YOORROOK Justice Commission

TRANSCRIPT OF DAY 9 – PUBLIC HEARING

PROFESSOR ELEANOR A BOURKE AM, Chair
MS SUE-ANNE HUNTER, Commissioner
MR TRAVIS LOVETT, Commissioner
DISTINGUISHED PROFESSOR MAGGIE WALTER, Commissioner
THE HON ANTHONY NORTH KC, Commissioner

MONDAY, 17 JUNE 2024 AT 9.31 AM (AEST)

DAY 9

HEARING BLOCK 7

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<THE HEARING COMMENCED AT 9.31 AM

CHAIR: Good morning, welcome to today's hearing of the Yoorrook Justice Commission. This is a continuation of the historic and ongoing Social Injustices of Victorian First Peoples, Hearing Block 7. To commence I would invite Commissioner Hunter to give a Welcome to Country.

COMMISSIONER HUNTER: Thank you. Chair.

So I would like to acknowledge we are on the lands of the Wurundjeri, my ancestors, acknowledge the Elders and the ancestors that come before us so we are able to have voice here today. I do think this is - today's witnesses will give crucial information about a system - another system that actually doesn't work for us, particularly health and falling behind. So I would encourage those online, 13YARN, if there is distressing information that they have to listen to today. I will acknowledge that Bunjil will watch over us as we conduct Aboriginal business, and this is a safe cultural place to do that. So Wominjeka, come with purpose and welcome to my lands.

CHAIR: Thank you, Commissioner Hunter.

Counsel, may we have appearances?

MS MCLEOD SC: Thank you, Chair, I appear with Ms Fitzgerald and Ms Weinberg with the witnesses today. I thank Commissioner Hunter for her Welcome to Country and for the blessing of her ancestors as we do business here today. I pay my respects to Elders and ancestors and acknowledge the importance of this work to the primary health and wellbeing of Aboriginal people in this State.

MS EVANS: Thank you, my name is Evans. I appear for the State of Victoria with Lachlan Carter for the Department of Health today; Euan Wallace the Secretary to the Department of Health; Ms Jodie Geissler sitting his right, Deputy Secretary to the Department of Health; Clare Looker, Chief Health Officer in the Department of Health.

Thank you, Commissioner Hunter, for your welcome. We acknowledge that today's hearing is held on the lands of the Wurundjeri people of the Kulin Nation. We acknowledge the Traditional Owners of this land, and that sovereignty has never been ceded. We pay respects to Wurundjeri Elders past and present and other Aboriginal Elders of other communities and other First Peoples who are here with us today and watching online. Thank you.

CHAIR: Thank you very much. Thank you.

MS MCLEOD SC: I might start with you, Professor Wallace, could you please state your full name?

PROFESSOR WALLACE: Yes, Euan Morrison Wallace.

MS MCLEOD SC: You are the Secretary of the Department of Health, a role you have held since February 2021?

PROFESSOR WALLACE: I have been in the Secretary role since 2020 what was Department of Human Health and Human Services then Department of Health in 2021.

MS MCLEOD SC: Is the evidence you will give to the Commission today the truth to the best of your knowledge?

PROFESSOR WALLACE: It is.

MS MCLEOD SC: Ms Geissler, I will come to you next, can you please state your full name?

MS GEISSLER: Jodie Geissler.

MS MCLEOD SC: Geissler, I'm sorry. You are the Deputy Secretary for Department of Health, a role you have held since March 2021. Is that correct? And is the evidence you are about to give the truth to the best of your knowledge?

Dr Looker, could you please state your full name?

DR LOOKER: Clare Olivia Ruth Looker.

MS MCLEOD SC: You are Victoria's Chief Health Officer?

DR LOOKER: I am.

MS MCLEOD SC: And you have held that role since 2023?

DR LOOKER: I have.

MS MCLEOD SC: Is the evidence you are about to give to the Commission the truth, to the best of your knowledge?

DR LOOKER: Yes.

MS MCLEOD SC: The Department of Health has prepared a response to a request for information issued by the Commission, which we may go to for some point. Just for the transcript the Doc ID is DOH.0004.0002.0008 and there are a number of annexures, which will be included in this morning's tender bundle.

CHAIR: Thank you, Counsel.

And, welcome.

MS MCLEOD SC: There may be some additional documents, Chair, that I will come to in due course.

CHAIR: Thank you.

MS MCLEOD SC: Professor Wallace, I understand you have some opening remarks you would like to make. Go ahead.

PROFESSOR WALLACE: Yeah. Thank you. Good morning.

Commissioner Hunter, thank you for your Welcome to Country.

Commissioners, thank you for the opportunity for me to appear with my colleagues from the Department of Health before you this morning. I too acknowledge that we meet on the traditional unceded lands of the Wurundjeri Woi Wurrung people. I pay my respects to Commissioner Hunter and Wurundjeri Elders past and present; to other Elders, especially to Bunurong Elders on whose Traditional lands I and my family have always lived since coming to Australia; and to other First Nations peoples present here today and viewing online. I also acknowledge that sovereignty was never ceded.

Commissioners, I acknowledge your leadership in this landmark process and if it pleases the Commission, in the accordance with the preferences of Victorian Aboriginal Community-Controlled Health Organisation, VACCHO this morning I will use the term "Aboriginal people" to respectfully refer to Aboriginal and Torres Strait Islander people.

In doing so I would like to acknowledge the leadership that VACCHO provides us all in the health sector, particularly its CEO, Aunty Jill Gallagher and its Chair, Mr Michael Graham, also CEO of the Victorian Aboriginal Health Service, VAHS. Commissioners, you have heard evidence from both Aunty Jill and from Mick, and from other health leaders from community and from academia. I and my colleagues have listened to that evidence to date carefully and we thank them for it.

More broadly, I also acknowledge the leadership role that Aboriginal Health and Wellbeing Partnership Forum plays in determining the health care priorities for Aboriginal health and wellbeing in our State. And last, I acknowledge and thank you Ms Nicole McCartney, a proud Yorta Yorta woman who is my Chief Aboriginal Health and Wellbeing Advisor. I have learnt much from her team and continue to do so and for that I am most grateful.

I am the Secretary of the Department of Health and I have been in in this role for just over three and a-half years. I am a Scottish Australian; I was born in Scotland. My father's people are from the west of Scotland, near Glasgow. And

my mother was from the Morrison clan originally from the Isle of Lewis, but since the 1700s from Ross and Cromarty in the Scottish Highlands. I migrated to Australia almost 30 years ago with my wife, Karen and then very young family.

The World Health Organisation defines health as a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity. It is a definition that aligns perfectly with the holistic Aboriginal concepts of health and wellbeing, of social and emotional wellbeing as well as physical wellbeing. It is a definition that, in my view should inform and shape health care provision more than it does today.

The enjoyment of the highest possible standard of health is a fundamental human right without distinction of race, culture or religion. There can be no wealth without health, whether that is at an individual level, at the level of community or as a nation. And by "wealth" I mean not just economic wealth, although I do mean economic wealth, but more importantly social and cultural wealth. You have already heard from others about the social determinants of health; the conditions in which people are born, grow, work, live and age and how since colonisation Aboriginal people have been malevolently and persistently disadvantaged in manners that have purposefully prevented them from being able to remotely enjoy their best possible health.

The forced removal of Aboriginal people from their Country and their family and their culture, and the first removal of language from them, actions seeking not just to diminish Aboriginal people but to erase them and actions that fundamentally undermine health and wellbeing in a transgenerational manner. The traumas experienced by past generations remain visible today through the poorer health outcomes of their descendants, and there are both biological and social explanations for that transgenerational impact.

Shamefully you have already heard that health services, the very services that should be providing care for you, have been complicit in many of those actions, in the past and today. Aboriginal people are denied access to health care, being forced to give birth on hospital verandahs and coloniser/settler health care that is not fit for purpose for Aboriginal people, Commissioner, as you referenced in your welcome. To use Aunty Jill's phrase, "A cultural arrogance in health care provision" that has without thought or care, disrespectfully swept aside traditional ways of health and wellbeing.

You have heard that even today some Aboriginal people are denied the care they need, that they experience racism in our mainstream health services and that our services are still not safe places for many. I am sorry and this must change. Set against those failings of mainstream health care, we have also heard about the successes and effectiveness of Aboriginal-led health services. We may get to discuss some of that in more detail later this morning.

I am committed to placing more Aboriginal health care in Aboriginal hands, not just because it is the right thing although it is the right thing, but because it works. So I and my colleagues are here to listen and to learn, but also to provide you as best we can with the information and insights that you need for your deliberations. I have spent my entire career in health care, nearly 30 years of that in the place that we now call Victoria. Victoria has one of the best health care systems in the world.

We have among the best population health outcomes in the world. That those are not equally shared and enjoyed by the state's First Peoples, is unacceptable. And for that I am both sorry and I am committed to the necessary change. Thank you.

MS MCLEOD SC: Ms Geissler, would you like to make some opening remarks as well?

MS GEISSLER: Thank you, Commissioner Hunter, for your Welcome to Country.

I would like to pay my respects of the Traditional Owners of the land on which we gather today, the lands of the Wurundjeri people of the Kulin Nation and acknowledge that sovereignty has never been ceded. I pay respects to Elders past and present to First Nations people in the room including my colleagues and the staff of the Commission, and to those watching online.

I too thank you, Commissioners, for allowing me to participate today.

I want to take the opportunity to also acknowledge the evidence provided by many First Nations people about experiences in our hospitals and health services, evidence that clearly demonstrates that hospitals have not been places of care and healing for many First Nations people. The history of hospitals being part of forced removal of children, the continued experiences of discrimination and racism. Health care that does not acknowledge First Nations ways of knowing, being and doing and the impact that this has on health outcomes.

I also acknowledge the work, the hard work of Aboriginal health care workers across the system and that of ACCOs to provide care that is inclusive of social and emotional wellbeing. This evidence and this process of truth-telling is of deep importance to my division and the Department to deliver the required change in the hopes expressed and for self-determination.

MS MCLEOD SC: Dr Looker, do you have an opening statement you would like to make as well?

DR LOOKER: I do. Thank you.

Thank you again, Commissioner Hunter, for your welcome.

I would also like to acknowledge that we are meeting on the lands of the Wurundjeri people of the Kulin Nation and that the sovereignty of these lands has never been ceded. I pay my respects to their Elders, to other Elders in the room and also to other First Peoples in the room who are joining us here or online.

I also acknowledge the critical contribution made by Aboriginal colleagues and Professor Wallace mentioned particularly Nicole McCartney and her team to our work in the Department and also across the health sector more broadly. And I thank you for the opportunity to participate today. I recognise it is a great privilege to be part of this truth-telling process and I am also committed to the opportunities for change that it brings. Thank you.

MS MCLEOD SC: Thank you, Commissioners. We acknowledge that Ms McCartney is in the room as well. Thank you. Can I just start with a few sort of organisational questions?

Professor Wallace, you are an obstetrician and gynaecologist by training.

PROFESSOR WALLACE: I am.

MS MCLEOD SC: And you had an extensive period of clinical practice and clinical leadership in that field?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: You are also an academic researcher particularly in issues around pregnancy and foetal development?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: You were seconded to the Department in 2020 to assist with the management of the pandemic, correct?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: And prior to that you were working in your academic research, so you have a special interest in maternity health and the health of the unborn child?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: How has that special interest informed your approach to your role as Secretary of the Department?

PROFESSOR WALLACE: I think – so thank you. I joined government in 2017, so leaving clinical practice in 2017 when I joined Safer Care Victoria as CEO. And then as you say in July 2020 was seconded, sort of self-seconded from

Safer Care to the Department to help with the pandemic response. I mean, my entire clinical career, I think it probably matters not that it was an obstetrics and gynaecology, although it has been a privilege that it has been in obstetrics and gynaecology. It has informed, you know, my entire philosophy around what health care is about and I tried to bring some of that to Safer Care when we established Safer Care in January 2017.

One of our mantras if you like, but it was in our DNA when we set Safer Care up, was patient first and last. It was all about my clinical experience, shaping my own views of what health care is about. There is no healthcare without care. And that requires having the needs of the patient or customer, client and their family first and foremost.

MS MCLEOD SC: Do have you a special interest in women's health, maternal health?

PROFESSOR WALLACE: Yes, I do, yes.

MS MCLEOD SC: And does that affect the way you approach those issues of women's health within the Department?

PROFESSOR WALLACE: Well, as Secretary my role is to ensure that the needs of our entire population are best met. Of course, I have a bias because of my professional background in women's health. I think women's health more broadly has not received the attention that it should have done, over a very long period of time, not just in Victoria, not just in Australia, but worldwide.

I think globally now we are seeing, rightly, increased attention to matters of women's health, not just in maternity and pregnancy but women's health more broadly. The fact that women who present with a heart attack are less likely to receive the care that they should simply because they are a woman and because the symptoms present differently, and the outcomes are significantly worse than they are for men. So much of that work in the Department is actually led by Ms Geissler and Professor Zoe Wainer, who is the Deputy Secretary of Community and Public Health and in whose division the women's health team is largely based.

MS MCLEOD SC: You have acknowledged publicly elsewhere that women's health requirements have not and are not adequately met today. Is that still the case?

PROFESSOR WALLACE: Yes, I think that is still the case.

MS MCLEOD SC: What is missing in terms of women's health?

PROFESSOR WALLACE: So much. I think fundamentally at its core I think the health systems globally haven't listened to women. Last week, the minister and I were in Adelaide for a Health Minister's meeting, but last Friday morning

was the launch of pelvic pain work that the minister is leading with Professor Zoe Wainer and her team. It is fundamentally about listening to women in ways that the health systems just haven't listened in the past, women with the average time to diagnosis and management of endometriosis of seven to nine years. So women living, trying to work and live in pain for an average of seven to nine years before a diagnosis is made probably at its core, because the health system just hasn't listened to them.

MS MCLEOD SC: So just to get to the heart of that, women are reporting their pain and health care practitioners and others are dismissing the seriousness of that pain and the need to intervene and assist?

PROFESSOR WALLACE: I think there is very strong evidence that that is the case across very much all Western health systems.

MS MCLEOD SC: Yeah. And for Aboriginal women, First Peoples of this State, I suggest that would be compounded because those women are also not listened to in terms of their health issues. Would you agree with that?

PROFESSOR WALLACE: I would agree with that. We don't, in Victoria have explicit evidence of that, but I agree with your proposition that the compounding of being an Aboriginal woman and being a woman is likely to make the voice of that woman heard even less.

COMMISSIONER HUNTER: Would you agree that the women even attempting to come to a Medical Centre would be early rather than late, would not happen?

PROFESSOR WALLACE: Yes, Commissioner, I do agree. Again, we don't have overt, explicit evidence focused on Aboriginal women as opposed to Aboriginal people, but as you know the evidence that Aboriginal people and Victorians - Victorians are not coming forward for health care as soon as they might, had the health care system felt safe and knowingly met their needs. There is very strong evidence for that. You have heard evidence from others, Aunty Jill, from Mick Graham from Professor Ray Lovett from ANU.

But we don't have evidence specifically about Aboriginal women, but I think your proposition of women per se's voices and health care needs have not been heard adequately and Aboriginal voices and needs have not been heard adequately. I would like to compound; I would agree with that.

COMMISSIONER WALTER: Excuse me, Professor. Do you think you should have data relating to Aboriginal women?

PROFESSOR WALLACE: Well, the short answer is yes, and we get to it later this morning. It can be - in health care improvement language there can be an -

you cannot improve what you cannot measure. If we are not measuring then we cannot improve it, so the short answer is yes.

MS MCLEOD SC: Professor, you also have responsibility for our mental health system, correct?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: You have also elsewhere described that system as "broken"?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: Can I ask you to explain the ways in which, in a summary way, the health system is broken?

PROFESSOR WALLACE: And I understand you will hear from a colleague, Ms Katherine Whetton and Minister Stitt later today in a specific mental health hearing. The Royal Commission into Mental Health found that our mental health system was broken and again, fundamentally because it hadn't listened to the voices and the needs of those. Like other Western health care systems, we went through a phase of closing down institutions, trying to provide acute care outside of institutional walls. That was the right thing to do, but we didn't replace it with anything.

So suddenly we had a whole cohort of our community with mental health needs that were no longer met. And the Royal Commission found that, of course, we needed to build additional acute mental health beds and government has been doing that over the last three years. But also about what the Royal Commission coined as the "missing middle"; provide necessary mental health and wellbeing supports for people who didn't need to be admitted to hospital if only they had earlier intervention in the community, and those supports were not available.

And again, under Ms Whetton's leadership and you will hear from her later, government and the Department and sector has been trying to build those supports. But in the same way as we have just discussed for the inadequacies of meeting women's health and wellbeing needs, the inadequacies in meeting mental health and wellbeing needs have, at its core, that we haven't listened.

MS MCLEOD SC: The closure of institutions that you have referred to were the result of revelations or understandings around neglect, abuse, gross violations of human rights of those people detained, sometimes and often involuntarily in those institutions, correct?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: And what you are pointing to as the failure to establish community services to support those people outside the institutions?

PROFESSOR WALLACE: Yes. I mean, we - and look, it was both right and necessary, and if I may tell a story from when I was a medical student, so a medical student in Scotland. I spent my psychiatric rotation, a month in what had been one of those institutions in the borders of Scotland, in Dumfriesshire. And there were old residents in that institution, women in their 80s and 90s who had been placed by authorities in that institution in their 20s, because they fell pregnant out of wedlock and, therefore, they had to be institutionalised.

Those were the sort of measures that health care and legal systems had operated on a century ago, and so there has been a necessary change as our understanding of health care and mental health care, and mental health care practices have evolved and improved. And there is no question that the triggers to the closure of many of these institutions were because of the appalling care, miss-care, mistreatment and fundamental infringements of human rights that went on in those institutions. But also driven by a maturation and an evolution of mental health care itself, you know, what is available to assist and support those with mental health needs.

MS MCLEOD SC: So those closures occurred, correct me if I am wrong, in the 90s, early 2000s?

PROFESSOR WALLACE: No. Look, the timing of the closures in Victoria were probably before I came. I think globally they began much earlier than that in the 70s and 80s. When they finally ended in Victoria I would have to check, probably in the 90s would be the final phase.

MS MCLEOD SC: My point is that we have had since that time, 80s, 90s, to provide the necessary resources and support to the community sector, to take up that responsibility of care for these patients, correct?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: And we are still struggling?

PROFESSOR WALLACE: Yes, and that is what the finding of the Royal Commission was.

MS MCLEOD SC: So, Ms Geissler, can I turn to you now? I might bring up the organisational chart for the Department. So you lead the Hospitals and Health Services Division, reporting directly to the Secretary?

MS GEISSLER: Correct.

MS MCLEOD SC: I don't know how good your eye-sight is looking at the white on pink there, thank you. You have a number of direct reports sitting beneath you?

MS GEISSLER: I do.

MS MCLEOD SC: And you report directly to the Secretary?

MS GEISSLER: I do.

MS MCLEOD SC: Now, your role was formally - the title was Commissioning and Systems?

MS GEISSLER: Commissioning and System Improvement when I first commenced in 2021, yes.

MS MCLEOD SC: Have those same functions now rolled into the new title?

MS GEISSLER: Mostly, but some of them have been absorbed in other parts of the Department. So, for example, I used to look after community health, now Zoe Wainer takes responsibility of that. I used to look after digital health that is moved into an eHealth division.

MS MCLEOD SC: You are not a medico?

MS GEISSLER: I'm not a medico.

MS MCLEOD SC: Or rather a health practitioner via training?

MS GEISSLER: That's correct.

MS MCLEOD SC: As Deputy Secretary for Hospitals and Health Systems what, broadly are your responsibilities?

MS GEISSLER: Yes. So I am responsible for commissioning and performance of all hospitals and health services, including ambulance services and public aged care services. I am also responsible for workforce policy, statewide programs such as cancer and Health Share and major projects, improvement projects around ambulance and emergency care, and access and planned surgery and care.

MS MCLEOD SC: You were formerly the CEO of the Royal Commission into Victoria's Mental Health Systems?

MS GEISSLER: That's correct.

MS MCLEOD SC: So you have a deep understanding of systemic conditions reviewed by the Royal Commission?

MS GEISSLER: I do.

MS MCLEOD SC: And the implementation of the recommendations?

MS GEISSLER: Yes. I am not responsible for the implementation of the recommendations, as the Secretary has indicated. That sits elsewhere in the Department, but I have a deep understanding of the challenges, yes.

MS MCLEOD SC: Do you agree with the Secretary's comments in relation to the brokenness of the mental health system?

MS GEISSLER: I certainly do.

MS MCLEOD SC: Is it any part of your responsibilities and those reporting to you to address mental health issues?

MS GEISSLER: Insofar as the responsibilities, the day-to-day responsibilities sit with my colleague Ms Whetton. But insofar as overall performance structures for the health system, that is my responsibility with my colleagues from the Mental Health Division feeding into those structures, so if I give an example of that if I set up a performance meeting with a particular health service there would be an expectation that colleagues from the Mental Health Division would attend.

MS MCLEOD SC: Okay, thank you. And you have a variety of roles which involve directly engaging with VACCHOs?

MS GEISSLER: Yes (crosstalk). Yes.

MS MCLEOD SC: In your role at the time. That includes addressing issues concerning holistic approaches to health?

MS GEISSLER: Yes.

MS MCLEOD SC: Dr Looker, you sit within this chart as well. I am sorry I can't pick you up, looking at the pink page it must be my -

DR LOOKER: It is in very small font.

MS MCLEOD SC: On the left-hand column, yes. You are just below Zoe Wainer in that left hand box.

DR LOOKER: I am, yes, I think I am the second column across, yes.

MS MCLEOD SC: And do you have independent responsibilities set out in the Public Health and Wellbeing Act as well?

DR LOOKER: I do, yes.

MS MCLEOD SC: Your clinical training is in epidemiology and public health?

DR LOOKER: Correct. Yes.

MS MCLEOD SC: Many of us became familiar with the work of the office of the Chief Health Officer, managing infectious disease, deploying public health policy during the COVID pandemic. You have responsibility for public health, population health systems including evidence gathering, statistical data and evaluations, and the Women's Health and Wellbeing Program?

DR LOOKER: Correct. The Women's Health and Wellbeing Programs sits in the division that I am part of. I lead that, along with other leaders (inaudible).

MS MCLEOD SC: And do you agree with the Secretary's comment in relation to that system being effectively broken and failing?

DR LOOKER: I do, yes.

MS MCLEOD SC: So do you have some independent role that reports directly to government during public health emergencies?

DR LOOKER: I do, yes. So part of my responsibilities are to provide public health and scientific advice to the Minister, Premier, Department, Secretary, of course, and more broadly also to the Victorian community and health sector and I have statutory function enshrined in the Public Health and Wellbeing Act.

MS MCLEOD SC: And just in terms of that responsibility are you always reporting through the Secretary or is there an independent function as well?

DR LOOKER: I typically am reporting through the Secretary, but I do also speak directly with the Minister on matters.

MS MCLEOD SC: So, I may direct the next questions to one or all of you, but please feel free to chime in if you would like to make a contribution.

Professor Wallace, you alluded in your opening statement to the vision of the Department that Victorians are the healthiest in the world and just to use your language you refer to the World Health Organisation's definition of health being a state of complete physical and mental wellbeing not merely the absence of disease and infirmity, which aligns with holistic concepts of health and wellbeing that are familiar to First Peoples and you note:

> "The enjoyment of the highest possible standard of health is a fundamental human right without distinction of race, culture or religion".

We can go to the legislation in a moment, but do you believe the objects of the Health Services Act are up to the task when we compare that to the language of the highest standard of health?

PROFESSOR WALLACE: I think the objects under the Health Services Act lay out, you know, just that, the purpose of health services and the provision of care about ready access to health care for Victorians irrespective of who those needs are, where they live and who they are, and the objects don't set out prescribed standards or goals. I think those are expressed through the strategic plan of the Department, through the performance and management frameworks that we use to work with health services and healthcare providers. I think the short answer to your question is the Health Services Act lays out foundational expectations of health service provision for our state, rather than aspirational expectations.

MS MCLEOD SC: Right. We'll come to that in a moment.

COMMISSIONER HUNTER: Sorry. The Act - has it been updated since 1988?

PROFESSOR WALLACE: Yes, it has Commissioner, yes. So it has a number of amendments, updates over time, the most recent of which was last year, I think, around quality and safety.

COMMISSIONER HUNTER: The Act that I have currently got up and I am assuming it is the current one, if I do a quick find the word "Aboriginal" does not appear once in this Act and we are actually overrepresented in all the criteria. So there is nothing - there is nothing in there.

PROFESSOR WALLACE: And as you may be aware on 1 July coming, so in a couple of weeks' time there is another amendment that will become live both to the Health Services Act and to the Public Health and Wellbeing Act that governs the Chief Health Officer's powers around formal recognition of Aboriginal people in the health care provision. But you are correct, until that amendment, there is not an explicit mention of Aboriginal people in the Health Act.

COMMISSIONER HUNTER: So what will that Act do for the most vulnerable in this country really? What will it do for Victorian Aboriginal people?

PROFESSOR WALLACE: I think the intent of the amendment is to formally recognise Aboriginal people in the Act and ensure - recognise their needs and ensure - the intent is to ensure that Aboriginal health and wellbeing needs are met by health services.

COMMISSIONER HUNTER: Thank you.

MS MCLEOD SC: We might find that legislation in a break just so that we can bring it up for you, Commissioners.

COMMISSIONER HUNTER: Thank you.

MS MCLEOD SC: So can I just go back a step and come to the Act in a moment, because obviously we need to have the Act that is coming in to make this a useful discussion. Your priorities as Secretary of the Department include investment in prevention and early intervention. You have made that point, correct?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: And the delivery of health care in community, in primary care centres and medical practices or at home instead of in hospitals?

PROFESSOR WALLACE: Yes, I mean I think as you know the health care system in Australia is broadly characterised as a two pair system. We have two major funders of health care in Australia, the Commonwealth Government and the State and Territory Governments. And States - if we just confine our comments to Victoria, the State Government is principally responsible for funding State hospitals, public hospitals and health services.

Since they were established in the 1970s under the Federal Whitlam government, the State has also continued to invest in community health services. Whereas the Commonwealth Government is principally responsible for primary care, including community care. But you are correct to say that particularly in recent times the Victorian Government has stepped into funding spaces that may have traditionally been characterised as a Commonwealth space.

So in the recent times, in the last two years they have established 29 so-called primary priority health care centres, because - and not uniquely in Victoria, but because of the fundamental failure of the Primary Health Care space in this country. Inaccessible primary care, because of falling bulk billing rates, et cetera, et cetera. But in part as a reflection of a stagnation in Medicare rebates for items for health care for a decade. Changes that have now happened under this current Federal Government.

But the investment of our government, State Government in primary care is a reflection that without that primary care understandably citizens need to access care, so they come to acute hospitals. The most expensive piece of our health infrastructure and frankly a piece of the health infrastructure that doesn't best serve their needs. Their needs are best served by the GP or by a priority primary care centre, or by community health services or if they are an Aboriginal Victorian by one of our ACCOs.

