VICTORIAN ombudsman

Investigation into healthcare provision for Aboriginal people in Victorian prisons

March 2024

Cover artwork by Jessie Waratah with Megan Williams and community members.

Warnings

Aboriginal and Torres Strait Islander readers are advised this report contains information about, and the names of, Aboriginal people who have died. Names and details are used for accuracy and transparency. The Victorian Ombudsman acknowledges Aboriginal families' statements that they have unfinished business about deaths of Aboriginal people in custody.

This report contains content about traumatic incidents and issues. Crisis support is available through Lifeline on 13 11 14. Aboriginal and Torres Strait Islander people can access free and confidential support by calling 13YARN on 13 92 76 or Yarning SafeNStrong on 1800 959 563.

This report contains language some readers may find offensive.

Terms used in this report

'Aboriginal' is used throughout this document to refer to all First People of Victoria. This includes Aboriginal Victorians who have Torres Strait Islander heritage and Torres Strait Islander people who now live in Victoria.

This report generally uses the phrase 'people in prison' rather than 'prisoners' to respect that a person's legal status as a prisoner does not define them. However, this report at times uses 'prisoners' in quotes from other sources.

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The Victorian Ombudsman pays respect to First Nations custodians of Country throughout Victoria. This respect is extended to their Elders past and present. We acknowledge their sovereignty was never ceded.

Letter to the Legislative Council and the Legislative Assembly

To

The Honourable the President of the Legislative Council

and

The Honourable the Speaker of the Legislative Assembly

Pursuant to sections 25 and 25AA of the *Ombudsman Act 1973* (Vic), I present to Parliament my report on the *Investigation into healthcare provision for Aboriginal people in Victorian prisons.*

Deborah Glass OBE
Ombudsman

6 March 2024

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Foreword

This is the tenth report I have tabled into issues concerning prisons and other closed environments; an average of one a year. People may wonder if we need another one. But this investigation concerns a specific group of people and a specific issue about which there is much more to be done.

It is not news that Aboriginal people are significantly over-represented in Victorian prisons, as indeed they are around Australia. They make up less than 1 per cent of the Victorian population but 11 per cent of the prison population. It is a shameful legacy for all Australians, rooted in a colonial history of dispossession and violence, the impact of which continues to this day.

It is less well known that healthcare is the issue raised most often with the Ombudsman by people in prison and their advocates. And while healthcare is an issue for all people in prison, the available evidence shows that Aboriginal people suffer worse and more complex health outcomes than non-Aboriginal people in prison and in the community.

I launched this investigation on that basis.

In doing so, I was well aware that for more than 30 years numerous bodies have investigated the causes of poor Aboriginal health outcomes and deaths in custody – from the 1991 *Royal Commission into Aboriginal Deaths in Custody*, to the 2022 *Cultural Review of the Adult Custodial System* and the coronial inquest into the death of Veronica Nelson in prison.

These reviews made multiple recommendations to improve healthcare in prisons, some repeated over the years, and various Governments made multiple commitments to implement them.

Yet little has changed, or at best, not enough.

Despite commitments at every level of government to Aboriginal peoples' self-determination and Aboriginal-led solutions, the experiences of Aboriginal people in prison are often missing from discussions about policies that affect them. We spoke with Aboriginal people in three prisons about their healthcare experiences. It is crucial for the Government to listen to their voices now, instead of waiting to hear these stories during a coronial inquest.

The voices of some of the Aboriginal people we spoke with are in this report. Some of the things we heard were deeply confronting and distressing, and not all of the stories made it into this report.

What we heard reflected that for Aboriginal people, health is holistic and includes not only physical but mental, social, emotional, cultural and spiritual wellbeing.

We heard about a yearning for cultural connection. About the devastating impact a lack of cultural and family connection in prison can have, and what a huge difference it makes when they do receive cultural support with their healthcare needs.

They described connection to family and community as a powerful motivator for staying out of prison, including addressing alcohol and other drug dependence. They also spoke of pain, frustration, stress and other negative health impacts caused by separation and barriers to contacting family while in prison.

We did not only talk to people in prison. We engaged with representatives of the Department of Justice and Community Safety and healthcare providers, as well as Aboriginal organisations and community representatives working with Aboriginal people in the prison system.

My investigation was also assisted by two experts specialising in issues relating to the health of Aboriginal people in the criminal justice system to ensure the investigation was culturally informed. We are deeply grateful to Professor Megan Williams and Jack Bulman for their contributions to the investigation, including leading our discussions with Aboriginal people in prison.

I thank all who assisted the investigation and acknowledge the experience of many Aboriginal people of being over-consulted but under-included.

Aboriginal people and organisations often expend significant resources participating in consultations. However, too often these do not lead to meaningful action in line with their needs.

Aboriginal people and organisations told us that prisons need Aboriginal models of healthcare, led by Aboriginal organisations. This has been a consistent theme in previous reports, and despite Government commitments, this issue has not been adequately addressed. Government commitments to self-determination, consultation and evidence-based health policy appear to stop at the prison gates.

The prison health system is highly complex, and our investigation took place at a time of transition. Victoria's public prisons have had new primary healthcare providers since July 2023, and to some extent it is too early to say whether new measures are working. But these changes were made without meaningful input from key Aboriginal community representatives. And while new standards have been adopted, these do not yet apply to private prisons.

We do not think it is too early to say the system is currently failing to meet the needs of Aboriginal people and is not ensuring their best health outcomes. In my opinion this is wrong, and discriminatory.

Ensuring culturally responsive healthcare requires systemic change. But meaningful change will only happen when commitments translate into meaningful action, based on principles of self-determination. I am pleased the recommendations in this report have been accepted, at least in principle. For the sake of our over-incarcerated First Peoples, I can only hope this report finally provides the spur for change.

Deborah Glass OBE

Ombudsman

Glossary

1991 Royal Commission	The landmark *Royal Commission into Aboriginal Deaths in Custody* examined causes of deaths of Aboriginal people in custody in Australia between 1 January 1980 and 31 May 1989. Several of the 339 recommendations assert that Aboriginal health services should be funded to provide leadership of and healthcare for Aboriginal people in prison.
2014 Quality Framework	The *Justice Health Quality Framework* 2014 outlines standards for primary healthcare in Victorian prisons that were part of the contractual requirements of healthcare providers in public and private prisons. As of 1 July 2023 the framework is only in force in private prisons.
2023 Quality Framework	The *Healthcare Services Quality Framework for Victorian Prisons 2023* outlines standards of primary healthcare for Victorian public prisons. It includes new requirements for the delivery of Aboriginal healthcare in prisons.
Aboriginal Clinical Governance Officer – Aboriginal Health	A role in Justice Health to provide a secondary consultation service and advice to health staff working with Aboriginal people in prison.
Aboriginal Health Checks	Introduced as a requirement of the prison healthcare provider contracts from July 2023 in order to improve continuity of care. Intended to be equivalent to the Health Assessment for Aboriginal and Torres Strait Islander People available in the community under the Medicare scheme (item 715).
Aboriginal Health Liaison Officer	A role introduced by Western Health at the Dame Phyllis Frost Centre to provide culturally appropriate support and advocacy for Aboriginal people in prison. Aboriginal Health Liaison Officers may attend appointments, assist women with accessing services and work on improving health service engagement.
Aboriginal Health Risk Review	Carried out by Justice Health's Health Risk Review in 2021 to identify barriers to Aboriginal people accessing healthcare in prison. It reviewed the files of 659 Aboriginal people in prison, conducted by prison healthcare providers, to identify clinical risks and indicators for poor health outcomes.
Aboriginal Health Unit	A unit within Justice Health established in January 2023 by Justice Health, intended to develop a cultural safety audit framework.
Aboriginal Health Practitioners	Aboriginal Health Practitioners hold a Certificate IV in Aboriginal Primary Health Care (Practice) and are registered with the Australian Health Practitioner Regulation Agency. Aboriginal Health Practitioners perform a range of clinical practice and primary healthcare duties for the community in which they work.

Aboriginal Health Workers	Aboriginal Health Workers must undertake a minimum Certificate III in Aboriginal Primary Health Care. The role is intended to provide better access, liaison, health promotion and preventative health services to Aboriginal people.
AJA	The *Burra Lotjpa Dunguludja – Aboriginal Justice Agreement* is a long-term partnership between the Victorian government and Aboriginal community. The first AJA (2000-2006) was developed in response to recommendations from the 1991 Royal Commission, and the AJA is now in Phase 4 (2018).
AJC	The Aboriginal Justice Caucus is made up of all the Aboriginal signatories to the AJA and includes Chairpersons of each of the nine Regional Aboriginal Justice Advisory Committees, representatives from statewide Aboriginal Justice programs, peak bodies and ACCOs. The AJC is a conduit between Aboriginal communities and the justice system.
Aboriginal programs staff	Used in this report to mean prison workers whose roles relate specifically to supporting Aboriginal people in prison. Includes AWOs and ALOs in public prisons, and Aboriginal Keyworkers at Ravenhall Correctional Centre.
Aboriginal Social and Emotional Wellbeing Plan (2015-2018)	Developed by Justice Health and Corrections Victoria as part of the AJA Phase 3. It aimed to improve health and justice outcomes for Aboriginal people through programs supporting connections to culture, community and Country and partnerships with Aboriginal organisations to provide social and emotional wellbeing support to Aboriginal people in custody.
ACCO	Aboriginal Community-Controlled Organisations deliver holistic, culturally safe services that strengthen and empower Aboriginal communities. They are incorporated under relevant legislation and not for-profit; controlled and operated by Aboriginal people; connected to the communities in which they deliver services; and governed by a majority Aboriginal governing body.
ACCHO	An ACCHO – a type of ACCO – is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected governing body.
ADR	Additional Data Requirements are reporting requirements for prison health care providers covering prisoner complaints, workforce information, population health tests and AOD treatment programs. They do not measure health outcomes, cultural safety or the quality and safety of care.

ALO	An Aboriginal Liaison Officer is an Aboriginal programs role in Victoria's prisons. Applicants do not have to identify as Aboriginal but are supposed to 'demonstrate knowledge of and an ability to communicate sensitively with the Victorian Koori community'.
AOD	Alcohol and other drugs.
AWO	An Aboriginal Wellbeing Officer is an Aboriginal programs role in Victoria's prisons. It is a 'designated' position, meaning only people who identify as Aboriginal and/or Torres Strait Islander can be appointed to the role.
CCA	Correct Care Australasia is a private custodial healthcare provider at Ravenhall Correctional Centre. Until 1 July 2023, it was the primary healthcare service provider in all Victorian public prisons.
Code Black	A Code Black is one of the emergency prison codes (a type of alert) for serious medical events or death of a person in prison. It leads to people in prison being put into lockdown in their cells.
Corrections Victoria	A business unit of the Department of Justice and Community Safety which is responsible for the oversight of all prisons in Victoria.
Cultural responsiveness	Culturally responsive services respectfully use and embed Aboriginal peoples' knowledge, values and actions in the design, delivery and evaluation of services and programs. Culturally responsive services support Aboriginal people in ways that ensure cultural safety.
Cultural Review	The 2022 *Cultural Review of the Adult Custodial System* was established by the Victorian government to inquire into and report on culture, safety and inclusion, and integrity within the Victorian custodial corrections system. The Cultural Review found that Aboriginal people in prison did not feel culturally safe accessing mainstream prison health services and made recommendations for change.
Cultural safety	The practice of creating environments that are spiritually, socially, emotionally and physically safe for Aboriginal people. It involves caregivers critically reflecting on their practices and services and providing care that is free of racism and respects people's dignity. Cultural safety is defined by the recipient of care, not the caregiver.
DFFH	The Victorian Department of Families, Fairness and Housing.
DPFC	The Dame Phyllis Frost Centre is a Victorian public women's prison operated by Corrections Victoria. It is the state's only maximum-security prison for women.
Elders	Recognised knowledge-holders in Aboriginal communities, with local permissions and roles to provide leadership. It is an Aboriginal cultural protocol and essential for cultural identity and safety that connections with local Elders occur in a prison context.

Forensicare	The Victorian Institute of Forensic Mental Healthcare provides specialist forensic mental health services across 12 of Victoria's 14 prisons.
GEO Group	GEO Group Australia Pty Ltd is the private operator of Ravenhall Correctional Centre and Fulham Correctional Centre and the parent company of GEO Healthcare.
GEO Healthcare	The private primary healthcare provider in all of Victoria's public men's prisons.
Health Services Review	Established by Justice Health in 2020 to review and recommission health services in public prisons at the expiration of CCA's public prison healthcare contract.
Holistic health	Aboriginal peoples' concept of health is holistic, and has been recognised by Australian Governments since the 1989 *National Aboriginal Health Strategy*. Holistic health encompasses social, emotional, mental, spiritual, environmental and physical domains, intergenerationally across the past, present and future for individuals and whole communities to achieve their full potential, and according to local cultures and protocols. The mainstream healthcare sector often refers to social and emotional wellbeing.
Integrated Care Plan	A healthcare plan that takes account of the whole of a person's health and social needs. For Aboriginal people this should include access to culturally appropriate care.
Justice Health	A business unit of the Department of Justice and Community Safety responsible for the delivery of health services in Victoria's prisons.
KPM	Key performance measures are embedded in prison healthcare contracts to measure adherence with requirements of the contracts. Some relate to healthcare for people in custody.
MATOD	Medication Assisted Treatment for Opioid Dependence is a medical treatment program within Victoria's prisons (formerly known as Opioid Substitute Therapy Programs).
MAP	The Melbourne Assessment Prison is a Victorian public men's maximum-security prison operated by Corrections Victoria.
NACCHO	National Aboriginal Community Controlled Health Organisation. The national leadership body for Aboriginal and Torres Strait Islander health in Australia, representing 145 ACCHOs across Australia.
National Agreement on Closing the Gap	The *National Agreement on Closing the Gap* (2020) is between all Australian Governments and the Aboriginal and Torres Strait Islander-led Coalition of Peaks, and commits to priority reforms with targets to track progress on overcoming entrenched inequality experienced by Aboriginal and Torres Strait Islander people and to achieve life outcomes equal to all Australians.

NSQHS Standards	National Safety and Quality Health Service Standards are administered by the Australian Commission on Safety and Quality in Healthcare. Healthcare providers in Victoria's public prisons are accredited against these standards.
Primary health	In Victorian prisons, primary healthcare services include health assessment and planning, population health, AOD treatment and MATOD, primary mental healthcare, dental services and medication management.
Quality Domain 5	The section of the 2023 Quality Framework which sets out 22 actions that healthcare providers are required to take relating to the provision of healthcare to Aboriginal people.
Ravenhall	Ravenhall Correctional Centre is a Victorian private men's mixed medium and maximum-security prison, operated by GEO Group.
Secondary health	Health services to which people in custody may be referred, such as a specialist or surgery.
Social and emotional wellbeing	A strengths-based concept used in Australian Government frameworks since 2004. Social and emotional wellbeing programs address Aboriginal peoples' health holistically, requiring human, health and Aboriginal peoples' rights to be enacted including to self-determination, and to be free of racism and stigma. These programs recognise the importance of connections to land, culture, spirituality and kinship, and how these affect the individual and the whole community.
Strengthening Aboriginal Custodial Health Care Project	A 2021 Justice Health project aimed at understanding inequalities and barriers to Aboriginal people in prison accessing health care.
VAAF	The *Victorian Aboriginal Affairs Framework* (2018-2020) is the Government's overarching framework for working with Aboriginal Victorians, organisations and the wider community to provide a consistent framework for the numerous existing strategies to embed self-determination and improve outcomes for Aboriginal people in Victoria.
VACCHO	The Victorian Aboriginal Community Controlled Health Organisation is the peak body representing 33 Victorian ACCOs. The Australian and state governments formally recognise VACCHO as Victoria's peak representative organisation on Aboriginal health.
VAHS	The Victorian Aboriginal Health Service, an ACCHO, provides a comprehensive range of medical, dental and social services for the Aboriginal community, including delivering programs to people in some Victorian prisons.

VALS	The Victorian Aboriginal Legal Service Co-operative Limited, an ACCO, provides referrals, advice and information to Aboriginal and Torres Strait Islander peoples, specialising in criminal, family and civil law.
Veronica Nelson Inquest	Coronial inquest into the death of 37-year-old Veronica Nelson, a proud Gunditjmara, Dja Dja Wurrung, Wiradjuri and Yorta Yorta woman who died at DPFC on 2 January 2020. The Coroner's finding was handed down on 30 January 2023.
Victorian Closing the Gap Implementation Plan	The *Victorian Closing the Gap Implementation Plan 2021-2023* details the action the Victorian Government committed to take to achieve the objectives of the *National Agreement on Closing the Gap* (2020).
The Yilam	Naalamba Ganbu and Nerrlinggu Yilam ('the Yilam'). The Yilam is a business unit within the Rehabilitation and Reintegration Branch of Corrections Victoria. It leads Corrections Victoria's policies, programs and services aimed at reducing the overrepresentation of Aboriginal people in prison and provides support to Aboriginal programs staff in prisons.
Yoorrook Justice Commission	The first formal truth-telling process into historical and ongoing injustices experienced by First Peoples in Victoria. In 2023, the Commission published its *Report into Victoria's Child Protection and Criminal Justice Systems*.

Summary

Background

1. On 7 November 2022, the Ombudsman began an 'own motion' investigation into healthcare provision for Aboriginal people in Victorian prisons. We examined the following questions:

    - To what extent does healthcare provided in Victorian prisons meet the needs of Aboriginal people?
    - To what extent is the healthcare system in Victorian prisons adequate to ensure the best health outcomes for Aboriginal people?
    - What is needed to ensure that Aboriginal people in Victorian prisons can access healthcare that is culturally safe, continuous, and of an equivalent standard and quality as that which is available to people who are not in prison?

2. Health from an Aboriginal perspective is holistic. It is not just about the physical but includes mental, social, emotional and cultural wellbeing. It recognises the importance of connection to land, culture, spirituality and ancestry, and how these affect the individual and the whole community.

3. There have been many commitments made by Australian and State Governments to improve Aboriginal peoples' self-determination and address inequities and disadvantage. Despite these commitments, Aboriginal people in Victoria continue to be over-represented and under-supported in the prison system.

4. The prison health system is highly complex, involving public and private providers and different contractual arrangements. Our investigation took place during a time of transition which saw changes to the primary healthcare providers in public prisons, the introduction of a public health model in women's prisons and a new Quality Framework in public prisons.

5. Our investigation focused on the State's responsibility to ensure that systems provide Aboriginal people in prison with culturally appropriate and responsive healthcare.

6. This report includes adverse comments about the Department of Justice and Community Safety ('the Department'), three Victorian prisons and various healthcare providers. These organisations were provided with a reasonable opportunity to respond to a draft of this report. This final report fairly sets out their responses.

7. Some adverse comments in this report were made by people in prison who gave evidence on the condition of anonymity. It is the usual practice of the Ombudsman to fact-check material before publication. However, in this case, verification would have compromised people's anonymity. We have not accepted the comments made by people in prison as fact but have included them with this caveat and in the context of other evidence.

8. To ensure our investigation was culturally informed, we engaged two experts specialising in issues relating to the health of Aboriginal people in the criminal justice system, Professor Megan Williams and Jack Bulman.

Aboriginal peoples' perspectives on prison healthcare

9. Recognising the need for Aboriginal peoples' experiences and ideas to be at the heart of this investigation, in May 2023 we met with Aboriginal people in three major Victorian prisons – the Dame Phyllis Frost Centre ('DPFC'), the Melbourne Assessment Prison ('MAP') and Ravenhall Correctional Centre ('Ravenhall'). New primary healthcare contracts and primary health service providers commenced in public prisons, including DPFC and MAP, on 1 July 2023. The provider at Ravenhall, a private prison, remains the same.

10. People at all three prisons spoke of how important their culture, spirituality and connection to Country are to their social and emotional wellbeing. They told us of insufficient supports to promote health and wellbeing through connection to culture and Country.

11. They described connection to family and community as a powerful motivator for addressing reincarceration risks, including alcohol and other drug dependence. They also spoke of pain, frustration, stress and other negative health impacts caused by separation from loved ones and barriers to staying in contact while in prison.

12. People spoke of having to rely on their own strength, resourcefulness, and each other, in the absence of adequate health care. We heard stories of people being unable to access programs to address their drug use, having their ongoing medications abruptly stopped and resorting to doing their own 'surgery'.

13. Common themes included:

    - delays in access to healthcare
    - inadequate mental health support
    - a lack of trauma-informed care and services to treat trauma
    - prison officers blocking access to healthcare
    - barriers such as the attitudes held by some custodial and healthcare staff.

14. People described feeling powerless to obtain the care they needed. Some spoke of simply giving up trying to get help, even for serious health issues. Others told of having to exaggerate their symptoms, make trouble or even threaten to self-harm to access healthcare.

15. Prison healthcare providers and the Department responded to the comments made by Aboriginal people in prisons. As the comments were anonymised, healthcare providers and the Department were unable to confirm the facts of each case. Their responses broadly emphasised that the experiences described did not align with their standard ways of operating and, in some cases, they called into question the stories we heard from Aboriginal people in prison.

16. Correct Care Australasia ('CCA') was the primary healthcare provider at all three prisons at the time we visited them in May 2023 (with new providers commencing at DPFC and MAP on 1 July 2023). CCA stated that it views cultural safety and cultural responsiveness as 'vital elements in delivering appropriate healthcare'. CCA refuted several comments made by Aboriginal people in prison, stating that their described experiences did not reflect the way CCA operates. CCA also noted, with reference to accessing drug treatment programs, that it operated in accordance with Departmental policies.

17. The GEO Group Australia ('GEO Group'), the operator of Ravenhall, said it is committed to providing culturally safe and appropriate healthcare for Aboriginal people in the prison system. As with CCA, GEO Group noted that some of the stories we heard did not align with their practices. GEO Group also clarified the reasons for various policies that had been criticised by people in prisons.

18. The Department stated that some of the comments did not accurately represent issues and potential solutions and did not provide enough context about broader health system challenges, such as workforce shortages and wait times for specialists and treatment at public hospitals. It said that some of the stories that appear to indicate service gaps may simply be the result of poor communication between health service providers and patients.

19. The Department also emphasised that our prison visits occurred in May 2023, before significant changes to healthcare provision in public prisons came into force on 1 July 2023.

20. As well as speaking with Aboriginal people in prison, we approached key Aboriginal organisations and community representatives.

21. The three organisations that provided us written responses all raised concerns about the current state of prison healthcare. They identified systemic barriers to the delivery of healthcare that is culturally safe, continuous, and of an equivalent standard and quality as in the community.

22. They also advocated for an end to the use of private healthcare providers in the prison system, and for the Government to contract Aboriginal Community-Controlled Health Organisations ('ACCHO') directly (rather than through sub-contracts) to deliver prison healthcare services for Aboriginal people.

23. They stated that ACCHOs have multiple reasons why they do not want to enter into sub-contracting arrangements, particularly with multinational private organisations, including that subcontracts place ACCHOs under other providers, diminishing their authority and compromising the way they work. They noted that the Department can only oversee ACCHOs effectively and ensure they meet expectations, if ACCHOs are contracted directly.

The Victorian prison system

24. The delivery of health services in Victoria's prisons is the responsibility of Justice Health, a business unit of the Department of Justice and Community Safety.

25. In Victoria, prison healthcare is contracted to a mix of public providers and private companies. These contracts are managed by Justice Health in public prisons, but in private prisons healthcare contracts are managed by the company that operates the prison, rather than the State.

26. Before 30 June 2023, all public prison primary healthcare services were provided by private company CCA. From 1 July 2023, new public prison contracts began with new healthcare providers, including:

    - GEO Healthcare
    - Western Health
    - Dhelkaya Health.

27. Healthcare in Victoria's private prisons is provided by:

    - CCA
    - GEO Group
    - St Vincent's Correctional Health Services.

Previous reviews related to Aboriginal healthcare in prison

28. For more than 30 years, numerous national and state-based bodies have investigated the causes of poor Aboriginal health outcomes and deaths in custody. These included the 1991 *Royal Commission into Aboriginal Deaths in Custody*, and the 2022 *Cultural Review of the Adult Custodial System* ('Cultural Review') among others.

29. These reviews made recommendations about how to improve healthcare in prisons, with some repeated over the years. They encompassed consistent themes:

    - Prison health standards must be updated to include and embed cultural safety.
    - Aboriginal organisations must be engaged as decision-makers about healthcare practices and not merely consulted.
    - Aboriginal health providers get better health outcomes and should provide healthcare in the prison system.
    - Funding for Aboriginal-led health services must be increased to meet these recommendations.

30. One of the fundamental recommendations was that prisons needed Aboriginal models of healthcare, led by ACCHOs.

Aboriginal models of healthcare

31. The Aboriginal people and organisations we consulted strongly advocated that for Aboriginal people, equivalence of healthcare and culturally safe healthcare means care that is delivered by ACCHOs.

32. The Victorian Government has also articulated this principle, for example in the *Victorian Aboriginal Affairs Framework* and the *Victorian Closing the Gap Implementation Plan*.

33. ACCHO workers described ACCHOs as being uniquely placed to provide culturally safe healthcare, overcome barriers to Aboriginal people accessing health services and bridge gaps in understanding between Aboriginal patients and non-Aboriginal healthcare providers.

34. There are currently some Aboriginal Community-Controlled Organisations working in prisons in Victoria providing various programs, however no prison uses an ACCHO as the primary provider of healthcare for Aboriginal people.

Government policies and commitments

35. A range of policies, agreements and standards commit the Victorian Government to recognising and enabling self-determination of Aboriginal people and ensuring that government services are culturally safe and culturally responsive.

36. Many of these documents commit the government to providing healthcare to Aboriginal people that:

    - is holistic
    - is culturally safe
    - is continuous
    - is equivalent to community standards
    - promotes rehabilitation and addresses over-representation of Aboriginal people in the prison system
    - is delivered in partnership with Aboriginal communities and in accordance with principles of self-determination.

37. Despite these many commitments, we heard from the Aboriginal people and organisations we spoke to that there is a disconnect between what Government policies say and the reality for people in prison.

Mechanisms for Aboriginal stakeholders' input into prison healthcare policy

38. There are a range of ways the Department can seek input from Aboriginal stakeholders about prison healthcare policy and provision.

39. There are various formal bodies, like the Aboriginal Justice Caucus, the Aboriginal Justice Forum, the Justice Health Clinical Advisory Committee and the Rehabilitation and Reintegration Collaborative Working Group, that can be consulted. Justice Health advised that it consults these groups on specific issues.

40. To gather feedback from Aboriginal people in prison about their experiences of healthcare provision, Justice Health conducted 'patient voice' focus groups at six public prisons in mid-2023. However, it has no formal ongoing program of consultation with Aboriginal people in prisons.

41. Despite these mechanisms for consultation, Aboriginal organisations told us that they are either not consulted at all about important custodial health matters, or that consultation is inadequate or does not lead to meaningful action on their feedback.

42. In its response to a draft of this report in January 2024, the Department said it has established mechanisms in 'response to feedback on the level of consultation', including monthly meetings with the Aboriginal Justice Caucus Co-Chairs, an Implementation Learning Network, a Youth Collaborative Working Group and a Youth Social and Emotional Wellbeing sub-group.

43. The Department also said it is working on the establishment of a new external oversight board, which it said will:

    - Provide a dedicated, formalised mechanism for external oversight of the delivery of healthcare services to people in custody.
    - Consist of paid members with clearly defined roles, responsibilities and appointment terms.
    - Include representation of clinical and policy experts from relevant fields, with the skills and experience to assess the quality-of-service delivery against best practice community standards.

44. To increase access to a range of expertise, the Department said it is replacing its Clinical Advisory Committee with a Clinical Advisory and Health Professionals Panel to provide expert advice on an 'as-needs basis', which will include experts in Aboriginal health.

Prison healthcare contracts and providers

45. All Victorian prison healthcare providers, both public and private, are bound by Justice Health's Quality Framework which sets standards of primary healthcare and forms part of all providers' contractual requirements.

46. Each of Victoria's three private prison operators subcontracts healthcare delivery to a provider of their choice. The Department does not directly manage the contracts of these healthcare providers.

47. Under these contracts, providers are bound by the 2014 *Justice Health Quality Framework*, while the providers in public prisons are bound by the *Healthcare Services Quality Framework for Victorian Prisons 2023* ('2023 Quality Framework') and specifications.

48. The 2023 Quality Framework includes a section specifically detailing the requirements for providing healthcare to Aboriginal people in prison. It incorporates all previous requirements for the delivery of Aboriginal healthcare in prisons and includes some new requirements.

49. The Department has said that for the 2023 Quality Framework to be applied to private prisons, the contracts will need to be renegotiated, which is complex and costly.

50. In July 2023, new healthcare contracts began for Victoria's public prisons. In the lead up to this, Justice Health conducted a Health Services Review to review and recommission the delivery of prison health services.

51. The Health Services Review could have considered various options, including using ACCHOs to deliver Aboriginal-led healthcare services to Aboriginal people in prison. Ultimately, Justice Health made a policy decision to look for a single provider to service the whole prison system and opened a tender for this in January 2022.

