YOORROOK Justice Commission

TRANSCRIPT OF VAHS FITZROY G2

Transcript Produced by
LAW IN ORDER PTY LIMITED
ACN 086 329 044
T: 1300 004 667
W: www.lawinorder.com.au

LAW IN ORDER
Where work flows.

<THE RECORDING COMMENCED

SPEAKER 1: So the first question we've got is around what people's experience of the Victorian health system has been like and, like, what are the challenges or barriers to access into care that you might have faced or you know people have faced or your clients might have faced.

SPEAKER 2: No worries. So in terms of the experience for clients, our clients, that I've seen firsthand is unbelievable. So in terms of the gaps how they're actually looked after through the system and when they tend to - there's no follow-up either for clients. So therefore a lot of clients get missed. So then by the time clients are going back to hospital it's actually with - it can't be preventable any more, you know. If we can't actually start at the forefront, and this is why Aboriginal community controlled health organisations are so important.

Our Aboriginal health workers play vital roles in the care of our community, you know, and mob going through their health journeys basically. And what frustrates me is because I constantly advocate for my clients but it's the other person on the other end of the phone doesn't get it. And it's like, hold on, I need to speak to somebody else. And if it's not me advocating clients miss out, you know, and that's not right. And I mean it's right across the board. It's not just Aboriginal people, it's all people. And I've found when I go into a hospital, because I wear a uniform, I've got non-Aboriginal people asking me: where's this, where's that, you know.

But it's because I'm able to be approached and some people can't be approached, you know, so, yeah. But that's my 2 cents worth for now. And when you talk about education stuff too, sorry. Because I do cultural mentoring with one of my other colleagues to universities, to students actually doing their courses, so actually giving them some tools and skills to be able to actually work appropriately with our Aboriginal and Torres Strait Islander people. And I've been doing that with my colleague for the last three years now. And she's been doing it longer than me. So [name edited] I think she was in the previous one would have just spoken about it.

SPEAKER 1: When you say - I know what you mean, but if you could elaborate [name edited] when you say you called and you're advocating for a client or someone and they just don't get it, what's the "it" that they don't get?

SPEAKER 2: So in terms of - so because I understand hospitals have like a policy, you know, three strikes and you're out sort of thing, you know, because there are other people, but understandably there's reasons why clients aren't attending.

And it's understanding what those barriers are before they actually say, no, sorry, but we're taking you off the list. And that's where health conditions change constantly, you know, and then in terms of what clients go into hospital or patients go into hospital then they can start to see an increase because there's been no follow-up.

SPEAKER 1: Yes.

SPEAKER 2: You know, and that's why the medical journey is so difficult but they don't have - that so many engage with their clients and understandably because it's huge, whereas the community environment, we do have that engagement and we know our clients, you know, and we know what's actually happening on the ground.

SPEAKER 1: So they don't know the background or the context or the full person behind that person that walks in.

SPEAKER 2: Yeah.

SPEAKER 1: And they're more rigid in terms of doing step by step no matter what the person needs or what's the cause of the (indistinct).

SPEAKER 2: Exclusionary. But then it's like it's a rotating door. The sooner we get you in we get you out.

SPEAKER 3: I think that like I was saying before about our grandmothers who were taking care of their grandchildren, put themselves last so they might miss their appointment because something is going on with the grandkids or the parents, you know. So I think that's taken into account, that holistic health when it's mainstream services.

SPEAKER 1: Yeah, they do that similarly. Anyone else got any thoughts on other things they've faced or clients face when they go into mainstream health systems?

SPEAKER 4: I think just following on from what you were saying, [name edited], as a dietitian working in community health it's well-known that dietetics think, even in mainstream, there's often a heightened rate of people not attending appointments for lots of different reasons and as well because the things that - the changes are often hard for people to make. So we're asking people to do difficult things. But what - knowing that there's all these other pressures on people, you know, social pressures, family, finance, all different pressures on people.

We follow people up so if they don't come to an apartment we'll call them and see what's going on, see how they are. And we've got, since COVID we now have telehealth as part of our normal everyday work which is fantastic. So that's given other way of re-engaging and really understanding what the barriers to people and helping them where they are. So that's something that's part of our practice now. We do it a bit before but not as much as now.

SPEAKER 1: Great. Anyone else got thoughts around that?