MS MCLEOD SC: So the investment in primary health care centres are useful for a budgeting resource allocation point of view, but also driven by the interests of patients in recovering at home?

PROFESSOR WALLACE: It is primarily about, exactly that, it is primarily about providing the right care in the right space and for more than half of people

who had been attending our hospital emergency departments that was not the right place for their care. They waited too long to receive care they could get much faster, they are now getting much faster in our PPCCs, in our Priority Primary Care Centres. But more than that, the government has invested in trying to move care that has been traditionally delivered in hospital, out of hospital.

Now, those care pathways have existed for a very long time. In the State, we have had a program called Hospital in the Home or HITH program for a very long time. Over the last two or three years we have expanded that program in something that we call Better at Home, so really asking - investing in the health services, asking them, "What care you provide as an inpatient today that you could provide in someone's home tomorrow?" That program has been enormously successful. Over a million episodes of care and day care has been provided.

So just to elaborate on it, over a million nights a Victorian that has had her head on her own pillow rather than the pillow of a hospital bed, receiving care that yesterday she would have had in hospital, today she gets at home. That isn't primary care, but it is moving care out of hospital to be delivered safely at home. And the feedback from patients and their families is overwhelmingly positive.

So the rates of that care being good or very good are higher than similar care in hospitals. Complication rates like infections and falls are lower, of course, they are at home in their own environment, cared for in part by hospital staff, but also part by those who love them and surround them.

COMMISSIONER HUNTER: Can I - do you have stats on that of how many Aboriginal Victorians have used that program?

PROFESSOR WALLACE: I don't this morning, I will see, Commissioner, if we have stats on that.

COMMISSIONER HUNTER: It sounds like a great program but again, would our people feel safe accessing that having people coming into their home, due to all the issues that we know.

PROFESSOR WALLACE: When we set the program up - and I am mindful that the program is quite young, it is two to three years old. When we set the program up it was about, necessarily, I think at the time it was about providing explicit and additional funding to hospitals to say, "You are providing this care today in your beds, can you now provide that care in the patient's bed at home or in the patient's home?" We haven't fully evaluated the program.

We have done some interim evaluations of the program, which is how I can share the very high rates of satisfaction, but also the very low rates of complications. But one of the things over this past 12 months, in particular, we have been turning our minds to, really triggered by VACCHO and ACCOs, and community health services, could we not be providing that care?

Understandably I think we targeted funding at hospitals to move the care out. I think it is now time to ask the question, "Could there be others providing that care?" And to go to your point, if the care was being provided at the outset by an ACCO or Aboriginal-led provider, is it more likely that that service would be used? I think the short answer is, yes.

COMMISSIONER HUNTER: Yeah. I was going to ask a Medicare question, but you can -

MS MCLEOD SC: Just to understand the pathway there. The hospital - the patient presents with an acute issue or just presents, because they are not presenting to their primary health carer, their GP?

PROFESSOR WALLACE: There are broadly two pathways, I don't want to oversimplify it, there is an acute pathway and sub-acute pathway. The acute pathway is essentially that a patient for whatever reason and through whatever means presents to hospital. It might be through ED, but it might not be through ED. It might be for an elective admission for something. So they're an inpatient and then they get to a point where they are no longer required to be an inpatient. They could now be an outpatient or they still have inpatient-like care, but they can now receive that in the home.

And, look, this is not unique to Victoria. I think other places in the country, but other places in around the world are doing exactly the same. We are really trying to remodel care so that our hospitals are providing care for those who cannot get the care at home and expand the complexity and the scope of the care that yesterday was provided in hospital, but tomorrow could be provided in your own home.

MS MCLEOD SC: That is provided - my question was around the hospitals -

PROFESSOR WALLACE: The hospital staff -

MS MCLEOD SC: The outpatient service.

PROFESSOR WALLACE: It is not so much an outpatient service. It's still - outpatients you typically come through an appointment like you go to your GP, you go to a specialist, and it is a follow up appointment. This is still a continuum of care. The patient is normally admitted to the hospital, except the hospital is now in their home and the care is being provided by the hospital staff.

MS MCLEOD SC: I see.

PROFESSOR WALLACE: To Commissioner Hunter's question, the care could not be provided by someone else to expand the capability and capacity of the system. And we have been challenging that not just by you, Commissioner, but by

VACCHO in the past and also - in recent past, but also by community health care providers. The short answer is, of course, yes. We have a skilled and diverse health and wellbeing workforce, and we need to utilise the full scope of that workforce.

COMMISSIONER HUNTER: I will say we have heard evidence you already admitted it is quite culturally unsafe in the hospitals or using the hospital systems. So just in evaluating that and understanding and I know from - from the Commission hearing evidence, but others that particularly our Elders would like to be at home in their own environment, particularly at those particular last days of life. So I would encourage just from my point of view to look into what that could possibly look like to be held by an ACCO.

MS MCLEOD SC: In terms of the levers that you have for ensuring that hospitals are providing services that are culturally safe, and adhere to anti-racism programs and policies, how do you ensure that hospitals are sending people who are appropriate into people's homes? I have asked that poorly. What are the levers you have as a Department over the conduct of hospitals and their day-to-day business?

PROFESSOR WALLACE: We commission services, we commission the services provided to the hospitals and we have - we have - we ask hospitals - we ask hospitals and health services to sign up to a Statement of Priorities, "These are the services that you will provide for your community." These are - those Statement of Priorities or SOPs are co-signed typically by the board Chair or the Minister, or a senior official in the Department. And supporting those SOPs is a performance management framework that is overseen by Ms Geissler and her division. And if there are deviations from performance standards then we would have conversations with hospitals and health care services.

Ms Geissler's team already have regular meetings with all of our health services to have conversations around performance and challenges and opportunities, but where there is deviation from expected standards then we might have specific meetings.

MS MCLEOD SC: Ms Geissler, can I invite your comment on the efficacy of the Department coming in and saying to the health service providers, the hospitals, “You're not up to scratch?” In terms of central events, in terms of racism in terms of anything else?

MS GEISSLER: Yes. As the Secretary has outlined, we have expectations that we set under the Statement of Priorities and we have measures against those expectations. We have a performance process where we have guidance through the performance management framework about how we can step through when we have a concern about a performance issue. And sometimes when we are discussing qualitative matters around cultural safety historically, we have found it hard to do that in a systematic, thorough, comprehensive way across the State.

COMMISSIONER HUNTER: Sorry to interrupt you. What - is a standard, cultural safety?

MS GEISSLER: Yes. So there's certain - there is priorities within the Statement of Priorities and cultural safety has been in there in the last few years, yep. So we do have - do have processes around looking at the Statement of Priorities, so the qualitative data, qualitative information rather and qualitative data. I am happy to go into that further if it pleases the Commission. But I will say that historically we have had challenges and the Minister's statement responds to that - responds to these challenges in terms of walking through every step of the performance framework with our health services when it comes to cultural safety.

COMMISSIONER HUNTER: Can I - so if someone breaches these standards consistently, like in a hospital, what is the outcome? What happens to the hospital?

MS GEISSLER: So when it comes to - so we have got two measures - probably the easiest way to speak to that is around the qualitative data which is measured. So we have two measures in the Statement of Priorities around - they're called "proxy measures for cultural safety". That goes to, "Did not wait in an emergency department" and, "Left against medical advice." Those are the two measures.

We have data monthly that comes into the Department and health services on those two measures, and we compare Indigenous versus non-Indigenous outcomes. There is an expectation and a target in the Statement of Priorities that there would be 25 per cent improvement year on year by our health services against those targets. We are changing that next year to be no gap, but needless to say that is a mechanism to have a conversation around cultural safety.

We have had cultural safety conversations with health services where we have seen them - the trajectory not heading in the right direction about - regarding those two measures. Have we taken all the steps in the performance framework to remedy those situations? No. No, we haven't.

COMMISSIONER HUNTER: So our people aren't attending, because they are culturally unsafe and there is really no true mechanism to hold anybody accountable for being culturally unsafe. And I am just going to add it was only a month ago I was in hospital with my daughter, and it was really culturally unsafe for me, so I have seen it firsthand. We actually didn't end up getting treatment, because we left early.

So this isn't good enough. Our people are dying because they are not accessing and there is no accountability for anybody or any hospital that doesn't reach this standard. I don't actually expect an answer. I just - we need to do something and it is drastic, like it is crisis point for our people not attending hospitals. I've seen

people not attend and then find out months, maybe years later they've got cancer, and it is just too late.

Things like that are not acceptable for our people. And as you would know, maybe if I call you Euan, our women attending when they are pregnant as well or not seeking treatment. If you don't seek treatment the Department becomes involved. There are all these cascades and flow on effects for not having cultural safety in a hospital.

COMMISSIONER LOVETT: Under the performance targets how much of them are linked to Funding? I am not talking about the Aboriginal targets.

MS GEISSLER: Well, the Statement of Priorities really is - it has a funding component, but it is an overall bucket. It is not broken down against each performance expectation.

COMMISSIONER LOVETT: So if a hospital doesn't deliver on the Statement of Expectations, what happens to them?

MS GEISSLER: There are a few levers under the Health Services Act. The most extreme of those would be dismissal of a board or appointment of a delegate. Those are the most extreme. Mostly, what we do is work on remediation plans with health services where we have a deep concern. So we will chart out a course of action. We have done that a couple of times with health services we have been concerned about, those two proxy measures I have mentioned but they haven't gone through to the full, you know, the quite extreme measures, I think, the Minister's powers really, under the Act in terms of dismissal of boards.

COMMISSIONER LOVETT: How much weight do you give cultural safety and racism in this Statement of Expectations? Probably can you link it to tangible review mechanisms rather than personal opinion? Like how much weight do we really give it? Because it doesn't feel - the responses I have heard already today that there is much weight given to it. Yes.

MS GEISSLER: I understand the question. In the statement of - the supporting document of the performance framework has a raft of measures and I think this current financial year there were about 46 measures I think roughly against the quality and safety bucket and two of those - two of those were the cultural safety measures. And I will get you the specific numbers if we have a break.

But we have condensed the priorities significantly in this most recent Statement of Priorities as we head into next financial year, because a long list of expectations doesn't allow us to distil properly the conversations that we should be having. So we will still have those proxy measures heading into next year but they will be in a much shorter list of expectations.

COMMISSIONER LOVETT: With respect that doesn't answer the question on how much weight they are given. I am hearing a lot about bringing them all together, but I am not getting clarity around how much weight cultural safety is given and racism. We just heard the Commissioner articulate a lived experience here and we have heard hundreds of stories, including my own where my brother was turned away from a hospital and not long after that, because of his experience around cultural safety and racism he died, 42.

So this is deeply personal to all of us, and our people listening in as well. So we are trying to really understand and get clarity from the questions we are asking here. And I think that that is - I am just not feeling or hearing rather than feeling, you know what does accountability look like? If you are the Deputy Secretary tasked with performance and overall delivery on those performance mechanisms then, you know, I am trying to understand how that role can, you know, further drive that, I suppose.

MS GEISSLER: Thank you for the question, I will be happy to respond. I think fundamental to moving forward beyond the technical answer I have given you is the work that VACCHO is currently doing. It is a huge piece of work around how we accredit our hospitals against cultural safety, how we set standards differently. Once that work is complete it will be my responsibility, along with - shared across the Department about how that is implemented. I think that is a very solid pathway forward. It is an enormous piece of work for VACCHO, but once we have that I think the pathway forward is a lot more solid, the conversations and the expectations.

COMMISSIONER LOVETT: Is there funding - I don't need to know the figures, but is there funding to VACCHO to undertake that work and analysis?

MS GEISSLER: I understand there was. I think so, but I would have to -

COMMISSIONER LOVETT: I would like to get that, thank you.

COMMISSIONER HUNTER: How far is that work along?

MS GEISSLER: I think there is draft - there are draft documents and I think there are conversations occurring between my colleagues in the Department and VACCHO in those documents.

MS MCLEOD SC: Just coming back to the accountability architecture, Safer Care Victoria is the agency responsible for health care quality and safety, correct?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: They assist health services to learn and prevent patient harm, correct?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: And there is a system of reviewing of sentinel events, which are defined. Hospitals and others have to report those sentinel events to Safer Care Victoria. And then there should be an accountability piece where families or next of kin in the case of a patient passing are informed about the outcome of that review, correct?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: If a family was not informed about the outcome or there was an unsatisfactory response from their point of view where do they go next?

PROFESSOR WALLACE: If I may, I might just step back for a moment to explain the sentinel event reporting in the program.

MS MCLEOD SC: Yes.

PROFESSOR WALLACE: It is a program. So a sentinel event is defined nationally by the Australian Commission Health Care Quality and Safety. Victoria has its own additional category so an additional - in addition to the national categories Victoria has an additional category as a catch-all. They are meant to represent the most serious adverse events in health care delivery in our state. About 80 - in about 80 per cent of cases the patient doesn't survive whatever the event was, just to give you a sense of how serious these events are.

MS MCLEOD SC: And the other 20 per cent are serious injury or harm?

PROFESSOR WALLACE: Well, serious harm, yes. When Safer Care was established in 2017 rightly the sentinel event program transferred from the Department proper into Safer Care and since 2017 Safer Care has been progressively refreshing and modernising and improving the sentinel program.

One of the - two of the key components of that program of those improvements are assessing - so the reviews, the investigation or the reviews of what led to the event are led by the hospital or the health service where the event happened. So two of the most important, I think, most important initiatives that Safer Care has brought to the sentinel event program is that those reviews now have rigorous and robust quality standards against them.

So when the review is received by Safer Care it assessed the review for its rigor and its quality and will then feedback and work with the health service where the review doesn't look of sufficient quality. And sometimes we will step in and actually do the review itself.

The other significant improvement - and there have been many that Safer Care has done, but the other significant improvement is they have brought the patient and/or

her family to the table with a requirement that is progressively getting traction where the patient or if patient hasn't survived, the family are invited to be part of the review. Now, that is really important, because there are insights provided by the patient or her family that are not then provided by another party.

And it goes to the evidence that the Commissioners heard before about the experiences of the patient that has then driven, you know, their responses to the care that is being provided. And in addition, whether the family or the patient choose to be involved in the review, the review itself is provided to the family.

MS MCLEOD SC: So who does the patient or their family advocate in this circumstance?

PROFESSOR WALLACE: Well, Safer Care is there to ensure that the offers are made for the patients to be involved. If there is dissatisfaction with either the process or the outcome or both, all health services have a patient consumer liaison office or a complaints office. That would be the first port of call for a patient to say, "Look, you know what, I am not satisfied with my care or the outcome of this review" or whatever it was.

Ultimately, of course, the Health Complaints Commission or if it is a mental health issue, the Mental Health and Wellbeing Commissioner, would be an independent resource for patients and/or family and Safer Care itself also takes complaints, and tries to advocate on behalf of the patient or the family.

MS MCLEOD SC: Professor Wallace, I am sure you are aware that when these matters, in the case of a patient dying, go to the Coroner's Court for review the Department has not always been forthcoming in terms of the failure of systems. They don't readily admit the failure of systems. Now, that is not universal, I accept that, but there are many instances where the hospital is defensive, and the hospital staff are defensive of their staff. It might be a natural response, but it is not adequate, is it? It is not acceptable.

PROFESSOR WALLACE: Well, it isn't, I have to say that is not my experience of the current Department.

MS MCLEOD SC: But you acknowledge that has been the position in the past?

PROFESSOR WALLACE: It is possible, yes.

MS MCLEOD SC: And I take it you would direct your staff, you yourself or your deputy secretaries would direct staff to offer all assistance to families and the coroners in those instances.

PROFESSOR WALLACE: Yes. And, indeed, government introduced new legislation around duty of candour to support that explicit point, that it is

important that we are transparent and honest with the patients and families and always, but particularly when things go wrong.

MS MCLEOD SC: Does that duty of candour.

Sorry, Commissioner.

Does that extend to ambulance and policing services as well where there is an interaction with the health system?

PROFESSOR WALLACE: It doesn't extend to police.

COMMISSIONER HUNTER: Can I just ask, and you would know the system better than I would, my understanding is when there is a death there is also an internal process that is done with hospitals, but that is never released to the public or to the patient's family.

PROFESSOR WALLACE: The intent, Commissioner, of two things, first the duty of candour legislation I have just referred to is that that information would be provided. The expectation is that health services - hospitals and health services share information openly and transparently with patients and families. And secondly, that one of those improvements to that sentinel event program where the very formal investigation - it is called a root cause analysis that RCA process - that the findings of that are shared. Not just they are shared, but the patient and or the family are given the opportunity to be involved in the RCA, to hear their voice and then the outcomes are shared with the family when the investigation is complete.

Now, I acknowledge that we are starting from a very low base. That has not been widespread practice. I mean it has been practised in some places and - but it has not been widespread practice, which is why in part the duty of candour legislation was brought forward by the Department and Safer Care.

COMMISSIONER HUNTER: Also with complaints do we have - do you have numbers around complaints for Aboriginal people?

PROFESSOR WALLACE: Yes, we do.

COMMISSIONER HUNTER: Okay. If we could get hold of them that would be great. I just think every system we are our people are not encouraged in a State system or feel confident that they can complain or put a complaint in, or that it will even be answered or responded to.

MS MCLEOD SC: Is the sharing of deidentified data by the Health Services Commissioner and Mental Health Complaints Commissioner with the Department.

PROFESSOR WALLACE: Yeah. Both - both mental health - well, there is formal sharing. Both the Commissions and Commissioners, they publish annual

reports on complaints. And, actually, while I was at Safer Care we did some work with the Health Complaints Commission around trying to unify, trying to share the complaints thematic descriptions, so that we can track trends and complaints, using same, sort of, analytical processes. So when the Commission sees an increase in one particular cause of complaints we can see - it is reflected in our own systems.

So both Commissions publish annual reports that provide deidentified summary data. And Safer Care and the complaints commissions, under other agencies in our health care ecosystem like AHPRA, like VMIA, the public hospital insurer, et cetera, share information and deidentified manners so that they get more timely awareness if you think there are issues going on in a particular service or across the system.

MS MCLEOD SC: So there is an ability to analyse that data for themes emerging, for example, if there is a persistent complaint or a number of complaints over time of racism in delivery of health services you would be able to pick that up?

PROFESSOR WALLACE: That is the intent. Actually, when I was at Safer Care we had our PhD student, he was a medical student, a PhD student at the time, a clinician called Ben Nowotny who is now, a trainee in obstetrics gynaecology through Monash. He did a beautiful piece of work trying to develop predictors of system failures, and actually reran data collected out of a health service failure in the State. And one of the potential predictors of future failure that Ben found in his paper, in this study that he published was a rise in complaints that predated the public awareness or the system awareness of failure by a number of years.

So the intent of information sharing is to do exactly as you have suggested, is to get forewarning of something that looks amiss here. Not just to give early detection of a failure, but actually to prevent the failure in the first place.

MS MCLEOD SC: Is that happening now?

PROFESSOR WALLACE: Yes.

COMMISSIONER HUNTER: Could I just say that most Aboriginal people would not complain to a government system, so whatever there is, is probably an underreporting. Do have you a mechanism which goes through for First Peoples in this State to make a complaint that is safe for them to do so?

PROFESSOR WALLACE: No, we don't and I agree with you, that, "Why would I complain when I am not listened to or I am dismissed", or – so it is something actually that Nicole McCartney and I have been discussing over the last 12 months or more. What would a dedicated Aboriginal complaint process look like for our State's health system? And how could we enact that?

So we are certainly doing the thinking about it, Commissioner. We don't have it. Have we acted? Yes. Have we started building something? We haven't. But there are ready-made facilities that we could adopt and dedicate to an Aboriginal complaints process that could be fit for purpose for the State.

COMMISSIONER HUNTER: I would suggest that is probably a really high, maybe recommendation that we will make, because if people have an opportunity to complain and they are going into the system they are more likely to use a system where they feel safe enough to make a complaint. And it actually makes it easier for yourself, because the place becomes more culturally safe in the first place and once you understand what those complaints actually are and where they are pointed it makes it safer for everybody in the system.

COMMISSIONER LOVETT: I think just from my point of view I think just crack on and get it done now. You don't have to wait for the recommendations of Yoorrook. Crack on, you are already doing some thinking. Let's turn it into the tangible changes that are required. That is not to take away that recommendations may be made, but you don't have to wait.

MS MCLEOD SC: Ms Geissler, can I ask you about the levers that you mentioned before to Commissioner Lovett? These include dismissal of boards, appointment of administrators or delegates, you said. You also mentioned ministerial directions, the Secretary can also issue directions to health services, correct?

MS GEISSLER: That's correct.

MS MCLEOD SC: And at the extreme end there is a possibility of censure for appointment of a delegate to a board.

MS GEISSLER: That's correct.

MS MCLEOD SC: And I think you said you used that twice?

MS GEISSLER: Look, those measures are very, very rarely used. They haven't been used in my time for cultural safety purposes. Delegates are appointed to boards for a variety of different reasons and have been over many years, but administrators and dismissal of boards is a very, very rare event.

MS MCLEOD SC: Given how rarely they are used and given that you are not the employer or operator of these health services, the State is not the operator, are there effective means for dealing with the issues with these hospitals and other boards?

MS GEISSLER: Look, I think that is a very important question. There are ways and if I think about particular issues we have had with health services, there are ways we can remediate a situation. So we can send in independent teams to help a

health service remediate a particular performance issue they have. And I think this is definitely part of - this is part - it is actually one of the most powerful tools we have, because it's a process of improvement in a health setting.

I think as part of the accreditation standards work that VACCHO is doing, there will be a process inherent or necessary out of that about how you - how a health service will move through accreditation, if it fails an accreditation process, how that will be remediated. That work as I said, is still ongoing. So the nuts and bolts of how that remediation would work are yet to be resolved, but I think there is an opportunity there.

PROFESSOR WALLACE: For me then it goes to Commissioner Lovett's question before about the weight that is placed on these measures. So since 2019-'20 cultural safety has been in the Statement of Priorities. But the work that we have asked VACCHO to do around the cultural safety standard is to elevate that, so essentially to get s list of prescribed standards on which the (inaudible) accreditation is based. That elevates the importance, if you like of the - of cultural safety as a necessary component of health care delivery.

MS MCLEOD SC: And as he also asked, you don't need to wait for that, you could initiate that work now.

PROFESSOR WALLACE: We are not waiting. So VACCHO is delivering as Ms Geissler said and the Commissioners have been aware. VACCHO is already working on those cultural standards for us.

MS MCLEOD SC: I might turn to the current legislation.

The Health Services Act if we can bring that up on the screen, please, Section 9.

So while that is coming up - actually before I turn to that, I might ask - I might ask about the COVID response just to bring you into the conversation, Dr Looker. The state emerged from the pandemic with a significant backlog of deferred care, correct?

DR LOOKER: Correct, yes.

MS MCLEOD SC: And clinics were closed, surgeries were ceased for a period of time. Vital services continued, but under extreme pressure both in terms of delivery of health care and upon the health care workforce, correct?

DR LOOKER: Yes, indeed.

MS MCLEOD SC: And the burden of that deferred care including deferred surgical interventions continues to this day, correct?

DR LOOKER: That is true, yes.

MS MCLEOD SC: I guess you would say ware not out of the woods yet in terms of the pandemic, are we?

DR LOOKER: No, we are not, no.

MS MCLEOD SC: So that burden of deferred care and burden on the health workforce, which - who are presumably all exhausted from the response to the pandemic, continues to this day and there is a vital need to investment heavily in the health care workforce. Do you agree?

DR LOOKER: I would, yes.

MS MCLEOD SC: Did the pandemic response draw resources away from other aspects of the Department's work?

DR LOOKER: It did definitely within the Department and also more proudly across the health Secretary sector, yes.

MS MCLEOD SC: What were the areas that suffered?

DR LOOKER: So I think was a pivoting within the Department. There was a pivoting of staff resource and attention to - to according to what risk lay in front of us, which at that stage was assessed most greatly as being the pandemic. That meant we had reduced staffing on our - in my area, on our broader health protection functions, which is responding to other infectious diseases, responding to environmental health hazards. Also reduced attention to ongoing work in the health promotion space, the health prevention space, the work that we do driving that both from the Department but also across the sector.

MS MCLEOD SC: So COVID is the new normal. We are now in a work space where - in a reality where COVID is with us, and those deferred care instances of delivery of services, deferred surgical intervention, all of those things, we are still going to be playing catch up for a long time, agreed?

DR LOOKER: I think that is fair. I would reflect, I think that obviously our health systems have evolved significantly and in how they respond to COVID. So whilst we do still have persistent high levels of transmission across the community and we are experiencing that particularly in the last couple of months, I think there is less focused resource required on COVID, I think it is better absorbed alongside other business as usual.

MS MCLEOD SC: Professor Wallace, you might want to jump in here as well, I was going to ask you about the measures of the Department where the Department did not perform well, as set out in your annual reports.

PROFESSOR WALLACE: Yeah. So in terms of catchup, there are two components to that. One is to ensure that there been additional resources, health care resources, available to provide catchup care and government provided specific funding, for example, for planned surgery recovery. And in this current financial year the State would have delivered - the State's hospitals and health services would have delivered more surgery than it ever has done in this history, around 40 or 50,000 more procedures collectively than it has ever done in the State's history. And it has seen the planned surgery waiting list fall from nearly 90,000 to 50,000 over two years, an extraordinary effort by hospitals and health services.

That is about health care provision and that will be appropriately slowly wound back as catchup has been delivered. But the other bit is that, and Cancer Council have commented on this independently, the other bit is that appropriately and necessarily people didn't come forward for care during the pandemic for lots of reasons. That tail of people still not coming forward, so-called self-deferred care, but these are not conscious decisions if you understand, that will be a long tail. And I think the Cancer Council have commented that there are some 3 or 4,000 cancer diagnoses that we don't know about yet that in normal times would have been evident. So there is that catchup care, but it goes to previous points.

Commissioner Hunter, whether it is an Aboriginal person or non-Indigenous person, they need to feel safe to come forward to access care, so there are two bits to the catchup.

You are phrasing - you are quite right your phrasing of COVID is now the new normal. We have something like 300 people in hospital today in Victoria with COVID. We knew that back in 2021 when it was clear the pandemic was going to be an enduring phenomenon for us and for the world. We started planning back then around how do we create - I thought back then it would be - we would need 500 additional beds. I remember saying to Ms Geissler in the division, "Build me 500 new beds" virtually and we have referenced the Better at Home program before.

The Better at Home program operating today is currently the equivalent to the size of a - equivalent to a hospital the size of Royal Melbourne Hospital. So effectively, by moving care out of hospital we have created new beds without actually having to build new beds, if that makes sense. Because we are anticipating that COVID will be an enduring feature of our health care system and we need to build extra capacity for it.

MS MCLEOD SC: It sounds too good to be true, I have to say, because it depends in large part as Commissioner Hunter was saying on people being willing to have health care workers in their home, delivering services to them. There has to be that level of trust in the services provided, correct?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: And while it might have a significant cost relief impact unless those moneys are being invested into VACCHOs and the Aboriginal-Controlled Health Services then there will be potential for another inequality there.