52. Justice Health acknowledged this decision was at odds with Aboriginal community wishes to use ACCHOs. Justice Health told us it expects mainstream healthcare service providers to offer a culturally safe service.

53. In October 2022, the Department saw a draft report of the Cultural Review which recommended that prison healthcare should be delivered under a public health model, on the basis that outsourcing it to a private provider is 'inconsistent with best practice and results in inconsistent and delayed healthcare for people in custody'.

54. The decision was made to stop providing healthcare in women's prisons through private providers and use mainstream public health providers instead. This decision reflects the Cultural Review's advice and shows that the Department was willing to compromise on its desire to have a single healthcare provider across the system.

55. Contracts for healthcare provision to Victoria's women's public prisons were signed with public health providers Western Health and Dhelkaya Health. Healthcare in Victoria's men's prisons was contracted to a single private provider, GEO Healthcare.

56. Given the importance of self-determination and the strength of various government commitments to it, we would expect Justice Health to engage with Aboriginal stakeholders about significant changes to prison healthcare. However, we heard from key Aboriginal organisations that engagement with them about the new contracts was lacking.

57. Justice Health stated that consultation with Aboriginal stakeholders was limited due to 'probity'. However, the Aboriginal Justice Caucus said there was no reason it could not have been consulted about the healthcare model while still meeting probity requirements, as it had done on other occasions.

58. The new contracts require providers to meet the standards set out in contract specifications and in the 2023 Quality Framework.

59. A number of Aboriginal-health specific processes that were not in the old contract were added to the specifications of the new contracts. Similarly, the 2023 Quality Framework contains far more requirements relating to the provision of healthcare to Aboriginal people.

60. While these initiatives are positive there are still limitations with the 2023 Quality Framework. As well as not being designed or implemented by Aboriginal people, the contracts do not require compliance with the requirements to be measured or evaluated with tools designed by Aboriginal people.

Monitoring Aboriginal healthcare outcomes

61. Good healthcare is informed by reliable and comprehensive data, however Victoria does not collect good quality prison health data.

62. The Cultural Review found that 'the objectives set out in the Justice Health Quality Framework are not supported by information systems, data monitoring and reporting processes that can ensure accountability of the custodial healthcare system'.

63. Justice Health has taken some steps to improve its monitoring of health outcomes for Aboriginal people. It developed an *Aboriginal Social and Emotional Wellbeing Plan* and conducted an Aboriginal Health Risk Review, which examined the clinical records of 659 Aboriginal people in prison.

64. There is no evidence that Justice Health has a systemic approach to the collection and review of health data regarding Aboriginal people in order to assess their needs and develop appropriate responses.

65. Justice Health is currently overhauling its electronic records system. Issues with the data quality and capacity of this system were raised by both Western Health and GEO Healthcare.

66. The new public prison healthcare contracts include 16 key performance measures, which track the delivery of individual healthcare processes in a specified timeframe. Health care providers are also required to report against additional data requirements such as prisoner complaints, workforce information, population health tests and alcohol and other drug treatment programs.

67. Justice Health is responsible for monitoring providers' performance and their compliance with their contracts. However, neither the key performance measures nor the additional data requirements measure health outcomes, cultural safety or the quality of care.

68. Justice Health has a considerable role to play in ensuring that healthcare delivery incorporates all government policies and recommendations. Justice Health needs to lead by example and demonstrate that it understands what is involved in delivering culturally safe healthcare.

69. There have been some recent positive developments, notably the creation of an Aboriginal Health Unit, and it is clear that Justice Health's intent in the newly drafted contracts was to create provisions that would ensure culturally safe and responsive healthcare for Aboriginal people. However, we did not see evidence that this change was rooted in an organisation-wide shift at Justice Health.

70. Currently, Justice Health lacks Aboriginal clinical governance expertise and an evidence-based understanding of culturally responsive care, limiting its ability to consider healthcare delivery through the lens of cultural safety.

Conclusions and recommendations

71. Over the years, the Australian and Victorian Governments have made many commitments to Aboriginal peoples' self-determination, consultation and evidence-based health policy. However, these commitments appear to end at the prison gates.

72. This investigation found a system that is failing to meet the needs of Aboriginal people and is not ensuring their best health outcomes.

73. The way healthcare is currently provided is at odds with the evidence and the wishes of Victoria's Aboriginal communities. The evidence is that Aboriginal people need holistic healthcare that attends to cultural, spiritual and social dimensions which is designed and delivered by the community.

74. The current system is also at odds with government commitments to Aboriginal people's self-determination, equivalency and continuity of healthcare, and improving health outcomes to reduce the over-representation of Aboriginal people in prisons.

75. This investigation took place during a transition in the way prison healthcare is provided. It is clear that some of the changes made by the Department during this period have the potential to improve healthcare for Aboriginal people.

76. However, these changes were made without meaningful input from the key Aboriginal community representatives who should have been involved. These changes did not deliver a system of healthcare that is Aboriginal-designed and led.

77. These changes have not brought about the substantive, system-wide change that previous inquiries and Government commitments have acknowledged is required to ensure that Aboriginal people in Victoria's prisons can access continuous, equivalent and culturally safe healthcare.

78. Justice Health did not demonstrate a strong understanding of health from an Aboriginal perspective, the provision of culturally responsive healthcare and factors impacting the health of Aboriginal people in prison.

79. It is clear from the Aboriginal people in prison who spoke with us, public health research, the extensive evidence compiled by previous inquiries, the submissions of Aboriginal community representatives and the Victorian Government's own commitments, that for Aboriginal people in prison to receive culturally safe, continuous and equivalent healthcare, more work needs to be done.

80. The Government needs to work with Aboriginal community representatives to implement an Aboriginal-designed and Aboriginal-delivered model of healthcare for Aboriginal people in prison. This needs to include evaluation and assessment with an Aboriginal lens as to its cultural responsiveness. It needs a qualitative focus on user experiences and on health outcomes.

81. Justice Health needs to develop an evidence-based understanding of the health and healthcare needs of Aboriginal people in prison. It needs to build its capacity to monitor and provide effective oversight of whether these needs are being met by health services.

82. This report makes five recommendations which aim to:

- involve Aboriginal Community-Controlled Organisations in designing and delivering holistic custodial health services
- increase Justice Health's capacity to oversight healthcare provision to Aboriginal people
- find ways to vary the current custodial primary health contracts to provide oversight that is more culturally safe and responsive to Aboriginal people
- develop an audit framework to regularly assess the clinical effectiveness and cultural responsiveness of healthcare delivery to Aboriginal people across all Victorian prisons
- increase the number of Aboriginal health professionals in Victoria and better support their career development.

Background

Why we investigated

83. As an independent oversight body of Victorian public organisations, the Victorian Ombudsman frequently receives confidential complaints from people in prison.

84. In 2022, we reviewed all the complaints we received in 2020-21 from people in prisons. The top issue raised was healthcare services, which made up a third of the complaints. Eleven per cent of these were from people who told us they identified as Aboriginal.

85. While healthcare provision and the treatment of Aboriginal people in prisons always warrant close monitoring by oversight bodies, several factors, in addition to the complaints we received, prompted this investigation:

- Six Aboriginal people have died in Victorian prisons in the past four years, and there have been 24 such deaths since the 1991 Royal Commission into Aboriginal Deaths in Custody ('1991 Royal Commission').
- The coronial inquest into the 2020 death of Veronica Nelson at the Dame Phyllis Frost Centre ('Veronica Nelson Inquest') focused on how poor healthcare provision contributed to her death.
- Aboriginal organisations and community legal centres have raised concerns with us about the access to and provision of healthcare to Aboriginal people in prisons.

86. On 7 November 2022, the Ombudsman began an own motion investigation, under section 16A of the *Ombudsman Act 1973* (Vic), into healthcare provision for Aboriginal people in Victorian prisons. We examined the following questions:

1. To what extent does healthcare provided in Victorian prisons meet the needs of Aboriginal people?
2. To what extent is the healthcare system in Victorian prisons adequate to ensure the best health outcomes for Aboriginal people?
3. What is needed to ensure that Aboriginal people in Victorian prisons can access healthcare that is culturally safe, continuous, and of an equivalent standard and quality as that which is available to people who are not in prison?

Context

87. This investigation took place against the backdrop of a national conversation about the experiences of Aboriginal people within colonial institutions and the right of Aboriginal people to self-determination. This conversation gained momentum with the Australian Government's Voice to Parliament referendum on the constitutional recognition of Aboriginal people.

88. Victoria is the first state in Australia to act on all elements of the 2017 *Uluru Statement from the Heart* – Voice, Treaty and Truth.

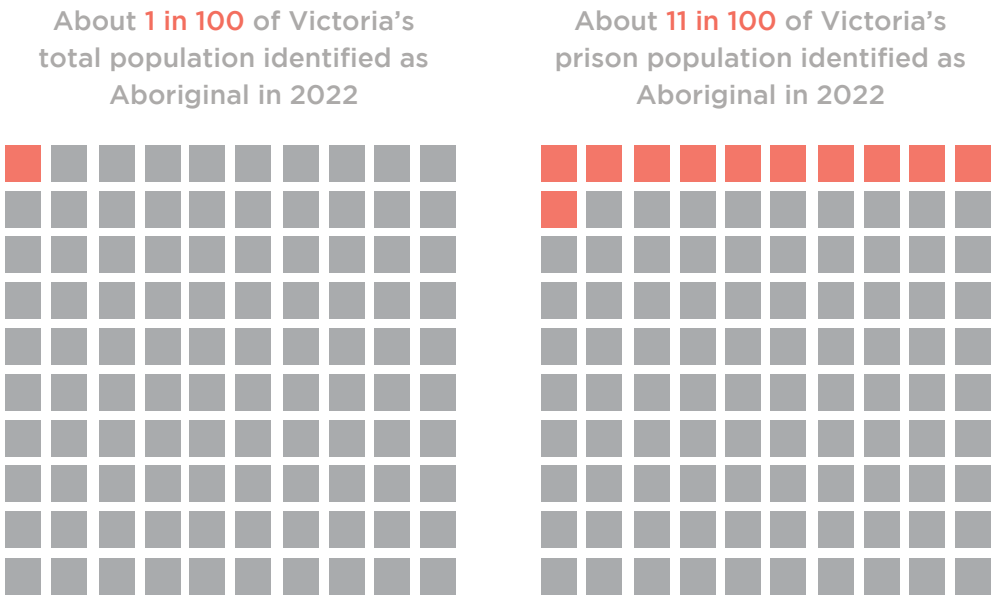
89. This included establishing:

- the First Peoples' Assembly, an independent and democratically elected body representing Traditional Owners of Country and Aboriginal peoples in Victoria
- the Treaty Authority, an independent body to oversee negotiations between the State Government and Aboriginal Victorians to ensure a fair treaty process
- the Yoorrook Justice Commission, set up to examine ongoing and past injustices experienced by Aboriginal people in Victoria.

90. Other commitments by Australian and State Governments to improve Aboriginal peoples' self-determination and address inequities and disadvantage include the *National Closing the Gap Agreement, the Victorian Aboriginal Affairs Framework* and the *Aboriginal Justice Agreement*.

91. Despite these commitments, Aboriginal people in Victoria still experience disadvantage and continue to be over-represented in the prison system, as shown in Figure 1.

Figure 1: Over-representation of Aboriginal people in Victorian prisons



Source: Victorian Ombudsman, based on information from the Australian Bureau of Statistics and the Department of Justice and Community Safety

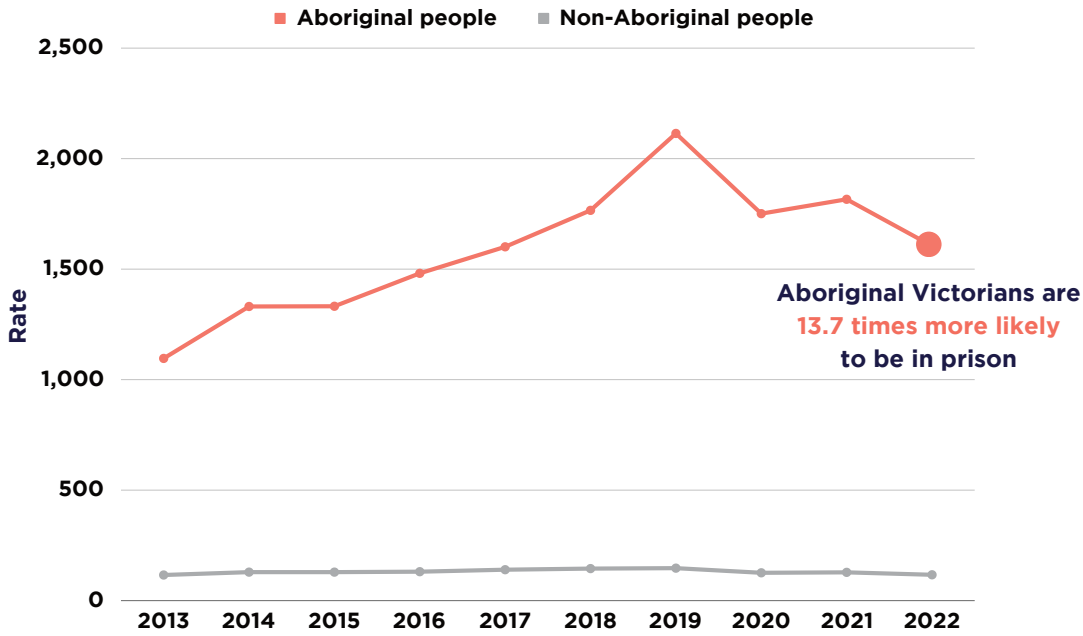
92. The Australian Institute of Health and Welfare reports that nationally, people in prison are likely to have multiple health conditions and poorer health than people in the general community with double the rates of disability. Aboriginal people are generally more likely to experience chronic conditions than other people in prison, particularly arthritis, cardiovascular disease, kidney disease and diabetes.

93. National data (which does not, however, include data from Victoria) from 2022 shows that Aboriginal prison entrants generally fared worse across social determinants of health than others, reporting generally lower education levels, and higher unemployment and homelessness.

94. While good quality data about the health of Aboriginal people in prison in Victoria is limited, the available evidence shows they suffer worse and more complex health outcomes than non-Aboriginal people in prison and in the community.

95. Research evidence from Australia and internationally shows that people in prison have significantly higher rates of mental illness than the general population. A 2013 study commissioned by the Department found that Aboriginal people in prison in Victoria have higher rates of almost every type of mental illness than the general prison population, most commonly major depressive episodes, and post-traumatic stress disorder.

Figure 2: Imprisonment rate per 100,000 Victorian adults*



* Age-standardised rate at June 30 each year

Source: Victorian Ombudsman, based on information from the Productivity Commission, *Closing the Gap Information Repository*, accessed 15 December 2023

96. Since the 1991 Royal Commission, multiple investigations, inquests, and government reviews – including by the Department of Justice and Community Safety – have made findings and recommendations to address the impediments to Aboriginal people in prison receiving appropriate and effective healthcare. However, we know these issues persist.

Scope of the investigation

97. The prison health system is highly complex, involving multiple public and private providers and different contractual arrangements. The provision of healthcare to Aboriginal people within this system is a vast topic about which much has already been said. While our investigation was underway, for example, this included the Veronica Nelson Inquest, the report of the Victorian Cultural Review of the Adult Custodial Corrections System ('Cultural Review'), and the Yoorrook Justice Commission's *Report into Victoria's Child Protection and Criminal Justice Systems*.

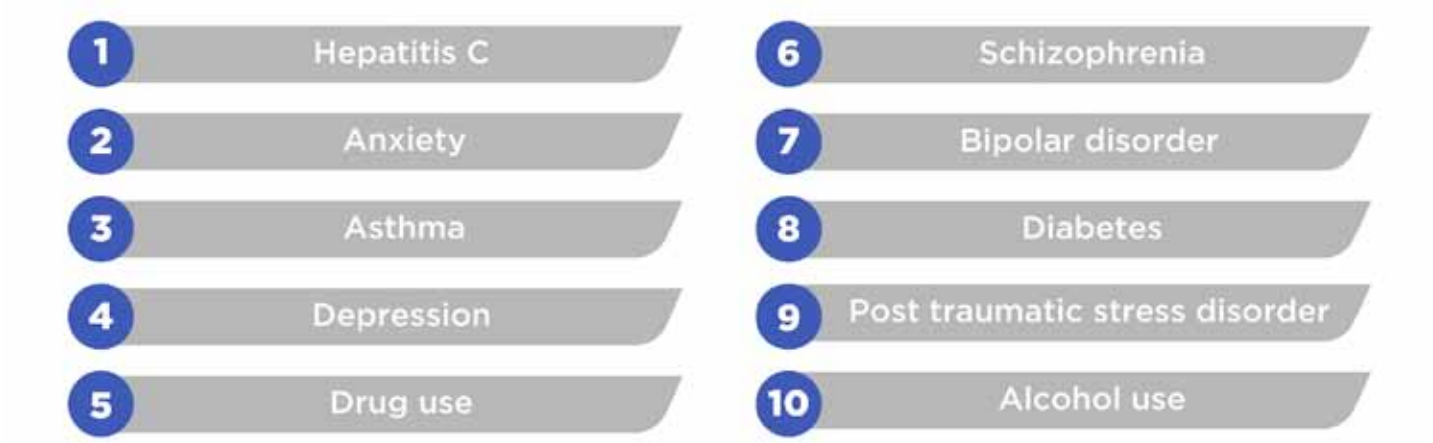
98. Our investigation took place during a time of transition for the prison health system. On 1 July 2023, the primary healthcare providers in public prisons changed, with public providers in women's prisons, and a new *Healthcare Services Quality Framework for Victorian Prisons 2023* ('2023 Quality Framework') was introduced in public prisons.

99. These factors informed our decision to focus on the State's responsibility to ensure that systems – including oversight mechanisms and contractual arrangements – provide Aboriginal people in prison with culturally appropriate and responsive healthcare. The timing of our investigation enabled us to examine whether the Department's changes to prison healthcare provision had resulted in meaningful improvements.

Figure 3: Health and social snapshot of Aboriginal people entering Australian prisons in 2022

Source: Victorian Ombudsman, based on information from Australian Institute of Health and Welfare, *Health of people in Australia's prisons 2022*. Note data collection excludes Victorian prisons.

Figure 4: Most common diagnoses for Aboriginal people in Victorian prisons, 2015 to 2021



Source: Victorian Ombudsman, based on information from the Victorian *Aboriginal Justice Agreement, Aboriginal Health Risk Review*, July 2022

100. We looked at how the State chose new providers and changed requirements regarding healthcare for Aboriginal people in public prisons, including the nature and extent of the Department's engagement with Aboriginal stakeholders. We also considered whether these processes, and the final outcomes, aligned with Government commitments to Aboriginal people's self-determination.

101. The investigation focused solely on the provision of healthcare to Aboriginal people and this report does not make conclusions about the overall quality of the prison healthcare system. However, some of the issues raised in the report are not exclusive to Aboriginal people in prisons, and some of our recommendations would have broader impacts.

102. This report also does not comment on the appropriateness of private healthcare provision in the prison system. Soon after our investigation began, the Cultural Review recommended that all prison healthcare transition to a public health model 'to improve the quality and clinical oversight of health services provided to people in custody and enable continuity of care'. To date, this has occurred only in the women's system.

103. We did not specifically examine the mental health services provided by the Victorian Institute of Forensic Mental Healthcare ('Forensicare'), although the report includes some comments about mental health services made by people in prisons. Similarly, we did not specifically look at alcohol and drug services, or at post release housing, although some people in prison comment in the report about access to those services.

Procedural fairness and confidentiality

104. The investigation is guided by the civil standard of proof, the balance of probabilities, in determining the facts – taking into consideration the nature and seriousness of the matters examined, the quality of the evidence and the gravity of the consequences that may result from any adverse opinion.

105. This report includes adverse comments (although not necessarily made by the Ombudsman) about the Department of Justice and Community Safety ('the Department'), the Department of Families, Fairness and Housing ('DFFH'), the Dame Phyllis Frost Centre ('DPFC'), the Melbourne Assessment Prison ('MAP'), Ravenhall Correctional Centre ('Ravenhall'), Correct Care Australasia ('CCA'), Forensicare, GEO Healthcare and Caraniche.

106. In accordance with section 25A(2) of the Ombudsman Act, the investigation provided the Department, DFFH, GEO Group Australia Pty Ltd ('GEO Group') (which operates Ravenhall and GEO Healthcare), CCA, Forensicare and Caraniche with a reasonable opportunity to respond to a draft of this report.

107. Some adverse comments in this report were made by people in prison who gave evidence to the investigation on the condition of anonymity. As part of our investigation, we were also provided with anonymised case studies by the Victorian Aboriginal Legal Service ('VALS').

108. It is the usual practice of the Ombudsman to fact-check material before publication. However, in this case, verification would have required us to request individual records through Corrections Victoria and Justice Health, compromising confidentiality. We have included these stories with this caveat and in the context of other evidence.

109. In response to a draft of this report, the Department advised:

> A number of case studies are presented as evidence of issues with service delivery by custodial health service providers but appear to reflect the impact of broader health system challenges, such as workforce shortages and wait times for specialist services provided by public hospitals. Other case studies appear to reflect the need for improved communication between in-prison health service providers and people in custody (such as clearer information on the safety risks of prescribing medication without adequate collateral from health services in the community).

110. The Ombudsman acknowledges that the Department and healthcare providers were not able to respond to individual stories due to their anonymous nature. We have carefully considered the inclusion of these stories alongside our obligations to ensure procedural fairness.

111. Removing these case studies would remove an essential element of the investigation: the lived experience and perceptions of those most affected by the issues under investigation. Whether or not those perceptions are fairly held, they were not anonymous to the investigators and others to whom they were expressed, nor are they invalidated by being anonymous. The investigation accepts the perceptions expressed as being genuinely held, and that is in itself valid.

112. We have maintained the confidentiality of individuals in these case studies for their own welfare, but as we were equally unable to independently verify their stories, we have not accepted them as fact. None of the findings or recommendations in this report are based solely on the stories we heard from people in prison. As set out elsewhere in this report our evidence base is far broader, and we note that the experiences we heard from people in prison were consistent with reports about prison healthcare from other sources.

113. In accordance with section 25A(3) of the Ombudsman Act, any other persons who are or may be identifiable from the information in this report are not the subject of any adverse comment or opinion. They are named or identified in the report as the Ombudsman is satisfied that:

- it is necessary or desirable to do so in the public interest
- identifying those persons will not cause unreasonable damage to those persons' reputation, safety, or wellbeing.

How we investigated

114. Most Ombudsman investigations involve meeting with the relevant parties and analysing the evidence provided. Key sources we spoke with or gathered written information from included:

- the Department, primarily business units:
  - Corrections Victoria
  - Justice Health
- some of the healthcare providers contracted by the State to deliver health services in prisons:
  - CCA
  - GEO Healthcare
  - Western Health.

115. Further details about how we investigated are in Appendix 1.

Figure 5: Our investigation, by the numbers

Source: Victorian Ombudsman

Being culturally informed

116. The Victorian Ombudsman engaged experts specialising in issues relating to the health of Aboriginal people in the criminal justice system to ensure the investigation was culturally informed. We are deeply grateful to them for their contribution to the investigation.

117. Professor Megan Williams provided public health and cultural expertise and devised the cultural safety framework for the investigation. She led discussions with Aboriginal women at DPFC, along with a female Yorta Yorta member of Ombudsman staff.

Professor Megan Williams PhD is Principal of Yulang Indigenous Evaluation, an Aboriginal-led business that reviews and develops policies to reduce discrimination against and uphold the rights of Aboriginal people, and carries out cultural safety reviews of organisations and services. Professor Williams is Wiradjuri on her father's side and has more than 20 years of research experience working on programs and research to improve the health and wellbeing of Aboriginal people, particularly in the criminal justice system.

Professor Williams has Indigenous and Western social science research training and is an alumnus of the Lowitja Institute, Australia's national Aboriginal and Torres Strait Islander health research institute. She is also a past chair of the Justice Health and Forensic Mental Health Network Human Research Ethics Committee. Professor Williams was an expert witness in the Veronica Nelson Inquest, and worked on the recent Cultural Review.

118. Jack Bulman contributed to the investigation methodology and led discussions with Aboriginal people at Ravenhall and MAP, with assistance from a male member of Ombudsman staff.

Jack Bulman, a Muthi-Muthi man of south-western New South Wales, has worked in men's health for the past 15 years. He has been Chief Executive Officer of Indigenous health promotion charity Mibbinbah Spirit Healing since 2009. Mibbinbah seeks to help Indigenous people take their rightful place, whatever that may be, in both Indigenous and non-Indigenous society, as a means of improving their health and the health of those with whom they live, work and play. Mr Bulman holds a degree in health sciences from La Trobe University and was awarded a Master of Philosophy by University of Melbourne for his thesis on First Nations fathering.

Listening to Aboriginal people and community

119. We visited three prisons – DPFC, MAP and Ravenhall – and held group and individual discussions with Aboriginal people about their experiences of healthcare in prison.

120. We also invited participation from Aboriginal organisations and community representatives that work with and advocate on behalf of Aboriginal people in the prison system. These included the peak body for Victorian Aboriginal Community-Controlled Health Organisations ('ACCHO'), the Aboriginal Justice Caucus ('AJC'), service providers, and an organisation that represents the families of Aboriginal people who have died in custody.

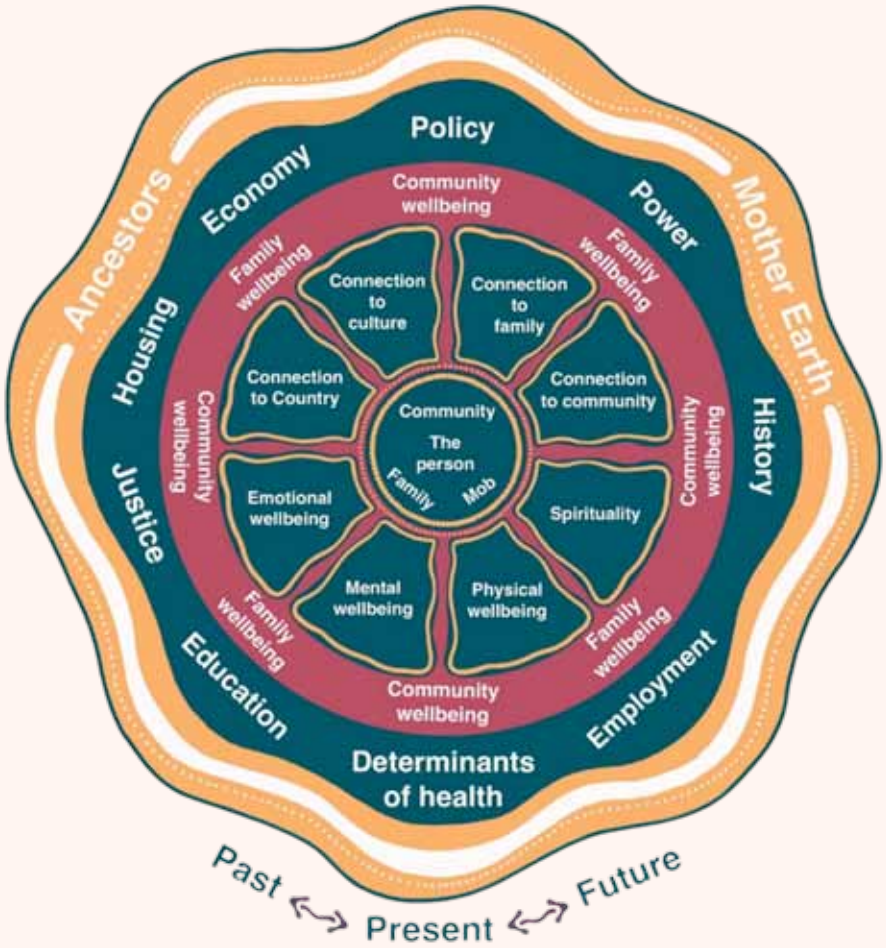
Key concepts

121. Several concepts are fundamental to any discussion of healthcare delivery to Aboriginal people in prison. We developed the concept definitions presented here with help from Professor Megan Williams, based on information and research she shared with us.

Cultural safety is about creating environments that are spiritually, socially, emotionally and physically safe for Aboriginal people. The Australian Health Practitioner Regulation Agency states 'Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism'. Cultural safety is defined by the recipient of care, not the caregiver.

Health from an Aboriginal perspective is holistic. It is not just about the physical but includes mental, social, emotional and cultural wellbeing. It recognises the importance of connection to land, culture, spirituality and ancestry, and how these affect the individual and the whole community, as depicted in Figure 6.

Figure 6: Aboriginal people's holistic view of health



Source: A holistic view of health, 2023, Yulang Indigenous Evaluation, Williams, M., Ragg, M., and Bulman, J.