SPEAKER 5: I do a lot of palliative care outreach and I find because we're not a 24-hour service here we do have to rely on mainstream palliative care services. And one thing I've really struggled with is that they are not culturally appropriate in a lot

of areas. So I feel there needs to be a lot of education around that to mainstream services. Yeah, because I do struggle with that a lot.

SPEAKER 1: Are there any examples of things of what that looks like, like un-culturally safe palliative care?

SPEAKER 5: I just feel like sometimes they've got a tick box that with some of our patients aren't in their tick box. They're sort of just forgotten, where we're very flexible in our work that. Yeah, and just understanding Aboriginal culture I think and what that patient - their journey, what it wants to look like, not their journey, you know, the services journey. And the same with [name edited]. I advocate for a lot of patients and if it wasn't for our voice too a lot wouldn't be heard. Like, just with if they've got a home care package that they're not understanding something or - yeah, we're there for them as well for that sort of -

SPEAKER 2: So we're the ones that make sure they're not falling through the gaps and missing out on that health care that they're entitled to and that they need.

SPEAKER 1: How do you do that? By calling and advocating for them?

SPEAKER 2: Advocating, making sure that the mainstream services follow-up and re-engage and make them aware of things they need to take into consideration when they're dealing with First Nations clients.

SPEAKER 6: The translators too sometimes, I know the personal - like, my family, you know, mum will say: what happened at that appointment? I don't know. So, you know, trying like all the old - they'll call me Dr [name edited] and then you - so I think language also and communication styles and texts and techniques of another family member absconded from the Emergency Department with a cannula still in his arm thinking, no, they said that it was all done.

They said that we were right, off you go. And, you know, what falls over, like being in hospitals as it is and then you don't understand - not everybody understands triaging and why are we sitting here waiting so long. I think we're lucky in this sort of sense because we work in the health centre so we're able to explain that. But, you know, experience, they don't tell you the old woman that there's a triage process. Unfortunately we're going to have to see those that are more in need but we will get to you. You know, sometimes it's just those simple communication that is missed. And, you know, we already get stereotyped and painted as this picture so we're already feeling uncomfortable in the setting that we don't necessarily feel like we belong here. So, you know, who wants to stick around.

SPEAKER 2: And it's the way they speak to us when we go to these hospitals or mainstream services.

SPEAKER 7: I suppose that's in there and - yeah. You feel like you've been stereotyped and judged before they -

SPEAKER 6: Actually get to know them better.

SPEAKER 7: - even get some care and service from (indistinct).

SPEAKER 8: (Indistinct) before mentioned you go to a health service expecting or not knowing what you're going to get because you're sort of half expect, I'll get the wrong person or they're too busy for me. You know what I mean? It's a bit like Russian roulette, like, what am I going to get here and so you're already - what's this going, you know, whereas is what (indistinct) the other hospital, oh, you're going to come away better, whereas you don't know.

SPEAKER 7: But I think the support of the ALOs at the hospital, like, if we know one of our patients is again going up to ED or something we'll ring ahead and say: could you, you know, please be in ED waiting for them or someone's, like, a patient recently passed away at the Austin and I made sure that the right people were there for that patient, for end of life care, but in a hospital scenario.

SPEAKER 1: What about GPs? Has anyone got any different experiences or thoughts on sort of barriers or the (indistinct) is you or, you know, your community or (indistinct) when they go to a GP?

SPEAKER 2: So one of our clients that came and seen a GP recently here, had a bad experience and her bad experience was because when she went to see the GP she had a carer with her so automatically the GP assumed that that Aboriginal woman could not speak for herself. So therefore she was speaking to the carer. Now, this carer was only picking this client up to bring her in to come and see her GP but didn't give her an opportunity to speak.

So when she - and when she did speak she advocated very well for herself and told her, you know, what for. But it's wrong assumptions already because thinking because the client is frail, got a walker, can't talk, you know, so already assumptions are being made and in thinking because that carer came in with her, that's who I should be speaking to. It's not right. And that's here, and that's not good. It's not good enough.

SPEAKER 1: Anyone else got similar or other thoughts about this?

