YOORROOK Justice Commission

TRANSCRIPT OF VAHS FITZROY G1

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<THE RECORDING COMMENCED>

SPEAKER 1: There's a few questions that we've got which are on the screen now and on the page in front of you. But is there something that you guys feel like you'd like to talk about? We can note sort of note them and make sure we get to them at some point. Are there any in particular?

SPEAKER 2: So the idea of having [name edited] here and having it on here was to sort of start the conversation, you know, to prompt. So something that came through certainly the, you know, the submission I wrote and the evidence that was given to the Commissioners regards is about people's experience of mainstream around cultural safety, compared to community control, what's been your - and then, you know, I thought when I positioned this to have staff speak, it was probably about what's your experience as a clinician, as a worker?

What do you think works but also as a community member and family in your own experience about getting access to services or, you know, so it's just an opportunity. So the sort of things around your - you know, you wearing the hat as a worker, as a VAHS staff member but also as a community member and what you - and what would look better, what would different look like and whether that's GPs or hospitals? You know, that's probably the starting point to think about why we wanted to give youse the opportunity to sort of talk.

SPEAKER 1: What about this first question? So it's about thinking about, like necessarily as a staff member although you might think of a few clients as well, but on your own, like you said, when you go to a health service what are the challenges or barriers that you face to access that care? What makes it hard?

SPEAKER 4: I think besides, like, going to VAHS, I know judgment, being an Aboriginal person, like, sometimes (inaudible) services for like - they're there seeking drugs and not taking on board that somebody might have diabetes or might be close to having heart failure, stuff like that. we've definitely had clients that have thought they were going to hospital for one situation and end up having surgery and that not being explained to them. And sort of like this person was a homeless person so thinking like they just judged things, stuff like his clothes smell. Where would a homeless person have access to showers and clean clothes and food for that matter?

And so, yeah, they really judged this person by not really talking to them. We've had several situations where people just sort of - Aboriginal people maybe don't feel safe going to hospitals because they're just not treated in a humane way, like that respectful manner that you would treat anybody. I think a lot of Aboriginal people end up going to hospitals feel nervous because we're like - we don't know if this is going to be a good situation or a positive situation, or are they just going to be condescending I guess in the (indistinct). Are you turning up to your appointments or - yeah.

SPEAKER 1: Yeah, just looking down. Does that ring true to other people?

SPEAKER 3: Yeah.

SPEAKER 2: Do you find that Aboriginal liaison staff at the hospitals are playing their role in that where you're saying there now?

SPEAKER 4: Let's just say this hospital couldn't keep an Aboriginal liaison staff there because they generally only want to hire one person and that Aboriginal Health they've got no peer support culturally speaking. They - I think sometimes they feel like they're there to keep the black fellas happy without making changes like, you know, higher up positions or with the other staff and staffing. Some hospitals do it better than others. Let's just say that. So, yes, although sometimes when you do get that assistance with the Aboriginal Health worker - sorry, liaison, they're that (indistinct) they probably have got a few minutes to see you and then they've got to go on to another ward or, you know.

SPEAKER 2: Yeah, and like we said, they're not really in a decision making role, can't change (indistinct).

SPEAKER 4: Yeah.

SPEAKER 5: Yeah, and the turnover of staff in those ALO positions is just tremendous. I found this team at Royal Melbourne to be very helpful. They're headed up by an Aboriginal woman and they go over and beyond at that hospital, in my experience as a patient. And there's a (indistinct) had two Aboriginal and two (indistinct). That's - but I've only referred them through the First Nations Unit and then they help the (inaudible) there, what they -

SPEAKER 1: Yeah.

SPEAKER 5: So I don't know what that - what the particular patient's experience was afterwards. I can't say.

SPEAKER 6: I feel as though a lot of the - like, a lot of the people as well are like sort of parking off a lot of stuff to the liaison officers that aren't in their scope of knowledge and it's taking away as well from those non-Indigenous practitioners actually learning how to work with mob, learning strategies and learning how to connect. So both sides of it aren't actually gaining anything from it.

