So we're focusing on youth before they're sexually active. So it might need to be, you know, depending on the population, pretty young people. We'd be focusing on wellbeing, sexual health, contraception, engagement and inclusion in either education or trade. So kids need to be occupied, you know, in a positive environment. So they need to be surrounded by positive people, they need to have something that gives them the will to kind of contribute. They need to be included. I really think that inclusion, that's really one of the most important things about the early childhood system is, is feeling included in a group of people, I belong here. You know this, it is right that I should learn how to read because that's really important for me. So there's this, that kind of pride of being included, I think it's critical. I really think that kind of, yeah, so that kind of focus on the well-being of all. Prior to we're we're into one hand, we're improving people's mental health that's good anyway. Improving their participation in society good anyway. Also delaying childbirth and by the time the children are born, people have a lot more resources and then they're kind of out of that kind of spiral that I talked about earlier, that would be an example of a public health approach to child protection. You can see, there's no children, no actual babies involved, we're we're right back. So you know, but we could also think about other other parts, so once a child's born, for example, and this is more in the secondary prevention, so this is where we've already got a risk, that's what we mean by secondary, there's it's not been realised, but there's a risk. Disability is, disability in a child, is a also a risk factor for ending in the child safety system. That's not surprising if people don't have, you know, if it's already difficult and a child with a disability does have extra needs that need to be met. That can sometimes be easy, sometimes not easy, it really depends on the situation, but you know, early diagnosis as early as we can in that child's life of a disability and supports not just for the child and their their best development, but also for the parents like respite care and just being, you know, mindful that different people will need different kinds of supports with the very same disability for example. It's not universal, but here, this is why we're in the secondary prevention area because what we're doing is we're now tailoring to the situation in front of us rather than kind of a universal everybody should get this sort of care. What I would as well say in this kind of secondary prevention area is that we should be actively engaging families who are at risk. Now I think we we do know those families because we also know that there's associations been with connection to juvenile justice like there are so there are so many kind of risk factors, if you like, that that are well known. So we kind of know who is at greater risk. And we should really be engaging with them as early as possible and at least at the time of pregnancy, if not before. I think it's really important and I'm going to go to the kind of inclusion thing again, but I think the work that needs to happen with those individuals who really at very high risk, is a focus on trust building and engagement. So if I can give an example of personal experience in working at Nunkuwarrin Yunti where we had the No Pulgi homeless program. And that was in partnership with other agencies, but what it was so it was a primary healthcare outreach service and it expressly did not wait for people to come in to Nunk or any other kind of physical

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entity to get healthcare. But we were mobile, so we had a multidisciplinary team. We had Aboriginal health worker, I was a GP at the time, and we, and there were nurses as well, and we would literally drive around and find people and offer them health care exactly where they were. Now, from my own experience, I at the very beginning when I was doing this work, I set up a clinic in as well in Hutt St Centre, you know, where people often went for food and at the start I'd get, you know, people really trying to get as much out of me as they possibly could, which they and they worked out that didn't work very well at the beginning, but what happened over time was people were checking me out. They would, they would, you know, people would talk about how the interaction went with me, you know, that I'd talk to people outside the clinic room. They'd see me out in the parklands. And then, it took months, but then people started to say, well, can I actually come and see you today? And I went, yeah, of course, come in. And then I'd find out that they had this horrendous problem that had just not ever been dealt with because they did not trust any system. So they were just not prepared to go to the emergency department because they were treated unfairly when they got there. So but the people who were completely socially marginalised or isolated from the rest of society. So I when I say we need to actively engage with families, that's what I mean. I don't mean go visit them once and talk to them or whatever. I mean relationship building, trust over time, and yes, it's very, I guess, labour intensive but well, the reward as a clinician was enormous. But the feeling of being trusted, that was such a reward for me and also being able to help people with really serious problems. So it's good, it's good for the clinicians as well. It's obviously good for the person receiving the service. And then over time, you know, we were able to move from, that kind of I guess high intensity support required for the engagement, to people being able to be transitioned to a regular general practice, and and people even being able to be transitioned into a house. So it's not a, it's not necessarily a forever thing in terms of that intensity of engagement required, but it absolutely is necessary. And so that might mean that when you know a worker goes to someone's house and the house you know is in a bit of disarray, helping.

