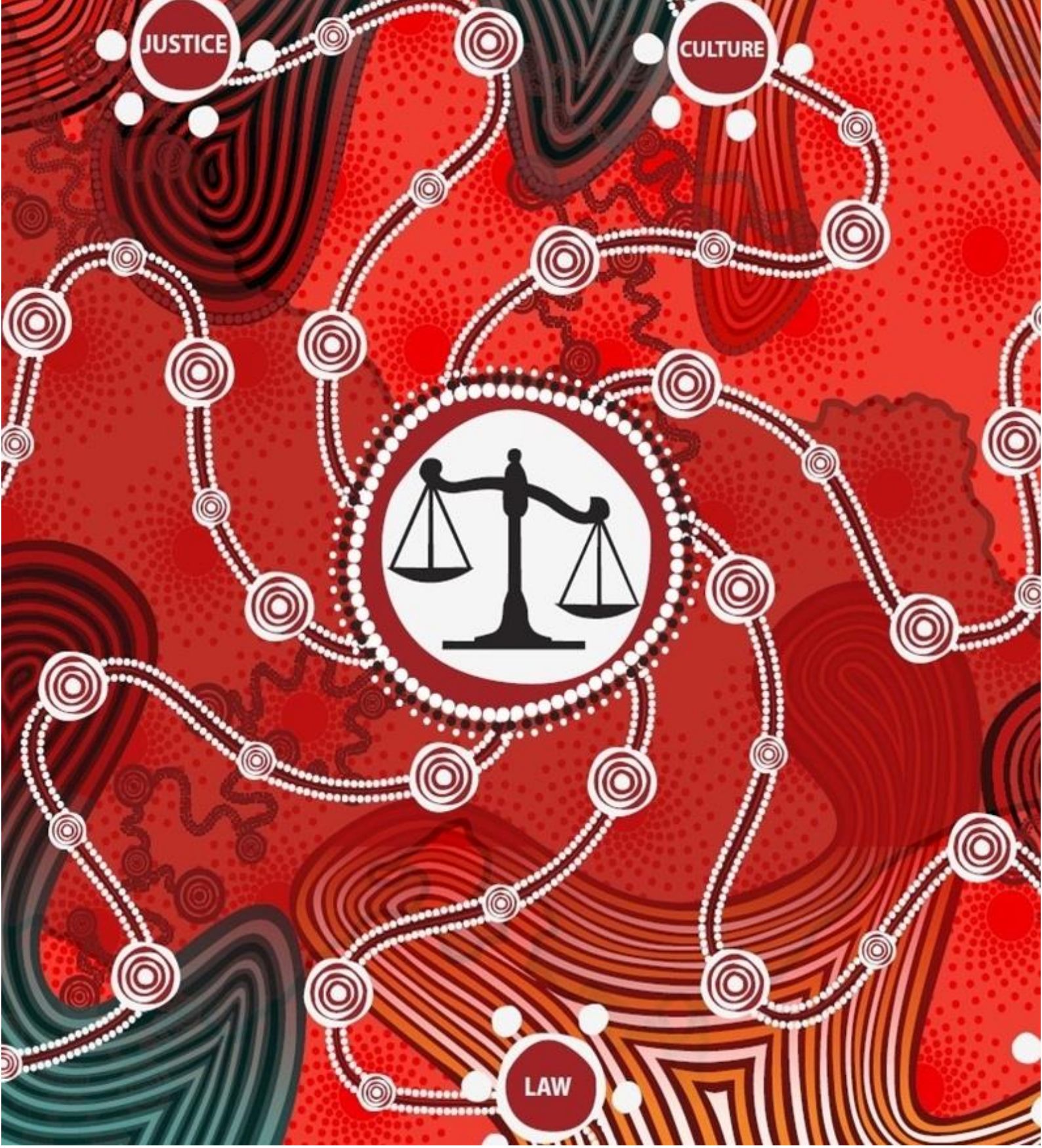

Victorian Aboriginal Legal Service Nuther-mooyoop to the Yoorrook Justice Commission: Health, Social and Emotional Wellbeing (SEWB) and the Healthcare System

February 2024

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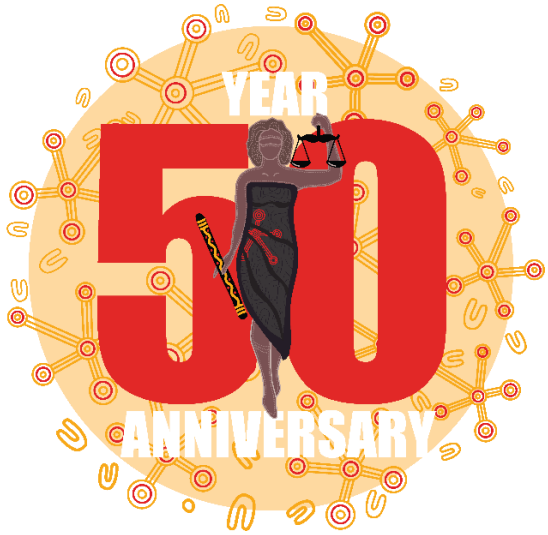
Background to the Victorian Aboriginal Legal Service

The Victorian Aboriginal Legal Service (**VALS**) is an Aboriginal Community Controlled Organisation (**ACCO**) with 50 years of experience providing culturally safe legal and community justice services to our people across Victoria.



In 2023, we're proud to launch the official logo of our 50th anniversary, 'Koori Woman of Justice'.

The artwork was designed by the deadly Natashia Corrigan, a Walabhul, Bundjalung, Dungidau/Dala and Jinibara artist born and living on Wurundjeri land.

In Natashia's words, the design is a representation of VALS' work over the past 50 years towards the Victorian Aboriginal Communities.

The colours used are a depiction of our Aboriginal flag. Aboriginal symbolisms are used to showcase the journeys made by community members and VALS representatives, these symbols tell the story of our journey from one place to another or symbolically from one situation to another. They represent each person, family and organisation that has been and continue to be supported by VALS.

Legal Services

Our legal practice serves Aboriginal people of all ages and genders. Our 24-hour criminal law service is backed up by the strong community-based role of our Client Service Officers (**CSOs**). CSOs help our clients navigate the legal system and connect them with the support services they need.

Our **Criminal Law Practice** provides legal assistance and representation for Aboriginal people involved in court proceedings. This includes bail applications; representation for legal defence; and assisting clients with pleading to charges and sentencing. We aim to understand the underlying reasons that have led to the offending behaviour and ensure this informs the best outcome for our clients.

Our **Civil and Human Rights Practice** supports clients with consumer issues, infringements, tenancy issues, coronial matters, discrimination issues, working with children checks, employment matters and Personal Safety Intervention Orders.

Our **Aboriginal Families Practice** provides legal advice and representation to clients in family law and child protection matters. We aim to ensure that families can remain together and children are kept safe. We are consistent advocates for compliance with the Aboriginal Child Placement Principle in situations where children are removed from their parents' care.

Our **Wirraway Police and Prison Accountability Practice** supports clients with civil litigation matters against government authorities. This includes for claims involving excessive force or unlawful detention, police complaints, and coronial inquests (including deaths in custody).

Balit Ngulu is our dedicated legal practice for Aboriginal children providing support in criminal matters. Balit Ngulu is designed to be trauma informed and provide holistic support for our clients.

Community Justice Programs

Our Community Justice Programs (**CJP**) team is staffed by Aboriginal and Torres Strait Islander people who provide culturally safe services to our clients and community.

This includes the Custody Notification System, Community Legal Education, Victoria Police Electronic Referral System (**V-PeR**), Regional Client Service Officers and the Baggarrook Women's Transitional Housing program.

Policy, Research and Advocacy

VALS informs and drives system change initiatives to improve justice outcomes for Aboriginal people in Victoria. VALS works closely with fellow members of the Aboriginal Justice Caucus and ACCOs in Victoria, as well as other key stakeholders within the justice and human rights sectors.

Acknowledgement

VALS pays our deepest respect to traditional owners across Victoria, in particular, to all Elders past, present and emerging. We also acknowledge all Aboriginal and Torres Strait Islander people in Victoria and pay respect to the knowledge, cultures and continued history of all Aboriginal and Torres Strait Islander Nations.

We pay our respects to all Aboriginal and Torres Strait Islander Elders who have maintained the struggle to achieve justice.

Across Australia, we live on unceded land. Sovereignty has never been ceded. It always was and always will be, Aboriginal land.

Contributors

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Note on Language

Throughout this document, we use the word ‘Aboriginal’ to refer to Aboriginal and/or Torres Strait Islander people, communities and organisations. VALS acknowledges that there are many Aboriginal people in Victoria who have Torres Strait Islander heritage, and many Torres Strait Islander people who now call Victoria home.

SUMMARY OF RECOMMENDATIONS

Timeframe and Scope of Inquiry

Recommendation 1. The Victorian Government should extend the deadline for Yoorrook's Final Report to at least June 2026.

Recommendation 2. Yoorrook should provide further opportunities for individuals and organisations to make written nuther-mooyoop, with longer timeframes and consultation periods.

Recommendation 3. Yoorrook should commence a dedicated inquiry into the experiences of Aboriginal people with disability, with sufficient time for organisational and individual submissions and dedicated hearings.

Racism and discrimination in the health system

Recommendation 4. The right to enjoy the highest attainable standard of physical and mental health without discrimination, and the right to access healthcare that is equivalent to that available in the community, should be embedded in legislation, including the *Charter*, the *Mental Health and Wellbeing Act 2022 (**MHWB Act**), the Corrections Act 1986*, and the *Youth Justice Bill 2024.*

Indigenous Data Sovereignty and Governance

Recommendation 5. In accordance with Aboriginal Data Sovereignty and Aboriginal Data Governance, legislation should be adopted in Victoria to enshrine the right of Aboriginal people and communities, individually and collectively, to:

(a) Exercise control over the manner in which data concerning Aboriginal individuals and communities is gathered, managed, interpreted and utilised; and
(b) Access and collect data obtained about Aboriginal individuals and communities.

Recommendation 6. Victorian government departments and entities – including the Department of Health (**DH**), Department of Justice and Community Safety (**DJCS**), Corrections Victoria, Justice Health, Victoria Police, the Victorian Institute of Forensic Mental Health (**Forensicare)**, the Mental Health and Wellbeing Commission (**MHWC**) and the Mental Health Tribunal (**MHT**) – should develop and enter into data access and data sharing agreements with ACCOs to ensure governance, choice and control over data about Aboriginal communities.

Recommendation 7. The Victorian government must invest in data management and analytics as a core function of Aboriginal Community Controlled Organisations (**ACCOs**) and Traditional Owners, as provided by under the Victorian Closing the Gap Implementation Plan.

Oversight and Accountability

Recommendation 8. As part of the Treaty process, an Aboriginal led public accounts and estimates committee be established so that Ministers and Victorian Government departments and agencies are regularly held to account on the implementation and adherence to all current agreements including:

Balit Murrup Aboriginal social and emotional wellbeing framework 2017–2027, the Victorian Aboriginal Affairs Framework and the National Agreement on Closing the Gap.

Systemic Injustices in the Mental Health System

Improve access to culturally safe mental services

Recommendation 9. As recommended by the Royal Commission into Victoria's Mental Health System (**RCVMHS**), the Victorian Government must continue to support and invest in the Victorian Aboriginal Community Controlled Health Organisation (**VACCHO**) and Aboriginal Community Controlled Health Organisations (**ACCHOs**) to provide Aboriginal Social and Emotional Wellbeing (**SEWB**) services across Victoria, including through the Balit Durn Durn Centre for Aboriginal SEWB, multidisciplinary SEWB teams in ACCHOs, and Aboriginal Healing Centres.[1]

Recommendation 10. The *MHWB Act* should be amended so that all entities exercising powers or functions under the Act are required to "comply" with the Cultural Safety Principle when performing a function under the Act, and to "give proper consideration" to the Principle when making a decision under the Act.

Recommendation 11. The Government should improve understanding, implementation and compliance with the Cultural Safety Principle, by:

- Developing a robust regulatory framework modelled off the *Gender Equality Act 2020*, including impact assessments, indicators, Action Plans, transparent and regular reporting and other monitoring and compliance mechanisms.
- Working with ACCOs and other Aboriginal stakeholders to develop guidance, resources and training on what is required by individuals and entities to comply with the Cultural Safety Principle.

Recommendation 12. The Government should improve the cultural competency of mental health and wellbeing service providers by:

- Addressing the stigma associated with the Aboriginal Social and Emotional Wellbeing Model within the mainstream health system.[2]
- Adequately funding and supporting Aboriginal mental health workers at all mental health treating hospitals.
- Employing Aboriginal people in senior management roles.
- Ensuring that Aboriginal mental health workers and Aboriginal senior management are involved in reviewing all policies, with a view to improving their cultural appropriateness.

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[1] Royal Commission into Victoria's Mental Health System (RCVMHS), *Interim Report*, (2019) Recommendation 4; RCVMHS, *Final Report*: *Summary and Recommendations* (2021) Recommendation 33.
[2] Victorian Aboriginal Community Controlled Health Organisation, '*Health and Healthcare, Housing and Homelessness, Education*' Submission, Recommendation 3.

- Ensuring that Aboriginal people with lived experience of the mental health system provide renumerated advice on the cultural competency of providers.
- Requiring all mental health staff to complete mandatory and regular refresher training in cultural awareness, anti-racism and unconscious bias.

Emergency responses to mental health crises must be led by health professionals

Recommendation 13. Yoorrook should request information from the Minister for Mental Health and the DH, regarding when it will implement the shift to health-led responses to mental health crises. It should also request updated data from Victoria Police (disaggregated by Aboriginality and LGA) regarding exercise of police and Protective Service Officers (**PSO**) powers under the *MHWB Act.*

Recommendation 14. The *MHWB Act* should be amended to provide a robust legal framework for health-led responses to mental health crises, including by:

- Replacing the *Health Led Response Principle* with robust statutory obligations on both Victoria Police and health professionals, that can be adequately enforced;
- Removing all PSO powers to respond to mental health crises;
- Significantly investing in health-led responses and divesting from Victoria Police.

Recommendation 15. Victoria Police members involved in responding to mental health crises must complete mandatory, regular and specialised training in trauma-informed responses and mental health crisis responses.

Overhaul compulsory assessment and treatment

Recommendation 16. Yoorrook should request an update from the Minister for Mental Health and DH regarding the Independent Review of Compulsory Treatment, now being carried out by the Department. If this Review has stalled, it should urgently recommence.

Recommendation 17. Yoorrook should request deidentified data (disaggregated by Aboriginality, age, service provider and geographic location) from the MHT and the Victorian Agency for health Information (**VAHI**) on compulsory assessment and treatment.

Recommendation 18. The Government should make progress towards significantly reducing the use of compulsory assessment and treatment by:

- Working with relevant stakeholders – including Aboriginal people with lived and living experience of compulsory treatment – to develop a strategy to reduce compulsory mental health treatment.
- Investing adequate resources to implement the strategy, including by addressing social determinants of poor mental health, and building a mental health system that is rights based, accessible, culturally safe and where supported decision-making is used when consumers do not have capacity to make their own decisions.

Recommendation 19. Embed a will and preferences framework within the *MHWB Act*, including by providing that:

- Decision makers must give all practical and appropriate effect to a person's will and preferences and can only override them if it is necessary to prevent serious and imminent harm, and if the least restrictive means is adopted to achieve this purpose.[3]
- Advance statements reflecting the will and preferences of individuals must be binding and enforceable. Further work should be carried out with people with lived experience to design a robust and accessible process for developing an Advance Statement.[4]

Recommendation 20. The compulsory assessment and treatment criteria should be overhauled to:

- Create a presumption of voluntary treatment, with compulsory treatment only permitted in exceptional circumstances to prevent serious and imminent harm.[5]
- Create a presumption of decision-making capacity and codify a strict test to rebut this presumption based on the capacity principles set out in *PBU & NJE v Mental Health Tribunal.*[6]
- Require that supported decision-making and adherence with consumer will and preferences – including that other treatment and support options to prevent serious and imminent harm have been considered, trialled and excluded – must be demonstrated, before compulsory treatment can be ordered.[7]
- Require that compulsory treatment be ordered in the narrowest and least restrictive way possible.[8]
- Require decision-makers to consider Aboriginal cultural rights and strengths-based approaches to Aboriginality, including connection to culture, Country, Community and kin as protective factors for mental health and social and emotional wellbeing.[9]

Recommendation 21. In fulfilling the requirements for supported decision-making, clinicians should be required to respect and protect Aboriginal cultural rights and prioritise connection to country, community, culture and kin as protective factors for good mental health and wellbeing. This should include a right for Aboriginal consumers to be supported by Aboriginal people in supported decision-making (including Mental Health Aboriginal Liaison Officers or Aboriginal non-legal mental health advocates), in an environment where they feel comfortable, and with a reasonable amount of time to reach their decision without undue pressure, and where information is provided in an accessible, culturally safe and trauma informed way.[10]

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[3] See Victoria Legal Aid (VLA), *Submission to Independent Review of Compulsory Assessment and Treatment Criteria and Alignment of Decision-Making Laws* ("Submission to Independent Compulsory Treatment Review") (2023) Recommendation 12.
[4] VALS, *Submission to Independent Review of Compulsory Assessment and Treatment Criteria and Alignment of Decision-Making Laws* ("Submission to Independent Compulsory Treatment Review") (2023), Recommendation 4.
[5] VLA, *Submission to Independent Review*, Recommendation 10; VALS, *Submission to Independent Compulsory Treatment Review*, Recommendation 8.
[6] Ibid.
[7] VLA, *Submission to Independent Review* (2023), Recommendation 8; VALS, *Submission to Independent Compulsory Treatment Review*, (2023) Recommendation 5(a).
[8] VLA, *Submission to Independent Review* (2023), Recommendation 10; VALS, *Submission to Independent Compulsory Treatment Review* (2023) Recommendation 8.
[9] VALS, *Submission to Independent Compulsory Treatment Review* (2023), Recommendation 10.
[10] VALS, *Submission to Independent Compulsory Treatment Review* (2023), Recommendation 6.

Recommendation 22. Strengthen the safeguards for temporary treatment orders by:

- Changing the authorisation process to require multiple, independent and diverse views and expertise, and ensuring that cultural expertise is incorporated into decisions about temporary treatment orders for Aboriginal people.
- Limiting the maximum duration of temporary treatment orders to 14 days.
- Requiring applications for revocation of a temporary treatment order to be heard and determined within 5 days.[11]

Recommendation 23. Require practitioners to provide early detailed reasoning on why compulsory assessment and treatment criteria apply, why assessment orders and temporary treatment orders are justified, how supported decision-making has been tried and why it has not succeeded.[12]

Improve cultural competency at the Mental Health Tribunal

Recommendation 24. Improve cultural competency at the MHT by:

- Creating a Koori Engagement Team;
- Establishing a Koori List;
- Create more identified positions for Aboriginal Community Panel Members;
- Ensuring that hearings for Aboriginal people include an Aboriginal Community Panel Member.[13]

Recommendation 25. Consider approaches similar to Aboriginal Community Justice Reports (**ACJRs**), as a way of: (i) empowering Aboriginal people to tell their story on their own terms; and (ii) providing relevant cultural information to the Tribunal, including the way in which connection to culture, Community, kin and Country can support good mental health and wellbeing.[14]

Eliminate Restrictive Practices and prohibit solitary confinement

Recommendation 26. Yoorrook should request deidentified data (disaggregated by Aboriginality, age, service provider and geographic location) from DH, the Chief Psychiatrist and VAHI regarding the use of restrictive interventions in Victoria.

Recommendation 27. Yoorrook should request a detailed update from the Minister for Mental Health, the Health Secretary, the Chief Officer for Mental Health and Wellbeing and the Chief Psychiatrist on the progress in developing Victoria's Strategy towards Elimination of Seclusion and Restraint, and the way in which this Strategy will eliminate the use of seclusion and restraint against Aboriginal people in Victoria.

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[11] VALS, *Submission to Independent Compulsory Treatment Review* (2023), Recommendation 11.
[12] VLA, *Submission to Independent Review* (2023), Recommendation 16; VALS, *Submission to Independent Compulsory Treatment Review* (2023), Recommendation 13.
[13] VALS, *Submission to Independent Compulsory Treatment Review* (2023), Recommendation 15.
[14] VALS, *Submission to Independent Compulsory Treatment Review* (2023), Recommendation 16.

Recommendation 28. The *MHWB Act* should be amended to provide a robust regulatory framework for reducing and eliminating seclusion and restraint. The framework should be modelled off the *Gender Equality Act 2020* and include impact assessments, indicators, Action Plans, transparent and regular reporting and other monitoring and compliance mechanisms.

Recommendation 29. The *MHWB Act* should be amended to explicitly prohibit solitary confinement (the isolation of someone for 22 hours or more each day, without meaningful human contact) and prolonged solitary confinement (solitary confinement in excess of 15 days) in mental health services.

Recommendation 30. Persons authorised to use bodily restraints during a mental health crisis response (including police and PSOs) must be subject to the same obligations and legal requirements as mental health and wellbeing service providers, namely:

- Obligation to reduce and eliminate restrictive interventions
- Obligation to comply with the Balancing of Harm Principle
- Requirement to record which other options were tried or considered and why these were found to be unsuitable.
- Requirement for police to report regularly on the use of bodily restraints whilst exercising powers under the *MHWB Act.*
- Requirement to immediately end the use of the bodily restraint if it is no longer necessary.

Establish robust oversight and accountability mechanisms

Recommendation 31. Yoorrook should request deidentified data (disaggregated by Aboriginality, service provider and geographic location) from the Mental Health and Wellbeing Commission and its predecessor, the Mental Health Complaints Commissioner, regarding complaints and inquiries over the past 9 years, including the outcomes of complaints.

Recommendation 32. Yoorrook should request information from the MHWC regarding its role and functions[15] as a core component of the oversight and accountability framework, including:

- Ensuring that the Government implements recommendations from the RCVMHS.
- Issuing guidance materials about how the mental health and wellbeing principles should be applied;
- Monitoring and reporting on the performance, quality and safety of the system, including restrictive interventions and compulsory treatment;
- Providing a robust and culturally appropriate complaints process, which leads to culturally appropriate complaints outcomes, where relevant;
- Supporting compliance across the sector, by issuing compliance notices where needed;

[15] *Mental Health and Wellbeing Act 2022* (Vic) (*MHWB Act*), s. 415.

- Conducting own-motion inquiries into systemic issues in the mental health system, including systemic racism.

Recommendation 33. To improve oversight and accountability within the mental health system – particularly in relation to compliance with the Cultural Safety Principle, the obligation to reduce/eliminate restrictive interventions, and significantly reduce the use of compulsory treatment – the government should implement the following additional reforms:

(a) All mental health service providers must be required by legislation to report publicly and regularly on: the use of restrictive interventions and compulsory assessment and treatment; steps taken to comply with the obligation to reduce and eventually eliminate restrictive interventions; compliance with the Cultural Safety Principle.