SPEAKER 1: That's a good point.

SPEAKER 4: Can I elaborate on what [name edited] has just said as well. Sometimes they'll look to services like ours to take up the first acute care where it's like their responsibility. It's like, "Oh, well, you seem to know this person. Can you deal with them? rather than, like, you know, the hospital doing their duty of care.

SPEAKER 5: It emotes time experience as a (indistinct) in VAH health.

They would bring an Aboriginal person in to the discharge meeting for the patients and ask their opinion. So I don't know how much they took - value they put on the person's input but they certainly invited them in on the discharge meetings and where they think the best services outside of the hospital could be. I don't know. Do they do that because it was here when they discharge patients, have an Aboriginal or Torres Strait Islander person in the discharge meeting because you have - not you just have all your allied health there and social worker and then they brought in the ALO as well.

SPEAKER 4: I imagine, like, with the hospitals now they do have an Aboriginal liaison team so I would say they would be a part of that post duty of care or like family meetings or anything like that. But, yeah, so that's hopefully what should be happening.

SPEAKER 2: The reason I asked that question is it just seems to be a lot of liaison, Aboriginal liaison positions open to a lot of major hospitals and do you think it's just mob don't want to do that job?

SPEAKER 5: I think it's because they're not valued and they're not getting paid enough to do a really tough job. They've got to connect community to mainstream and that's a real tough gig sometimes. And especially if you get people who come from other states. Like, I've seen a lady from NT come down and had to deal with St Vincent's and Royal Melbourne, St Vincent's, and she was out of her element not being in her home place and English is her second language and all this. But I think that the way they have - this is my opinion, I don't know if there's anything to it but shit pay and they ask too much of them. So who would want to do that? Like, you love your community so much but sometimes you've got to have that self-care as well.

SPEAKER 3: And it's one of those things where you're - it's often one person in these huge bureaucratic orgs. Like you said, they get to - they're made to do everything in that space. You know, you can run a Reconciliation Week, you still have to call the hospital, all that kind of stuff.

SPEAKER 5: Yeah, why is it up to us Aboriginal staff, when we work in mainstream, to run the Reconciliation? (Crosstalk).

SPEAKER 4: (Crosstalk), yeah.

SPEAKER 5: (Crosstalk) us.

SPEAKER 4: That extra cultural load that that Aboriginal person is expected to provide because other staff might ask, you know, questions that don't have to deal with - pertain to the work that they do. They just want to know, "Like, why do you think your people don't take to alcohol very well?" Or, you know, like us - that person to explain, like, you know, every Aboriginal problem in the country.

SPEAKER 3: That's right.

SPEAKER 5: Yeah, and just that spirit of (indistinct). Once upon a time I was a dialysis nurse in the Territory and everyone just assumed that people are on dialysis because they drink too much and the reason why they're on dialysis is because of a complication of diabetes, you know. You know, people just are set in their ways. There was another example and I can't think of it now, that you reminded me of - yeah, all of it - we've all got diabetes or we're all going to get it. And I fought tooth and nail with a doctor once because he dead-set said that I had diabetes like 15 years ago. And, you know, it wasn't to be.

SPEAKER 5: And also if you're putting an Aboriginal liaison officer in a hospital and they're the only person there without any support, it's just not going to work. We had in one of the hospitals further out, there was a new worker there and he used to come here all the time for support because he was on his own, didn't know what he was supposed to do. There was no cultural support. So he would come here for that support.

SPEAKER 1: Yeah.

SPEAKER 5: And for me maybe it (indistinct) like this one actually have an important role in supporting those people outposted in making sure they get the right supports they need.

SPEAKER 1: Yeah, interesting.

SPEAKER 2: It's a good point. We're getting asked at the moment, [name edited] and me, [name edited] was in the - oh, we need to employ Aboriginal people, how do we do it? Hang on a minute, like, is that tick-a-box so you've got an Aboriginal staff member to be the layer - you know, what are you trying - the fact that you have to ask that is already - that's the start of the problem, isn't it, having a workforce.