Commissioner Lawrie:
Yep

Prof Katina D'Onise:
And I know that's not a normal role of someone, but I did things outside of my normal role as the GP because it, you could say it was out of my normal role, except it wasn't. If you consider your role to be important to build a relationship.

Commissioner Lawrie:
Yeah.

Prof Katina D'Onise:
So, yeah, I guess they're my couple of, well, I've given you kind of three or four kind of versions, but it's really about getting in before and when we're moving into that kind of, you know, I guess the tertiary is when you really have got a problem and you really need to intervene. And that's when I think that we could be thinking about other, yes, we need to offer that intensive support that I've just talked about, but then you might also you know just want to think a little laterally like maybe this child or children would do well in a place like Kura Yerlo five days a week.

Commissioner Lawrie:
Mm hmm.

Prof Katina D'Onise:
To give the parents some space to deal with whatever whatever things they have. I mean, I think the

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thing we have really have to remember is that parents are people, they're not just the corollary of the child, if you like. You know they have their own needs and and you can almost guarantee that if they've ended up in this situation, their needs have not been met either, repeatedly over their life. And so I think that kind of kindness that says, you know, you need to be looked after too and what do you need to be looked after to help you is and and there's something about, I don't know someone believing in you, I know that sounds a bit kind of soft, but I think it I think it actually for some people they've had a life where that's just not been part of their normal, they haven't had that.

Commissioner Lawrie:
So I've got a question. Yes. So in the in the structure of, I guess, the Aboriginal Torres Strait Islander Child Placement Principle, prevention is, you know, a pivotal element within that. What do you think or what is your take on the things that are going on within South Australia with how prevention could be, is happening and could be improved with a public health approach for all those families that are struggling that are having contact from within our Aboriginal community. Cause we know that most of the child removals relate to issues that are preventable, like domestic violence, family violence, neglect et cetera. So I'm I'd I'd like to hear from you about that in terms of public health in in the child protection realm or the child wellbeing realm.

Prof Katina D'Onise:
Yeah, I mean, I can't say that I have an in depth knowledge of how it's actually being applied. I can only see the end data if you like, that shows that it doesn't, you know, well, it doesn't appear that there's it's being applied, but that's a that's guessing, I need to say. I think, I I think that working across different agencies can always be improved. And I think that because we know these families are interacting with, these are these are generalisations, of course, but that's kind of what we're talking about in public health, we're talking about averages, so forgive me if it sounds like I'm placing people in a in a box, but that's not the intent, on average people have had interaction with the criminal justice system. They do that from childhood, but also into adulthood, and so we could ask the question to what could happen in those systems that would improve the lives of people such that they never you know when they have children, it's not good. So that would be an example for me of prevention that I'm pretty sure is not, not being done at it's at its foremost. That's not to say that Corrections doesn't have good plans, but they're probably not focused on child protection, for example.

Commissioner Lawrie:
Hmm.

Prof Katina D'Onise:
Nor does that need to be their focus. But if child protection were to partner with, I guess, what public health does, perhaps I could, this is an easier conversation, what public health does is we say, right, we think this is a really important matter and agency X is the agency responsible, we're going to go and talk to that agency. And when we talk to that agency, we'll use what we call a health in all policies approach.

Commissioner Lawrie:
Mm hmm.