SPEAKER 4: I'm just thinking, sometimes - like, here's dietitians because we have no appointments and there's often opportunities to explain to people why they're on certain medications. They might be on things and know they've got to take them but they might not necessarily know what they're for, why they're taking them. And that gives us the opportunity to say someone has diabetes, for example, or high blood pressure and we can actually say that one, this does this and just explain in a very everyday language because I think a lot of time - we all do this as health professionals, we speak a different language and when patients come in our medical jargon, we're used to it, we've spoken this for years, but it's a foreign language to

everybody else. So, you know, talking in everyday terms of why and how something works and then they think: okay, fair enough, I'll take that, and that can help compliance with their treatment as well because they know why they're asked to take something.

SPEAKER 1: So it's not - I mean, there's basic respectfulness there in just making sure that it informs patient's assistance.

SPEAKER 8: What you were saying before there, advocating, I took my father into Royal Melbourne into Emergency once and I started speaking for him. Well, did I learn a lesson. I didn't know and she ripped into me. I'm not speaking to you; I'm talking to him. I said: well, he can't talk. I want to find that out, not you. Why don't you tell me.

SPEAKER 5: She's not going to do that again.

SPEAKER 1: Look at that. What about you were giving a few examples around cultural safety or lack of cultural safety both in - you know, you were saying how you feel, you don't know - it's a bit like Russian roulette, you don't know who you're going to get or what sort of treatment you're going to get when you walk into a hospital and maybe similar with some GPs. Any other examples of whether they are culturally safe or where they're not culturally safe? I mean, someone said - you know, you said the ALOs are a helpful support for that or a helpful link for you guys to make sure there's okay supports. Any other thoughts?

SPEAKER 4: So I'm just reflecting back. So given - given it's taken a long time have actually ALOs within the hospital.

SPEAKER 1: Yes.

SPEAKER 4: But they also need to be supported.

SPEAKER 1: Yes.

SPEAKER 4: They can't just be a stand-alone person, you know, trying to navigate internally. They need to be able to support our clients that are going there as well. But we have been fortunate with, you know, some of the hospitals that they have been able to maintain their staff as well. So then they build up the engagement with community and start to know, you know, our clients that are coming through, you know. We have had a lot. But without - prior to that it was our clients - the conversations, because of the experience, because of the racism and, you know, it - just being treated really unfairly, seen our mob suffer.
And that's why we lost so many, you know, within - within our early days. But we are also suffering now because it's still happening. So why hasn't it changed? You know. As much as they say they are putting all these systems and processes in place to actually support Aboriginal and Torres Strait Islander peoples, it's not happening. So that's my question.

SPEAKER 1: Yes.

SPEAKER 4: You know. And if we are having a Commission around it, they really need to think seriously, well, you know, we need to acknowledge that really we - we really haven't made any inroads or changed things. You know. But then I think as a community, and all our community bonds, if we didn't have our families and our connections and keeping one another strong, you know, things would even be more dire.

SPEAKER 1: Yes.

SPEAKER 4: So, yeah.

SPEAKER 1: I think that's a good kind of segue to, you know, we spoke a bit about what's missing, what is not being done. What about, you know, VAHS as a place for people to come and feel safe and you can get flexible, you know, holistic care. What are the sorts of things that you think you guys do well across VAHS that you could replicate or help put in mainstream health systems that they could adopt? Are they kind of things that they could learn from your practices? Do you want to start?

SPEAKER 4: So given - given community health - community health centres were actually made, or out of VAHS' holistic approach, you know, it was the Aboriginal community control sector that actually helped start up mainstream community health service, you know. And it's - and it's duplicated that way. But in terms of how it's opportunistic for VAHS and our clients when they walk through the door to be able to - as a one-stop-shop and having everything here.

Whereas when - when appointments are made at community health services, whether or not you can have two at a time or - or whether or not it's just they are going in for one thing and then that's it, and, you know. So that is - that is the difference, you know. And that's what makes VAHS so unique, to be able to offer that to our community. VAHS has always been a home away from home for a lot of - for all mob coming through here. You know. It's - it's an opportunity to be able to follow up with your health stuff but also to catch up with family.

To see family that you haven't seen for years or just to have a yarn and a cuppa. When COVID hit that whole feeling of connection and everything really broke, you know. Because VAHS has never been like that, you know. In all the years I've worked here, there has not been an opportunity that anybody could walk through the door and feel that connection, yeah. And it was sad, you know. And - and it's trying to rebuild that. And I need to shut up and everybody else needs to have a go.