SPEAKER 7: Well, a lot of places, like I've come from a few different areas working with this but bringing up the ALOs, not working in hospitals, but working in Corrections very much tokenistic with that is you've got someone in there to provide culture, to be able to talk to these guys about that because you've got staff in there that are still of that old mindset. They've got these very skewed stereotype view of who we are, what we are, what we do, and they don't have any understanding of that.

Now they try and get in there to do cultural awareness training, all this other gear. Like, I was employed to provide a package like that, bought about half way through it and then it was taken off because it was too truthful. It was decided not to go ahead with it. So that was about four-and-a-half months of work that I'd put into that and then it was just - you know, ait was just taken away and just said, "Okay, thank you for your time. So we've now ticked that box, okay. We've got input and we can move on with it.

SPEAKER 5: Thanks, but no thanks.

SPEAKER 7: Yeah. So it's, yeah, racism comes in all sorts of forms, (indistinct), yeah, pretty (indistinct) the way -

SPEAKER 2: That's one of the reasons why I asked that question because I was an ALO in the prison system for many years and we had the same issues and I thought it may mean the same issues in the medical industry as well and it seems to be.

SPEAKER 8: I think - and this is going to be controversial of what I'm saying but it must be said, employment of Aboriginal and Torres Strait Islander people - now, if you have been an Aboriginal and Torres Strait Islander person all your life from the beginning, you're going to have a different world view to Aboriginal people that may have found out later. It's just the education of culture starts from infancy and, you know, I know for some people it's not their fault but they've got to go and do the work. They've got to go back to their clans and do the work, if they can, you know, connect with that clan. So I think they may be a bit, like, people that may not have done the work and want the job because they, you know, claim, are the wrong people because they're going to give you not the Indigenous experience, Aboriginal and Torres Strait Islander experience. Like I said, it starts from infancy.

SPEAKER 4: Yeah, from infancy and also me, I'm from Queensland but I've worked all around the country, but I just - I don't think - I have held back from applying for jobs down here in Victorian Aboriginal community because I don't know this community so well and everybody knows everybody and knows all the - you take me home, you take me NT, I could slot you in every - anywhere. But down here I may as well have come from Italy or something. But it's that sort of thing it's not just hiring someone because they're Aboriginal or Torres Strait Islander, but they've got to have that cultural knowledge and the community networking thing as well.

Like, I think it would be a hard - it's a hard thing wherever you go in the health care, you know, health workers and nurses, you get patients come in, you treat their wound or you do this and then you go down the street and then you see your cousin down the road, "How's uncle?" So which way do you stand? Confidentiality from work or that's my cousin, that's our grandfather, you know, things like that. So we've got a really hard job to do at the best of times in working in Aboriginal health. We juggle a lot of things. And then people say, "No, but youse get millions for health care." "No, we don't."

SPEAKER 1: What about on the flipside, so I mean, the next question is about whether it's culturally safe or not (indistinct) spoken to a lot of unsafe - it being unsafe culturally the lack of support for ALOs and their one-out-ness, because you spoke about discrimination, stigma and stereotyping and all this kind of stuff, what about on the flipside?

So, you know, good practice from ACROs such as VAHS, I guess the question is, like, what are the things that VAHS are able to do that mainstream aren't able to do? Why did (indistinct) really come here instead of going to mainstream?

SPEAKER 5: (Inaudible) for one.

SPEAKER 1: That's (indistinct), yeah.

SPEAKER 5: We're not rigid the way mainstream is.

SPEAKER 1: Yeah. So how does that work, responsibility?

SPEAKER 8: What would you say, [name edited], because we are flexible. I've come from mainstream and I know how rigid everything was, but in this organisation it's different.

SPEAKER 6: We accommodate - like, it's not black and white here. It's understanding somebody's walking in and they may not be engaged with any other services but we know we've got them in the door then let's get what we can wrapped around that person while they're here, whereas you might know we only have appointments.