PROFESSOR WALLACE: Yes, it is - it is less about - so what has driven programs like Better at Home was not about cost relief so much. It was about "right care right place", so what care could we deliver at home where people want to be. None of us want to be in hospital, where they want to be. And the quality of the care as experienced and reported by the user by the patient and the family looks higher than it is for like care in hospital.

So it wasn't about cost savings. It was about increasing capacity and capability of the system, delivering the right care in the right place. But you are absolutely right. If that care, whether it is in hospital or at home is not seen as safe then patients aren't going to use it.

MS MCLEOD SC: Just looping back to the COVID response. Dr Looker, the Department worked cooperatively and very successfully with VACCHO during the pandemic, correct?

DR LOOKER: Correct, yes.

MS MCLEOD SC: And, in fact, there have been plaudits internationally for the work that occurred in First Peoples communities in terms of their response to COVID, correct?

DR LOOKER: Definitely.

MS MCLEOD SC: So what was the winning formula there?

DR LOOKER: Look, I think from my perspective there were many reasons for that success really driven by the Victorian First Peoples of Victoria. I would say five things, limit myself to that. Firstly, this is my reflection, was the preexisting strength and agility and capability that existed in the community-controlled organisations, I think to recognise that there was a novel and very different threat to community and the risk that that proposed, particularly for First Peoples in Victoria. So I think there was that initial recognition from community.

Secondly, I think First Peoples' very implicit understanding of the holistic approach to health meant that the community-controlled sector and community more broadly was much quicker to realise the need for wrap around supports for not only people who had COVID, but their families and the community more broadly. I don't think we were as quick to recognise that more broadly across the Victorian population and, in fact, I think we learnt a lot from what we saw happening and being driven by community-controlled organisations.

I think there was a strong mechanism for coordination between and collaboration between government and the Aboriginal health sector. There was the establishment of the COVID-19 Joint Community Taskforce quite early in the pandemic, in March 2020. That became a key forum to share reflections about the pace that the - the nature of the pandemic as it unfolded to draw attention to where there was a need for priority actions and to advocate to get further resource directed at those.

Fourthly, decision-making and resource was handed - was in the hands of community much more than it is for many of our other programs and I think that in my mind that is a much more self-determined process than is always used. And I think was key to success. Then I think finally a key element of the pandemic response was around communications, community engagement, making sure that all the Victorian community understood the health messaging, the changing nature of testing, vaccination, and we saw that particularly well delivered to First Peoples communities.

So the communications were - there was an opportunity for that to be designed and led and implemented by community-controlled organisations and directly informed by their experiences and what they were hearing were concerns on the ground. And I think we saw the fruits of that in much lower rates - the fruits of all of those things but in much lower rates of transmission, particularly in 2020, free vaccine being available but also in the rate of vaccine uptake across First Peoples in Victoria, which was higher than we saw elsewhere in the country and, you know, quite standout really.

COMMISSIONER HUNTER: Would you agree that is - that the majority of what happened there was true self-determination for Aboriginal people?

DR LOOKER: Yes, I would, yes.

COMMISSIONER HUNTER: Yes, did that work?

DR LOOKER: Yes. It did.

COMMISSIONER HUNTER: What was funding like for First Peoples during that time?

DR LOOKER: So there were different funding mechanisms. There was targeted response and recovery money related to COVID and COVID funds for specific pieces of work. There was also as Professor Wallace has referenced, the usual funding mechanisms as well that are delivered both from the Commonwealth and the State.

COMMISSIONER HUNTER: What was - I guess what was the strain put on in reporting back? Because we know with funding, without going into all the other

funding and we'll probably get into that later and the - what was it like around COVID having to report all this? I will just say that we have heard from several ACCOs across the state that they left like they had this bucket of money go, "Here you go" and they were able to save their people and they had these great outcomes. But I don't feel like we have learnt from that, that experience.

PROFESSOR WALLACE: I think we have learned. Have we learned sufficiently? Probably not. But your characterisation is correct. We were at war, weren't we? As a nation, we were at war with the virus and we recognised that to fight this war effectively we had to give the weapons to the hands of the people who needed it most, and let them manage it. And in the context of our Aboriginal communities you are right, they were given dedicated funding as Dr Looker said, without the myriad of reporting lines that you have heard from Aunty Jill and Mick and others that are a burden of delivery of - getting in the way of health and wellbeing care and the other thing was it was framed positively.

There was not this negative Indigenous framing. It was - the vaccine program was 'Stronger Together'. There was that I was annoyed when the vaccine program for Aboriginal people created this community unity immunity thing, because it was a brilliant banner for community. We should have been applying it to the whole of the state. And the Bunjil assets, the artistic assets particularly for our children, first and foremost our Aboriginal children, but actually non-Indigenous children loved coming to our vaccination centres where we had the Bunjil assets and the art artwork.

You are right. I think we have learned. Have we learned sufficiently? That is for others to judge I think and the Commission to judge. We have learned. I think some of the most recent investments over the last couple of budgets, around - two budgets ago around the urgent care pathways, the funding for prevention, early intervention, for health checks to ACCOs specifically, for them to shape exactly what the interventions are. We have not determined exactly what we will do with multi-year funding, without the myriad of reporting lines. I think we have learned. But have we learned sufficiently? I think that is for others to judge and probably not yet, but we have learned.

COMMISSIONER WALTER: And look, I guess it is the frustration of this Commission, because we have department after department coming to speak with us. Health, education housing, justice, all of them. All of them say they have learned. All of them say they know what to do. All of them have frameworks and strategies in place. None of which are being monitored or delivering and haven't over 20 years.

So the frustration is hearing again and again that the evidence is there, the evidence for how to improve health, education, housing, justice, is all there, yet it is not being done. We are always being told that we are at the start of doing something, but doing something hasn't happened yet. So having said you have learned, I am really keen to hear what are the concrete steps.

And we also have been told we have got more pilots than Qantas. We have pilot after pilot, after pilot. And I think we have, you know, had more frameworks than Bunnings. Where are we going to get something where the rubber actually hits the road and self-determination, as is proven to be effective, is actually delivered?

PROFESSOR WALLACE: I think from my own Department we have heard - I think the Partnership Forum for us has been fundamental to how we plan and invest in Aboriginal health. Again, I reference the urgent care pathway investment from the budget one year ago. That was a self-determined investment. So through the Partnership Forum very strong voices from ACCOs around, "This is what you need to be investing in" and we have done that and we have done it in a manner and we may get to it in further conversations around funding.

But we have done it in the manner which is not about single year budgets funding lots of widgets. It's multi-year. We have in partnership with VACCHO, through the Partnership Forum and led by Nicole McCartney, Ms McCartney and her team and the Department more broadly, we have begun a four-phase program around changing how we fund Aboriginal health and wellbeing not just uniquely through VACCHO but through ACCOs. Multi-year funding, outcomes based rather than widgets.

Trying to remove the burden of reporting that we hear very strongly from the ACCOs that is getting in the way of health care or health and wellbeing care and delivery. So we have moved to multi-year funding and the next phase is progressively to remove the reporting burden. So I think we have heard and we are acting, it may not be fast enough for some, I acknowledge that.

COMMISSIONER LOVETT: Self-determination you are talking about. How - have you involved the ACCOs in the development of the budget bid? You are talking about the outcome of the budget bid process, but did you involve the ACCOs in the development and the design of the budget bid before it went to Cabinet? Obviously Mob don't have a say in the Cabinet process, neither do you. But I am trying to understand if we are talking about self-determination did you involve them in it? Yes or no?

PROFESSOR WALLACE: Yes.

COMMISSIONER LOVETT: Okay. And what - you are talking about resources that you have transferred over, but what power - what systematic power have you transferred over to ACCOs in self-determination?

PROFESSOR WALLACE: In the context of investment there are no budget bids going in from my Department on Aboriginal health and wellbeing matters that have not come through the Partnership Forum, that have not been identified by the partnership forum as the priorities for community. And one of the four working groups we have for the Partnership Forum is on funding. Have we got it

singing perfectly? Probably not. And, you know, that budget bids ultimately, the bid itself, the bid case for the bid are Cabinet documents.

COMMISSIONER LOVETT: Yes.

PROFESSOR WALLACE: But in terms of what the priorities are and building those priorities, those are done through the Partnership Forum through the working group and they are determined by community.

COMMISSIONER LOVETT: I guess - thanks for that, and I understand that process. I'm trying to understand what power has been transferred, though, to community in the context of health, health system, health services? Yeah. What power? Is there any power been transferred over? So I get the resource component I with what is you have clearly articulated there, but power, which - yeah.

PROFESSOR WALLACE: Yeah. I guess there are two bits to that probably. One is the partnership, the Health and Wellbeing Partnership Forum for the moment is our peak voice for all matters health and wellbeing for Aboriginal people in Victoria. So that is the Forum in which the decisions are made about "what should health and wellbeing care provision look like for our community?" No one else is making the decisions.

But the second thing is, and it goes to my commitment in my opening statement about my commitment to increasing Aboriginal health care delivery in Aboriginal hands, how do we do that? I will give you just one and it is a tiny granular example, but very early on in my role in 2021 Aunty Jill came to me and said, "Secretary, it is a nonsense that our Aboriginal health practitioners are limited in the vaccines that they can deliver to immunise community."

So we have changed it, we have changed our regulations so that our Aboriginal health practitioners now have a full suite of immunisation authority. So the authority to determine what the priorities are lie with the Forum and the sector. And then I agree, it is up to the Department to then respond to what those priorities are.

COMMISSIONER LOVETT: But the Minister ultimately has overall say in that process, right? If you don't have the delegation it is the Minister who has delegation. Say, for instance the collectively decide that they want something, the governance forum or the partnership forum as you call it, they don't get everything they want I suppose is the point I am trying to make. So they don't have ultimate power and authority.

PROFESSOR WALLACE: Well, that is true and that is true of the whole sector, right.

COMMISSIONER LOVETT: Yeah, that's right.

PROFESSOR WALLACE: And I think that is the journey we are on as a State through Treaty and what will that look like as part of Treaty and what is the role of authorities like the Partnership Forum in Treaty. That will be determined by the First Peoples Assembly and the Treaty process.

COMMISSIONER LOVETT: And whatever recommendations we make.

PROFESSOR WALLACE: And the Commission, yes. And we stand ready to respond to that.

COMMISSIONER LOVETT: It is just got to be really clear from us around - we are trying to understand where self-determination is truly happening true self-determination not components of it. Thank you.

MS MCLEOD SC: Chair, is that a convenient time to take the morning break?

CHAIR: Yes, I think so. Thank you.

MS MCLEOD SC: 10 or 15 minutes?

CHAIR: 15 minutes shall we say. Thank you. We will adjourn for 15 minutes. Thank you.

MS MCLEOD SC: Thank you, Chair.

<THE HEARING ADJOURNED AT 11.09 AM

<THE HEARING RESUMED AT 11.24 AM

CHAIR: (Inaudible) will resume the next session of the Yoorrook Justice Commissioner.

MS MCLEOD SC: Professor Wallace, I just want to come back to something you acknowledged in your opening statement. You acknowledged the traumas experienced by past generations remain visible today because of the poorer health outcomes of their descendants, speaking of First Peoples. And you said this was both in terms of biological and social explanations for intergenerational trauma. Can I just ask you to explain what you mean by that?

PROFESSOR WALLACE: Yeah, of course. The Commission has heard evidence from others already about intergenerational or transgenerational impacts on health and wellbeing, and largely addressed the social aspects and we have touched upon it this morning, principally through Commissioner Hunter, but around Aboriginal people not accessing health care because of not necessarily their own personal experience, but the experiences of their parents or their grandparents or uncles and aunties, et cetera. "Why would I go and have a baby in

hospital if I know that others have had their babies taken away from them?" That is a social aspect.

But there is also a biological aspect and actually the discoverer of this phenomenon is an Australian, Elizabeth Blackburn. She won the Nobel Prize for her discovery of something called a telomer. It's the very end of our chromosomes. It's like a cap that protects the very end of our chromosomes and as we age the length of our telomers get shorter and shorter.

What Elizabeth Blackburn and her laboratory has gone on to show is stress shortens telomers and there is work emerging now that telomers of Indigenous peoples across the world, not just our own, have shorter telomers. So there is a biological - and one of the impacts of shorter telomers is that actually you age and you get diseases earlier in life. And so - and this is an emerging science.

It is a science that I am not - it is not my experience or expertise, but it is clear that there is emerging a sound biological basis for some of the health and wellbeing expressions in Indigenous peoples, plural, across the world but, of course, our own Aboriginal people. And because of the transgenerational trauma, the relentless stress that they live under since colonisation.

COMMISSIONER HUNTER: Sorry, can I just add to that? Dr Michael, I can't remember his surname - he's the Canadian.

MS MCLEOD SC: Michael Mullet.

COMMISSIONER HUNTER: No, another Canadian. Did a Canadian study about being in culture and about meditation and being one and the telomers of First Peoples lengthened, which increased their life expectancy and protected against - which we already know. Culture is also a protective factor for our people. Sorry to give evidence there.

MS MCLEOD SC: So fascinating new areas of science and understanding. You would also be aware of changes to the individual brain chemistry through the impact of stress, cortisol and so on and the impacts that it have on an individual's health and wellbeing.

PROFESSOR WALLACE: Yeah, and not just on the individual. I referenced in opening my own research interests in my past academic life around foetal health. So it is clear that if a pregnant mother is under chronic enduring stress that impacts the wellbeing of her unborn baby and shapes the health of that baby as the baby grows up. This is the so-called foetal origins of adult disease first proposed by David Barker, a scientist in Southampton in England.

The placenta is a highly effective barrier. So the placenta obviously belongs to the baby, to the foetus. It's a very effective barrier against the stress hormones that you referenced, cortisol from the mother. But in an environment of enduring

severe stress the mother is under the placental barrier gets overwhelmed. So maternity cortisol, the stress hormones flood across the placenta and expose the foetus to very high levels of cortisol some when the natural state of the foetus has naturally low rates of cortisol. How does it play out? High blood pressure, high rates of diabetes, high - higher rates of obesity. The very things that we see in First Peoples across the world have these biological bases.

MS MCLEOD SC: So given that intergenerational trauma and the effects on chromosomes and brain chemistry, what does that require of governments in terms of the delivery of health services?

PROFESSOR WALLACE: I think first and foremost it's about an awareness, isn't it. Again, I think you have heard evidence principally from Professor Ray Lovett and also others about how it is framed. It is almost framed at having high blood pressure and diabetes earlier in life is the fault of the individual, rather than an awareness and an understanding that actually there is biology at play here that is out of the control of the individual, that has been handed through generations past.

We know from work from Scandinavia that the diets of the grandmother affect the health of the grandchild through transgenerational effects. So I think first and foremost it's about an awareness that this transgenerational impact that has both biological and social opponents are out of the hands of the individual, community that is alive today. And if we are going to make a difference how do we reverse the effects.

And it goes to - I was not aware of that evidence from Canada that Commissioner Hunter referred to, but we return to the ways of health and wellbeing that are traditional to community, because that is likely to reduce the stress both with a positive impact on today's generation, today's community but definitely on the health outcomes of tomorrow's generations. And that is true for all people.

This isn't something that is peculiar to Indigenous peoples but the stress and the trauma of additional - that First Peoples live under since colonisation is peculiar to them, specific to them.

COMMISSIONER HUNTER: Can I - sorry, Counsel. You have brought it up I will get you to understand it, so it is understood. A mother under stress, pregnant during the times of colonisation and give it say, five generations now, does that still affect that?

PROFESSOR WALLACE: I don't know the answer to that question. It is possible and the work that has led principally out of Scandinavia, not uniquely so, but - the reason Scandinavians have led it is because they have data repositories that link, you know, that link every citizen. So they now have three generations of data on what was the weight of a woman when she was giving birth, what was the

weight of her daughter, what was the weight of that daughter when she was giving birth the next time around, et cetera, et cetera.

So they have some of the more elaborate data systems in health and social outcomes, so they can interrogate in a manner. But in theory the answer is, yes. And there are plenty, I'll call them natural experiments, that show the power of the stress on the mother. The most well written about are when pregnant women are pregnant during times of warfare, the Bulken War, or times of earthquake.

COMMISSIONER HUNTER: I would say colonisation was warfare.

PROFESSOR WALLACE: I was going to come back then to colonisation. So what was the impact on those women and their children and children's children? And to go to your point, the generations there after?

COMMISSIONER HUNTER: Thank you.

MS MCLEOD SC: Profession Wallace, would you agree that that science and that understanding create a positive obligation on the State to do all it can to reverse the harm to First Peoples?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: The physical and mental harm and I might say psychological, culture, spiritual harms? It's incumbent on the State to do all it can to reverse those harms.

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: And do we know from the science how long it takes to observe those changes of reversal?

PROFESSOR WALLACE: I don't know, again, it's not my particular area of expertise. I don't know if it is known. It may well not be, because while this field - the biological component of the field rather than the social component is relatively new and clearly informs proposed interventions, I would not have thought we would have the generation time to see the impact on that intervention in terms of human health and wellbeing outcomes.

Of course, the experimental fields use animal models to study these things and there are models in - animal models in mice, et cetera, that try to model exactly the same thing as mammals to see and there may well be evidence from those experimental studies. It is just not my field of particular expertise.

MS MCLEOD SC: Nevertheless, you would agree it is something we absolutely have to look at?

PROFESSOR WALLACE: Yes, I mean, again -

MS MCLEOD SC: At least a couple of -

PROFESSOR WALLACE: Obtaining the highest standard of health is a fundamental human right.

MS MCLEOD SC: That is the biological. The social, we are talking about social determinates of health. We are talking about housing. We are talking about education. We are talking about -

PROFESSOR WALLACE: Employment.

MS MCLEOD SC: Employment. We are talking about percentage of the population who smoke. We are talking about use of addictive substances. All of those things are critical features of the health of a person and their ability to achieve the highest achievable standard of health, agree?

PROFESSOR WALLACE: Yes.

COMMISSIONER HUNTER: Would you agree with all the - it needs to be a different approach for First Peoples, to health care?

PROFESSOR WALLACE: Yes.

COMMISSIONER HUNTER: So, for instance, a good example is during COVID, during the epidemic. What - and seeing - do you think we need to follow those steps of what was done then to have really good practice for First Peoples in this State?

PROFESSOR WALLACE: Yes, and, you know, I think Commissioner Lovett tried to get that also what was it that was different, what have you learned and I think it is clear and Dr Looker gave examples from COVID about - well, firstly, that it was successful, you know. The highest rate of COVID vaccination rates in Aboriginal people was in this State in the country. That it wasn't an accident. It was health care delivered by Aboriginal people, for Aboriginal people.

How do we apply that lesson to broader health care services? And taking the priorities as determined by the Partnership Forum, which is around prevention and early intervention, not to the exclusion of other things and how do we deliver that? That feels like the sweet spot. It is community-based health care, health and wellbeing care. That feels like the sweet spot for Aboriginal-led providers, the ACCOs principally and others. And we will see improvements in acute outcomes.

It won't be tomorrow or the day after, but in sectors who have done this, not in the First Peoples population, but sectors that have done this that are some standout sectors in the US I think of Intermountain Healthcare system who essentially said

and it was largely for finance reasons, "We cannot afford this journey we are on, with increasing hospitalisations. Let's invest upstream."

They turned around and so they saw a decline of acute hospitalisations of some core outcomes within 12 months and ongoing decline in hospitalisations. "If we treat and management diabetes upstream, we won't need to do amputations downstream." And that care I think is the sweet spot for ACCOs.

COMMISSIONER HUNTER: Would you agree if we get it right for ACCOs we get it right for everybody?

PROFESSOR WALLACE: If you go to - Commissioner, you go to a much broader point and I did sort of reference it in my opening statement about - about the WHO's definition of health, and how that definition, that more holistic definition should shape health care provision more broadly. So the short answer is, yes. And again, it is not - it is not that our health system has fundamentally failed. It hasn't. Evidently it hasn't. It has been a system both in Scotland and in Australia that I have been very privileged and honoured to be part of it.

We have, as whole of population, some of the best health outcomes to the world. But they could be better and they could be particularly better for some of our most disadvantaged populations, particularly our Aboriginal population in Victoria, but others also. And it requires additional spend on those populations and it requires an approach that is fit for those populations which goes to that holistic approach. So how do we listen and say, "Here are some of the issues challenging community. How do we best solve these?" And let's do in a self-determined manner.

MS MCLEOD SC: There are at least a couple of PhDs in this, but if it took five or six generations to damage - the cause of the damage and we don't yet know how long it will take to repair the damage, surely a precautionary and protective approach would require significant investment in that research, and in the work to address both social and biological aspects of intergenerational trauma.

PROFESSOR WALLACE: Yes, if - I think if that is a priority for community and I think, you know, the principal funding agencies for health and medical research in this country NHMRC, MRFF, et cetera, rightly have dedicated Indigenous committees that determine where health and medical research spend should be spent. If that was determined to be a priority for a community through those committees then, yes, I think that is very sensible thing to do.

MS MCLEOD SC: I know it is not your field of expertise, but just so those following can understand, there is a potential to restore health and wellbeing through culture as Commissioner Hunter has pointed out, which can actually change brain chemistry even late in life, agree?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: Do you want to explain those broad mechanics?

PROFESSOR WALLACE: It isn't my field of expertise. I think one of the - and it has been - not intentionally discarded or not disregarded, not intentionally discarded or disregarded by so-called Western health care. But this connection to Country that is profound here, is profound elsewhere.

I have a very - I have a very strong sense of my connection to my - particularly my mother's Country. When we visit the UK with family I always - always visit my mother's Country. It matters to me and as I stand in her Country I feel at peace with myself. That is what community has been telling colonisers, settlers for 200 years. But they have also been telling us that it feeds into their - fundamentally feeds into their health and wellbeing and it is what I referenced, Aunty Jill's cultural arrogance.

We have discarded it and we have discarded it to the penalty of community. And we discarded it to the penalty of health care providers, because I think and again, my whole professional life I have been surrounded by those who seek to provide care. They get up in the morning fundamentally to provide care, to look after people, to look after others to make them better. Our doctors, our nurses, our midwives. I think it - and it goes to the cultural safety training that the Department has been funding through our health services, that is still in its infancy. But I think if our health workforce understood what matters to community it would matter to them. How couldn't it matter to them?

COMMISSIONER LOVETT: What is the role of Secretary in making that happen?

PROFESSOR WALLACE: A lot.

COMMISSIONER LOVETT: Mm. Can you give us some examples of what are you doing as part of your leadership role to just kind of drive those principles as to what you have just clearly articulated?

PROFESSOR WALLACE: Well, I referenced the very - a tiny example this morning. When - whether it is Aunty Jill, she is a fairly persuasive individual as you well know, whether it is Jill or Mick or others, whether it is the Partnership Forum, the Secretary saying, "These are the priorities for us." And it is my responsibility with the Department and with my ministers to try our best to deliver in those priorities. But it is more than that. It is a cultural journey and our own Department has undergone cultural safety training. It is about leadership in that space. It matters to me. It is in small ways and large ways.

We have - in the Department we have a monthly all-staff forum and Aboriginal matters feature largely in those forums often, because it matters. It is a real privilege to the live in a nation where we have acknowledgements of Country and

welcomes to Country at the beginnings of meetings. I have visitors who come from overseas, particularly from north America who are blown away.

But in the health sector there is not just a willingness, and again, I think the majority of our workforce get up in the morning to serve the population as best they can. I think what has been missing is a visibility, missing in part from me also. I have learnt so much in listening to the evidence from the Commission over these past months, so much. So there is a lack of understanding of what are traditional Aboriginal and Torres Strait Islander ways of wellbeing and how do we deliver them.

COMMISSIONER LOVETT: I mean we are the first inventors and we are also the first innovators.

PROFESSOR WALLACE: You are.

COMMISSIONER WALTER: Can I just ask about within your Department itself where are your senior First Peoples bureaucrats? We know that that visibility and the presence of the people who are at the decision-making tables every day, even when decisions are being made that don't think will impact First Peoples but usually do, what is the executive structure and the place of First Peoples in that?

PROFESSOR WALLACE: So they're here in the room this morning. When the new Department was formed, so 20 - end of 2020 we were the Department of Health and Human Services and through opportunity of government we were separated into the Department of Health and the Department of Families, Fairness and Housing. You have heard from my colleague, Peta from DFFH already. When we created the Department of Health in February 2021, we have always had an Aboriginal Health and Wellbeing Office, previously it sat in what was the predecessor division of Ms Geissler's. And I lifted it out of the division and had it reporting directly to my office and myself.

Ms McCartney, Nicole McCartney is our Chief Aboriginal Health and Wellbeing Advisor. She sits at my executive board along with Deputy Secretaries.

COMMISSIONER WALTER: And all those peoples are First Peoples?

PROFESSOR WALLACE: Nicole is, yes, and below her she has two executive directors who are First Nations people.

COMMISSIONER LOVETT: Is that position a Deputy Secretary level position?

PROFESSOR WALLACE: It is not.

COMMISSIONER LOVETT: Do you see that as potentially an issue, Secretary?

PROFESSOR WALLACE: Well, it is about functions and outcomes. I don't. I mean I think - and maybe I'm the wrong person to ask. Maybe you should ask my Aboriginal Health and Wellbeing team if it is an issue. I think it is important for me that Nicole is present at board meetings. She is there as a full member of the board. And it is a relatively small team and I think in the information we have provided in our response to requests for information where we detail some of our workforce make-up, workforce structures. It is a team that has been around 24 - it is currently growing to about 40. So it is a relatively small team for a Deputy Secretary-level position, but in terms of authority, she has the same authority as a Deputy Secretary.

COMMISSIONER LOVETT: But I would say, Secretary, though, that is the level of complexity from a non-Aboriginal point of view around - and it is not about Nicole. It is about the position navigating as well as the cultural load and the complexity that is associated with someone in that position, I would think, and I would encourage you to maybe just consider that extra weight that your other deputy secretaries would not have to have. And also I understand that there is equity of voice, but there is also - there is not equity of resources, if that makes sense.

PROFESSOR WALLACE: No, it does make sense.

COMMISSIONER LOVETT: To the individual, not the team.

PROFESSOR WALLACE: No, it does make sense and there is a tension that we should call out, which is that matters of improving Aboriginal health and wellbeing cannot be the burden of an Aboriginal Health and Wellbeing team. It has to be the burden of the whole Department and the responsibility and the accountability of the whole department. And I think that is that is exactly what Nicole and her team deliver for us, which is ensuring that decisions and policies and matters of improvements and investments are appropriately considering the needs of Aboriginal people in the State. But she has a broader role. She has a role in helping shape broader policy for health and wellbeing not just in for First People, but I agree with you.

MS MCLEOD SC: We might bring up now Section 9 of the Health Services Act, just following on from the discussion around intergenerational trauma. There is now to be introduced on 1 July a statement of principles including a recognition of the fact of intergenerational trauma to be introduced into the Act, correct? And those principles, the new Section 11(e) do not affect the interpretation of the Act. They do not create legal rights and do not create entitlements to compensation. Are you familiar with that new provision?