(b) Victoria Police, Ambulance Victoria and DH must be required by legislation to report publicly and regularly on responses to mental health crises, including exercise of police powers under the *MHWB Act* and the transition to Health Led crisis responses.

(c) Complaints against police relating to exercise of powers under the *MHWB Act* must not be investigated by police; they must be investigated by a new independent police complaints body, as recommended by the Yoorrook Justice Commission.[16]

(d) The MHT should be granted powers to make findings and orders in relation to non-compliance by mental health services and treating teams with their obligations.[17]

(e) Immediately implement the *Optional Protocol on the Convention Against Torture, Cruel, Inhuman and Degrading Treatment and Punishment* (**OPCAT**), including to urgently undertake robust consultations regarding culturally appropriate OPCAT implementation.

Health and Disability Injustices in the Criminal Legal System

Overhaul the prison healthcare system

Recommendation 34. Yoorrook should examine witnesses relating to implementation of recommendations from the Veronica Nelson Inquest and the Cultural Review into the Adult Custodial Corrections System (**Cultural Review**), and should request relevant documents including:

- The Implementation Plan for the Cultural Review;
- Reports to the Aboriginal Justice Caucus (**AJC**), and the AJC Rehabilitation and Reintegration Collaborative Working Group regarding implementation of recommendations from the Veronica Nelson Inquest.

[16] Yoorrook Justice Commission, *Yoorrook for Justice: Report into Victoria's Child Protection and Criminal Justice System* ("Yoorrook for Justice") (2023), Recommendation 27.
[17] VLA, *Submission to Independent Review* (2023), Recommendation 24; VALS, *Submission to Independent Review* (2023), Recommendation 22.

Recommendation 35. The Government must end privatisation of prison healthcare and urgently implement an adequately resourced public health model for delivery and oversight of health services across the adult prison system. [18]

Recommendation 36. The Government should properly fund VACCHO and ACCHOs to develop a model of healthcare and provide their services in prisons.

Recommendation 37. Yoorrook should examine witnesses from GEO Healthcare regarding the provision of "culturally safe healthcare" by GEO and health outcomes for Aboriginal people in Victoria's men's public prisons.

Recommendation 38. Yoorrook should request deidentified data on the numbers of Aboriginal women currently incarcerated, and in the previous 12 month, who have been pregnant and given birth while incarcerated, and the antenatal, postnatal and neonatal supports that have been available to them.

Recommendation 39. Yoorook should examine government witnesses in relation to the quality and cultural safety of mental healthcare services in Victorian prisons, including implementation of relevant recommendations from the RCVMHS and the Cultural Review.

Recommendation 40. Justice Health should carry out a comprehensive review of the Opioid Substitution Therapy (**OST**) Program Guidelines and consult with relevant experts as part of this review.

Recommendation 41. The OST Program Guidelines should be immediately amended to ensure that individuals cannot be rapidly and involuntarily withdrawn from the OST Program, as a disciplinary measure, including for failure to comply with the Program Contract of Consent and Agreement.

Recommendation 42. People in prison should be able to access harm reduction services available in the community, like needle exchanges and addiction specialist services.

Recommendation 43. Yoorrook should examine government witnesses in relation to progress in implementing recommendations from the Cultural Review and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (**DRC**), including culturally safe disability screening, access to disability supports and adjustments, and health outcomes for people in custody with a disability.

Recommendation 44. The Federal Government must ensure that incarcerated people have access to the Pharmaceutical Benefits Scheme (**PBS**) and the Medicare Benefits Schedule (**MBS**). The Victorian Government should advocate with other States and Territories and the Commonwealth to enable this access.

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[18] Cultural Review of the Adult Custodial Corrections System, *Safer Prisons, Safer People, Safer Communities: Final report of the Cultural Review of the Adult Custodial Corrections System ("Cultural Review") (2022),* Recommendation 6.13.

Recommendation 45. The Victorian Government should create and resource a legal service dedicated to providing legal advice and representation for people to prison, and properly resource Aboriginal Legal Services to provide such services to Aboriginal people in prison.

Recommendation 46. VALS telephone number should be free and accessible to all people in prisons in Victoria.

Recommendation 47. The Government should transfer oversight and management of prison healthcare from DJCS to the DH.

Recommendation 48. The Government should make further changes to the Justice Health and Justice Assurance and Review Office (**JARO**) Death in Custody Reviews, to ensure that they meet the requirements set out in Coronial Recommendation 36 from the Veronica Nelson Inquest. Stakeholders views, including from VALS, should be incorporated into this review process.

Recommendation 49. The Victorian government must urgently revise the system for auditing and scrutiny of custodial healthcare services, to ensure that there is a robust oversight and accountability system for all providers of prison healthcare (both public and private).

Recommendation 50. The Government should significantly reform the system for monitoring prison healthcare services, to ensure that prison healthcare outcomes are the primary mechanism for measuring the delivery of prison healthcare services.

Recommendation 51. Yoorrook should examine Government witnesses regarding implementation of the recommendations from the Cultural Review on oversight and accountability.

Recommendation 52. Yoorrook should request information and data relating to monitoring and oversight of the prison healthcare system including monthly and quarterly reports from GEO Healthcare on health services and health outcomes for Aboriginal people in Victorian prisons, as well as compliance with the *Healthcare Services Quality Framework for Victorian Prison 2023*.

Recommendation 53. Prison complaints, including complaints against private prisons and contractors, should be handled by an appropriately resourced independent oversight body with sufficient powers to refer matters for criminal investigation. The body must be accessible to people in prison and complainants must have adequate legislative protection against reprisals.

Investigate access to healthcare and disability supports in police custody

Recommendation 54. Yoorrook should investigate the quality of healthcare provided to Aboriginal people detained in police custody, including police stations and the Melbourne Custody Centre (operated by G4S).

Recommendation 55. The requirement for Independent Third Persons (**ITPs**) to attend police interviews with individuals who have a disability, must be embedded in legislation and adequately resourced.

Recommendation 56. All police officers and prison staff should be required to complete mandatory and regular training on how to interact with people with disabilities, including mental illness.

Increase access to disability supports at court

Recommendation 57. The Victorian Government should support and build on the Disability Advice Response Team (**DART**), currently being piloted in the Children's Court in Dandenong, Geelong, Shepparton, Broadmeadows and Melbourne, to ensure that Aboriginal children with a disability who are involved in the child protection and youth justice systems are supported to access culturally safe disability supports.

Suicide Prevention for people in contact with the criminal legal system

Recommendation 58. The Government must invest in and support Aboriginal led solutions to prevent and respond to suicide and self-harm, including for people in contact with the criminal legal system.

Health Injustices in the Child Protection System - implement recommendations from the Inquest into the passing of Sasha

Recommendation 59. The Victorian Government must urgently implement the recommendations from the Inquest into the passing of Sasha,[19] including to require child protection practitioners to, wherever possible, seek familial medical history that may impact the health of a child in its care.

[19] Coroners Court of Victoria (**CCoV**), *Finding into Death Following Inquest,* Inquest into the Death of Sasha, COR 2019 4069, 17 July 2023.

DETAILED SUBMISSIONS

Introduction

VALS welcomes the opportunity to make a further nuther-mooyoop to the Yoorrook Justice Commission (**Yoorrook**) regarding the health and social and emotional wellbeing (**SEWB**) of Aboriginal Communities in Victoria, as well as systemic injustices in the healthcare system. Our nuther-mooyoop builds on our previous submissions to the Commission regarding the child protection and criminal legal systems,[20] as well as other key submissions regarding healthcare and disability supports (see Annex A).

Aboriginal SEWB is integral to achieving Aboriginal health and wellbeing. The SEWB model is a comprehensive and holistic approach, which incorporates strengths-based approaches, cultural safety, holistic care which addresses both psychosocial supports and the influences of social determinants of health, and the inclusion and empowerment of Aboriginal knowledges and communities.[21]

Aboriginal Community Controlled Health Organisations (**ACCHOs**) are experts in Aboriginal SEWB and the provision of culturally safe and trauma-informed healthcare services. We acknowledge the advocacy, leadership and services provided by the Victorian Aboriginal Community Controlled Health Organisation (**VACCHO**) and ACCHOs across Victoria and acknowledge their advocacy, leadership and services. We endorse VACCHO's vision of a health and wellbeing system that includes ACCOs as a thriving and integral part of that system.

Our nuther-mooyoop is grounded in the experiences of our clients and Community, including the way that violent and racist systems continue to impact Aboriginal SEWB. It also examines racism and discrimination across the health system (with a particular focus on the mental health system and the custodial healthcare system), the critical need to continue to invest in culturally safe healthcare – including for Aboriginal people in custody – and the need for robust oversight and accountability mechanisms.

Our practice experience relating to Aboriginal SEWB includes:

- Coronial inquests: Assisting families whose loved ones have passed away whilst involved with the mental health system, whilst in custody and whilst in out of home care (**OOHC**);
- Mental Health Tribunal: Assisting individuals on compulsory mental health treatment orders at the Mental Health Tribunal (**MHT**);

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[20] VALS, *Nuther-mooyoop to the Yoorrook Justice Commission: Child Protection* (2022); VALS, *Nuther-mooyoop to the Yoorrook Justice Commission: Criminal Legal System* (2022).

[21] P. Dudgeon, E. Carlin, K. Derry, J. Alexi, M. Mitchell, R. Putu Agung-Igusti, "Evaluating a social and emotional wellbeing model of service piloted in Aboriginal Community Controlled Health Services in Western Australia: an Aboriginal Participatory Action Research approach," *BMJ Open*, (2023) 13(10); *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027.*

- Providing legal assistance to community members involved in the criminal legal and youth justice systems, including civil law complaints relating to treatment by Victoria Police, Corrections Victoria and Child Protection.
- Custody Notification Service (**CNS**): providing support to Aboriginal people detained in police custody, including welfare checks and pre-interview legal advice.

As with our previous nuther-mooyoop, we strongly support Treaty as a key step towards progressing Aboriginal self-determination in the health and wellbeing system. Sustainable and independent resourcing is critical, as well as Indigenous Data Sovereignty (**IDS**) and Indigenous Data Governance (**IDG**) and robust oversight and accountability mechanisms. Yoorrook has already made a significant contribution to transparency and accountability, by accessing and making public, information and data that is closely guarded by government authorities. Our submission includes recommendations regarding data and information that will increase transparency about Aboriginal SEWB and Aboriginal experiences of the health and wellbeing system.

Timeframe and scope of inquiry

As indicated previously,[22] we are concerned about the limited timeframe provided for truth telling in Victoria. Although the timeframe has been extended by 12 months, the process of truth telling and the creation of an official public record about historical and contemporary injustices should not be rushed. We reiterate our previous recommendations that the timeframe for Yoorrook should be extended.

We are disappointed that the Commission is not specifically investigating the experiences of Aboriginal people with disability. Whilst we acknowledge that the Commission has a limited timeframe and an expansive Terms of Reference, we believe this is a missed opportunity. The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (**DRC**) has recently handed down 222 recommendations, but it is important that both historical and contemporary injustices experienced by Aboriginal people with disability in Victoria form a part of truth telling. Our submission highlights key concerns regarding access to disability supports and adjustments for Aboriginal people involved with the criminal legal system.

VALS is also of the belief that it is only in recent times that we have observed a stronger community understanding of Yoorrook's purpose and how they can be involved.[23] As we have mentioned in previous nuther-mooyoop's, other truth telling processes around the world have had significantly increased timelines (starting at 1-3 years and being extend to up to 10 years) to ensure proper community involvement. We understand that a primary purpose of Yoorrook is to inform Treaty and that has created time pressures, but it must be acknowledged by all interested parties that Yoorrook's success will rely, at least in part, on strong buy-in and support from Aboriginal communities.

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[22] VALS, *Nuther-mooyoop: Child Protection*, (2022), p. 16; VALS, *Nuther-mooyoop: Criminal Legal System* (2022), p. 21.
[23] VALS staff have noted a significant shift in community understanding in late 2023 after a series of community engagement events held by Yoorrook.

RECOMMENDATIONS

Recommendation 1. The Victorian Government should extend the deadline for Yoorrook's Final Report to at least June 2026.

Recommendation 2. Yoorrook should provide further opportunities for individuals and organisations to make written nuther-mooyoop, with longer timeframes and consultation periods.

Recommendation 3. Yoorrook should commence a dedicated inquiry into the experiences of Aboriginal people with disability, with sufficient time for organisational and individual submissions and dedicated hearings.

Racism and discrimination in the health system

Racism in the health system is well documented, including both systemic and interpersonal racism. Systemic racism is the way that laws, policies and practices produce a discriminatory outcome for racial or cultural groups,[24] whereas interpersonal racism involves interactions between people which "serve to maintain or exacerbate the unequal distribution of opportunity across ethnoracial groups."[25]

We refer to the submission by VACCHO, which summarises current research relating to racism experienced by Aboriginal people in health settings. In particular, the 2017 Victorian Population Health Survey indicated that 1 in 5 Aboriginal people experienced racism in the 12 months preceding the survey, and the second most common place where racism took place was healthcare settings.[26]

Through our Civil and Human Rights Practice, we provide legal services to Aboriginal people who have experienced racism and discrimination in the health system, including discrimination by health providers. The case study below is but one example of the kind of interpersonal racism that Aboriginal people experience every day in Victoria and across Australia.

Case Study - Andrew

Our client took their 1-year-old child to a public Emergency Department to receive care for a broken arm.

The hospital notified Child Protection based on mandatory reporting obligations, however, Child Protection did not commence an investigation due to lack of merit. Despite this, the doctor contacted our client's wife (not Aboriginal) on multiple occasions (including 10pm on a Sunday night), lied to her about Child Protection involvement and pressured her to re-present to the hospital without her husband. The doctor said he believed the child was at risk because the father

[24] G. Berman and Y Paradies, "Racism, disadvantage and multiculturalism: Toward effective anti-racist praxis," *Ethnic and Racial Studies* (2008) 1-19, p. 4.
[25] According to H. Blagg et al, systemic racism arises in "situations where what appear to be 'facially neutral' laws, policies and practices operate in an uneven or unfair manner that is detrimental to Indigenous people." See H. Blagg et al., Systemic Racism as a Factor in the Over-representation of Aboriginal People in the Criminal Justice System, p. 12
[26] Victorian Agency for Health Information (VAHI), *The Health and Wellbeing of Aboriginal Victorians: Findings for the Victorian Population Health Survey 2017* (2021), p. 9.

"ticked too many boxes." During their engagement with the hospital, the family were not provided any support by an Aboriginal Liaison Officer.

The family were incorrectly led to believe that Child Protection had commenced an investigation and spent weeks fearing that Child Protection would become involved and that their child would be removed.

Both parents were left fearful of the hospital system as a result of their treatment and received psychological support for anxiety and ongoing fear and mistrust of doctors. The parents are also reluctant to identify their child's Aboriginality to any government institution for fear of subsequent personal bias and further abuses of power by those in positions of authority.

Our nuther-mooyoop sets out detailed recommendations to address racism in healthcare settings and ensure that Aboriginal people can access culturally safe healthcare provided by an Aboriginal organisation. In addition, the legislative framework in Victoria should be strengthened, to ensure that there is adequate legal protection of the right to enjoy the highest attainable standard of health, without discrimination.

Currently, the right to enjoy the highest attainable standard of health is protected under both international human rights law and Victorian laws and policies. Under international human rights law, everyone has the right to life,[27] the right to enjoy the highest attainable standard of physical and mental health without discrimination,[28] and is protected from torture, cruel, inhuman or degrading treatment or punishment.[29]

In Victoria, the *Charter of Human Rights and Responsibilities 2006* (**Charter**) does not expressly protect the right to enjoy the highest attainable standard of health. However, other rights under the Charter incorporate aspects of the right to health, including: the right to life,[30] and the right of all persons deprived of liberty to be treated with humanity and with respect for the inherent dignity of the human person.[31] The Charter also prohibits torture, cruel, inhuman or degrading treatment,[32] prohibits discrimination[33] and protects Aboriginal Cultural Rights.[34]

In the Inquest into the passing of Yorta Yorta woman, Tanya Day,[35] and the Inquest into the passing of Veronica Nelson,[36] the Coroners Court found that the right to humane treatment when deprived of

[27] *International Covenant on Civil and Political Rights* (ICCPR), article 6; *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP), article 7.
[28] ICESCR, article 12; UNDRIP, article 24(2); See also, *Convention on the Rights of Persons with Disabilities* (CRPD), article 25.
[29] ICCPR, article 7; UNDRIP, article 24(2).
[30] *Charter of Human Rights and Responsibilities Act 2006* (Vic), s. 9.
[31] Ibid., s. 22.
[32] Ibid., s. 10.
[33] Ibid., s. 8(2).
[34] Ibid., s. 19.
[35] CCoV, *Finding into Death Following Inquest*, Inquest into the death of Tanya Louise Day (2020), [532].
[36] Ibid., [96].

liberty requires police and prison staff to ensure access to medical care.[37] Additionally, in the Veronica Nelson Inquest, the Coroner highlighted that "the right to life, includes an obligation on the State to ensure that the health and wellbeing of people in detention are adequately secured by, among other things, providing requisite medical assistance, prompt and accurate diagnosis and care and regular supervision."[38]

Additionally, the *Corrections Act 1986* protects the right to access reasonable medical care and treatment, the right to access special care and treatment for individuals who have an intellectual disability or mental illness, and the right to access reasonable dental treatment.[39] The legislation that governs youth prisons, the *Children, Youth and Families Act 2005* does not specifically protect the right to health for children and young people in custody, however this must be included in the new Youth Justice Act.

Despite the existing legislative protection in Victoria, Australia's international human rights obligations under the *United Nations Declaration on the Rights of Indigenous Persons* (**UNDRIP**), the *International Covenant on Economic, Social and Cultural Rights* (**ICESCR**) and the *Convention on the Rights of People With Disabilities* (**CRPD**) are not fully incorporated into Victorian legislation. VALS continues to advocate for stronger legal protection of the right to enjoy the highest attainable standard of physical and mental health without discrimination, and the right to access healthcare that is equivalent to that available in the community, including by protecting this right under relevant legislation.

RECOMMENDATION

Recommendation 4. The right to enjoy the highest attainable standard of physical and mental health without discrimination, and the right to access healthcare that is equivalent to that available in the community, should be embedded in legislation, including the *Charter*, the *Mental Health and Wellbeing Act 2022 (**MHWB Act**), the Corrections Act 1986*, and the *Youth Justice Bill 2024.*

Indigenous Data Sovereignty and Governance

IDS[40] and IDG[41] continue to be a key priority for VALS, and are fundamental to self-determination. We refer to our previous nuther-mooyoop's to the Yoorrook Justice Commission, which outlined critical legislative and policy reforms to ensure that Aboriginal communities can:

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[37] See also *Castles. v Secretary of the Department of Justice*- [2010] VSC 310: "Access to health care is a fundamental aspect of the right to dignity."

[38] CCoV, *Finding into Death Following Inquest*, Inquest into the death of Veronica Nelson (2023) [91].

[39] *Corrections Act 1986* (Vic), ss.47 (1)(f), (g) and (h). The right to access medical care, including IVF treatment, was affirmed in *Castles. v Secretary of the Department of Justice*- [2010] VSC 310. Additionally, the Cultural Review recommended that the *Corrections Act* be amended to include the right to equivalent healthcare and health outcomes as a minimum standard. See *Cultural Review* , Recommendation 6.12.

[40] IDS refers to "the right of Indigenous peoples to exercise ownership over Indigenous Data. Ownership of data can be expressed through the creation, collection, access, analysis, interpretation, management, dissemination and reuse of Indigenous Data." See Indigenous Data Sovereignty Summit, *Communique*, 20 June 2018, p. 1.

[41] IDG refers to "the right of Indigenous Peoples to autonomously decide what, how and why Indigenous Data are collected, accessed and used. It ensures that data on or about Indigenous peoples reflects our priorities, values, cultures, worldviews and diversity." Ibid.

(c) Exercise control over the manner in which data concerning Aboriginal individuals and communities is gathered, managed, interpreted and utilised; and
(d) Access and collect data obtained about Aboriginal individuals and communities.[42]

In its Yoorrook for Justice Report, the Commission recommended that the Victorian Government must transfer decision-making power, authority, control and resources, to give full effect to the right of Aboriginal communities to self-determination in the criminal legal system and the child protection system.[43] VALS strongly supports transformational change in both of these systems, which must include Aboriginal ownership and control of data.

Additionally, we continue to advocate for immediate legislative and policy reforms to ensure that information about Aboriginal people and communities across all sectors, is treated in accordance with the principles of IDS and IDG. In this regard, we reiterate the following key points:

- IDS and IDG are a specific exercise of the right to self-determination as enshrined in Articles 3, 4, 5, 18 and 20 (alongside others) of the UNDRIP, which Australia has endorsed.[44]
- Under the Victorian Closing the Gap (**CTG**) Implementation Plan, the Government has committed "to develop sector wide data access and data sharing agreements with and for ACCOs and Traditional Owners in their sector (local, state wide and peak) with advice and input from the appropriate Aboriginal governance mechanism."[45] There has been limited progress (if any) in developing data access and sharing agreements.
- The government continues to control access to data, and in turn controls the narrative about Aboriginal people's involvement across all sectors including, education, health, housing, child protection, and the criminal legal system. Control of data also allows the Government to control the narrative about their own accountability.
- VALS and other ACCOS face consistent challenges in accessing, let alone having control over, data about our communities. If we are going to provide adequate services, access sufficient resources, advocate for change, and hold the government accountable, we need access to data, and we need to be able to use this data as we choose.[46]

Deidentified data on Aboriginal people's health and access to healthcare must be shared with Aboriginal communities in accordance with IDS and IDG. As detailed throughout this nuther-mooyop, this includes data held by the Department of Health (**DH**), Department of Justice and Community Safety (**DJCS**), Corrections Victoria, Justice Health, Victoria Police, private companies providing healthcare services in prisons, Forensicare, the Chief Psychiatrist, the Mental Health and Wellbeing Commission, the MHT, and other providers of health services.

Recently, the Productivity Commission also made key recommendations on IDS and IDG, including that the *National Agreement on Closing the Gap* should be amended to include IDS and IDG in Priority

[42] VALS, *Nuther-mooyoop: Criminal Legal System* (2022), p 7.
[43] Yoorrook Justice Commission, *Yoorrook for Justice* (2023), Recommendations 1 and 2.
[44] UNDRIP, Articles 3,4,5,18 and 20.
[45] Victorian State Government, *Victorian Closing the Gap Implementation Plan 2021-2023*, (2021), p. 27.
[46] VALS, *Nuther-mooyoop: Criminal Legal System* (2022), p 25.