Self-determination is a foundational principle for Aboriginal communities. It is the right for Aboriginal people and communities to make decisions about issues that affect them. It involves transferring power to Aboriginal people and communities and partnering with them in a way that acknowledges Aboriginal people as the experts.

Cultural responsiveness is about treating Aboriginal people in a way that promotes and maintains cultural safety. Culturally responsive services respectfully use Aboriginal peoples' knowledge, values and actions when designing, delivering and evaluating services. Indigenous Allied Health Australia states that 'Cultural responsiveness is what is needed to transform systems; how individual health practitioners work to deliver and maintain culturally safe and effective care'.

Cultural load refers to the burden of largely unrecognised and unpaid responsibilities that Aboriginal employees are expected to take on, beyond their specified job. For example, the Cultural Review found that Aboriginal staff in prisons carry the burden of making prisons safe for Aboriginal people, despite this being the Department's responsibility.

Equivalence of care is a principle which aims to ensure that prison health services do not drop below the standard of those available in the community.

Continuity of care in a prison setting is the ability for a person to continue receiving the same level and type of healthcare when they enter prison, if they move within a prison or to another prison, and when they return to the community.

Racism at both an individual and systemic level is long recognised as a frequent experience of Aboriginal people, resulting in higher levels of stress, greater feelings of powerlessness and poorer mental health and social and emotional wellbeing than experienced by the general Australian population.

Trauma and mental illness are highly prevalent among Aboriginal people in prison. One study found that post-traumatic stress disorder occurred among 12 per cent of Aboriginal males and 32 per cent of Aboriginal females in prison. A range of international research links mental illness, trauma, and substance misuse. The Australian Institute of Health and Welfare has stated that prisons do not help people recover from mental illness or trauma, but that incarceration contributes to trauma.

Intergenerational considerations. Intergenerational care is of fundamental importance to, and a strength of, Aboriginal cultures. Aboriginal people often live closely with three or four generations and have caring roles, obligations and reciprocal relationships with younger and older generations. Western values and health practices often disregard these, with health interventions, research and policies often focused on individuals. Intergenerational trauma is also a well-documented experience of Aboriginal people, where trauma is compounded and passed down across generations by experiences of dispossession, incarceration, forced removal of children, poverty and other forms of inequity.

Aboriginal peoples' perspectives on prison healthcare

122. Despite commitments at every level of government to Aboriginal peoples' self-determination and Aboriginal-led solutions, the experiences of Aboriginal people – particularly in prison – are often missing from discussions about policies that affect them. There is also a lack of academic and policy research about Aboriginal people's lived experiences of healthcare while in prison.

123. Recognising the need for Aboriginal peoples' experiences and ideas for improvements to be at the heart of this investigation, we held group discussions and individual conversations with Aboriginal people in three major Victorian prisons.

124. We also spoke with some Aboriginal staff members at these prisons, and some formerly with Justice Health. However, we did not engage extensively with Aboriginal employees of the Department for several reasons:

- Aboriginal staff within the justice system are recognised to be overburdened and we were conscious of not adding to their work and cultural load.
- The small number of Aboriginal staff in prisons and within the Department meant their contributions may be easily identifiable.
- The Cultural Review had recently engaged with Aboriginal employees of the Department and made findings and recommendations aimed at reducing cultural load and improving cultural safety within custodial environments.

125. We approached and invited participation from Aboriginal organisations and community representatives, including Aboriginal Community-Controlled Organisations ('ACCO') and ACCHOs.

126. We received written submissions from three organisations, and we acknowledge the work and resources invested in these.

People in prison

127. Across Victoria, there are 11 public prisons, which are run by the Department, and three private prisons, run by private companies under contract to the Department. Prison healthcare is contracted to a mixture of public providers and private companies. These contracts are managed by Justice Health (a business unit of the Department) in public prisons, but in private prisons healthcare contracts are managed by the company that operates the prison rather than the State. People in prison generally have to be seen by a nurse in order to see a doctor. Processes for seeking medical attention vary between prisons.

128. In late May 2023, we spoke with Aboriginal people at DPFC, MAP and Ravenhall. New primary healthcare providers commenced in the public prison system – including at DPFC and MAP – shortly afterwards, on 1 July 2023. The provider at Ravenhall, a private prison, remains the same.

129. We chose these prisons based on advice from Aboriginal organisations that work with Aboriginal people in Victorian prisons, and to represent different types of prisons, people and services.

Figure 7: Prisons visited by the investigation

Source: Victorian Ombudsman, based on information from DPFC, MAP and Ravenhall

Figure 8: Types of prison units

Mainstream unit	For the main population of people in prison
Separation unit	For people removed from the mainstream units for the safety or protection of them or others, or for the security, good order or management of the prison
Protection unit	For people who need to be isolated from the main population for their own protection, due to having committed certain types of crime, having certain intellectual disabilities or having given information to police
Mental health custodial unit	For assessing and treating people with mental health concerns. These include the Acute Assessment Unit at MAP; the Marrmark Unit at DPFC; and the Aire, Erskine and Moroka Units at Ravenhall

Source: Victorian Ombudsman.

130. Our approach to engaging with Aboriginal people in prisons was based on the previous experiences of the Victorian Ombudsman and of the Aboriginal public health experts engaged to assist the investigation.

131. The methodology was informed by the holistic definition of Aboriginal peoples' health affirmed in Australian and State government policies – spanning social, physical, mental, emotional, spiritual and environmental dimensions, and involving not just the individual but family, community and the environment.

132. We also considered the Ngaa-bi-nya Aboriginal evaluation framework, which prompts the user to think about four aspects of Aboriginal health and healthcare – 'landscape' contextual factors, resourcing factors, Aboriginal peoples' ways of caregiving, and learnings from evidence and others' practice.

133. Our methodology was also framed by principles for culturally safe health care, which reflect the rights of Indigenous peoples including self-determination, participation in decision making, respect for Aboriginal culture, equity, freedom from discrimination, accountability, and systems thinking as set out in the Victorian Government's *Aboriginal and Torres Strait Islander cultural safety framework for the Victorian health, human and community services sector*.

134. Aboriginal health research ethical values also shaped the methodology – spirit and integrity, cultural continuity, equity, reciprocity, respect and responsibility.

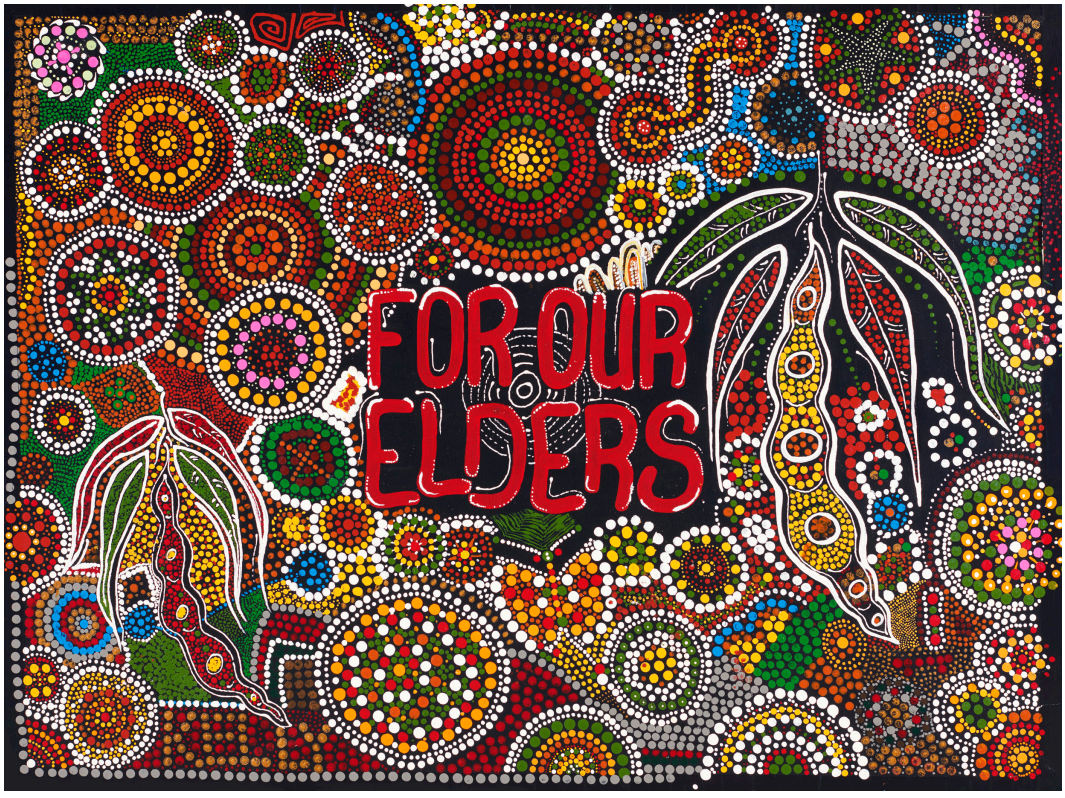
135. To build trust and create a supportive environment for answering questions and sharing experiences, we drew on strengths of Aboriginal culture. Each of the discussions in prisons began with general yarning to make connections to Aboriginal nations and identify Country. Yarning was an opportunity for all present to be introduced, to respectfully share experiences of prison settings, to identify things in common, to build a sense of safety and reciprocity, and to deepen discussion. We asked questions based on developing trust and on the holistic Aboriginal concept of healthcare.

136. Most were group discussions, but our team held individual conversations with people where they requested this or where necessary, for example due to the person being in a separation unit.

137. Research shows group discussions improve the quality of data by offering engagement with others, support when sensitive or complex issues arise, and accountability when sharing. For many Aboriginal people with collective cultures and identities, this can also be preferable to being interviewed alone.

138. DPFC granted permission to bring in and work on a canvas painting with Aboriginal women. We did not consider it practical to do so in the men's prisons. The canvas was designed by Yulang in collaboration with Gamilaraay and Warlpiri artist Jessie Waratah, and we used it as a focal point; it signified a strengths-based approach to engagement, not beginning with concerns or negatives. Its theme, 'For Our Elders', affirmed the 2023 NAIDOC Week theme and the sense of being cared for and caring about Aboriginal people across generations.

Figure 9: The artwork created during our session at DPFC



Source: Artwork by Jessie Waratah with Megan Williams and community members. Photo by Gus Armstrong.

139. Time together working on the canvas was also used to deconstruct the misconception of prison being separate from the general community; it is a setting of the community. The painting was designed to serve as a visual connecter across the settings and to be retained as a record of our discussions, as Aboriginal knowledge systems require.

140. We also incorporated follow-up into the methodology, including providing people with information about organisations to assist them with specific concerns and information on how to report reprisals or other concerns after speaking with us. At our request, each of the prisons made extra support available to people who may have been distressed following the discussions. In line with much Indigenous health research, our team members also critically self-reflected on their own values and beliefs and how these might influence their work.

141. Participants agreed we could record the conversations and use the information provided in this public report, in a de-identified way. Their stories and contributions are organised under three headings:

- Connection to culture, Country and spirituality
- Connection to family and community
- Physical, emotional and mental wellbeing

142. The quote about Veronica Nelson is included with the permission of her family.

Some people we spoke with were in severe distress or had urgent medical issues. A member of Victorian Ombudsman staff took complaints separately from people who wished to make them, and with their permission, Ombudsman staff followed up with prison authorities. In some cases, Ombudsman staff raised welfare concerns with relevant prison staff on the day of the visit.

The comments in this section of the report were made by people in prison who gave evidence on the condition of anonymity. We were not able to fact-check these comments against Corrections Victoria and Justice Health records without compromising people's anonymity, privacy and safety. As we could not independently verify these comments, we have not accepted them as fact, but include them with this caveat and in the context of other evidence.

Connection to culture, Country and spirituality

143. Most Aboriginal people are able to make some connection to family, Country, nation or clan group, even where their cultural identity has been disrupted by governments' forced removal of children, separation from homelands and other colonisation processes. If these connections are not known, some people might identify as Stolen Generations, or with Aboriginal organisations or roles.

144. The Victorian Aboriginal Community Controlled Health Organisation ('VACCHO') – the peak body representing 33 ACCOs in Victoria – noted in its submission:

> For Aboriginal and Torres Strait Islander individuals, their cultural identity is deeply intertwined with their well-being and sense of self. Incorporating cultural practices, traditions, and teachings into rehabilitation efforts not only acknowledges the historical trauma and systemic injustices they have faced but also provides a pathway to healing and empowerment. These programs help prisoners reconnect with their roots, strengthen their cultural pride, and foster a sense of belonging.
>
> By nurturing a positive cultural identity, individuals are better equipped to address the underlying issues that may have contributed to their involvement in the criminal justice system, such as trauma, substance abuse, and mental health challenges. Connection to culture provides a foundation for personal growth, resilience, and positive change, ultimately contributing to reduced recidivism rates and more successful reintegration into the community.

145. Many government documents at the national and state levels acknowledge Aboriginal people's strong connection to Country and culture, and state that this connection will be respected. In practice, this means making it possible for them to use their language and follow their cultural protocols – for example, processes for engaging with death and dying.

146. People at all three prisons spoke of how important their culture, spirituality and connection to Country are to their social and emotional wellbeing. Some gave examples of how Aboriginal cultural practices could play a major role in improved mental and physical health.

147. However, people at all three prisons also spoke about insufficient supports to promote healing, health and wellbeing through connection to culture and Country. For example, MAP lacks a designated space for cultural use by Aboriginal people and some of those held there said the prison requires Aboriginal people to paint alone in cells rather than communally.

Access to Country

148. People spoke to us of yearning to be on their Country, whether of their ancestors or of their communities. They said that culturally specific programs that respected and included strengthening connections to Country would benefit them:

> I reckon [we] should go to the bush for rehabs. I reckon bush should be the go for the blackfellas. As soon as they go to court, they've got to put their hands up for, 'Either you go to jail or you do rehab. If you can't do rehab, you go to jail'. *(Person at DPFC)*
>
> This is a concrete jungle. As Aboriginal men, we're used to having dirt under our feet and being in the bush. Even the ones who live in the city, go bush, where you come here and there's nothing. All you've got is a poxy little bit of grass every now and then and that's it. *(Person at Ravenhall)*

149. Several people at DPFC said rehabilitation programs for Aboriginal people with alcohol and other drug dependence should be more readily available, be run by Elders, and include time in the natural environment:

> I reckon they should have, for people who haven't got a place … a rehab to go to, to get themselves better … you've got to take them out of here I reckon into the bush and that and do get them back into connection. The real stuff, not sitting there being bored … *(Person at DPFC)*

Access to art

150. The Torch is a not-for-profit organisation that supports Aboriginal people in prison to create visual art as a cultural practice. This art is made available for sale, with artists potentially earning income.

151. People at all three prisons highly valued the sense of connection to Country, culture and community the Torch program provides. They described it as beneficial for their mental health and an important part of their rehabilitation.

152. On the other hand, they said the program is one of the only cultural supports available, and that limited spaces mean it is not available consistently or to everyone who would like to participate:

> If there's too many girls in there that day … in the classroom… if it's overcrowded, [we are told] 'Get up and come back'. *(Person at DPFC)*

> There's only one art thing and some language thing and that's it. And you know with us blackfellas, we like to sit around and yarn. The young girls, they call us Aunty, this and that. You want to be able to show them, just yarn up on things, things like this, make jewellery, sit around and have a yarn at the same time. *(Person at DPFC)*

153. A person at Ravenhall said he was excluded from the program without explanation. He described it as an example of officers making arbitrary and unfair decisions that can then escalate a person's behaviour.

154. People in a mainstream unit at MAP said their ability to fulfil cultural duties is hampered by restrictions against painting communally, which they said resulted from a long-ago incident where someone had used a paintbrush as a weapon:

> It's culturally significant for an Aboriginal man to paint and teach others. The way I learnt, I learnt … 'cos I come from a big family and one thing I see in my unit is like I love to [teach] people. How can I help them when they're painting in their cells at night-time? I want to teach people, like the whole storytelling behind art is huge. How can I teach him there if he's locked in his cell at night-time? *(Person at MAP)*

155. Other people at MAP described physical and mental health impacts of only being permitted to paint in their cells alone:

> … [W]hy should we have to pay the price for someone else? … I get that someone did something wrong with a paint brush. Now, how long ago was that and why should we still pay the price for it? … I paint and my painting is a big part of my mental health, a big part of me getting released. But the only thing I can do is in lockdown, come on. *(Person at MAP)*

> My own mental health is suffering. I'm used to painting and painting is one of the things I want to use when I get out of prison to help my drug use, as a distraction for my drug use. I'm getting to the stage where over the last month, I now am taking pills for my back 'cos I'm constantly bending over and painting on my bed … Okay, we're allowed to have a pen. What's the difference with a paint brush?

> And this is where I said the prison has got to sooner or later go, 'Hey, all right, we've got no issues with you having a paint brush during the day, but as soon as you use it for a weapon, boom, that's it'. I get that. *(Person at MAP)*
>
> Person 1: I'm back on medication right now because of how much pain I'm getting through my back from leaning over, bending over.
> Person 2: Yeah, well I'm getting the same thing. I get the same pain.

156. Person 1 said he was not on pain medication before having to paint in his cell.

Access to Elders

157. It is an Aboriginal cultural protocol and essential for cultural identity that connections with local Elders occur. Similarly, Aboriginal people need to connect with Countrywomen or Countrymen of the same nation or family groups, for specific gender and life-stage cultural support.

158. There were mixed reports from the three prisons about access to Elders. There were no reports of Elders from a diverse range of nations being available to people in prison, to respect the diversity of Aboriginal people around Victoria or Australia.

159. A person in a mainstream unit at MAP said there was '100 per cent' enough cultural support at the prison and confirmed that the prison arranges visits from Elders and celebrations of NAIDOC week.

160. People in both mainstream and protection units at DPFC, however, said they do not receive visits from Elders. One person in a mainstream unit said the prison had made no attempts to connect her with Elders from her Victorian community, or with her language or culture.

161. A person at Ravenhall said:

> It doesn't really happen [Elders coming in]. Last time, I was here for four and a half years, got out for six months and back for another 12 months. In that time there hasn't been many times where the Elders have come down to talk to us.

Access to cultural spaces

162. The 2022 Cultural Review recommended that within two years 'all existing prisons must include a dedicated, permanent and accessible cultural space that is designated for cultural practices by Aboriginal people'.

163. In 2022, DPFC opened a designated cultural space, the Healing Centre, where Aboriginal women can access dedicated programs and the Aboriginal programs staff, obtain information about Aboriginal cultures, contribute to the garden and meet and talk with other Aboriginal women.

164. People in protection units at DPFC said they have no access to the Healing Centre, but a person in a mainstream unit said the centre's creation had improved access to the Aboriginal Wellbeing Officers:

> It's got better over here, but when we need stuff to move on, like with the doctors and that, we come up and get … one of the [Aboriginal Wellbeing Officers] to push it for us.

165. Ravenhall has a similar cultural space called Kulin Yulenj. There were also reports of limited access:

> The only time we can come down here is if there's something booked, and a lot of the times there's … big periods of [time] you don't get down here. *(Person at Ravenhall)*

166. At MAP, at the time of our visit in late May 2023, there was no designated cultural space. Aboriginal people and a worker at MAP advised that a room formerly used as a cultural space is currently being used for remote court hearings.

Cultural responsiveness of healthcare staff

167. The consensus among people held at all three prisons was that prison healthcare staff lack cultural knowledge.

168. People at Ravenhall said no Aboriginal healthcare workers came to the prison. One added:

> It's like you're always put in the too hard basket [as an Aboriginal person]. That's what it seems like. We'll handball you to someone else, we'll handball you over here.

169. A person at DPFC said doctors do not engage with the women on a cultural level at all:

> [We're] never asked, 'Are you Aboriginal?', or anything like that, never.

170. Someone who had served multiple sentences at DPFC over more than a decade said they were not aware of any mental health support services that consider cultural needs at the prison and that no one had ever asked them about it.

171. Another person at DPFC, who said she had a lump on her breast, described the lack of Aboriginal health workers as a barrier to accessing healthcare.

> The only thing we get is the privilege to go out and get our teeth done, that's it. There should be more things around like breast tools like that … I've got a lump there now. Just around all those sort of things, there needs to be more done about it. We should get regular health checks [by Aboriginal health workers] more with the girls in here.

172. Asked how important it was for her to have checks done by Aboriginal health workers, she replied:

> I think it's more important because even though there's white volunteers and mainly whitefellas, but I think most of the girls might feel a bit comfortable with an Aboriginal health worker.

173. She said access to an Aboriginal health worker had never been on offer to her at DPFC.

Aboriginal programs staff

174. Aboriginal people in prison told us that a lack of cultural knowledge, skills and experience in prison healthcare workers meant they relied heavily on the small number of staff whose roles relate specifically to supporting Aboriginal people in prison (referred to here as 'Aboriginal programs staff').

175. The Department's *Correctional Management Standards* outline different requirements for the various types of Aboriginal programs staff. For example:

- Aboriginal Wellbeing Officers ('AWO') are 'designated' positions, meaning only people who identify as Aboriginal or Torres Strait Islander can be appointed.
- Aboriginal Liaison Officers ('ALO') are 'identified' positions. Applicants do not have to be Aboriginal but must demonstrate 'knowledge and understanding of the Victorian Koori Community' and 'ability to communicate sensitively and effectively with members of the Victorian Koori Community'.

176. In May 2023, there were:

- two female AWOs and one female ALO at DPFC
- two male ALOs at MAP
- two Aboriginal Keyworkers, (the equivalent of AWOs) one male and one female, reporting to a female Aboriginal Programs Manager at Ravenhall.

177. The Cultural Review explored in detail the major challenges facing Aboriginal programs staff in supporting Aboriginal people in custody. It found:

- insufficient resourcing, training and support
- understaffing
- high and complex caseloads
- heavy cultural load
- exposure to vicarious trauma
- unreasonable responsibilities and accountabilities for pay level
- a tendency of non-Aboriginal staff to 'handball' to them any issues relating to an Aboriginal prisoner
- a lack of support for their social, cultural and emotional wellbeing.

178. Comments made by Aboriginal people at the three prisons reflect some of these issues.

179. People at DPFC spoke of their reliance on a highly respected Elder who has worked at the prison for many years and was until recently the facility's only AWO:

> If they had more of her we would get respect and get things done, and they wouldn't treat us the way they do. *(Person at DPFC)*

180. When asked what they would do if the AWO no longer worked there, replies included:

> I don't know what we'd do.
>
> We don't, we wouldn't have any other options.
>
> We don't have any other options that we know of, anyway. Like, I'm not sure … I don't even think about that actually.

181. A person in a mainstream unit at DPFC said the Aboriginal programs staff are the only people Aboriginal women feel able to approach to arrange routine female health checks, such as pap smears, and that it 'wouldn't happen quickly' if they were to try to approach health staff directly.

182. When not in lockdown, at work or under other restrictions, Aboriginal people in mainstream units at DPFC are able to knock at the door of the Healing Centre and can often speak to an AWO or ALO immediately.

183. However, people in protection units said they must put in a form in the morning and wait until an Aboriginal worker is available. One said this is always within a week, but never on the same day:

> So I wonder if maybe, having our own Aboriginal centre, or just a person … like for the main compound girls, but just a person that works for us here [in protection], would be more beneficial. Because we don't get that correspondence back from anybody, so that makes it hard because if it's a matter that you need to talk to someone about now, it just, you won't get that happening. (*Person in a protection unit at DPFC)*

184. Despite this, people in protection at DPFC described the effectiveness of Aboriginal programs staff, and respected their professional capabilities:

> The only thing I can say is that when I had an issue, a little while back [the AWO] was just super, super amazing. She was on it, she got it sorted out, because it was very racial, and she got it sorted … she's super good like that. Yeah, I felt very, very supported and not left alone with that, and … recently when I went to hospital, [she] was the one that kept in contact with … my friends and family and stuff. *(Person in a protection unit at DPFC)*

185. A person in protection at DPFC said the Aboriginal programs staff had significantly helped her, including by organising her grandmother's and mother's funerals, assisting with prison administration, providing personal support, remaining in touch with her family and keeping her updated:

> And … around the same time, you know, I wasn't coping very well, I was letting staff know, I was putting in medical form after medical form after medical form. [The AWO] would actually go down to medical and say, 'What is going on?'.

186. People at MAP spoke appreciatively of the work of the ALOs. However, the importance of separating the roles of prison officer and Aboriginal programs officer was discussed. Some people at MAP believed they had to be careful how closely they associate with a prison officer who had a dual ALO role, for fear of reprisals from other people in prison, although this did not appear to be an issue for some of them.

Connection to family and community

187. People at all three prisons spoke of connection to family and community as a powerful motivator for addressing reincarceration risks, including alcohol and other drug dependence and factors contributing to that. They also spoke of pain, frustration, stress and other negative health impacts caused by separation from loved ones and barriers to staying in contact while in prison.

Family contact

188. For some people, the prison environment was a barrier to receiving family visits:

> I don't have visits from family, because my family's just simply too old … So I don't get many visits. I've got kids, but it's not a place I want to be, you know, seeing them here. *(Person at DPFC)*

189. A person at MAP, who described himself as having an intellectual disability, said:

> I'm just trying to stay off all the drugs, trying to stay clean. I'm trying to do it for myself, but do it for my mum as well. But I haven't seen my mum for, say, going four and a half months.

190. Where visits are not possible, people in prison can, in theory, contact their families by phone and through online video calls. However, some described barriers to accessing these methods.

191. A group at DPFC described the cost of phone calls (which they said cost $8 dollars per call out of a $30 weekly allowance), and a 12-minute time limit as barriers to staying in touch with family. They said that while they are entitled to two 30-minute online video calls with family, these are often cancelled, and poor internet reception means they often drop out or take a long time to connect:

> For girls who don't have the children and family come visit, how do they stay connected when they can't afford to call more than once a week? *(Person at DPFC)*

Case study 1: Person unable to access antidepressants or contact family

A visibly distressed person in a separation unit spoke of the health impacts of not being able to call family in his several days at MAP. He said this was due to a delay in his money being made available to him to make calls.

He said he suffered anxiety and panic attacks and was unable to sleep after recently suffering a life-threatening assault in the community. He said he had been unable to obtain his prescribed antidepressant since arriving at MAP. He said he underwent an initial medical assessment but had not seen a doctor despite submitting requests.

During the reception assessment, he said he was told 'well, see how you go' without the medication and 'they just put me here [in separation], they just left me'. He said a psychiatric nurse had told him it would 'take weeks' to see a doctor.

He told the investigation team:

> I just to want to see a doctor, cos I just keep getting anxiety, and I wake up in a panic attack … I don't know if you've ever had one, but you feel like you're dying. You feel like you're dying, man, right in there.

He claimed a prison officer had taunted him:

> He said something about, 'Oh, your missus and that have called to see if you're ok,' with a smirk on his face. I said, 'Of course, 'cos I haven't been able to call them. There's money in my account and I can't make a phone call'. And he's like, 'Ok, cool' and I said 'it's not fucking cool', and he's like 'All right, you're being aggressive ….'

He told the investigation team, 'I just want to call my family … That's all I want to do, just talk to my kids … It affects your health …'.

192. People spoke of access to family being limited because of a Corrections Victoria policy, the *Corrections Alcohol and Drug Strategy 2015*, which removes contact visits for identified drug users for a specified period. A group at one prison said the prison removes contact visits with their families for extended periods of time in punishment for a 'dirty urine' (returning a positive drug test). They said a first positive test sees visits denied for three months, and a second positive test for six to twelve months.

Community within prison

193. People at all three prisons described the importance of solidarity and looking after one another, including keeping each other's families informed. They said this was especially important when they could not access medical care, which sometimes happened because they had trouble convincing staff they needed help.

194. This was highlighted by the discussion of a potentially fatal situation at DPFC.

Case study 2: Person with critical illness unable to contact family

A group at DPFC described how one of them had fallen ill with a contagious and life-threatening illness she believed was contracted at the prison.

With initial symptoms presenting like a minor illness, the woman said she felt too lethargic to call for help and lay down in her cell, simply wanting to sleep. She said she did not think there was any point asking officers for help:

> [They] just [do] not come to help. If you've got migraines, you're vomiting because of it, they just won't come … it was just like, why bother, they're not going to come and do anything.

Another person noticed she was 'so hot she smelt like a burnt cheeseburger' and asked a friend of the woman to confirm, 'she doesn't smell right, hey?'. The friend said she had to 'at least call six codes' (requests for help) before anyone attended.

Ultimately, the woman was hospitalised for nearly a week.

> My mum and dad didn't know I was in hospital … I didn't call them for [several] days, and my mum was so stressed out she rang the prison. The prison said, 'We can't give you any information I'm sorry.' My girlfriends here rang another girlfriend of ours that's just been released, and that girlfriend contacted my parents for us.

She said she does not know what would have happened if the other women had not intervened:

> I'm so thankful too, the girls were amazing … but you know, I think that comes back down to, you're calling codes and stuff like that … I've had times where [prison staff have] just not come.

On release from hospital, she said medical staff at the prison 'just swept it under the carpet very quickly' and 'didn't want to talk about it'.