PROFESSOR WALLACE: Yes, I am.

MS MCLEOD SC: And let us bring up section 9 now. Perhaps if we could zoom in on (a) and (b).

I am not sure if you have that in front of you. The panel have that in front of you, but:

> "The objectives of the Act are to ensure under (a) health care agencies provide safe patient centred and appropriate health services, foster continuous improvement and (b) an adequate range of essential health services available to all persons resident in Victoria irrespective of where their live."

And perhaps the other one that might be relevant is (g):

> "Users of health services are able to choose the type of health service appropriate to their needs."

So you said earlier this morning these were foundational expectations, they were not aspirational. Are these objectives adequate, given that the statement of principles don't guide and don't bind the Department in a legally relevant sense? Are these objectives sufficient to deliver the highest attainable standard of health?

PROFESSOR WALLACE: They are not explicit around the highest possible attainable standard of health. There may be merit in us reflecting on these objectives. I think the objectives remain fit for purpose today. Do they optimally serve the creation and delivery of a health system that delivers the highest possible attainable standard of health? There may be merit in reflecting on that question. So again, I think they very clearly and precisely, which is the intent of legislation, lay out what the requirements are of health agencies in the provision of health care for community.

MS MCLEOD SC: Reference, for example, to, "an adequate range of health services" you would agree is not the same thing as aspiring that Victorians be the healthiest in the world?

PROFESSOR WALLACE: No. I mean the - one is to delineate a provision of services, the other is the outcome and as we have discussed already this morning, of course, for Victorians to be the healthiest population in the world requires much more than health care. In fact, health care itself probably makes up about a quarter of the contributors to health and wellbeing and we talked about social determinates and others before. Good employment, housing and education, et cetera. So there are many things that make up being the healthiest population in the world that are out with the remit of health services and certainly health service legislation.

MS MCLEOD SC: Okay. I just want to turn now to the Victorian Charter of Health Care. If we could bring that document up as well. This is a document that we have is dated 2016. Are you familiar with this document?

PROFESSOR WALLACE: I am now, yes.

MS MCLEOD SC: And I understand it has been updated, but the 2019 update is not available online. Do you know why that would be?

PROFESSOR WALLACE: I don't.

MS MCLEOD SC: If this document has been updated you would accept that it should be publicly available?

PROFESSOR WALLACE: Yes, and if it is available, we will make it available to the Commission.

MS MCLEOD SC: And will you make it available online?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: If we turn to page 3 of the documents, in terms of Guiding Principles this is the 2016 document so let's just work off that one, assuming that it is still -

CHAIR: Is it in the folder?

MS MCLEOD SC: No, this document is not on the folder. We have it available online. The Guiding Principles include:

> "Everyone has the right to be able to access health care and this is right for essential for the Charter to be meaningful. The Australian Government is committed to the international agreements about human rights, which recognise everyone's right to have the highest possible standard of physical and mental health. And Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects those differences."

So no explicit recognition of the standing and role of First Peoples under the heading of Guiding Principles. Do you know if that is still the case?

PROFESSOR WALLACE: I don't. I assume that these are the current guiding principles.

MS MCLEOD SC: Let us turn over to page 4, Your Rights in the Australian Charter of Health Care Rights and there are various dot points:

> "Access, safety, respect, communication, participation privacy, and comment."

These rights apply to all health care in Victoria, correct?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: Can I turn to page 10 under the heading of Respect? And you will see there:

> "The right to be shown respect, treated with dignity and conversation without discrimination."

Again, no specific mention of First Peoples under the heading of Respect. Are you aware, Professor Wallace, of the evidence given to this Commission that the right to respect is and has been breached and continues to be breached -

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: - for First Nations people in this State?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: You'd be aware that the Close the Gap reports say as much?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: And you'd be aware of the evidence of Professor Ray Lovett that these breaches and the impacts of the extent, seriousness and persistence of racism and discrimination in the delivery of health services are serious?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: You would accept that the impact of that racism or one of the impacts of that racism is adverse health outcomes for First Peoples?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: Can I invite your comment on whether we are meeting this Charter of Health Care Rights for First People in this State?

PROFESSOR WALLACE: I think, evidently, we are not. We are falling short of the Charter. The evidence that Professor Ray Lovett gave from the research that he and his team have done at ANU around experiences of racism are very challenging. They are whole of nation work. We have examples of our own in Victoria. So I think in VACCHO's submission to the Commission they reference

work the work from 2017 or '18 from RMIT reporting very high rates of experiencing racism in our health services by Aboriginal people.

And the Department itself, principally through Victorian Agency of Health and Information or VACCI, it's part of the Department, has got a number of reports from patient experience of racism, that led into a specific piece of work that looked at racism as being experienced by Aboriginal people. So the first piece of work around experience of racism in a health care setting was whole-of-State racism by country of birth of the individual, of the patient reporting it. And then out of that pooled and created a dedicated report on health experiences by Aboriginal people in - in using the Victorian health care system.

And I think those data, both Professor Lovett and others and our own data have been discussed by the - before the Commission before. Something around the order he have one out of five Aboriginal people report racism in a Victorian health care setting. That next to experiencing racism in the general public the next highest is a health care setting, the very setting where you would expect the rates to be the lowest. So I think the short answer to your question is, yes.

MS MCLEOD SC: When you say you expect that to be the setting in which racism experiences are the lowest, is that because those health care services are being delivered by trained health care professionals, or is there some other reason you would point to for that expect nation?

PROFESSOR WALLACE: The former. I mean, I - the - health care at its heart is about helping others. And those who choose to train and work in their professional life in that setting, I referenced it to before, get up in the morning to do good. This is a fundamentally good health - good workforce and people come to health care settings for help, to get better, hopefully, and for care. The heart of care. It is hard to understand why experiences of racism are so high.

COMMISSIONER WALTER: Professor, would you agree, I mean, and this isn't the first document we have seen at this Commission is all about these values, but which invisiblise First Peoples, even though we know in all of those that Aboriginal people are heavily overrepresented. The fact that there is no mention of First Peoples in those documents, would you agree that that means that when people are reading these it is failing to bring First Peoples and the prejudices, the discriminations all the other things that First Peoples face in people's minds? So when they are thinking respect they are not thinking racism and not making and stereotypes, challenging stereotypes.

PROFESSOR WALLACE: I do. It is a missed opportunity and I think the intent of the new Statement of Recognition, to be inserted in the Act to be current from 1 July is intended to correct that. So an explicit mention of First Peoples in the Acts. But I agree with you. It is an omission, it is an important omission that misses an opportunity to highlight the lack of respect and racism, frankly, that leads to - it is a major contributor to the health outcomes.

In one of the submissions before the Commission was the PhD from Monash I referenced earlier, which even suggested - and I am not an expert in the field, but first reading suggested that racism was the most important contributor to poor health outcomes.

COMMISSIONER WALTER: And yet I think many people from First People's communities would agree to say this continued absence of any mention of First Peoples in these foundational documents feels deliberate. It feels marginalising. It feels excluding. That it is not an oversight, because it happens - the pattern is there, it happens again and again, and again.

PROFESSOR WALLACE: I hear that.

COMMISSIONER HUNTER: So what did you say the intent of the Act - is it the Act that has been changed?

PROFESSOR WALLACE: The Statement of Recognition that Counsel Assisting referred to in the two Acts, Public Health and Wellbeing Act and the Health Services Act. I can read it to you if you like.

MS MCLEOD SC: We will see if we can bring that up.

COMMISSIONER HUNTER: I am just wondering how that stops racism and discrimination in the system.

PROFESSOR WALLACE: It goes to the Commissioner's comment about the absence of an explicit acknowledgment of Aboriginal people and their rights, and their right to access holistic care that meets their full health - health and wellbeing needs. The absence of that explicit mention -

COMMISSIONER HUNTER: That assists, right, in going forward.

PROFESSOR WALLACE: Yes.

COMMISSIONER HUNTER: It doesn't stop the racism.

PROFESSOR WALLACE: No. No. It doesn't stop the racism and you have heard what you had heard from Ray Lovett that that requires a formal, structured anti-racism approach to improvement.

MS MCLEOD SC: So if we do have the document, which is the new - the Amendments to the Health Services Act. It is page 84 onwards. Just while we are bringing that up, are you familiar with the work of - you'd be familiar with the coroner's report, last year into the death of Veronica Nelson and the highlighting by the coroner there of issues of racism in delivery of health services in a detention setting, custodial setting.

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: You'd be aware this wasn't the first time there has been an examination of racism within the delivery of health services. So, for example, First Nations doctors' groups themselves are reporting these matters. In Queensland, for example, the Human Rights Commission and I have forgotten the other partner with it now, conducted a baseline study using a tool called the Matrix to assess racism within the delivery of health services. You'd be aware of those tools and measures?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: So what steps has the Department taken to address an anti-racism strategy across all health delivery services - health services in the state?

PROFESSOR WALLACE: Yeah. The - I mean, as a whole of system approach from the Department, apart from the investment and cultural safety training, the collaborative that Safer Care and VACCHO impactive and program - Safer Care and VACCHO are doing together, we haven't imposed a matrix approach that the Human Rights Commission in Queensland developed. At individual health service levels there are examples of work. Loddon Mallee, for example. Loddon Mallee health network have a piece of anti-racism work that they've been delivering with sense of good outcomes, you know, falling rates of experience of racism. But the Department itself hasn't led a piece of work yet on anti-racism.

MS MCLEOD SC: The evidence - the nature of the evidence we have heard in this Commission and the lived experience of those witnesses who come before the Commission, about the effect of racism whether it is overt or whether it is 1,000 cuts for minor offences, "minor" offences, is a significant inhibitor to good health outcomes, both in terms of presentation and trust in the delivery of health services, in terms of compliance with recommendations, in terms of the failure to take into account traditional ways of healing and practice. A whole range of issues that go well beyond having to deliver a baby on the verandah of a hospital. It is a persistent, continuous thread and as you acknowledged, one in five people reporting experiences of racism in health care delivery. It is outrageous, isn't it?

PROFESSOR WALLACE: Unacceptable.

MS MCLEOD SC: And Commissioner Lovett asked what is in your power to do about it. What will you do about it?

PROFESSOR WALLACE: We - as I just replied, we - as a Department we have not to date done a piece of work on collecting, purposefully collecting experiences of racism across health care system. The data - our own data that we have from Victorian Agency of Health Information and derived from the Victorian Health

Survey in 2018, I think the data were published in 2021 and earlier this morning I commented that 2023 collection of data are under analysis as we speak.

So we will hopefully have another look at those health experiences, which includes reports of racism shortly. But I said this morning that - I both thanked various witnesses before the Commission for the evidence that they have given and said that we as a Department, me as an individual and my colleagues and the Department, have listened very carefully. It is clear. It is clear that experiences of racism are profoundly affecting health outcomes for Aboriginal people in this State.

Whether racism is the major contributor to poor health outcomes, it is sadly a major contributor. That rates of racism in our health services are unacceptable. The most recent data we have, one in five. Half of the people, half of Aboriginal people that report racism experienced it in a health care setting. These numbers are unacceptable, and I am convinced by the evidence and I have heard Professor Lovett speak before at the Aboriginal Health and Wellbeing round tables in Canberra earlier this year in Canberra. His evidence, his data, his research is compelling, and I am convinced that if we are to improve this, we need a purposeful approach and improved approach to collect the data, purposefully, specifically. We need to report it in the manner that will inform improvements and we design interventions that will be effective.

We don't need to start from zero. I have referenced others, the Loddon Mallee Health Network. But there are other across the system that are already showing positive results in driving down rates of racism being reported within the service. I think the Department does have a role in bringing that together and delivering, designing and delivering an intervention and hold our elves and our services accountable.

MS MCLEOD SC: And who else - yes. Sorry, Dr Looker, were you going to jump in?

DR LOOKER: No.

MS MCLEOD SC: Who else has a role? Medicine, for example, is a hierarchical structure. Senior consultants model poor behaviour and trainees who might never have thought to have acted in a discriminatory way assume that is the way to behave. Turning people away, inadequate treatment, inadequate investigation. All of these things we have heard about. So how do we nip it in the bud for those trainees who come with the intentions that you have described and learn bad behaviours on the job? Is a role for the colleges?

PROFESSOR WALLACE: Yes, and our - the colleges - yes, our colleges are stewards and curators of training programs for medical specialists and for nursing and midwifery and allied health professionals. I think just - I would say two things in response. First, we do need to collect the data in a meaningful manner

and a timely manner. So intermittent health experience surveys every three or four years are neither timely enough or granular enough to tell us where are those experiences being felt.

So the fact that nearly one in five Aboriginal people report experiencing racism in health care doesn't tell me where that is. So we need to build a system of data reporting, which is not rocket science. That we can see it in near real-time and we know where it is happening, so we can then work with the health services in support of removing it. The other -

COMMISSIONER LOVETT: I think it comes to the point, Secretary, as well we raised in housing one in five - you are talking about one in five Aboriginal people experience racism, one in five Aboriginal people experience homelessness. Sorry - yes, homelessness. Now, if you put that in mainstream figures that would be one million people in Victoria experiencing racism. One in five, like, that is a lot of people. We listened - talk about tangible numbers here.

PROFESSOR WALLACE: It is one in five Aboriginal people experiencing racism in Victoria, so our Aboriginal population is what, about 65,000.

COMMISSIONER LOVETT: But if you are looking at it in the context of non-Aboriginal people -

PROFESSOR WALLACE: Yes.

COMMISSIONER LOVETT: - that would equate to one million people.

PROFESSOR WALLACE: Yes. Of course, the rates the -

COMMISSIONER LOVETT: What we are trying to highlight here, one in five is still a significant proportion of our people experiencing racism.

PROFESSOR WALLACE: Yes.

COMMISSIONER LOVETT: Whilst we have a small amount of the population, because if we go to, "It is only one per cent or three per cent of population" diminishes one this in five people experiencing racism. That is the point I am emphasising here.

MS MCLEOD SC: And those reporting that fact, so the number could be well higher.

COMMISSIONER HUNTER: Considering those who will even turn up in the first place.

MS MCLEOD SC: So can I invite all of you, if there are any other responses you have to this issue, before we drill down into the data a little more. Are there

any other responses to this issue of racism that you would like to highlight for the Commission and how we deal with this?

DR LOOKER: I think it's correct that there is obviously an urgent need for focused attention on racism in health services. What is also apparent from evidence that has been given to the Commission and I think to all of us in our understanding of the issue is that it also reflects a much broader approach of society.

So the people that are working and the systems that they come from in health services are drawn from the rest of the population. So there is an absolute critical need for action on racism in health services but, of course, it also reflects I think the much broader issue of attitudes across our broader population, and lack of understanding.

MS MCLEOD SC: So a respected journalist was recently held up and rebuked for saying the word "racism" at a Writer's Festival recently. What does that say about our maturity and our ability to discuss this issue that you are seeing in the delivery of health services?

PROFESSOR WALLACE: I think, you know Laura Tingle's experience is instructive, for us as a nation. The other thing I was going to say is that for 25 years I had the privilege of being involved in teaching medical students and junior midwives. They are not, at their origin, a racist workforce in my experience and I had the privilege of teaching in Monash's medical school for more than 20 years with the very, very diverse origins of medical students coming through Monash.

We have - we have - and it is not unique to health care, but the experiences that are expressed through the Victorian Health Experience Survey that we have referenced today and the data that Professor Lovett presented to the Commission from his work at ANU, tell us that we have a health care system that racism systemised. And again, to go to his evidence, it needs a formal, structured approach to remove it. At its core its people do not - my experience is people do not enter the workforce as a racist workforce. But, again, the broader horizon of Laura Tingle's experience I think is instructive for us as a nation.

COMMISSIONER LOVETT: What changes them then? To go on your lived experience, which is very different to my people's lived experience, what happens when they get in that system then? If they are coming in genuine wanting to help people, which I can understand where you are coming from, but from a system point of view why are our people, one in five being treated this way?

It doesn't - like, I am trying to translate your response to the lived experience from our people and it's not anecdotal, it is actually evidence. You know, a lot of people in Aboriginal Affairs is just how we see and feel the world rather than this is data. This is a mainstream way of capturing evidence. Data, and yet I am just trying to reconcile your response then to actual - the system itself.

PROFESSOR WALLACE: Commissioner Lovett, it is a complex answer, I think. If I might - if I might just step back for a moment. Over the last decade there has been a movement in health care improvement more broadly called What Matters to You. And it is about teaching health care providers, whether it is doctors or nurses or physios or whoever they are, to ask the question to the patient in front of them, "What matters to you?" And then try to meet that need, rather than bringing to them what they think matters to the patient.

It goes to the comment this morning around - my comment this morning around the WHO's definition of health and health care, that it is a holistic approach and it is complex. I think for our First Peoples that holistic concept of health and wellbeing that is grounded in Country is not understood by the majority of our health care workforce. And so rather than asking, "What matters to you?" They bring - because if you ask the question, "What matters to you?" "This is what matters to me, it matters to me that my Aunty can come into the birthing room with me." Or whatever it is.

COMMISSIONER LOVETT: I am still trying to grapple with the system, though, Secretary. Because people created these systems, not our people. They were created by people. And I understand you coming and saying the people are coming in with goodwill and intent from their training and they are getting meaningful training. I would probably question that, but I didn't go through the level of education or the - that you did, and others to become a doctor.

But I am just trying to understand people going in, you know, with the right mindset and the intent, when they get in there the system is not changing but people created these systems and how you change a system is not from robots. People need to change the system back or enhance it and so forth. So I am still trying to understand the actual - how is the system so wired against Aboriginal people still, you know.

MS MCLEOD SC: Dr Looker?

DR LOOKER: Can I make a quick comment? I think there is a fundamental element of the biomedical model that is delivered by health care which directly or perhaps inadvertently, but some would argue directly, excludes that holistic understanding of health. So you can have good people trying to deliver a Western model of medicine and measuring outcomes by that, but it is - that is naturally then where the focus goes.

And I think that is to the exclusion of all the other critical elements of wellbeing that are not considered, and I think then make - when there is such a fundamental part of somebody's - a First Person's experience of wellbeing in hospital means that it is excluded and not met. So I think there is a fundamental aspect of that.

COMMISSIONER LOVETT: I can understand that, but I come back to - sometimes our people need to come to a hospital for a particular thing they want to get sorted it is not all caught in the spiritual side of our Country and connection, because that can be lost. I'm not saying that is not a key part of it around our healing. But the fact is they have a matter they needed to get dealt with they are turning up and treated with racial behaviour.

It's - kind of we understand is that we turn up, we need this level of service because it is a human right. To talk about all your opening statements, it's basic human rights. I am not talking about cultural rights. I am talking about human rights to get meaningful health care or support, because that is what we need. That is what I am trying to understand the system, let us not get too caught in the cultural side of things but we can get to that service delivery, basic service delivery being treated with racial behaviour. That is what I am trying to understand.

COMMISSIONER NORTH: Ms McLeod, we only have a few minutes left.

COMMISSIONER LOVETT: I still want an answer to my question, Commissioner.

PROFESSOR WALLACE: I don't have an answer for you, Commissioner Lovett, this morning. I don't understand why one in five Aboriginal people have experienced racism in health care delivery in this State, but we need an approach to sort it.

COMMISSIONER NORTH: Yes, Ms McLeod? We only have a few more minutes left -

MS MCLEOD SC: Thank you, Commissioner North.

COMMISSIONER NORTH: - getting on, on this discussion.

Obviously one way of dealing with the question of racism in the system is to devote resources to ACCOs, correct?

PROFESSOR WALLACE: Well, yes. I mean, I think improving - increasing Aboriginal health care provision into Aboriginal-led providers hands would be - would improve that.

COMMISSIONER NORTH: Exactly. So in the material that you have provided to the Commission, as I read it in this last financial year the percentage of the Departmental budget directed at ACCOs was 0.2 per cent.

MS MCLEOD SC: Can we bring up, please, Annexure B to the RFR response. The reference for the transcript is DOH.0004.0002.0007.

COMMISSIONER NORTH: The next page.

MS MCLEOD SC: Six and seven.

COMMISSIONER NORTH: Is 0.2 per cent devoted to ACCOs, which we said would at least address in part this question, but obviously others. Is that sufficient?

PROFESSOR WALLACE: I think, and I understand how you derived 0.2 per cent. That is 0.2 per cent of the whole of the Department's budget. I am not sure if that is the right - I understand highlighting that number. I am not sure that is the right comparator. So the function of - the principal function of ACCOs is to provide primary community-based care. So if you look at the departments, the proportion of the Department's spend in that space, in that primary community care space, so ACCOs and community health services, mindful that the majority of primary and community care health and investment is by the Commonwealth.

But if you look at the proportion of the Department's spend in that space it is about somewhere between four and seven per cent is on ACCOs. So if you just take the primary and community spend and say what proportion of that is to ACCOs then across the two years that we provided data for it has been four and seven per cent. The majority of spend, of course is in mainstream hospitals. But that is not a sector that ACCOs are providing care in.

Notwithstanding the comments we have made already this morning, which is about trying to move care out of that sector, into the home and could ACCOs play a component, a - you know, a larger role there. I think the short answer to that question is yes. But if we just focus on what proportion of Department spend in the community, primary care space and the proportion to ACCOs is somewhere between four and seven per cent.

MS MCLEOD SC: Could we just go back to table 13 for a moment on the previous page and focusing on the column for ACCOs for 2022-'23 and '23-'24. We see there - so the total spending across ACCOs, community health and mainstream hospitals for each year as round $20 billion, correct?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: If we look at ACCOs you see in the '22-'23 year the vast majority - well, sorry, just over 50 per cent of the spending on ACCOs for '22-'23 was by way of fixed-term one-year contracts.

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: With - so that is around - just a little over 50 per cent of the total spending for ACCOs is spent on fixed-term one-year contracts, and then for '23-'24 it is less than 10 per cent of the total. You see that?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: And so I understand that reflects the huge boost or surge funding that was spent during COVID, which has now been pulled back.

PROFESSOR WALLACE: Largely, I mean not uniquely, but the majority of that change in funding, both to ACCOs and its evident also in community health services, in '22-'23 that's not present in '23-'24, it reflects investment in '22-'23 and the prior year for that matter, specifically on COVID matters that has then come off.

MS MCLEOD SC: So we have heard evidence around the impact of those fixed one-term - one-year contracts, and the difficulty for ACCOs to retain staff when they are on these short-term contracts. The shortfall in the workforce for ACCOs do you know the numbers - the workforce shortage for ACCOs across Victoria, is it around 500, 600?

PROFESSOR WALLACE: I don't know how many vacancies our ACCOs have, I don't have that number.

MS MCLEOD SC: It would not surprise you if those numbers are higher, given the funding for short-term contracts versus ongoing projects, correct?

PROFESSOR WALLACE: Certainly short-term funding projects does not encourage and support enduring employment.

CHAIR: Counsel, could I just ask another question?

MS MCLEOD SC: Yes.

CHAIR: Slightly different from talking about what the ACCOs are doing and how much money they are getting. What about the training of the people who are working in the hospitals now to work with First Peoples and people from other cultures. Is that the same as it has always been or has that been stepped up, given the COVID experience? Because there is a lot of burden on the organisations who already are stretched and experiencing staff - but what about mainstream staff who need to be trained to work with our people, to understand the cultural differences and the way to do things better?

PROFESSOR WALLACE: Commissioner Bourke, we haven't explicitly stepped-up funding for training to work with Aboriginal people or the Aboriginal sector. There is explicit funding for our health services that is of our health services have explicit funding around cultural safety training. So there is funding that we have identified specifically for that. But in coming out of COVID, have we developed funding streams to increase training for the mainstream workforce to work better with ACCOs? We haven't.

CHAIR: Well, I am thinking about the patients and people who pass through, because I can testify that there were many mistakes made during COVID.

PROFESSOR WALLACE: Mm.

MS MCLEOD SC: So the two questions I wanted to ask you about this comparison between '22-'23, and '23-'24 is first, we see a winding back of the funding of ACCOs generally. Has that funding simply been re-allocated within the health budget?

PROFESSOR WALLACE: No, I don't think so. I think - I don't think we should interpret this as there has been winding back of funding for the ACCOs generally. And if you look at both the multi-year and ongoing funding lines between '22-'23 and '23-'24 there have been increases in both of those funding lines. I think the big swing between fixed term-one year for '22-'23 and '23-'24 is almost entirely explained by COVID-dedicated funding coming off and giving the needs for that funding have largely gone.

So there will be tail-end funding for testing, for vaccines, for educational support, et cetera, et cetera. And you can see it evident also in a funding change in the same funding line, fixed term one-year for community health services and to a much lesser extent to mainstream hospitals. Again, I referenced this morning there was significant investment to mainstream hospitals during COVID to respond to COVID and that funding has come off, as we have returned to a more BAU, and we have created system capacity and capability.

So I don't think - I think it would be wrong to interpret this as funding for ACCOs is diminishing, it is not. And then the other element to this is and we talked about it earlier this morning, is that through the Partnership Forum and through the advocacy of VACCHO we have heard very clearly that single-year funding just does not work for the ACCOs. And so they much prefer multi-year funding and we are now making those changes. We are doing a multi-year funding contract with VACCHO itself and looking how do we now take a similar approach to ACCOs.

COMMISSIONER WALTER: Can I just - it just strikes me looking at this though, that the reduction from 56 million to 3 million is a huge reduction and while there is little bits of reduction in the community health service and your mainstream hospital, it is nothing like the reduction that is occurred in - all the reduction is in that first year and it sort of doesn't seem to have gone into longer term or fixed, or ongoing funding. It just seems to have disappeared completely.

PROFESSOR WALLACE: And again, I think that is because the funding is principally for COVID-facing functions. So this was the last year, '22-'23 was the last year of the COVID-facing functions when we - and we've talked about the successes of the COVID response and for community delivered principally by

ACCOs and others, but - so I think that swing is a reflection that those functions are no longer there. They are no longer required. Those COVID-facing functions.

COMMISSIONER WALTER: I guess my point is that the reduction from community health services if we were to do a comparison rather than hospitals, doesn't seem to have gone down to anywhere near the same extent and they also had COVID boost funding.

PROFESSOR WALLACE: Yeah. And I think - they did, but I think it reflects that the particular investment that government made in ACCOs to deliver the services that they needed to deliver for community during COVID and that there was a proportionately larger investment in the ACCO space than there was in the community health space.

MS MCLEOD SC: So we saw a rapid scale up within the ACCOs to address the COVID response, particularly for the fixed term, one-year contracts, which has now been scaled back significantly in the current year budget, correct?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: And what - I mean this was a highly successful response, as we have heard.

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: So what is the significance in terms of the loss of that workforce and recruitment, and retention of that workforce if there is no adjustment to the multi-year and ongoing funding of the workforce? Will we simply lose all those people?