Reform 4, and to establish a Federal Bureau of Indigenous Data.[47] VALS supports these recommendations.

RECOMMENDATIONS

Recommendation 5. In accordance with Aboriginal Data Sovereignty and Aboriginal Data Governance, legislation should be adopted in Victoria to enshrine the right of Aboriginal people and communities, individually and collectively, to:

(e) Exercise control over the manner in which data concerning Aboriginal individuals and communities is gathered, managed, interpreted and utilised; and
(f) Access and collect data obtained about Aboriginal individuals and communities.

Recommendation 6. Victorian government departments and entities – including the Department of Health (**DH**), Department of Justice and Community Safety (**DJCS**), Corrections Victoria, Justice Health, Victoria Police, Victorian Institute of Forensic Mental Health (**Forensicare)**, the Mental Health and Wellbeing Commission (**MHWC**) and the Mental Health Tribunal (**MHT**) – should develop and enter into data access and data sharing agreements with ACCOs (including VALS) to ensure governance, choice and control over data about Aboriginal communities.

Recommendation 7. The Victorian government must invest in ACCO data management and analytics as a core function of Aboriginal Community Controlled Organisations (**ACCOs**) and Traditional Owners, as provided by under the Victorian Closing the Gap Implementation Plan.

Oversight and Accountability

Our previous nuther-mooyop to Yoorrook, and the *Yoorrook for Justice Report* both highlighted the critical gap in Government accountability and oversight in the child protection and criminal legal systems. We strongly support Yoorrook's recommendations to transfer decision-making power, authority, control and resources to First Peoples, including accountability and oversight functions, which should include new First Peoples led bodies, oversight processes or complaints pathways.[48] We also support the establishment of an independent and authoritative oversight and accountability commission to monitor and evaluate First Peoples related policies and programs.[49]

Lack of robust accountability and oversight is also a key feature of the health system. In our practice, we continue to see how the lack of accountability is leading to loss of life and a failure to achieve significant progress in Aboriginal health outcomes.

The dire accountability vacuum is not just a Victorian issue and is not only present in certain sectors. In February 2024, the Productivity Commission released a *Review of the National Agreement on*

[47] Productivity Commission, *Review of National Agreement on Closing the Gap* (2024), Recommendation 2.
[48] Yoorrook Justice Commission, *Yoorroook for Justice*, Recommendation 1(a) and 2(d).
[49] Yoorrook Justice Commission, *Yoorroook for Justice*, Recommendation 4. See also Recommendation 3 (rigorous monitoring and evaluation of First Peoples programs and policies).

Closing the Gap, which found that "the Agreement risks becoming another broken promise to Aboriginal and Torres Strait Islander people."[50] Despite signing onto the Agreement, governments face little accountability to deliver on these commitments. Governments agreed to establish independent mechanisms in each jurisdiction by 2023, yet there has been limited progress. In Victoria, the Government's commitment to establish an Aboriginal-led evaluation and review mechanism[51] has stalled. The Productivity Commission has recommended that these mechanisms must be established without delay and should be governed and led by Aboriginal people.[52]

We note that several oversight mechanisms have been advocated for by Aboriginal communities over many decades, including an Aboriginal Social Justice Commissioner. We appreciate that much of the detail will be negotiated through Treaty, but suggest that an Aboriginal Public Accounts and Estimates Committee could be part of that mechanism. It could be shaped on the best practices of the Victorian Public Accounts and Estimates Committee and the Federal Senate Estimates Committee, but focused on Aboriginal governance principles. While this would not be a Parliamentary Committee, it could have the same effective powers by modelling it on the Independent Commission Against Corruption in New South Wales which operates as a rolling Royal Commission. In a sense, an Aboriginal estimates committee could continue the work that Yoorrook has done in questioning Ministers about contemporaneous issues. There is no doubt that several Ministers were heavily impacted by the experience of providing evidence in front of Yoorrook and that this influenced the way they think about their work – at least in the short term. A public Aboriginal estimates committee would also ensure greater media and public attention to issues that the committee believed were important to our communities.

VALS believes that Treaty is the best path forward to achieve self-determination and change that benefits all of our people. Local level treaties, alongside a state-wide treaty with strong oversight and accountability are the best way to close the gap. Additionally, our submissions below identify sector specific reforms to strengthen oversight and accountability mechanisms in the mental healthcare system and the prisons healthcare system.

RECOMMENDATIONS

Recommendation 8. As part of the Treaty process, an Aboriginal led public accounts and estimates committee be established so that Ministers and Victorian Government departments and agencies are held to account regularly on the implementation and adherence to all current agreements including: *Balit Murrup Aboriginal social and emotional wellbeing framework 2017–2027*, the Victorian Aboriginal Affairs Framework and the National Agreement on Closing the Gap.

Systemic injustices in the Mental Health System

[50] Productivity Commission, *Review of the National Agreement on Closing the Gap:* Study Report, Volume 1, Canberra. (2024), p. 3.
[51] Victorian State Government, *Victorian Implementation Plan for Closing the Gap* (2021), p 11.
[52] Productivity Commission, *Review of the National Agreement on Closing the Gap* (2024), Recommendation 4, Action 4.1.

In 2021, the Royal Commission into Victoria's Mental Health System (**RCVMHS**) handed down 65 recommendations aimed at overhauling the broken mental health system. The Commission heard extensive evidence from Aboriginal communities regarding their experiences with the mental health system and made a number of recommendations to support Aboriginal SEWB, improve access to trauma-informed culturally safe services and set the foundations for a new mental health system founded on respect for human rights.[53]

As discussed further below, there has been significant progress to date to implement the RCVMHS recommendations, including the establishment of the Balit Durn Durn Centre for Aboriginal SEWB, new multidisciplinary SEWB teams embedded in ACCHOs across Victoria, and co-design of two new Healing Centres.[54]

Despite this, we continue to see systemic injustices in the mental healthcare system, including:

- Lack of culturally appropriate mental health inpatient services.
- Discrimination/racism in the mainstream mental health system.
- Traumatic and harmful responses to mental health crises, which continue to be primarily led by police and run the risk of criminalising individuals experiencing a crisis.
- Disproportionate use of restrictive practices against Aboriginal consumers, and high rates of compulsory treatment.
- Limited cultural competency at the Mental Health Tribunal.
- Weak oversight and accountability mechanisms, including lack of enforcement and regulatory framework.

Our recommendations relating to the mental health system are based off our practice experience providing legal services to Aboriginal people who are subject to compulsory mental health treatment, as well as our coronial work representing the families of loved ones who have passed away whilst involved with the mental health system.

VALS established a Mental Health Legal Practice in July 2022 which represents clients at the MHT who are subject to compulsory treatment orders, including both inpatient and community orders. We have also worked with people with lived experience, Victoria Legal Aid (**VLA**) and DH to co-design a Mental Health Legal Rights Service (**MHLRS**), which is commencing in 2024. VALS Mental Health Practice will be part of the new MHLRS.

VALS Mental Health Legal Practice

Our Mental Health Legal Practice provides culturally safe, trauma-informed and accessible legal services that are flexible and responsive to client needs. Face to face service is offered where possible, and a phone service or video service as alternative modes. Wrap around assistance is provided to ensure clients are referred to any other relevant support services and all other unmet

[53] RCVMHS, *Interim Report* (2019), Recommendation 4; RCVMHS, *Final Report* (2021), Recommendation 33.
[54] RCVMHS, *Interim Report* (2019), Recommendation 4; RCVMHS, *Final Report* (2021), Recommendation 33.

legal needs are addressed. There is no limit on the amount of assistance that can be provided outside of capacity and resource constraints and the general VALS eligibility criteria.

We provide a culturally safe service by working closely with Aboriginal Liaison Officers, other Aboriginal organisations, our own Community Justice Team and a client's family and other supports to the extent that our clients would like us to. We will also work closely with the recently recruited First Nations advocates at Independent Mental Health Advocacy (**IMHA**). We also advocate for reforms at the MHT to improve cultural safety.

With legal representation, clients who have MHT Hearings are generally able to obtain less restrictive treatment than their treating team are seeking. In some cases where the maximum 6-month inpatient order has been sought by a client's treating team, we have supported them to instead obtain a community treatment order or voluntary treatment.

Our practice is state-wide and includes a Senior Lawyer, Junior Lawyer and Paralegal who are situated within the Civil and Human Rights Practice at VALS. The Senior Lawyer has also trained other lawyers in the Civil team to be able to increase the capacity of the service, although the ability of other lawyers to assist is limited by their own caseloads. The service will expand further in 2024 as funding commences for the MHLRS. This will include additional lawyers and a dedicated community support role, to provide long-term case management to clients, including to assist clients to move off long-term community treatment orders.

Mental Health Legal Rights Service

The new MHLRS has been codesigned by people with lived experience, VALS, VLA and DH, to increase access to legal assistance and better serve and support people who appear before the MHT.

The new model was finalised in June 2023 and is now in the implementation stage, despite significant delays with the funding. The service will have a dedicated stream for Aboriginal people who wish to be supported by VALS.

Improve access to culturally safe mental health services

The RCVMHS heard extensive evidence regarding the lack of culturally safe mental health services in Victoria and the importance of incorporating a model of care based on Aboriginal SEWB. In both its interim and final reports, the Commission made recommendations to address this issue, including the establishment of the Balit Durn Durn Centre for Aboriginal SEWB, new SEWB Teams embedded in ACCHOs across Victoria and two Healing Centres, codesigned with Aboriginal communities.[55] The Commission also recommended that the Government resource ACCHOs to provide SEWB services for children and young people and to design and to design and establish a culturally appropriate, family-oriented service for infants and children who require intensive SEWB supports.[56]

[55] RCVMHS, *Interim Report* (2019), Recommendation 4; RCVMHS, *Final Report* (2021), Recommendation 33.
[56] RCVMHS, Final Report (2021), Recommendation 33.

SEWB is a comprehensive and holistic approach to healthcare, which incorporates strengths-based approaches, cultural safety, holistic care (which addresses both psychosocial supports and the influences of social determinants of health), and the inclusion and empowerment of Aboriginal communities.[57] As noted in VACCHO's submission to Yoorrook, the SEWB model is integral to achieving Aboriginal health and wellbeing and ACCHOs are exemplars in providing this model of care.[58]

VALS strongly supports the work and role of VACCHO and ACCHOs across Victoria in advocating for and implementing the SEWB model of care, and the SEWB reforms flowing from the RCVMHS. We endorse the recommendations from the Balit Durn Durn Centre to the Yoorrook Justice Commission, including to invest in recurrent funding arrangements for multidisciplinary SEWB teams in ACCOs, and to appropriately invest in Aboriginal leadership and culturally safe service delivery across mainstream primary, secondary and tertiary health services.[59]

Despite significant work to date in implementing the Royal Commission recommendations on Aboriginal SEWB, there continues to be a lack of culturally safe mental health services in Victoria, and a lack of cultural competency in mainstream healthcare providers.

According to VACCHO, cultural safety is about creating an environment free of racism, in which individuals feel respected, understood and safe in their cultural identity.[60] Cultural safety is also defined as an "environment which is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need."[61] The National Safety and Quality Health Service Standards identify the following essential features of cultural safety:

- An understanding of one's culture;
- An acknowledgement of difference, and a requirement that caregivers are actively mindful and respectful of difference(s);
- Informed by the theory of power relations; any attempt to depoliticise cultural safety is to miss the point;
- An appreciation of the historical context of colonisation, the practices of racism at individual and institutional levels, and their impact on First Nations people's living and wellbeing, in both the present and the past;

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[57] P. Dudgeon, E. Carlin, K. Derry, J. Alexi, M. Mitchell, R. Putu Agung-Igusti, "Evaluating a social and emotional wellbeing model of service piloted in Aboriginal Community Controlled Health Services in Western Australia: an Aboriginal Participatory Action Research approach," *BMJ Open*, (2023) 13(10).

[58] Victorian Aboriginal Community Controlled Health Organisation, '*Health and Healthcare, Housing and Homelessness, Education*' Submission, Part Two, pg 33-36. VACCHO, Submission to the Yoorrook Justice Commission addressing the historical and ongoing systemic injustice experienced by Aboriginal people in the child protection and criminal justice systems in Victoria (2022), p 7.

[59] Victorian Aboriginal Community Controlled Health Organisation, '*Health and Healthcare, Housing and Homelessness, Education*' Submission, Social and Emotional Wellbeing, Recommendation 2, pg. 64.

[60] VACCHO, Cultural Safety Services (webpage).

[61] A. Eckerman et al, Binang Goomj: Bridging cultures in Aboriginal health (University of New England Press, 1994) cited in R. Williams, "Cultural safety - What does it mean for our work practice?" *Australian and New Zealand Journal of Public* Health (1999) 23, p. 213.

- That its presence or absence is determined by the experience of the recipient of care and not defined by the caregiver.[62]

In recent years, VALS represented senior next of kin in the coronial inquests into the passing of Harley Larking and Matthew Luttrell. Both inquests have examined the quality and cultural competency of mental healthcare at generalist mental health services.

Inquest into the passing of Harley Larking[63]

Harley Larking was a proud Palawa and Nunga man, who passed away in 2016 at the age of 23 years. At the time of his death, Harley was an involuntary patient at NorthWestern Mental Health (**NWMH**) in Epping. VALS represented Harley's mother and senior next of kin in the coronial inquest, which concluded in 2020.

In the coronial findings, the Coroner highlighted that the lack of cultural competency of nurses and other support staff contributed to an environment where Aboriginal mental health workers were intermittently refused access to Harley Larking, and their advice and recommendations were not given adequate weight.[64]

The Coroner recommended that all inpatient psychiatric staff at NWMH must undertake regular training in cultural competence in mental health clinical practice.[65] In its response to the coronial findings, NWMH indicated that in 2020, they implemented a mandatory E-learning package for all clinical staff.[66]

Inquest into the passing of Matthew Luttrell[67]

Matthew Luttrell was a proud Yorta Yorta man and a father who loved his children and his partner. He was a hard worker and a Carlton Blues supporter.

Mr. Luttrell passed away in Mildura in 2018, a day after being discharged from the Mildura Base Hospital, without a discharge plan.[68] Matthew had been admitted voluntarily to the hospital following a suicide attempt. VALS represented Mr. Luttrell's family in the coronial inquest, which concluded in 2023.

The Coroner found that Mildura Base Hospital failed to ensure that Mathew Luttrell was provided culturally-specific care and treatment during his in-patient stay, and also failed to provide culturally-

[62] Australian Commission on Safety and Quality in Health Care. *National Safety and Quality Health Service Standards: User Guide for Aboriginal and Torres Strait Islander Health* (2017), p. 75.
[63] CCoV, Finding into Death Following Inquest, *Inquest into the Death of Harley Robert Larking*, COR 2016 2137, 18 September 2020.
[64] Ibid., p 44.
[65] Ibid., [225] and Recommendation 7.
[66] The Royal Melbourne Hospital, Response to Coroner's Recommendations in the matter of Mr Harley Larking, 23 November 2020
[67] CCoV, *Finding into Death Following Inquest*, Inquest into the passing of Matthew James Luttrell, COR 2018 005721, 16 May 2023.
[68] Ibid., p 7.

specific follow-up options or support for his discharge.[69] The Coroner also found that there was a failure to provide Mathew with care and treatment in a way that responded to his complex health needs and afforded him with cultural safety, dignity and respect.[70]

The Coroner made a number of recommendations to improve the cultural competency of the Mildura Base Hospital, including the following:

- All staff at the Mental Health Unit must complete mandatory cultural awareness training, including refresher training on a recurrent basis.
- All hospital policies must be reviewed by the Director of Aboriginal Health and the Aboriginal Health Unit (AHU), with a view to improving their cultural appropriateness.
- All AHU staff must have culturally appropriate clinical supervision arrangements.
- All clinicians must be advised of the role of the AHU during induction, and be required to document steps taken to contact AHU in relation to Aboriginal patients, including any reasons why contact has not been made.[71]

In response to the coroner's findings, Mr. Luttrell's son, Aidan Luttrell, made the following statement:

> *Dad should not have died, he should have received the healthcare he needed. We always knew that, and we are glad that the Coroner agrees.*
>
> *This has been a very long and tough process, but we hope that it will be worth it. We hope that the Hospital will implement the Coroner's recommendations so that other families don't have to go through this.*
>
> *Aboriginal people deserve access to culturally appropriate care.*[72]

Despite implementation of coronial recommendations at specific mental health facilities, VALS continues to advocate for comprehensive reforms across the mental health system to increase access to culturally safe services provided by ACCHOs and to improve cultural competency in mainstream services providers. In this regard, we endorse the submission and recommendations of VACCHO.

The new *Mental Health and Wellbeing Act 2022* (**MHWB Act**), which commenced in September 2023, has also introduced legislative reforms to improve cultural competency in the mental health system, including the Statement of Recognition[73] and a new Cultural Safety Principle (see below).

The Cultural Safety Principle is one of several Mental Health Principles, which are binding on all mental health and wellbeing providers. Providers must make all reasonable efforts to comply with the

[69] CCoV, Inquest into the Death of Veronica Nelson, Finding 3.
[70] Ibid., Finding 10.
[71] Ibid., Recommendation 2.
[72] VALS, Mathew Luttrell Coronial Inquests recommends culturally-specific mental health services (Webpage, 18 May 2023)
[73] *MHWB Act 2022*, s. 13.

principles when exercising a function to which the Act applies; and give proper consideration to the principles when making a decision under the Act.[74]

Other entities exercising powers under the Act are also required to "give proper consideration to" the Cultural Safety Principle, although they are not required to "make all reasonable efforts to comply with" the principle. This includes: persons exercising powers under the Act as part of a mental health crisis response (including police and health professionals),[75] non-legal mental health advocacy service providers,[76] Community Visitors,[77] the Health Secretary,[78] the Chief Officer for Mental Health and Wellbeing,[79] the Chief Psychiatrist,[80] the Mental Health Tribunal,[81] the Mental Health and Wellbeing Commission[82] and Forensicare.[83]

Cultural Safety Principle (Section 27, Mental Health and Wellbeing Act 2022)

1. Mental health and wellbeing services are to be culturally safe and responsive to people of all racial, ethnic, faith-based and cultural backgrounds.
2. Treatment and care is to be appropriate for, and consistent with, the cultural and spiritual beliefs and practices of a person living with mental illness or psychological distress. Regard is to be given to the views of the person's family and, to the extent that it is practicable and appropriate to do so, the views of significant members of the person's community. Regard is to be given to Aboriginal and Torres Strait Islander people's unique culture and identity, including connections to family and kinship, community, Country and waters.
3. Treatment and care for Aboriginal and Torres Strait Islander peoples is, to the extent that it is practicable and appropriate to do so, to be decided and given having regard to the views of elders, traditional healers and Aboriginal and Torres Strait Islander mental health workers.

VALS supports the inclusion of the Cultural Safety Principle as a step towards increasing access to culturally appropriate mental health services. However, the Principle is meaningless without a strong legislative base and robust oversight and accountability mechanisms to monitor compliance. Currently, the primary mechanisms to support compliance, oversight and accountability are:

- Individuals can make a complaint to the Mental Health and Wellbeing Commission about non-compliance with the Principles (including the Cultural Safety Principle),[84] however, as discussed further below, we have significant concerns about the complaints process.

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[74] *MHWB Act 2022*, s. 29.
[75] *MHWB Act 2022*, s. 229.
[76] *MHWB Act 2022*, ss. 44(2)(c)(ii) and 50.
[77] *MHWB Act 2022*, s. 400.
[78] *MHWB Act 2022*, s. 255.
[79] *MHWB Act 2022*, s. 262.
[80] *MHWB Act 2022*, s. 268.
[81] *MHWB Act 2022*, s. 333.
[82] *MHWB Act 2022*, s. 414.
[83] *MHWB Act 2022*, s. 615.
[84] *MHWB Act 2022*, ss. 431(c), 432(c), 433(a).

- The Commission can conduct an own motion inquiry into systemic issues within the mental health system,[85] including lack of cultural competency and cultural safety.
- Mental health and wellbeing service providers are required to include information in their annual report regarding actions taken to give effect to one or more of the Mental Health Principles.[86]
- Other entities under the Act must also report on compliance with the Mental Health Principles, including the Chief Officer for Mental Health and Wellbeing,[87] the Chief Psychiatrist,[88] the Mental Health and Wellbeing Commission,[89] and the Community Visitors Mental Health Board.[90]

The Act specifically prevents a consumer from taking any legal course of action in relation to non-compliance with a Mental Health Principle, there is limited training and guidance about the Principles and there is no regulatory framework in place that will lead to meaningful change. Although the Principle has only been in operation since September 2023 and has not been properly tested, it is clear that it will not drive the change that is needed, without further strengthening and enforcement.

VALS strongly recommends that the Mental Health Principles - including the Cultural Safety Principle - must be strengthened by imposing a more robust legal obligation on entities that are bound by the Principles. All entities sunder the Act must be required to comply with the Principles when performing a function under the Act, as well as giving proper consideration to the principles when making a decision under the Act.

Additionally, VALS strongly recommends that the Mental Health Principles must be supported through a robust regulatory framework modelled off the approach set out under the *Gender Equality Act 2020* (Vic) in relation to the duty to promote gender equality. Under this framework, entities bound by the obligation to promote gender equality must: undertake gender impact assessments, develop a Gender Equality Action Plan which is made public and also lodged with the Gender Equality Commissioner, report publicly every 2 years on progress in implementing the Action Plan, and demonstrate reasonable and material progress to achieve gender equality indicators.[91]

Finally, there is a clear need for guidelines, training and other resources, to increase understanding and support compliance with these principles. Under the Act, the Commission is empowered to "issue guidance materials about how the mental health and wellbeing principles should be applied in relation to actions and decisions made under this Act."[92] Any guidelines and/or materials developed in relation to the Cultural Safety Principle must be developed with Aboriginal communities and ACCOs.

RECOMMENDATIONS

[85] *MHWB Act 2022*, s. 505(a).
[86] *MHWB Act 2022*, s.30.
[87] *MHWB Act 2022*, s. 261(2)(e).
[88] *MHWB Act 2022*, s. 274(1)(c)
[89] *MHWB Act 2022*, s. 427(2)(b).
[90] *MHWB Act 2022*, s. 409(1)(b).
[91] *Gender Equality Act 2020* (Vic), ss. 9, 10, 16, 19.
[92] *MHWB Act 2022*, s. 415(g).