> I have a feeling I know where I got [the illness] from [within the prison], but medical won't even discuss [it] – I had to find out what [the illness] was from family outside … [Prison medical staff] go on Google and they say to you, 'look, there's lots of reasons you can get it, but the thing is, you're better now'.

She added: 'I'm meant to get follow ups and I haven't had any – nothing.'

Housing upon release

195. The lack of appropriate housing in their communities upon release was identified by the people we spoke with as a key factor in their reoffending and reincarceration. They described it as a major barrier to continuity of care and their ability to address physical and mental health issues, access family support and reintegrate into their communities.

> Housing support workers spoke to me [pre-release and said] … 'So, we'll leave a pack in your [belongings] for when you leave with our number on it'. I left, [but they had left] no number. I couldn't get in contact with them, and I didn't have that support, and I was homeless on the street, and then I was back in a week later. *(Person at DPFC)*

> When you go out to a hostel, you've got to pay money, right? If they don't have money, they don't have a bed … But most of the ones who want to get better, there's nothing for them to go to. They can't get a unit because there's no housing … I'm just talking about in the long run how people should be getting better or stopping getting back in here. Like we said, we see the same ones in here all the time and most of them, the girls in here are young. *(Person at DPFC)*

196. One person at Ravenhall explained that because he could not find suitable housing, he was refused parole. At the end of his sentence, he was released without the support and supervision provided on parole, and quickly ended up reoffending:

> Hopefully [my release will go] better than last time, 'cos I went with nothing. I was trying to get parole so I had support when I got out there and didn't get it, 'cos there's no suitable housing … When I went out I had no support and in three weeks was already offending. In six months, I was back in. Yeah, there's not much access to housing, especially for sentenced people … When I got out on straight release, the house I ended up going back to was … full of mice, cockroaches, nowhere to sit, sleep. I ended up thinking [about] coming back to jail instead of here. *(Person at Ravenhall)*

Case study 3: Person set for release to housing far from community

A person in his fifties with an acute mental illness, who was due for release from Ravenhall soon, said a lack of suitable housing in his regional hometown meant he would be released to a suburban hostel in Melbourne which housed 25 people. He was worried because he had no support in this area and would find it harder to resist getting back onto 'hard' drugs.

He said:

> Housing's the biggest problem. I come from [regional Victoria] and they just can't find me any housing [there], so I've got to move to [Melbourne], somewhere I don't know … As much as I understand they can't get me housing in [regional Victoria], the thought of moving to [Melbourne] and moving back down to [the] city and all that, like they don't understand … I've got to try and stay away from the hard drugs …

He added:

> See this is what's worrying me … I know nothing of Melbourne. The only place I know in Melbourne is [suburb] and I can't go back to [suburb], 'cos it's too easy to get on the drugs, which I don't want to do. But I know nothing of [Melbourne]: where doctors are and where shopping centres are.

He indicated this was a 'scary' thought at his age. He also said he would have to give up his dog, 'the only thing I had left', to stay in the hostel.

> But what do you do? It's either that or I go home and they'll pay for a motel for two weeks and then I'm out on the street in the middle of winter. I want to move back home to [regional Victoria], but they go, "We'll look at that as a long-term goal". It's not going to happen and I know it. In six months' time I'm going to be stuck still in the same hostel paying $230 a week and apparently the bedrooms are no bigger than the cells we live in now, so all it's going to do is remind me [of prison] all the time.

Being housed so far from his community would also be a barrier to the continuity of treatment for his addiction and mental health issues:

> See, I had good workers and everything in [regional Victoria], people that I built up a trust with, everything like that, and that's what is going to fuck me this time, 'cos I've got to get out, I've got to meet new mental health workers, I've got to go see new [alcohol and drug] workers, new Corrections workers and all these things.

Physical, emotional and mental wellbeing

197. People at all three prisons spoke of having to rely on their own strength, resourcefulness and each other, in the absence of adequate medical care.

198. Common themes included:

- delays in access to healthcare
- inadequate mental health support
- a lack of trauma-informed care and services to treat trauma
- prison officers blocking access to healthcare
- barriers such as the attitudes held by some custodial and healthcare staff.

199. People also described feeling powerless to obtain the care they needed due to being routinely disbelieved by custodial and healthcare staff. Some spoke of simply giving up trying to get help, even for serious health issues.

200. The experiences described by a person at MAP touch on some of these issues.

Case study 4: Person writing letters for months to get medical attention

A person at MAP said he had few health problems other than being 'a little bit overweight' after a lack of activity in prison. However, he also said he had been diagnosed with a chronic mental health condition.

He described accessing healthcare at MAP and two other prisons he had experienced, one private and one public, as 'easy if I needed it'. Despite this, he then described needing to write letters to advocate for himself and of not being believed or able to obtain the healthcare he needed.

He added that he had been sent to MAP because healthcare there is 'really good' compared to the other prisons, and that the nurses at MAP are 'quicker' than at other prisons.

He described mental health care delivered by Forensicare at the Metropolitan Remand Centre, a public prison, as 'good', but added: 'Things didn't happen in a hurry until I started writing letters. Then everyone started listening …'. He said it 'took a couple of months, writing letters. When I first come in, nothing got met' but after persisting in advocating for himself he eventually 'got my help that I needed, and I'm still getting help, which is good'.

He said:

> with medical it's sometimes slow, sometimes it's fast. Sometimes you don't get it, and sometimes it takes time. But when we're in the right, we get told we're in the wrong … Staff don't listen to us, and medical don't listen. No-one listens to us.

At the time we spoke, he said he was in pain and had been asking for help for three weeks. He said health staff believed he was drug-seeking and had given him Panadol for the weekend.

> I honestly thought [a health staffer] was going to put me down to see the specialist, but [they] just gave me … this Panadol and Ibuprofen, and said, 'You're right'. They just don't listen in here.

He was worried it would turn out to be a serious health issue and said he was too scared to do anything for fear of making it worse:

> I've just got to lay here for a couple of days in pain, and then press the button, and then call up [to be given more Panadol].

He described being in so much pain that he could not sit down properly or get off the bed. He said he had given up trying to obtain treatment while at MAP and was going to wait until he got out of prison – which he hoped would be in a few weeks.

Quality of care

201. Aboriginal people at all three prisons described the overall quality of healthcare as poor.

202. A person at DPFC said she had experienced ongoing, severe bleeding after giving birth while incarcerated at DPFC some years ago:

> I kept bleeding, bleeding, bleeding. I bled for four years straight. And I told the medical team here and they didn't do nothing about it. Now, I don't know what's going to happen … I don't know what to do about it.

203. Several people at MAP compared the health services there favourably with those at other Victorian prisons.

204. One person said wait times for doctors were shorter at MAP than at other prisons he had been in. He put this down to MAP's role as an assessment prison which meant it had better support for entrants. The same person rated healthcare at MAP as 'seven or eight' out of ten.

205. Another person in a mainstream unit at MAP, who said he had been at the prison for several weeks, described healthcare access there as 'pretty good, pretty quick' and rated it 10 out of 10. He noted his medical records had been transferred with him from another prison without any problems.

206. He described himself as not having any health issues, so he only needed to access the routine health check on arrival, which he was satisfied with. He also noted that having a good experience with prison health services was not the norm for people in mainstream units, and that at other prisons 'it takes a while … a week or two, you know, to get in to access medical'.

207. A group at Ravenhall rated overall access to healthcare at the prison as one out of 10, with one person there adding:

> You might get lucky sometimes and have a good run, but not very often.

208. A person at Ravenhall said:

> I've had that many black codes [serious medical events] called against me 'cos I get chest pains and … they just, they take me blood pressure, they check me temperature and they go, 'That's all right, you're doing okay. Back to the community [the unit]'. I've been into hospital four times. Twice when they thought I had had a stroke, twice with chest pains. I know the chest pains aren't a heart attack, but …

209. Another person at Ravenhall said:

> What they say is care, is Panadol.

210. However, a different group at Ravenhall said it is difficult to even obtain a Panadol. They said it has to be prescribed and is distributed on Wednesdays in a weekly pack of 14 tablets (two per day):

> So basically, you've got to know a week before you get a headache so you can get some Panadol for you. *(Person at Ravenhall)*

> You have to put in a form, and even then before you can put in that form you have to do a request to be put on the Panadol, which takes you a couple of weeks as well. *(Person at Ravenhall)*

211. From what we heard during our prison visits, it appeared that people in prison were having varied experiences accessing Panadol. Healthcare providers and the Department told us that many of the stories we heard do not align with their standard practices and that Panadol is readily available to people in prison as needed.

Continuity of care

212. A common theme was a lack of continuity of care, not only between the community and prison but also when people transfer between prisons.

213. The person whose story is detailed in case study 1 who said he had had to abruptly stop the antidepressants he was prescribed in the community when he arrived at MAP, was not the only example.

214. A person at Ravenhall spoke of similar issues accessing his mental health medication. He said he was repeatedly denied his anti-psychotic medication without explanation:

> I've never [had] any issues with medication [in terms of trafficking or misusing it] in the jail at all. And so, for them to just stop it, which they've done multiple times … if you stop it today for the next two weeks, it's going to take another ten days for it to get in my system again to work.
>
> That's what I'm trying to tell them. They know that. So, I say to them, 'Why are you playing God up here? You're not God. It's been explained by professionals that I need anti-psychotics. I've got to take them so it's easier for you, it's easier for me, everyone gets on'. … They give you no reason why.

215. Other examples included a person at MAP who said that after being in intensive care in hospital with a respiratory illness, he could not access his prescribed antibiotics when he returned to MAP even though he had not finished the full course.

216. Another person at MAP said:

> Doctors override other doctors. So, if I get put on a medication, another doctor will see me and go, 'No, we don't want him on that'. Even if the doctor's prescribed it. I came in on [a particular medication] … The doctor turned around and said, 'We can't have you on that because you're on [another medication]'. I said, 'A proper specialist, a neuro specialist put me on it'. 'I'm overriding them'. So, they just don't care, really. They want to put you on what they want to put you on, or nothing, to be honest.

217. People at MAP also described not receiving the results of medical tests. These concerns were echoed by people at DPFC who said that an ACCHO had come in to do hearing tests but they never received the results:

> That's really sad … we've just kind of learnt to adapt to having nothing … like we just have adapted to not wanting or asking … we have to do that, otherwise you get so upset and so worked up when you don't get the help you need, you just learn to try and deal with it. *(Person at DPFC)*

218. A number of people said that when they were transferred between prisons, medical staff at the new prison did not seem to have access to their clinical history. Medical records of people in prisons from May 2014 onwards are electronic, held centrally by Justice Health and should be available to medical staff across prisons. The Department advised that hard-copy files containing 'historical information on treatment' from before May 2014 are supposed to be transferred with people when they move prison locations.

219. A person with an intellectual disability at MAP said:

> … [E]very time I go to a different jail, I've got to say the same things over and over … sometimes I get that much pissed off with saying it again and again that sometimes it's too much … frustration turns to anger.

220. Some people reported being removed from waiting lists to see specialists on transfer to another prison.

221. Another person at Ravenhall said he had been waiting three years for hand surgery. He said he saw a surgeon while at another prison in late 2022 and was told he would have surgery within three months. However, in early 2023 he was transferred to Ravenhall:

> I said to the medical team here, 'What's going on with it?' and they go, 'We're not looking [it] up for you. Bad luck you moved jails. We're not following it up'. I put in to see [a medical staff member who said] …, 'We've been cancelled and bad luck'. Back to square one.

222. Even when ongoing healthcare is provided, some people said staff movements can disrupt continuity of care. Someone at DPFC, who said they had been waiting eight months to access counselling there and spoke of self-harming in the meantime, said at another prison she had seen five different counsellors due to staff turn-over.

Delays and wait times

223. Many people at all three prisons spoke of long delays in accessing healthcare of all kinds. This applied to both specialists and onsite staff such as nurses, general practitioners and dentists. It applied to simple matters, such as headaches, as well as serious health issues that would be treated urgently in the community.

224. A person at MAP said he was supposed to be given his medication on the day he arrived at the prison. He said an officer finally agreed to check up on it only after he submitted request forms every day for a month: 'Then the next week they put me on it. So, then I seen a doctor and the doctor called me up. Then the next week I was put in hospital'.

225. A group at Ravenhall described waiting times as one of the biggest issues. They said while you might be able within a few days to a week see a general nurse who would refer on if necessary, it could take four to 10 weeks to see a doctor – and never less than two.

226. One person in the group said he had to wait several months for crutches after entering prison in early 2023 with a shattered limb despite complaining of pain and suffering.

227. Another person in the group said:

> Me, I fractured my hand [late] last year and they didn't get me to see a doctor, no x-ray, no nothing, they just moved to into a different jail. And by the time that I saw the doctor and they got me in for an x-ray, it was already healed 'cos it's been three weeks.
>
> I got transferred from that prison to this prison. So I had this fracture, it healed without a cast and without being properly looked at. I only saw a physio once only … and then they bring me here.

228. Regarding mental health care at DPFC, a person there said:

> Literally we get nothing … I've been here [over a year], I'm still waiting to get into counselling services, I still haven't had any. I've had an intake appointment, but that's all.

229. A person at Ravenhall said:

> The radiology, I had that [several] weeks ago and they've found I've got a snapped tendon in me … shoulder. They wanted to do radiology on that, but they have to do it on the outside and yeah, [they] said, 'You'll get that done before you get out,' and yeah, I've got three weeks … until I get out and there's no sign of it getting done.

Case study 5: Person performs 'surgery' on own toe due to delays in seeing a doctor

A person at Ravenhall showed the investigation team how he had resorted to performing 'surgery' on his own toe with tweezers and a pencil sharpener because he was unable to get care for an ingrown toenail.

He said he had been in prison several years and had been attempting to see a podiatrist for a long time, including multiple requests for an appointment over a period of weeks. He said he had finally managed to obtain one, but this would not be for several months – 'and that was after it was brought forward I think'.

In the meantime, he said he had taken matters into his own hands and 'made a pretty good mess there of the toe'.

He said he had approached prison officers because:

> I knew I was going to have another crack at that toe again … to try and get the rest of the nail out properly … I said to them, 'Can I get some Band-Aids please?'. They go, 'What for?'. I said, 'I've got an issue with my toe'. I go, 'Can I get some Band-Aids?'. They went and had a look, they didn't even have any Band-Aids there.

His friend added:

> Simple things like just the basics that you need … like a basic Band-Aid, where you've got to fill out a form, you've got to go through the protocols, got to go through this chain of command and then it comes back to you and says, 'Oh, we haven't got any'.

Roles and responsibilities

230. Another common theme was a perception that role confusion between prison officers and healthcare workers was a major barrier to receiving appropriate healthcare.

231. Some people reported instances of:

- prison officers making decisions about whether people received medical care
- prison officers inappropriately listening in on medical consultations
- healthcare workers breaching privacy.

232. People at MAP also reported prison officers sometimes undertaking medical tasks such as taking a person's blood pressure.

233. One of the problems identified by people in prison was that prison officers are often the first port of call when someone needs medical attention, seeks to make a medical appointment, or has a medical emergency. This gives them the power to block access to medical care.

> Biggest problem is, if you go and ask the staff [prison officers] for help on something, they go, 'Yeah, we'll do it,' and then you don't hear nothing back, so you're just in no-man's land all the time. *(Person at Ravenhall)*

> [Prison officers have] told me, you know, 'You're on these meds'. And I'm like, 'Hang on a sec, you're not a nurse'. *(Person at DPFC)*

> Youse all [prison officers] sit there trying to diagnose someone … and you're a prison worker. You don't know nothing about this. Don't know anything about my body. I know about my body. I know what's wrong. *(Person at MAP)*

234. A person at Ravenhall who said he experiences seizures said that a prison officer decides if you get to see a nurse, and the nurse decides whether to refer you to a doctor. He said:

> I've had nights where I've had six or seven seizures during the night and fallen out of bed and clunked my head and that, but because by the time they get down there everything's back to normal, it's, you know, 'You'll be right'.

235. A person at one of the prisons said they had lost part of a finger while held at a different prison in Victoria, and claimed this was due to decisions made by prison officers and prison management to deny access to the medical care they needed:

> I had the infection in my [finger] and I was in quarantine and kept telling them I need to see a doctor. I told them that it swelled up to three times its normal size. Took 10 days to see a doctor, then when I finally seen the doctor she goes 'We'd better get you to hospital before you lose your [finger]'. She started doing the paperwork and then [prison management] goes, 'If it's not life-threatening leave it 'til tomorrow because we're short-staffed'. So they put me back in the cell for another 12 hours and when I finally got to hospital it was too late.

236. The person explained that it was prison officers who made the initial decision not to refer them to medical staff:

> Because I was in quarantine, all I could do was fill out paperwork, like to see the doctors. And I made them [prison officers] call a code black twice just saying I had chest pains so I could finally get someone to see me. They come and [say] 'There's nothing we can do. We can give you some Panadol'. It actually took the psych nurse to complain to the doctors about me not being seen, for them to see me.

237. People in a group at Ravenhall said:

> Person 1: If you have a problem and you need to seek triage, you have to go see a Supervisor [custodial staff] and they have to see whether or not you're fit to go see the triage nurse
>
> Person 2: And this is a prison officer, so he's not really qualified to be making any judgments on whether you need help.
>
> Person 3: Well, especially on our mob. He's not going to understand the cultural side of things.

238. A person at MAP said he had put in multiple request forms – which have to be handed to prison officers – to seek emergency dental care and arrange to have an X-ray for a separate health condition. He said he had been waiting weeks for a response on both matters and that while prison officers claimed to have handed in his forms, medical staff claimed not to have received them.

239. There were reports of prison officers attending medical and mental health consultations and remaining within earshot:

> And what I find funny is … the confidentiality when I see the doctor. I've got two officers standing here, and the doctor's here … I'm not on [a handcuff regime]. I'm not from the slot [a cell where a person is held alone, often as a punishment]. Why does an officer … have to listen to all my medical stuff? That's why a lot of us don't open up to the doctors here, or the psychs, 'cos we've got an officer standing right there who can use it against you. Or you don't want to tell them the truth 'cos you don't want him to overhear what you're actually saying. So how do you get around that? *(Person at MAP)*

240. In some cases, people also said that healthcare staff breached their medical confidentiality, or acted like prison officers, and that this is a barrier to seeking treatment.

241. A person at one of the prisons said:

> I've come across a lot of nurses, and they try to tell you what to do. And you go … 'You're not an officer, you're a nurse, do what you're good at, and stay out of what they're meant to'. I said, 'Officers tell me what to do, you don't tell me what to do'

242. Two people at MAP spoke of contrasting experiences of medical confidentiality at another men's prison in Victoria. One said that years ago he saw a nurse for an infected DIY tattoo. He said the nurse asked the prison officer to leave the room to allow him to openly discuss what had happened.

243. Another person, speaking of the same prison, said he was charged with a prison disciplinary offence after a doctor disclosed his drug use in front prison officers:

> I got told to go to medical because my lips went blue, I had septicaemia. I went up there and then [a] medical [worker] looked at my arm and she wasn't going to say nothing. But then another doctor come in and the [prison officers] were standing in there and the doctor comes in straight away and he's like, 'Oh, you've been using needles'. *(Person at MAP)*

Attitudes of staff

244. There were both positive and negative comments made about individual healthcare practitioners – including doctors, nurses, dentists, psychiatric nurses and psychologists – at the three prisons.

245. Someone at MAP, for example, said the doctors there were 'alright' and 'actually do care about you'.

246. However, many people said that the attitudes of both prison officers and healthcare staff were sometimes a barrier to accessing and receiving appropriate care.

247. People at all facilities said healthcare staff 'don't listen' and 'don't care' about their problems, and a common complaint was not being given reasons for medical decisions, including decisions to deny medical treatment:

> I know I done wrong, I deserve to be here, but I deserve to be treated like a human too. I'm not an animal. *(Person at Ravenhall)*

> He's not an animal. I'm not an animal. But they talk to us like we're animal. You go down there [to medical], you know, 'Get over there. Go in there'. And I say, 'Excuse me, I wouldn't talk to you like that'. *(Person at Ravenhall)*

> We're not being validated that we are actually, you know, people. We are entitled to have the care and attention we need. *(Person at DPFC)*

> They really don't listen to what you're saying, they don't. *(Person at DPFC)*

> Medications and things like that are almost, like, impossible. [Mental health staff] don't listen to what you're saying about medications that work, don't work, or anything like that, they just do what they think. *(Person at DPFC)*

248. A group in a protection unit at Ravenhall said some medical staff refer to them as 'the putrids'. One said this had occurred in front of another medical staff member, who heard but said nothing:

> I say to them, 'Excuse me… what did you just say?' and [the healthcare worker] goes, 'What did I say?'. I said, 'You just said we're from putrid side. What do you mean by that? What's putrid?'. And [the healthcare worker] goes, 'Oh no, I said protection'. I said, 'No you didn't. You just said… "Oh, this one's the putrid section". *(Person at Ravenhall)*

249. People spoke of their health concerns being routinely disbelieved or dismissed by healthcare staff:

> They assume … we're after drugs, so it's like, you know, they're not assum[ing] we've got a problem, so they just assume that we're trying to just get what we want. *(Person at Ravenhall)*

> It's not like they even care. It's like they don't even believe we're calling for help, that we just want attention or we want a certificate to get out of doing something. *(Person at Ravenhall)*

250. A person at MAP who was being treated for blood clots reported that he and others in his unit tried in vain for hours to get help for him one night:

> I'm on medication [but] you can still get clots on medication. … I had about seven people buzzing up in the unit saying, 'Mate, you've got to go see him. He's not well'. … [For] three hours I buzzed up like heaps of times and then they just put me on obs [observations] instead, so I cracked the shits and I covered me fuckin' window up. I said, 'Well, what's the point? You don't care anyway … You haven't done me blood pressure'. … [My] legs were up and down for days [afterwards]… I went to medical the next day and the [medical staff member] … looks at my leg and…goes, 'Oh, they've gone down a bit now. You'll be fine. You're on a strong medication for clots'. Like, and my friend on the [outside], she's got a clot as well…so she's like, 'Listen, you can die from that. It's not something to fuck around with. It's a clot, it's bad, goes to your heart you're dead'. *(Person at MAP)*

Case study 6: Person with health condition not believed by prison staff

A person at DPFC spoke at length about being disbelieved in relation to a serious health condition and reflected on why prison healthcare staff might develop these attitudes:

> So I've actually got a heart condition. And many times, I've explained to them … why I'm feeling chest pain, and they try to tell me that it's anxiety. You know, part of it might be anxiety, but I'm actually feeling pain … So I was born with my heart condition. So they go, 'Oh, you're just, you know, overreacting,' [and tell me] to try and take some deep breaths, and they try to tell me everything's okay. But I know that I'm not okay …
>
> And they say, 'Oh, your scans look well.' You know, it might look well to them, but I know what my heart rate's meant to be, my stats, because I've dealt with it my whole life … There's been deaths in custody with Aboriginal women, and not just Aboriginal women, other women as well that have, you know, heart failure.
>
> To be honest, it feels like they don't think what we're saying is valid or telling them that it's valid. And they think that, you know, maybe it's a way to get out for the day, or out for the night, or that'd be too much paperwork for them to do. And, you know, they've got better things to do. That's how it comes across to me …
>
> I think working in this kind of environment, and copping what you cop every day from all different kinds of people can take a toll. And then you go, 'I've had enough.' So they think that one person might be the same as the other, they stereotype you …
>
> And then something goes wrong, and then they try to cover it up because someone died in custody. They go, 'Oh, well, that wasn't my fault,' you know. 'I did what I had to do,' and they just try to swipe it to the side and go onto the next. They think they can get away with it because they work in this facility, this government facility.

Difficulties accessing care

251. A number of people said that they are routinely ignored or disbelieved when attempting to access healthcare, and that as a result felt they needed to exaggerate their symptoms, make a fuss or even engage in self-harm in order to get medical attention.

> We don't get the support we need from medical … So we tend to be a little bit over-dramatic sometimes, I think, so when we are really unwell, we, they just sometimes brush it off as, you know.
>
> So, and it is that feeling of not being heard, I'm not being, you know, taken seriously. *(Person at DPFC)*

> When you ask quietly and normally, they don't listen. And when you start chucking things around and abusing them … then they'll listen. *(Person at MAP)*

> You've got to dead-set bust balls to like get shit done [for yourself regarding healthcare], you know what I mean? *(Person at MAP)*

> But we've got to say we're going to hurt ourselves or something before we can see the psych. That shouldn't have to be. If we say one thing, 'I need my medication put up,' something like that, I reckon that they should do that straight away. *(Person at DPFC)*

252. A person who said they suffered from a medical condition that had resulted in code blacks (for serious medical events) being called said:

> The only way you get to see the nurse straight away is if they called a code black [like I have had] … [but] the boys in the yard get pissed off, 'cos every time they call a code black everyone gets locked down. So either the turns you're having are they for real or are they put on or what, because they just send you straight back into the yard. *(Person at Ravenhall)*

Dental services

253. People reported poor access to and quality of dental care, including long delays resulting in teeth having to be removed.

254. Aboriginal people at DPFC are eligible to receive dental treatment by the Victorian Aboriginal Health Service ('VAHS'). A staff member at DPFC explained that they would generally be seen by an in-house dentist at DPFC before being seen by VAHS, which involves being taken out of the prison under escort. The staff member said:

> They don't know when they're getting on the bus or anything like that, so a lot of them don't want to go because of the uncertainty of it all. But unfortunately, we can't tell them when they're due to go on an external escort for security reasons. So yes, they can access [dental care] through VAHS, which we definitely recommend they do.

255. Those who had accessed treatment through VAHS, either in the community or while at DPFC, compared VAHS favourably to the service provided by the prison dentists.

256. One person said she waited eight months to see the prison dentist while serving a sentence at DPFC in 2021. By the time she was able to get the appointment, she said, some of her teeth were rotting and needed to be removed. She said the dentist began the work but went on planned extended leave before completing it.

> They should've had someone else in, you know? To finish my teeth. But now she's finally getting them done up, how many years [later].

257. A person in a protection unit at MAP, who said he had been at the prison for a week – his fifth prison in five months – said he had not managed to see a doctor or dentist despite submitting 10 forms to speak to someone:

> I was on pain killers for my teeth because I need some teeth removed. So I need some teeth removed … I do mouthwash and all that, and sometimes I bite on something, and I have real pain in my bottom jaw. And I haven't got my pain killers ever since I've been here.

258. People at Ravenhall said:

> I've got a dental appointment tomorrow for severe pain in my mouth. I don't like banging on thinking mine is real bad 'cos I'm all right, but it's taken about 10 weeks … they've got them on site here and that's just to get a tooth removed. I just need it removed.

> They took me out for a dentist appointment. I sat in the car for two hours, that mini van. The aircon cut out half way and apparently it was cancelled. I've waited nine months for that appointment, you know.

> I've been in to see the dentist a few times about getting my dentures and … I've done the moulds but yeah, they keep saying they'll book appointments, and it just never happens.

259. A person at MAP told the investigation team:

> I've got a hole in my tooth at the back of my tooth, and the other tooth's about to fall out. I've put in a dental form, I haven't seen anybody.

260. He noted that it was prison officers, rather than a dentist, who decided he did not need to be referred for emergency dental treatment.

Medication Assisted Treatment for Opioid Dependence

261. People described long delays in accessing Medication Assisted Treatment for Opioid Dependence ('MATOD'), formerly known as Opioid Substitute Therapy Programs.

262. They said this caused severe withdrawal symptoms and made it difficult to avoid using illicit drugs, with all of the inherent risks, including disease and disciplinary consequences. They spoke of their frustration at being unable to access treatment despite their desire to break their addiction, and of dismissive attitudes from healthcare workers.

263. People at DPFC described disruptions to their treatment due to being in and out of prison, highlighting a lack of continuity of care in the delivery of MATOD:

> That [healthcare staff member] that they've got in there now … is no good because [they're] like, 'You bloody girls, keep getting in and out [of prison], keep going, in and out, jumping off to take the suboxone and methadone'. It's like not [their] business. Who cares? That's our problem, you know what I mean, but it's your duty of care to fucking help us, not just to look at it like that. [They'll] just leave it like that and, what, we've got to be here for more than eight weeks just to get on the program? But when you're coming in from out there and coming down off heroin especially, ice, all the drugs, you can go into rapid withdrawal straight away. *(Person at DPFC)*

Case study 7: Person unable to access drug treatment program

A person at Ravenhall who had been in custody for three months said he had been attempting to get on the methadone program since his first week there and had only been given a doctor's appointment after he 'exploded' with frustration. 'Once they send the email to the Doctor, [requesting an appointment] it has to be processed the following week.' He said he was told he would have wait another month.

> I said, 'No.' [I] said, 'Can't wait another month. I have to be on the medication I need to be on, or I have to be on [illicit] drugs' … So I don't know, I'll just keep bringing it up to the people. I rang the lawyer and told them to send them another letter. Just send them about four letters through the system here … I'm still not on the methadone.