PROFESSOR WALLACE: Not entirely. I mean, many of them will have left, but not entirely. If we look at the combined of multi-year and ongoing funding in between the two years there has been a significant increase in funding between the two years. With a particular increase and not quite doubling, but not far from it of multi-year funding. Again, reflecting what we have heard from VACCHO and from ACCOs that their strong preference is for multi-year funding programs.

MS MCLEOD SC: So the multi-year has gone from close to four to around six?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: But nowhere near making up the difference between fixed-term, one-year 56 down to three, correct?

PROFESSOR WALLACE: No. Correct. Because the need for that, the functions of that 56.5 million fixed-term one-year contracts were supporting - were COVID-facing functions, they were no longer needed.

MS MCLEOD SC: I understand that, my question was around workforce.

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: We had a skilled workforce stepping in and stepping in, in a very successful way to fulfil this function during COVID and there is simply no funding for them. So what does that do to the workforce in terms of their willingness to come back and work in the space? In terms of our ability to recruit people? In terms of the ability to deliver services through ACCOs that we know are successful, as a successful model? We have lost that workforce, haven't we?

PROFESSOR WALLACE: Not entirely. They would not all be on workforce. There would be a decent proportion on workforce, but some of that will be around buying vaccines for our ACCOs to give vaccines, testing, equipment, et cetera, and there may well be a reference there to Aboriginal health practitioner workforce before and expanding the ability to deliver now, a whole array of immunisations of vaccines, but during COVID to give COVID vaccines. They can still give COVID vaccines but, of course, the volume of COVID vaccines and the hours they need to be doing is much less now.

MS MCLEOD SC: So this funding line for '22-'23 and presumably the two years before that, that fixed term one-year contract includes the purchase cost of COVID vaccines, does it?

PROFESSOR WALLACE: It will include all sorts of things, yes.

MS MCLEOD SC: So I am just trying to understand this. As between the Commonwealth and the State, the Commonwealth purchased vaccines for use by the States?

PROFESSOR WALLACE: We shared the costs of vaccines 50/50 through a National Partnership Agreement.

MS MCLEOD SC: So at first instance the Commonwealth secured those purchase orders?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: And shared the cost of purchase with the State?

PROFESSOR WALLACE: Cost and distribution, yes.

MS MCLEOD SC: So how does the cost then become a line item for the ACCOs?

PROFESSOR WALLACE: Because that is the money we would provide ACCOs in terms of providing those vaccines.

MS MCLEOD SC: Were they literally putting their hands in the pocket for the vaccine or is in a line item to say that ACCOs are delivering that service?

PROFESSOR WALLACE: We were funding it through the National Partnership Agreement with the Commonwealth. The State was funding 50/50 the cost of vaccines and vaccine delivery.

MS MCLEOD SC: Yes.

PROFESSOR WALLACE: In we had in terms - this won't be uniquely a vaccine program, but in terms of the vaccine program we had a dedicated vaccine program for community, largely but not uniquely, but largely delivered through our ACCOs. The cost of that vaccine program would be, in part, reflected in that line item.

MS MCLEOD SC: Any questions about the funding, Commissioners?

I did want to touch on the targets before we move on, but, yes Commissioner Hunter?

Medicare just before I leave the funding entirely, Medicare is funded by the Commonwealth, correct?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: In terms of services provided within custodial settings Medicare is not available?

PROFESSOR WALLACE: No.

MS MCLEOD SC: That means the State has to step in with health services in custodial settings?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: And you have heard evidence - no doubt you are aware of the evidence of the inadequacy of delivery of health services within custodial settings?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: What are you going to do to fix that?

PROFESSOR WALLACE: I am not in the custodial health care and delivery, is over seen by my colleagues in the Department of Justice and Community Safety. So custodial health is a program that sits in DGSC, not The Department of Health.

MS MCLEOD SC: Should it be in Health?

PROFESSOR WALLACE: That is not a matter for me. It is a matter for government.

MS MCLEOD SC: No views as to who is best placed to deliver health services to those of our most vulnerable people in custodial settings?

PROFESSOR WALLACE: I am not able to assist the Commission on this matter this morning. Again, it is a matter for government.

MS MCLEOD SC: We might ask the ministers. All right. Leaving funding then and just quickly touching on funding and data, you said if you can't measure it you can't improve it. So I just wanted to touch on the measures and data before we finish. So in addition to - there are four principal Close the Gap targets that are relevant, correct?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: We have - I am not sure if we have got the document, but we have:

> "Long and healthy lives",

- which is life expectancy for males and females separately maintained. Is life expectancy currently reported for Victoria for First Peoples?

PROFESSOR WALLACE: It is not.

MS MCLEOD SC: Could you just explain why that is?

PROFESSOR WALLACE: Two things here. One is that the Closing the Gap measures and reporting is a national program. The data that go into those various measures, but including life expectancy and in the case of life expectancy come from the Australian Bureau of Statistics, ABS. So ABS data - they're derived from the states and territories, collated by ABS then go into Closing the Gap. That ensures a uniform approach, makes sure that like is compared with like, et cetera, it is appropriate.

ABS have determined that the size of the population, the Aboriginal population in Victoria and the number of deaths in that population are too few and unstable to provide reliable estimates of life expectancy. So in order to calculate life expectancy you take in every year of life, take the number of the population in that

year of life and the number of deaths and then calculate for every year of life and then bring them all together to give us an average life expectancy.

ABS has determined that the Victorian - not uniquely to Victoria, South Australia, Northern Territory, Tasmania, that the data are too unstable and unreliable to provide data for Closing the Gap.

MS MCLEOD SC: So do you interpolate from that data the position of Victoria or is there another trusted source you could look to for that information?

PROFESSOR WALLACE: Yeah. So we can't extrapolate from Closing the Gap, because our data aren't there. Clearly the eight to 10-year average life expectancy gap between Aboriginal people and non-Aboriginal people, both men and women, we would not expect to be very different for Victoria, but we cannot extrapolate. Is there another way to do that?

We are working both with our own data agency, VAHI, but also we are required to work with Births Deaths and Marriages, the holder of these data. Could we develop a work around, if you like? So to report ourselves I don't think it would necessarily provide the reassurance that ABS would want, but it might. The answer is, yes, we would - we want to be able to report life expectancy data for our own population.

MS MCLEOD SC: So the states and territories who are not included because of the sample size are, you said Victoria, South Australia, Tasmania and ACT?

PROFESSOR WALLACE: ACT.

MS MCLEOD SC: So accumulating that data would still be useful in terms of urban populations, regional populations, compared with remote and very remote populations?

PROFESSOR WALLACE: I think that would be a matter for ABS to determine if there was a validity to do that as a collective jurisdiction as it were. And again, it is not a matter of my experience. I think the data scientists in ABS would be best placed to decide is that a useful sort of second line approach.

PROFESSOR WALLACE: So, Dr Looker, could I invite yourself as well. Life expectancy is obviously a key measure for delivering of health programs and measuring successful outcomes, would you agree?

DR LOOKER: Definitely.

MS MCLEOD SC: So do you have any ideas how from a public health perspective we might capture that data and measure success against it?

DR LOOKER: Look, I think I would agree with the Secretary there is a need to do that and to look at the other data sources that we are routinely collecting to see if there is another way of getting that understanding of the Victorian experience. I am not across all the available data in enough detail to propose a methodology for that, but I definitely support its development, yes.

PROFESSOR WALLACE: And I mean there are - sorry, counsel, there are other - lying underneath these so-called principal measures there are supporting measures and the supporting measure for life expectancy. There are a number of health checks per head of population. We do have those data for Victoria and comparably there are fewer health checks per 100,000 population in Victoria than they are - for Aboriginal people than they are for other jurisdictions.

MS MCLEOD SC: And what do you make of that?

PROFESSOR WALLACE: Well, it goes - it goes to the conversations we have had earlier about the need to invest in prevention and early intervention, partly informs decision of government two budgets go about investing the Closing the Gap - the urgent care pathways by providing additional and specific funding to ACCOs to deliver prevention, early intervention, those very health checks. And actually the only measure, if you like, of the performance of those urgent care pathways is the number of health checks.

MS MCLEOD SC: The second Close the Gap target is:

> "Children are born healthy and strong."

So this relates to proportion of babies with a healthy birth weight. The gap here I understand for Victoria has not moved from beyond 90 per cent compared to 94 per cent for non-Aboriginal people for around a decade. Is that correct?

PROFESSOR WALLACE: Yes, it is about 90 per cent. It is getting better, so it is improving year by year. It is - as assessed by the Closing the Gap it is on target.

MS MCLEOD SC: On target?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: To reach equivalence?

PROFESSOR WALLACE: Yes.

MS MCLEOD SC: Okay. And what are the things that are succeeding in terms of lifting that target in Victoria?

PROFESSOR WALLACE: Well, it is difficult to say. There are lots of things that feed into having a baby with a healthy birth weight. We touched upon some

of them this morning. In Victoria for just over 20 years now, nearly 24 years we have had a Koori Maternity Service. It is difficult to say what the precise impact on the KMS has been on pregnancy outcomes including healthy birth weight. I think it has been significant.

So the other measure not part of Closing the Gap is the so-called perinatal mortality rate, so the number of stillbirths and early neonatal deaths in - among Aboriginal women and non-Indigenous and the rate for Aboriginal women for perinatal mortality for Aboriginal people have almost halved in the 20 years since the KMS has been running. I think - can you point to that and say it is causative, or is that just an association?

It is difficult to say it is causative, but I would be surprised if it wasn't. So I think the improvement in healthy birth weight - and we have as a jurisdiction we are one of the best on target to healthy birth weights and progress in the country I think is in large part due to our KMS.

MS MCLEOD SC: The third rate, and I do not mean to depersonalise this by reference to statistics, but target 14 concerns the number of people who took their own life. And Victoria does not keep data on this issue, and just noting there is no trajectory for this one, because there is no acceptable rate of suicide in the population. So a recognition that this is a difficult one to target, in terms of outcomes, but Victorian data is not kept on this. Is this correct?

PROFESSOR WALLACE: Not kept centrally. It is very difficult. Like you, counsel, it is important not to depersonalise this. There are lives and families at the centre of this number of this target. And any death by suicide is unwanted. The coroner, I imagine, you know, keeps data on Aboriginal deaths by suicide and from time to time issues a report. There are no central data collections currently for this. And the target really is there is no gap between - the rates should be the same between Indigenous and non-Indigenous populations, as low as possible.

MS MCLEOD SC: I did want to - (crosstalk) I did - you know, we are up against time, but there are also measures under the Victorian Aboriginal Framework, various health and wellbeing domain measures that are measured, some of which are improving, some of which are not. Is there anything you wanted to say about those measures, Measure 11, 12, 13 and 14 in terms of the goals set out under the Framework and at a high level?

PROFESSOR WALLACE: No, I think, you know, those are a fairly extensive suite of measures, some 27 measures across those goals. And also in Domain 1, which is Goal 1 around children, family and home, I think there are - in many of those measures there is good improvement, but in far too many there is not, there is insufficient improvement. I think they point to us the comprehensive suite of measures. They point to us where attention needs to be paid.

They also highlight rates where there have been successes and ask us to be curious about why they have been successful. We have had some of those conversations this morning. So, for example, rates of immunisation of Aboriginal children are higher than more non-Indigenous children. What a wonderful success. Why is that? Why have - why have as a State we have managed to deliver that? And it goes back to the same findings that we have discussed this morning, that in large part we have put the care of and the responsibility for those immunisations in the hands of community, of Aboriginal-led services.

But there are others, you know. There is still a gap, an unacceptable gap. But there is an increase - there is a narrowing of the gap of uptake of breast screening among women 55 and older. Why is that? Well, Aboriginal women, why is that? It is initiatives like the Beautiful Shawl Project and the Possum Cloaks that make Aboriginal women feel safe when they come forward for a breast screen, they know they will be cared for. How do we remain curious about the measures we see improvement on continue to see improvement? Not just say, "That measure is done now." It is, "Why did that measure succeed when the other measures haven't?" And apply the lessons learned to those that haven't.

MS MCLEOD SC: I don't want to rush that conversation, but I am mindful of the time. Is there data you could be collecting on service utilisation and equity of health outcomes that you are not currently collecting?

PROFESSOR WALLACE: I think the short answer to that question is, yes, but I think actually the suite of measures, 27 or so measures is probably sufficient. There is a risk that we spend time creating new measures, rather than time improving care and care provision. So there are measures around service provision and service access under Goal 12. There is a whole suite. There are five measures around Aboriginal Victorians accessing the services they need, the proportion who receive a health check. We have talked about rates of cancer screening, both breast cancer, cervical screening, bowel screening, accessing disability services, et cetera, et cetera.

I mentioned cervical screening. The introduction of self-testing, so women taking the swab themselves in the last couple of years has seen a profound increase in cervical screening among Aboriginal women. So self-testing - three years ago self-testing was one per cent of all cervical screens taken. 99 per cent of cervical screens were done by health practitioner. Within three years that is now touching 30 per cent of cervical screens are self-tested.

And we are on a trajectory where very shortly the vast majority of cervical screens will be done by the woman herself. The biggest increases in uptake of cervical screening have been in previously unscreened populations, including Aboriginal women. So Aboriginal women will be having rates of cervical cancer detection or pre-cancer detection that have otherwise - been previously unwitnessed in this State. Why? Because we have made care accessible and safe for the women. It's not rocket science.

So there are - there are significant lessons for us to learn from the improvement and many of these measures but we need to remain curious about what is it that is driven those improvements that we can now apply to the others. And I think the health checks and again, you know the investment the government has made in the urgent care pathways for Aboriginal communities to improve the provision, the capability and capacity to provide health checks, particularly for middle aged and older Aboriginal men.

"Come forward and get your blood pressure, et cetera, et cetera done." And I would hope that against that measure over current years as the ACCOs roll out those expanded services we will see the numbers lifted and we will ask the question, why? Why has it worked? It worked because care felt safe so people came forward to receive it.

MS MCLEOD SC: I am going to ask Commissioners if they have further questions in a moment. But is there anything further you would like to add to the evidence and the discussion we have had today or reflections on the examples that the Commissioners have raised for you, for each of you?

PROFESSOR WALLACE: I think that - I thank the Commissioners for their time this morning, but I think also we have heard individual stories from both Commissioner Hunter and Commissioner Lovett of their own recent health experiences and family and we want to acknowledge, thank you for sharing those deeply personal examples. They are a reminder of the deficiencies in our system.

MS MCLEOD SC: Dr Looker, anything further you want to add to the discussion we have had this morning?

DR LOOKER: No, just to thank you for having us.

HIS HONOUR: Commissioners?

COMMISSIONER WALTER: I have one thing. I heard at a recent forum, as you know a lot of First Peoples do not identify when they go into a health setting and they do that for reasons of safety. I heard at a recent forum a plan to actually data link with other data such as education data to get around the fact that people aren't identifying and increase the numbers of people being noted on health records. I want your reassurance that that will not happen, that First Peoples' right to identify or not identify is maintained and they do not have that choice taken away from them.

PROFESSOR WALLACE: That is a very complex issue, and I don't want to oversimplify it. We have a whole-of-government approach to data sovereignty that the government has committed to and the Department is part of that commitment to data sovereignty. It is very, very important. There are two bits to what you have said. One is an individual's right that needs to be protected to

either self-determine or otherwise as an Aboriginal person. But the other bit is that in the data, that we have those data, that less than half of Aboriginal people are asked whether they identify as Aboriginal and Torres Strait Islander. That is not acceptable.

COMMISSIONER WALTER: No.

PROFESSOR WALLACE: So everyone needs to be asked, which is the individual's right to determine whether they wish to reveal that or not. I agree. And we have seen an increase in self-declared Aboriginality in Victoria in our health system. I think that is a good thing, because I think it reflects that people are feeling safer. Nowhere near safe enough. And knowing the proportion of people who identify and choose not to identify I think is useful.

It is how do we get that data, because of the proportion of Aboriginal people using our health services in Victoria who choose not to identify as Aboriginal and Torres Strait Islander, if that proportion is high I think that is telling us something about the cultural safety of our service. So I agree with you. It is an individual's right that should be protected and it is how do we get those insights that help us shape to improve the service.

COMMISSIONER WALTER: Not use data linkage to get around people's personal choices. Yes.

COMMISSIONER LOVETT: One about board appointments. Who appointed the board at these hospitals?

MS GEISSLER: Sorry.

COMMISSIONER LOVETT: No, no, I would like for you to answer that, please.

MS GEISSLER: It does come through my division. These are Cabinet processes. We have quite an extensive recruitment process. We put up suggestions to Cabinet and they approve the appointments. I am really pleased to share we have seen significant improvement between this current financial year and next financial year in terms of representation of First Nations people on our health service boards. It is critically important that representation occurs across the organisation. Next financial year - I can share the data with the Commission, but next financial year it will double.

COMMISSIONER LOVETT: Okay. How long is the tenure?

MS GEISSLER: So, it is three years, three years.

COMMISSIONER LOVETT: A three-year appointment, all right.

MS GEISSLER: Three years, sometimes they cycle over, if the individual so chooses. Yes.

COMMISSIONER LOVETT: Okay, is there gender parity already?

MS GEISSLER: We do look at gender parity. I don't have the data on gender parity in terms of our representation from First Nations people, but I can get that data.

COMMISSIONER LOVETT: Okay, thank you.

MS MCLEOD SC: Just following up on those, so we have got the numbers. As at 30 April 2024, the Department has 26 staff that identify as First Peoples or about one per cent of the workforce, is that right?

PROFESSOR WALLACE: That's right.

MS MCLEOD SC: And about 1.1 per cent are in leadership positions?

PROFESSOR WALLACE: That's correct, and we are committed, like other government departments, to having both of those proportions at two per cent.

MS MCLEOD SC: In terms of the public health workforce 0.39 per cent of Victoria's public hospital workforce or around 574 people identify as First People.

PROFESSOR WALLACE: Correct.

COMMISSIONER LOVETT: And hopefully sooner Deputy Secretary's Secretary.

MS MCLEOD SC: Is there a formal process for recruitment and retention?

PROFESSOR WALLACE: In the Department or in the health sector?

MS MCLEOD SC: Both.

PROFESSOR WALLACE: We are expand - so we have a commitment to proportion within our own Department and have processes to deliver that commitment and as the Commission will be aware all government departments have gone through some changes over recent times in the workforce. Our Aboriginal Health and Wellbeing team is expanding, so we are on track to increase to 40, which will take the team to around two per cent.

As opposed to the sector, we have both an - and shared with VACCHO an Aboriginal health and wellbeing strategy and a broader health workforce strategy that belongs to the Department, in which there are specific actions to increase the proportion of Aboriginal people in the health workforce.

MS MCLEOD SC: Here's your opportunity, Secretary, to make a plug for the workforce.

PROFESSOR WALLACE: It is very important. I mean in terms of the workforce if we - even if we increase the provision of prevention and early intervention care into Aboriginal-led care providers, increasing the capability and capacity of our ACCOs, our Aboriginal people are still going to need to access mainstream services. They need to be culturally safe places for them to do so, and in helping that we should increase the number of Aboriginal people who are in the workforce. Now, it has increased.

It is increased almost 10-fold over the last decade, but to get to one per cent will require another 500 to 600 people coming into our health sector workforce at a time that everyone knows that the workforce, the sector is very challenged in terms of vacancies, nurses, midwives, physios, et cetera, doctors, et cetera. We have a number of programs of investments specifically targeting Aboriginal people to give them work experience and cadetships, for example, to support them on our midwifery and nursing scholarship programs as another example.

This will require a concerted effort from us as a department, from our health services, from VACCHO and from others, tertiary providers. It is no small task to deliver a proportionate Aboriginal workforce in our health workforce, one per cent would require again, another five or 600 people to get to two or three per cent would see that the health workforce is actually employing one in ten of all Aboriginal people in the state. Let us get to one per cent.

MS MCLEOD SC: Commissioners?

COMMISSIONER HUNTER: I have a number of questions, but I am really mindful of time. So if I can put them in writing?

PROFESSOR WALLACE: Of course.

COMMISSIONER HUNTER: That would be best for now.

MS MCLEOD SC: Other Commissioners?

Thank you very much to the panel for your time this morning and staying over time.

Could we resume, please, Chair, at 2 o'clock for the Minister and Deputy Secretary? Is that sufficient? Yes.

COMMISSIONER HUNTER: Can I just make people aware of 13YARN for any evidence that was given today that people are feeling not so great about or unwell to reach out to their services if required.

MS MCLEOD SC: Thank you, Commissioner.

<THE HEARING ADJOURNED AT 1.05 PM.

THE HEARING RESUMED AT 2.01 PM.

MS FITZERGALD: Thank you, Chair.

I understand that my appearance has been announced. I would like to acknowledge that we continue the hearing on the unceded lands of the Wurundjeri. My learned friend will announce their appearance.

MS COGHLAN: Thank you, Chair. Ms Coghlan, I appear for the State of Victoria today with Ms Batten and we appear for the mental health State witness panel, which includes the Minister for Mental Health, Ageing and Multicultural Affairs, Ms Ingrid Stitt and also Deputy Secretary Mental Health and Wellbeing Division, Katherine Whetton.

Thank you, Commissioner Hunter, for your welcome this morning. We weren't here to hear it in person, but we did watch it online.

We acknowledge that today's hearings are being heard on the lands of the Wurundjeri people. We pay our respects to Elders past and present and acknowledge, of course, that sovereignty was never ceded. We pay our respect to other Aboriginal Elders and also any First Peoples who happen to be here today or are otherwise watching online.

CHAIR: Thank you.

MS FITZGERALD: Thank you, Chair.

Before I ask the witnesses to give an undertaking to tell the truth, I would just highlight for anyone in the room anyone watching that some of the topics we will be discussing in this this section will be sensitive. There will, in particular, be a discussion of and focus on the quite concerningly differential suicide rates. And so I just warn for some viewers that may be upsetting.

Welcome, witnesses.

Minister, I will swear you in first. Minister Stitt, could you please tell the Commissioners your full name?

THE HON INGRID STITT: Ingrid Stitt.

MS FITZGERALD: You hold the position of Minister for Health.

THE HON INGRID STITT: Mental Health.

MS FITZGERALD: Mental Health. And is the evidence you are about to this Commission the truth?

THE HON INGRID STITT: It is.

MS FITZGERALD: You have prepared a witness statement dated 12 June 2024?

THE HON INGRID STITT: I have.

MS FITZGERALD: And just for the record it has been numbered DOH.0010.0001.0001. Are the contents of that witness statement true and correct?

THE HON INGRID STITT: Yes, they are.

MS FITZGERALD: Thank you, Minister.

Ms Whetton, will you tell the Commissioners your full name.

MS WHETTON: (Inaudible).

MS FITZGERALD: You told the position of Deputy Secretary Mental Health and Wellbeing?

MS WHETTON: (Inaudible).

MS FITZGERALD: You are also the Chief Officer for Mental Health and Wellbeing under Part 6.26 of the Mental Health and Wellbeing Act?

MS WHETTON: (Inaudible).

MS FITZGERALD: Is the evidence you are about to give this Commission the truth?

MS WHETTON: (Inaudible).

MS FITZGERALD: And you have prepared a witness statement dated 11 June 2024?

MS WHETTON: Yes, I have.

MS FITZGERALD: Now, that is numbered DOH.0009.0001.0001. I understand that paragraph 74 there is a typographical error. Before I ask you to attest to its

truth at paragraph 74 you say this represents five per cent of all clients. I understand you wish to change that to four per cent. Is that right?

MS WHETTON: I do.

MS FITZGERALD: And with that amendment are the contents of that witness statement true and correct?

MS WHETTON: They are.

MS FITZGERALD: Minister, I understand that you have prepared some opening remarks and I will invite you to read those.

THE HON INGRID STITT: Thank you.

And thank you, Commissioners. It is a privilege to be with you here today and I would like to provide a short opening statement.

I would like to begin by acknowledging the Traditional Owners of the land on which we are gathered today, the Wurundjeri people of the Kulin Nation and pay my respects to Elders past and present. I extend that respect to the Traditional Owners right across the State including those here and those joining us online. I acknowledge this is and always will be Aboriginal land and that sovereignty has never been ceded.

Thank you, Commissioner Hunter, for your warm Welcome to Country this morning that we had an opportunity to watch online.

I acknowledge the Commissioners who have led this truth-telling process and all of the First Peoples who have been heard by the Commission. I acknowledge that colonisation has caused historic intergenerational and ongoing trauma, and I acknowledge the profound impact this has had on the mental health and wellbeing of First Peoples.

I acknowledge that there are ongoing injustices within the mainstream mental health and aged care systems including racism, a lack of cultural safety, insufficient funding and Western models of care, which do not reflect a holistic approach to social and emotional wellbeing, which goes beyond good mental health and extends to connection to land or Country, culture, spirituality, ancestry, family and community. In my relatively short time in the mental health and ageing portfolios I have reflected on how these injustices are continuing to reinforce barriers to the First Peoples community receiving the care and support they need and deserve.

I've seen how ongoing and compounding traumas are triggering to First Peoples including a spike in emergency department presentations following the outcome of the referendum in 2023. I wholeheartedly and unreservedly apologise for the

ongoing injustices in mental health and aged care systems that have caused or contributed to the trauma experienced by First Peoples. Self-determination for First Peoples' social and emotional wellbeing has not been prioritised enough.

Ultimately First Peoples' communities hold the knowledge to determine how to best support the social and emotional wellbeing of their communities. And while I recognise that the current structural framework of government is a barrier to self-determination, I am committed to continuing to look for opportunities to hand over power and resources to communities to determine how community can best be supported to be mentally well and age well, in a way that is guided by First Peoples' holistic understanding of health and social and emotional wellbeing.

To achieve true self-determination, significant structural change is required. I am committed to continue working with First Peoples and organisations, including VACCHO and the Aboriginal Health and Wellbeing Partnership Forum to continue implementing the recommendations of the Royal Commission into Victoria's mental health system.

I would like to respectfully advise that the evidence I give today may contain references to suicide of First Peoples, which I understand can be confronting and distressing. I recognise that the use of suicide data can depersonalise the pain and loss associated with experiences of suicide which is not my intention. I extend my deepest sympathies to the individuals, families and communities affected by the effect of loved ones to suicide. Every death by suicide is one too many.

Before I finish, I would like to thank the Chief Aboriginal Health Advisor and the Balit Murrup Unit of the Department of Health. The positive work and change I describe in my statement has been driven by these teams and I acknowledge the burden and cultural load that is often placed on them.

We have a long way to go, but I give you my commitment to work hard to realise change. I will listen. I will be accessible, and I will work hard to enable First Peoples to effect true self-determination. Thank you.

MS FITZGERALD: Thank you, Minister.

Ms Whetton, your witness statement also contains a number of important acknowledgements. Could I take you to – starting with paragraph 3, and ask you to read paragraphs 3 to 7 and the first sentence of paragraph 8?

MS WHETTON: Before I do, I would also like to acknowledge that – the Wurrundjeri Woi Wurrung peoples of the Kulin Nation as the Traditional Owners of the lands we are meeting on today. I pay my respects to Elders past and present and to all First Peoples in Victoria, and to their ancestors. I acknowledge that First Peoples' sovereignty was never ceded.