Recommendation 9. As recommended by the Royal Commission into Victoria's Mental Health System (**RCVMHS**), the Victorian Government must continue to support and invest in the Victorian Aboriginal Community Controlled Health Organisation (**VACCHO**) and Aboriginal Community Controlled Health Organisations (**ACCHOs**) to provide Aboriginal Social and Emotional Wellbeing (**SEWB**) across Victoria, including through the Balit Durn Durn Centre for Aboriginal SEWB, multidisciplinary SEWB teams in ACCHOs, and Aboriginal Healing Centres.[93]

Recommendation 10. The *MHWB Act* should be amended so that all entities exercising powers or functions under the Act are required to "comply" with the Cultural Safety Principle when performing a function under the Act, and to "give proper consideration" to the Principle when making a decision under the Act.

Recommendation 11. The Government should improve understanding, implementation and compliance with the Cultural Safety Principle, by:

- Developing a robust regulatory framework modelled off the *Gender Equality Act 2020*, including impact assessments, indicators, Action Plans, transparent and regular reporting and other monitoring and compliance mechanisms.
- Working with ACCOs and other Aboriginal stakeholders to develop guidance, resources and training on what is required by individuals and entities to comply with the Cultural Safety Principle.

Recommendation 12. The Government should improve the cultural competency of mental health and wellbeing service providers by:

- Addressing the stigma associated with the Aboriginal Social and Emotional Wellbeing Model within the mainstream health system.[94]
- Adequately funding and supporting Aboriginal mental health workers at all mental health treating hospitals.
- Employing Aboriginal people in senior management roles.
- Ensuring that Aboriginal mental health workers and Aboriginal senior management are involved in reviewing all policies, with a view to improving their cultural appropriateness.
- Requiring all mental health staff to complete mandatory and regular refresher training in cultural awareness, anti-racism and unconscious bias.
- Ensuring that Aboriginal people with lived experience of the mental health system provide renumerated advice on the cultural competency of providers.

Emergency responses to mental health crises must be led by health professionals

[93] RCVMHS, *Interim Report* (2019), Recommendation 4; RCVMHS, Final Report (2021), Recommendation 33.
[94] Victorian Aboriginal Community Controlled Health Organisation, '*Health and Healthcare, Housing and Homelessness, Education*' Submission, Recommendation 3.

Police and Protective Service Officer (**PSOs**) should not be frontline responders to mental health crises. They do not have the skills, expertise or experience to provide trauma-informed and culturally safe responses to mental health crises, and their presence and involvement leads to increased criminalisation of mental illness. Mental health crises and psychological distress are health issues that require a health response.

Under the *Mental Health Act 2014* (Vic), Victoria Police played a pivotal role in responding to emergency responses to mental health crises. The Royal Commission heard extensive evidence about the growing role of police in responding to mental health crises since 2014, and the humiliating, traumatic and harmful experiences of people apprehended and searched by police.[95]

Given historical and contemporary violence perpetrated by police against Aboriginal communities, Aboriginal people often have a well-founded distrust in police, which can lead to further escalation if police are present and involved in responding to mental health crises.

The Royal Commission made a number of recommendations aimed at reducing the role of police in mental health crises responses, and shifting towards health-led responses wherever possible.[96] The Commission also recommended that mental health clinical assistance should be available to ambulance and police via: 24-hours-a-day telehealth consultation systems for officers responding to mental health crises; in-person co-responders in high-volume areas and time periods; and diversion secondary triage and referral services for Triple Zero (000) callers who do not require a police or ambulance dispatch.[97]

The Commission's recommendations have been implemented in part, through the new *MHWB Act*, which commenced in September 2023. However, the Government has delayed the shift to health-led responses to mental health crises on the basis that paramedics are not yet equipped to take on this role, and has not provided a timeframe for implementing this reform.[98] In the meantime, we continue to see inappropriate police responses to mental health crises, including criminalisation and use of force, as well as disrespectful and undignified treatment.

Yoorrook should request information from the Minister for Mental Health and DH regarding when it will implement the shift to health-led responses to mental health crises. It should also request information from Victoria Police regarding exercise of police and PSO powers under the MHWB Act.

Even when the shift to health-led crisis responses is implemented, the new *MHWB Act* is not robust enough to support this much-needed reform. Under the Act, police retain significant power to apprehend, detain, transport, search and seize in relation to someone experiencing a mental health

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[95] RCVMHS, Final Report, Volume 1, pp. 510-567.
[96] RCVMHS, Final Report, Recommendations 10(1) and (2). Wherever possible and safe: emergency services' responses to people experiencing time-critical mental health crises are led by health professionals rather than police; Triple Zero (000) calls concerning mental health crises are diverted to Ambulance Victoria rather than Victoria Police; and responses to mental health crises requiring the attendance of both ambulance and police are led by paramedics (with support from mental health clinicians where required).
[97] RCVMHS, Final Report, Recommendation 10(3).
[98] S. Ilanbey, Paramedics put on hold as mental health triple 0 overhaul delayed, 30 May 2023.

crisis.[99] In a robust health-led model, Victoria Police involvement must be a last resort, once all other options have been exhausted. Inadequate funding of the health response is not an adequate justification for empowering Victoria Police within a health response.

The Act also expands the powers of PSOs in responding to mental health crises,[100] which is fundamentally at odds with the shift towards a health-led response. Under no circumstances should PSOs be involved in the health response to mental health crises.

Additionally, the *Health Led Response Principle* in the MHWB Act[101] does not provide an adequate legal framework to support the shift towards a health response to mental health crises. It should be significantly strengthened by creating statutory obligations for both Victoria Police and relevant health professionals. If Victoria Police do exercise powers under the Act as a last resort, they should only be exercise on the advice of an authorised person who is a health professional.

To ensure that the powers under the MHWB Act to apprehend, detain and transport someone who is experiencing a mental health crisis are not abused, robust safeguards should be embedded in the Act, including public reporting requirements, review of any criminal offences arising from an emergency response to a mental health crisis, a strict prohibition on strip searches and body cavity searches and strict limitations on the use of restrictive interventions.

To the extent that Victoria Police remain involved in responding to mental health crises, members must receive specialised and mandatory training in mental health crisis response. This issue was examined in the Inquest into the passing of Nish Cash, which took place in 2023. Nish passed away in 2020, after significant delays in the arrival of emergency services after she called 000 for help.[102] Coronial findings have not yet been handed down in this Inquest.

RECOMMENDATIONS

Recommendation 13. Yoorrook should request information from the Minister for Mental Health and the DH, regarding when it will implement the shift to health-led responses to mental health crises. It should also request updated data from Victoria Police (disaggregated by Aboriginality and LGA) regarding exercise of police and PSO powers under the *MHWB Act.*

Recommendation 14. The *MHWB Act* should be amended to provide a robust legal framework for health-led responses to mental health crises, including by:

- Replacing the *Health Led Response Principle* with robust statutory obligations on both Victoria Police and health professionals, that can be adequately enforced;
- Removing all PSO powers to respond to mental health crises;
- Significantly investing in health-led responses and divesting from Victoria Police.

[99] *MHWB Act 2022*, ss. 232, 241, 246, 247, 250.
[100] *MHWB Act 2022*, ss. 235, 240-247, 249, 250.
[101] *MHWB Act 2022*, s. 228.
[102] VALS, "Family of beloved Nish want answers from Coronial Inquest," (media release), 23 October 2022; Z. Rizmal, "Artist Nish Cash died in Melbourne home waiting more than an hour for emergency services, inquest is told," 24 October 2022.

Recommendation 15. Victoria Police members involved in responding to mental health crises must complete mandatory, regular and specialised training in trauma-informed responses and mental health crisis responses.

Overhaul compulsory assessment and treatment

In March 2021, the RCVMHS recommended that: the law relating to compulsory mental health assessment and treatment should be simplified and clarified; the Government should act immediately to ensure that compulsory treatment is only used as a last resort; and set targets to reduce the use and duration of compulsory treatment on a year-by-year basis and gather and publish service-level and system-wide data in this regard.[103]

To progress these recommendations, the Government established an Independent Panel, which commenced in October 2022, but was disbanded in July 2023. The DH is now leading the Review and is due to provide advice to the Government by June 2024. We are concerned that this Review is no longer independent, is being conducted in an opaque and non-transparent manner, and may have in fact stalled.[104]

VALS provided a submission to the Independent Review,[105] which includes key concerns and recommendations relating to:

- Reducing compulsory assessment and treatment
- Embedding a will and preferences framework
- Strengthening supporting decision-making (including Advance Statement of Preferences)
- Creating a legislative requirement to consider Aboriginal cultural rights and connection to culture as a protective factor.
- Strengthening safeguards for Assessment Orders, temporary Treatment Orders and Community Treatment Orders.

Key asks from our submission are extracted below. For further detail, see the full submission.

Reduce compulsory assessment and treatment

Compulsory mental health assessment and treatment undermines human rights, is discriminatory and disempowering, and often leads to trauma which can undermine mental health. For Aboriginal people, compulsory treatment also compounds historical and intergenerational trauma. It can be viewed as an ongoing form of colonial oppression, and an abrogation of rights that disempowers and obstructs self-determination and healing. Such treatment is often viewed by our clients as another form of state

[103] RCVMHS, Final Report, Recommendations 42(2)(e) and 55(1)-(2).
[104] Despite multiple requests to DH, no information has been provided about the new process (including scope, timeframes and opportunities to provide further feedback).
[105] VALS, *Submission to Independent Compulsory Treatment Review* (2023).

violence, comparable to other forms of historical and contemporary violence, such as police mistreatment and removal of children. As discussed above, the structural violence perpetrated through compulsory assessment and treatment is accentuated for Aboriginal people given the ongoing central role of Victoria Police to respond to mental health crises under the *MHWB Act.*

Since 2014, the legislative framework in Victoria has required that compulsory mental health treatment should only be used as a last resort, when there are "no less restrictive means reasonably available" to enable the person to be assessed and/or receive immediate treatment.[106] Despite this, compulsory assessment and treatment in Victoria continues to increase.[107]

Under resourcing and limited access to voluntary mental health care and support contributes to the use of compulsory treatment as a default response. For Aboriginal communities, ongoing racism within the mental health system and a lack of culturally safe mental health care and support is also a key factor contributing to high rates of compulsory treatment.

VALS strongly supports the vision of the Royal Commission for a new mental health and wellbeing system that respects human rights and responds to people's needs and preferences.[108] This requires significant investment in the front end of the mental health system, to increase access to voluntary, culturally safe and trauma-informed treatment, care and support. It also requires significant investment to address the social determinants of mental health (poverty, housing instability, and adequate access to culturally safe physical healthcare services).[109]

The Government should also work with relevant stakeholders to develop a strategy to reduce compulsory mental health treatment, and to adequately fund and support implementation of this strategy. In doing so, it will be essential to ensure that the reduction of compulsory treatment correlates with an increase in voluntary treatment, and does not lead to further criminalisation of mental illness.

Require decision makers to consider Aboriginality as part of compulsory assessment and treatment criteria

The compulsory assessment and treatment criteria and the current court process mean that it is challenging for Aboriginal people and their legal representatives, to ensure that Aboriginality is given adequate consideration during Tribunal hearings.

To address this, both the compulsory assessment and treatment criteria should incorporate a legal requirement to consider and prioritise Aboriginal cultural rights and connection to culture,

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[106] *Mental Health Act 2014* (Vic) ss. 5(d) and 29(d); *MHWB Act 2022*, ss. 142(d), 143(d).
[107] See RCVMHS, *Final Report: Volume 4* (2021), p. 377-378: "Since 2015–16, the number of compulsory Assessment, Temporary Treatment and Treatment Orders made in Victoria continues to increase on average by approximately 2–3 per cent per year for each type of order across all ages…In 2019–20, 0.20 per cent of the Victorian population aged 26–64 years were subject to compulsory treatment orders, which has increased from 0.17 per cent of the population in 2010–11."
[108] Royal Commission, *Final Report: Volume 4* (2021), p. 363.
[109] Royal Commission, *Final Report: Volume 4*, (2021) p. 375.

Community, Country and kin as protective factors for Aboriginal mental health and social and emotional wellbeing.

Currently, Section 3A of the *Bail Act 1977* (Vic) requires bail decision makers to take into account someone's Aboriginality in relation to all bail decisions. VALS believes that a similar legislative requirement should be embedded into the compulsory treatment criteria. The content of this legislative requirement would need to be developed in consultation with Aboriginal communities, but could include a requirement for decision-makers to consider the importance of SEWB, the historic connotations of compulsory treatment for Aboriginal communities, and access to alternative culturally grounded mental health supports and services.

Additionally, VALS is currently piloting Aboriginal Community Justice Reports (**ACJRs**) in sentencing processes, as a mechanism to reduce Aboriginal incarceration rates. ACJRs support Aboriginal people to tell their life stories on their own terms during the sentencing process. ACJRs "endeavour to amplify the aspirations, interests, strengths, connections, culture, and supports of the individual, as well as the adverse impact of colonial and carceral systems on their life."[110]

A mechanism similar to ACJRs may be relevant for individuals on compulsory treatment orders (particularly Community Treatment Orders), as a way of empowering Aboriginal people to tell their story on their own terms. The report would also provide information to the MHT about the person's culture and the importance of culture, Country, kin and Community as protective factors for mental health. Approaches such as this would be more relevant for consumers who are placed on orders for longer than 6 months, given the time required to develop this kind of report.

RECOMMENDATIONS

Recommendation 16. Yoorrook should request an update from the Minister for Mental Health and DH regarding the Independent Review of Compulsory Treatment, now being carried out by the Department. If this Review has stalled, it should urgently recommence.

Recommendation 17. Yoorrook should request deidentified data (disaggregated by Aboriginality, age, service provider and geographic location) from the MHT and the Victorian Agency for health Information (**VAHI**) on compulsory assessment and treatment.

Recommendation 18. The Government should make progress towards significantly reducing the use of compulsory assessment and treatment by:

- Working with relevant stakeholders – including Aboriginal people with lived and living experience of compulsory treatment – to develop a strategy to reduce compulsory mental health treatment.
- Investing adequate resources to support implementation of the Strategy, including by addressing social determinants of poor mental health, and building a mental health system that is rights based, accessible, culturally safe and where supported decision-making is used when consumers do not have capacity to make their own decisions.

[110] T. Anthony, A. Lachsz and N. Waight, (The Conversation) "The role of 're-storying' in addressing over-incarceration of Aboriginal and Torres Strait Islander Peoples," (Webpage, 17 August 2021).

Recommendation 19. Embed a will and preferences framework within the *MHWB Act,* including by providing that:

- Decision makers must give all practical and appropriate effect to a person's will and preferences, and can only override them if it is necessary to prevent serious and imminent harm, and if the least restrictive means is adopted to achieve this purpose.[111]
- Advance statements reflecting the will and preferences of individuals must be binding and enforceable. Further work should be carried out with people with lived experience to design a robust and accessible process for developing an Advance Statement.[112]

Recommendation 20. The compulsory assessment and treatment criteria should be overhauled to:

- Create a presumption of voluntary treatment, with compulsory treatment only permitted in exceptional circumstances to prevent serious and imminent harm.[113]
- Create a presumption of decision-making capacity, and codify a strict test to rebut this presumption based on the capacity principles set out in *PBU & NJE v Mental Health Tribunal.*[114]
- Require that supported decision-making and adherence with consumer will and preferences – including that other treatment and support options to prevent serious and imminent harm have been considered, trialled and excluded – must be demonstrated, before compulsory treatment can be ordered.[115]
- Require that compulsory treatment be ordered in the narrowest and least restrictive way possible.[116]
- Require decision-makers to consider Aboriginal cultural rights and strengths-based approaches to Aboriginality, including connection to culture, Country, Community and kin as protective factors for mental health and social and emotional wellbeing.[117]

Recommendation 21. In fulfilling the requirements for supported decision-making, clinicians should be required to respect and protect Aboriginal cultural rights and prioritise connection to country, community, culture and kin as protective factors for good mental health and wellbeing. This should include a right for Aboriginal consumers to be supported by Aboriginal people in supported decision-making (including Mental Health Aboriginal Liaison Officers or Aboriginal non-legal mental health advocates), in an environment where they feel comfortable, and with a reasonable amount of time to reach their decision without undue pressure, and where information is provided in an accessible, culturally safe and trauma informed way.[118]

Recommendation 22. Strengthen the safeguards for temporary treatment orders by:

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[111] See VLA, Submission to the Independent Review of Compulsory Treatment (2023), Recommendation 12.
[112] VALS, *Submission to Independent Compulsory Treatment Review* (2023), Recommendation 4.
[113] VLA, Submission to the Independent Review of Compulsory Treatment (2023), Recommendation 10; VALS, *Submission to Independent Compulsory Treatment Review* (2023), Recommendation 8.
[114] Ibid.
[115] VLA, Submission to Independent Review into Compulsory Treatment, Recommendation 8; VALS, *Submission to Independent Compulsory Treatment Review* (2023), Recommendation 5.
[116] Ibid.
[117] VALS, *Submission to Independent Compulsory Treatment Review* (2023), Recommendation 10.
[118] VALS, *Submission to Independent Compulsory Treatment Review* (2023), Recommendation 6.

- Changing the authorisation process to require multiple, independent and diverse views and expertise, and ensuring that cultural expertise is incorporated into decisions about temporary treatment orders for Aboriginal people.
- Limiting the maximum duration of temporary treatment orders to 14 days.
- Requiring applications for revocation of a temporary treatment order to be heard and determined within 5 days.[119]

Recommendation 23. Require practitioners to provide early detailed reasoning on why compulsory assessment and treatment criteria apply, why assessment orders and temporary treatment orders are justified, how supported decision-making has been tried and why it has not succeeded.[120]

Improve cultural competency at the Mental Health Tribunal

The MHT is not a culturally safe space for Aboriginal people. This is in part because of the historical and contemporary role that courts and tribunals have played, and continue to play in dispossessing, disempowering, and destroying Aboriginal Communities. It is also because of the inherent power imbalances, systemic racism, and limitations in the legislation, process, composition and approach of the tribunal.

Ultimately, all of these factors make it very hard Aboriginal people to feel spiritually, socially, emotionally and physically safe; to feel that there is "no assault, challenge or denial of their identity, of who they are and what they need."[121] Too often in generalist courts, there is a lack of "shared respect, shared meaning, shared knowledge and experience," and an inability to learn together with dignity and truly listen.

Across other jurisdictions, efforts have been made to improve the cultural competency of courts and tribunals, including by establishing Koori Courts,[122] Koori Lists[123] and Koori Engagement Units.[124]

We acknowledge that several changes have been implemented recently at the MHT, which seek to improve the cultural competency of Tribunal, including development and implementation of a Reconciliation Action Plan, and providing for longer hearings for Aboriginal people if requested. We support these reforms, noting that there is still a significant need for further change.

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[119] VALS, *Submission to Independent Compulsory Treatment Review* (2023), Recommendation 11.
[120] VLA, Submission to Independent Review of Compulsory Treatment, Recommendation 16; VALS, *Submission to Independent Compulsory Treatment Review* (2023), Recommendation 13.
[121] Williams defines cultural safety an "environment which is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity and truly listening." See Williams, R. (1999). Cultural safety – What does it mean for our work practice? Australian and New Zealand Journal of Public Health. 23. 213 – 214.
[122] Koori Courts have been established across the Magistrates Court, Children's Court and County Courts jurisdictions in both metro and rural courts.
[123] In the Federal Circuit and Family Court of Australia and the Children's Court of Victoria, Koori Lists have been established in some locations.
[124] See for example, the Koori Engagement Unit at the CCoV.

Additionally, there has previously been an Aboriginal Community Panel Member at the Tribunal, although this position is not established under legislation or policy, and there is no requirement for an Aboriginal Community Panel Member to be part of the Panel for Aboriginal consumers.

In addition to changes at the MHT, increasing access to culturally safe legal representation is critical. In 2028-29, only 13% of people appearing before the Tribunal had legal representation, compared to 83% of hearings at the NSW Mental Health Tribunal. Data is not publicly available on legal representation for Aboriginal people appearing before the Tribunal.

RECOMMENDATIONS

Recommendation 24. Improve cultural competency at the MHT by:

- Creating a Koori Engagement Team;
- Establishing a Koori List;
- Create more identified positions for Aboriginal Community Panel Members;
- Ensuring that hearings for Aboriginal people include an Aboriginal Community Panel Member.[125]

Recommendation 25. Consider approaches similar to Aboriginal Community Justice Reports (**ACJRs**), as a way of: (i) empowering Aboriginal people to tell their story on their own terms; and (ii) providing relevant cultural information to the Tribunal, including the way in which connection to culture, Community, kin and Country can support good mental health and wellbeing.[126]

Eliminate Restrictive Practices and prohibit solitary confinement

VALS strongly opposes the use of restrictive practices in mental health settings, including seclusion chemical, mechanical and physical restraints. These practices infringe human rights and are inherently harmful and traumatic. We support Recommendation 54(1) of the Royal Commission, to reduce the use of seclusion and restraint in mental health and wellbeing service delivery, and to eliminate these practices by 2031.

Although there is limited publicly available data on the use of restrictive practices in mental health settings, research by VMIAC indicates that Aboriginal people are being secluded and restrained at higher rates compared to other people: while Aboriginal people make up 3.5% of all inpatients, they account for 5.3% of all people subjected to seclusion practices.[127]

International standards are clear that restraint and solitary confinement (isolation for 22 hours or more each day without meaningful human contact) of people with psychological or intellectual disabilities should be banned in all places where people are deprived of their liberty, including

[125] VALS, *Submission to Independent Review* (2023), Recommendation 15.
[126] Ibid., Recommendation 16.
[127] VMIAC, *Seclusion Report #3*, (2022) p. 9.

psychiatric and social care institutions.[128] According to former United Nations Special Rapporteur, solitary confinement of persons with mental disabilities may constitute torture, cruel, inhuman or degrading treatment or punishment.[129] The United Nations Committee on the Rights of Persons with Disabilities has also expressed concerns about the use of seclusion, physical restraint and psychotropic medications (antidepressants and other medications that affect people's emotions and behaviours) in Australia and urged the elimination of restrictive practices in all settings.[130] International standards also prohibit solitary confinement of children, which constitutes cruel, inhuman and degrading treatment[131] and prolonged solitary confinement.[132]

In our practice experience, we see that restrictive practices are overused and are incredibly traumatic and harmful.[133] In the Inquest into the passing of Matthew Luttrell, the Coroner found that the decision to use restrictive interventions – including seclusion – was unlawful and constituted a breach of Matthew's human rights to liberty and physical integrity.[134]

More recently, the DRC made a number of key recommendations to reduce and work towards elimination of restrictive practices across various sectors, including mental health. In particular, the DRC recommended that the following forms of restraint must not be permitted in health and mental health settings:

- using seclusion and restraint as a means to reduce behaviours not associated with immediate risk of harm
- using seclusion and restraint as a form of discipline, punishment or threat
- restrictive practices that involve or include deliberate infliction of pain to secure compliance
- using prone or supine holds, using any restraint intended to restrict or affect respiratory or digestive function, or forcing a person's head down to their chest
- secluding a person who is also mechanically restrained
- secluding a person who is actively self-harming or suicidal

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[128] United Nations General Assembly (UNGA), Report of the Special Rapporteur on torture and other cruel inhuman or degrading treatment or punishment, Juan Mendez A/HRC/22/54, 1 February 2013, [63].
[129] UNGA, Report by the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, A/66/268, 5 August 2011, [78].
[130] United Nations, *Committee on the Rights of Persons with Disabilities: Concluding Observations on the Combined Second and Third Periodic Reports of Australia*, 2019, p. 8.
[131] UNGA, Report of the Special Rapporteur on torture and other cruel inhuman or degrading treatment or punishment, Juan Mendez A/HRC/22/54, 1 February 2013, [77]. In 2016, the Australian Children's Commissioners and Guardians stated that children should never be subjected to solitary confinement. See Australian Children's Commissioners and Guardians, *Human rights standards in youth detention facilities in Australia: the use of restraint, disciplinary regimes and other specified practices* (2016), p. 63.
[132] Prolonged solitary confinement is solitary confinement (isolation for 22 hours or more each day without meaningful human contact) for a period in excess of 15 consecutive days.
[133] Charlotte Grieve, Nicole called an ambulance for help. She ended up shackled to a bed," The Age (Webpage, 30 July 2023)
[134] CCoV, Inquest into the Passing of Veronica Nelson, 30 January 2023, Finding 4.