SPEAKER 5: I'm just thinking similar to what [name edited] is saying there as a health professional. So working in two community health sectors. So Banyule Community Health, we have our own GPs and allied health and counselling and similar to here, but we also have a lot of clients that are referred externally. And

having here all our staff in their - the one organisation is fantastic because we can do those secondary consults. Like this morning I met with one of the GPs about a young person I'm seeing next week who she knows very well and has referred to me.

So we could sit down and have a chat about this person so I'm prepared. And that is fantastic. And I think that really enriches the clients' care because we - we are on the same page. And it's really hard contacting people who work in a different clinic and another place. You don't even know them face-to-face to talk to them and the clients are the ones that suffer in that. Yes. So that's a real strength I see of VAHS.

SPEAKER 1: Yes.

SPEAKER 5: And even the fact that we can communicate electronically through the patient record system, and email each other internally is great too.

SPEAKER 1: Yes. Great. That's good.

SPEAKER 2: And in community health what if the funding stops they will stop that program? It is a bit hard to do that here, isn't it. So sorry, we don't do that anymore, you will have to go somewhere else. Oh yeah, try that and see how far that gets you here. But community health -

SPEAKER 5: Yes, exactly. It does happen, absolutely.

SPEAKER 2: Funding stops, program stops.

SPEAKER 4: Yes. But then in saying that, when funding stops and then new if funding comes it is the actual same program that we just had before.

SPEAKER 2: Yes. (Indistinct) through.

SPEAKER 4: And it's like, here we go again, haven't we seen this before? Why - why can't government see if things are working and there are best practice and a lot of outcomes all - for clients, why can't they continue? You know.

SPEAKER 6: Why fix what's not broken?

SPEAKER 4: Exactly. But - but then we get new funding but it's exactly the same. So it just doesn't make sense.

SPEAKER 1: When you said before that, you know, apart from all the primary and preliminary health services you guys provide, there is also just that connection. Do people come here to see friends and family or whatever, and there is - you know, I assume there is some health benefits from just feeling connected, right, not feeling isolated, especially for some people. Is that something that you could replicate in mainstream settings? There is spaces that feel safer, to have community staff there,

that people could have more, you know, chances to connect and feel safe? Is that something -

SPEAKER 5: It does happen in the mainstream settings as well, yes. Because I know - like a Banyule Community Health we also have an Aboriginal health team and we have - one of our Aboriginal health workers runs a playgroup for Aboriginal families. And they, you know, they will all meet there and it's a very much a social catch-up for parents as well. So - yes. It does help.

SPEAKER 6: I do think just my experience, I regularly attend a big hospital here in Melbourne and they have got an Aboriginal unit, their own room. And it's a nice feel, but you need more than just that one space too, I think. Me, personally. You know, I'm - I don't want to be just like, there is our space in the corner type thing. This is just again my personal experience.

I think I've been lucky because there's been some really great nurses who actually do know about community or have family that have (indistinct) so it's been great to connect with them, and they are always like, "Hey, how are you going?" Because when you're there regularly you get to build those relationships. But I think there needs to be more. Not just the artwork, not just the space, it needs to be engrained properly. Not just again that tick box, we need to feel I guess some sort of ownership too. Like community - some community, some don't feel ownership over places likes VAHS where there is no shame, there is no - yeah.

SPEAKER 1: Yes, yes.

SPEAKER 6: So I think how you get to that I'm not 100 per cent sure, but - well, I do know. It's the change in people's perceptions and I guess what they think is important. Instead of telling us or walking in front of us, walk beside us and actually ask us and bring us along for the ride.

SPEAKER 1: Yes. And if you don't feel welcome in the main section of the place with the main special little room for you, that is still not that welcoming, hey.

SPEAKER 6: Yes, if I think about, you know, the Austin, for instance. They have got beautiful artwork, don't get me wrong. And then on level 3 there's the - is it Ngarra Jarra?

SPEAKER 4: Yeah.

SPEAKER 6: Like that's a nice - we went there one time and, like it's a nice feeling and the workers are great, but you just need more. Like here, the floor, the people. Hey, how are you going? You know. Like the fire. It's just - it's less clinical than what it is when you walk - and I understand, they have to have certain standards and all of that, but how do you also make it like human and homely and less threatening?

SPEAKER 1: Yes.