So to my statement:

"I acknowledge the colonisation and dispossession of First Peoples' lands have caused deep and continuing trauma and harm. The mainstream mental health care system in Victoria is based on colonial structures and Western models of care that do not embrace First Peoples' holistic approach to social and emotional wellbeing. As a result, the system has perpetuated harm to First Peoples in far too many cases. This is not just historical. I acknowledge the Western system to this day does not appreciate First Peoples knowing, being and doing. This includes not understanding the First Peoples' model of social and emotional wellbeing, which is grounded in connection to Country, culture and kinship, and ancestry.

While there have been some recent improvements, I accept that the mental health system remains too focused on crisis-driven services and not enough is being done to support First Peoples' self-determination. This includes a lack of funding for Aboriginal community-controlled organisations for prevention, but it is broader than that. I accept that the Department is only beginning to come to terms with how far it needs to go to hand over true power and control for First Peoples when it comes to the social and emotional wellbeing for individuals, families and communities.

I also acknowledge the significant experiences of racism within the health sector and broadly in community contribute to First Peoples in Victoria experiencing a disproportionately high level of distress. This has an impact on their contact and engagement with the mainstream mental health care system, which can lead to poorer social and emotional wellbeing. I acknowledge the disproportionate and devastating incidents of suicide in First Peoples' communities. I acknowledge that the effects of colonisation and dispossession, along with the failure of the mental health system to support First Peoples' social and emotional wellbeing has contributed to this. I acknowledge that each death by suicide retraumatises community.

The failings of the mental health care system were examined by the Royal Commission into Victoria's mental health system. The Royal Commission found that Victoria's mental health system has failed to meet the needs of First Peoples. The mental health system was found to have failed to genuinely recognise or reckon with this exclusion of First Peoples and the ways in which it has contribute today or exacerbated mental illness. These failings are unacceptable and must be addressed."

MS FITZGERALD: Thank you, Ms Whetton.

Minister, Ms Whetton has just acknowledged in some of the evidence that she has read from her witness statement at paragraph 4 that the Department is only beginning to come to terms with how far it needs to go to hand over true power. And you, also in your witness statement at paragraph 41 very candidly state that:

> "The Victorian Government is only beginning to appreciate the fundamental and significant change required to realise true self-determination."

Is that an accurate reflection of where you at least are at the moment?

THE HON INGRID STITT: Yes, it is.

MS FITZGERALD: Realising that you have embarked on a project that was perhaps - you are only really discovering now, what it really involved.

THE HON INGRID STITT: Yes, I think that the Royal Commission findings really did lay out very clearly what deficiencies existed in the system. And, you know, in order to deal with that in an honest and frank way we have to look at the way in which we make decisions within government and within departments. So, yes, I think I would acknowledge that we have a significant amount of work to do.

MS FITZGERALD: This morning Professor Wallace acknowledged that the mental health system is broken. Do you accept the professor's diagnosis of the mental health system?

THE HON INGRID STITT: Yes. Unfortunately, the Royal Commission report again, I think confirmed that the system needs significant reform and that it is at least a 10-year reform journey to make the fundamental changes that are necessary. And in particular, of course, the findings around the disproportionate impacts on First Nations people are significant.

MS FITZGERALD: In your witness statement at paragraphs 19 and 21, you accept that Victoria's mental health system does not accord with First Peoples' holistic concept of health and social and emotional wellbeing. Do you agree that the current mental health system and the government's system of commissioning does not currently accept wellbeing and doesn't currently allow for self-determination in developing models of care?

THE HON INGRID STITT: I think that historically the system has been focused on clinical support and, you know, there is a challenge there for systemic reform to ensure that lived and living experience are embedded in our models of care. I absolutely accept that models of care do not adequately address the social and emotional wellbeing needs of First Nations people. And I am keen to continue to listen and work with our ACCOs and VACCHO and other organisations who are, I believe, best-placed to lead this important work.

MS FITZGERALD: The intention was that Balit Murrup, which was the Aboriginal social and emotional wellbeing framework, was intended to embed First People's self-determination. In your witness statement, you reflect on the funding that was allocated to Balit Murrup, you acknowledge from the outset that Balit Murrup was insufficiently funded.

THE HON INGRID STITT: Yes, I do acknowledge that.

MS FITZGERALD: Even though you made have acknowledgment it remains the government's primary framework to embed self-determination. And how - the question is how can it achieve that goal if you accept that it was insufficiently funded from the outset?

THE HON INGRID STITT: I think that the framework - there were a number of important projects that flowed from that framework, the demonstration projects. But I acknowledge it was not ever properly resourced from the outset to be able to realise the goals that were set in that framework.

I am absolutely committed to working closely with the Aboriginal Health and Wellbeing Partnership Forum, which now has carriage of the framework. And there are a number of important - there is an important agreement, a joint agreement between the Department, the government and the Forum. And I am absolutely committed to ensuring that I am supporting the work of the Partnership Forum and I will be keen to see how we can move towards and achieve proper self-determination through that process, including adequate funding for some of the initiatives that are going to be required.

COMMISSIONER WALTER: Can I just go to that, the Balit Murrup? Because I think - I am not sure where it is, but somewhere in the statement you make the - that monitoring and evaluation hasn't happened and that it was never funded to happen. So there really is, even though we were coming to the end of what is nearly a 10-year strategy, there is no way of - well, there is a way, because we can see the lack of outcomes on the ground.

But the strategy itself, despite all the fanfare with which it was launched has never been evaluated or monitored or anything else. Leaving aside that Balit Murrup has nearly finished, what is going to happen next? And how can this Commission be assured that we don't just get Balit Murrup part two, which is full of lofty ambitions without any actual follow through, or without holding anyone accountable for the fact that platitudes are offered instead of action?

THE HON INGRID STITT: I would not disagree with anything you have said. I think that - I am sure there have been a number of good intentions that have not been acted on or followed through with the vigour and accountability necessary. I have had the opportunity in the short time I have been in the portfolio to meet with the Aboriginal Health and Wellbeing Partnership Forum members and I have given them a commitment directly that I will engage closely with them.

I am keen to make sure that it's actions, that we see actions flow. I am sure that turning up to a meeting every now and again is inadequate and I am committed. And I will work hard to ensure that we see concrete actions through that forum and through the agreement that we have with a number of important action items that we have committed to as a government.

COMMISSIONER WALTER: Look, I have to admire those First Peoples who turn up at meeting after meeting, despite no actions actually coming out of it in the desperate hope that somehow something will happen sooner or later. I would like their work to be rewarded.

THE HON INGRID STITT: I share that view.

MS FITZGERALD: Minister, I will just step back to finish the issue of funding before we move on. In the 2021-'22 State budget, $3.8 billion was allocated to start rebuilding the mental health system, following the Royal Commission?

THE HON INGRID STITT: Yes.

MS FITZGERALD: And a further $1.3 billion was allocated in the '22-'23 State budget?

THE HON INGRID STITT: Yes.

MS FITZGERALD: That is a total of 5.1 billion allocated to the mental health system. In terms of funding specifically for First Peoples' social and emotional wellbeing 166 million was allocated in the '21-'22 budget over four years to implement the Royal Commission recommendations. Is that right?

THE HON INGRID STITT: 116 actually, 116 million.

MS FITZGERALD: Thank you. That is a typo in my notes. Thank you, Minister. 116 million. And is that funding part of the overall $5.1 billion investment for the entire scheme?

THE HON INGRID STITT: Yes, that's right.

MS FITZGERALD: So whilst 116 million appears to be a large sum of money it is not in comparison with the $5.1 billion going towards overall system reform, is it?

THE HON INGRID STITT: No.

MS FITZGERALD: And importantly, you accept that the currently allocated funding or the - has not been sufficient to deliver substantive change in mental health responses and outcomes for First Peoples, has it?

THE HON INGRID STITT: No, it hasn't, and I detail that in my statement.

MS FITZGERALD: From '25 to '26 recurrent funding of 32.3 million dollars will be provided for First Peoples' social and emotional wellbeing. Is that right?

THE HON INGRID STITT: Yes, that's correct.

MS FITZGERALD: And from that recurrent funding, 21.559 million will be made available to ACCOs and VACCHOs for up to 25 social and emotional wellbeing teams?

THE HON INGRID STITT: Yes, that's right, with a rollout plan for a statewide coverage of that program by 2025.

MS FITZGERALD: So that works out to about $850,000 per ACCHO, ACCO per year for emotional and social wellbeing?

THE HON INGRID STITT: I don't have those figures in front of me in terms of each individual ACCHO and ACCO's funding envelope.

MS FITZGERALD: So it may be that it is not divided by 25 -

THE HON INGRID STITT: It may be. Some ACCHOs, as I understand it, are ahead in terms of their work and recruitment of staff for those social, emotional, wellbeing teams. They might be a little bit further ahead than other ACCHOs and ACCOs.

MS FITZGERALD: So in terms of those ACCOs, including ACCHOs - I should say the acronym stands for Aboriginal Community-Controlled Organisation or Aboriginal Community-Controlled Health Organisation, just for viewers. In terms of the traditional means of funding those organisations have historically been by short-term project specific funding agreements. Is that right?

THE HON INGRID STITT: Yes, that's right.

MS FITZGERALD: And you have accepted that that historical funding model imposes a significant administrative burden on ACCOs, because it requires them to make frequent applications for funding and imposes a substantial reporting burden on them, doesn't it?

THE HON INGRID STITT: Correct.

MS FITZGERALD: The Productivity Commission recommended a transition to seven-year funding agreements. Are you aware of that?

THE HON INGRID STITT: Yes, I am.

MS FITZGERALD: The Department of Health is working on an outcomes-based funding model, but that will not involve seven-year funding agreements, will it?

THE HON INGRID STITT: The project will involve moving to four-year recurrent funding arrangements, as I understand it and the second part of that project will look at streamlining reporting requirements. I think there is a strong acknowledgment that the reporting burden is significant under the current model and that we need to move to a much more streamlined system, so that we can able ACCHOs and ACCOs to concentrate on the work that they want to deliver to their communities.

MS FITZGERALD: And that - the work on report reducing the reporting requirements was due to commence on 1 July this year?

THE HON INGRID STITT: That's right.

MS FITZGERALD: And can you confirm when that reduced reporting requirement will commence?

THE HON INGRID STITT: As I understand it, it was commenced next financial year. Yep.

MS FITZGERALD: So it will be 1 July?

THE HON INGRID STITT: 1 July, that's right.

MS WHETTON: Perhaps to add moving to the funding agreements moved to 1 July 2023, so for the current financial year and moving to streamlined reporting is commencing 1 July 2024.

MS FITZGERALD: So in about two weeks?

MS WHETTON: Correct.

MS FITZGERALD: Commissioners, I am moving on from funding. If anyone had any questions on those budget specific issues.

COMMISSIONER HUNTER: I am just wondering did the Balit Murrup - that is still current?

THE HON INGRID STITT: The framework, yes, it is.

COMMISSIONER HUNTER: Is there any funding going into that currently?

THE HON INGRID STITT: It is being taken up through the partnership agreement, is my understanding.

MS WHETTON: Yes, so the - so some of the key projects funded out of Balit Murrup, so the demonstration sites that were about working in partnership between ACCHOs and mental health services to improve outcomes for people

with moderate to severe mental illness and those - those four demonstration projects have now rolled into what we're - the social and emotional wellbeing teams funded recurrently through the Royal Commission implementation. There is also the mental health traineeship program that was funded under Balit Murrup and is also continuing to be funded now.

COMMISSIONER HUNTER: They are continuing, though. So that is the only two lots of funding?

MS WHETTON: There were also - there were 10 clinical and therapeutic mental health positions that were funded through Balit Murrup that are also now forming part of those SEWB teams in the Royal Commission.

COMMISSIONER HUNTER: We haven't mentioned it I want to mention that Korin Korin Balit-Djak is being funded?

THE HON INGRID STITT: I am advised the work associated with that framework has also now been incorporated into the action plan through the action plan through the Partnership Forum.

COMMISSIONER HUNTER: Right. So Korin Korin Balit-Djak has been put into the Partnership Forum as well?

MS WHETTON: Yes. So the actions that the Department of Health is responsible for have now become a part of the Aboriginal agreement and action plan.

COMMISSIONER HUNTER: So that is a partnership with Aboriginal organisations I am assuming.

THE HON INGRID STITT: Yes, with the Partnership Forum.

COMMISSIONER HUNTER: In the Partnership Forum and probably dealing with this from Commissioner Lovett there, what authority does that have, that Partnership Forum?

THE HON INGRID STITT: It works on a consensus model and there has been work on particular action items from the agreement that has been struck and funding has flowed for a number of those projects, but there is still more funding that will be required to move to some of the other action items in that Federal Parliament agreement.

COMMISSIONER HUNTER: Sorry, Counsel. But just on Korin Korin Balit-Djak, I just noticed that it's - every three years it's supposed to be evaluated. Has that happened?

MS WHETTON: I am not aware of that. I think the Department of Families, Fairness and Housing might take the lead on Korin Korin Balit-Djak. So it is not something I am aware of, but it could provide some information (crosstalk).

COMMISSIONER HUNTER: Yeah. I just want to know where it sits, who has the funding, who is the lead and I guess, has it been evaluated would be good, because it does say every three years it will. And if we have a 10-year plan we need to evaluate it to make sure it is working and if it is not, we need to adjust it.

MS WHETTON: All right. Can I add one detail around Balit Murrup? And just about the evaluation question for that one is that for the things that were rolled out that we will be undertaking an evaluation of Balit Murrup as well as where the Royal Commission Aboriginal social and emotional wellbeing recommendations are up to in '25-'26. So it's just to give the Commission a sense that - for the work that has been done and the impact so far we will be undertaking an overarching evaluation.

COMMISSIONER HUNTER: I think for being 10-year plans if we don't assess them and evaluate them as they go and we are putting money into them or not then we don't know it is working. And mental health is crucial for our people, as you said in your opening statement. But unless we are evaluating and looking at where those dollars are going, if it is working and we are putting them in the right - we are just going along blindly particularly the 10-year plan and things change in those.

MS FITZGERALD: Given we have focused on Balit Murrup I might just ask my - the remaining question I have about that now rather than going back later. Balit Murrup contained immediate actions for the next few - four years of Balit Murrup which was, in fact, up until 2021. Can you tell the Commission whether all of those what were at the time immediate action items were implemented?

THE HON INGRID STITT: Ms Whetton will take that one.

MS WHETTON: I can speak to that. Balit Murrup, the framework, it included 28 immediate actions to be undertaken over the first four years. And as the minister said earlier that a number of the actions were not resourced to commence. I think it is approximately half of those immediate actions were funded to be delivered and they are either completed or part way through.

MS FITZGERALD: And of the other half are they - has there been a decision not to proceed with them or are they just awaiting funding? Where are they?

MS WHETTON: A number of the objectives and intentions in Balit Murrup have then been brought to life through the Royal Commission implementation. So there are a number of actions that will now be being picked up as part of the Royal Commission implementation.

COMMISSIONER HUNTER: If they were not brought up in a Royal Commission and they - and they're in Balit Murrup, would they have ever come to light?

THE HON INGRID STITT: Well, I would hope if they are identified as a priority for the Aboriginal Health and Wellbeing Partnership Forum, which I understand a number of them have been, they would still have a high priority for action.

COMMISSIONER HUNTER: And does that forum come out of Balit Murrup, the people who were part of consulting on that?

MS WHETTON: That reference group wrapped up after the framework was delivered as I understand it, the Balit Murrup framework. The Partnership Forum is now chaired - it's co-chaired by the Minister for Health with the chairperson of VACCHO, then it has all of the ACCOs, some mainstream health services and the Department of Health on it.

COMMISSIONER HUNTER: So when did that come into play? We are looking at - that is 2017, then when did that - sorry, that group of people come together that you co-chair?

THE HON INGRID STITT: In 2020.

COMMISSIONER HUNTER: There is a gap between Balit Murrup and then having a group that has consensus about how we move forward and there was no funding. So how - for me, that is set up to fail. If you have this three-year gap between a reference group, got no money, no one is implementing it and then three months later you have a group. I must ask what do you mean by, "Consensus"?

THE HON INGRID STITT: Agreement is reached at that forum on both the agreement and the action items, and the prioritisation of those action items. And I absolutely acknowledge that that does not reflect self-determination, that model.

COMMISSIONER HUNTER: No, not at all. You have got this three-year gap and no money coming in. And is that consensus between the government and the Aboriginal Orgs at the table or the Aboriginal Orgs at the table?

THE HON INGRID STITT: I think it would be collectively across the representation of that forum.

COMMISSIONER HUNTER: If that means consensus isn't agreed what happens?

THE HON INGRID STITT: That is an excellent question and I think it goes to the need for structural change as I mentioned in my opening statement, to have the

ability for proper self-determination or what the priorities are for First Nations people in social and emotional wellbeing.

COMMISSIONER HUNTER: I get that you are new to the portfolio, but I also think you have a gap between Balit Murrup and then you've got Korin Korin Balit-Djak. And you've got again, frameworks that there's no money going into, they are not happening until a Royal Commission comes into play and we've gone, "Now it is an issue." I just feel that it shouldn't take - and, you know, the mental health of our people and a Royal Commission to address that. It should be more important than having a Royal Commission tell you that it is important. We've got the stats.

THE HON INGRID STITT: I don't disagree with you, Commissioner. I do - I think it's important also that the Royal Commission recommends there is role for the Partnership Forum to have an ongoing role in assessing implementation of each of the Royal Commission recommendations that - not only the ones that pertain to First Nations people, but more broadly. So that is certainly an important area for responsibility for the Partnership Forum as well.

COMMISSIONER HUNTER: Did the Partnership Forum happen out of the Royal Commission as well?

THE HON INGRID STITT: No it, didn't, no. It didn't.

COMMISSIONER HUNTER: So between 2017 and 2020 someone decided we needed a Partnership Forum?

THE HON INGRID STITT: It precedes my time in the portfolio. Perhaps Ms Whetton might have a bit more of the background.

COMMISSIONER HUNTER: I am just trying to understand the gap between 2017 and 2020, and then you have a Royal Commission that tells you to do all this stuff, so you do it. And meanwhile and I don't know the rates of suicide, but I am sure they are pretty high and we went through COVID in that time as well.

THE HON INGRID STITT: Yes.

COMMISSIONER HUNTER: No. I am just lost for words.

MS FITZGERALD: I had one more question just in relation to - for Ms Whetton in relation to Balit Murrup before we move on.

It also - so it had those first immediate actions for the first four years and then it also had aspirations for 10 years' time, which will be until 2027. How is Victoria tracking in terms of achieving those 10-year aspirations?

MS WHETTON: The 10-year aspirations, they have not been tracked, as we mentioned earlier the monitoring and evaluation has not been resourced. So we haven't been tracking along the way. There have been evaluations of particular elements, but as I mentioned earlier that in '25-'26 the overall framework will be subject to an overarching evaluation alongside the Royal Commission recommendations.

COMMISSIONER WALTER: Ms Whetton, would you agree that putting in a framework without funding evaluation and monitoring suggests that you are not serious about the outcomes, it is more about the optics than the realities?

MS WHETTON: I agree, it is unacceptable not to fund monitoring and evaluation when you set up frameworks like this, I do agree.

COMMISSIONER WALTER: We have seen it again and again, and again with Aboriginal frameworks. Like, literally 30, 40, 50, 60 of these things, none of which have been reviewed. And it is as if it's - we pretend we are doing something when we are not doing anything. We are just trying to kick the can down the road or even worse, maintain the status quo.

MS WHETTON: One of the aspects of the Royal Commission implementation is that when we seek and have sought funding for the particular initiatives coming out of the Royal Commission that we build evaluation into all of our funding proposals, so that there is that -

COMMISSIONER WALTER: I think as Commissioner Hunter pointed out that the other - it said in there it would be reviewed every three years. So many of these frameworks actually have evaluation and monitoring built into them with all sorts of strong statements about what is going to happen and then it doesn't happen. So how would you build something in where First Peoples could be confident that what you said was going happen, the evaluation and the accountability, would actually be delivered?

THE HON INGRID STITT: I think from my perspective, Commissioner, it comes down to prioritising that work and prioritising that funding, so that work happens. And that is certainly something that I am keen to lean in on.

COMMISSIONER WALTER: Perhaps - and it has been suggested by many First Peoples' submissions there needs to be an independent accountability model that holds the State to account for the commitments that are made and the evaluation and measurement is run by this body, so that it isn't the State saying it will do something and they are not doing something or marking its own homework.

THE HON INGRID STITT: I would accept that proposition.

MS FITZGERALD: Ms Whetton, I have got some questions for you about the Closing the Gap targets. In particular - well firstly, Closing the Gap Outcome 14:

> "Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing."

That is the outcome that is sought and also the related Target 14:

> "Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero."

CHAIR: Counsel, can I just check, are you following the document there with that reference, or not?

MS FITZGERALD: Yes. Yes, I am. I should be, although we have jumped around a little bit.

How is Closing the Gap Outcome 14 and Target 14 measured in Victoria?

MS WHETTON: So before I speak to this I will be talking about suicide and just acknowledging a sensitive area and devastating for families and communities affected.

The target for Outcome 14 in Closing the Gap, as you say it is a rate of suicide by First People's population and in Victoria at this stage that target is not reported against. And there are a small number of jurisdictions including Victoria that that is not reported. And it relates to the Australian Bureau of Statistics owns the data source for calculating that rate.

And the ABS believes that Victoria's data is not reliable, because of the number of First Peoples who participate in the Census and then that Victoria has, in the ABS's view, a small population. Now, I say this recognising it is deeply offensive to First Peoples and I do say that in the statement as well. But just to explain that is how the ABS currently calculates it. So it is not currently reported.

MS FITZGERALD: And what is being done to enable Victoria to report against the target?

MS WHETTON: So we are seeking to resolve this with the ABS. We have been - So when I say, "We", the Department of Health. We have been raising this with the ABS for quite some time to understand their methodology and how that can be changed. We are also seeking the help of the Australian Institute of Health and Welfare, to see if they can undertake with us to do some work as well to try to find a way to solve this problem of not reporting.

And we are also raising - there are a number of official committees around data. That we are using some of those committees as well to raise the under numeration

of First Peoples in the Census, that this is a national issue as well. I will mention as well is that we - not wanting to wait for the work that the ABS will do, and we are seeking that they will do, the Coroner's Court of Victoria has reliable, very reliable accurate data around suicide in Victoria.

And we have been looking, as a Department, about whether we might be able to look at our local data and perhaps some data linkage work to understand that rate for Victoria. If we were to do that as part of Closing the Gap, we would need to seek the agreement of the Productivity Commission. That is something that we are just in the initial stages of considering. So it is not acceptable to not have a way of measuring it.

MS FITZGERALD: That might answer my next question, which was why can't the State of Victoria rely on the very reliable figures produced by the Coroner's Court to report on that target?

MS WHETTON: The – it's a good question. As I understand it, and colleagues in the Department of Health who are working on this, that the methodologies that are used by the ABS across the country for Closing the Gap is different to the way we - the Coroner's Court collects that data in Victoria. So it comes down to a methodology question which again, I just want to acknowledge how offensive that is.

COMMISSIONER LOVETT: But we have the VGAAF here in Victoria, the Victorian Government Aboriginal Affairs Framework, which is also aligned to Closing the Gap. So what are you doing to publicly report through that mechanism?

MS WHETTON: I don't believe we'd be reporting a rate through that, because it is not - but I can take that on notice and see what it is that we do there.

COMMISSIONER LOVETT: Because I mean, we have our own implementation plan as you'd be aware of. Yes.

MS FITZGERALD: Just turning to those - the very reliable information that the Coroner's Court provides. You've - the State is provided the 2018 to 2023 statistics to us, and that is BAL7.0004.0006.0001. And in those statistics, we are told that in 2018 there were 10 suicides of Aboriginal and Torres Strait Islander men and this rose to 22 in the year 2023. And in that same period there were four suicides of Aboriginal and Torres Strait Islander women in 2018 and six in 2023. So the numbers are increasing.

MS WHETTON: They are.

MS FITZGERALD: And it is also fair to say the numbers - there is consistently a differential between the rates for First People's men and the rates for First People's women in those suicide rates, isn't there?

MS WHETTON: Yes, yes, there are.

MS FITZGERALD: And does the Department acknowledge and accept that there are particular, specific issues in relation to men's business that need to be addressed to genuinely address those rates?

COMMISSIONER LOVETT: Can you articulate some of the things? What investments have been made to work with men on this stuff?

THE HON INGRID STITT: Commissioner, there is a number of important pieces of works. Obviously the - increasing the resources for the ACCHOs, social and emotional wellbeing teams, noting those teams understand community best and have built those models of care that are about early intervention. I think early intervention is certainly an area that needs more focus and resourcing, because for too many people, care and support is not sought early enough and so people are getting into an acute situation before they present for help.

We have also been doing some work through the Balit Durn Durn Centre and ACCO to lead the design of a First People's lead approach to preventing suicide and response to suicide risk. So that is very important work, which I am very keen to make sure that we are supporting the resourcing of. And we have also been working on a broader, statewide suicide strategy arising from the work and the recommendations of the Royal Commission and again VACCHO are doing the work and leading the work on what that strategy needs to encompass to address First Nations particular priorities.

COMMISSIONER LOVETT: Thank you.

MS FITZGERALD: Looking at the overall numbers what we can see from the Coroner's Court statistics is that for those years, from 2018 to 2023 in Victoria, First Peoples died by suicide at a rate nearly three times higher than non-Indigenous people, didn't they?

THE HON INGRID STITT: Yes.

MS FITZGERALD: And, Minister, accepting that far too many, disproportionately too many, accepting that any rate is unacceptable, but a disproportionate number die by suicide each year, with that rate increasing rather than decreasing, what is the government doing to stop that?

THE HON INGRID STITT: As I just outlined to Commissioner Lovett, we have a number of important programs that we are supporting and resourcing. Obviously those numbers are completely devastating and completely unacceptable. And we need to work much harder in terms of addressing the issues that are driving these numbers and I am keen to learn more directly from ACCOs

and also the Balit Durn Durn Centre and VACCHO about what other supports are needed.

I have heard the message loud and clear already from a number of ACCOs that I have been able to speak with about the importance of early intervention and the importance of having a holistic approach to addressing social and emotional wellbeing. But also acknowledging that there are other factors that might feed into emotional - social and emotional wellbeing of First Nations people.

I think I mentioned in my opening statement that we - for example, we did see an increase in emergency Department presentations immediately following the referendum result. So there are obviously issues that are - that are causal issues, society- wide. So, of course, addressing those is critically important in driving this - turning this situation around for First Nations people in Victoria.

MS FITZGERALD: A lot of those drivers are within your portfolio to the extent that the Coroner's Court statistics show that 81.7 per cent of those deceased had a diagnosed history of mental health. You accept that?

THE HON INGRID STITT: Yes.

MS FITZGERALD: And 10.6 per cent had a suspected, but not diagnosed history. So that is a total of 90 per cent.