He described his withdrawal symptoms as 'very bad' and said he had received no support to manage them. He described his frustration that he had not been able to access the treatment despite wanting to kick his drug habit.

> So I'm very close to have a shot to get on the drugs here … And I'm telling them, like the truth and they think it's a joke. They just … laugh at you and they say, 'No, we'll give you another month and you'll be right.'

He said that being unable to access the treatment he needed and lacking support to manage his withdrawal symptoms had led him to relapse:

> I'll be honest with you, yeah, I've been on drugs, for my habit. And it's their fault … I'm trying to get off it but they just make me fuckin' want to stay on it. And it's giving me, I'm in debt, money you know. That's pretty fuckin' unfair.

Asked if he had been given a reason as to why it was taking so long to get an appointment with the doctor, he said he had been told:

> because like there's a lot of people on the methadone. That's not my fault, you know what I mean. That's a jail, you fellas have to do that. They make their own rules, you know what I mean?

264. A separate group at Ravenhall raised many of these issues and said it was unfair that to get on the program, they needed to prove they were drug users by providing a positive urine sample, which resulted in disciplinary consequences.

Case study 8: People resort to using drugs while waiting to qualify for the drug treatment program

People at one prison told us how they had relapsed after being unable to access treatment in custody.

Person 1: I need it now. I want to try and get in that program and stop all that shit and they just keep knocking me back … I've been trying for like seven months now.

Person 2: And in the meantime, the boys have to resort to other things and then start scoring in the yard and that.

Person 3: Using drugs, coming into risk of Hepatitis C and injections.

Person 2: Yeah, the risks outweigh the benefits, you know what I mean? And it's being denied a simple thing where the jail is supposed to supply that.

Person 1: Yeah, a couple of times I end up re-using needles in the yard and that.

Person 3: That's a young man that wants to go home to his family soon, do his sentence and get clean and healthy.

Facilitator: Do they give you a reason why?

Person 1: No, they give me no reason. They talk to the doctor and that. I showed them my track marks, everything from when I was out using and even in here. I got the urine test, dirty urine. I've got dirty urine and that now.

Person 3: This is very important. So the brother is trying to get on this program, the [MATOD] thing. So what most jails say is, 'You've got to [test] positive.' So in fact, you've got to throw a dirty urine and go and use drugs to prove to them that you actually need that help. But when you do that, there's so many punishments that come with it. You lose your visits, you lose your job, you get fined in a … disciplinary hearing.

Person 1: That's what just happened to me just then. I got fined … and I don't even have that money because of me scoring in the yard and that.

Person 3: It's crazy and it's been like that forever. Some jails might say you even have to throw a couple of dirty urines. Well, your first dirty urine, you lose your visits for three months. The second one, you lose them for six to twelve months. So there's twelve months you're not seeing your family, all because you want to get on something that is a problem already. It's just crazy. So that definitely needs to change, a hundred per cent.

Person 1: Well, I showed them all my track marks and enough reasons, told them I'm using on the outside. I'm only young … and they're not helping me out and that. That's what keeps causing me dramas. I come back in 'cos I'm looking to feed my habit outside and that. And even inside too, I'm trying to just get off it and that so when I go home I'm healthy.

Person 3: …They actually run these programs in the prison. I'm on it myself, I'm on a monthly injection. They've got hundreds of positions available. There's three, four different groups that go up from each yard every day, 50, 60 blokes from each yard and go collect methadone or buprenorphine, the stuff that he's trying to get on. The problem is getting on it when you need to get on it and the ways you can go about getting on it … You've got to get into trouble pretty much to get on it.

265. People also expressed frustration at not being provided reasons for being denied access to MATOD. Some perceived access as unequal or arbitrary:

> I've been here [for weeks] and … I put my medical appointment in as soon as I got here [to get on] the suboxone and that … And I put forms in and my lawyer sent the form in, 'cos you've got to get a lawyer's letter to be approved on the suboxone. Anyway, so I've been here for [weeks], then my [relative] comes in and they put her straight on it … I don't know why. *(Person at DPFC)*

> They run it in all the prisons, but they seem to pick and choose who can go on it, at what time and it doesn't necessarily fit. A brother might need it last week and someone who doesn't necessarily need it might get it. *(Person at Ravenhall)*

Mental healthcare

266. As with other health services, people spoke of long wait times to access mental health services and difficulties accessing specialist mental health support.

267. A person at Ravenhall said:

> You see the psych nurse, but it's for 20 minutes and you don't get anything resolved. *(Person at Ravenhall)*

> There was someone [in a mainstream unit] the other day who was having a bit of a rough time there and he kept telling the officers that he needs to see someone for mental health, because otherwise he was going to do something stupid. And five days later he ended up cutting his wrists and they took him off to … the hospital … [where they] patched him up and sent him back to the unit. And he said to them [recently] he needed to see someone to talk to him about his mental health again and [they] got on the phone and [he was told] 'They'll come and see you in three days'. *(Person at Ravenhall)*

268. People at Ravenhall said the inability to access medical care for physical conditions has a severe impact on mental health, even at times leading to suicidal thoughts:

> It has [a] snowball effect. *(Person at Ravenhall)*

> They don't care about that, they don't care. And we go to say something about that, the best they can do is an antidepressant. *(Person at Ravenhall)*

> At the end of the day when you're in so much fuckin' pain, the only option really is suicide. Even I thought about getting there with a knife or something and just falling back onto it and trying to fuckin' cut my fuckin' spinal cord to try and take away the pain. *(Person at Ravenhall)*

> They [put] people on antidepressants or antipsychotics. It's a way of just stopping all this thinking, quieten them all down, keep them calm. I've been on psych meds, I've been off psych meds, I've been fiery, I've been quick to react, and then I've been on meds where the same thing won't let me react. It's just a blanket punishment to shut us all up. *(Person at Ravenhall)*

269. People at MAP said the psychologists were good, but it was futile trying to access them, even after repeated episodes of self-harm:

> [Psychologists] are very hard to see. *(Person at MAP)*

> You're wasting your time trying to see them. *(Person at MAP)*

270. A person in a protection unit at DPFC said that after a close relative died:

> I literally had to beg to get down to see a psych … And then had to beg to get grief counselling, and you know, like up in here, everything's out of our hands, whereas out in the [mainstream] compound you have the ability to go to the medical centre and say, 'Look I'm not coping'.

Case study 9: Person unable to see psychologist punished with isolation

A person who had been at MAP for several months said his mental health had spiralled while waiting to see a psychologist, resulting in him being placed in separation. He said:

> So what happens is I can't get help, I lose the plot, I get slotted [placed in a cell alone as a punishment]. I've been trying to see a psych, I was trying to see a psych, I was on a P1 [a risk rating used by Corrections to indicate a person has a 'serious psychiatric condition requiring intensive and/or immediate care'] when I first got here … For a month, I had issues … I thought someone was out to get me … I got slotted over it. I pulled a pencil in someone. I turned around and said, 'I've been trying to see a psych for the last eight weeks because of the issues I've got.' … The psych only come and seen me four days ago …
>
> That's the first time I've seen them the whole time I've been here … So that's how far I had to push it, and that's how far my issue got, to the point where now I'm on 24-hour lockdown, and only been seen by a psych through a trap for 10 minutes … I've only seen them once. Once since I've been here. It's not an ongoing thing. [The psychologist] goes, 'Look, I'll come and see you in a week and we'll see how you're going'. Now, like I said, that's four days to go, we'll see how we go, see if I see [them] in two more days. But you're not going to hear this just from me, you're going to hear it from everybody. It's very fucking slow here.

271. People also said that while they suffered as a result of being unable to access the mental health support they needed, seeking help often made things worse as they would be placed in observation cells in inhumane conditions. Observation cells are usually monitored by camera, and people in them wear no clothes, just a canvas gown or canvas blanket. Prison officers or health staff are required to sight people in observation cells at regular intervals. This is designed to prevent people self-harming but does not address their underlying distress or therapeutic needs.

> I cut myself. Just to relieve some of the feelings, emotions, things like that that I can't articulate into words, or don't have the opportunity to be able to express … So sometimes it's just easier to self-harm. Yeah, doing counselling and stuff like that does help, but sometimes it is hard to get that counselling, so therefore, what do you do? (*Person at DPFC)*

> Person 1: [If you] go down and talk to a psych nurse, because you never get to a psych doctor … they don't listen.
>
> Person 2: No.
>
> Person 1: They don't, they just, 'Are you going to self-harm?'. You say, you know, 'Well yes I have,' or 'Yes I want to,' or 'I feel like I'm not being supported so, you know, I think about it'. Boom, you're back down, you down to a 'wet cell'.
>
> Person 2: Yeah.
>
> Person 1: You're stripped of everything, you feel, like it's just, so you, the girls don't say stuff because they don't, you know [want this to happen]. *(People at DPFC)*.

272. Similarly, people at MAP described Unit 13, an observation unit where people deemed at risk of suicide and self-harm are held, as 'freezing' and said they found it distressing to be held there without clothes. Some described conditions in the unit as a deterrent to seeking help.

> You can't take phone calls there. They do give you a phone call, but you've got to walk out the hallway to another unit to use the phone in a smock [canvas gown], no pants on, nothing. Or the shower, they decide when you get a shower. So they can say, 'No, we haven't got the staff today to give you a shower,' so you sit there for a day, no shower. *(Person at MAP)*

> Even if you ask to go to Unit 13 and you're not going to self-harm, if you just want to go there because there's a camera, you still can't have your clothes. We don't get a … pillow and the blanket, it's freezing in there. I've been in there heaps of times. It's cold. So, like if you're sitting there asking to go to Unit 13 but you're not going to self-harm, you just want to go there 'cos there's a camera there, why can't you have your clothes there? *(Person at MAP)*

273. Others spoke of a sense of powerlessness and lack of control about what would happen to them if they tried to get help:

> So there's a bloke in the unit, he's been buzzing up lately with anxiety at night. And I know what it's like to get really bad anxiety myself. So the other night … he's going, 'I can't breathe'. He wants to go to Unit 13 because there's a camera in there, he feels like he's going to die, he's getting older in prison … but they're, 'We'll get the psych to come and see you. Calm down mate'. If he wants to go to Unit 13, let him go there. If it makes him feel better, you know what I mean? *(Person at MAP)*

> You know how I said … we can't refuse going to Unit 13? But they can refuse to come and speak to us. So they can say 'no' to speaking to us, but when we slash-up [self-harm] we can't refuse to go to Unit 13. *(Person at MAP)*

Trauma

274. A common theme was inadequate or non-existent treatment for trauma, including a lack of access to specialist counselling.

275. The person described in case study 1 – who was being held in separation at MAP and said he was unable to see a doctor, contact his family or access his prescribed anti-depressants – was far from a lone example.

276. A person at Ravenhall said:

> I've been stabbed [multiple] times. I've got trauma, bad, and all they put me on was [an antipsychotic] and antidepressants. I have nightmares every fucking night about getting stabbed. I see blood and shit in my dreams and they freak me out. I wake up thinking I'm getting stabbed.

277. A person with an intellectual disability said he had been unable to access trauma counselling since arriving at MAP:

> I'm supposed to see a specialist counsellor from [regional Victoria], what actually helps me, 'cos I've had some things done to me when I was a kid, and trying to work through it, and like make me feel a better person than I was. I think … me getting in trouble, was because of me use of drugs and what happened to me when I was a kid. But it's not me saying I'm doing these crimes for that reason, it's just me; I was just fucked up as a kid. And I've been in trouble since I was nine years old. I'm trying to change my life around, I've got [various professional certificates].

278. Some people we spoke to at DPFC were grieving for Veronica Nelson, including people who had known and loved her since childhood. Some were among the last people to see her alive.

Veronica's story

Veronica Nelson was a proud Gunditjmara, Dja Dja Wurrung, Wiradjuri and Yorta Yorta woman who died at DPFC on 2 January 2020. She was 37 years old.

On New Year's Eve, Veronica was arrested outside Southern Cross Station for shoplifting. She was denied bail and taken on remand to DPFC.

At the time of her arrest, she was withdrawing from heroin and suffering from Wilkie's Syndrome, a medical condition that was undiagnosed. Upon arrival at DPFC, Veronica received a medical assessment lasting 13 minutes and was put in a holding cell.

Over a period of 36 hours, Veronica used the intercom in her cell to request assistance at least 49 times. In his report, Coroner Simon McGregor asked 'how the people who heard them and had the power to help her did not rush to her aid'.

The Coroner accepted Veronica's medical cause of death as 'complications of withdrawal from chronic opiate use and Wilkie Syndrome in the setting of malnutrition'. They found that Veronica received 'cruel and degrading treatment' by prison staff, and that her death was preventable.

Veronica passed away alone in a prison cell.

VALS described her as a 'strong' woman who was connected to her culture. 'Veronica Nelson should be alive today, living with her community and sharing culture.'

Further detail about the Coroner's finding can be found in Appendix 4.

279. Aboriginal people at DPFC who had known Veronica said they had not been offered any support, including critical incident debriefing or grief counselling. One said:

> I still haven't experienced no mental health support … And they leave me in Yarra [unit]. Like, Yarra is where Veronica passed away. I was one of the last girls to talk to her.

280. The same person spoke of what Veronica meant to her:

> They think Veronica Nelson was no-one to no-one, but she was someone. She had helped in me growing up. I wouldn't be the strong young warrior I am now if it wasn't for half the words from that woman.
>
> And I wouldn't know half the knowledge, stuff about Country, about anything, about women's stuff if it wasn't for her. And you know how hard it is?

281. One person said she happened to be receiving trauma counselling through a specialist sexual assault service, but had not been offered anything by the prison relating to Veronica's death:

> Trauma counselling I do with [the specialist service], but like no-one from this [prison] or from anywhere else has sat down and said to me, '…how are you feeling about Veronica?'

Ability to practice self-care

282. People at Ravenhall in particular said they faced barriers to maintaining their dignity and basic hygiene, due to the higher cost of goods from its canteen compared to other men's prisons.

> I work all week and I still can't afford to buy a lot of things on the canteen because I don't get enough … How are we meant to save when we can't even afford to buy the basics, soap, shower, toothbrush, whatever. By the time you've bought those three items your whole work's week is gone. Your pay is gone. *(Person at Ravenhall)*

> [You earn $9.40 a day but] really I earn $8.20. Take $1.20 off that a day to put it into your compulsory saving … I don't get the extravagant stuff, I only get what I need. Maybe once a month I'll buy another toothpaste, I'll throw the old one out, and my toothbrush. I'll get a toothpaste and maybe one or two items like eggs and milk and that's all gone. I've got nothing left. *(Person at Ravenhall)*

283. For some people, this impacted on their emotional wellbeing and mental health:

> I've been at maximum jail, [Metropolitan Remand Centre] and all that and their stuff is a quarter of what we're paying here, at maximum. You go to [Metropolitan Remand Centre] [and] a $30 spend will get you like a big bag full of heaps of stuff and you're happy, walking back. Here, 30 bucks will get you about five items and you're broke … I don't get money from the outside. I've never had money from the outside. So I get up every day to go to work so I can buy just the basics, you know what I mean? It's hard, because after a while it starts to do your head. *(Person at Ravenhall)*

284. Another person said that due to this situation, 'physically, I'm working like a horse, like a bull. Mentally, I'm getting tired'.

Making a complaint

285. People at all three prisons said there is no way to effectively complain about healthcare provision, with people at MAP and Ravenhall saying it was at best, ineffective or at worst, resulted in reprisals.

> It falls on deaf ears … All they do is, if you make too many complaints they shift you from one … unit to another. It's catastrophic for me. I suffer from agoraphobia. I have trouble coming out of me cell as it is, and if they move me [to a different unit], it would just destroy me for weeks … . *(Person at Ravenhall)*

> They do nothing about it. *(Person at Ravenhall)*

> If you complain about them, you watch what happens to you … if you make a complaint against any of these people here, you watch how … the officers, you get treated totally differently. *(Person at Ravenhall)*

> They just target you after that. *(Person at Ravenhall)*

> The problem here … there's two ways they deal with stuff here, one, you fill out a form, or two, ring up the Ombudsman and complain, and that's the support you get from people here. It's not just this prison, it's other prisons. And this is where it's getting so pathetic that why should this bloke have to sit there for two weeks and he's getting told to fill out a form? Mate, he should be getting taken to hospital. *(Person at MAP)*

> So I'll hand [the complaint form] to the officer … and then after that sometimes they get lost. *(Person at MAP)*

286. A person at Ravenhall who was unable to work due to a medical condition claimed he was being underpaid. When he complained about this, he said he was falsely accused of spitting at a prison officer, and had disciplinary action taken against him.

287. A person at DPFC said she had attempted to make a formal complaint about aspects of her medical treatment, but the prison refused to provide her with a copy of her medical records, forcing her to request them under the *Freedom of Information Act 1982* (Vic), a process which took a year.

288. In separate conversations with the investigation team, two people at MAP claimed they had suffered reprisals for making complaints to the Victorian Ombudsman. One said:

> I've rung the Ombudsman and they've rung the prison and then I got to the stage where instead of something I should have done over one consultation, one day, it took three weeks and they told me if I ring up the Ombudsman again, it'll take longer … then I just stopped because I almost lost it, because I thought 'hey, look, your staff told me that if I'm not happy to ring up the Ombudsman'. [They said] 'Well, tough luck, you ring them again and we'll take longer'. *(Person at MAP)*

289. The other said that after complaining:

> Oh, just I can't get anything. I can't get a request done, the accounting form goes missing from canteen. I don't get any canteen … my food becomes cold. I can't get out to clean my cell as often, that sort of stuff. Like, it doesn't sound like much, but to me it's a daily routine. *(Person at MAP)*

Aboriginal public health experts' reflections

290. Professor Megan Williams and Jack Bulman, who assisted with this investigation, led discussions with Aboriginal people at DPFC, MAP and Ravenhall. Both have worked with Aboriginal people in prisons around Australia for many years.

291. These are their reflections on our prison visits.

Professor Megan Williams

I've visited and worked in prisons and on prison-related health issues since the mid-1990s, including asking Aboriginal people about their experiences of health care and reviewing state and national data about health. I knew to prepare well for asking Aboriginal women about health services in the Dame Phyllis Frost Centre visit. I'd written a report for the inquest of the death of 37-year old Gunditjmara, Yorta Yorta, Dja Dja Wurrung and Wiradjuri woman Veronica Nelson, been an expert witness as part of the medical conclave at the Coroner's Court, and reviewed reports and records from DPFC. I'd also contributed to the *Cultural Review of the Adult Custodial Corrections System in Victoria*.

As Wiradjuri like Veronica I had cultural and professional responsibilities to be trustworthy, open-minded, and also aware of preconceived ideas.

One very useful strategy was developing a collaborative artwork in the community with Gamilaraay and Warlpiri artist Jessie Waratah. Entitled 'For Our Elders', this was designed to be taken to DPFC with permission, to create a neutral, inspiring focus for us as Aboriginal women coming together. The painting was literally a visual reminder for us to keep bringing into view Aboriginal cultures and protocols because Aboriginal women in prisons have the right to experience and use these, including in health care, as in the general community.

The gaps in cultural models of healthcare were very obvious. The confusion and disconnects described seemed to result in and perpetuate unmet healthcare needs. These ranged from treatments partly in place but not able to be continued, worries about pains and symptoms, worsening of chronic conditions, isolation and depression, and sheer stress of uncertainty including about health service access.

All the domains of Aboriginal peoples' holistic definition of health had stories of current and likely future unmet need. Quality of care and workforce cultural capabilities, cultural responsiveness of services and systems-level planning – multiple and compounding barriers come to mind. Prevention and health promotion – perhaps there are some possibilities but punitivity and restrictions in the setting produce many barriers. Hearing about dehumanising experiences is always disturbing, but the gaps in policy framework implementation and their evaluation perhaps even more so.

Jack Bulman

I have done various work in jails across Australia in the past 15 years, and for me going into the jails in Melbourne and asking about access to health services, I was really shocked at the inadequacy. Some months later I am still remembering the visits and the issues. I still can't believe the differences and disparities and how much worse it was than I thought it would be. There are peoples' truths and real truths and three sides to a story but to hear the sameness of the stories that were talked about in the places visited said to me there really were very real issues to address.

It was a real eye opener despite doing a fair bit of work in prison about how much power prison guards have. Even the fellas who had made complaints talked about how hard it is to complain, and there was a sense of fear if they did make a complaint, what the repercussions would be for them. They said they were not sure what the Ombudsman's office could do.

Some of the young lads – remembering them, there is just a lot about hope and not much about actual action. One of the young lads was talking about how his prized possession was a picture of his young daughter but he was not allowed to have it in his cell. He said he understands there could be predators in prison and pictures of children could be an issue for them but doesn't really understand how that applies to him and where he was in the prison and for how long etcetera. It's become a real wellbeing issue for him, and he is that distressed that he had self-harmed. The loss of hope was and is a real wellbeing issue.

Another issue raised by a number of fellas was about detoxing and seeking drug and alcohol rehabilitation – they talked about such conflicting messages about how to get onto programs and what it means for loss of privileges. They said it was a real catch-22 situation about whether to go on medication or do programs or whatever else and were finding it hard to comprehend the information.

The different needs of people who are young compared to people who are older – that was really worrying. There was a fella who was in his fifties who had all these different health conditions … but he didn't know exactly what was happening. He was focussed on being released in a couple of weeks and worried about going to a regional area, being returned to a place he was not from and didn't know what could be done to change that. He was concerned he was going to be lost, again. It was about his recovery too, already being clean and abstaining from alcohol and drugs – he was worried about going to a place with no support what that means for his recovery. We just had a yearning to be there and talk more but we couldn't, and they didn't seem to have enough support.

These lads wanted to yarn. They wanted to tell their story, but were unsure what this would do for them if they did. Some lads had even resorted to calling a code saying they had chest pains to enable them to be seen by a medical officer. This is fraught with danger as everyone is put in lockdown and causes anger among everyone.

We know there are trust issues – not sure which staff to trust and who really does what and roles seem to blur. Trust is fundamental to wellbeing. These fellas need to see good stuff happening too or hope and trust is lost. When we lose hope, we become hopeless.

All in all, a sad state of affairs, and yes people need to be held accountable for what they have done, but there is the fundamental basic human rights that everyone is entitled to.

Aboriginal organisations

292. The investigation approached and invited participation from Aboriginal organisations and community representatives that work with and advocate on behalf of Aboriginal people in the prison system.

293. These approaches took place against the backdrop of the Voice to Parliament referendum, the release of the Yoorrook Justice Commission's *Report into Victoria's Child Protection and Criminal Justice Systems* and the transition to new healthcare providers in the public prison system.

294. Not all of the organisations approached were in a position to provide information to the investigation. We acknowledge that Aboriginal organisations often have the experience of being 'over-consulted' and that providing information upon request can be a significant use of scarce resources.

295. In submissions received in late August and September 2023 respectively, all three organisations raised concerns about the current state of healthcare provision to Aboriginal people in prison. They identified systemic barriers to the delivery of healthcare that is culturally safe, continuous, and of an equivalent standard and quality as in the community.

296. They also advocate for an end to the use of private healthcare providers in the prison system, and for the Government to contract ACCOs directly (rather than through sub-contractual arrangements with private providers) to deliver healthcare services to Aboriginal people in prison.

297. Each of the organisations also made proposals for the change they wish to see which are included in Appendix 2.

Figure 10: Organisations that provided written submissions

- The Aboriginal Justice Caucus ('AJC') is a self-determining body made up of representatives from a range of Aboriginal justice and community organisations. It provides statewide representation and leadership to amplify Aboriginal voices in all areas relating to justice. The AJC acts as a conduit between Aboriginal communities and the Victorian justice system.
- The Victorian Aboriginal Community Controlled Health Organisation ('VACCHO') is the peak body representing 33 ACCOs in Victoria. VACCHO builds the capacity of its membership and advocates for issues on their behalf. The Australian and State Governments formally recognise VACCHO as Victoria's peak representative organisation on Aboriginal health.
- The Victorian Aboriginal Legal Service ('VALS') is an ACCO with 50 years' experience providing legal and community justice services to Aboriginal people across Victoria. VALS' Wirraway Police and Prison Accountability Practice runs a prison advocacy service, which provides legal assistance to individuals in custody. At the time of its submission to the investigation in August 2023, VALS was representing the families at the coronial inquests for three of the four Aboriginal people who had died in custody in Victoria since 2020.

Source: Victorian Ombudsman

Concerns regarding prison healthcare

298. All three organisations stated that prison healthcare provision currently does not meet the needs of Aboriginal people and is not adequate to ensure the best health outcomes for them.

299. According to VACCHO:

> The disproportionate number of Aboriginal deaths in custody remains a deeply troubling issue and remains as a shameful reminder of colonisation and the impacts that it has had on Aboriginal and Torres Strait Islander people. It necessitates comprehensive reforms in prison practices, including mental health support, use of force policies, and increased oversight to prevent further tragedies.
>
> Substance abuse is a pervasive issue among Aboriginal prisoners. The availability and effectiveness of alcohol and other drug programs must be improved to address the root causes of addiction and reduce recidivism.

300. Echoing many of the people we spoke with in prison, VALS advised that its clients regularly face a lack of access to medication, drug specialists and programs, mental health care and allied health services. According to VALS, health information is poorly documented and often lost when people move between prisons, and not shared with community healthcare providers or patients. VALS also noted there is a 'lack of clinical oversight, reflective practice, or appropriate responses to complaints and adverse events'.

301. In response to a draft of this report, GEO Group disagreed with VALS's statement that people in prison regularly face a lack of access to medications and health programs. GEO Group argued this should be further investigated and that the comments about access to medication are incorrect because:

> The percentage of people in prison who are on medications is high (approximately 80%) and all prescribed medications are provided free-of-charge. Many people in prison are on five or more medications daily.

302. The AJC submitted:

> We know that in Victoria, prison healthcare delivery does not work for Aboriginal people. Custodial health services are part of an institutionally racist system focused on security and punishment rather than wellbeing and rehabilitation.
>
> The AJC's vision for the future is an Aboriginal Community-Controlled Justice System that is safe, fair and works for Aboriginal people across Victoria. This requires ***transformation*** (emphasis in original) of the existing criminal legal system and its institutions. Change of this scale will take time but is desperately needed as each day the current system continues as is, Aboriginal people enmeshed in it experience harm, trauma and injustice. To mitigate these harms and prevent further Aboriginal lives being lost, urgent reforms are also required.
>
> An overhaul of custodial healthcare is a crucial step in this vision …
>
> Experiences documented [by the Cultural Review] demonstrate a lack of cultural safety, difficulty when seeking timely healthcare and medication, and overwhelming fear of dying from inadequate care.
>
> While … the Government committed to increase access to culturally appropriate healthcare models in Victorian prisons, policy commitments and implementation fall short of ensuring that Aboriginal people in prisons can access culturally safe, equivalent healthcare provided by an ACCHO.

Access to culturally safe, continuous and equivalent care

303. The submissions were unanimous in stating that culturally safe, continuous and equivalent healthcare can only be provided by ACCOs.

304. VALS also said it has observed a lack of continuity of care within the current prison system:

> Currently, the prison healthcare system is delivered by a web of contractors and sub-contractors, meaning that there is no consistency in the care provided across prisons …
>
> In our experience, each prison acts as its own separate entity. This means that even when we have been advocating for medical care for a person in one prison for months, once they change prisons, the whole process starts again. Healthcare providers are often unaware that a person will be moving prisons, and receiving providers are unaware of the person's arrival and healthcare needs or if they have systems in place to ensure they can assist … This can have significant health implications …

305. VALS illustrated this issue with a case study, stating that a client on court-ordered anti-psychotic medication did not receive it for over a month after entering custody despite persistent requests from the client and their family members. VALS said the family did not receive a response when they followed up with Justice Health and the issue was only resolved after VALS became involved. In the meantime, their client experienced 'significant distress'. VALS said:

> … the client's community mental health records … were … placed onto the client's JCare record [Justice Health's electronic record system]. However, as our client was transferred between prison facilities, the new primary healthcare providers didn't check JCare and no one realised the records had come through.

Access to alcohol and drug support

306. VACCHO and VALS identified the lack of access to culturally safe alcohol and other drug ('AOD') support as a key issue. Echoing the Aboriginal people in prison who spoke with the investigation, VACCHO called for culturally appropriate rehabilitation programs:

> Research has consistently shown disproportionately high rates of AOD-related problems among Aboriginal and Torres Strait Islander inmates in Australia's correctional facilities. These issues are deeply intertwined with historical trauma, socio-economic disparities, and systemic discrimination. The overrepresentation of Aboriginal and Torres Strait Islander individuals within the criminal justice system exacerbates these problems, creating a cycle of disadvantage and incarceration.
>
> The current system's approach to addressing AOD problems in prisons is largely inadequate. The punitive nature of the criminal justice system often fails to address the underlying causes of AOD use … The lack of culturally sensitive programs, insufficient support for rehabilitation, and the absence of community-driven initiatives further contribute to the system's shortcomings in tackling this issue effectively. To create meaningful change, a paradigm shift is needed, emphasizing community-led approaches and the involvement of Aboriginal Community Controlled Organisations (ACCOs) to ensure culturally appropriate and holistic interventions that address the root causes of AOD use among Aboriginal and Torres Strait Islander prisoners.