Like, I know I've rocked up here with my kids and, you know, they're the first ones, "Yep, we'll get them in. Like, it's all good, don't worry. You might have to wait a little bit but that's okay, we're going to see them." Whereas I couldn't go to a mainstream organisation and they'll be like, "No sorry, the appointments are full."

SPEAKER 8: I've got an example. Sorry, could I give an example?

SPEAKER 6: Go, go, go.

SPEAKER 8: And this was - I saw this yesterday. We had a client who had lost - her dog passed and she was really, really distressed and she spoke to the OT and said, "Oh, you know, I have no one. This was my family." So my whole team, we found her a dog, a new dog and I saw her at a function just the other day and she said, "You know, that was the best thing. I am so happy." And things - they're little things but it took a lot of work for all of us but we all united to find one.

SPEAKER 1: Yes.

SPEAKER 8: And that's - and you know, my team is OTs and physios and podiatrists but we found a dog.

SPEAKER 1: They're not passively trying to deal with (crosstalk).

SPEAKER 4: Yeah. We were looking to the missions, like there's always dogs on the mish.

But speaking of what [name edited]'s talking about too, our funding, you know, say it - we're funded for the north of Aboriginal elders, 50 plus, but we see Aboriginal people all over Victoria basically, Melbourne, all over metro. But they don't capture early onsets like that and we're, like, and we're like health government, that doesn't work for us because we're not subjected to locality like other organisations will be.

Okay, you've got the City of Darebin so that's the only people that you can look after. We're not going to turn away mob regardless so age barriers, sexual orientation barriers, like we get asked, you know, we do look after somebody that is trans. Just say are they Aboriginal, Torres Strait Islander? They will get seen. It does not matter what their sexual orientation is or if they have a disability or if they're able-bodied. If they're mob they will get seen. We will find an appointment for them. And that's down on to what [name edited] is saying as well, you know, like, we - from dental to optometry to -

SPEAKER 5: Podiatry, physio, all of those.

SPEAKER 4: In the chronology. You know, we try and make it work to support our people, like, you know, the more sick are people the more well people that are uptodate with their health, that's what VAHS is for.

SPEAKER 6: There's also so much VAHS is not funded to deliver that we do.

SPEAKER 4: Sorry, this is -

SPEAKER 6: (Indistinct) sitting as the EA for a bit I got to see a wide range of things that VAHS just doesn't get funding for but we will do it. They'll find a way. They will find a way no matter - yeah. You might have a community that needs it, that person needs it.

SPEAKER 4: People that are suddenly homeless, all those homeless going into accommodation for the first time and then it's like, "Oh my gosh, I've got no money for beds or fridge or, you know. We might send out an email through our networks and say, "Has anybody got a spare fridge?" or something like that that's in good condition or, you know, again -

SPEAKER 8: Lots of sorry business support, lots of it.

SPEAKER 4: Yeah.

SPEAKER 8: It's not the one person, it's whole families too.

SPEAKER 1: It's holistic, yeah.

SPEAKER 4: Yeah.

SPEAKER 8: It's people not just from here too because, like, obviously our families are interconnected. So, you know.

SPEAKER 4: We have clinicians that do home visiting. So like occupational therapy. They might go there for one person and then there's like, "Can you help my nephew out? They need blah, blah, blah, blah." And, you know, you pick - you've suddenly picked up another client.

SPEAKER 6: That was me the other day with the GP. I had one son and I was , "Like while we're here can we do this?" and the doctor was brilliant. She's like, "Oh my God, I'm so sorry to put that on you." It's like, "No, you're right, you're here so", you know.

SPEAKER 4: Yeah. Let's get it sorted.

SPEAKER 7: Also it's about the ACAP(?) shows - look at all the social interns and help and we address everything, like, someone might not turn up for their appointments relentlessly and you sent me, like, might fit in, get you well, why aren't they coming? But then you've got to look at what else is going on at home, what other things, you know, if somebody is - you know, just got high numbers in - not just, but if someone has got high blood glucose levels and it's going through the roof that's the last thing on their mind.