Prof Katina D'Onise:
Which doesn't have to be health, it could be anything, wellbeing in all policies, whatever. And we will go to that agency and we will start a long conversation. And sometimes that conversation is a two or

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three-year conversation, sometimes it's shorter, depends on how well the agencies kind of come together. But we then we'll talk with them about, you know, their business. So we think about what in their business if they were to do a little bit better, or a little bit whatever, or do this little shift that will make a difference to public health. It also will have the benefit of meeting their agency objectives. So we we what we're doing here, we're looking for a win-win, but we're going to come in there and we're going to try and do everything we can to help you meet that objective. So what we haven't done in that is said, right, you're responsible in your agency for our objective, off you go. That is not partnering. That's not how we do it. Well, not if you want to achieve something useful. So, I mean, if I can, you know we we do have some more public partnering that we've done, but this is I think this is a really good example. We worked with Corrections, who were a fantastic partner with us, they still are, to change the diet for prisoners because we had identified that it was not healthy, something like 70% was red, you know, as in not good food that's meant to be discretionary. Obviously, prisoners don't have a choice, there is no discretion. But we've managed in almost all prisons now in working over years, and in collaboration with Corrections and with lots of support from our nutritionists, to shift it to 70% green for all prisoners. And they have a choice now, like I said there's an option, including a vegetarian choice, which some people actually select, and the satisfaction amongst prisoners is much higher. But we, you know, we did all the evaluation pre and post because I've, you know, I've talked to you about the public health approach and how we do this in a very kind of rigorous fashion. But what we have there is a win-win. From a public health perspective we identified that the most vulnerable people in society are, you know, that's where we will find people. It's also an opportunity because, you know, they're obviously in prison, for people to get good nutrition, but then to learn about good nutrition as well. So that's an opportunity for them for when they leave prison to take to their families and for themselves. That's that's really what needs that there's what needs to happen. So it's a it's a partnering approach that's about what how do we jointly achieve our objectives and how how do we do this in a respectful way and I look, I think to be honest, I think it was an incredibly successful, and I think if you ask Corrections, they feel the same.

Commissioner Lawrie:
Good.

Prof Katina D'Onise:
So that sort of, let's call it deep partnering.

Commissioner Lawrie:
Yep.

Prof Katina D'Onise:
With a lot of skill in partnering, is, probably needs to happen at a grander scale. I'm not really sure how much of that's happening now. So, what else, I do, I have to say I think racism is a problem in institutions. I don't think it's a like I think this is a universal thing, so it's not really pointing fingers, but, I think it's very hard to say that the the difference between Aboriginal child removals and the differing pattern, not just the difference in proportions but differing pattern of reasons for child removal amongst Aboriginal and Torres Islander children, is it, you know, I couldn't tell you what proportion of that relates to racism, but it's it's a it's a warning signal for me.

Commissioner Lawrie:
Mm hmm.