307. Like the people at Ravenhall who said they resorted to using drugs after being unable to access drug treatment programs, VALS identified the lack of timely access to drug treatment programs as a major risk for Aboriginal people in Victorian prisons.

> It is evident from numerous inquests and reports that drug treatment programs in prison are inadequate to meet demand, and there are significant barriers to access, including for people on remand. Like any other treatment, people in prison should be able to access proper and reasonable care for their health conditions, and like in the community, people in prison should be able to access harm reduction services like needle exchanges and addiction specialist services.
>
> Without proper treatments, people may be unnecessarily forced to source drugs by other means. This has dangerous consequences, including the risk of procuring unsafe drugs, the sharing of needles, risk of overdose, blood born viruses, ulcers, and other health risks. It also counterproductively contributes to poor order of the prison by encouraging black market drug trade which may undermine security concerns and lead to further sanction.

308. VALS welcomed recent changes to the delivery of the MATOD program. In response to the Coroner's finding in the Veronica Nelson Inquest, people in prison can now 'be inducted onto MATOD at the earliest opportunity upon entry to custody, the duration of time in custody no longer affects MATOD eligibility'.

309. However, VALS said that the new rules are not being applied in practice. VALS said it had to intervene on behalf a client who was barred from accessing MATOD when they entered custody, and was told it was because they had been in custody for less than six weeks.

310. VALS also raised concerns about Justice Health's *Victorian Prison Opioid Substitution Therapy Program Guidelines*, which the Coroner found 'restrict access to pharmacotherapy'. This effectively denies people in prison equivalent care to what they would receive in the community.

311. VALS raised concerns that people can be 'rapidly and involuntarily' removed from the program for disciplinary reasons such as 'failing to collect their methadone or buprenorphine at the time specified' and 'failing to treat the correctional health service staff with respect'. Prison security seems to be prioritised over people's health. VALS stated:

> Removal of medication should never be used as a disciplinary measure to punish or incentivise certain behaviours … it would be unethical to remove someone's anti-psychotic medication as a disciplinary response to poor behaviour. [MATOD] should be no different.
>
> Further, we have heard alarming reports of the prescription of [MATOD] to people in prison who are not opioid dependent. Many of our clients and community organisations have reported that [MATOD] is being sought and prescribed to manage boredom associated with extended lockdowns and lack of programs. Many people have said they'd prefer to 'get high' than sit in their cell all day. We suspect that due to the sedative effects of [MATOD], overuse is a way for prison authorities to 'manage' the population with low staff numbers.
>
> AOD treatment, such as [MATOD], is life-saving medical treatment. It should be used appropriately and in situations where it's needed, and should not be impacted by the security or management priorities of the prison.

312. In response to this, GEO Group stated:

> VALS' statement [that] "Many of our clients and community organisations have reported that [MATOD] is being sought and prescribed to manage boredom …" is refuted and appears to contradict earlier statements that people in prison are unable to access MATOD …
>
> Patients entering the MATOD Program sign a 'contract' to confirm they will not misuse the medication or divert it to other people in prison. There are clauses in the contract that also require patients not to be violent towards staff. The removal of a patient from the MATOD program for misusing medication, diverting it to others or being violent towards the administrating staff is instigated for the safety of the patient, other people in prison and the safety of staff. This is not used as punishment.

Needs of women and transgender people

313. VACCHO said that women in prison 'confront a complex array of challenges within the corrections system that are distinct from those faced by their male counterparts'. Gender-specific trauma, mental health concerns and histories of abuse are prevalent among incarcerated women. VACCHO noted that the increase in the remand population in recent years has disproportionately affected Aboriginal women.

314. VACCHO cited research which found that:

> The intersection of gender and race discrimination meant that Aboriginal and Torres Strait Islander women experienced compounded disadvantages within the prison system. They were more likely to be imprisoned, less likely to receive proper medical attention, and faced cultural insensitivity that further compromised their well-being during labour and childbirth …

315. It noted that women in prison, and particularly Aboriginal women, are more likely to be primary carers for children, with their incarceration having devastating effects on families:

> Incarcerating women who are primary caregivers also leaves their children in a precarious position that can exacerbate their health issues perpetuating the cycle of ill physical and mental health, which … can then increase the likelihood of those children coming into contact with the justice system.

316. VACCHO identified access to healthcare treatments for gender-specific conditions, such as menopause, endometriosis, post-partum care and pelvic floor dysfunction, as 'a critical concern'.

317. VACCHO's submission also highlighted the vulnerability of Aboriginal transgender people in prison, including that they:

> frequently face difficulties in accessing hormone therapy and gender-affirming medical care, leading to adverse physical and mental health outcomes. They are also at higher risk of experiencing verbal and physical abuse from both staff and fellow inmates. For Aboriginal transgender prisoners, these issues are intensified by the historical and ongoing marginalisation faced by Aboriginal and Torres Strait Islander communities … resulting in an urgent need for culturally sensitive healthcare services that address their specific needs.

318. In response to this aspect of VACCHO's submission, the Department stated:

- … access to hormone therapy is an issue within the broader community.
- The new primary health service delivery model [in the public prison system] included enhancements for people who are transgender, gender diverse or intersex.
- The reception medical assessment must now consider endocrinology, mental health including suicide risk, family violence, sexual health, preventative care, and any current treatments.
- Providers are also required to develop Integrated Care Plans for all people who are transgender, gender diverse or intersex. As part of this requirement, providers must build and maintain strong partnerships and referral pathways under a secondary consult model with community health service providers or in-reach service providers who specialise in health services for transgender, gender diverse and intersex people to deliver in-reach services at prisons.
- Compliance with this requirement is measured through KPM 9 - Integrated Care Plan (Transgender, gender diverse and intersex people).

Wait times and access to time sensitive treatments

319. In line with what we heard from Aboriginal people, VALS advised that it had 'seen that delay and failure to respond to requests for medical attention is standard practice'.

320. VALS provided case studies of clients which it said illustrated this issue:

- A client who VALS said had an asthma attack in their cell, with staff taking 45 minutes to deliver a puffer to the cell, which they only pushed in through the slot rather than opening the door. The client said they had to crawl on the floor to get the puffer, and staff did not check if they were okay. The client said they thought they were going to die.
- A client who VALS said waited over a year to get a colonoscopy despite blood in their stools for over a year and a family history of bowel cancer.

- A client who VALS said had been in prison since 2017 and had had necessary surgery rescheduled or cancelled three times due to issues with 'security escort, security related costs and prison staffing issues'. VALS said their client still had not had the surgery and had decided to wait until their release in late 2023 to address this health issue.

321. In response to a draft of this report, GEO Group raised concerns that it could not determine the accuracy of claims made by VALS about failings, nor identify opportunities to improve service quality without the identifying details of the complaints referenced by VALS.

322. VALS stated that 'in many cases, prison and health care authorities only act satisfactorily when legal services come on board', noting that advocacy services are limited and often inaccessible, which disadvantages people in prison who are not able to advocate for themselves.

323. VACCHO also raised similar concerns:

> Access to time sensitive healthcare treatments, such as abortion and HIV post-exposure prophylaxis (PEP), presents significant challenges for prisoners within Victorian correctional facilities, particularly for those who have experienced assault. Research indicates that incarcerated individuals often face delays and barriers in accessing essential medical services due to bureaucratic processes, lack of appropriate facilities, and inadequate staff training. For prisoners who have been victims of sexual assault, timely access to abortion services is crucial for their physical and mental well-being.

Systemic issues

Lack of Aboriginal-designed and delivered healthcare

324. The submissions from Aboriginal organisations all endorsed previous findings from the 1991 Royal Commission, the Veronica Nelson Inquest and the Cultural Review, stating that for Aboriginal people to receive healthcare that is culturally safe, continuous and equivalent to what they would receive in the community, it must be delivered by ACCOs.

325. VACCHO stated:

> Outside of prison, it is accepted that Aboriginal people should have the choice of accessing health care from Aboriginal Community-Controlled Organisation (ACCOs) aligning with the principle of self-determination and recognising the importance of cultural safe health care to improving health and wellbeing outcomes. The same logic should apply inside prisons too.
>
> ACCOs have demonstrated a remarkable track record in delivering culturally sensitive and community-specific healthcare services, which have led to better health outcomes for Aboriginal people. ACCOs prioritise holistic approaches that address not only physical health but also consider cultural, social, and emotional factors that contribute to overall well-being. The need for this type of care is even greater in prisons than outside prisons.

326. VALS stated:

> … VACCHO and Aboriginal Community Controlled Healthcare providers should be at the forefront of prison healthcare. Aboriginal people who are incarcerated – either on remand or serving a sentence – must be able to access culturally safe healthcare, as is available in the community …

> For decades, ACCHOS have been providing culturally safe and trauma-informed primary healthcare (and other services) to Aboriginal communities in Victoria. This is not the case for Aboriginal people in custody, who are forced to access healthcare from the mainstream healthcare system, which is not culturally safe.

327. The AJC said:

> In line with the AJC's vision for an Aboriginal Community Controlled Justice System, the AJC continue to advocate for the progressive transfer of resources, authority and responsibilities from government to the Aboriginal community over time until the Aboriginal community has full control over all custodial health and wellbeing responses for Aboriginal people.
>
> … the AJC believe Aboriginal organisations should be adequately funded and supported to develop a model and associated standards.
>
> We strongly support the Corrections Cultural Review's recommendation for the Government to commission Aboriginal organisations to develop a model of healthcare for Aboriginal people in custody.

Lack of community engagement

328. All three submissions alleged that the Victorian Government failed to engage with Aboriginal organisations and communities in a meaningful way about recent changes to the way healthcare is provided to Aboriginal people in prison.

329. They stated that this lack of engagement:

- effectively excluded Aboriginal organisations from being in a position to tender for the new primary healthcare contracts
- resulted in changes to the requirements and performance measures in the new contracts that do not reflect Aboriginal perspectives
- resulted in a model of prison healthcare that is at odds with community wishes for healthcare to be delivered directly by ACCHOs
- resulted in a model that is in breach of government commitments to self-determination.

330. These issues are discussed in more detail in the section on 'Public prison contracts'.

331. The AJC said there were several recent examples of Government failing to meaningfully consult, including:

- Failure to engage early and proactively with the AJC, particularly in the formulation stage of policy, program or legislative development.
- Government creation of policies/ frameworks that AJC are 'consulted' on without any real opportunity for changes to be made that reflect our feedback.
- Engaging Aboriginal public servants, or an individual Aboriginal organisation or Elder instead of capturing the collective views of the AJC (and the communities and organisations that our members represent).

Prison health administered through the Department of Justice and Community Safety

332. The AJC and VALS called for responsibility for prison healthcare to be transferred from the Department of Justice and Community Safety to the Department of Health.

333. According to the AJC:

> Intrinsically, the Department of Health contains higher levels of health expertise and experience in health service delivery than the Department [of Justice and Community Safety], where the focus is on criminological and security matters.

334. VALS said:

> Health care in prisons is provided or contracted by Justice Health, a subdivision of [the Department of Justice and Community Safety]. This inherently prioritises security concerns and 'management' of prisoners over independent medical services that are in the best interests of the patient. In our experience, medical staff in prisons are influenced by 'dual loyalty' or conflicting demands from their employer and the patient. As a result, medical decision making and interactions with patients are influenced by the correctional culture of management and security rather than health outcomes, which leads to limited quality and availability of care.

Use of private providers

335. All three submissions argue that the privatisation of prison healthcare is a major barrier to the delivery of culturally safe healthcare to Aboriginal people.

336. According to VACCHO:

> The privatisation of prison healthcare has been widely criticised for its inherent conflicts of interest. Research and experience demonstrate that such privatisation often leads to cost-cutting measures that compromise the health and well-being of incarcerated individuals. The Victorian Government, however, has continued the use of private healthcare providers in male adult prisons, recently signing a five-year contract with GEO [Healthcare] Australia, a subsidiary of the American company GEO Group.

337. The AJC said:

> There is no incentive for GEO Group to provide quality care to people in prison, if the 'quality' of care required is not clearly described in their contracts, and effectively assessed over time.

338. In response to a draft of this report, GEO Group disputed this, stating:

> GEO's contractual obligations for Service Delivery Outcomes (SDO), Key Performance Indicators (KPI) and Key Performance Measures (KPM), its compliance against legislation (which is scrutinized and regularly audited by the client [the Department]) as well as its performance against quality framework, are some (but not all) measures it is assessed against.

339. The section of this report titled 'Monitoring outcomes under the new public prison healthcare contracts' discusses contractual obligations in more detail, including that the measures healthcare providers are required to report against do not measure healthcare outcomes or the quality of care provided to Aboriginal people.

340. VALS also said:

> Despite the findings and recommendations in the Veronica Nelson Inquest and the Cultural Review, the Government has continued to prioritise privatisation, which is fundamentally at odds with culturally safe and community-based healthcare.

341. VALS went on to note that the revised 2023 Quality Framework, includes several requirements that:

> are impossible tasks for a private security corporation without community connections and cultural knowledge. Culturally safe care requires more than simply hiring Aboriginal health workers. It requires health care to be organised and assessed from the perspective of Aboriginal people. It requires Aboriginal people to have trust in the health care arrangements and quality and responsiveness of service provision.

Funding and resourcing

342. VALS and the AJC noted that an additional barrier to the delivery of culturally safe healthcare in Victorian prisons is that people in prison are ineligible for services funded under Medicare and the Pharmaceutical Benefits Scheme. These are both federally funded, but the delivery of healthcare in prison is a state responsibility.

343. VALS noted that ACCOs provide services in the community through access to a mix of Commonwealth and State government funding.

344. The State Government would therefore have to create an alternative funding arrangement to allow ACCOs to provide some of the same services in prison as it does in the community.

345. VACCHO highlighted the shortage of Aboriginal health professionals, calling on the Victorian Government to invest in boosting the Aboriginal health workforce:

> The declining numbers within the Aboriginal health workforce present a critical challenge that exacerbates the already substantial health disparities faced by Aboriginal and Torres Strait Islander people. The shortage of Aboriginal healthcare professionals, including doctors, nurses, and allied health workers, is deeply concerning as it hinders the delivery of culturally competent and sensitive care. Aboriginal health organisations should be funded to provide health care in prisons and the Victorian Government should take action to increase the Aboriginal health workforce to enable this.

Oversight and monitoring

346. All three submissions said that current oversight and monitoring arrangements for prison healthcare providers are insufficient to prevent deaths in custody and improve health outcomes for Aboriginal people.

347. VALS said:

> The system is failing by not providing a robust independent oversight system of prison healthcare providers. This includes monitoring of contracts, independent auditing and scrutiny, clinical oversight and robust mechanisms for reviewing any deaths in custody that relate to access to healthcare … In our experience, the current mechanisms for monitoring delivery of health services in prison do not work.

348. In its response to a draft of this report, the Department noted that the investigation received these submissions before the Department began its current work on establishing an external oversight board and replacing its Clinical Advisory Committee with a Clinical Advisory and Health Professionals Panel, which it states will provide increased access to clinical expertise, including in Aboriginal health.

349. Both VALS and the AJC raised concerns that under the new contract with GEO Healthcare, the quantity of certain services provided to Aboriginal people is measured – but the quality of the service and people's health outcomes are not. VALS submitted:

> This is particularly concerning considering the complex needs of people in prison, and the time and care that is required to build trust in a prison environment. Measuring quantity alone may incentivise providers to cut quality.

350. VALS and the AJC also stated that the prison healthcare complaints system is inadequate. They said there is:

- poor knowledge of complaints processes
- the risk of reprisals against people who make complaints while still incarcerated
- restrictions around prison phone calls which can prevent people contacting services such as VALS
- limited outcomes from complaints processes
- challenges for bodies like the Ombudsman in enforcing any recommendations that have been made
- limited compliance action being taken by regulators against healthcare providers.

351. All of the submissions noted that these problems can only be fixed by transforming the whole prison health system.

Responses from the Department and healthcare providers

352. To provide procedural fairness, healthcare service providers and the Department were given an opportunity to respond to the material relating to them in this report, including the comments made by Aboriginal people in prison.

353. As the comments made by Aboriginal people in prisons were anonymised, healthcare providers and the Department were unable to confirm the facts of each case. Their responses broadly emphasised that the experiences described did not align with their standard ways of operating and, in some cases, they called into question the stories we heard from Aboriginal people in prison.

354. They also stated that some of the decisions the people in prison had perceived as unfair were in line with departmental policies and made for justifiable reasons. They suggested that people in prison are sometimes unaware of the reasoning behind healthcare decisions or that their expectations do not align with the way healthcare can be provided in a prison environment.

Service providers

Correct Care Australasia

355. At the time of the investigation's prison visits in late May 2023, CCA was the primary healthcare provider at all three prisons and also provided primary mental health services at DPFC and Ravenhall. It remains the provider of primary health and mental health services at Ravenhall.

356. CCA's lawyer's response to a draft of this report stated:

> … the extent of the redactions to the draft report render our client incapable of providing a qualitative response. This is not conducive to the production of a report that is fair, balanced and factually accurate, and moreover, amounts to a denial of procedural fairness.

357. CCA was particularly concerned about the inclusion of anonymous quotes from people in prison and case studies that had not been independently verified. In correspondence with the investigation team, CCA said that this material is presented 'in a way that the reasonable reader will construe as fact'.

358. Early in our investigation, CCA provided information about its practices and approaches to the provision of healthcare to Aboriginal people in prison. CCA stated that it views cultural safety and cultural responsiveness as 'vital elements in delivering appropriate healthcare to Aboriginal and Torres Strait Islander people within the prison system'. CCA advised that:

- it has developed a holistic model of healthcare for Aboriginal people guided by the principles of Justice Health's *Aboriginal Social and Emotional Wellbeing Plan* (2015)
- since 2012, its staff have been required to complete an annual Aboriginal cultural awareness e-learning module, and are encouraged to attend Cultural Mental Health Training run by Indigenous Psychological Services
- trauma-informed care workshops are offered and promoted to its health staff
- there is close engagement between health staff and Aboriginal support staff at Ravenhall to address 'specific health needs, cultural considerations, and support mechanisms for individual patients'
- it engages in continuous improvement to enhance cultural safety for Aboriginal people, with input from Aboriginal people gathered through 'yarning circles, data analysis from audits, focus groups and facilitated conversations'

- monthly drop-in clinics for Aboriginal people at Ravenhall would shortly be introduced, to be held in the prison's cultural space, and including an acknowledgement of Country, health education deriving from feedback by people in prison, and an opportunity to consult with nurses. CCA noted that this more flexible approach will make healthcare more accessible to Aboriginal people.

359. CCA stated that it recognises the importance of partnering with Aboriginal community organisations for healthcare provision. It noted that there are currently no contractual or funding mechanisms to support the direct delivery of healthcare by ACCHOs into Ravenhall, but that it refers Aboriginal dental patients to VAHS and engages with ACCOs to provide cultural awareness and safety training to CCA staff.

Pandemic

360. In its response to a draft of this report, CCA stated:

> The draft report refers to the Ombudsman conducting a review in 2022 of all the complaints received from people in prison in [2020-21] … It is uncontroversial that the pandemic was a significant barrier to accessing healthcare for all Victorians, in and out of custody during this period. Accordingly, complaints about the access and provision of healthcare throughout this period should not be treated as representative of the ordinary and current availability and provision of healthcare services by CCA.

Quality of care

361. Responding to statements by Aboriginal people at Ravenhall who alleged they do not have timely access to Panadol, CCA said that the supply of all medications is regulated for the security and health of people in custody:

> A person in custody who requires a non-prescription medication urgently will be clinically assessed, and if a non-prescription medication is indicated, will be provided the medication.

362. CCA also disputed the claim that Panadol is only dispensed once a week:

> It is not the case that non-prescription medications are dispensed only once per week. Where indicated, a person can be provided a supply of non-prescription medication, such as Panadol, for a period, such as a one-week period, although the quantity of medication supplied at one time will be limited for the security and health of the people in custody. Prisoners can request review by nursing staff including to obtain medication at any time of day.

Continuity of care

363. Responding to comments describing poor continuity of care, such as people being abruptly taken off prescribed antidepressants when arriving at prison, CCA said the choice of medication prescribed in prison is based on many factors, 'including but not limited to the safety and security of the individual and all other prisoners'.

Delays and wait times

364. CCA's response referred only to comments by people in prison about wait times for specialist and tertiary services, which are not provided by CCA. It did not respond to allegations by Aboriginal people in prison that they experience long delays in accessing healthcare delivered by CCA staff, such as doctors and nurses.

365. CCA stated that provision of specialist services depends on the availability of the external providers and Corrections Victoria's ability to provide transport and security, which are 'entirely outside CCA's control'.

366. The response also stated:

> Moreover, issues around the availability and wait times for specialist services reflect difficulties for all patients in the public health system, not only people in custody. It is notable that the Global Pandemic occurred during the period in question. It placed significant pressures on the public health system.

Medication assisted treatment of opioid dependence

367. CCA stated:

> The eligibility of persons in custody for pharmacotherapy is prescribed by the policy issued by Department of Justice and Community Safety. The policy previously included restrictions on how long a person in custody needed to be in prison to be eligible for pharmacotherapy, how the medication is to be taken, and what types were available. This policy has since been revised in order to permit quicker access to [MATOD]. CCA provided and provides pharmacotherapy services in accordance with the policies of Department of Justice and Community Safety.

The GEO Group Australia

368. GEO Group is the operator of Ravenhall and therefore responded to comments in the draft of this report about custodial operations at Ravenhall. GEO Group also responded on behalf of GEO Healthcare, a related GEO Group entity with the same Principal Officer.

369. In its response to a draft of this report, GEO Group acknowledged the importance of the investigation and said it is committed to providing culturally safe and appropriate healthcare for Aboriginal people in the prison system.

370. It raised concerns about the investigation's 'lack of fact checking' of statements by Aboriginal people in prison and submissions by Aboriginal organisations and said that 'procedural fairness cannot be achieved when comments and criticisms against an organisation are given anonymity'.

Roles and responsibilities

371. GEO Group disagreed that people at Ravenhall sometimes had to access medical attention via custodial staff, saying:

> Prison staff (including nurses) do not decide whether prisoners access healthcare services. The men directly refer themselves to medical services/ clinic. The contracted health service model does, however, involve initial triage by a nurse — prior to a referral being made to a General Practitioner.

372. The issue of access to medical services triaged by prison officers was raised by people across all three prisons we visited.

Attitudes of staff

373. In response to the statement that many people in prison told us the attitudes of prison and healthcare staff are barriers to accessing healthcare, GEO Group said:

> Ravenhall has been widely acknowledged and frequently applauded for the genuine and professional high standard of care afforded to men who present with complex health related issues. Ravenhall's integrated service delivery model brings together various stakeholders to discuss and resolve complex health related matters.

Medication assisted treatment of opioid dependence

374. GEO Group devoted a significant proportion of its response to the issue of access to MATOD.

375. The response expressed concerns that statements in the report by people in prison, Aboriginal organisations and public health experts do not reflect the complexity of the considerations around access to MATOD in a prison environment. GEO Group stated that some of the issues in correctional environments include people presenting with drug-seeking behaviours to try and access programs such as MATOD inappropriately. According to GEO Group, a person may not have an opioid addiction (they may have another type of drug addiction and be seeking a substitute) or they may also be vulnerable to being 'stood over' by other prisoners.

376. In response to comments by people in prison that there is unclear messaging about the requirements to access the MATOD program and that decisions to grant or deny access often appear arbitrary, GEO Group stated:

> Messaging [to] people in prison around the MATOD program is aimed at providing information of the services available and how services can be accessed including alcohol or other drug assessments. Aspects of a MATOD assessment relies on people in prison advising health professionals of their symptoms and alcohol and drug history. Prisoners are capable of providing 'textbook' answers informed by pre-published material around criteria in order to access MATOD — to the detriment [of] their own health.

377. Responding to discussions by people at Ravenhall about the how the requirements to access the program can have unintended consequences, GEO Group said:

> People in prison sometimes manipulate on how to commence the MATOD program with comments about needing to fail a urine drug test (be found to have opioids in your system through a random or targeted drug screen by correctional officers) or having visible opioid injecting scars on arms. While these may be indicators that a person is using opioids, there is no set 'checklist' criteria to be able to access MATOD. Access is based on a comprehensive health assessment by a Medical Practitioner that also considers collateral information from community providers.

378. GEO Group also said there was no delay in people who have been on a MATOD program in the community or regular drug users starting on MATOD when they first enter prison, stating:

> They are assessed by qualified medical practitioners who are trained to assess MATOD suitability and credentialed to prescribe MATOD. In the event they are not started on MATOD at reception, any withdrawal symptoms would be identified by a staff member.

379. GEO Group also said that medical practitioners making decisions about MATOD access in a prison setting do so in accordance with their qualifications, clinical training and addiction medicine guidelines, and must decide who would benefit from MATOD and who 'would be further harmed by supporting their drug-seeking behaviour'. It stated:

> It should be recognised that Medical Practitioners are often required to have difficult conversations with patients who are seeking an alternative for non-opioid addictions … people in prison seeking medications often place considerable pressure on Medical Practitioners to prescribe them specific medications, even when it may not be in the patient's best interest.

380. GEO Group stated that while it supports scrutiny of medical practitioner's decisions as part of quality improvement, this 'should be undertaken by other appropriately qualified health professionals on an individual case by case basis':

> Blanket and unsubstantiated statements that people in prison are not prescribed MATOD in a timely manner, or are over-prescribed, are not reflective of the complex environment where many dedicated health professionals are helping people in prison to achieve better health and wellbeing outcomes.

Mental healthcare

381. GEO Group described Ravenhall as 'the pinnacle location to where men in the Victorian prison system are transferred in order to receive specialist support for their mental health conditions':

> Ravenhall has been designed and specifically staffed to assist people with complex mental health conditions. The primary healthcare provider, CCA, has General Practitioners and Mental Health Nurses skilled at assisting people in prison with mental health conditions to remain stable and in good mental health … the centre also has in excess of over 100 full-time equivalent staff employed by Forensicare, the State's leading provider of specialist mental health services to the Victorian prison system — providing mental health services for people with acute mental health conditions. The centre includes 75 dedicated mental health beds sub-divided into acute, sub-acute, complex behaviours associated with mental health and mental health rehabilitation …
>
> Forensicare also provides a SASH [suicide and self-harm] risk assessment service at Ravenhall. All staff at Ravenhall are trained to recognise indicators that a person may be at risk of SASH. When a person in prison is exhibiting SASH indicators, the staff member is obligated to report this risk to Forensicare who then conducts a comprehensive at-risk assessment within two hours. Staff will stay with the person in prison until the patient is assessed. If the patient is assessed as being at risk of SASH, a risk management plan will be developed and implemented using the least restrictive measures as possible.

382. In response to the statement that people in prison told us of inhumane conditions in observation cells, GEO Group said:

> Placement in observation cells occurs only when there is significant immediate/imminent risk of self-harm, and the decision is part of the required processes across the system for the management of at-risk behaviours by people in prison. At Ravenhall, if someone is identified with ongoing SASH concerns, there is a range of therapeutic services that can support them including GEO Clinical Services, CCA Primary Health (Mental Health/ Psych Nurses), Forensicare ICM and Moroka Programs.

Trauma

383. GEO Group's response stated:

> Addressing trauma in a correctional setting focuses on symptom management through pharmacological interventions (and in some cases psychological support). However, the contracted primary health service model across the prison system has minimal psychological intervention for mental health issues which reflects a gap. Trauma counselling (involving exploring and processing trauma) would not routinely be undertaken in prisons due to the nature of the environment (and the additional safety and support for this in the community).

Ability to practice self-care

384. GEO Group said that items in its canteen at Ravenhall are regularly market tested to ensure prices are not sold above the recommended retail price 'to remain competitive and with all savings passed on to the men', while public prisons sell canteen items at the (lower) wholesale price. The response did not explain why GEO Group uses this method to price canteen items.

Making a complaint

385. In response to allegations by people in prison, including at Ravenhall, that making complaints is at best ineffective and at worst results in reprisals, GEO Group stated that access to complaint pathways within prisons is comparable to that in the community, with people in prison being provided a toll-free phone line to the Victorian Ombudsman and the Health Complaints Commissioner:

> The Victorian Health Complaints Commission advised GEO Healthcare that 964 complaints were lodged with the Commission during 2022/23 by prisoners concerning healthcare within the Victorian prison system.

386. The response also noted that the relevant health accreditations for service providers in Victorian prisons require them to have appropriate complaints handling processes, including ensuring that people in prison are informed about how to make a complaint.

Forensicare

387. Forensicare provides secondary mental health services at all prisons except for Fulham Prison, and also provides primary mental health services at MAP.

388. Forensicare said:

> We would like to take this opportunity firstly to express our support of this critical work. Our position as a major provider of mental health services in Victorian Prisons, across time, enables Forensicare a unique perspective on challenges and improvement opportunities relating to access, continuity, and quality and safety of health service provision in custody.