SPEAKER 2: So it adds a perception, doesn't it? Or on the phones when you ring up and you have got to question how people speak to your - you know, that sets - well, you sort of experienced it.

SPEAKER 6: Just being acknowledged when you walk up to the reception. There was a time when I went to a health service - not any one of ours, mainstream - and I just stood there and I felt like a dummy. Like, do I say hello or do they - they saw me and just kept writing. It's that little, our you know, our number one receptionist here.

SPEAKER 3: Team leader, thank you.

SPEAKER 6: Team leader, sorry.

SPEAKER 3: Even when the - and I have seen my team, even when three of us are out there and we are all on the phone, we will just give them a quick hi, you know, wave. One minute. We see you, we can - you can see they are on the phone. That's all it takes. And when one of us is finished we go, "Aunty, I'm free now". Or sometimes if they are by the fire and even though they have been checked in I just say, "Aunty, are you waiting for us?" They say "No, I'm just keeping warm". It is easy.

SPEAKER 2: Yes. It is easy, hey. It's not even a cultural thing, it's a person - it's a human thing. You know, like to do your very busy, important work. Just to acknowledge someone. You know.

SPEAKER 3: I always tell my team, the most - the number one priority is everyone that in the waiting room. Phone is a close second, but number one is always watching - watching the floor.

SPEAKER 4: So just on that, one of my clients went to the hospital for an appointment and was there at their reception. So there was one receptionist speaking to other clients and then there was another one on the phone but then was off the phone and then was typing. And my client was still standing there, so the time it took to actually check her in she missed her appointment and then had to be re - had to be rebooked.

SPEAKER 1: Rescheduled.

SPEAKER 5: And they would be thinking of course they rock up.

SPEAKER 4: Yeah, yeah, yeah. Basically - basically they put the blame back on my client and said "No, sorry, we can't see you now, you know, we are too busy". And it's like, the person is there, why - yeah. So that's frustrating too.

SPEAKER 1: Is that like a key difference between, you know, the mainstream, the less flexible and somewhere like you where you work it out.

SPEAKER 4: You know.

SPEAKER 1: You know, move things or change things, or -

SPEAKER 4: Opportunistically if we can do it and staff are available - and I know myself that I've actually done it for my clients because they will come in and I will go and check with my colleagues and say, "Is it possible that we can just see this aunty or uncle while they are here?" Because I know they are not - you know, they are very busy and we won't see them. So our staff will actually make the time where they can, you know. And we work very closely together to be able to do that so then our client is happy and then, yeah.

SPEAKER 1: Yes.

SPEAKER 4: Then they don't need to come back so frequently either, because they know their care is being looked after. If it wasn't then it would be - you know. And this is why I think sometimes some of our clients, they come - some of our clients are very isolated, they live alone so therefore they are here with us. So those clients also need to be treated, you know - even though they are coming, they just want to have that yarn and somebody to talk to.

And knowing that there's not always somebody here to do that, but that's why I try and say to some of my clients that are like that, let's catch up, let's book it in. You know. Or otherwise we will just go for a walk, we will go for lunch or whatever. Our program has the opportunity to be able to run lunch club every Wednesday, and we had our final last supper at Charcoal Lane on Wednesday. Yes, for our clients. So - which was a great outcome, you know, because a lot of our clients are isolated and don't get out. Yeah.

SPEAKER 1: Yes. Great. More of that connection stuff as well. Are there any other changes to the health system that you think? You mentioned the whole bunch, both of limitations, barriers there. The examples of that kind of flexibility and like just human input, basic care, human-centred. You know, like caring for the person, knowing the person. Any other big changes that you think you would like to see? So, you know, we will be making recommendations around these are some changes to the healthcare systems.

SPEAKER 5: If they are going to discharge people from hospital when they know that they need more care, do an outreach. Follow up with them so that they don't just end up being another statistic.
SPEAKER 1: Yes. Do you know of any (indistinct).

SPEAKER 3: Yes, absolutely. I could tell many stories but I'm just going to keep it brief. Being discharged from prisons, for example, [name edited] will know exactly what I'm talking about. Some patients need to go on to open up a placement therapy, and the - they sort of get released and given our address and told to come here for

ongoing care. They do ring us up and try to warn, but it is like you gave them two days worth of medications and you want us to just fit them in tomorrow to suddenly do their ongoing care. Our GPs are booked out for weeks upon weeks.