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Prof Katina D'Onise:
You know, it suggests it, even though I haven't got proof. Yeah, and so I, I do think we have to, I think we have to look at racism as its own thing. One of the other things, and I think we will talk obviously a bit more about that later, but one of the other on the flip side, because we've talked a lot about risk factors, we also should be thinking about protective factors. What are those things that are going to keep people happy and well and you know, there are some protective factors for all of us, so they're those things I was talking about like, you know, having enough money, having some sort of education, having a good job where you're happy to go, that kind of stuff, a house that's liveable, all of those things are protective factors. But for Aboriginal people, there's also access to culture. And that so those those we would call, so there's other ones I, they would call them the socio-economic determinants of health. But there's it's it's absolutely certain that there are cultural determinants of health. We all have cultural determinants of health, but for, here we're talking about Aboriginal people and most certainly Aboriginal people have cultural determinants of health. So because of some of that inter, because of the intergenerational trauma and colonisation, it's obviously had an absolute direct hit on people's ability to freely access culture. That's even separate from the marginalisation and all the other things we've already talked about. So if we, you know, public health approach here would be an explicit focus on supporting Aboriginal people to access culture. Now there are some things in our HR systems, for example, that that work there, so that's in government. So you know people having access to cultural leave but I suspect, for example, that a lot of that cultural leave is used for sorry business that and that obviously that's important, but that's not just what I'm talking about here, it's actually about positive, you know, personally enriching, community enriching access to culture. So, yeah, I don't know how much of that public servants are using for because it, you know, it's probably not enough actually, if you if you got sorry business, it's gonna, you know, it gets used up pretty quickly. But so the Aboriginal Health Promotion team in Wellbeing SA has the Strengthening Cultural Determinants Health Promotion Plan and that's not, when we say health promotion, you know, I guess that's just what it's called as a discipline, but it's not actually about health, it's actually about wellbeing. So what I was talking about this, this is what we would call primordial prevention, so the the actual, you know, base of wellbeing for people. So, you know, all of our government systems could could be better at at these sorts of things. We've just done a grant program. And the, a large number of, it was only open to Aboriginal community controlled groups to come up with an idea on how they would like to strengthen culture and people came up with just the the most enormous array, so there were obviously things like language or taking Elders back to country, but even art classes, music classes or events, really kind of enriching positive stuff for people, rather than always just focus on the negative. I think that's the case as well with youth. Like if we if we were going to think very seriously about youth and I really think we should if we really mean to prevent matters getting to child protection. That's got to be positively framed, you know, instead of, you know, don't, you you can't take drugs or drink alcohol, which of course, you know, we don't want adolescents doing either. The focus is more on kids being diverted into other activities for which that's not, that's not what people do. Yeah. And so and we know that diverting kids away, you know giving them something to do with their time and that's fun, and with their friends and with a mentor of sorts, so it might be a sports coach or an art leader or whatever, those sorts of yeah, positive diversion as opposed to removing the negative. So yeah, I think we we could, yeah, I think we need to focus more on protective factors and more on supporting people to access culture.

Commissioner Lawrie:
Was that one of the biggest protective factors, access to culture? Were there other, what are some of the other protective factors in public health?

Prof Katina D'Onise:
Well, I think all those things like having a, having a proper job. By proper, I don't, I mean one that for that individual is good for their wellbeing. Enough money, enough hours, treated well at work. You know that. So I don't, I don't, it's not just the job, but you have it has to have all those other safe, engaging. Educational attainment is is basically the lynchpin of everything.

Commissioner Lawrie:
Mm hmm.

Prof Katina D'Onise:
Yeah. And so, you know, we could think about, you know, education systems, for example, What are those, you know, who are the kids who get excluded from school, for example.

Commissioner Lawrie:
Hmm.

Prof Katina D'Onise:
And you know how helpful is that when what we're actually talking about, I think fundamentally what we need to be talking about, is inclusion and you're part of the group, not exclusion, and you can't come here anymore. It is, it's probably one of my, yeah, obviously I have a bit fixed on it, but I really think that you know, and there are models like trauma informed care within schools, they're very successful. And you know they are resource intensive, but equally a well implemented trauma informed school will have will run so much more smoothly, kids will come to school more regularly, it's not going to require all that other effort. But I think, we really have to, I think that is a big opportunity. Stopping the exclusion. Focusing on, you know, children's behaviour as being communication as opposed to being naughty, or bad. And you know, and it's not like this is new to Education Department in South Australia, this is well advanced, but I really am highly supportive of it and it being a kind of model for other systems as well.

Commissioner Lawrie:
We've heard lots today about the importance of workforce. And you've you've mentioned, I guess, the issue of racism in institutions being a problem. And I I can hear from what you've been talking about that the access to culture is important for the Aboriginal workforce but what does that look like in terms of a public health approach when the children and families who are accessing services, in this occasion in the Inquiry, it's about those children and families who are involuntary being referred to by a child protection system of reporting and so forth. So my question to you is in a public health approach how does cultural safety play out as a prevention for vulnerable children and their families?