389. It stated that Forensicare endorsed any direction that addressed:

> … the provision of culturally safe and accessible healthcare to Aboriginal people in prison, regardless of a person's location or status as a remanded or sentenced prisoner.

390. Forensicare also expressed its support for an increased role for ACCHOs in the delivery of healthcare to Aboriginal people in prison:

> Forensicare notes multiple recommendations from inquiries and investigations support the role of Aboriginal Community-Controlled Health Organisations … becoming more central in the provision of health care to Aboriginal people in prison. We would welcome the opportunity to work in partnership with ACCHOs in supporting self-determination in the design and delivery of care. Forensicare also notes the non-health specific services provided in the prison setting, such as forensic intervention services, which are aimed at supporting holistic wellbeing and safe reintegration into the community upon release.

Caraniche

391. Caraniche provided AOD programs in Victoria's public prisons until 30 June 2023. At the time of the prison visits, it was the AOD provider at MAP and DPFC. It had no role at Ravenhall.

392. In its response to a draft of this report, Caraniche advised:

> At DPFC we provided a range of health and criminogenic AOD programs, including an accredited Therapeutic Community that offered longer term AOD rehabilitation. At MAP, we provided single session harm reduction sessions and very brief interventions focussed on reducing drug related harm due to the limited time prisoners stayed at MAP. The type and number of programs we delivered was determined by Justice Health.

393. Caraniche indicated its support for culturally safe and appropriate AOD programs for Aboriginal people, stating:

> During our tenure in the Victorian prisons system, Caraniche worked with Aboriginal advisors to develop a 42-hour Koori AOD program that combined cultural learning, art and song with AOD treatment and was co-facilitated by a clinician and an Aboriginal Elder … The program was run in Loddon and Barwon and evaluations show that it was effective and highly valued by participants. Unfortunately, the delivery was not extended to other prisons and during [the COVID-19 pandemic] the program was suspended and lost momentum.
>
> During our transition out of the Victorian Prison System Caraniche advocated for the Koori program to be retained and handed over to an Aboriginal controlled agency to deliver. Caraniche and VAHS have been in an ongoing dialogue with the goal of having VAHS take over delivery of the program, unfortunately there has been little interest from Corrections Victoria or Justice Health.

394. Caraniche also stated that it had recommended the development of a Koori Women's AOD program similar to the men's program to Justice Health in 2018.

395. Caraniche told the investigation that since it ceased providing services in the public system, AOD treatment is split between the primary healthcare providers and Corrections Victoria. Caraniche believes the separation of AOD treatment 'is likely to reduce outcomes for all prisoners, including Aboriginal prisoners'.

396. Caraniche explained that this is because:

> The previous AOD model offered a holistic service from harm minimisation and drug education through to psychosocial programs and criminogenic treatment that address drug related offending. It enabled clients to be engaged at multiple points of the change cycle to build motivation and deliver continuity of care. Prisoners could self-refer for treatment that was provided by specialist AOD clinicians. The treatment pathway addressed a range of underlying issues including trauma, relationship issues, childhood abuse or neglect etc.
>
> The new model implemented by Justice Health and Corrections Victoria separates the Health AOD programs (drug awareness and drug education) from the criminogenic programs. The health AOD programs are delivered by the Primary Health services and the criminogenic AOD program delivered by [Corrections Victoria's] Forensic Interventions Service which services higher risk offenders. Both services have other priorities and AOD is not their core business.

397. Caraniche acknowledged that there may be benefits from linking the health-run MATOD program more closely to AOD programs, but is concerned that the new system may result in lower-risk offenders having reduced access to AOD treatment.

The Department

398. In its response to a draft of this report, the Department emphasised that the investigation spoke with Aboriginal people at DPFC, MAP and Ravenhall in May 2023 before significant changes to healthcare provision in the public prisons (including DPFC and MAP, but not Ravenhall) came into force on 1 July 2023.

> [The Department] notes that the timing of the interviews means that many of the quotes and case studies relate to experiences under the previous service model and/or providers and that a number of substantial changes have since been made since the [Ombudsman] conducted their interviews. These include:
>
> - expanding eligibility for MATOD
> - changes to AOD program delivery
> - increased numbers of Aboriginal health practitioners
> - enhanced requirements on providers to partner with patients in the planning, design, measurement and evaluation of services.

399. The Department's response stated that some of the comments and case studies do not accurately represent issues and potential solutions and do not provide enough context about broader health system challenges, such as workforce shortages (especially in regional areas) and wait times for specialists and treatment at public hospitals.

400. It also said that some of the stories told by people in prison that appear to indicate service gaps may simply be the result of poor communication between health service providers and patients. Examples cited by the Department as opportunities to communicate better are explaining to patients about the safety risks of prescribing medication without adequate information from community health services, and being clear what services are dependent on public hospital waiting lists.

Access to culture, Country and spirituality

401. In response to comments by Aboriginal people at DPFC about limited access to cultural supports at the prison, the Department said that a range of cultural programs and services focused on healing are available for Aboriginal people in custody there, and that the prison has 'the highest number of cultural programs offered of all locations statewide'. Further details of such programs can be found in Appendix 5.

402. In response to comments by Aboriginal people in prison about limited access to Elders, the Department advised that it formally engages Elders to visit prisons regularly, in addition to Elders who may be engaged as part of program and service delivery through external providers. The Department stated that at DPFC, this includes two Yawal Mugadjina Elders, who visit monthly, while Ravenhall also offers an Elders visiting program. The Department stated:

> Elders who visit locations will not be from the same mob as all Aboriginal people in prison, however it is not realistic to expect Elders from every mob across the state (or country) to reach into their community members in prison. If a person was engaged with an Elder in particular, they can arrange a visit (in person or remotely) via the Aboriginal Wellbeing Officer.

Aboriginal programs staff

403. The Department's response recognised the 'critical and multifaceted role' played by Aboriginal Wellbeing Officers in Victoria's correctional system and stated that while Corrections Victoria has previously struggled with recruitment and retention of AWOs, 'current Aboriginal staffing numbers are at the highest level they have been for some time'.

> In recognition of the importance of the role for Aboriginal people in prison, and to respond to the cultural load and burnout impacting AWO staff wellbeing and their continued interest in the role, Corrections Victoria has developed a recruitment and retention strategy … designed to build on current initiatives to create a system wide approach to the successful and sustainable recruitment and retention of [AWOs]. The strategy has been developed in consultation with staff, as well as Aboriginal community stakeholders as required through commitments under the Aboriginal Justice Agreement.

404. The Department noted that the strategy directly supports Recommendation 5.15 of the Cultural Review concerning the attraction, retention and support of AWOs.

Connection to family and community

405. In response to comments that people were sometimes abruptly taken off medication, such as antidepressants, the Department stated that all people entering custody are required to receive an initial reception health assessment within 24 hours. This includes a review by a GP and identifies the patient's treatment requirements, including medication.

406. The Department noted that where a patient identifies they have been prescribed a medication in the community, the GP will 'exercise clinical judgement to determine whether collateral information is necessary in order to continue the prescription or whether the medication can be prescribed without this information'.

> Some medications have significant side effects/risks and/or are prescribed in increasing doses to ensure the patient is able to tolerate the full dose. Generally, these types of medications will not be continued on entry into custody until collateral information is obtained to confirm current dosage. All health service providers have processes in place to support prompt requests of collateral information. How soon this information is obtained is dependent on how quickly the community provider responds to the requests.

Housing upon release

407. The Department acknowledged the significant unmet demand for affordable housing for people exiting prison and stated:

> The housing and homelessness portfolio is located and led within the DFFH. To support linkages into the broader housing system, DFFH-funded Initial Assessment and Planning Workers are based at prison locations. [The Department] provides some smaller scale, specific housing responses that supplement the DFFH response however, with approximately 40 per cent of people in prison without long term sustainable housing, there remains significant unmet demand for housing supports for people engaged with the justice system. Corrections Victoria housing initiatives include the following:
>
> - 76 transitional housing properties for people exiting prison that have been assessed as having complex and high reintegration needs and face particular barriers to obtaining accommodation within the broader housing system.
> - A brokerage program that assists to establish or maintain properties for tenants who have returned to prison on remand or for short sentences.
> - The Baggarrook Aboriginal Women's Transitional Housing Program, an Aboriginal led response for Aboriginal women, including a property to accommodate up to six women, with a fully integrated Aboriginal case management service.
> - A program targeted for women on remand or with short sentences, providing housing assessment, advice, referral, advocacy, and funding to eligible women as well as case planning and referrals to meet needs parallel to housing such as family violence, alcohol and other drugs, mental health and other support needs.
> - The Maribyrnong Community Residential Facility, which provides accommodation for men exiting prison or involved with Community Correctional Services, including a fully integrated case management service provided by a community agency. The residential facility is able to accommodate up to 42 men, providing housing stability that encourages residents to make pro-social decisions to increase their chances of successful rehabilitation and reintegration.

408. In response to this comment, DFFH confirmed that it is responsible for, and committed to, supporting people experiencing or at risk of homelessness. Through its Corrections Housing Pathways Initiative, Homes Victoria provides assessment and planning services to support people exiting prison at risk of homelessness. Homes Victoria is also piloting an Aboriginal Corrections Housing Pathway Initiative which aims to deliver culturally safe, tailored responses for Aboriginal people exiting correctional facilities. DFFH said it is:

> not able to comment on the [Department of Justice and Community Safety] statement regarding the percentage of people in prison without sustainable housing nor to the significant unmet demand for housing support referenced. Homes Victoria is not provided with data regarding individuals leaving the prison system. However, anecdotally, this figure is likely a lot higher. Homes Victoria will explore with [the Department of Justice and Community Safety] the prevalence of housing need to inform future housing demand modelling and responses.

Physical, emotional and mental wellbeing

Delays and wait times

409. According to the Department:

- Wait times for custodial health services vary depending on need.
- Patients with urgent or suspected urgent health or mental health needs are prioritised.
- All new receptions and transferring prisoners receive a health assessment within 24 hours of arrival.
- For non-urgent self-referrals the following targets apply:
  - Registered Nurse – 3 Business Days from the date of referral
  - Medical Practitioner – 10 Business Days from the date of referral

Quality of care

410. In response to a group at Ravenhall who said it is difficult to even obtain a Panadol, the Department said the process for distributing Panadol is not restricted to individual days:

> Requests for Panadol can be made at any time via prison officers or directly to health staff. Health staff must approve all distribution. Where appropriate, doctors can prescribe packs of Panadol, allowing prisoners to collect a week's supply. These additional measures are taken in custodial settings to reduce the risk of misuse.

Continuity of care

411. In response to the section of the draft of this report dealing with comments by people in prison about continuity of care, the Department stated:

- Custodial healthcare focuses on primary health and primary and secondary mental health services.
- People in custody who require specialist services are referred to the public health system. Access to the public health system is not prioritised for custodial patients and they are subject to the same waiting lists as all other Victorians.
- All healthcare service providers are required to undertake health assessments within 24 hours of a patient transferring to their facility. These assessments including identifying any appointments or referrals that need to be rescheduled.
- Referrals may need to be resubmitted where the transfer results in a change in the specialist provider.
- How appointments are prioritised where patients have moved prison location are decisions made by the relevant community provider.

Roles and responsibilities

412. In response to statements by people in prison that some medical and custodial staff inappropriately disclosed their private medical information, the Department stated that health service providers are required to respect the privacy of health information.

413. The Department also noted that there are some limits to confidentiality where there are identified risks to health and safety, for example the availability of unsecured needles within a custodial facility.

Dental services

414. The Department noted that access to public dental services is an issue within the broader community, with data from the Victorian Agency for Health Information indicating that at 30 September 2023 waiting times for public general dental services were 16 months.

415. The response added that the new primary health service delivery model [in the public prison system] included enhancements to dental access, and that all service providers are required to provide urgent general services.

The Victorian prison system

416. In Victoria, the establishment, management and security of prisons as well as the welfare of people in prisons, is regulated by the *Corrections Act 1986* (Vic). The Act does not mention the cultural rights or cultural safety of Aboriginal people and does not refer to equivalency or continuity of healthcare.

417. The Corrections Act affords all people in prison:

- the right to have access to reasonable medical care and treatment necessary for the preservation of health including, with the approval of the principal medical officer but at the prisoner's own expense, a private registered medical practitioner, dentist, physiotherapist or chiropractor chosen by the prisoner
- if intellectually disabled or mentally ill, the right to have reasonable access within the prison or, with the Governor's approval outside a prison, to such special care and treatment as the medical officer considers necessary or desirable in the circumstances
- the right to have access to reasonable dental treatment necessary for the preservation of dental health.

418. Across Victoria, there are 11 public prisons, which are run by the Department, and three private prisons, run by private companies under contract to the Department. Corrections Victoria is the unit within the Department responsible for the oversight of all prisons.

419. Australia has the highest rate of private incarceration in the world. In 2020-21, one in five Australian prisoners were held in private prisons.

420. Within Australia, Victoria has consistently had the largest proportion of prisoners housed in private prisons. In 2021-22, almost two in five of Victorian prisoners were held in private prisons.

421. This means that the healthcare provided to the almost 40 per cent of people in Victorian prisons is subcontracted through private for-profit prison operators.

Healthcare in prison

422. Prisons, including the provision of healthcare within them, are a State Government responsibility.

423. People in prison do not have access to Medicare and the Pharmaceutical Benefits Scheme, which are federally funded.

424. Justice Health is a business unit of the Department and is responsible for the delivery of health services in Victoria's prisons.

425. In many other countries and some states of Australia, prison healthcare is administered through health departments, not justice departments, an arrangement recommended by the World Health Organisation.

Healthcare providers

426. In Victoria, prison healthcare is contracted to a mixture of public providers and private companies. These contracts are managed by Justice Health in public prisons, but in private prisons healthcare contracts are managed by the company that operates the prison rather than the State, with oversight from Corrections Victoria's Contracts and Infrastructure Branch.

427. Prison primary healthcare contracts detail how care must be provided and what standards are expected. Primary healthcare is the type of care normally provided by a General Practitioner and excludes specialist services like podiatry or optometry. In Victorian prisons, primary health services include health assessment and planning, alcohol and other drug treatments, dental services and medication management.

428. Before 30 June 2023, all public prison primary healthcare services were provided by private company CCA. From 1 July 2023, new public prison contracts held by new healthcare providers began.

Figure 11: Healthcare providers in Victorian prisons from 1 July 2023

Prison	Prison type	Provider type	Healthcare provider
Public prisons			
Barwon Prison	Male	Private	GEO Healthcare
Beechworth Correctional Centre	Male	Private	GEO Healthcare
Dhurringile Prison	Male	Private	GEO Healthcare
Hopkins Correctional Centre	Male	Private	GEO Healthcare
Langi Kal Kal Prison	Male	Private	GEO Healthcare
Loddon Prison	Male	Private	GEO Healthcare
Marngoneet Correctional Centre	Male	Private	GEO Healthcare
Melbourne Assessment Prison	Male	Private	GEO Healthcare
Metropolitan Remand Centre	Male	Private	GEO Healthcare
Dame Phyllis Frost Centre	Female	Public	Western Health
Tarrengower Prison	Female	Public	Dhelkaya Health
Private prisons			
Ravenhall Correctional Centre	Male	Private	CCA
Fulham Correctional Centre	Male	Private	GEO Group
Port Phillip Prison	Male	Private	St Vincent's Correctional Health Services

Source: Victorian Ombudsman

Healthcare services and access

429. All prisons in Victoria have an on-site health centre, with staff including nursing staff, mental health nurses and general practitioners. Each of the three prisons (see Figure 7) we visited has a forensic mental health unit or units operated by Forensicare.

430. Mental healthcare consists of primary mental healthcare (mental health nursing, triage and referral to specialist services) and secondary mental health services (specialist outpatient services, visiting clinics and voluntary acute and sub-acute mental health custodial unit-based care).

431. Forensicare is contracted to provide secondary mental health services to all Victorian prisons except Fulham Prison. It also provides primary mental health services at MAP. At all other prisons, primary mental healthcare is provided by their respective primary healthcare provider.

432. In its response to a draft of this report, Forensicare noted that it:

> has previously advocated for the Department of Justice and Community Safety to consider Forensicare as the provider of primary mental health services at least at all Reception prisons (namely MAP, [the Metropolitan Remand Centre], [Ravenhall] and DPFC), in order to assist with continuity of mental health care across the system.

433. People in prison generally have to be seen by a nurse in order to see a doctor. Processes for seeking medical attention vary between prisons. To book appointments, people in some prisons can contact the medical team directly, others must go through a prison officer. Some prisons have a locked box for medical request forms, in others these forms are delivered through prison officers.

434. At Ravenhall, people can submit a medical request directly to the health service via an in-cell device or through a paper form. Requests submitted through the in-cell device are monitored by CCA's administration team and a nurse-in-charge to prioritise requests. Paper forms can be submitted to the pharmacy technician/nurse during routine medication rounds and are then provided to the CCA administration team and nurse-in-charge for action.

435. At DPFC, people must request a medical appointment by submitting a form to custodial staff, who pass it on to the health service. The forms can be obtained from information boards, display areas, or from custodial staff.

436. People at MAP can request medical treatment by placing a form in locked boxes in their unit. The prison advised that these are checked by health service staff 'at least daily' and then triaged.

437. At MAP and DPFC, if a person is locked in their cell and requires medical attention, they can only request help through prison officers, through the in-cell intercom, who will contact medical staff if they consider it necessary.

438. On entry to prison, health staff are required to conduct a physical and mental health assessment of the individual's health and medication needs. An individual's physical and mental wellbeing is meant to be reviewed by health staff if they are transferred between prisons.

439. Access to services differs across locations. Some health services – for example dental and allied health – are not available at every prison, and a person may need to be transferred to another location for an appointment. Similarly, people may be transferred to other locations for a secondary health service, such as a specialist appointment or surgery. Follow-up, an essential aspect of healthcare, can be disrupted by people moving between prisons.

440. There are restrictions on medications that can be prescribed to people in prison to prevent certain drugs being traded.

441. People in prison have a right to make complaints, including about access to healthcare and its quality. People can complain:

- directly to the health service
- to the General Manager of the prison via a written complaint
- to Justice Health via a written complaint, which prison staff are prohibited from opening or reading.

442. There are also several external complaint avenues, which people in prison are entitled to contact confidentially and are exempted from monitoring by the prison. All people in prison can contact these bodies free from the phone system in each prison; the calls are not monitored by prison authorities. People in prison can complain to:

- the Victorian Ombudsman regarding access to healthcare
- the Health Complaints Commission regarding clinical matters
- the Mental Health and Wellbeing Commission regarding mental health complaints
- the Independent Broad-based Anti-Corruption Commission regarding improper conduct and corrupt conduct.

Justice Health

443. Justice Health is responsible for the delivery of health services in Victoria's prisons. Its key responsibilities are to:

- set the policy and standards for health care in prisons
- contract manage the health service providers in the public prisons
- monitor and review health service provider performance across public and private prisons
- facilitate an integrated approach to planning and service delivery
- lead health prevention and promotion activities
- facilitate the release of health information to community health care providers, legal representatives and individuals.

444. In 2015, Justice Health released the *Aboriginal Social and Emotional Wellbeing Plan* (detailed in Appendix 3).

445. One of the commitments in the plan was the recruitment of a Clinical Aboriginal Consultant to 'provide a secondary consultation service and advice to health staff working with Aboriginal prisoners'. This position was adapted to be a Clinical Governance Officer – Aboriginal Health ('Aboriginal Clinical Governance Officer') in 2017. The person in the role at that time had no clinical experience. During their time in the role they drafted Aboriginal Cultural Safety Standards.

446. The position was a 12-month position and after the position became open again a new Aboriginal Clinical Governance Officer was not employed until 2019. They were responsible for finalising and trialling the standards, but again the role was only for 12 months and they left the role without the standards having been rolled out. The position remained open again until September 2020.

447. The Aboriginal Clinical Governance Officer who took the position in 2020 finalised the Aboriginal Cultural Safety Standards and initiated and designed projects like the Strengthening Aboriginal Custodial Health Care Project of 2021 (detailed in Appendix 3).

448. They also continued to handle clinical governance issues regarding Aboriginal people, as the sole Aboriginal employee in that role. This role involved working on a 24-hour rotating on-call roster, responding to hospital transfers or code blacks for Aboriginal prisoners, reviewing medical files, providing advice on best practice approaches and working with other specialist Clinical Governance Officers.

449. Until 2020 there was only one staff member working on Aboriginal health within Justice Health at any one time.

450. This changed after the 2021 death of a 41-year-old Aboriginal man, Michael Suckling, at Ravenhall. Justice Health subsequently created an Aboriginal Custodial Health team, made up of one manager (who also continued to work in a clinical governance role) and two project and policy officers.

Michael's story

Michael Suckling was a 41-year-old Aboriginal man who died at Ravenhall on 7 March 2021. On the morning of 5 March 2021, a code black was called when Michael was found in his cell with impaired motor skills and the right side of his face drooping. He died two days later.

Michael had been serving a sentence of 10 years and three months for culpable driving causing death. Michael had ongoing pain from the injuries he sustained in the accident and was prescribed pain medication for his injuries. He also suffered from depression and post-traumatic stress disorder. When he went into custody Michael weighed 82 kilograms. He weighed 199 kilograms when he died.

There is an ongoing Coronial inquest into the causes of Michael Suckling's death.

VALS described Michael as 'a loving father, son and brother. Michael was known for his sense of humour and loved having a laugh with his family and mates'.

451. In January 2023, Justice Health introduced a new Aboriginal Health Unit, which consists of a Director and five team members. The Director position is a designated position, meaning it must be filled by a person who identifies as Aboriginal, and for the other roles it is preferred. The Unit does not have any clinical governance roles, nor do any of the roles require clinical experience.

Human rights in prison

452. Various government agreements at the international, national and state level protect the rights of Aboriginal people, including their cultural rights, and the rights of people in prison to equivalence of healthcare.

International agreements

453. Australia is a signatory to a range of human rights laws and instruments. These include the:

- Universal Declaration of Human Rights
- International Covenant on Civil and Political Rights ('ICCPR')
- International Convention on the Elimination of All Forms of Racial Discrimination
- UN Declaration on the Rights of Indigenous Peoples ('UNDRIP').

454. Article 1 of the ICCPR enshrines the right to self-determination for all peoples – to determine their 'political status and freely pursue their economic, social and cultural development'.

455. The meaning of self-determination is further reinforced for Indigenous Peoples by UNDRIP.

Figure 12: Select UNDRIP provisions

Article 2: Freedom from discrimination based on Indigeneity and identity, and in addressing disparities

Article 3: The right to self-determination including social and cultural development

Article 4: The right to autonomy and self-government in internal and local affairs

Article 5: The right to maintain and strengthen political, legal, economic, social and cultural institutions

Article 8(2): States shall provide effective mechanisms for prevention of, and redress for any action which has the aim or effect of depriving them of their integrity as distinct peoples, or of their cultural values or ethnic identities

Article 11: The right to practise and revitalize their cultural traditions and customs

Article 15: States shall take effective measures, in consultation and cooperation with the indigenous peoples concerned, to combat prejudice and eliminate discrimination

Article 16: Indigenous peoples have the right to participate in decision-making in matters that affect their rights

Article 23: The right to be actively involved in developing and determining health and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Source: UN Declaration on the Rights of Indigenous Peoples

Nelson Mandela Rules

456. The United Nations Standard Minimum Rules for the Treatment of Prisoners, known as the Nelson Mandela Rules, were adopted by the United Nations General Assembly in December 2015. They recognise that people in prison must be provided with equivalency and continuity of healthcare.

457. Rules 24 to 35 relate to prison health services. Rule 24 states:

> 1. The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.
>
> 2. Health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence.

Victorian legislation

458. The *Charter of Human Rights and Responsibilities Act 2006* (Vic) ('Charter of Rights Act') applies to public authorities such as Government departments and public prisons. It also applies to private organisations contracted to carry out state functions, including private prisons and private healthcare providers in prisons. It requires public bodies to properly consider and comply with human rights. Decisions that do not meet this test are unlawful.

459. The Charter of Rights Act enshrines the right to life (section 9), the right to humane treatment when deprived of liberty (section 22) and the right to freedom from torture, cruel, inhuman and degrading treatment (section 10). It recognises that:

> human rights have a special importance for the Aboriginal people of Victoria, as descendants of Australia's first people, with their diverse spiritual, social, cultural and economic relationship with their traditional lands and waters.

460. Section 19(2) protects the cultural rights of Aboriginal people:

> Aboriginal persons hold distinct cultural rights and must not be denied the right, with other members of their community –
>
> (a) to enjoy their identity and culture; and
>
> (b) to maintain and use their language; and
>
> (c) to maintain their kinship ties; and
>
> (d) to maintain their distinctive spiritual, material and economic relationship with the land and waters and other resources with which they have a connection under traditional laws and customs.

461. The Charter of Rights Act also provides that 'measures taken for the purpose of assisting or advancing persons or groups of persons disadvantaged because of discrimination, do not constitute discrimination'.

Previous reviews related to Aboriginal healthcare in prison

462. For more than 30 years, numerous national and state-based bodies have investigated the causes of poor Aboriginal health outcomes and deaths in custody.

463. Further details about each of these reviews is contained in Appendix 4, but what is striking is how similar many of their findings are. They also echo what we heard from Aboriginal people in prisons and from Aboriginal organisations.

Figure 13: Previous reviews that made recommendations about Aboriginal healthcare in prison

Source: Victorian Ombudsman

464. According to the Cultural Review:

> Without exception, every Aboriginal person in custody that we spoke to reported serious challenges in accessing medical treatment including an overwhelming sense that they had no control over their health needs. We heard many stories of people living in custody with chronic pain that was poorly treated, under recognised, dismissed and which over time, in addition to the physical pain, resulted in anxiety, depression and emotional instability. Aboriginal people in custody are more likely to experience health issues and chronic disease. Aboriginal people are also likely to experience further barriers to accessing healthcare given the impact of trauma, dispossession, family separation, systemic racism, and stigma.

465. The Yoorrook Justice Commission reported:

> Aboriginal prisoners told of significant delays in being able to see a doctor, a dentist or mental health practitioner, and of being denied medical care and medication, including pain relief like Panadol and Nurofen for acute pain. They expressed frustration that health practitioners assume they want medication to get high, when they really need it to manage pain and address underlying health issues. Yoorrook heard that you 'needed to be "half-dead" to see a doctor … prison officers should not determine whether or not prisoners see a doctor or nurse'.

466. All of these reviews made recommendations about how to improve healthcare in prisons, and many have made the same recommendations over the years. Yet Aboriginal people continue to be over-represented in the criminal justice system, experience worse health outcomes and die in custody at higher rates than non-Aboriginal people, often due to inadequate provision of healthcare.

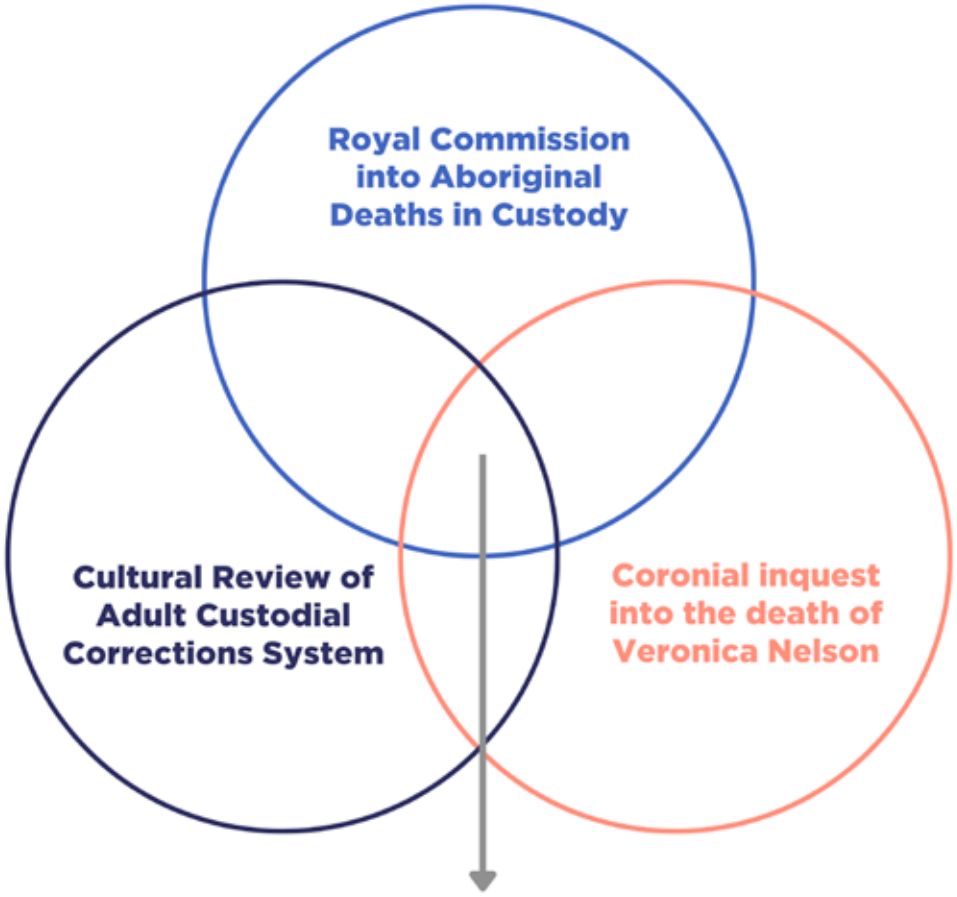
467. In his January 2023 finding into the death of Veronica Nelson, the Coroner said:

> Governments have had the answers to the problems identified in Veronica's case for over 30 years. The findings and recommendations of [the 1991 Royal Commission] were reasonable and implementable, and they should have resulted in the type of widespread systemic changes that could have prevented the tragedy of Veronica's passing from occurring.