If they've got their grandchildren being taken away from home plus DV plus someone going to gaol, all in the one family group, they're health - and the old grandmothers usually put themselves last and it's things like this where - this is what I like about working at this place because you've got all these different teams that all work together.

SPEAKER 8: Help support the person, like, you know, from young people to the middle ages, the elderly.

SPEAKER 7: Yeah. And one thing that I -

SPEAKER 8: Carers even.

SPEAKER 6: - I'm curious about in Victoria is - here I know there's a - we've got our EAP thing but for people and families who are post-suicide, support for those people, that's something that sometimes gets not overlooked but, like, you know, everyone supports a person who might try to prevent the suicide, that's well and good but after the fact has happened it's the family who has been left behind afterwards. They're all at different levels of grieving and have you thought all this out and then bring it into your health care, it's that thing, it's that wheel, our cultural, our land, our health, spiritual, all that. If one of those things is out of whack then that wheel won't roll along smoothly.

SPEAKER 7: Obviously (indistinct).

SPEAKER 6: Yeah, that's it.

SPEAKER 5: Because, you know, even though this is a health service, it's not necessarily the medical model that's used. It's the holistic health so once, you know, a client trusts their doctor they will ask for other things like, "Could you read this letter?" "Can you write me a letter to Housing?" And that's really important. We don't kick people out and say, "No, no, no, we only do medical". We can't do that.

SPEAKER 1: Yes.

SPEAKER 7: It's interesting though, isn't it, because with that question around what could be adopted more likely, mainstream at the moment have got this innovate idea called "social prescribing" and apparently that's where you look after the whole person. And it's these new funded - oh, that's new, we don't just look - and going, this community controls have been doing it forever and they literally - it's called social prescribing. It's being funded and they say, okay, we'll trial and community health loving it because it's - you're going -

SPEAKER 4: They capture it in their data and then they make out what they could come up with it.

SPEAKER 7: It's a new thing, and I even said to a CEO, like, going did you say new? Like, open your eyes, look up.

SPEAKER 6: It's like they super clean it.

SPEAKER 7: Yeah.

SPEAKER 6: We've been - jeez. It's only you, 51 years now rather than doing all different - and then they open those super clinics, what, 10 or so, maybe longer, this is brand new, no it's not.

SPEAKER 7: Yeah, it's not. Yeah, but they're - like, it's innovation and it's like, no, this has been done already. This is how business is done and evolved. You could learn so much if you actually looked and start to come and understand what holistic care is truly about, you know.

SPEAKER 8: But I've learned so much from here but we never had kind of any other setting of before. But even some of the most basic things. Like, there is that big picture but, like, we had a man who had a complicated story but he basically had severe pain in his eye and every time he went to a hospital they'd just call a Code Grey and, like, they didn't give him pain relief and finally the liaison officer from the hospital got into VAHS and he got pain relief and then he could be examined and then all of the other things could happen. But the lack of humanity of just not starting with pain relief before you call security, you know, is like - that's what he went for. He literally went because he was in pain.

SPEAKER 6: I've got to duck out but I just wanted to say one last thing is I think people here at VAHS don't feel - like, in a hospital system, mainstream, it's very transactional. They're treated as a number, they're in and out, whereas here they're treated with respect and dignity and even, you know, offered a cup of tea or a coffee, treated as a human, not a number or a pay check.

SPEAKER 1: What do they call it? What did you just say they're calling it now?

SPEAKER 7: Social prescribing.

SPEAKER 1: Social prescribing I think they're calling it, treating you as a human.

SPEAKER 5: I have a question for (indistinct) been in prison. I had an experience working in prisons and my job was to go to the patients - and this is in psychiatric high - up in Queensland in Washington Park. I'd go in and they would have all these inmates there who wanted to talk to an Aboriginal person and then my job was to tell the psychiatrist what they said but as an Aboriginal woman and as a nurse and being - you know, knowing these people's families and what's going on for them outside, my job was really tricky. It was to try to impart the important clinical side of things to the psych but also keep that patient safe and not - you know, because mainstream psychology is really weird. It doesn't take into account that - they say hearing voices but in an Aboriginal way the hearing of the voices - people might think I'm stupid but hearing the voices could also be your ancestors guiding you.