And we do it, but it's like if we weren't here these patients will just be back on the streets and without their medications. They will just end back up in the prison or in hospital or worse. Even this morning we had a patient that was released from hospital, discharged from hospital a day or two ago and they were told to come here, specifically yesterday or today, to get their medication and injection medication that they have to get done by a nurse or health worker. But why wouldn't they just do that at the hospital when they could have instead of telling them to come here? Which we don't mind, but it's a bit like, well, you guys have the resources and everything to do it there.

SPEAKER 1: Why make it harder for them?

SPEAKER 3: Why make it harder for them and make it, yeah, easier for them to slip through the cracks. And sometimes these can be things such as anti-psychotic medications and things like that. So we found that that puts it into a high risk of not being able to come here because their head is not on quite right and they could forget. They could end up in a bad -

SPEAKER 5: Relapse

SPEAKER 3: A bad relapse or someone could just say the wrong thing to them and then -

SPEAKER 5: Set them off.

SPEAKER 3: Which would then end up in hospital or with the police. So it's just very frustrating. Like we are happy to do it, but you guys really should have done this yourself and then tell them to come and see us in two weeks or four weeks where they can - where they are in the right mind space to make those preparations with us.

SPEAKER 6: Or fund us appropriately.

SPEAKER 4: But I think it is - and just on that, I think as - I think it's a hospital's expectations that we are going to pick it up. We do pick it up because we know our clients, but hold on, you guys have got a duty of care to this client that has been in that hospital.

SPEAKER 3: Yes, yes. That's exactly it.

SPEAKER 4: They have got a duty of care and this is where it falls back on VAHS. You know. And - yes.

SPEAKER 6: It's like the mentality of come in, okay you are right, out. In, out, in, out. They are just like a machine.

SPEAKER 4: Exactly.

SPEAKER 6: And then we are here to pick it all up. But, again, we are not funded appropriately. I think everybody can agree on that.

SPEAKER 4: Definitely.

SPEAKER 6: So fund us appropriately then so we can. It's not going to add extra pressure to the GPs and everybody here, the workers, to have to fit that person in.

SPEAKER 4: And that's where who - who makes the hospitals accountable for that duty of care? Because they are not looking after clients.

SPEAKER 3: Yes. And a lot of vulnerable clients too.

SPEAKER 4: Definitely.

SPEAKER 2: You mentioned before the prisons. I used to work in prisons as AI. When prisoners come in they are taken off all their medication. They are given Panadol. They are off anti-psychotic medication, all that sort of stuff. How do you guys handle that when - because I know it has been - it takes weeks to go through the system to get that medication into them for the prisoner. How do you go with the prisoners that out, that have been off that medication for so long? You would be starting again, wouldn't you?

SPEAKER 3: My understanding or my hope would be that they - when they are outpatients, for example, we do get requests for their medications list or medical information which we send away so we can begin that process. My understanding would be that they can continue the care and that treatment but then once again they are working off a very limited supply on leaving the prison and tell them to just come here. They might give them a train ticket, like a myki ticket or a train ticket to get here, but there is no real follow up care.

And sometimes, you know, we organise it, we book them in, we make notes, we send messages and then they don't ever show up and we never actually do one. I have seen, as I said, someone who has fallen through the cracks because there's no - let's make sure that you get in this car to send you here, which I know is a lot of resources and everything, but it's what we would do basically.
We will book someone a taxi from their home to the hospital because they need to go see the liver specialist, and we will book that to make sure that they go and then book them a taxi back home if we need to just to make sure they actually go because we want them - we want to make sure that they are taken care of and have no barriers to getting their healthcare. And we just - we just feel like the wrong decisions are being made. Sometimes, yes, there is probably a fifty-fifty (indistinct) the person is

self-determinate enough and able to make their way to the health service to continue their care with us, whether they have seen us before or as a new patient. But I still say there's a 50 per cent that they have made the wrong judgment call and they haven't been able to have -

SPEAKER 5: They are set up to fail from -

SPEAKER 3: (Indistinct) exactly.

SPEAKER 5: - from what they walk out of those prisons.

SPEAKER 3: Exactly, yes.

SPEAKER 5: They are setting those people up to fail.