- using metal handcuffs or hard manacles as a form of mechanical restraint (unless under police or other custodial supervision while in the health facility)
- vest restraints for older people
- neck holds
- drugs, or higher doses of drugs, that create continuous sedation to manage behaviour
- seclusion of children and young people.[135]

The DRC also recommended that by July 2025 (at the latest), state and territory governments should establish sector-specific targets and performance indicators to drive the reduction and elimination of restrictive practices over time.[136]

The *MHWB Act 2022* introduced several changes to the legal framework for the use of restrictive interventions, including:

- A legal requirement for mental health and wellbeing service providers to aim to (a) reduce the use of restrictive interventions; and (b) eventually eliminate the use of restrictive interventions in mental health treatment.[137]
- A legal obligation on the Chief Officer for Mental Health and Wellbeing to set targets to reduce and ultimately eliminate the use of restrictive interventions in mental health and wellbeing services; and a requirement to develop, monitor and report on appropriate measures to progressively reduce and ultimately eliminate the use of restrictive interventions in mental health and wellbeing services.[138]
- Regulation of chemical restraint (which had not previously been regulated under the *Mental Health Act 2014);*
- A new *Balancing of Harm Principle*, which provides that restrictive interventions are not to be used unless the serious harm or deterioration to be prevented is likely to be more significant than the harm to the person that may result from their use[139];
- The previous threshold of "last resort" was replaced with a new threshold for authorising restrictive interventions. Accordingly, seclusion and restraint can only be used if: (a) it is necessary to prevent imminent and serious harm to the person or to another person, or in the case of bodily restraint, to administer treatment or medical treatment to the person; and (b) all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable.[140] The intervention must end if it is no longer necessary.[141]
- Legislative guidance and requirements relating to the least restrictive principle, including:

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[135] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (DRC), *Final Report: Volume 6* (2023), Recommendation 6.36(b), p. 33.
[136] Ibid., Recommendation 6.40, p. 36.
[137] *MHWB Act 2022*, s. 125.
[138] *Ibid.,* ss. 261(1)(g) and (h).
[139] *Ibid.,* s. 82.
[140] *Ibid.,* s. 127-128.
[141] *Ibid.,* s. 129(1).

- In determining whether there is no less restrictive option available, the person authorising the restrictive intervention must – to the greatest extent possible – have regard to: (a) the likely impact on the person, considering the person's views and preferences, and any relevant past experience of trauma; (b) the person's views of, and preferences relating to, the use of restrictive interventions (including as expressed by a support person or in any Advance Statement of Preferences); and (c) the person's culture, beliefs, values and personal characteristics.[142]
- The person authorising the restrictive intervention must record the reason why the intervention was necessary, the other less restrictive means tried or considered, and the reasons why those other means were found to be unsuitable. [143]

- Reporting requirements: authorised psychiatrists must report to the Chief Psychiatrist about the use of restrictive interventions in a mental health service;[144] and the Mental Health and Wellbeing Commissions is empowered to monitoring and report on the use of restrictive interventions.[145]
- Power for the Chief Psychiatrist to investigate the use of restrictive interventions.[146]

Additionally, the DH (Mental Health and Wellbeing Division) has commenced work on developing a Strategy to eliminate Seclusion and Restraint,[147] however, the timeframe for finalising the Strategy is unclear. Yoorrook should request a detailed update from the Minister for Mental Health and the Department of Health regarding the Strategy.

Despite these reforms, there is a critical need for strong oversight and accountability mechanisms (discussed further below) to ensure that the commitment to eliminate restrictive practices is achieved as soon as possible, and no later than by 2031. Similar to the Mental Health Principles, we strongly recommend a robust regulatory framework modelled off the *Gender Equality Act 2020* (see above), to ensure that there is concrete and steady progress towards reducing and eliminating restrictive practices.

Finally, VALS strongly believes that the following legislative reforms are necessary to further restrict the use of seclusion and restraints:

- The Act should explicitly prohibit solitary confinement and prolonged solitary confinement.
- The Act should impose further requirements on police, PSOs, and other authorised persons when using bodily restraints during a mental health crisis response. Currently, a bodily restraint is permitted if it is necessary to prevent imminent and serious harm to the person and all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable.[148] As noted above, VALS Strongly opposes police and PSO involvement in mental health crisis responses. To the extent that they are involved, police

[142] *Ibid.,* s. 131.
[143] *Ibid.,* s. 133.
[144] *Ibid.,* s. 138(4).
[145] *Ibid.,* s. 415(h).
[146] *Ibid.,* s. 76.
[147] Engage Victoria, Victoria's strategy towards elimination of seclusion and restraint (Webpage).
[148] *MHWB Act 2022*, s. 250(2).

and PSOs they must be subject to the same legal obligations regarding restrictive interventions, including:

- Obligation to reduce and eliminate restrictive interventions.
- Obligation to comply with the Balancing of Harm Principle.
- Requirement to record which other options were tried or considered and why these were found to be unsuitable.
- Requirement for police to report regularly on the use of bodily restraints whilst exercising powers under the *MHWB Act.*
- Requirement to immediately end the use of the bodily restraint if it is no longer necessary.

RECOMMENDATIONS

Recommendation 26. Yoorrook should request deidentified data (disaggregated by Aboriginality and service provider) and a detailed update from the Minister for Mental Health, the Health Secretary, the Chief Officer for Mental Health and Wellbeing and the Chief Psychiatrist on the use of restrictive interventions in Victoria and progress in developing Victoria's Strategy towards Elimination of Seclusion and Restraint.

Recommendation 27. Yoorrook should request a detailed update from the Minister for Mental Health, the Health Secretary, the Chief Officer for Mental Health and Wellbeing and the Chief Psychiatrist on the progress in developing Victoria's Strategy towards Elimination of Seclusion and Restraint, and the way in which this Strategy will eliminate the use of seclusion and restraint against Aboriginal people in Victoria.

Recommendation 28. The *MHWB Act* should be amended to provide a robust regulatory framework for reducing and eliminating seclusion and restraint. The framework should be modelled off the *Gender Equality Act 2020* and include impact assessments, indicators, Action Plans, transparent and regular reporting and other monitoring and compliance mechanisms.

Recommendation 29. The *MHWB Act* should be amended to explicitly prohibit solitary confinement (the isolation of someone for 22 hours or more each day, without meaningful human contact) and prolonged solitary confinement (solitary confinement in excess of 15 days) in mental health services.

Recommendation 30. Persons authorised to use bodily restraints during a mental health crisis response (including police and PSOs) must be subject to the same obligations and legal requirements as mental health and wellbeing service providers, namely:

- Obligation to reduce and eliminate restrictive interventions.
- Obligation to comply with the Balancing of Harm Principle.
- Requirement to record which other options were tried or considered and why these were found to be unsuitable.

- Requirement for police to report regularly on the use of bodily restraints whilst exercising powers under the *MHWB Act.*
- Requirement to immediately end the use of the bodily restraint if it is no longer necessary.

Establish robust oversight and accountability mechanisms

Following the RCVMHS, several reforms have been introduced to strengthen oversight and accountability within the mental health system, including a new Mental Health and Wellbeing Commission (**MHWBC**). Despite this, we are concerned that the rights of consumers, including our clients, continue to be undermined by poor oversight and accountability within the mental health system. The ongoing lack of transparency and weak oversight mechanisms means that racism, discrimination and a lack of access to culturally appropriate care continues to persist without adequate checks and balances. The MHWBC commenced in September 2023, with the role of ensuring that the government: promotes, supports and protects the rights of consumers, families, carers and supports; and is accountable for the performance, quality and safety of the mental health and wellbeing system, including implementation of the recommendations from the RCVMHS.[149]

VALS strongly supports reforms to improve oversight and accountability within the mental health system. However, we are concerned that the MHWBC is simply a rebranding of its predecessor, the Mental Health Complaints Commission, which drastically failed to provide effective oversight since its creation in 2014. Over a 9-year period, the Commission received 14,000 complaints and did not make a single compliance order.[150] A report released by the Commission in 2023, indicated that only 24% of complainants found that the complaint process was helpful for them.[151]

In addition to poor oversight and enforcement, the work of the Commission has been underpinned by a lack of transparency: information regarding complaints was only available pursuant to a Freedom of Information request, and the Commission has continued to resist calls to release deidentified information about recommendations it has made to mental health and wellbeing service providers to drive systemic change across the sector.[152] The Commission is now fighting a legal challenge to access this information.[153]

Dissatisfaction with the Commission has been so high that many advocates across the sector have advocated for a Victorian Ombudsman investigation into the role and work of the Commission.

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[149] *MHWB Act 2022*, s. 413(a) and (e).
[150] A. Ore, You don't have a choice': Victoria's mental health regulator criticised over complaints handling, The Guardian, (Webpage, 29 May 2022); K. Rooney, More than 16,000 mental health complaints, but watchdog yet to bite, The Age, (Webpage, 8 December 2023).
[151] Mental Health Complaints Commissioner, The Role of Complaints in System Oversight (2023), p. 23.
[152] A. Ore, Victoria's mental health watchdog criticised after fighting release of secret recommendations, The Guardian (Webpage, 12 July 2023)
[153] Ibid.

We understand that the staff at the new Commission have been carried over from the previous Commission. Despite the addition of two new Commissioners, we are concerned that this will not be enough to underpin the underpin a change in culture and approach that is drastically needed. Additionally, the Chief Commissioner still retains power and Commissioners can only exercise power/functions once delegated by the Chief Commissioner.

VALS strongly supports the role and work of the new Aboriginal Commissioner for Mental Health, Jacqui Gibson. We understand that the Commission is in the process of developing a culturally appropriate complaints process, to ensure that Aboriginal people who would like to make a complaint to the Commission are able to do so. This is an important change, which must also be accompanied by significant change to ensure that the Commission is well placed to provide culturally appropriate complaint outcomes.

The Mental Health and Wellbeing Commission has a critical role to play to ensure that the Government implements recommendations from the RCVMHS. To do so, it must be independent, transparent and prepared to exercise its functions in a way that will lead to significant change across the sector. In this regard, we note that the Commission has new powers to carry out an inquiry into systemic issues within the mental health system,[154] and is empowered under the Act to monitor and report on the use of restrictive interventions and compulsory treatment.[155] Despite a lack of progress in implementing some of the key recommendations from the Commission – including the Independent Review into Compulsory Treatment, the Strategy to eliminate Restrictive Interventions, and the shift to health led responses to mental health crises – the Commission has remained silent. Yoorrook should subpoena documents and witnesses from the Commission regarding steps taken to fulfil its legislative functions, including to ensure that the Government implements recommendations from the RCVMHS.

As above, we strongly recommend that the Act should be amended to establish a robust regulatory framework to drive change and compliance with the Mental Health Principles, the commitment to eliminate restrictive interventions, and the need to significantly reduce compulsory treatment. We believe that a robust and independent Mental Health and Wellbeing Commission should play a pivotal role under this proposed framework. However, significant change would need to take place within the Commission for it to fulfil this role.

In addition to much-needed changes at the Mental Health and Wellbeing Commission, we strongly recommend the following additional reforms, to ensure robust oversight and accountability particularly in relation to compliance with the Cultural Safety Principle, elimination of restrictive practices, and dramatic reduction in the use of compulsory treatment:

- Requirement for all mental health service providers to report publicly and regularly on steps taken to comply with their obligation to reduce and eventually eliminate restrictive interventions.

[154] *MHWB Act 2022*, Part 9.6,
[155] Ibid., ss. 415(h)(ii) and (iii).

- Increase access to data on compulsory assessment and treatment, in accordance with Indigenous Data Sovereignty and Indigenous Data Governance (see further below)
- Implement Recommendation 27 from the Yoorrook for Justice Report, to establish an independent police complaints body – all complaints regarding exercise of police powers under the MHWB Act should be investigated by this body.
- Empower the MHT to make findings and orders in relation to non-compliance by mental health services and treating teams of their obligations.[156]
- As recommended by Yoorrook, take urgent measures to implement OPCAT, including to urgently undertake robust consultations regarding culturally appropriate OPCAT implementation.[157]

RECOMMENDATIONS

Recommendation 31. Yoorrook should request deidentified data (disaggregated by Aboriginality, service provider and geographic location) from the Mental Health and Wellbeing Commission and its predecessor, the Mental Health Complaints Commissioner, regarding complaints and inquiries over the past 9 years, including the outcomes of complaints.

Recommendation 32. Yoorrook should request information from the MHWC regarding its role and functions[158] as a core component of the oversight and accountability framework, including:

- Ensuring that the Government implements recommendations from the RCVMHS that impact Aboriginal consumers of mental health services.
- Issuing guidance materials about how the mental health and wellbeing principles (including the Cultural Safety Principle) should be applied;
- Monitoring and reporting on the performance, quality and safety of the system, including the way in which Aboriginal people are disproportionality impacted by the use of restrictive interventions and compulsory treatment;
- Providing a robust and culturally appropriate complaints process, which leads to culturally appropriate complaints outcomes, where relevant;
- Supporting compliance across the sector, by issuing compliance notices where needed;
- Conducting own-motion inquiries into systemic issues in the mental health system, including systemic racism.

Recommendation 33. To improve oversight and accountability within the mental health system – particularly in relation to compliance with the Cultural Safety Principle, the obligation to reduce/eliminate restrictive interventions, and dramatic reduction in the use of compulsory treatment – the government should implement the following additional reforms:

(a) All mental health service providers must be required by legislation to report publicly and regularly on steps taken to comply with their obligation to reduce and eventually eliminate restrictive interventions.

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[156] VLA, *Submission to Independent Review of Compulsory Treatment*, Recommendation 24.
[157] Yoorrook Justice Commission, Yoorrook for Justice (2023), Recommendation 41.
[158] *Mental Health and Wellbeing Act 2022* (Vic) (*MHWB Act*), s. 415.

(b) In accordance with IDS and IDG, Aboriginal communities and Aboriginal organisations must have access to deidentified data regarding the use of restrictive practices and compulsory assessment and treatment.
(c) Complaints against police relating to exercise of powers under the MHWA must not be investigated by police; they must be investigated by a new independent police complaint body, as recommended by the Yoorrook Justice Commission.[159]
(d) The MHT should be granted powers to make findings and make orders in relation to non-compliance by mental health services and treating teams of their obligations.[160]
(e) Immediately implement the *Optional Protocol on the Convention Against Torture, Cruel, Inhuman and Degrading Treatment and Punishment* (**OPCAT**), including to urgently undertake robust consultations regarding culturally appropriate OPCAT implementation.

Health and Disability Injustices in the Criminal Legal System

In December 2022, VALS provided a submission to Yoorrook on systemic injustices in the criminal legal system. This submission highlighted concerns relating to the impact of the criminal legal system on Aboriginal people's health and wellbeing, as well as the lack of access to culturally safe healthcare and disability supports for people in the system, particularly people in prisons.

The Yoorrook for Justice Report included several recommendations relating to the health and wellbeing of people in the criminal legal system, including decriminalising public intoxication and offences linked to disadvantage arising from disability and mental ill-health,[161] reforming the prison healthcare system,[162] prohibiting strip searching and solitary confinement,[163] and implementing the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (**OPCAT**).[164] After 5 months, the government has still not responded to these recommendations.

This section builds on our previous submission to Yoorrook and recommendations made by Yoorrook in August 2023. We continue to see significant challenges with the prison healthcare system, and are concerned about the lack of progress towards implementation of the recommendations from the Veronica Nelson Inquest and the Cultural Review into the Adult Custodial Corrections System (**Cultural Review**).

We also take the opportunity to raise concerns about the lack of culturally safe disability supports for people involved in the criminal legal system. Many of these concerns were examined by DRC which handed down its final report in September 2023.[165] We strongly encourage the Commission to

[159] Yoorrook Justice Commission, Yoorrook for Justice (2023), Recommendation 27.
[160] VLA, Submission to Independent Review of Compulsory Treatment, Recommendation 24; VALS, *Submission to Independent Compulsory Treatment Review*, Recommendation 22.
[161] Yoorrook Justice Commission, Yoorrook for Justice (2023), Recommendations 30 and 39(a).
[162] Ibid., Recommendation 43(e).
[163] Ibid., Recommendations 40(a) and 44.
[164] Ibid., Recommendation 41.
[165] DRC, Final Report (2023).

examine government witnesses in relation to Victoria's implementation of the recommendations from this Royal Commission.

Overhaul the prison healthcare system

People who are incarcerated in Victoria have a right to enjoy the highest attainable standard of physical and mental health, and to access the same standards of healthcare that are available in the community. Yet inadequate and culturally unsafe healthcare in Victorian prisons is leading to the preventable deaths of Aboriginal people.

In August 2023, Yoorrook recommended that as soon as possible, and after consultation with the First Peoples' Assembly of Victoria (**FPAV**) and relevant Aboriginal organisations, the Victorian Government take all necessary steps to structurally reform the Victorian prison system based on the recommendations of the Cultural Review,[166] which recommended significant changes to the prison healthcare system.

In addition, Yoorrook highlighted the experience of Veronica Marie Nelson – a proud and strong Gunditjmara, Dja Dja Wurrung, Wiradjuri and Yorta Yorta woman – who passed away in her cell at the Dame Phillis Frost Centre (**DPFC**), after days of crying out for help. The Coroner investigating Veronica's passing also made significant recommendations to reform the prison healthcare system.

Since the Yoorrook for Justice Report was published, the Victorian Government has continued to implement recommendations from the Veronica Nelson Inquest and has developed an Implementation Plan for the Cultural Review for 2024-2025. We are concerned that the Implementation Plan does not go far enough. We strongly recommend that Yoorrook should request access to the Plan and examine relevant government witness's implementation of the Cultural Review recommendations on prison healthcare.

Despite some changes to the prison healthcare system – including new healthcare providers since July 2023 – **the experience of our VALS lawyers and clients is that not much has changed on the ground. There continues to be a significant gap between policies and procedures regulating healthcare, and daily practice.**

Thirty three years have passed since RCIADIC recommended that prison health care "be of an equivalent standard to that available to the general public" and should be "accessible and appropriate to Aboriginal prisoners."[167] This is required under international human rights law,[168] and the Victorian

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[166] Yoorrook Justice Commission, Yoorrook for Justice (2023), Recommendation 43.
[167] Royal Commission into Aboriginal Deaths in Custody (RCIADIC), *Final Report, Volume 5*, Recommendation 150.
[168] People who are incarcerated have the right to be treated with humanity and respect for the inherent dignity of the human person. ICCPR, article 10(1). The *United Nations Standard Minimum Rules for the Treatment of Prisoners* (Mandela Rules) require that "prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary healthcare services free of charge, without discrimination on the grounds of their legal status." See *Mandela Rules*, Rule 24(1); *United Nations Rules for the Treatment of Women Prisoners*, Rules 6-18; *United Nations rules for the Protection of Juveniles Deprived of Their Liberty* [49]; *United Nations System Common Position on Incarceration* (2021) p. 12.

Charter.[169] Equivalency of healthcare means that Aboriginal peoples physical and mental health needs must be met to an equivalent standard, not just that there is an equivalence of services available.

VALS continues to represent Aboriginal families in three ongoing coronial inquests which involve access to healthcare in prisons,[170] and continues to provide legal assistance to people in prison whose healthcare needs are not being met. It is unacceptable that Aboriginal people in Victorian prisons are suffering unimaginable harm – including death – because of inadequate healthcare.

In the context of the current inquiry into health and healthcare, we strongly recommend that the Commission continue its examination of the prison healthcare system, including limited progress to substantially improve health outcomes for Aboriginal people in prisons. In this regard, we also note that the Victorian Ombudsman is currently carrying out a systemic investigation into prison healthcare.[171]

RECOMMENDATION

Recommendation 34. The Yoorrook Justice Commission should examine witnesses relating to implementation of recommendations from the Veronica Nelson Inquest and the Cultural Review into the Adult Custodial Corrections System (**Cultural Review**), and should request relevant documents including:

- The Implementation Plan for the Cultural Review;
- Reports to the Aboriginal Justice Caucus (**AJC**) regarding implementation of recommendations from the Veronica Nelson Inquest.

Complex and intersecting healthcare needs are not being met

People in Victorian prisons have complex and intersecting healthcare needs,[172] and the health needs of Aboriginal people who are incarcerated are even more pronounced than the non-Aboriginal prison population. According to research by VACCHO, Aboriginal people in Victorian prisons are less healthy than both Aboriginal people in the community and non-Aboriginal people in prison.[173] They have higher rates of chronic health conditions, drug and alcohol use, blood borne viruses and sexually

[169] *Charter of Human Rights and Responsibilities Act 2006* ss. 19.
[170] In March 2021, Michael Suckling, passed away in his cell at Ravenhall Correctional Centre, two days after a 'code black' was called in relation to this health. In November 2021, Ms Heather Calgaret passed away at Sunshine Hospital after she was transferred from the Dame Phyllis Frost Centre prison in a critical condition. On 11 September 2022, Clinton Austin, a 38-year-old Gunditjmara and Wiradjuri man, passed away in custody at Loddon Prison in Victoria.
[171] Victorian Ombudsman, *2023 Annual Report* (2013), p. 8.
[172] According to research carried out by the Australian Institute for Health and Wellbeing (**AIHW**) in 2018, 89% of prison entrants in Victoria had a chronic health condition, 68% were smokers, 83% had used illicit drugs in the previous 12 months, 42% identified as having a disability that limited their activity, employment or education, and 61% had a diagnosed mental illness and 35% were referred to a prison mental health service. AIHW, *The Health of Australia's Prisoners, Supplementary Tables—States and Territories*, (2019) Data Tables S201, S216, S225, S213, s169 and s193. RCVMH *Interim Report* (2019), p. 49.
[173] VACCHO, *Keeping our mob healthy in and out of prison: Exploring Prison Health in Victoria to Improve Quality, Culturally Appropriate Health Care of Aboriginal People* (2015), pp. 9, 13.

transmitted infections. Aboriginal people in prison are also less likely to have accessed healthcare outside prison.