SPEAKER 4: Don't they take it into consideration culturally?

SPEAKERS: (Multiple speakers - crosstalk).

SPEAKER 2: It's very common. I used to have to - because I was the only Aboriginal person in the whole prison. My years were mainly spent in the Melbourne Assessment Prison so it was fellas who would come straight off the street, straight out of the prison gaol cells and in to be assessed. I was seeing a lot of psych assessments with people because they were petrified to mention that they heard voices, they could hear voices. And a lot of time they're in the cell on their own and they were thinking about things and they'd hear voices. But if they mentioned that to a mainstream psych, they'd be put straight into Unit 13 which was a padded cell.

And they have no one to talk to, there was nobody. And then the medical industry seems to be the same. My father is in and out of hospital all the time. He just does not get that help that (indistinct), the same as what we have in the prison system. But yeah, it is very, very common. Anything our people speak about culturally it doesn't sink in. I ran pilot programs in the prison system for that reason through setting some training - Professor Tracy Westerman, and got involved in that a fair bit and did quite a few of those. We ran some pilot programs in the prison system but it all ran into a brick wall.

SPEAKER 4: They can't relate to it. They can't relate to it so they can't comprehend it.

SPEAKER 2: Forensicare was the main contractor, the main stakeholder for the prison system, they didn't have one Aboriginal site, one Aboriginal doctor, through any - all the locations. So our people were just being starved and just put into gaols and trying to help and that's another thing, it's (indistinct)'s story, not about me. And when you've started up (indistinct) that's where we get taken advantage of because of our connection.

SPEAKER 5: Yeah, and just to not have people acknowledge our cultural and spiritual values, that's a big thing because especially in counselling, in grief counselling, I'm sure there's a way to mix in mainstream academic learning and our learning to make - you know, bring it all together for the good of the person who needs it.

SPEAKER 6: I think that comes down to respect. I think that comes down to the western world respecting our world. That's the only way I can kind of see it coming together and putting aside or learning about us.

SPEAKER 8: It's like being called home, like people listen to those (indistinct) and some of those voices, if they get called home and they don't go home, what happens? They become sick.

SPEAKER 5: Yeah, yeah.

SPEAKER 8: At a very advanced level and, like, explaining that to people that don't have spirituality or culture like us they think it's not real.

SPEAKER 3: Yeah, they (indistinct) spirituality and the respect in the respect in parallel with the Victorian prison systems and health systems.

SPEAKER 1: I'm conscious - I think we've got to finish up in a few minutes. I know we could keep talking for a long time. So just in terms of the next steps for this, so if - are you guys happy for this to be - we had as a group submission with just a group name rather than everyone's individual names on it? It could be like "VAHS Staff", something like that. We'll have a few groups, I think we might have four or five, to Group 1. We'll just write it up in your words, we'll use the questions that we got to and we'll write your comments underneath them and then put that - and if you're happy. Are you happy for it to be not published and just go to commissioners or also published with the group name, "VAHS Staff" and the statement. How do you guys feel?

SPEAKER 4: (Crosstalk), yes.

SPEAKER 7: You're going to send a transcript of this through, aren't you, is that right?

SPEAKER 1: Yeah.

SPEAKER 7: Is that how it is? Yeah. So I'll make sure everyone gets it just to make sure you're okay. Is that right?

SPEAKER 1: That's right. And I think rather than a transcript, so we'll make a transcript and then turn it into a bit of a statement so it will read easier. Otherwise, it'll be all ums and has and interjecting and all that kind of stuff.

SPEAKER 3: (Indistinct).

SPEAKER 1: Yeah. So we'll just have, like, the questions and then you're kind of quotes all underneath each of those questions. And I'll send it to you and (indistinct).