SPEAKER 3: Yes. And Aunty would know it better than I do. We have had a lot of improvements with opioid replacement therapy in particular since Aunty has moved into community programs which we are really thankful for and have seen massive success. But before we had these systems Aunty has probably seen this exact story so many more times, a lot of times. And it's really, really crushing because some of these patients are my age and younger. Like 27 years and younger. And they are just fall through it because they have been set up to fail.

SPEAKER 7: Yes, because it's around not having enough comprehensive supports when they are being discharged and not having enough of that follow up outreach, putting extra barriers there they don't need to. Like jump through hoops or go through the service to get the medication you need rather than getting it on the spot.

SPEAKER 3: Yeah. Or even just giving them a bit of extra time. And I know they might think that if we only give you two days it will make sure that you get there,

SPEAKER 6: But there is also a high risk of them not.

SPEAKER 3: Exactly.

SPEAKER 7: Right.

SPEAKER 4: But then it's, like, them going and finding the alternative. And then they are right back to square one.

SPEAKER 3: Exactly.
SPEAKER 2: The responsibility is on that individual, isn't it? You have got to find the appointment. You have got to get through - you know, it's all.

SPEAKER 4: Yes.

SPEAKER 7: Thanks. That's a really important one to (indistinct) one of the things we can do as well.

SPEAKER 3: I just think at least give them the opportunity to get here for their first appointment and then we will set up their - yes, to help organise their ongoing care. How these (crosstalk). At least let us try to get our - our small group there to keep - keep them coming back.

SPEAKER 1: Yes. And it is at a place where they are going to feel probably a bit more welcome, would you say, than not.

SPEAKER 3: Yes.

SPEAKER 1: Yeah. And supported than mainstream hospitals or something. All right. I think we are going to finish up pretty soon unless there is anything else people want to share.

SPEAKER 8: I just have one comment.

SPEAKER 1: Yes.

SPEAKER 8: I'm just thinking, just from conversations I've had with people externally and other health professionals and just other family and things, and I think still - and I know that you talked about this in the first part of your study, but I think still there is just a really - a lack of understanding of Aboriginal Australians and the history and what they have been through, and where things are now.

SPEAKER 1: Yes.

SPEAKER 8: And people don't - I think a lot of people in the mainstream do not understand and they think that everyone's needs are pretty much the same and they don't appreciate all those sort of social determinants of health and - and all those things in the background. And I think that is where a lot of those programs like your mainstream health and things fall down because they don't appreciate that there needs to be better supports because people's situations are different. They have been - had different experiences, different histories and different barriers that they don't even know about.

SPEAKER 1: Yes. Absolutely. And like part of the mission of Yoorrook, that why Yoorrook is there is about drawing this line as well between colonisation and impacts, right. So it's not about saying people are like this because, you know, it's on them.

SPEAKER 8: Yes.

SPEAKER 1: It's saying because of policies that were put in, many that are still happening even in other forms, just trying to draw that line between, you know, the

impact of State policies and laws and systems and institutions that are, you know, historically have been (indistinct) and don't support people.

SPEAKER 2: Still the same.

SPEAKER 5: So can I - just saying, whilst we are in the education system, when we were go through, they didn't tell us any of this. So that has been a problem too.

SPEAKER 1: Totally.

SPEAKER 6: Even with us, like my age, we didn't learn nothing.

SPEAKER 1: Yeah, yeah.

SPEAKER 4: So can I just ask a question? With all this truth telling, because it does show and history shows, why can't we be written into the Constitution without that ridiculous referendum, because the way it was set up - and it was set up to fail to start with anyway, you know, but, yeah, just put more trauma, you know, and just brought up old wounds for every person across - nationally, you know. And - and I think is there an opportunity that this could actually segue so that it is - we are embedded in the Constitution? What happens after it is another whatever discussion, but I think that's where it needs to be written because history is this is Aboriginal land.

SPEAKER 1: Yes.

SPEAKER 4: You know. And they come and - you know, colonisation, everything that happened to - to our people, recognise it, put us in there, and then what youse decide later go for it. But, yeah.