Through our prison advocacy practice – which provides legal assistance and representation to individuals in custody – we see many clients who have challenges accessing adequate medical care, including:

- Lack of adequate and fulsome intake health assessments;
- Failure of practitioners to check a person's medical history or JCare records;
- Lack of clear escalation pathways for people who are seriously unwell;
- Lack of adequate qualifications for medical professionals;
- Lack of access to opioid substitution therapy for people on remand or serving short sentences (despite recent policy changes);
- Arbitrary and punitive reduction of opioid substitution therapy;
- Lack of access to specialists in drug addiction and withdrawal;
- Lack of access to quality and culturally safe mental health care, including no access to culturally safe grief counselling after a death in custody;
- Lack of continuity of care between community healthcare and healthcare in prisons, including a failure to obtain or delays in receiving, information and prescriptions from community healthcare providers;
- Failure to follow-up on referrals to allied health providers;
- Loss of information and lack of continuity of care when people are transferred between different prisons;
- Lack of oversight over prison healthcare, with no single entity or person with overarching responsibility over healthcare;
- Lack of appropriate information sharing between community healthcare and prison healthcare providers, as well as lack of information sharing with patients;
- Delays following requests to see GPs and specialists;
- Poor quality dental care (e.g. removal of teeth as option of first resort);
- Lack of access to appropriate medication, including adequate pain medication;
- The location of the medical ward in prisons being a disincentive to accessing medical care;
- Lack of adequate medical records, documentation of medical events and handovers;
- Lack of clinical oversight, reflective practice, or appropriate responses to complaints and adverse events.

The following case studies highlight issues with delays and failure to respond to requests for medical attention.

Case studies

One client had an asthma attack in their cell. It took staff 45 minutes to deliver a puffer to their cell, and staff only pushed the puffer in through the slot. The client had to crawl on the floor to get the puffer. Staff did not check if the client was ok. They thought they were going to die.

One client waited over a year to get a colonoscopy despite blood in stools for over a year and family history of bowel cancer.

One client has been incarcerated since 2017 and has faced obstacles in accessing medical treatment for a shoulder injury resulting from a motor vehicle accident in late 2017. The client was in significant pain and required surgery, however the procedure was cancelled three times due to issues with security escort, security related costs and prison staffing shortages. The client never received treatment while in custody and was released in September 2023 after six years of self-advocacy to address his shoulder pain and a risk of advanced nerve damage.

The experience of our clients closely aligns with findings from previous inquiries, including: investigation by the Victorian Ombudsman into conditions and treatment at DPFC,[174] the Parliamentary Inquiry into Victoria's Criminal Legal System,[175] and the Cultural Review.[176]

Additional challenges identified by the Cultural Review include: custodial staff 'gatekeeping' access to healthcare; people being moved between custodial locations frequently, which disrupts access to and continuity of healthcare; and the unmet health needs of people contributing to the already-volatile custodial environment; the impact of pain, distress and confusion on people's behaviour, resulting in disciplinary consequences; and poorly treated chronic pain resulting in anxiety, depression and emotional instability.[177] The Cultural Review also identified a number of barriers that prevent Aboriginal people from accessing culturally safe healthcare.[178]

End privatisation of prison healthcare

Prison healthcare in Victoria has been privatised for decades, resulting in a fragmented, opaque system, which is driven by profits rather than quality of care, and where there is little accountability and oversight. Combined with Victoria's reliance on private prisons (over one third of the adult prison population are in the states three private prisons),[179] privatisation within the prison system has significant detrimental consequences for access to healthcare and health outcomes.

Until July 2023, all healthcare in Victorian prisons was contracted out to a multinational corporation, Correct Care Australasia (**CCA**), a subsidiary of Wellpath, the largest prison healthcare provider in the United States.[180] Wellpath (formerly named Correct Care Solutions) has allegedly been sued more than

[174] The investigation "heard stories of women who had spent weeks in pain and discomfort, or whose conditions had deteriorated to the extent that they ended up in hospital," as well as "stories of women on remand with swollen faces and bleeding mouths who had not been able to see the dentist." In response to surveys, 41% of prison staff rated in-prison health services as poor or very poor and 41% of prison officers rated mental health services as 'poor' or 'very poor'; 21% of women said it was difficult to see a doctor and 71% said it took a long time; 13% of women said it was difficult to see a psychiatric nurse and 41% said it takes a long time; Corrections. See Victorian Ombudsman, *Implementing OPCAT in Victoria: report and inspection of the Dame Phyllis Frost Centre* (2017), p. 72.
[175] Parliament of Victoria, *Inquiry into Victoria's Criminal Justice System* (2022) pp. 587-592.
[176] See *Cultural Review* (2022), pp. 36, 133, 515, 518.
[177] Ibid.
[178] Ibid., pp. 518-519.
[179] The prison healthcare system stretches across 15 adult prisons (including 12 public and 3 private prisons), as well as the Judy Lazarus Transition Centre, and two youth prisons. Across these facilities, the combined adult and youth prison population is 7,000 on average, including 750 Aboriginal people. In June 2022, 2,415 out of 6,568 people incarcerated in Victoria's adult prisons were in private prisons. See *Cultural Review*, p. 112 and Government of Victoria, *Youth Justice Strategic Plan 2020-2030*, p. 8.
[180] S. Schwartz, Indigenous Victorians pay a high price when prisons prioritise profit, The Age (Webpage, 4 November 2022)

140 times[181] and is accused of contributing to more than 70 deaths in the US between 2014 and 2017.[182]

Inquest into the passing of Veronica Nelson: findings relating to CCA

In the Inquest into the passing of Veronica Nelson, the Coroner found that:

- CCA at DPFC failed to provide Veronica with care equivalent to the care she would have received from the public health system in the community, and that this failing causally contributed to her passing.[183]
- Justice Health failed to ensure that CCA delivered a standard of health care equivalent to that available in the public health system at DPFC, and this failing causally contributed to her passing.[184]
- Veronica should have been transferred to hospital at the time of her reception to DPFC, and that CV and CCA staff continually failed to transfer her to hospital thereafter, and this ongoing failure causally contributed to her death.[185]
- The failure of CCA and CV to establish proper procedures for information sharing between staff causally contributed to Veronica's passing and meant that decisions in relation to Veronica's medical care and custodial management were made on the basis of incomplete and inaccurate information.[186]
- The failure of CCA and DJCS to clearly establish an adequate procedure for the medical clearance of a prisoner from the Medical Centre to a mainstream unit causally contributed to Veronica's passing.[187]
- The failure of CCA and DJCS to clearly define the role and purpose of the Medical Centre at DPFC causally contributed to Veronica's passing.[188]
- CCA's failure to develop an adequate system for the handover of critical information between staff in relation to prisoners at DPFC causally contributed to Veronica's passing.[189]

The Coroner recommended:

- The Department of Health and DJCS consult to determine, from a clinical patient outcome perspective, which department should have oversight of custodial health services.
- The Department of Health and DJCS consult with stakeholders (including peak clinical bodies, organisations representing the lived experience of prison, public health services, private health providers, Aboriginal and Torres Strait Islander community representatives) to determine what model of healthcare delivery will achieve the best health outcomes for people in Victorian prisons.

[181] Global group linked to jail deaths wins $50m youth justice contract, 24 October 2018; Prison Health Care Provider Sued 140 Times Now Blamed for at Least Six Deaths, 22 November 2017.
[182] B. Ellis & M. Hicken, 'Please help me before it's too late', CNN (Webpage, October 2016)
[183] CCoV, Inquest into the Passing of Veronica Nelson, 30 January 2023, Finding 30.
[184] Ibid., Finding 31.
[185] Ibid., Finding 23.
[186] Ibid., Finding 27.
[187] Ibid., Finding 28.
[188] Ibid., Finding 29.
[189] Ibid., Finding 37.

As a result of the Veronica Nelson Inquest and sustained advocacy by Veronica's family, the Victorian government restructured prison healthcare providers in Victoria in July 2023. However, the complex web of contractors and subcontractors is still dominated by private multinational companies.

Healthcare providers in Victorian Prisons[190]

Private primary healthcare providers

- **GEO Healthcare** provides primary healthcare (including primary mental healthcare) in the 13 men's public prisons, and the Judy Lazarus Transition Centre.
- **CCA** is subcontracted by the GEO Group to provide primary healthcare in Ravenhall Correctional Centre.
- **GEO Group** both operates and provides primary healthcare at Fulham Correctional Centre.
- **St Vincent's Correctional Health Services** are contracted by G4S Custodial Services to provide primary healthcare at Port Phillip Prison.

Public primary healthcare providers

- **Western Health** provides primary healthcare at DPFC
- **Dhelkaya Health, Bendigo Health and Bendigo & District Aboriginal Co-operative (BDAC)** provide primary healthcare at Tarrengower prison.
- **Barwon Health** and **Wautherong Aboriginal Cooperative** will provide primary healthcare at the new youth prison at Cherry Cree once it opens.

Mental healthcare providers

- **Forensicare** (Victorian Institute of Forensic Mental Health) provides secondary mental healthcare services across all of Victoria's public and private prisons.[191]

Despite changes introduced in July 2023, **95% of the adult prison population in Victoria[192] continue to access healthcare through a private multinational company.** Not only has GEO Group got a track record of providing poor quality services in prisons across the world,[193] it is also closely entangled with CCA, which was previously a subsidiary of GEO Group. [194]

From our practice experience we have the following concerns regarding ongoing privatisation of the prison healthcare system:

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[190] Yoorrook Justice Commission, Yoorrook for Justice (2023), p 369.
[191] Corrections, Prisons & Parole, Justice Health (Webpage)
[192] In November 2023, there were 6,019 males and 304 females in Victorian adult prisons. See Corrections Victoria, Monthly Time series prison and community corrections data.
[193] GEO group has been subject to a number of lawsuits and inquiries across the world due to the poor quality of services they provide in prisons. J. Diaz, NPR, GEO Group sickened ICE detainees with hazardous chemicals for months, a lawsuit says, 25 March 2023; J. Iannelli, Miami New Times, Five Reasons South Florida's Pro-Trump Private-Prison Company Is Evil, 7 January 2018; D. Sadler, The Saturday Paper, Controversial prison health contractor back in business, 22 April 2023.
[194] S. Schwartz, The Age, Indigenous Victorians pay a high price when prisons prioritise profit (Webpage, 4 November 2022); D. Sadler, The Saturday Paper, Controversial prison health contractor back in business (Webpage, 22 April 2023)

1. Privatization of prison healthcare inherently prioritises security concerns and 'management' of prisoners over provision of independent medical services that are in the best interests of the patient. Medical staff in prisons are influenced by 'dual loyalty'[195] or conflicting demands from their employer and the patient. As a result, medical decision making and interactions with patients are influenced by the correctional culture of management and security rather than health outcomes, which leads to limited quality and availability of care.
2. The security element of the prison acts a deterrence to access care. Clients are often deterred from accessing treatment in the community because of the humiliating conditions and traumatic conditions experienced by clients when they are transferred to and from prison. For example, clients are handcuffed and shackled while walking through hospitals, guards are present in the clinic room.
3. Private corporations prioritise profits over healthcare outcomes, especially when providing a no fee service to people in prison. There is no incentive for GEO Group to provide quality care to people in prison, especially as the 'quality' of care and health outcomes are not included in contractual relationships.
4. Fragmentation within the prison healthcare system means that continuity of care is very hard to provide, particularly since people in prison often move between facilities. Each prison operates as its own entity, meaning that even when VALS has been advocating for medical care for a person in one prison for months, once they change prisons, the whole process starts again. Healthcare providers are often unaware that a person will be moving prisons, and receiving providers are unaware of the person's arrival and healthcare needs or if they have systems in place to ensure they can assist. The disconnect often means workers regularly fail to check and/or update JCare records to ensure what treatments people need or that their treatments are up to date. This can have significant health implications, as demonstrated in the case study below.
5. Doctor-patient continuity is also rare within the current healthcare system. Due to a variety of factors, including movement between prisons, understaffing and cost cutting, people in prison do not develop ongoing relationships with particular medical professionals, which undermines trust. This is particularly important for Aboriginal people, who continue to face discrimination and exploitation from institutions, including medical professionals.
6. Fragmentation of the prison healthcare system also acts as a deterrence to access care. For example, the cancer ward is in Port Phillip Prison, a high security prison. People who have cancer but are not high security often refuse treatment to avoid placement at a high security prison.
7. Privatization further compounds the opaqueness and lack of transparency within prisons, which enables poor conditions to flourish without regular scrutiny. As highlighted in the Cultural Review, companies may face significant financial penalties for breach of contract or failure to achieve certain KPIs, which "may encourage under-reporting of issues or attempts to skew data to avoid adverse action."[196]
8. There is a lack of information sharing between community and prison health providers, and between providers within the prison. Information falls through the gaps leading to inadequate case management.

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[195] Victoria Law, "*Prisons Make Us Safer": and 20 Other Myths about Incarceration'* (2021).
[196] *Cultural Review* (2022), p. 68.

9. It is extremely difficult for prisoners and their advocates to access their own health information, which is only made available through the long and cumbersome Freedom of Information (**FOI**) process. We continue to experience the following challenges with the FOI process:
    - Despite the legislative timeframe of 30 days from a valid request, extensions are always sought by DJCS.
    - Our requests are often considered 'too voluminous' to process, despite being simple requests for medical records within a certain small timeframe. This does not happen in community requests for records, for example, through an FOI request to a hospital.
    - People in prison and support workers are unable to access their own health records when they request them.
    - Requests go missing and unaccounted for, with no oversight.[197]
10. Privatisation and fragmentation within the system creates an accountability vacuum, where people's experiences on the ground are very different from the policy and legislative framework. The disconnect between policies and practice was a key theme in the Inquest into passing of Veronica Nelson, which we continue to see time and time again.

[197] VALS, Submission to Inquiry into the Operation of the Freedom of Information Act 1982 (2024).

Case Study

A client was on court ordered anti-psychotic medication (via depot injection) in the community.

After two weeks in custody, the client still had not received their medication, despite consistent requests from the client and his family members. The client had moved between two different prisons during their two weeks in custody.

The client's family members, and community mental health team, had attempted to contact Justice Health about the matter but did not receive a response. The family contacted VALS, and lawyers advocated on his behalf with Justice Health.

Within days, the client was placed on medication. The result of the incident was that our client had not received his prescribed anti-psychotic medication for over one month. They experienced significant distress as a result.

Following the incident, VALS followed up with Justice Health to inquire how this could have happened and to see whether changes had been made to practices and procedures.

Forensicare informed us that a request had been made for the client's community mental health records when our client entered custody. These records were received shortly after the request and placed onto the client's JCare record. However, as our client was transferred between prison facilities, the new primary healthcare providers didn't check JCare and no one realised the records had come through.

Forensicare advised VALS that as a result, it has changed its policies so that it instructs receiving practitioners to notify primary healthcare providers as soon as records are received. VALS has attempted to follow up with Justice Health in regard to what changes have been made in respect of the primary healthcare provider but has not received any response.

The Cultural Review and Yoorrook[198] have both carried out detailed investigations into the privatisation of prison healthcare and recommended that the Government must "urgently implement an adequately resourced public health model for delivery and oversight of health services across the adult prison system." [199] The Veronica Nelson Inquest also recommended that DH and DJCS consult with stakeholders to determine what model of healthcare delivery will achieve the best health outcomes for people in Victorian prisons.[200] We anticipate that issues relating to privatisation will also be highlighted in the ongoing coronial inquests.

Although healthcare at DPFC, Tarrengower (and Cherry Creek when it opens) is being delivered under a public model, no further steps have been taken to urgently implement a public health model for prison healthcare. Developing and implementing the *Healthcare Services Quality Framework for*

[198] Yoorrook Justice Commission, Yoorrook for Justice, pp. 368-371.
[199] *Cultural Review* (2022), Recommendation 6.13.
[200] CCoV, *Inquest into the Passing of Veronica Nelson*, 30 January 2023, Recommendation 19.2.

Victorian Prisons 2023,[201] does not constitute genuine and meaningful consultation on which model of healthcare will achieve the best health outcomes for people in Victorian prisons.

RECOMMENDATION

Recommendation 35. The Government must end privatisation of prison healthcare and urgently implement an adequately resourced public health model for delivery and oversight of health services across the adult prison system. [202]

Access to culturally safe healthcare provided by ACCHOs

Instead of private multinational companies, VACCHO and ACCHOs should be at the forefront of prison healthcare for Aboriginal people. For decades, ACCHOS have been providing culturally safe and trauma-informed primary healthcare (and other services) to Aboriginal communities in Victoria. They are best placed to provide both culturally safe care and continuity of care.

In the Veronica Nelson Inquest, the Coroner found that Veronica was culturally isolated and provided with no culturally competent or culturally-specific care or support from the moment of her arrest to her passing.[203] This included a lack of culturally safe medical care and treatment during her time in prison.

As noted above, cultural safety is defined as an "environment which is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need."[204] During the Veronica Nelson Inquest, experts also highlighted that "culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practicing behaviours and power differentials in delivering **safe, accessible and responsible health care, free from racism."**[205]

The lack of culturally safe healthcare in Victorian prisons has been well known for some time.[206] Most recently, the Cultural Review reported that Aboriginal people had "serious challenges in accessing medical treatment including an overwhelming sense that they had no control over their health needs."[207] Additional issues included that Aboriginal people were frightened to access healthcare because of fears of dying in custody; they were afraid of medical intervention or sharing information that might result in separation from other Aboriginal people; they were reluctant to use health services because they had been subjected to racism and discrimination (including minimising the role of health conditions or undermining people's healthcare needs and experiences); Aboriginal women

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[201] Department of Justice and Community Safety (DJCS), *Healthcare Services Quality Framework for Victorian Prisons 2023* (2023).
[202] See *Cultural Review* (2022), Recommendation 6.13.
[203] CCoV, *Inquest into the Passing of Veronica Nelson*, 30 January 2023, Finding 26.
[204] A. Eckerman et al, Binang Goomj: Bridging cultures in Aboriginal health (University of New England Press, 1994) cited in R. Williams, "Cultural safety - What does it mean for our work practice?" *Australian and New Zealand Journal of Public* Health (1999) 23, p. 213.
[205] CCoV, *Inquest into the Passing of Veronica Nelson*, [172].
[206] VACCHO, *Keeping our mob healthy in and out of prison: Exploring Prison Health in Victoria to Improve Quality, Culturally Appropriate Health Care of Aboriginal People* (2015); Victorian Ombudsman, *Implementing OPCAT in Victoria: report and inspection of the Dame Phyllis Frost Centre* (2017), p. 92.
[207] *Cultural Review*, (2022) p. 515.

were reluctant to share information with a mainstream health service; and the requirement to make a written request and communicate with non-Aboriginal staff acting as a further barrier.[208]

VACCHO,[209] the Cultural Review and the Veronica Nelson Inquest have all made significant recommendations on the role of ACCHOs in delivering healthcare services in prisons. The Cultural Review recommended that the Government commission an Aboriginal organisation to develop a model of healthcare for Aboriginal people in custody,[210]and Coroner McGregor recommended that DJCS and/or Justice Health, in partnership with VACCHO, must take concrete steps to build the capacity of VACCHO to provide in-reach health services in prisons.[211]

We also note that the *Inquiry into children affected by parental incarceration* found that "being pregnant while incarcerated risks various poor maternal and neonatal outcomes."[212] The inquiry recommended the Victorian Government ensure the same level of antenatal, postnatal, and neonatal care provided in Victorian prisons is equitable to that which is provided in the community.[213] VALS supports this recommendation and encourages the Commission to include the final report of this inquiry in their considerations and to seek deidentified data from DJCS regarding the numbers of Aboriginal women currently incarcerated, and in the previous 12 month who have been pregnant and given birth while incarcerated, and the antenatal, postnatal and neonatal supports that have been available to them.

In other jurisdictions in Australia, ACCHOs are directly contracted by the Government to provide in-reach primary health care and AoD services to Aboriginal people in prisons. In the ACT, Winnunga Nimmityjah Aboriginal Health and Community Services has provided primary healthcare services to Aboriginal people who are incarcerated since 2000.[214] In the Northern Territory, the Danila Dilba Health Service has provided healthcare at the Don Dale Youth Detention Centre since 2020.

In September 2023, DJCS commenced a project partnering with the ACCHO sector to develop an Aboriginal model of healthcare.

Based on the experience of ACCHO's in other jurisdictions, VALS believes it is vital that ACCHO's delivering healthcare in prisons have their own governance model and are not overseen by generalist service providers. The Victorian Government must properly fund ACCHOs to develop a model of care

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[208] Ibid., p. 518.
[209] VACCHO, *Keeping our mob healthy in and out of prison: Exploring Prison Health in Victoria to Improve Quality, Culturally Appropriate Health Care of Aboriginal People* (2015).
[210] See *Cultural Review* (2022) Recommendation 5.8.
[211] CCoV, *Inquest into the Passing of Veronica Nelson*, Recommendation 25.
[212] Parliament of Victoria, Legislative Council Legal and Social Issues Committee, 'Inquiry into children affected by parental incarceration' 2022, Finding 46, pg 118.
[213] Parliament of Victoria, Legislative Council Legal and Social Issues Committee, 'Inquiry into children affected by parental incarceration' 2022, Recommendation 14, p119.
[214] This has included people at the Alexander Maconochie Centre (AMC), Bimberi Youth Justice Centre, Goulburn prison, Cooma Prison, and the Belconnen and Symonston Remand Centres. The services provided by Winnunga include health checks, mental and healthcare plans, social and emotional wellbeing services, medication management, referrals to specialists and allied health, women and men's health and drug and alcohol rehabilitation services See H. Shukralla and J. Tongs, (2020) Australian first in Aboriginal and Torres Strait Islander prisoner health care in the Australian Capital Territory 44(4) *Australian and New Zealand Journal of Public Health* 324; Winnunga Nimmityjah Aboriginal Health Service, You Do the Crime, you do the Time: Best Practice Model of Holistic Health Service Delivery for Aboriginal and Torres Strait Islander Inmates of the ACT Prison (2007).

and provide their services in prisons. This is the only way to ensure continuity of care and access to culturally safe healthcare services.