THE HON INGRID STITT: Yes.

MS FITZGERALD: And so you accept that mental health is at the very least almost in the Venn diagram a complete coverage for almost all of those people who died by suicide?

THE HON INGRID STITT: Yes, I do accept that.

MS FITZGERALDN: In your statement you talk about the Suicide Prevention Office funding Living Works Australia to design and deliver a community program of community gate keeper training.

THE HON INGRID STITT: Yes.

MS FITZGERALD: And you mentioned that Monash University has evaluated that program and provided a report in 2024?

THE HON INGRID STITT: Mmm-hmm.

MS FITZGERALD: You say at paragraph 92 of your witness statement that:

> "The loss caused by suicide in First People's communities is acute."

THE HON INGRID STITT: Yes.

MS FITZGERALD: Now, the government has had the evaluation of that pilot program for two months. What has been done to get going on a permanent, non-pilot First People's suicide prevention program?

THE HON INGRID STITT: In relation to that particular report, this is related to the work of the Balit Durn Durn Centre and VACCHO, and it will inform future action in terms of implementing recommendation 27.1(c) of the Royal Commission's report. So that is work that is obviously critically important and that we are committed to ensuring continues.

MS FITZGERALD: So the - Living Works designed and delivered a pilot for community gate keeper training. It was evaluated by this office. Is the intention that the pilot that was being conducted by Living Works be continued as part of a permanent - permanently funded?

THE HON INGRID STITT: Yes, it is one of the action items out of the Partnership Forum agreement and my understanding is that that is agreed at the Forum that that will be a future action, that is undertaken.

COMMISSIONER WALTER: I just wanted to go back to - excuse me, counsel - the previous question, the Monash University evaluation of the pilot program. I didn't get the answer to that. That is now being delivered, so what was the evaluation? What did it say?

MS WHETTON: So the evaluation showed that - that the training it had been - had had some impact and that recalling the - from the report that training had supported community members to be able to be the gate keeper as they say it, to be a person who is safe in the community to talk to, wrap a social network around someone who might be thinking about suicide. And that that training had - I think the Monash report talks about it had - that training had been retained as - you know for people to use into the future.

Could I add from the earlier question that we would be proposing that from that pilot we recognise that pilots are just but one thing and that the Royal Commission said, "You need to deliver this training". But because it is something we hadn't done before that we ran the pilot and we'd be proposing as part of the next budget process that we would be seeking funding to be able to roll that out more generally.

COMMISSIONER WALTER: But to be clear the pilot has now completed?

MS WHETTON: The pilot is now completed.

COMMISSIONER WALTER: And there is nothing happening at the moment?

MS WHETTON: Not at the moment.

MS FITZGERALD: Just moving specifically to budgetary issues in relation to this area. How much funding has been allocated in the '24-'25 State budget to suicide prevention and response that is specifically for Aboriginal and Torres Strait Islander people?

THE HON INGRID STITT: It's - there are a number of programs that were funded in the '24-'25 State budget to the - and 3.5 million was allocated for suicide prevention programs, including the Strong Brother, Strong Sister program that operates in the Barwon region for young people and also the Yarning Safe and Strong 24/7 help line.

MS FITZGERALD: Thank you, Minister.

COMMISSIONER HUNTER: That is just two programs. Like, one is in the Barwon region. It is not much.

THE HON INGRID STITT: No, that's right. It is two specific programs that were funded in this year's budget, but there are some programs that are funded through the forward estimates from previous budgets that do go to suicide prevention work. And that includes, obviously, the resourcing of the social and emotional wellbeing teams within ACCHOs, although I acknowledge more work needs to be done in that area and more resources applied. There is also the work I mentioned earlier around the suicide prevention strategy, and a number of programs that flow from the Royal Commission's recommendations that continue to be a strong focus.

COMMISSIONER HUNTER: Just on the social emotional wellbeing tests, did you say there was four?

THE HON INGRID STITT: No, there is 25 and we are scaling up to have statewide coverage by 2025.

COMMISSIONER HUNTER: Thank you.

MS FITZGERALD: I also wanted to ask you some questions in relation to the Aboriginal healing centres that were recommended by VACCHO. I think they sought the establishment of five statewide healing centres and the Royal Commission recommended that two statewide healing centres be established by 2026.

MS WHETTON: Mmm-hmm.

MS FITZGERALD: Ms Whetton, I think I will leave this question to whichever of you has the answer. In total 1.2 million dollars has been allocated to VACCHO to undertake the co-design process for those healing centres. Is that right?

MS WHETTON: Yes, that's right.

MS FITZGERALD: In terms of the proposed locations for the healing centres the plan was that suitable locations were expected to be selected by the end of May this year. Have those now been selected? And if not, when do you anticipate they will be selected by?

THE HON INGRID STITT: They haven't been selected yet, but from my perspective it is important that those locations are led by First Nations. And so the work on locations and the budget bid that will facilitate the capital program and whether they are existing facilities or whether there are new facilities and new infrastructure required, all of that work is being led by VACCHO and the Balit Durn Durn Centre. And they are leading the budget bid process for that work, both in terms of capital, but also the operational funding ask for the two healing centres. And that budget bid will be brought forward at the next budget, which will be '25-'26, and that will have my very strong support as Minister.

MS FITZGERALD: So it is right to say that no funding has yet been allocated beyond June 2024 for those centres, has it?

THE HON INGRID STITT: That's right.

MS FITZGERALD: And the Balit Durn Durn Centre and the Department will develop a business case for the '25-'26 State budget process. Is that right?

THE HON INGRID STITT: That's right, yes.

MS FITZGERALD: In light of this is the timeline for 2026 for establishing those two healing centres still achievable?

THE HON INGRID STITT: Yes, I believe that it is, yes.

MS FITZGERALD: Just moving now to some of the specific recommendations made by the Royal Commission, in particular in relation to responses to mental health crises.

THE HON INGRID STITT: Yes.

MS FITZGERALD: And with particular focus on Recommendation 8, "Responding to mental health crises", Recommendation 9, "Developing staff spaces, and crisis respite facilities" and Recommendation 10, "Supporting responses from emergency services to mental health crises."

Ms Whetton, your witness statement outlines reforms undertaken to date to implement these recommendations. The full implementation of Recommendation 10 will occur through what you describe as a fazed transition in future years. How

many years does the Department think it will take to fully implement Recommendation 10?

MS WHETTON: We are not able to put a time frame on that just at the moment. The Recommendations 8, 9 and 10, when taken together, there is significant complexity around them. I would say, though, just in talking about these recommendations acknowledging the disproportionate impact on First Peoples in mental health crisis, because it means at the moment that First Peoples are often coming into contact with emergency responders, some of whom are Victoria Police.

It can also include paramedics as well under the current model. And so we are undertaking the work in phases, because it is about trying to build the capacity of the mental health system while at the same time preparing, in effect, the paramedic workforce to be able to step in to take on that role into the future.

MS FITZGERALD: Minister, in terms of funding allocated to implement those recommendations there was funding allocated in the previous three budgets for Recommendations 10 and 8.3(c), which is in relation to the emergency department treatment in each region.

THE HON INGRID STITT: Yes.

MS FITZGERALD: The '24-'25 State budget allocated 1.4 million over two years, 700,000 a year to continue the Teleprompt program, to provide paramedics with continued access to mental health expertise while reformed models of clinical assistance are developed. Is that all of the funding allocated in the '24-'25 state budget to the implementation of Recommendations 8, 9 and 10?

THE HON INGRID STITT: It is, but what I would say is that the funding for the planning and design activities that was provided in the '23-'24 budget are still being actioned, so that work continues. I think originally the Royal Commission provided a timeline of having these reforms in place by 2024. It is absolutely clear that we will not be meeting that timeline.

And I think we are mindful and acknowledge the fact that the health system and emergency services more broadly have been under significant pressure coming out of the pandemic and we want to make sure that the changes to the way mental health crises are handled, are done in a way that is safe and appropriate, so it will take a bit longer. But that design working continuing and there is a lot of work going on across agencies and departments to progress this work.

MS FITZGERALD: Ms Whetton, in your witness statement you say that additional funding will be required in successive future budgets to enable full implementation of these recommendations. Does the Department have any idea of how much funding is required?

MS WHETTON: Not at this stage. So the budget so far, as the Minister has mentioned, the funding that goes into the planning and design activities that will help us and when I say, "Us" it is the Department of Health but working with our colleagues across Ambulance Victoria, Department of Justice and Community Safety, Triple Zero Victoria. So there's a number of government agencies, recognising that we also need to work with First Peoples and other organisations in this. Those activities will help us determine an estimate for the full implementation.

MS FITZGERALD: Minister, you touched on and there is evidence in your witness statement that many First Peoples distrust and fear emergency services and particularly the police.

THE HON INGRID STITT: Yes.

MS FITZGERALD: At the moment emergency services are still involved in responding to mental health crises.

THE HON INGRID STITT: Yes.

MS FITZGERALD: Ms Whetton, do you know what specialist training emergency services, in particular Victoria Police receive in mental health crisis response?

MS WHETTON: I am aware that they do undertake mental health related training, but because it just sits outside, Victoria Police would be better able to answer that. But I am aware that they do undertake some training.

MS FITZGERALD: Minister, given your acceptance that there is a level of fear and distrust of emergency services amongst First Peoples do you consider it is appropriate for police to be used as the State's response when First Peoples are having a mental health crisis?

THE HON INGRID STITT: Clearly not and clearly the Royal Commission recommendations go to the importance of having a health-led response, which is what we are working towards. It will, unfortunately, take longer than we had hoped, but it is a very important part of the Royal Commission's recommendations, as is earlier intervention, so that First Peoples are not - do not find themselves in a position where they have to present in crisis.

So there is a holistic response to this, I think, beyond Recommendation 8, 9 and 10. But I do accept that this is not - this is not a good situation. But we are progressing the work as quickly as we can, noting the need to have safer systems in place.

MS FITZGERALD: Whilst it is not a good system for anyone because of Victoria's colonial history and the role of police in that history, it is a particularly bad system for First Peoples, isn't it?

THE HON INGRID STITT: Yes, I would agree with that.

MS FITZGERALD: Commissioners, I am going to move on to a new topic now if there are any further questions in relation to the Royal Commission recommendations.

COMMISSIONER WALTER: Just to say look, it is very disappointing that everything is behind time, just beginning, maybe in the next budget cycle. It is quite - yeah, it does not make me feel hopeful.

COMMISSIONER LOVETT: Yeah. I think just building on that, I mean, what is going to give us and our people hope that our recommendations that we make to you are going to be taken serious, taken on board and responded to?

THE HON INGRID STITT: I think that my view, my personal view is we haven't prioritised these recommendations that impact First Nations people in a disproportionate way enough. I am certainly committed within my ability to try and make sure that we are prioritising the work and the investment that has to go into delivering on these recommendations.

So I will continue to do whatever I can to progress these issues. But I also want to take every opportunity I can to hear directly from our First Nations health - community health organisations and community-led organisations about what is going to work best.

COMMISSIONER LOVETT: And I think that is fair enough and I understand your own personal advocacy, but I think, you know, probably needing more clarity from your colleagues about backing in that aspiration as well. I think because our people have been coming forward for the last 200 years, been saying the same thing, in particular last 50 years around education, or health or housing.

So the advocacy has been there but the actual - I think we have been heard but not listened to. So, yeah, I am really concerned about the work we do and the recommendations that will be provided by this Commission. They need to be taken seriously and - because they are generated by systematic exclusion and also First Nations voices.

COMMISSIONER NORTH: Minister, do you have any insights into what sort of recent history might explain some of these delayed outcomes? Because it is something that we have heard over and over from one minister, one secretary, one deputy secretary after another. And I am sort of searching for what is it that has blocked the execution of what seem to be good policies and genuine commitment, but then no delivery. And is there something in recent history? I mean I'm

thinking maybe COVID, I am thinking of maybe political changes in leadership. Is there something that explains this phenomenon?

THE HON INGRID STITT: I certainly am of the view that COVID disrupted a lot of government reform and priorities, no question about that. Also, I acknowledge that the Royal Commission into the mental health system's recommendations were very detailed, very complex, and did set out a 10-year reform journey, if you like, because of the complexity of the recommendations and the systems that need to change. I think that is a factor. But I think that there is absolute commitment to implement every single one of the recommendations.

That will not go to all of the issues that need priority and I am obviously, you know - will be very keen to see what the Commission recommends in relation to the mental health system and what more can be done to address the unacceptable disadvantage experienced by First Nations people in our mental health system. I think COVID is a big factor in terms of the timelines on some of these.

COMMISSIONER NORTH: Can you just elaborate on that a bit? Because as I say it is a real puzzle to me. It is a very unusual situation where you have government coming along and say, "Here are the policies." They seem to be the right ones. There is a genuine commitment, I think that can be accepted.

THE HON INGRID STITT: Yes.

COMMISSIONER NORTH: But then there is this blockage and how would COVID - how did it impact?

THE HON INGRID STITT: Well, I think from my perspective I would imagine that - and it was before I was in this particular portfolio, but I know that the Department of Health were completely focused on the pandemic response, you know, sort of one in 100-year event, with very significant health impacts across the community. So I know that that was, you know, sucking up a lot of resources of the Department at the time.

But I don't want to provide that as a way of giving an excuse, because there were some aspects of the Royal Commission implementation work that we were able to continue on during COVID. Not everything, but many of them were able to be progressed. We just need to redouble our effort and our focus on rolling out those recommendations that are critical for better outcomes, across the board.

MS FITZGERALD: Thank you.

Chair, it is now 3.14. I wonder if the Commissioners wanted to stop for a 10-minute comfort break. Can we adjourn for 15 minutes?

CHAIR: How long were you suggesting?

MS FITZGERALD: If the Commissioners would like 10 or 15 minutes I am in your hands.

CHAIR: 10 minutes. Thank you. All right.

MS FITZGERALD: Return at 3.25?

CHAIR: Yes, or 3.30.

MS FITZGERALD: Or 3.30. Thank you, Chair.

CHAIR: Thank you we will adjourn for 15 minutes.

<THE HEARING ADJOURNED AT 3.15 PM

<THE HEARING RESUMED AT 3.30 PM

MS FITZGERALD: Minister, I will move on now.

In fact, sorry - Ms Whetton, the questions I was going to address now relate to issues of cultural safety for First Peoples. You say in your witness statement that work has been undertaken within departments and agencies to focus on better understanding the needs and challenges being faced by mental health and emergency services.

MS WHETTON: Yes.

MS FITZGERALD: You also say that:

> "The Department will prepare a detailed plan for external engagement over the coming months including specific consideration of engagement with First Peoples and how to ensure the Department's engagement is culturally safe."

MS WHETTON: Yes, and that was in direct reference to Recommendations 8, 9 and 10 I recall, yes.

MS FITZGERALD: Does that mean at the moment there is not a process across the Department for considering cultural safety for First Peoples?

MS WHETTON: No, that direct reference was in relation to the work that we are undertaking for Recommendations 8, 9 and 10 and I talked earlier in the session around so far a lot of the work has been undertaken by government agencies. And that we recognise that part of the next stage of the work that we need to engage with First Peoples, particularly the disproportionate impact on First Peoples related to emergency responses to mental health crisis. And so - but we try to point out in the statement or I try to point out in the statement that we want to

make sure that any engagement we have for that work that is it is culturally safe, recognising that that can be a challenge.

MS FITZGERALD: And what work has been undertaken to date and what work remains to be done in order to ensure the Department's engagement with First Peoples is culturally safe?

MS WHETTON: You mean generally?

MS FITZGERALD: Yes, yep.

MS WHETTON: So I acknowledge that we have got a fair way to go in this and that it is something I think we say in earlier statements. It is one of the areas where we are really needing to grapple with this. It is something we haven't done particularly well in the past. We have an Aboriginal cultural safety framework in the Department. We use that both for the services we fund as a Department, also for our own Department as well.

That includes an assessment tool where either the service or the Department can look at where that particular group is - when I say, "Group", I mean in the Department or in the service. Where they are up to in terms of cultural safety and what else they need to do to be culturally safe.

MS FITZGERALD: And you are aware that the Charter of Human Rights and Responsibilities contains a right - a cultural right that is very specific to First Peoples in Section 19?

MS WHETTON: I am aware of that.

MS FITZGERALD: And are you aware that the cultural rights in Section 19 require some consideration of culturally protective factors, like social and emotional wellbeing? That the State is required, because of Section 19 of the Charter to give consideration to things like social and emotional wellbeing and other First Peoples culturally protective factors?

MS WHETTON: Yes.

COMMISSIONER HUNTER: Can I just, on that, you understand Section 19 of cultural rights?

MS WHETTON: As in - yes, I am aware of it.

COMMISSIONER HUNTER: So you would also know working in social and emotional wellbeing that they are our protective factors, correct? So would they be in all that you do? Would they be - would you say they are in all the work that you do? Putting the rights of culture first for First Peoples?

MS WHETTON: I would say it is something that we are improving on in the Department. It is something that we are focused on. One of the things in the Mental Health and Wellbeing division, which is the division that I lead in the Department, we are undertaking work at the moment to develop our own cultural safety plan in the division, because -

COMMISSIONER HUNTER: But it is in the Act, it is in the human - the Charter of the Human Rights of Victoria Victorians. Do you just decide whether you uptake that? Like is it just a decision that you make?

MS WHETTON: No, I would say that is about bringing it to the forefront and bringing it to life in every piece of work that we do.

COMMISSIONER HUNTER: How long has that been around, that Act? That -

MS WHETTON: I believe it is 2006.

COMMISSIONER HUNTER: What are we in?

THE HON INGRID STITT: 2024.

COMMISSIONER HUNTER: So it also applies to mental health principles and so the cultural safety principle applies in full conjunction with this, right. Can I just say that it states:

> "Treatment and care is to be appropriate for and consistent with cultural and spiritual beliefs and practices of a person living with a mental illness or psychological distress."

We go down further:

> "Regard is to be given to Aboriginal and Torres Strait Islander people's unique culture and identity including connections to family, kinship community and Country and waters."

Then it goes on to say:

> "Treatment and care for Aboriginal and Torres Strait Islander is to the extent that the practical, appropriate to do so and be decided and given having regard to the view of Elders traditional healers and Aboriginal and Torres Strait Islander mental health workers."

That is 2022 Act. So how long do we have to wait for these charters, these Acts? Who is responsible for these Acts and charters? We just come up with cultural rights that actually protect our people and they are not implemented in any way or it just feels like if you want to put it in there. This is the core of mental health

wellbeing for our people. It is in there, in - let us say in white law, l-a-w for people to follow. It is not there for a reason. So why are these not followed?

THE HON INGRID STITT: Commissioner, can I perhaps acknowledge again, as I do in my statement that in terms of our mental health services, so our mainstream mental health services there has been, in the Statement of Priorities that are provided to each of those mental health and overall health services a requirement to provide culturally safe care.

COMMISSIONER HUNTER: Well, why isn't it?

THE HON INGRID STITT: But clearly that has not been met and there is no accountability framework for that.

COMMISSIONER HUNTER: If you listen to Ray Lovett's witness - when he was a witness, his testimony, he talks about racism and discrimination causing PTSD on a daily basis to our people, which adds to suicide. And then we have got these charters and these policies and these laws and these frameworks, but no one seems to worry if they are implemented or not.

THE HON INGRID STITT: I would absolutely acknowledge that there hasn't been proper accountability within mental health services, which is why the Statement of Priorities will, in future require mandatory training in cultural safety.

COMMISSIONER HUNTER: Who is going to monitor that?

THE HON INGRID STITT: Well, there will be a set of requirements on each health service to demonstrate that they are applying the mandatory training and that they are applying the principles.

COMMISSIONER HUNTER: They can apply it, but who is monitoring it is actually a culturally safe service?

THE HON INGRID STITT: I think the Department has a number of monitoring mechanisms that would be available to them to step in if a particular health service, including a mental health service was not fulfilling its obligations under those Statement of Expectations that are provided by the Health Minister directly to the service. And I think that - understand the Secretary of the Department gave a little bit of evidence about that earlier today in in relation to what triggers and what steps could be taken if a health service was not complying with those cultural safety undertakings.

COMMISSIONER HUNTER: Well, I am just going to say that this Commission will be watching very closely how that does that, and in this day and age it is just - I am appalled that none - just for the mental health system, we know it is broken anyway. But for our people it is even worse and we have got in the Charter cultural rights, and then you have got the other Act, the Mental Health and

Wellbeing Act in 2022, which mentions our people again. We have been left behind and we are dying because of it.

THE HON INGRID STITT: And, Commissioner, if I can add, I have heard directly from ACCHOs about their - some of them experiencing great frustration trying to liaise with mental health services in our mainstream system, and then feeling that they have not been taken seriously enough in terms of individual community members', social and emotional wellbeing needs. So this is something that I am absolutely committed to working with our ACCHOs and ACCOs on what more can be done to make sure that those models of care are appropriate.

COMMISSIONER HUNTER: Do you fund those services they work with?

THE HON INGRID STITT: Yes.

COMMISSIONER HUNTER: Yes. So who can say - so they are obviously not culturally safe. So where does this authority lie that people either - I don't know. I'll use the word "reprimand" - be reprimanded for being culturally unsafe and racist?

THE HON INGRID STITT: I think it is an unacceptable situation and I see the statistics of First Peoples' reporting unacceptable levels of racism that they've experienced in the system, and we need to make sure that we have more accountability in place, including through funding arrangements of those mental health services.

COMMISSIONER HUNTER: I am going to say a lot more accountability and I will add while we are talking about statistics, each is a - number is a person.

THE HON INGRID STITT: Absolutely.

COMMISSIONER HUNTER: Yeah, and I want to remind people of that. While we are not upholding cultural rights and the system is racist and discriminatory, that adds to the suicide rates of our people and going untreated mental health issues. And so I just - it is just not, you know, I am just frustrated sitting here that Balit Durn Durn, Korin Korin Balit-Djak, we've got cultural rights, we have got all this stuff. We have got it all in writing and I just - it just fails to be implemented correctly for our people again and again and then we want to go - where do we end up? The Coroner's Court it is just not good enough for our people, it is just not.

MS FITZGERALD: Thank you, Commissioner.

COMMISSIONER LOVETT: I think we heard earlier, just building on that really, we heard earlier the sentiment being expressed by the Commissioner here that the Deputy Secretary from hospitals and health services was - one of her main responsibilities is organisational performance. Now, when it comes to cultural

safety and racism linked to funding outcomes threshold of the bar was incredibly low when it came to our people's rights and interests. So I think that is where - the strategic hooks are there but they haven't been followed and then again, there is no independent oversight there is no accountability on the system and, you know, our people are the ones that miss out.

THE HON INGRID STITT: I accept that that's the case.

MS FITZGERALD: Ms Whetton, in your witness statement you note that there is a commitment under the Aboriginal Health and Wellbeing Safety Plan to implement culturally safe planning in all community settings and you observe that it hasn't been implemented. And in September 2023 the Forum agreed to pause this action in order to progress other actions.

MS WHETTON: Yes, I understand that to be the case and this was about health services generally of which mental health services are part, but, yes, it was about health services generally.

MS FITZGERALD: Do you know when this pause on implementing this action item might be lifted?

MS WHETTON: I believe it has been lifted and that VACCHO is now undertaking work to develop cultural safety standards for health services and also a cultural safety accreditation program. And that, as I also mentioned in my statement and the Minister's referred to earlier for the 2024 statements of priorities that the cultural safety training will be mandatory. It has previously been a goal and it hasn't been mandatory and not a requirement, so that we are, I believe that work is now un-paused, getting back to that.

MS FITZGERALD: So currently it is not mandatory for health services to deliver cultural safety training, is it?

MS WHETTON: As I understand it, it has been a goal that is been included in statements of priorities of previous years, but not mandated, but it will be more the first time in '24-'25.

MS FITZGERALD: And you spoke about the funding that VACCHO has received in the '24-'25 State budget. As I understand it the total funding sought by VACCHO could not be allocated and this will limit the breadth of the cultural safety work that VACCHO is able to do, won't it?

MS WHETTON: I understand that to be the case.

MS FITZGERALD: Are you aware of what the short in all was between the amount that VACCHO sought and the amount it was allocated?

MS WHETTON: I am not. It is just a bit outside of the mental health portfolio, so I am sorry I am not aware of that.

MS FITZGERALD: Sorry. I have one more question in relation to that training. Your witness statement also mentions that VACCHO has drafted standards including delivering cultural safety training and undertaken a feasibility study for a First Peoples-led cultural safety accreditation scheme for health services. What was the outcome of that feasibility study?

MS WHETTON: Again, I don't have the details. It is just a broad Department of Health piece of work. But I can provide some information to the Commission if it would assist.

MS FITZGERALD: That would be useful. If you could provide further detail about what the program involves and who is delivering it. I've now got some questions about compulsory treatment.

COMMISSIONER LOVETT: Can I ask a question back to cultural safety? How many Aboriginal staff do you have in your area, working in the mental health side from the government's perspective?

MS WHETTON: Yes, so I think -

COMMISSIONER LOVETT: Not names, just positions. People have come and mentioned names. It is never about names, it's about how many people.

MS WHETTON: I understand. In the Mental Health and Wellbeing division I have called the Balit Murrup unit and I have a number of First Peoples working in that unit as well as the division. I have nine staff in the division who identify as First Peoples, which again, just acknowledging you are talking about numbers and statistics but it does represent about four per cent of my overall division and workforce.

COMMISSIONER LOVETT: And what is the most senior level there?

MS WHETTON: The most senior person who identifies as First Peoples is a director level, so who leads the Balit Murrup unit.

MS FITZGERALD: Ms Whetton, an independent panel was appointed in October 2022 to conduct the review of compulsory treatment and a public consultation process was started in April 2023 and there were 48 responses. And as I understand it in July 2023 the panel completed its work, is that right?

MS WHETTON: In 2023 the panel ceased its work but had not yet provided a final report.

MS FITZGERALD: And what is to be the result of that work?

MS WHETTON: So the panel, while it was working together, undertook fairly significant work in engaging with many organisations to talk around the compulsory treatment criteria. They undertook and engaged Victoria process, so a public process to seek submissions, undertook a number of pieces or commissioned I should say, commissioned pieces of research and analysis. So all of those pieces of work that had been undertaken by the panel, it is now sitting with the Department to synthesise that work and provide some advice to the Minister later this year.

COMMISSIONER NORTH: And my curiosity compels me to ask what happened, because the panel was asked to deliver a report but it didn't. Did they all die or?

MS WHETTON: It wasn't planned for the panel to cease work when it did, but there were - there were a number of factors being how the panel was working together that meant that it was disbanded that time.

COMMISSIONER NORTH: How many were on the panel?

MS WHETTON: Five people.

COMMISSIONER WALTER: Were some of those people First Nations people?

MS WHETTON: No.

MS FITZGERALD: Does that mean that nothing is currently being done to progress the recommendation on compulsory treatment, or nothing has been done other than the appointment of that panel?