Prof Katina D'Onise:
Mm hmm, so the, if let me just check that I've got this exactly right before I continue. So basically what, this is from the perspective of the workers and the and the users of the system, so this is everybody, this is how do we make this system altogether for the workers in it and the people that they're working with?

Commissioner Lawrie:
Exactly. Yes.

Prof Katina D'Onise:
More respectful of culture, or perhaps a, more respectful of culture?

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Commissioner Lawrie:
Yes.

Prof Katina D'Onise:
Yeah. OK. So yeah, I mean, when we think about anything, we always apply the public health approach. So racism is no different. And so when we think about this we do think about those different levels of racism, so the institutional, and I will say about the institutional one, the racism that's embedded within our institutions is generally speaking, pretty invisible to most people, even to people who are subject to the racism itself, because we've become so accustomed and used to the 'ominant culture, deciding how business goes, that people, you know what I mean, it's like a fish swimming in water, you don't recognise the water. So, and it's not to say that there was necessarily intent of racism or, you know, dominant culture taking over in that, but that is still where we are. The systems are still designed around the dominant culture. But you do need to be quite sophisticated to see that, to see how that bit of the system is favouring one culture over another, or worse still not just favouring but causing harm to one culture over another. There's the interpersonal and we that's about individuals talking to each other, but then there's also, as I talked about, the internalised. And so when we think about racism from a public health perspective, we need to be addressing each of those levels, and we need to kind of again draw back to, you know, what are the sorts of things we can do from a prevention, primary prevention through to now we have a problem, what do we do about it? So I think, I think what does need to happen is what we would call an anti-racist approach. So that's not just about people going to a cultural awareness or even a cultural safety training as an individual, you know, once every three years or whatever, it's actually about an active engagement in the process of identifying racism. This is particularly important when it comes to institutions because, as I said, they're they're generally pretty invisible. So we basically need to take that step of actively looking at the policies of an institution, the laws that guide that institution, and I'm obviously aware that you're, you know, you're, already released an interim report, so that is an example of using legislation which is a very powerful tool to support removing racism. But also we have to look at the systems that are in place that kind of hold racism in place, so when we identify these problems we really need to do something about fixing them. So one of the things that we can do, for example, when new laws are going to be put forward or we know we've got an amendment or whatever, that we actually really need to look at it from an anti-racism lens. It's not and it's not the, I'm sorry I can't remember the name of it now, the Aboriginal, you know, the when things go to Cabinet, the Aboriginal Impact Statement.

Commissioner Lawrie:
Yes.

Prof Katina D'Onise:
Yeah, it's not an Aboriginal Impact Statement. It's actually looking for how how will this, you know, make this unfair across society. So we have to do that. We do need to educate people. So that's it goes to the interpersonal. But when we do the education, it's not just a matter of educating people, you know about other people's cultures than their own, which is how we've kind of really done it. So that's a very external face, you know, we're looking at you and learning about you, for example. It needs to flip inwards. So the training really needs to be about bias and it's generally unconscious, if we're being kind, we'll say it's always unconscious, but we know that's not true. But there's definitely unconscious bias that people hold, and that bubble needs to be popped so people can see that even if it's unintentional, that perhaps this action or, you know, designing this committee like this, or having this panel for recruitment like this, is actually reinforcing a racist trope, however that might be. So there is something about the internally looking at what, what, how am I contributing,