DJCS has also highlighted that access to culturally safe healthcare is built into the new *Healthcare Services Quality Framework for Victorian Prisons 2023*.[215] Under this Framework, GEO Group is required to provide the following services:

- An Aboriginal Health Check provided by an Aboriginal Health Practitioner/Worker.[216]
- An Integrated Care Plan led by the Aboriginal Health Practitioner/Worker, in consultation with the broader health team, which provides access to cultural support and traditional healing.[217]
- Health promotion materials for Aboriginal clients, developed in consultation with internal and community Aboriginal health service providers.
- AOD health programs which may include in-reach from the community.
- Post-release continuity of healthcare planning, including sharing information with the CV Aboriginal Continuity of Care services, facilitating in reach cultural, social and health support during the person's prison term, and outreach and referral for post-release support noting treatment and support are integral for improved health outcomes for Aboriginal people.
- Employ a primary health Aboriginal workforce and build partnerships with Aboriginal community health service providers and Aboriginal cultural and social supports for in-reach services for Aboriginal people in prison and out-reach for continuity of care upon release to the community.

In our view, the above are impossible tasks for a private security corporation without community connections and cultural knowledge. This is demonstrated by the GEO Group's *Aboriginal Wellbeing Strategy 2021-2024*, which is entirely inadequate.[218]

Culturally safe care requires more than simply hiring Aboriginal health workers. It requires healthcare to be organised and assessed from the perspective of Aboriginal people, and it requires a holistic and trauma-informed approaches to addressing the SEWB of community members. It also requires Aboriginal people to have trust in the health care arrangements and quality and responsiveness of service provision.

There is also a staffing crisis in Aboriginal health, with services grappling for healthcare workers. ACCHOs have expressed concerns that the new model delivered by GEO Group will put further pressure on the system, and cause a brain drain away from Aboriginal service, due to higher salaries offered by GEO Group. This is also especially concerning where VACCHO is the main trainer for Aboriginal health providers. It is also culturally unsafe for the Aboriginal health worker to work for a private organisation with conflicting priorities, and not be funded and supported by community.

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[215] DJCS, Healthcare Services Quality Framework for Victorian Prisons (2023), pp. 29-32.
[216] The Health Check must be provided within 10 business days of the client's arrival or identification of Aboriginal status (whichever is sooner).
[217] The Plan must be completed within 29 Calendar Days of reception, or identification of Aboriginal status (whichever is sooner).
[218] GEO Group, *Aboriginal Wellbeing Strategy 2021-2024* (2021).

RECOMMENDATIONS

Recommendation 36. The Government should properly fund VACCHO and ACCHOs to develop a model of healthcare and provide their services in prisons.

Recommendation 37. Yoorrook should examine witnesses from GEO Healthcare regarding the provision of "culturally safe healthcare" by GEO and health outcomes for Aboriginal people in Victoria's men's public prisons.

Recommendation 38. Yoorrook should request deidentified data on the numbers of Aboriginal women currently incarcerated, and in the previous 12 month, who have been pregnant and given birth while incarcerated, and the antenatal, postnatal and neonatal supports that have been available to them

Culturally safe mental healthcare

Yoorrook has previously heard evidence about high rates of mental illness amongst the prison population,[219] and challenges experienced by Aboriginal people in accessing adequate mental health care in prisons, including reliance on restrictive practices such as heavy sedation, chemical restraints and solitary confinement.[220]

Despite ongoing implementation of recommendations from the RCVMHS regarding the forensic mental health system, there continues to be a significant gap in access to culturally safe mental healthcare for Aboriginal people in prisons. Holistic mental healthcare that responds directly to the needs of Aboriginal people in custody is critical, not only to support individuals with mental health needs that existed prior to incarceration, but also to support people in custody with additional needs arising as a result of the harm and violence perpetrated by the carceral system.

Mental healthcare for people in prisons is provided by GEO Group (primary mental healthcare) and Forensicare (secondary mental health care) and includes dedicated mental health units at DPFC, Melbourne Assessment Prison and Ravenhall.[221] Mental healthcare is primarily regulated under the *Healthcare Services Quality Framework for Victorian Prisons*[222] and the *Aboriginal Social and Emotional Wellbeing Plan,*[223] developed by Justice Health and Corrections Victoria in 2015 and not updated since.

The RCVMHS made the following recommendations relating to mental healthcare for people in prisons, but did not identify specific reforms to address the mental healthcare needs of Aboriginal people in Victorian prisons:

[219] Yoorrook Justice Commission, Yoorrook for Justice (2023), p. 258.
[220] Yoorrook Justice Commission, Yoorrook for Justice (2023), p. 370-371.
[221] *Cultural Review* (2022), p. 9.
[222] DJCS, Healthcare Services Quality Framework for Victorian Prisons 2023 (2023).
[223] Justice Health and Corrections Victoria, Aboriginal Social and Emotional Wellbeing Plan (2021).

1. Establish a program of supports for people in prison living with mental illness who require ongoing intensive treatment, care and support to transition the delivery from correctional settings to the mainstream mental health and wellbeing system upon their release.[224]
2. Upgrade and increase capacity at the Thomas Embling hospital by: (a) refurbishing the existing 136 beds; (b) providing an additional 107 beds by 2026.[225]
3. Expand specialist youth forensic mental health programs to a statewide model, including across the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services, to provide consistent and appropriately specialised treatment, care and support to children and young people in contact with, or at risk of coming into contact with, the youth justice system.[226]

The Cultural Review also examined access to mental healthcare for Aboriginal people in prisons, and made the following recommendations:

1. DJCS work with ACCHOs to identify and validate a culturally appropriate screening tool to assess any mental health issues for Aboriginal people entering the adult custodial corrections system. The screening tool should be administered as part of ongoing mental health care for Aboriginal people in custody.[227]
2. DJCS engage specific expertise to develop and embed a holistic approach to meeting the health, social and wellbeing needs of Aboriginal women.[228]
3. DJCS should specify training requirements for healthcare staff in custodial healthcare contracts, including training in Aboriginal cultural safety and responding to mental health needs.[229]
4. DJCS should provide mandatory training for corrections staff on mental health conditions.[230]

Although Yoorrook has previously recommended that the Government must implement the recommendations from the Cultural Review, we are concerned that there has been limited progress to invest in and increase access to culturally safe mental healthcare for Aboriginal people in prison.

VALS is currently representing the family of Ms. Heather Calgaret, who passed in November 2021 whilst serving a sentence at the DPFC. The Inquest into the passing of Ms Calgaret will commence on 29 April 2024 and is likely to examine issues relating to the quality and cultural safety of mental healthcare services in Victorian prisons. We strongly recommend that Yoorrook follow the evidence adduced as part of this Inquest, in relation to the quality of mental health care.

RECOMMENDATION

Recommendation 39. Yoorrook should examine government witnesses in relation to the quality and cultural safety of mental healthcare services in Victorian prisons, including implementation of relevant recommendations from the RCVMHS and the Cultural Review.

[224] RCVMHS, Final Report (2021), Recommendation 37(3).
[225] Ibid., Recommendation 38(1a).
[226] Ibid., Recommendation 20(1).
[227] *Cultural Review* (2022), Recommendation 5.10.
[228] *Ibid.,* Recommendation 5.11.
[229] Ibid., Recommendation 6.20(f).
[230] Ibid., Recommendation 6.20.

Increase access to meaningful Alcohol and Drug (AoD) supports

A prison's prioritisation of security and management particularly impacts the medical needs of people who suffer from the health condition of drug dependence. Currently, a system that criminalises drug use is responsible for treating the very health condition for which the person is often imprisoned for. This is an undeniable conflict. Coupled with a culture of stigma, this results in neglect and inadequacies in the provision of treatment, further surveillance of drug users and the removal of treatment as punishment.

It is evident from numerous inquests and reports[231] that drug treatment programs in prison are inadequate to meet demand, and there are significant barriers to access, including for people on remand. Like any other treatment, people in prison should be able to access proper and reasonable care for their health conditions, and like in the community, people in prison should be able to access harm reduction services like needle exchanges and addiction specialist services.

Without proper treatments, people may be unnecessarily forced to source drugs by other means. This has dangerous consequences, including the risk of precuring unsafe drugs, the sharing of needles, risk of overdose, blood born viruses, ulcers, and other health risks. It also counterproductively contributes to poor order of the prison by encouraging black market drug trade which may undermine security concerns and lead to further sanction.

A lack of proper care was evidenced in the Veronia Nelson Inquest. During her reception medical assessment, Veronica disclosed that she was withdrawing from an opioid dependence and requested methadone. She was given a rapid withdrawal pack and told that if she wanted opioid substitution therapy (**OST**) she would need to make an appointment with the relevant clinic, which could take up to 6 weeks. The 'rapid withdrawal pack' was standardised and not suitable for her needs.

[231] Victorian Ombudsman, Investigation into the rehabilitation and reintegration of prisoners in Victoria (2015) pp. 56-60; CCoV, Inquest into the death of Veronica Nelson, 30 January 2023.

The Coroner found that:

- Justice Health's OST Program Guidelines[232] deny people who are incarcerated equivalent care to that available in the community, and infringe their right to life and right to be treated humanely while deprived of liberty under the Charter.[233]
- Veronica's treatment by CCA - pursuant to CCA's Guidelines and the Justice Health Guidelines - constituted cruel and inhumane treatment contrary to the protection from torture and cruel, inhuman or degrading treatment under the Charter.[234]

The Coroner recommended that Justice Health immediately amend the OST Guidelines, so that OST can be prescribed to women whose health may be at significant risk by being required to undergo forced opiate withdrawal.[235] He also recommended that Healthcare service providers employ staff who are adequately trained specialists in addiction medicine and opioid pharmacotherapy.[236]

In response to the Inquest, Justice Health issued an Interim Practice Instruction (effective from June 2023) directing all Health Service Providers that the duration of time in custody and court matters no longer affect OST eligibility, and that patients can receive OST at the earliest opportunity.

Despite the Interim Practice Instruction, we continue to have concerns about the Guidelines and their implementation in practice, including that people can be removed from pharmacotherapy programs for disciplinary reasons. To access the program, individuals must provide voluntary, informed consent to the 'rules' of the program, including collect methadone or buprenorphine at the time specified and treating correctional staff with respect. Failure to comply with these rules may lead to the person being rapidly and involuntarily withdrawn from the Program, which demonstrates the prioritisation of management and security over health outcomes. Removal of medication should never be used as a disciplinary measure to punish or incentivise certain behaviours.

Justice Health is currently undertaking a broader review of the OST Guidelines. We strongly recommend that the Review includes consultation with relevant experts, and that the issues identified above are addressed.

RECOMMENDATIONS

Recommendation 40. Justice Health should carry out a comprehensive review of the Opioid Substitution Therapy (**OST**) Program Guidelines and consult with relevant experts as part of this review.

Recommendation 41. The OST Program Guidelines should be immediately amended to ensure that individuals cannot be rapidly and involuntarily withdrawn from the OST Program, as a disciplinary measure, including for failure to comply with the Program Contract of Consent and Agreement.

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[232] Justice Health, 'Victorian Prison Opioid Substitution Therapy Program Guidelines', *Department of Justice & Regulation* (July 2015), p 15-16.
[233] *Charter of Human Rights and Responsibilities Act 2006*, ss. 22 and 10.
[234] Ibid., s. 10.
[235] CCoV, *Inquest into the Passing of Veronica Nelson*, Recommendations 20.1, 20.2.
[236] Ibid., Recommendations 22, 29.3, 29.5, 31.2, 31.4, 31.5, 31.5.

Recommendation 42. People in prison should be able to access harm reduction services available in the community, like needle exchanges and addiction specialist services.

Culturally safe disability supports and adjustments

People with disability are significantly over-represented in prisons, particularly people with intellectual disabilities or cognitive impairment. Previously, Yoorrook heard evidence about high rates of disability within the youth[237] and the adult prison populations,[238] and recommended measures to reduce criminalisation of children with a disability.[239]

Despite this, there is no systematic disability assessment or screening when someone enters prisons, and no measures in place to ensure culturally safe disability screening.

From our practice experience, we see the following challenges experienced by our clients:

- Individuals with a disability are not provided with adequate supports or adjustments
- People with a disability are often put into isolation (often amounting to solitary confinement) as a way for the prison to "manage" the disability
- Due to the bureaucratic nature of the prison healthcare system and reliance on self-advocacy, access to healthcare further exacerbated when someone has a disability

The Cultural Review made a number of recommendations to address the needs of people with disability, including that DJCS should:

- Ensure that accommodation, infrastructure and specialist staffing across the adult custodial corrections system meet human rights standards and better support the needs of vulnerable cohorts including people with disability, people with cognitive impairment, young people, trans and gender diverse people, older people and people with other physical, behavioural or wellbeing needs.[240]
- Develop specialised training for new recruits to support key cohorts, including disability awareness, mental health, trauma-informed practice and Aboriginal cultural safety.[241]

More recently, the Disability Royal Commission also recommended timely screening and expert assessments for children with cognitive disability,[242] adequate training for staff,[243] and disability supports that place people with disability in the same position, so far as feasible, as other people in custody.[244] The Commission also highlighted the need to clarify who has responsibilities between

[237] Yoorrook Justice Commission, Yoorook for Justice (2023), pp. 316, 324-325.
[238] Ibid., p. 258.
[239] Ibid., Recommendation 35.
[240] *Cultural Review* , Recommendation 6.1. (2022), p 72.
[241] *Cultural Review* , Recommendation 3.7(h). (2022), p 50.
[242] DRC, *Final Report: Volume 8* (2023), Recommendation 8.4.
[243] Ibid., Recommendation 8.5.
[244] Ibid., Recommendation 8.1.

State/Territory criminal legal systems and the National Disability Insurance Scheme (NDIS) for supports and services for people in custody with disability.[245]

We are concerned that the 2-year Implementation Plan for the Cultural Review does not prioritise reforms relating to people with disability in Victorian prisons. Although the new model of healthcare in prisons includes tailored services for people with a disability,[246] we are yet to see notable changes in practice. The Yoorrook Justice Commission should examine government witnesses in relation to implementation of recommendations from the Cultural Review including culturally safe disability screening, access to disability supports and adjustments, and health outcomes for people in custody with a disability.

RECOMMENDATIONS

Recommendation 43. Yoorrook should examine government witnesses in relation to progress in implementing recommendations from the Cultural Review and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (**DRC**), including culturally safe disability screening, access to disability supports and adjustments, and health outcomes for people in custody with a disability.

Allow people in custody to access Medicare and the Pharmaceutical Benefits Scheme

Healthcare in prison is inherently unequal to healthcare in the community, as incarcerated peoples are excluded from the Medicare Benefits Scheme (**MBS**) and the Pharmaceutical Benefits Scheme (**PBS**).[247] Although this issue was examined in the Yoorrook for Justice Report,[248] the Commission did not make any recommendations regarding the MBS and PBS.

Excluding prison healthcare services from Medicare and PBS has important implications for access to certain healthcare services in prisons, as services that would otherwise attract Medicare and PBS rebates in the community, are too expensive to offer at scale in prisons.[249] This includes access to allied mental health services for people with a diagnosed mental condition.[250]

Since July 2023, Aboriginal people in prisons are being offered an Aboriginal Health Check (also known as a Medicare 715 check), which is available to Aboriginal people in the community to help improve detection and early treatment,[251] and is usually accessed through an ACCHO. Under the current model

[245] Ibid., Recommendation 8.17.
[246] DJCS, Healthcare Services Quality Framework for Victorian Prisons 2023 (2023), p. 26.
[247] Section 19(2) of the *Health Insurance Act 1973* (Cth) provides that Medicare does not apply to a health service provided by, on behalf of, or under arrangement with, any government entity (including both State, Territory and Federal).
[248] Yoorook Justice Commission, Yoorook for Justice (2023), p. 369.
[249] Craig Cumming et al, In Sickness and in Prison: The Case for Removing the Medicare Exclusion for Australian Prisoners (2018), 26(1), *Journal of Law and Medicine*.
[250] Department of Health, Better Access Initiative (Webpage, 2024)
[251] Australian Government Department of Health, Medicare Benefits Schedule, Item 715, Aboriginal and Torres Strait Islander Peoples Health Assessment. (2020) p 82.

of healthcare in men's public prisons, Aboriginal Health Checks are being offered by GEO Healthcare, and are being carried out by an Aboriginal Health Practitioner/Worker.[252]

Although access to Aboriginal Health Checks for people in custody is positive and addresses one of the challenges arising from not having access to Medicare, this reform is unlikely to substantially improve health outcomes for Aboriginal people in custody without further changes. Ultimately, Aboriginal Health Checks are about early detection and prevention and require accessible, culturally safe and consistent follow up to improve health outcomes.

Additionally, excluding prison healthcare services from Medicare and PBS undermines continuity of care for people transitioning out of prison, due to challenges with information exchange between prison healthcare providers and community providers as well as administrative barriers (individuals leaving prison are required to reapply for a Medicare Card).

For continuity of care and similar reasons to those above, governments should also consider how to make the National Disability Insurance Scheme available in prisons. It is clear that prison healthcare needs a radical transformation, and, in that spirit, we hope that governments will find a way to change their processes to allow people in prison to access these supports.

RECOMMENDATION

Recommendation 44. The Federal Government must ensure that incarcerated people have access to the Pharmaceutical Benefits Scheme (**PBS**) and the Medicare Benefits Schedule (**MBS**). The Victorian Government should advocate with other States and Territories and the Commonwealth to enable this access.

Increase access to advocacy services

Access to healthcare that is equivalent to that available in the community is not the reality for people in prison, particularly Aboriginal people. People in prison require advocacy to access reasonable healthcare, and to submit complaints about the quality of healthcare.

Through the VALS Prison Advocacy Practice, we see that people in prison are often forced to self-advocate to access medical care. Clients often submit multiple, if not dozens, of requests to access medical appointments. It is commonplace that medical request forms are 'lost' or not responded to, or updates (for example, test results) are not communicated to prisoners. Our clients report asking prison guards to support their medical requests before they are actioned. Not only is this unacceptable, but this reality disadvantages people less able to self-advocate.

[252] The Health Check must be provided within 10 business days of the client's arrival or identification of Aboriginal status (whichever is sooner).

We see first-hand the benefits of external advocacy services, and in many cases, prison and health care authorities only act satisfactorily when legal services come on board. The case study below demonstrates this point.

Case Study

VALS advocated for a client to get a colonoscopy. This client hadn't been granted access to a bowel screening, despite persistent blood in stools and consistent requests for over a year. Within a month of our advocacy, which included several letters to Justice Health and direct communication with head office, the client had a colonoscopy.

Despite the important role of advocacy services, they are limited and often inaccessible. VALS Wirraway team is one of the only dedicated services to address prison healthcare issues in the State, with our client base limited to Aboriginal people.

Due to prison call-out restrictions, a limited approved contact list (10 numbers only) and exorbitant call costs, prisoners are unable to contact services when they need them. For example, to access our advocacy services, prisoners need to have VALS' number on their call list. Approval processes are arbitrary and can take months until numbers are placed on phone lists. For medical matters, this is often unsustainable and unsatisfactory. VALS numbers should be free and accessible.

People also seek our services through referrals from concerned family members or other service providers. While this mitigates some accessibility issues, it excludes people without kin and support networks.

The Cultural Review recommended that the Government establish a dedicated and independent advice service for people in custody, to give them access to timely independent advice and support in relation to their rights and legal issues.[253] We are concerned that this recommendation has not progressed. The Yoorrook Justice Commission should reiterate Recommendation 6.10 of the Cultural Review and specifically recommend investment in Aboriginal Legal Services to support Aboriginal people who are incarcerated to access culturally safe healthcare.

[253] *Cultural Review* (2022), Recommendation 6.10.

RECOMMENDATION

Recommendation 45. The Victorian Government should create and resource a legal service dedicated to providing legal advice and representation for people to prison, and properly resource Aboriginal Legal Services to provide such services to Aboriginal people in prison.

Recommendation 46. VALS telephone number should be free and accessible to all people in prisons in Victoria.

Independent oversight of the prison healthcare system

The system is failing by not providing a robust independent oversight system of prison healthcare providers. This includes monitoring of contracts, independent auditing and scrutiny, clinical oversight and robust mechanisms for reviewing any deaths in custody that relate to access to healthcare.

At the Veronica Nelson Inquest, the Coroner found that there are substantial gaps in policies and procedures, which were not identified through Justice Health's monitoring of the prison healthcare contract, or through its oversight of Corrections Victoria and custodial healthcare. Accordingly, the Coroner recommended that the Government must revise the system for auditing and scrutiny of custodial health care services.[254] Similarly, the Cultural Review recommended that DJCS and DH should establish governance arrangements to support the proposed public health model for delivery and oversight of health services across the adult custodial corrections system.[255]

In response to the Inquest, Justice Health is reforming the governance of prison healthcare, including by establishing a new oversight board and reforming the existing Clinical Advisory Committee (CAC) to become an advisory panel.

At the Inquest, the Coroner also found that the Justice Health Death in Custody Report was grossly inadequate and misleading.[256] The Coroner recommended that DJCS urgently redesign the JARO and Justice Health Death in Custody Reviews, to ensure that they are independent, comprehensive, timely and identify opportunities for improved practice.[257] The Government's position is that it has implemented this recommendation, through new review processes that were introduced in August 2022.[258] VALS does not believe that this recommendation has been adequately implemented.

From our practice experience, we also have significant concerns about the quality of monitoring of private healthcare providers, which focuses primarily on quantity-based Key Performance Indicators (KPIs) rather than concrete health outcomes. This is particularly concerning considering the complex needs of people in prison, and the time and care that is required to build trust in a prison environment.

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[254] CCoV, *Inquest into the Passing of Veronica Nelson*, 30 January 2023, Recommendation 18.
[255] *Cultural Review* (2022), Recommendation 6.19.
[256] CCoV, *Inquest into the Passing of Veronica Nelson*, 30 January 2023, Finding 45.
[257] Ibid., Recommendation 36.
[258] Attorney General and the Victorian Government (responses to recommendations made to VGCS, Justice Health, Corrections, DoH & Hon. Dan Andrews MP), 28 April 2023.

Measuring quantity alone may incentivise providers to cut quality, for example, offer short appointments and different practitioners. This is further compounded by the privatised nature of healthcare, where GEO Group may face significant financial penalties for failure to achieve certain KPIs, which incentivises a reduction in quality.

The Cultural Review made a number of recommendations (endorsed by Yoorrook) relating to monitoring and oversight of health outcomes, including that DJCS:

- Develop an outcomes framework to monitor and report on health outcomes for people in custody, and report publicly against the outcomes framework (including to compare outcomes for people in custody with those of the Victorian community).[259]
- Embed individual responsibility for delivery of more culturally responsive services in key documents, policies and processes, (including position descriptions, contracts and departmental performance measurements) to support clear accountability consistent with existing laws, standards and policies. The performance measures should be developed in conjunction with the AJC and others as part of the development of a community-led framework for a more culturally safe custodial system.[260]

We are concerned that the 2-year Implementation Plan for the Cultural Review does not prioritise the development of a framework to effectively monitoring and report on health outcomes. Until the Department ensures that the new healthcare model will actually improve the quality of healthcare being provided in prisons, the new Healthcare Services Quality Framework is worthless.