MS WHETTON: So the review was one piece of work that had been announced by government. There is, if we are talking more generally around how we reduce compulsory treatment is that -

MS FITZGERALD: Yes.

MS WHETTON: The Royal Commission called out that compulsory treatment should absolutely be used only as a last resort and recognised that it is traumatic and harmful and particularly for First Peoples, that it is particularly triggering. There is a piece of work that Safer Care Victoria is currently leading called the - it's a reducing compulsory treatment piece of work. And they are just getting started in this piece and work and recommended by the Royal Commission to work with a number of services to look at their local data about what it is telling them, including for First Peoples and non-First Peoples and then to - they will work through methods and initiatives to reduce that compulsory treatment.

MS FITZGERALD: Your witness statement gives a fair amount of data in relation to compulsory treatment.

COMMISSIONER HUNTER: Sorry, counsel, what page is that on?

COMMISSIONER NORTH: 15.

COMMISSIONER HUNTER: Thank you.

MS FITZGERALD: I will just jump to the table. At page 15 and I am thinking in particular of - it starts on 15 and then the bulk of the tables are on pages 16 and 17. And, Commissioners, you will see each of the hospitals are listed there and the - using the top of the table we see the first column is Percentage of First Peoples clients with at least one compulsory assessment or treatment order, and the second column is non-First Peoples, and it is a percentage. And we can see that for each of those health services I think it was except St Vincent's Hospital, for everyone except St Vincent's Hospital the percentage of compulsory treatment odds were higher for First Peoples. And for St Vincent's the numbers are comparative, but slightly lower for First Peoples.

And I think we see similar - similar data on page 19 in relation to restrictive interventions, which continues on to page 20. So the numbers show that a significant number of First Peoples received at least one compulsory treatment over the past five years. That is five per cent of all clients of area mental health services, and 21.3 per cent of all First Peoples' clients during that time period.

MS WHETTON: That's right and that is the typo that we -

MS FITZGERALD: That five per cent is meant to be four per cent?

MS WHETTON: Yes.

MS FITZGERALD: Thank you very much.

MS WHETTON: Sorry, I just hadn't picked that up.

MS FITZGERALD: Minister, since 2014 as Commissioner Hunter mentioned earlier, the legislative framework in Victoria has required firstly that principles specific to First Peoples are taken into account, but also that compulsory mental health treatments should only be used as a last resort. So that is in the legislative framework already?

THE HON INGRID STITT: Yes, that's right.

MS FITZGERALD: And changes have also added human rights principles, and as I have said principles specific to First Peoples, but those legislative changes have not reduced the rates of compulsory treatment for First Peoples, have they?

THE HON INGRID STITT: No, the figures remain stubbornly unacceptable.

COMMISSIONER HUNTER: Why would that be?

THE HON INGRID STITT: It could be a number of issues. It could be of that First Nations people are seeking treatment and care later, instead of earlier. It could be that there have been low levels of cultural safety within that particular facility. It is difficult to pinpoint exactly, but the statistics remain unacceptably high and we need to drive those down.

COMMISSIONER HUNTER: Wouldn't it be your job, so to speak, to find out why that hasn't moved, like to make it safer for our people or why this is happening?

THE HON INGRID STITT: Yes, it is, and as Ms Whetton has pointed out there are a number of important pieces of work that are being driven by Safer Care Victoria to make sure that we are changing that trajectory. This is probably one of the Royal Commission's recommendations that was given a longer time frame to implement change, because of the complexity. But I absolutely accept that it is part of my role to make sure that the disproportionate impact on First Nations consumers is addressed.

COMMISSIONER HUNTER: (Crosstalk) and the work that Safer Care Victoria are doing are they doing it with Aboriginal people or are they just doing it for -

THE HON INGRID STITT: My understanding is there is work being done to ensure that we are working with First Nations organisations about this work. It would be my very strong expectation that that be the case.

COMMISSIONER HUNTER: Lots of expectations happening. Like, if it doesn't happen what happens if they don't -

THE HON INGRID STITT: I have given a very strong indication to my Department about what I expect in terms of proper engagement and working with organisations that are best placed to come up with the models that are going to see a reduction in compulsory treatment for First Nations people.

COMMISSIONER LOVETT: Minister, can you explain to us - we all have lived experience on this side of the table and our people of - in this regard we have got really good strategic hooks or opportunities to make sure that our people can, you know, have more safety and access to mental health services and health services, right. But - and it takes a long time to enact that.

But then when it comes to changes to bail laws through legislation, changes to the Child, Youth and Families Act around our children, Raise the Age, these things get enacted straightaway and so tightly and really to the point that our people are

significantly overrepresented in a detrimental context. Then when we have active policy and legislation that helps our people we don't see that level of services, minister. Can you share some response to that?

THE HON INGRID STITT: I think I have acknowledged in my witness statement and also in the evidence that I have given today that not enough priority has been placed on this work, and I want to do whatever I can to change that.

MS FITZGERALD: Just looking at those very stubborn numbers, which haven't changed since 2014 despite some very impressive - the inclusion of some very impressive legislative drafting. Is it possible that psychiatrists are continuing to do the same thing, regardless of the new legislative tests and thresholds?

THE HON INGRID STITT: That is possible, although I know that the chief psychiatrist is taking a lead role in terms of making sure that there are practice guidelines in place that go to the need to reduce compulsory treatment orders in the system.

MS FITZGERALD: And one of the issues maybe you are attempting to educate a cohort of people who no doubt went through University at a time when there - the idea of cultural safety or First Peoples as a specific cohort needing very specific care and treatment, was just not a part of their education.

THE HON INGRID STITT: I would not have thought so, no, and that needs to change, as does the accountability and the expectations that government place on our health services, and I think, you know, it is not going to be one measure that turns this around. It is going a range of different efforts and initiatives, across the system.

MS FITZGERALD: You mentioned in response to something Commissioner Lovett said that - or it might have been Commissioner Hunter that one of the reasons those numbers remain stubborn is potentially First Peoples are coming into contact with mental health services very late in the piece.

THE HON INGRID STITT: Yes.

MS FITZGERALD: And would it be fair to say that as a result of that if you are - and that may be because those services are not seen as culturally safe, so it is only when things are actually on fire that First Peoples will go to them.

THE HON INGRID STITT: Yes, I absolutely accept that. Because by its very nature compulsory treatment means that you have not successfully sought voluntary care and support before that point, or you may have but it has not resolved. So, yes, that would definitely, I think, be one of the issues that need to be addressed and part of addressing that is providing more resources for early intervention and prevention.

MS FITZGERALD: So to the extent that anyone might be under the illusion that this idea of cultural safety is a soft issue.

THE HON INGRID STITT: No, it is not.

MS FITZGERALD: It is directly contributing no doubt to compulsory treatment rates, to First Peoples feeling they are culturally not unsafe is no doubt contribute to go those high -

THE HON INGRID STITT: I would accept that premise, yes.

MS FITZGERALD: And moving to seclusion, the seclusion and restraint numbers, I think it is Ms Whetton's statement you refer to the recommendations of the Royal Commission, that the Victorian Government ensure the Chief Medical Officer for Mental Health and Wellbeing, which is you, develop and lead a strategy to reduce the use of seclusion and restraint.

THE HON INGRID STITT: Yes.

MS FITZGERALD: And you have mentioned that the Department is seeking to have the strategy finalised in 2025. Given we have seen in your witness statement that the - that those traumatic methods under the legislation continue to be used disproportionately against First Peoples, why is it taking so long for the strategy to be developed and implemented?

THE HON INGRID STITT: The work has been under way on the strategy for, I think at least a year and a half, almost two years, and the Royal Commission has this strategy as a long-term piece of work that needs to be undertaken. That is not an excuse for the work it is taking now. But we have been undertaking significant engagement including a public submissions process around this, because so much of it is around being much more transparent, around when and why restrictive interventions are used. And also then to change WorkSafe practice - I should say work practices.

And so working - yeah, it is quite a sensitive topic to develop it, so we have wanted to not rush it. I would say too, though that while we are undertaking the strategy that we have actually seen the rates of seclusion and restraint come down for all consumers, including for First Peoples over the past five years. So the evidence in my statement does point still to a disproportionate impact, but there are - there have been year on year reductions of those events.

COMMISSIONER HUNTER: So these numbers kept of restraints and would you include restraining and confinement in that? Would retraining also include police data?

MS WHETTON: No, this is only restraint in a mental health service.

COMMISSIONER HUNTER: Doesn't it apply - wouldn't it apply to both? Does it apply to both under the Mental Health Act or the police don't come under that, the Mental Health and Wellbeing? Sorry, I am trying to understand it.

THE HON INGRID STITT: It would.

MS FITZGERALD: It would be under data in the Mental Health Act that data is based on using those specific powers (crosstalk).

COMMISSIONER HUNTER: But we are just talking about mental health. How do you not apply it? Sorry, is it siloed?

MS FITZGERALD: As I understand it those acute interactions with police when there is a moment of detention would not be using the treatment powers under the legislation.

MS WHETTON: No, not the definitions of seclusion and restraint.

COMMISSIONER HUNTER: Okay.

THE HON INGRID STITT: It might be worth pointing out the reduction that we have seen over the last five years in the rate of seclusion. So we have seen a reduction of 56 per cent for First Nations people in the use of seclusion, and a 54 per cent reduction for non-Aboriginal people. And, of course, we still have a way to go, but I do think that we are on the right trajectory in terms of minimising and ultimately eliminating the use of seclusion in the mental health system.

MS FITZGERALD: Ms Whetton, just going back to the aspects of your witness statement that address this, in particular the strategy that is being developed, you mention that the work to date has not reflected a broad engagement with First Peoples' communities and organisations?

MS WHETTON: That's right.

MS FITZGERALD: What steps are being taken to rectify this, to ensure this engagement does occur before the strategy is finalised and implemented?

MS WHETTON: The work that we have done to date and, as you say, it is not broad engagement. We have undertaken some engagement. We did have a system leadership forum around the strategy that VACCHO was part of, but I think we do have a few more steps, quite a few more steps in strategy development to go. And so I think we'd be looking at the engagement work we have done to date to ensure we are working with First Peoples on that strategy.

MS FITZGERALD: At the moment there hasn't been enough, though?

MS WHETTON: Yes, I accept that.

COMMISSIONER HUNTER: When does - when's that due to be finished, that work? Is there a date on it or -

MS WHETTON: There is no date as I understand it, there is no date provided in the Royal Commission for this particular piece of work. It is something that is talked about over a long period of time, over the 10 years. We are aiming to have that strategy finalised in 2025.

COMMISSIONER HUNTER: Thank you.

MS FITZGERALD: Commissioners, I was going to move on to public intoxication reform.

Minister, in your statement you acknowledge that the criminalisation of public drunkenness unacceptably and disproportionately affects First Peoples.

THE HON INGRID STITT: Yes.

MS FITZGERALD: In terms of the monitoring and evaluation plan for the statewide model, you state that The Department of Health is currently conducting a process to engage a First People's led evaluator for the health component?

THE HON INGRID STITT: Yes.

MS FITZGERALD: And when do you expect that engagement process to be completed?

THE HON INGRID STITT: I think that the estimate for completing that work is 2025.

Correct me if I am wrong, Ms Whetton.

MS WHETTON: This is for the - yes, for the actual evaluation report would be around September 2025 and the process to have someone come on board we are expecting over the next one to two months. We are just working through that at the moment.

MS FITZGERALD: And in terms of engagement with ACCHOs in design, scope and implementation of the original trial site program and state-wide model, an evaluation report of that program found that the Aboriginal advisory group was under-utilised and that the public intoxication reforms would have benefited from earlier and more effective engagement of and communication with Aboriginal stakeholders. How will the Victorian Government ensure sufficient engagement with Aboriginal stakeholders going forward?

THE HON INGRID STITT: Yes, I absolutely acknowledge that that was a finding of the evaluation of the trial sites and the arrangements that fed into that trial. We have established and just recently appointed Helen Kennedy to chair the independent monitoring and oversight group that will advise the government. It will be made up of predominantly First Nations representatives who will continue to advise the government about the statewide model and provide feedback to me as Minister about what aspects of the public intoxication reforms are working well, which might need more attention, and how the service model is operating across the State.

MS FITZGERALD: And is - Helen Kennedy has extensive experience in relation to social and emotional wellbeing work?

THE HON INGRID STITT: Yes, that's right.

MS FITZGERALD: Is that the same person?

COMMISSIONER HUNTER: Yes, she is -

MS FITZGERALD: Just making sure I had the right person in my head. Just on a related topic, alcohol and other drug services. You have acknowledged in your statement that there is a pressing need for specific and culturally safe alcohol and other drug care, given the disproportionate number of First People seeking health from those services.

THE HON INGRID STITT: Yes.

MS FITZGERALD: Many of the alcohol and other drug services in Victoria are operated by NGOs, and the Department does not mandate cultural safety training for those services, does it?

THE HON INGRID STITT: No.

MS FITZGERALD: The Aboriginal health and wellbeing - the action plan involves supporting alcohol and other drugs services as a priority, including reviewing current care mechanisms to ensure that they are culturally appropriate and safe.

THE HON INGRID STITT: Mmm-hmm.

MS FITZGERALD: And privatising intake and assessment processes and ensuring mainstream alcohol and other drug organisations embed a consistent cultural safety practice in their models of care, correct?

THE HON INGRID STITT: Yes, that's correct.

MS FITZGERALD: Does this include NGOs as well as government organisations?

THE HON INGRID STITT: It is not a mandated system, but there is a high level of preparedness to engage in this work against our NGO providers across alcohol and other drug services. In addition to that, we recently announced a statewide action plan to try and reduce drug harm across the community. And one of the commitments we have made we will develop an AOD strategy across all of our services and I want to make sure that that process engages directly with our First Nations organisations that are already delivering alcohol and drug services.

But also broader than that, to make sure that our mainstream drug and alcohol services take into consideration what they need to do to provide cultural safety. For example, when we are commissioning services we, as part of the tendering process, require those organises to demonstrate to us how they will provide culturally safe services. So we want to strengthen that further by making sure that the AOD strategy has this as one of the key priorities.

MS FITZGERALD: The other agreed actions in the action plan include undertaking a whole of system first-people specific alcohol and other drug service, demand and planning assessment.

THE HON INGRID STITT: Yes.

MS FITZGERALD: And designing the service model of a culturally safe, gender-specific residential detoxification and rehabilitation facility for First Peoples women.

THE HON INGRID STITT: Yes, that's right and a very important initiative and something that I will be very keen to drive in terms of both the time frame associated with delivering that service and making sure that it is a service that is stood up. And that we are working very closely with First Nations organisations and ACCOs and ACCHOs to develop that service.

COMMISSIONER WALTER: That sounds like a very important service, can you give an indicative timeline?

THE HON INGRID STITT: Very. I think that this - this is a recommendation from a Coroner's report. I think the time frame that was given was 2030, but I would hope that we would be able to progress this work much quicker than that and that would be my desire to make sure that we are looking at, you know, not waiting that long. There is a significant need right across the state for specialist alcohol and drug services.

COMMISSIONER WALTER: And just I guess my concern is sort of what you might sort of get a little boutique, sort of, when obviously what is needed is a

reasonable size, long-term-funded First Peoples' led thing. So what sort of size would you look at for this treatment facility?

THE HON INGRID STITT: Look, I am not sure if I am in a position to say how large at this point in time, but it will obviously be really important to look at what the demand is across not just metropolitan but also regional Victoria and make some decisions based on, you know, what that evidence is showing us.

COMMISSIONER WALTER: Thank you.

MS FITZGERALD: Minister, in terms of funding for alcohol and other drug healing services for First Peoples, as I understand it 15.27 million was allocated in the '22-'23 financial year and is recurrent funding for 33 ACCOs and mainstream service providers across the state.

THE HON INGRID STITT: Yes, that's right.

MS FITZGERALD: All alcohol and other drug treatment providers are required to report to the Department various information in accordance with the Victorian Alcohol and Drug Collection, the VADC.

THE HON INGRID STITT: Yes.

MS FITZGERALD: Is it the case that VADC requires an organisation to have software systems and staff with particular skills and training in order to report this information?

THE HON INGRID STITT: Yes, that's correct.

MS FITZGERALD: And some service providers including First Peoples-led service providers may not be able to report VADC in full or in part?

THE HON INGRID STITT: Correct.

MS FITZGERALD: Without accurate data collection there is a risk that insufficient alcohol and other drug services are available to meet the needs of First Peoples?

THE HON INGRID STITT: Well, that is certainly a risk and one that we want to make sure we reduce. And obviously getting good data is a bit of a challenge in a number of different settings and we have talked about a little bit of that today. But I want to work closely with VACCHO and also with other AOD services who are providing support to First Nations communities about making sure that we address that situation and that we provide support from the Department to be able to improve data collection.

MS FITZGERALD: So that they can report fully?

THE HON INGRID STITT: Yes, that's right.

MS FITZGERALD: Minister, in your statement you reflect on key opportunities and changes for mental health for First Peoples.

THE HON INGRID STITT: Yes.

MS FITZGERALD: Sorry, challenges. I think that is what I meant to say. In your view what is the most urgent priority for the mental health of First Peoples?

THE HON INGRID STITT: I believe there is an urgent need to prioritise early intervention and models of care that are holistic and delivered as much as possible by our ACCHOs and ACCOs who, in my short time in the portfolio, I am convinced that they are the best place to know exactly what it is that communities need in order to address social and emotional wellbeing.

I obviously am very concerned about the levels of harm that are occurring and the disproportionate impact on First Nations people experiencing acute mental health distress, and I want to work closely with both VACCHO, the Balit Durn Durn Centre and the Aboriginal Health and Wellbeing Partnership Forum to continue to drive what First Peoples are telling me are the priorities for addressing that unacceptable trajectory and how we might turn that around.

I think another key challenge, but also opportunity for us is to look at ways that we can scale up First Nations people working across the sector, both in Aboriginal-controlled organisations, but more widely. I have heard directly from First Nations people in the sector that we don't want to have a situation where we create positions that might be seen as sort of standalone, Koori liaison officer-type roles that have got no support, no monitoring and that we are really not providing the systematic mentorship and building that workforce so that those individuals are not expected to carry an unacceptable load.

So I do want to have a close look at our workforce initiatives and priorities to make sure that we are adequately funding additional opportunities for Aboriginal people to work in the mental health system. So there is obviously a lot of demand pressure on the system right now. I want to make sure that that demand pressure does not have adverse impacts on First Nations consumers, whether they are seeking support through an ACCO or ACCHO or in the mainstream part of the system. So there are many priorities and many - and many pieces of work and opportunities that I want to get on with, and work with First Nations people on, but there is just a few of the key things that I think need a very strong focus urgently.

MS FITZGERALD: You also say there is a need for stronger accountability mechanisms.

THE HON INGRID STITT: Definitely.

MS FITZGERALD: To hold services to account when they lack cultural safety in particular.

THE HON INGRID STITT: I would agree with that.

MS FITZGERALD: What should, could these accountability mechanisms involve? There have been some questions earlier. What power does the government have to implement them across all mental health service providers?

THE HON INGRID STITT: I mentioned earlier that we are moving to a mandated system of training for our mental health services, and I welcome that change and I think it is well overdue. But that is only one aspect and there has got to be much stronger accountability measures, and I will be working closely with Ms Whetton and her team, and working across the Department to make sure that there are proper accountability measures put in place. And that it is not just another bureaucratic exercise to be gone through. That there are actual - and we measure how those accountability mechanisms are working and whether they are changing the culture within our mainstream mental health services.

MS FITZGERALD: Yes, you have received a number of questions from the Commissioners today, many of which do relate to accountability.

THE HON INGRID STITT: Yes.

MS FITZGERALD: And throughout the various hearings that Yoorrook has held there have been reflections on many recommendations that have not been implemented. So community is also very interested in how you will be making sure these things actually get done.

THE HON INGRID STITT: Yes. Well, I will be very keen to make sure that I am getting regular updates on how we are performing. But further to that I think that there needs to be much more accountability directly back to our ACCOs and ACCHOs who are at the front line really of the social and emotional wellbeing challenges across the community. And they also need to know that when they interact with our mainstream mental health services that they are going to be listened to, that their expertise are going to be respected and that there is going to be proper accountability back to them when they are trying to provide support for individuals that might need additional assistance through a mainstream service.

MS FITZGERALD: Commissioners, those were my questions. Were there any other questions?

COMMISSIONER HUNTER: I have one and it is in your statement under Aged Care 223, Minister.

THE HON INGRID STITT: Yes.

COMMISSIONER HUNTER: I am not going to ask you questions in particular about it, but what I want to talk about is that we have two facilities, ACES and Rumbalara, which I'm sure you are aware of.

THE HON INGRID STITT: Yeah.

COMMISSIONER HUNTER: We have heard evidence from both of those and I'll either call it "palliative care" or "end of life". They actually don't get funding, but each supply a room for that, for our people without funding because they want to make sure our Elders going to the dreaming in a way that is respectful. It is not funded, and I know Commonwealth is, but it says here that:

> "I am responsible for advocating on behalf of older Victorians to ensure equity and access to service."

So I implore that you go and speak to both those services and we were there in both those rooms and the amazing work they do, our Elders deserve better than to have one room that that is not funded for.

THE HON INGRID STITT: Thank you, Commissioner Hunter. I have actually been to Rumbalara and I have seen the amazing work the staff do in that aged care service and I will absolutely take that issue on and speak to my counterpart in the Federal Government about the palliative care funding.

COMMISSIONER HUNTER: Thank you.

COMMISSIONER LOVETT: Can I ask questions around what work your Department is doing to work with the Department of Education with our children in primary and secondary school, around mental health and mental health issues?

THE HON INGRID STITT: I am happy for Ms Whetton to supplement, but just from my perspective briefly, I know that the Department of Education has been doing quite a lot of work on mental health supports within our State school system, both secondary but also plans to roll out a similar program in primary school. As a former early childhood minister, I have seen first-hand some of the amazing work that is going on in our Aboriginal early childhood services and how important that early education is for three and four-year-olds in our state and the trajectory of starting kindergarten early. I know that there is work across departments in this regard, so I might ask Ms Whetton to add to my comments.

MS WHETTON: Thanks, Minister.

The - there is currently a children's related committee where we are coming together across departments to look at all issues for children in terms of their wellbeing, education, and the like. The Department of Education, it's something

that they've worked with us to a degree on this, but there is a schools mental health fund and this was a recommendation oust of the Royal Commission that you might have heard evidence around this already.

But it was - $200 million had been provided initially for that mental health fund and it is so that schools can look at what needs they have for their students, and then can select different pieces of work or initiatives to work for wellbeing for their students and there are also mental health practitioners in schools as well. I would say as well that there has been a focus on wellbeing for students that there is a thing they call the Framework for Improving Student Outcomes, and that learning outcomes sit alongside student wellbeing. So recognise that wellbeing is a - particularly think about - in the prevention and early intervention space just how important that is.

COMMISSIONER LOVETT: What it was, $200 million?

MS WHETTON: 200 million dollars was committed going back I said '21-'22 budget.

COMMISSIONER LOVETT: Yeah. And how much of that or how much emphasis has been put on the importance of Aboriginal children and young people, given the disproportionate impacts that has? Whether it be impacts of Stolen Gens, whether it be racism experienced. I mean we can go on, but I think I am preaching to the converted here.

MS WHETTON: You are. I can't speak to it directly, just that the fund has been developed by the Department of Education. I am sorry.

COMMISSIONER LOVETT: Okay.

Minister, what do you see your role as in the context to connection to Country?

THE HON INGRID STITT: Obviously incredibly important and that, as I understand it, forms part of that holistic social and emotional wellbeing framework that our ACCOs and ACCHOs have been delivering in community. I know that it is something that I am keen to work with First Nations organisations on what more can be done, and I say that in relation to the aged care portfolio as well as the mental health portfolio.

Because I know from speaking to a couple of our services, but also some ACCHOs that having Aboriginal-dedicated aged care services on Country is incredibly important for our Elders, so I am very keen to see what more we can do in that space. And I know that it is incredibly important to properly resource and fund our ACCHOs, which is why the social and emotional wellbeing teams being statewide by 2025 I think is critical in terms of, you know, your point on the importance of Country.

COMMISSIONER LOVETT: And I strategically asked that question, Minister, because my next one is how many of the Traditional Owner groups have you met with?

THE HON INGRID STITT: Yes. Well, prior to these portfolios I was privileged for a short period of time to be the Minister for Environment. So I did take every opportunity I could to go and visit a number of different TOGs and I went to a number of forums where a number of the Traditional Owner Corps came together. A little bit similar to the Forum that we have for health, but just in the context of the Department of Environment.

COMMISSIONER LOVETT: The Country Partnership Forum?

THE HON INGRID STITT: Yes, that's right. I learnt a lot going out and speaking directly with Traditional Owners across the state who are absolutely - they have the knowledge and should have the power to be able to continue to care for Country.

COMMISSIONER LOVETT: I think as well, access to Country is really important. We heard through land injustice about the limited ability for Mob to have access to their own Country, freehold or even just the significant barriers that they face. And it does link to mental health, health and wellbeing and so forth as well. So I just would continue to encourage you to meet with the Traditional Owner Groups particularly, as you are going play an active role as your statement says around Treaty and Treaty process and things like that.

And it's not to take away from VACCHO and the ACCOs who are doing really important work in the service delivery component of this or policy advocacy, but we still have access and barriers of access to Country, and that is how we heal our people. So the more barriers we can remove around that and the more funding that goes to language revitalisation or reclamation, will also ultimately also help our people be able to heal.

And hopefully we cannot have so many of our people having mental health challenges and so forth as well. You know, as you said, we don't uncouple the systems. They are all one system. I think it is just really important that and I encourage you to keep meeting with those Traditional Owner Groups around how important that is.

THE HON INGRID STITT: Thank you, Commissioner Lovett, I will absolutely do that.

COMMISSIONER NORTH: Just to add to what Commissioner Lovett has just said he and I both went out to a rehab facility in St Kilda.

THE HON INGRID STITT: Ngwala, was it?

COMMISSIONER HUNTER: Yes, Ngwala.

COMMISSIONER NORTH: And one of the things that the men said was, you know, "We crave getting out from the suburbs", because when you talk about Country being important and healing there is an example where it would really help a lot, (a) with the locating these facilities. But what we were talking about was actually, you know, just having as part of the program the ability to get out for a day or two days. So, you know, it comes down to those really practical, ground level applications.

THE HON INGRID STITT: And having the resources.

COMMISSIONER NORTH: Having the resources, of course.

THE HON INGRID STITT: They are important things, thank you.

MS FITZGERALD: Thank you, Commissioners.

Chair, as I understand it we would be adjourning until 10 am on Thursday, 20 July - June. I was hoping for a longer break there, but fine, Thursday.

CHAIR: (Inaudible) the session, sorry. I was not on. Thank you, Counsel, and thank you for clarifying that date. And I thank you very much for your appearances today. A good discussion, but very - a very hard space for everybody involved, so thank you. And we do adjourn until Thursday at 10 am. Thank you.

<THE HEARING ADJOURNED AT 4.34 PM