SPEAKER 6: Sorry, I know we're about to wrap it up but I think there's one thing and probably [names edited] you can probably talk this - the overburdening of reporting for an ACCO. You know, I heard about NDIS and how people can sign up and do NDIS and take money from people's plans but I know our experience in getting NDIS accredited, like, why is - I don't know if there is a difference between ACCOs and mainstream services.

We've got over 800 standards also, or 800 standards between 5 and 800 - don't quote me - that we have to meet through accreditations on top of reporting. Like, I know it's a bit different from talking about the people but - and we often see people, they're not - you know, things are not straightforward when somebody walks in the door, as we've heard. So, yeah, internal [names edited] you could probably speak more on that but I just know from what I've seen over the past seven years that working at VAHS that there is a lot of reporting.

SPEAKER 8: We recently went through the aged care audit and it was so culturally inappropriate my hair stood up. And they don't care if where we have a specific cultural needs, the government, they're like, no, you've got to meet these otherwise we don't pass you.

SPEAKER 5: Like it's inflexible.

SPEAKER 3: Like, that's - my perspective in the data team is that the state governments and the PHNs and federal governments all sort of seem to others as a transactional commodity and so I guess they don't really get treated with respect and they don't really treat ACCOs with respect to sort of have their own data teams to sort of have - perhaps just have control over their own data, and (indistinct) in their data and distort the data. So, yeah, and also I guess they all (indistinct) more so with the state government bodies is that they also bring in their own data systems and say: you have to enter it into this system and then it overburdens staff to double their task and things like that. And then keep - the data is stored, the data on their own - in their own warehouses and their own systems. So ACCOs don't really have full access to those - to the full database set which I think is problematic.

SPEAKER 6: And I think sometimes it doesn't capture what we actually do. I think there were times when you and I were having a yarn and I was the EA but I was also doing so much social kind of work. But where do I put that in there?

SPEAKER 3: And that comes down to the database second vendor, like the health (indistinct) systems, they haven't really catered in a great way towards ACCOs because they're more catered towards medical services and they don't really think about holistic health when they're creating their systems.

SPEAKER 8: Can I give you an example about the aged audit. One of the examples is that we had asked them to postpone the audit. The Aboriginal team leaders were on leave. They refused to change the date so we all could have the (indistinct) all non-Aboriginal people. And we couldn't change that because they were insistent. And then when we looked at some of the comments that clients had made, I understood exactly what the client was saying. A lot of the stuff was political. They didn't understand it. So they said: your clients are too scared to put - give feedback. I said: no, they're not. No, no, the clients said this and I thought they really don't get it, really don't get it.

SPEAKER 7: Because I feel like there's an over justification of what you do. It seems to be all the time.

SPEAKERS: (Crosstalk).

SPEAKER 7: Yeah.

SPEAKER 5: Exactly.

SPEAKER 7: I think we do.

SPEAKER 2: Between six and 800, understand us.

SPEAKER 5: And how many reporting? How many reporting?

SPEAKER 2: 105 reports and about one every - three a week, one every two days, thereabouts.

SPEAKER 5: So it will be interesting to see what I was - you know, in comparison.

SPEAKER 1: I guess it might be a little less (indistinct).

SPEAKER 7: Well, they don't understand self determination. It sort of says: here's the money but be accountable whereas some of them they just say actually you don't get to decide. That's for community to decide what's needed. The trouble having just - we're not saying we're not going to share it with you but you've got to even currently writing submissions for Aboriginal money but telling us which data system we'll use.

But, hang on, where's the conversations that the right data that you're - will be helpful. So even in this conversation we're currently in around closing the gap there's such a misstep of what that actually means. Like, yeah, here's your money, yeah, we're giving you heaps, be happy with it but you'll -

SPEAKER 8: Got strings with it. Like, who you can - what age group, like who can be supported. What areas can be supported. We have Aboriginal people from all over the country living in Victoria, like from all round, (indistinct), NT, everywhere.

<THE RECORDING CONCLUDED