Additionally, the Cultural Review recommended that the Government should establish a new independent Inspectorate of Custodial Services including an Aboriginal Inspector of Adult Custodial Services,[261] and take priority action to implement OPCAT.[262] Neither of these reforms have been prioritised in the Implementation Plan, which is a major shortcoming.

[259] *Cultural Review* , Recommendation 6.15. p 78.
[260] Ibid., Recommendation 5.1.
[261] Ibid., Recommendation 2.3.
[262] Ibid., Recommendation 2.4.

RECOMMENDATIONS

Recommendation 47. The Government should transfer oversight and management of prison healthcare from DJCS to the Department of Health (**DH**).

Recommendation 48. The Government should make further changes to the Justice Health and Justice Assurance and Review Office (**JARO**) Death in Custody Reviews, to ensure that they meet the requirements set out in Coronial Recommendation 36 from the Veronica Nelson Inquest. Stakeholders views, including from VALS, should be incorporated into this review process.

Recommendation 49. The Victorian government must urgently revise the system for auditing and scrutiny of custodial healthcare services, to ensure that there is a robust oversight and accountability system for all providers of prison healthcare (both public and private).

Recommendation 50. The Government should significantly reform the system for monitoring prison healthcare services, to ensure that prison healthcare outcomes are the primary mechanism for measuring the delivery of prison healthcare services.

Recommendation 51. Yoorrook should examine Government witnesses regarding implementation of the recommendations from the Cultural Review on oversight and accountability.

Recommendation 52. Yoorrook should request information and data relating to monitoring and oversight of the prison healthcare system including monthly and quarterly reports from GEO Healthcare on health services and health outcomes for Aboriginal people in Victorian prisons, as well as compliance with the *Healthcare Services Quality Framework for Victorian Prison 2023*.

Prison healthcare complaints

The existing system for complaints relating to prison healthcare is inadequate, meaning that many people in custody have little faith in the process.

Individuals who are incarcerated (or who have been incarcerated) can make a complaint to their Unit Manager, the General Manager of the prison, or the health care provider. However, in many cases, this may not be appropriate, if the individual is still incarcerated and is concerned about reprisals or unfair treatment as a result of making a complaint.

Complaints relating to prison healthcare in either public or private prisons can also be made to the following independent bodies[263]:

- Victorian Ombudsman[264]

[263] s. 47(1)(j) Corrections Act provides that people who are incarcerated have "the right to make complaints concerning prison management to the Minister, the Secretary, the Commissioner, the Governor, an independent prison visitor, the Ombudsman, the Health Complaints Commissioner and the Human Rights Commissioner."
[264] Victorian Ombudsman, Dealing with complaints about government (Webpage)

- Health Complaints Commissioner[265]
- Mental Health Complaints Commissioner[266]
- Independent Broad-Based Anti-Corruption Commission (IBAC)[267] which receives complaints and notifications of public sector corruption.

In 2021-2022, the Victorian Ombudsman received more complaints about Corrections Victoria than any other public authority, and healthcare was the most complained about issue within prisons.[268]

However, for individuals who are incarcerated at the time of making a complaint, there are multiple obstacles which deter/prevent individuals from accessing many of these bodies, including limited awareness of complaints processes and limited access to prison legal services.[269] In addition, the high cost of making a phone call from prison also acts as a blocker (only the Ombudsman and VLA has a free call service).

Aside from challenges in accessing complaints processes, another issue that may deter people from making a complaint is the limited outcome from the complaints process. For example, between 2014 and 2022, the Mental Health Complaints Commissioner received more than 12,000 complaints, but did not take compliance action against a single mental healthcare provider.[270] Similarly, the outcome of a complaint submitted to the Victorian Ombudsman may be limited by the lack of enforcement mechanism for the Ombudsman's recommendations.

More robust safeguards against systemic abuses are urgently needed, including an independent complaints system, which is culturally appropriate and can be accessed by people who are incarcerated without fear of reprisals.

Prison complaints, including complaints against private prisons and contractors, should be handled by an appropriately resourced independent oversight body with sufficient powers to refer matters for criminal investigation. The body must be accessible to people in prison and complainants must have adequate legislative protection against reprisals.

As noted above, the Victorian Government should resource a legal service dedicated to providing legal advice and representation for people to prison, and properly resource Aboriginal Legal Services to provide such services to Aboriginal people in prison.

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[265] Health Complaints Commissioner, Make a complaint (Webpage)
[266] Victorian Government, Mental Health & Wellbeing Commission (Webpage, 2024)
[267] IBAC, Report corruption or misconduct (Webpage)
[268] Victorian Ombudsman, *2022 Annual Report* (2022) p. 29.
[269] Fitzroy Legal Service operates a Prison Law Advice Line one day a week; VLA runs a Prisoners Legal Help phone line in 5 prisons (MRC, Port Phillip, DPFC, Loddon and Ravenhall; people in prison can make a free 12 minute call to the service five days a week). VALS runs a prison outreach program. The Mental Health Legal Centre provides civil legal services and other support services to people with cognitive impairment and mental health issues at DPFC and Ravenhall. The Djirra Prison Support Program provides after-hours support for Aboriginal women and focuses on the prevention of family violence.
[270] A. Ore and M. Davey, No action taken against Victorian mental health services despite more than 12,000 complaints The Guardian, (online), (26 May 2022).

RECOMMENDATION

Recommendation 53. Prison complaints, including complaints against private prisons and contractors, should be handled by an appropriately resourced independent oversight body with sufficient powers to refer matters for criminal investigation. The body must be accessible to people in prison and complainants must have adequate legislative protection against reprisals.

Investigate access to healthcare and disability supports in police custody

VALS is concerned that the police custodial healthcare system remains opaque, with limited oversight and accountability. We are also concerned that the mechanisms in place to support persons with a disability whilst in police custody, are not adequate. In the context of the current inquiry into health and healthcare, we strongly recommend that the Yoorrook Justice Commission investigate access to healthcare and disability supports for Aboriginal people in police custody.

Police custodial healthcare

Healthcare in police custody is provided by the Custodial Health Service (**CHS**), which is part of Victoria Police. CHS provides 24/7 clinical care and advice to people held in Melbourne Custody Centre (**MCC**) (operated by private security company G4S), as well as police stations across Victoria. CHS nurses are on site at MCC and custodial nurses can also provide 24/7 advice over the phone via the Custodial Health Advice Line (**CHAL**).[271] Detainees on remand and undergoing sentence can also be transferred to Corrections Victoria at the Security Ward at St Vincent's Hospital.[272]

Access to healthcare for people in police detention facilities is regulated under the *Charter*, as well as the Victorian Police Manual (**VPM**),[273] which provides that members and PCOs who take a person into care or custody must assess the person against the Medical Checklist and obtain medical assistance if required.[274] Further, if the member or PCO determines that there is a high risk of self-harm or suicide, they should transfer the person out of police custody and to an appropriate facility.[275] The VPM also includes guidance on giving medication, transfer to hospital, organising a private medical examination and individuals on OST.[276]

From our practice experience – including both the Custody Notification Service (**CNS**) and the Wirraway Police and Prison Accountability Practice – we have seen the following issues relating to access to healthcare in police custody:

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[271] Victorian Police Manual (VPM) Guidelines, *Safe Management of Persons in police care or custody.*
[272] VPM Guidelines, *Safe Management of Persons in Police Care or Custody*.
[273] VPM Policy Rules, *Persons in Police Care or Custody*; VPM Guidelines, *Safe Management of Persons in Police Care or Custody,* VPM*, Care and control under the Mental Health Act 2022.*
[274] VPM, Guidelines, *Safe management of person in police care or custody*, Section 2.
[275] Ibid., p. 16.
[276] Ibid., pp. 26-29.

- Not being seen by a nurse or doctor and sometimes being left in pain for hours
- An ambulance not being called for a client who required one
- Inappropriate responses to self-harm incidents
- Unsafe and traumatic responses to clients who are withdrawing, including placing the person in a protective cell without clothes and often under surveillance by someone of another gender.
- Lack of cooperation with VALS Custody Notification Officers (**CNOs**) including refusing to respond to questions around whether the client is on medication.

Police custodial healthcare was also examined in the Inquest into the passing of Aunty Tanya Day, who fell and hit her head in a police cell after being detained for public intoxication. The Inquest found that there was minimal evidence of compliance with the Medical Checklist,[277] and recommended Victoria Police implement training regarding the medical risks of individuals affected by alcohol.[278]

RECOMMENDATIONS

Recommendation 54. Yoorrook should investigate the quality of healthcare provided to Aboriginal people detained in police custody, including police stations and the Melbourne Custody Centre (operated by G4S).

Disability supports and adjustments

Despite gaps in publicly available data, it is clear that people with disability experience high rates of police contact, including being detained in police custody. One of the main safeguards for people with disability, is the Independent Third Person (**ITP**) program run by the Office of the Public Advocate (**OPA**). ITPs attend police interviews of people with disability or mental illness, to help them understand the process and their rights. The presence of an ITP depends on both Victoria Police contacting the ITP Service, as well as sufficient capacity within the ITP program.

Currently, the requirement for police to contact an ITP is provided for under the VPM[279] and not legislation. We continue to remain concerned that the ITP service is not always contact by Victoria Police, and that support for persons with a disability during a police interview should be a legislative requirement.[280] Additionally, the OPA has indicated that the ITP program is not adequately resourced to meet demand. The OPA estimates that it does not respond to 10% of requests for an ITP (approx. 42 interviews per month on average, where a person with a disability misses out on ITP service).[281]

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[277] CCoV, Inquest into the death of Tanya Louise Day, 9 April 2020, [281].
[278] Ibid., Recommendation 6.
[279] Victoria Police, Victoria Police Manual (2022)
[280] Centre for Innovative Justice (CIJ) & Jesuit Social Services, *Recognition, Respect and Support: Enabling justice for people with an Acquired Brain Injury* (2018), p 71.
[281] DRC, *Final Report: Volume 8*, (2023), p. 308.

Police responses to people with disability, including in police custody, was examined by the DRC. The DRC recommended that state and territory governments and police services should collaborate with people with disability in the co-design, implementation and evaluation of strategies to improve police responses to people with disability;[282] and that all police services should introduce adequate numbers of dedicated disability liaison officers.[283]

RECOMMENDATIONS

Recommendation 55. The requirement for Independent Third Persons (**ITPs**) to attend police interviews with individuals who have a disability, must be embedded in legislation and adequately resourced.

Recommendation 56. All police officers and prison staff should be required to complete mandatory and regular training on how to interact with people with disabilities, including mental illness.

Increase access to disability supports at court

Since September 2023, VALS has partnered with Melbourne City Mission as part of the Disability Advice Response Team (**DART**) currently being piloted in the Children's Court. DART is being piloted in Dandenong, Melbourne, Geelong, Shepparton and Broadmeadows, with Aboriginal DART workers available in Shepparton and Broadmeadows.[284]

VALS DART Workers can assist Aboriginal people aged 10-18 by:

- Screening for traits of disability and providing advice to Court and relevant supporting staff and family of a young person.
- Providing advice to those who are representing, adjudicating or working with a young person.
- Assisting with some advice on how to make Court processes and matters accessible for the young person where possible and appropriate.
- Supporting Aboriginal young people with a disability to apply for the National Disability Insurance Scheme (**NDIS**).

VALS DART workers accept referrals from anyone working with or familiar with an Aboriginal young person attending Marram-Ngala Ganbu or Children's Court Criminal Division in Shepparton and Broadmeadows.

[282] Ibid., Recommendation 8.20(a)
[283] Ibid., Recommendation 8.20(b).
[284] Melbourne City Mission, Disability Advice Response Team (Webpage).

RECOMMENDATIONS

Recommendation 57. The Victorian Government should support and build on the Disability Advice Response Team (**DART**), currently being piloted in the Children's Court in Dandenong, Geelong, Shepparton, Broadmeadows and Melbourne, to ensure that Aboriginal children with a disability who are involved in the child protection and youth justice systems are supported to access culturally safe disability supports.

Suicide Prevention for people in contact with the criminal legal system

Since 2020, the Coroners Court of Victoria has published four reports on suicides of Aboriginal people, including key data and analysis of trends.[285] VALS is particularly concerned about contact with the criminal legal system as a stressor contributing to suicide. Out of 88 Aboriginal passings by suicide in 2018-2022 that have been analysed by the Coroners Court,[286] 75% of those who passed had contact with Victoria Police in the 12 months prior to passing, 52% had contact with the courts and 33% had contact with Corrections Victoria.[287]

We note that the Balit Durn Durn Centre for SEWB has led the development of an Aboriginal suicide response strategy. We strongly recommend that there is ongoing investment in and support for Aboriginal led solutions to prevent and respond to suicide and self-harm.

RECOMMENDATIONS

Recommendation 58. The Government must invest in and support Aboriginal led solutions to prevent and respond to suicide and self-harm, including for people in contact with the criminal legal system.

Health Injustices in the Child Protection System - implement recommendations from the Inquest into the passing of Sasha

Since submitting our nuther-mooyoop on systemic injustices in the child protection system, the Coroners Court of Victoria has handed down findings and recommendations into the coronial inquest into the passing of Sasha.[288] Sasha passed away in hospital in 2019 whilst in out of home care. At the time of her passing, she was 12 years old. VALS represented Sasha's father in the coronial inquest.

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[285] CCoV, *Suicides of Aboriginal and Torres Strait Islander people: Victoria 2018-2022* (2023); CCoV, *Suicides of Aboriginal and Torres Strait Islander people: Victoria 2018-2022* (2022); CoCV, *Victorian suicides of Aboriginal and Torres Strait Islander people: 2020 end-of-year update* (2021); CCoV, *Victorian suicides of Aboriginal and Torres Strait Islander people* (2020).

[286] In the period 2018-2022, 90 Aboriginal people passed by suicide, however the contextual analysis of stressors of these passings only includes analysis of 88 passings. CCoV, *Suicides of Aboriginal and Torres Strait Islander people: Victoria 2018-2022* (2023), p. 10.

[287] Ibid., p. 13.

[288] CCoV, Inquest into the Death of Sasha, COR 2019 4069, 17 July 2023.

Inquest into the passing of Sasha (pseudonym)[289]

Sasha was first placed in out of home care in 2011 when she was 3 years old. From 2017, she was in the care of her maternal grandparents, subject to a Long-Term Care Order.

In a statement issued in response to the coronial findings, Sash's father stated: *I miss Sasha, she was so bubbly and full of life. We were a big part of each other's lives and always shared a special bond.*[290]

The Coroner found the cause of death to be complications resulting from pneumonia and heart valve infection in the setting of an undiagnosed congenital heart abnormality. Sasha's undiagnosed congenital heart abnormality was the same congenital heart abnormality that her father had been diagnosed with as a child.

The Coroner found that there were gaps in the information gathered by DFFH for children in care, and that the relaying of critical medical information about Sasha were at points delayed, and not communicated effectively. Notably, the Coroner found that there was a delay of more than 9 hours before staff at the Central Gippsland Health Service became aware of critical pathology results.

The Coroner made four recommendations to improve processes in the child protection system, so that DFFH is aware of information about a child's family history, and to improve how Child Protection and contracted agencies manage children in care when they are admitted to hospital:

1. That DFFH review its Child Protection Manual and other relevant policies or guidelines to include guidance to Child Protection practitioners to seek, where possible, familial medical history that may impact the health of a child in its care.
2. That DFFH implement a means of effective urgent communication with its case-contracting agencies, supported by appropriate policy and procedures, in respect of a child in care. The means adopted should be available at all hours and capable of actively alerting the recipient.
3. That DFFH review its Child Protection Manual and other relevant policies or guidelines to make clear to case-contacting agencies, the circumstances in which it expects to urgently receive information concerning a child in care.
4. That the Central Gippsland Health Service take all steps as may be required to eliminate facsimile transmission as the sole means of communication of critical clinical information.

In October 2023, the DFFH Secretary responded to the coronial recommendations, indicating that the Department accepts recommendations 1, 2 and 3 in-principle.[291] The Department is considering the recommendations, including any adverse implications, and expects to implement policy changes by June 2024. The Department of Health is also in the process of implementing recommendation 4.[292]

[289] CCoV, Inquest into the Death of Sasha, COR 2019 4069, 17 July 2023.
[290] VALS, Coronial Inquest into passing of 12-year-old Sasha reveals gaps in child protection and healthcare systems (Webpage, 7 September 2023).
[291] Letter from Peta McCammon, DFFH Secretary, 17 October 2023.
[292] Letter from Euan Wallace, DH Secretary, 6 September 2023.

RECOMMENDATIONS

Recommendation 59. The Victorian Government must urgently implement the recommendations from the Inquest into the passing of Sasha,[293] including to require child protection practitioners to, wherever possible, seek familial medical history that may impact the health of a child in its care.

[293] *Finding into Death Following Inquest,* Inquest into the passing of Sasha, COR 2019 4069, 17 July 2023.

Annex A: VALS relevant policy and research work

Submissions

- Submission to Independent Review of Compulsory Assessment and Treatment
- Submission to the Royal Commission into
- Submissions on behalf of Uncle Percy Lovett
- Submission to the Victorian Ombudsman's Investigation into Prison Healthcare (August 2023)
- Submission to the Consultation on RACGP Standards for Health Services in Australian Prisons (2nd edition) (May 2022)
- Submission to the Department of Health on the Victorian Suicide Prevention and Response Strategy (August 2022)
- Submission to the Cultural Review of the Adult Custodial Corrections System (December 2021)
- Ending human rights abuses in Victorian prisons: Joint Submission to the Cultural Review of the Adult Custodial Corrections System (December 2021)
- Submission to the Parliamentary Inquiry into the Criminal Legal System (2021)
- Submission to the Royal Commission into Victoria's Mental Health System
- Supplementary Submission to the Royal Commission into Victoria's Mental Health System
- Supplementary Submission following public hearing evidence to the Scrutiny of Acts and Regulations Committee Inquiry into the *Charter of Human Rights and Responsibilities Act 2006* (Vic)
- Submission to the Scrutiny of Acts and Regulations Committee (SARC): Review of the Victorian Charter of Human Rights and Responsibilities (2011)

Letters

- Feedback on the Cultural Review of the Adult Custodial Corrections System's Draft Implementation Plan

Webinars

- Webinar, prison healthcare

Community Factsheets

- Community Factsheet, *The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT) (2022)
- Community Factsheet, Inquest into the passing of Veronica Nelson

Annex B: witnesses that Yoorrook should examine in relation to SEWB and the healthcare system

Mental Health

- Minister for Health
- Minister for Mental Health
- Secretary, Department of Health
- Deputy Secretary, Mental Health and Wellbeing
- Chief Commissioner of Police
- Chief Psychiatrist
- Chief Officer for Mental Health and Wellbeing
- Chief Commissioner, Commission for Mental Health and Wellbeing
- Chief Commissioner of Police

Prison healthcare

- CEO, GEO Group
- Justice Health
- Manager, Justice Assurance and Review Office (JARO)

Child Protection

- Minister for Child Protection

Annex C: information, documents and data that Yoorrook should request relating to SEWB and the healthcare system

Documents

- Implementation Plan for the Cultural Review of Adult Custodial Correction System
- Reports to the Aboriginal Justice Caucus (AJC), and the AJC Rehabilitation and Reintegration Collaborative Working Group regarding implementation of recommendations from the Veronica Nelson Inquest.
- Monthly and quarterly reports from GEO Healthcare on health services and health outcomes for Aboriginal people in Victorian prisons, as well as compliance with the *Healthcare Services Quality Framework for Victorian Prison 2023*.

Information and data

Department/ Agency/Individual	Information/ Updates	Deidentified data
Minister for Mental Health	• Update on transition to health-led responses to mental health crises. • Update on Independent Review of Compulsory Treatment, now being carried out the Department. • Update on Victoria's Strategy towards Elimination of Seclusion and Restraint, and the way in which this Strategy will eliminate the use of seclusion and restraint against Aboriginal people in Victoria.	
Department of Health	• Update on transition to health-led responses to mental health crises. • Update on Independent Review of Compulsory Treatment, now being carried out the Department. • Update on Victoria's Strategy towards Elimination of Seclusion and Restraint, and the way in which this Strategy	• The use of restrictive interventions (disaggregated by Aboriginality, age, service provider and geographic location) • Compulsory assessment and treatment orders (disaggregated by Aboriginality, age, service provider and geographic location)

	will eliminate the use of seclusion and restraint against Aboriginal people in Victoria.	• Numbers of Aboriginal women currently incarcerated, and in the previous 12 month, who have been pregnant and given birth while incarcerated, and the antenatal, postnatal and neonatal supports that have been available to them.
Mental Health Tribunal		• Compulsory assessment and treatment orders (disaggregated by Aboriginality, age, service provider and geographic location) • the use of restrictive interventions in Victoria.
Victorian Agency for Health Information		• Compulsory assessment and treatment orders (disaggregated by Aboriginality, age, service provider and geographic location) • The use of restrictive interventions (disaggregated by Aboriginality, age, service provider and geographic location)
Chief Psychiatrist	• Update on Victoria's Strategy towards Elimination of Seclusion and Restraint, and the way in which this Strategy will eliminate the use of seclusion and restraint against Aboriginal people in Victoria.	• The use of restrictive interventions (disaggregated by Aboriginality, age, service provider and geographic location)
Victoria Police		• Exercise of police and PSO powers under the *MHWB Act* (disaggregated by Aboriginality and LGA).
Mental Health and Wellbeing Commission	• Information from the Mental Health and Wellbeing Commission regarding its role and functions[294] as a core component of the oversight and accountability framework, including: - Ensuring that the Government implements recommendations from the RCVMHS.	• Complaints and inquiries over the past 9 years, including the outcomes of complaints (disaggregated by Aboriginality, service provider and geographic location).

[294] Section 415, MHWB Act 2022.

	- Issuing guidance materials about how the mental health and wellbeing principles should be applied; - Monitoring and reporting on the performance, quality and safety of the system, including restrictive interventions and compulsory treatment; - Providing a robust and culturally appropriate complaints process, which leads to culturally appropriate complaints outcomes, where relevant; - Supporting compliance across the sector, by issuing compliance notices where needed; - Conducting own-motion inquiries into systemic issues in the mental health system, including systemic racism.	
Mental Health Complaints Commissioner		• Complaints and inquiries over the past 9 years, including the outcomes of complaints (disaggregated by Aboriginality, service provider and geographic location).
GEO Healthcare	• Provision of culturally safe healthcare by GEO • Health outcomes for Aboriginal people in Victoria's men's public prisons.	•