SPEAKER 1: That's right. I think so. I mean, the referendum, obviously that was a federal process, and so we are a state process. I think one of the things that's happened since, you know, that was unsuccessful was that now, you know, the opportunity is now at a state level. Or, you know, you see these different treaty processes. Obviously Victoria is leading by a fair bit of treaty and truth-telling, but other states are also starting their treaty processes and truth-telling processes. So I think that's where it is. Post referendum there has been bipartisan support for both of them has dropped post the referendum. You know, I think it has given pause for more conservatives to think that there is some political success in being against these kind of things now. So -

SPEAKER 6: [Name edited] we have had so many MPs come in recently, and they are all in the starting comments, "we are sitting on stolen land".
SPEAKER 4: We should -

SPEAKER 8: So we had the - what's her name, Jacinta Allan, who is the premier, she started off by saying we are sitting on stolen land. We had the Treasury in on

Wednesday admitting sitting on stolen land and then he was kind of asked about well why are we paying land tax? You know, why are we paying land tax. So there is momentum in Victoria. But, yeah, like if saying the Federal stuff, Yoorrook won't have any party to. But it is a momentum.

SPEAKER 4: Yes. But I just think in terms of the whole - the whole process of that was wrong. It was wrong to start with, and really to do it should have just been Aboriginal and Torres Strait Islander people making our own decisions because you actually - they actually took away our self-determination by actually giving the broader community -

SPEAKER 1: The vote.

SPEAKER 4: Yeah, yeah.

SPEAKER 8: And they actually knew the damage. From 2016 we had the same-sex marriage debate. We saw the division in community and how damaging it was for those communities being affected. We did the same thing like not many years later, and there was no support set up for people that felt it really hard to go into - you know, go back into schools and education and hospitals after that.

They set up no social emotional wellbeing programs. They had no counsellors on call. I found that was horrific and I know that you have probably dealt with the aftereffects as I did in my small role as a counsellor. I'm sure you guys had devastated clients not feeling safe in community.

SPEAKER 4: Definitely.

SPEAKER 9: And I can't believe they did that. That was horrific.

SPEAKER 4: But then I - but then I also see impacts on the broader community who actually supported - supported the yes vote but were also gutted, you know, because of it. And then that even made them wild too. So, yeah.

SPEAKER 9: It was a sad time.

SPEAKER 1: It is.

SPEAKER 9: Sorry, can I just say - I think this, brilliant, the truth-telling, but it needs to go at all levels. Does that make sense? It needs to go to those hospitals to understand why separating that baby from that mother is - causes such trauma for us.

The - like too from prep to obviously, you know, like you are going to tailor it to suit the audience, but it needs to be - it can't just be - like I know that the public intoxication, the police officers have a 15 minute mandatory training and then a 45 minute video or something that wasn't mandatory.

SPEAKER 1: Yes.

SPEAKER 9: So now we have to go out there - this huge machine of a thing, and try and get people to understand why.

SPEAKER 1: Yes. Yes.

SPEAKER 9: Why do we have to do that?

SPEAKER 1: That's right.

SPEAKER 9: So I think with this, this is brilliant and we are all listening and people that are engaged, but you have got to get it further than that. Whatever findings and all that, it is about education, about why - what actually happened here and how it's very still alive for us.

SPEAKER 7: And so in June next year we will be bringing down recommendations that have to do with health. So it will be, you know, what we heard today, also (indistinct) VAHS has made a significant submission themselves that spells out some potential recommendations. Other ACCOs and health services have made suggestions to the sorts of changes they want to see.

We have spoken to ALOs and separate groups as well about the struggles that they face. So that's when we will try to have some of those key changes recommended, and a big part of them around accountability and mechanisms within government as well, right. Oversight. So you say you are going to do this, where is the market for it? Lots of what we have seen is the minister saying having these nice strategies but having real no oversight of any of the changes, no accountabilities that don't give any of those markers.

So, yeah, that's hopefully that will be the middle of the next year. We will make sure we send them to you guys. But thanks for helping inform them and making sure that your (indistinct) really appreciate it. We are going to run to the press office. We will write this up into a little statement, for the VAHS staff group 2 and we will send it across to Grant to -

SPEAKER 2: Send it out to youse just to make you are -

SPEAKER 7: Then it will be published on our website and (indistinct) we won't have your names on it at all, it will be all anonymous.

SPEAKER 10: You can do individual submissions too. If you want to add to the conversation online. You can go online and just do one on our website if you want.

SPEAKER 2: (Indistinct) do one. Will you get in touch with me and I will come out and do one, an individual one?

<THE RECORDING CONCLUDED