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what's my role? And that is a tricky thing, like I'm not going to suggest that that's easy, nor is it easy to do at scale. But that doesn't mean we shouldn't do it, because for most people, as I say, it is unconscious, it's not intended. Obviously that's not going to reach everybody, but we're still looking to improve, you know, we're, as I said, we're looking to shift the curve, we're not looking to, you know that would be an an achievement if we could. The other thing that's really critical, that I don't think is part of routine practice with our education and training, is bystander training. So this is about not just, and I should say that leadership plays a particularly important role here, so this is about basically saying that we we won't tolerate racism and if we see it, we are all trained in how we should deal with that appropriately. And by that, I mean sometimes it might be appropriate to deal with it on the spot. Sometimes that's not gonna be the best strategy in terms of achieving a positive outcome. Sometimes we wait until the end of the meeting, for example, or whatever, or we have a conversation with a colleague and we bounce off our ideas. But nevertheless, there's a responsibility that we all need to have that if we see it, we need to call it out. And we also then need to take that next step of helping whoever that person is or that agency is, or organisation, what can they do about it? You know and having that conversation that says this is this looks like an individual personal event, but this is not, this is a pattern, this is epidemiology in practice, and we can deal with that because we know how to using a public health approach. One of the things that's the kind of you could call it an arch enemy of public health is saying that everything happened because of 50 reasons in one person only. And you know, people do say this even with, you know, injury, well I fell over because of, you know, particular circumstances and particular this and particular that, except that actually when we look at injury as a whole population, we can see patterns. And so you know this, it's a fallacy to pretend that it's not a system that supports whatever's happened, as opposed to an individual event. So bystander skills, I think are really, really critical because they also signal to our Aboriginal Torres Strait Islander colleagues that we mean business here, we're not paying lip service, this isn't, see what I mean about that active process and that active conversation.

Commissioner Lawrie:
Mm hmm.

Prof Katina D'Onise:
So it's live, it's not it's not a side side thought. In terms of the inter, the internalised level, we do need to have systems that enable reporting of the experience of racism within our systems. Those systems should include, they should be outside of the normal work environment because we know that people experience racism and don't report it because they have to go through their line manager. Their line manager may in fact have been the source of the racism. And and the other problem that people talk to us about a lot is that sometimes when you report and you're reporting to a non-Aboriginal person they just really don't see it, they don't see that as racist, even if. So this goes to that level of sophistication in terms of the unconscious bias, so we need people with lived experience on the receiving end of complaints really to help with that.

Commissioner Lawrie:
Yep.

Prof Katina D'Onise:
So I think communicating to our partners is a really critical part of this so, and I think cause, you know even, kind of high-level discussions sometimes in our world we call these things community of practices, but there's something about, you know the this field needs a greater degree of intellectual rigour. There's not much proper empirical evidence about what to do to shift things. And so that it means it's a space that does need, you know, intellects to come together, and I use that term in the

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in its broader sense, to get to to trial things, to pilot actions, to measure properly what the outcomes were because, yeah, this is a space that is pretty in doing something about racism is pretty new in the scheme of, you know, level of research.

Commissioner Lawrie:
Yeah.

Prof Katina D'Onise:
Mm hmm. So I think we need to do something about that actually. And yeah, we need to ongoing evaluate everything we do, that's obviously the standard we need to we need to make. But we do need to think about, you know recruitment of staff, we do need to think about having, you know, ideally you would have representation of Aboriginal staff that matches the clients. You know, so if you if if 10% of clients are Aboriginal, Torres Strait Islander, so should the staff be. And should be across all levels of kind of discipline or skill or whatever. And I mean that's, that's true for non-Aboriginal people as well. I mean our service system should reflect, you know, the people they serve. And that's about, you know, HR policy, that's an example of a policy and legislative system that most likely has some inherent bias in it that could be scrutinised to flip that.

Commissioner Lawrie:
Thank you.

Counsel Assisting:
Dr D'Onise, thank you very much for a very informative presentation and evidence today. Commissioner, is there anything else you wanted to ask?

Commissioner Lawrie:
No, that's been good. Thank you so much.

Prof Katina D'Onise:
Thank you both.

Counsel Assisting:
It's been excellent. Thank you very much for your time.

Prof Katina D'Onise:
Thanks.

Commissioner Lawrie:
You have a good afternoon. Thank you.

Counsel Assisting:
Thank you.

Prof Katina D'Onise:
See you.

Counsel Assisting:
Bye.

END

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