468. In 2018, the Australian Government reviewed the implementation of the 1991 Royal Commission's recommendations and found that most had been partially or fully implemented. However, the Coroner noted that the fact his recommendations overlapped those of the 1991 Royal Commission suggested that any implementation that had occurred had 'achieved too much policy, and not enough change'.

469. One of the fundamental recommendations – made by 1991 Royal Commission, the Cultural Review and the Veronica Nelson Inquest – was that prisons needed Aboriginal models of healthcare, led by ACCHOs.

Figure 14: Key health-related recommendations



Previous recommendations

Over the last 30 years, the most prominent enquiries into Aboriginal deaths in custody have made recommendations with consistent themes:

1. Prison health standards must be updated to include and embed cultural safety.
2. Aboriginal organisations must be engaged as decision-makers about healthcare practices and not merely consulted.
3. Aboriginal health providers get better health outcomes and should provide healthcare in the prison system.
4. Funding for Aboriginal-led health services must be increased to meet these recommendations.

Source: Victorian Ombudsman

Aboriginal models of healthcare

470. The Aboriginal people and organisations we consulted strongly advocated that for Aboriginal people, equivalent and culturally safe healthcare means care that is delivered by ACCHOs.

471. The Victorian Government has also articulated this principle, for example in the *Victorian Aboriginal Affairs Framework* and the *Victorian Closing the Gap Implementation Plan* (both detailed in Appendix 3).

472. This aligns with the findings of the Royal Commission, the Coroner, the Cultural Review and the Yoorrook Justice Commission, as well as with recent research.

473. For example, a 2018 study from the South Australian Health and Medical Research Institute found that ACCHOs are considered more effective than mainstream services because they offer local community-controlled supports, strengthening local cultures and values, and operating in a comprehensive way with follow-up care. Research commissioned in 2014 by the National Aboriginal Community Controlled Health Organisation ('NACCHO') found that ACCHOs are efficient, effective services for Aboriginal people.

ACCHOs

474. More than 140 ACCHOs operate across Australia. They are organised regionally, in state and territory jurisdictions, and nationally, coordinated by NACCHO.

475. According to NACCHO's 2021 pre-Budget submission, over half of staff in ACCHOs identify as Aboriginal, span three to four generations and are diverse in terms of gender, location, experience and training.

476. NACCHO's submission describes ACCHOs as designed to centre Aboriginal cultures, particularly respecting the Aboriginal definition of health. Services are self-determined by local boards of governance of Aboriginal people, including Elders and based on local cultural protocols.

477. A 2010 study by the University of Queensland and Deakin University found that ACCHOs are cost-effective in that their work results in greater health benefits per dollar spent. NACCHO states that:

> The lifetime health impact of interventions delivered by our services is 50% greater than if these same interventions were delivered by mainstream health services, primarily due to improved Indigenous access.

What ACCHOs provide

478. The Lowitja Institute describes itself as Australia's only Aboriginal community-controlled health research institute. In 2020, the Lowitja Institute interviewed ACCHO workers for its *Aboriginal and Torres Strait Islander Health Career Pathways Project.*

479. These workers described ACCHOs as being uniquely placed to provide culturally safe healthcare, overcome barriers to Aboriginal people accessing health services and bridge gaps in understanding between Aboriginal patients and non-Aboriginal healthcare providers:

> … understanding the hardships that our mob go through, we've all lived it, we all understand where aunties and uncles and grandparents and our ancestors before us, you know, what they went through and so you've got that intergenerational understanding of the hardships and the challenges. *(Manager, ACCHO)*

> I think we're really good at advocating for our patients should they need outside services. We always take that work on. *(Worker, ACCHO)*

> Living in two worlds … you're living in the medical terminology, you know, the academic terminology, the Westminster education terminology. And you're also living in your own community knowledge and communication styles, which is important. And the best people to do that is our grass-roots people coming through. *(Worker, ACCHO)*
>
> There's the spiritual knowledge that we carry in regards to the deep stuff with our people, the going back to Country, the saying hello to the spirits, the walking through the creek … that is part of us, and when you look at that from a healing point of view it helps the western healing things line up with the spiritual and the cultural healing side of things. *(Worker, ACCHO)*

480. In submissions to the investigation, VACCHO, VALS and the AJC outlined what is different about the care provided by ACCOs compared to mainstream services. According to VACCHO:

> ACCOs have a deep understanding of the cultural and healthcare needs of Aboriginal communities and can provide culturally appropriate care. Directly contracting ACCOs ensures that healthcare is tailored to the specific needs of Aboriginal people and respects their cultural values and traditions.

481. VACCHO pointed to the example of the Prison Support Program for Aboriginal women at DPFC and Tarrengower prison run by Djirra, an ACCO that focuses on supporting Aboriginal women and children. According to the Yoorrook Justice Commission's report, the program provides:

> access to legal support, case management support, post-release support and culturally appropriate services that address complex individual needs … legal and non-legal support for Aboriginal women in prison who have experienced or are at risk of experiencing family violence.

482. VACCHO told the investigation that Djirra's Prison Support Workers:

> work to address the unique challenges faced by Aboriginal prisoners, who often experience intersecting issues related to trauma, family violence, mental health, and cultural disconnection. By building trusting relationships with prisoners, these workers help navigate the complexities of the criminal justice system and provide emotional support. Djirra's Prison Support Workers play a vital role in improving outcomes for Aboriginal prisoners by providing tailored support, advocacy, and culturally sensitive assistance within the prison system.

483. The AJC told the investigation:

> The trust developed between ACCHOs and their clients in the provision of custodial healthcare would enable and encourage continuity of care, connecting people in with their community health providers. On a broader scale, this connection can encourage people to address underlying causes of offending over time which reduces recidivism and increases community safety …
>
> The evaluation of [the Aboriginal Justice Agreement Phase 3] found successful programs under the [Aboriginal Justice Agreement] employ Aboriginal staff who are known in the community, respected and trusted by program participants, highly motivated, well-trained, and skilled at providing cultural support to clients. These workers 'walk between the two worlds' of community and government and act as a mediator and sometimes translator for both. Successful programs resource workers adequately and provide supports to manage cultural loads and vicarious trauma.

484. VALS stated:

> We strongly support the Cultural Review's recommendation for the Government to commission an Aboriginal organisation to develop a model of healthcare for Aboriginal people in custody. In our view, this is the only way that culturally safe healthcare can be practically implemented, and based on the experience of ACCHOs in other jurisdictions. VALS believes it is vital that ACCHOs delivering healthcare in prisons have their own governance model and are not overseen by generalist service providers.

ACCHOs working in prisons

485. There are already some custodial health services being delivered by ACCHOs in Victoria and elsewhere in Australia.

In Victoria

486. In August 2023, Victoria's Cherry Creek Youth Justice Centre opened. Health services at Cherry Creek are provided by a public health service, Barwon Health, in partnership with a local ACCO, the Wauthorong Aboriginal Co-Operative.

487. In September 2023, the Department opened an Aboriginal Healing Unit at DPFC, which provides cottage-style accommodation for up to 12 Aboriginal women. An ACCO, Elizabeth Morgan House, will deliver programs and services in the unit and be onsite five days a week. These will include individual therapeutic support, cultural mentoring by Elders and Respected Persons, group-based cultural activities and programs and transition planning and referrals for post-release support.

488. Other programs delivered by ACCOs and ACCHOs in Victorian prisons are summarised in Appendix 5.

Interstate

Don Dale Youth Detention Centre (Northern Territory)

489. A Northern Territory ACCO, Danila Dilba, provides healthcare to children in the Don Dale Youth Detention Centre. In addition to clinical health services, Danila Dilba offers holistic services to the children and their families. For example, its Youth Support program offers 'therapeutic group work and one-on-one support', after-hours and weekend sports and recreation activities, and a 'Balanced Choices in Life' program.

490. Danila Dilba also offers paralegal support for children attending court, working with families to provide 'a more rounded picture of the young person's background that may have caused them to become caught up in the criminal justice system'. Its youth workers support children and families affected by the 2017 *Royal Commission into the Protection and Detention of Children in the Northern Territory*, which investigated human rights abuses at Don Dale.

Alexander Maconochie Centre (Australian Capital Territory)

491. The Alexander Maconochie Centre is the Australian Capital Territory's only prison, holding people of all genders, sentenced and on remand and with security ratings from minimum to maximum.

492. Since 2019, healthcare services for Aboriginal people at the prison have been provided by an ACCHO, Winnunga Nimmityjah Aboriginal Health and Community Services ('Winnunga') through its onsite independent health and wellbeing service. This came about because of a recommendation made by an independent inquiry into the death of an Aboriginal man at the prison in 2016.

493. An evaluation of Winnunga's Alexander Maconochie Centre service surveyed 16 patients (ten men and six women) who accessed Winnunga's services from February to March 2020, out of 26 who were eligible. The survey states that it was the first ever evaluation of patient satisfaction at a prison health service operated by an ACCHO.

494. All 16 respondents reported that they felt that they were treated with dignity and respect and all but one reported that their religious and cultural beliefs were respected by staff.

495. Respondents reported high satisfaction with Winnunga's services, with 13 saying they 'would change nothing about the service' and 8 saying there was 'nothing they would improve'.

496. The study concluded that Winnunga is capable of providing 'highly satisfactory, timely, respectful, and culturally safe care to its patients and contribute to the growing "precedent" for other Australian jurisdictions to utilise holistic models of ACCHO-led prison healthcare'.

Government policies and commitments

497. A range of policies, agreements and standards commit the Victorian Government to recognising and enabling self-determination of Aboriginal people and ensuring its services are culturally safe and responsive.

498. Many of these documents commit the Government to providing healthcare to Aboriginal people that:

- is holistic
- is culturally safe
- is continuous
- is equivalent to community standards
- promotes rehabilitation and addresses over-representation of Aboriginal people in the prison system
- is delivered in partnership with Aboriginal communities and in accordance with principles of self-determination.

499. In addition to these, all Victorian prisons are subject to the Commissioner's Requirements, a high-level set of operating instructions for prisons. Public prisons are also subject to the Deputy Commissioner's Instructions, while private prisons each have their own Local Operating Instructions. All of these documents include some directions specific to Aboriginal people in prison.

500. Below, some of the key documents listed in Figure 15 are explained in more detail. Further information on the other documents mentioned above can be found in Appendix 3.

Figure 15: Documents relating to Aboriginal healthcare and corrections

Document	Date implemented	Responsible entity
Correctional Management Standards	1996 – most recent version dated 2014	Corrections Victoria
Justice Health Quality Framework	2014	Justice Health
Aboriginal Social and Emotional Wellbeing Plan	2015 to 2018	Justice Health and Corrections Victoria
Indigenous Strategic Framework	July 2016	Endorsed by the Corrective Services Ministerial Council (which includes the Victorian Minister for Corrections)
Koori Inclusion Action Plan	2017-2020	The Department
Burra Lotjpa Dunguludja – Aboriginal Justice Agreement	Most recent commitment – Phase 4 2018	Victorian Government
Guiding Principles for Corrections in Australia	Most recent commitment – February 2018	Endorsed by the Corrective Services Administrators' Council (comprised of the heads of Corrective Service agencies across Australia and New Zealand, including the Corrections Victoria Commissioner)
Victorian Aboriginal Affairs Framework	2018-2023	Victorian Government
National Agreement on Closing the Gap	Most recent commitment – 2020	Victorian Government
Strengthening Aboriginal Custodial Health Care Project	2021	Justice Health
Victorian Closing the Gap Implementation Plan	2021-2023	Victorian Government
Healthcare Services Quality Framework for Victorian Prisons 2023	2023	Justice Health

Source: Victorian Ombudsman

Victorian Aboriginal Affairs Framework (2018-2023)

501. The *Victorian Aboriginal Affairs Framework* (2018-2023) ('VAAF'), developed through extensive consultations with Aboriginal communities, is the government's overarching framework for 'working with Aboriginal Victorians, organisations and the wider community to drive action and improve outcomes'. It 'sets out whole of government self-determination enablers and principles, and commits government to significant structural and systemic transformation'. It aims to provide a consistent framework for – rather than replace – the numerous existing strategies to embed self-determination and improve outcomes for Aboriginal people in Victoria.

502. The VAAF states that 'Self-determination is the guiding principle in Aboriginal affairs', because 'it works' according to national and international evidence, because 'it is what community wants', and because it is a human right:

> We acknowledge that the way government enables Aboriginal self-determination will continue to evolve over time, based on changing community expectations and needs. However, community has identified four self-determination enablers which government must commit to and act upon over the next five years to make Aboriginal self-determination a reality:
>
> 1. Prioritise culture
> 2. Address trauma and support healing
> 3. Address racism and promote cultural safety
> 4. Transfer power and resources to communities.

503. It also acknowledges that Aboriginal peoples' self-determination 'involves more than consulting and partnering with Aboriginal Victorians' and that government should continue to strive towards transferring decision-making control to Aboriginal peoples and community on the matters that affect their lives.

504. The VAAF sets out goals in key domains including 'Health and wellbeing' and 'Justice and safety'.

505. Goal 14 is that 'Aboriginal Victorians enjoy social and emotional wellbeing':

> It is important that Aboriginal Victorians have access to Aboriginal-led services that are appropriately resourced and trained to respond to mental-health care needs, as well as culturally informed mainstream services that understand Aboriginal concepts of social and emotional wellbeing.

506. Goal 15 – to eliminate Aboriginal over-representation in the justice system – acknowledges social and structural barriers, such as racism and entrenched social and economic disadvantage, as factors leading to higher rates of imprisonment.

507. Goal 16 – that Aboriginal Victorians have access to safe and effective justice services – notes the need for a range of services, including health services, to work together to keep Aboriginal people out of the justice system.

Victorian Closing the Gap Implementation Plan 2021-23

508. The Victorian Government developed this implementation plan to outline the actions it would take to achieve the objectives of the *National Agreement on Closing the Gap* (2020). The national agreement commits the Australian and state governments to address 'the fundamental divide between the health outcomes and life expectancy of the Aboriginal and Torres Strait Islander peoples of Australia and non-Indigenous Australians'.

509. The plan commits the Victorian Government to four priority reform areas designed to change the relationship between governments and Aboriginal people. These include boosting formal partnerships and shared decision-making; building the Aboriginal community-controlled sector; and transforming government organisations.

510. The plan repeatedly emphasises that self-determination and culturally safe services are at the heart of addressing poorer health outcomes:

> The Victorian Government is committed to improving health, wellbeing and safety outcomes for Aboriginal Victorians. At the very heart of this change is self-determination, whereby Aboriginal people take ownership, carriage and responsibility for designing, delivering and evaluating policy and services on their own terms.

511. The plan commits to ensuring that service systems are culturally safe and culturally responsive and acknowledges that Aboriginal community-controlled services:

> produce better, more sustainable outcomes … They achieve better results … and are often preferred over mainstream services. Empowering the sector to provide culturally sensitive, appropriate, and accessible services to Victorian Aboriginal communities is in line with Victoria's ongoing commitment to self-determination.

512. The plan sets out a series of outcomes and targets. For Outcome 1 – that 'people enjoy long and healthy lives' – the plan states:

> A well-resourced ACCHO sector is crucial for addressing the underlying factors that contribute to Aboriginal life expectancy rates and ensuring that the Aboriginal community has access to culturally safe care that reflects their definition of health and wellbeing … Increased focus on preventative strategies and timely access to culturally safe services are ways the health system can contribute to improved health and wellbeing for Aboriginal people.

513. In relation to Outcome 14 – that 'Aboriginal people enjoy high levels of social and emotional wellbeing' – the plan restates Goal 14 from the VAAF and adds:

> … social and emotional wellbeing emphasises the importance of individual, family and community strengths and resilience, feelings of cultural safety and connection to culture, and the importance of realising aspirations, and experiencing satisfaction and purpose in life.

Burra Lotjpa Dunguludja – Aboriginal Justice Agreement

514. The *Burra Lotjpa Dunguludja – Aboriginal Justice Agreement* ('AJA'), embeds the principles of self-determination in the justice system.

515. The AJA is a long-term partnership between the Victorian Government and the Aboriginal community. The first AJA (2000-2006) was developed in response to recommendations from the 1991 Royal Commission, and the AJA is now in Phase 4, which began in 2018.

516. Signatories to the agreement include:

- the Aboriginal Justice Caucus
- Regional Aboriginal Justice Advisory Committees
- key Aboriginal organisations
- representatives of the Victorian government including the Minister for Corrections.

517. The AJA commits signatories to 'working together to improve Aboriginal justice outcomes, family and community safety, and reduce over-representation in the Victorian criminal justice system'. It includes a number of domains reflecting critical areas in which outcomes need to be achieved, and the goals that are considered achievable within the current phase.

518. Domain 3 is creating 'a more effective justice system with greater Aboriginal control' and has the goal of meeting 'the needs of Aboriginal people … through a more culturally informed and safe system'. Justice Health has committed to partnering with the Aboriginal Justice Caucus, the ACCHO sector, people in custody and subject matter experts to build the cultural safety of prison healthcare, focusing on three priority areas:

- Developing Aboriginal-led custodial and post-release healthcare models across Victoria.
- Strengthening the cultural safety of health care service delivery, by implementing the Aboriginal Cultural Safety Standards and an audit framework for them; monitoring feedback and complaints; and building staff capabilities.
- Developing the evidence base to continuously improve the quality and cultural safety of healthcare for Aboriginal people in custody.

Government's ongoing commitment

519. The various other documents listed in Figure 15 make similar commitments to enabling Aboriginal peoples' self-determination and providing culturally safe healthcare.

520. Various State Government representatives also reiterated their support for self-determination at the Yoorrook Justice Commission:

> Aboriginal people must have a leading role in this work, recognising that advancing Aboriginal self-determination is a fundamental right of Aboriginal people and also because we know it leads to better outcomes. (The Hon Enver Erdogan MLC, Minister for Corrections, Youth Justice and Victim Support)

> For too long, Aboriginal communities have been denied their right to self-determination through the dispossession of land, the denial of culture and very often the silencing of voices. I do recognise that self-determination is not just the correct thing to do; it's a fundamental right of Aboriginal people. And inherent to self-determination is the right of Aboriginal people to define for themselves what self-determination means. (The Hon Jaclyn Symes MLC, Attorney-General)

521. Despite these many commitments, we heard from the Aboriginal people and organisations we spoke to that there is a disconnect between what Government policies say and the reality for people in prison.

Mechanisms for Aboriginal stakeholders' input into prison healthcare policy

522. There are a range of ways the Department can seek input from Aboriginal stakeholders, including people in prison, about prison healthcare policy and provision.

523. Despite this, Aboriginal organisations told the investigation that they are either not consulted at all about important custodial health matters, or that consultation is inadequate or does not lead to meaningful action on their feedback.

Aboriginal Justice Caucus

524. The AJC is a self-determining body made up of the Aboriginal signatories to the *Aboriginal Justice Agreement* ('AJA'). This includes the Chairpersons of each of the nine Regional Aboriginal Justice Advisory Committees, as well as representatives from statewide Aboriginal justice programs, Aboriginal peak bodies and certain ACCOs.

525. In its submission to the investigation, the AJC said:

> The AJC are a crucial conduit between Aboriginal Communities and the Victorian 'justice' system. We are privileged to work with and listen to our communities, colleagues and clients and seek to ensure their voices are heard by government, and those responsible for the day-to-day operation of police, corrections, courts and other 'justice' services …
>
> … the AJC have been instrumental in the creation of numerous positions, programs, policies and plans to prevent our people coming into contact with the system, and to ensure that, for those caught up in the system, it is more responsive to their needs.
>
> … to move beyond reform and transform the system into one that can truly deliver justice for our mob requires true self-determination.
>
> Self-determination in prison healthcare delivery necessitates new and greater responsibilities for the AJC, Aboriginal Communities and Organisations to determine, design and deliver services that reflect Aboriginal ways of knowing, being and doing.

Aboriginal Justice Forum

526. The Aboriginal Justice Forum, established in 2000, brings together Aboriginal community leaders and senior representatives of the Departments of:

- Justice and Community Safety
- Health
- Families, Fairness and Housing
- Education.

527. The forum has been held more than 50 times in different locations around Victoria and aims to:

- promote and coordinate the AJA's principles and initiatives in the Aboriginal community and the justice system
- create partnerships with other Aboriginal-based structures in government and the community to tackle Aboriginal disadvantage and over-representation in the justice system
- report to the Victorian government on justice issues
- improve accountability and transparency of the justice system
- promote awareness of Aboriginal justice issues and develop the identification or development of solutions to improve justice outcomes.

Justice Health Clinical Advisory Committee

528. The Clinical Advisory Committee provides expert clinical advice to Justice Health regarding prison health service policy and provision. Its membership includes a mix of clinical expertise and specialists. VACCHO is represented on the committee and experts in a range of areas, including 'Aboriginal health', may be invited to join from time to time.

529. The committee has regular meetings, but Justice Health also seeks feedback in between meetings about specific issues. For example, in May 2023 Justice Health sought feedback on changes to the delivery of MATOD.

530. While it is encouraging to see Justice Health seeking input from this committee, there is a question over whether Justice Health always provides sufficient opportunity for participants to provide considered feedback. In this example the email seeking feedback was sent at close of business on a Wednesday and requested the response by the following Monday. In another example, the committee was given a week to provide feedback.

Rehabilitation and Reintegration Collaborative Working Group

531. The Working Group brings together senior Department staff from across Justice Health, Corrections Victoria and other relevant Department business units, as well as representatives of the AJC, Regional Aboriginal Justice Advisory Committees, VACCHO, VALS, Aboriginal Housing Victoria, VALS, the Koori Youth Council, and an Aboriginal Independent Visitor. The group is also the agreed working group for the implementation of the Coroner's recommendations from the Veronica Nelson Inquest.

Ad hoc consultation

532. Justice Health also advised that it consults on an ad hoc basis about particular issues.

533. For example, it consulted on the introduction of Aboriginal Health Checks equivalent to those available in the community under the Medicare scheme. This was an initiative intended to improve continuity of care and was a requirement of the new healthcare provider contracts for public prisons, that began in July 2023.

534. In May 2023, Justice Health held a workshop with the incoming healthcare providers, community stakeholders and the Naalamba Ganbu and Nerrlinggu Yilam ('the Yilam'). As detailed in the Cultural Review, the Yilam sits within the Rehabilitation and Reintegration Branch of Corrections Victoria. It leads Corrections Victoria's policies, programs and services aimed at reducing the overrepresentation of Aboriginal people in prison.

535. The May 2023 workshop also included representatives from VACCHO, the Victorian Aboriginal Health Service, the Bendigo and District Aboriginal Cooperative and the AJC.

536. The feedback provided by the Aboriginal attendees was that Aboriginal Health Checks performed in the community rely on strong and trusting relationships with healthcare providers, which is unlikely to be possible in a person's first week in prison. The Department told us that as a result of this feedback, the performance measure in the contracts relating to Aboriginal Health Checks was amended to require Health Checks to be offered within 10 days of reception so that healthcare providers have time to build strong and trusting relationships.

537. The workshop report also documents 'for future reference' that participants raised concerns about the contractual arrangements for prison healthcare for Aboriginal people. The participants preferred 'direct contracts with Aboriginal community-controlled health services to provide services directly instead of sub-contracting arrangements'.

Feedback from people in prison

538. The Department told the investigation:

> The Aboriginal Health Unit [within Justice Health] recently conducted a series of patient voice focus groups across six public adult prisons … to invite discussion with Aboriginal people in custody about changes to primary health care and the adaptation of Aboriginal Health checks to custodial settings. The Unit intends to hold these kinds of sessions with people in custody in public prisons to understand whether healthcare is being provided in a culturally safe way.

539. While Justice Health said it would like to run more focus groups in future, it did not provide any firm commitment to do so. Justice Health has no formal ongoing program of consultation with Aboriginal people in prisons.

540. Justice Health also obtains information through complaints. Justice Health told us that people in prison can write to or call Justice Health. However, the Commissioner's Requirement 4.2.1 Prisoner Telephone System states that requests to add Justice Health's telephone number to a prisoner's authorised call list will not be approved (along with numbers such as gambling agencies and Corrections Victoria's head office).

541. Justice Health also receives complaints from families of people in prison and through oversight bodies such as the Victorian Ombudsman, Health Complaints Commission and Mental Health and Wellbeing Commission. Justice Health stated it 'does not have a dedicated staff member who handles complaints; each complaint is triaged to the most appropriate business area, depending on the nature and urgency of resolving the complaint'.

Prison healthcare contracts and providers

542. In Victoria, prison healthcare is contracted to a mixture of public providers and private companies. All Victorian prison healthcare providers are bound by Justice Health's Quality Framework which set standards of primary healthcare in Victorian prisons and forms part of all providers' contractual requirements.

Private prison contracts

543. Each of the three private prison operators subcontracts healthcare delivery to a provider of their choice. The Department does not directly manage the contracts of these healthcare providers.

544. The Department described their role in relation to Ravenhall to the investigation:

> Neither the State nor [the Department] is a party to the contract for primary health services at Ravenhall.
>
> The State has contracted a private company to build, operate and maintain that prison – GEO Ravenhall Pty Ltd (GEO Ravenhall). GEO Ravenhall has subcontracted the GEO Group to operate Ravenhall. GEO Group has, in turn, subcontracted Correct Care Australasia to provide primary health services at Ravenhall. GEO Group manages the primary health contract with Correct Care Australasia and manages all contract management independently of [the Department] and the State.

545. Despite the independent management of the contracts by the private prisons, the Department does play a clinical governance role through Justice Health. The contracts with the prison operators include key performance measures ('KPM') and a range of other obligations related to healthcare for people in custody.

546. A Justice Health Executive stated:

> We'll also do audits of health service delivery and that can both be clinical but also performance-based and we also meet quite regularly with all of the providers to talk to them about their opportunities to improve … the basis of healthcare is really about continuous improvement so a real big focus is not just on us responding to the incident but have they actually got the right systems and processes in place …

547. A Justice Health Executive spoke about the changes that had been made by CCA after the death at Ravenhall of Michael Suckling. This is an example of how Justice Health works with private prison healthcare providers to identify and implement opportunities for improvement.

548. The Justice Health Executive stated:

> We did some work immediately after Michael's passing to really look at the range of actions that they thought that they could take … It is very holistic … the one plan has a mixture of custodial and health actions. They have also been doing case management working groups that involve the case managers – so, the health staff and custodial staff – looking at obesity management. They've got a whole range of initiatives which … I think happened pretty organically … it's the stuff that we need to probably work on a bit more.
>
> …
>
> And I think Ravenhall's a really good example of how we want our health providers to work. That we want them to be really innovative and actually come to us with those ideas. That doesn't mean that it absolves our responsibility for auditing and monitoring … what we're culturally trying to imbed, is that the provision of health services is about their learning from their mistakes or opportunities … we need to make sure that they have the systems to learn and we're just making sure that they are doing that right. But if a health provider is not learning from every single opportunity, then that is what is going to impact on the care.

549. The Department stated in its response to a draft of this report that the example was intended to show 'how custodial and healthcare providers can and should work together to identify and implement opportunities for improvement'.

550. Despite this positive feedback about Ravenhall and CCA, it is worth noting that CCA has gone from providing healthcare for the whole public prison system, to only operating at Ravenhall from 1 July 2023 when the new contracts in the public prison system came into force. The Coroner found that CCA had failed to provide Veronica Nelson 'with care equivalent to the care she would have received from the public health system in the community, and that this failing causally contributed to her passing'. The Coroner ultimately notified the Director of Public Prosecutions that they believed CCA may have committed an offence under section 23 of the *Occupational Health and Safety Act 2004* (Vic) which requires an employer to ensure that people other than their employees are not exposed to risks to their health or safety.

551. In response to a draft of this report, the Department noted that any endorsement of the steps taken by GEO Group at Ravenhall following Michael Suckling's death should not be considered 'a rejection of the validity of the Coroner's criticism of CCA in relation to Veronica Nelson's passing'.

552. CCA is contracted to provide healthcare at Ravenhall until 2042. Under that contract CCA is bound by the 2014 Justice Health Quality Framework ('2014 Quality Framework'), while new providers at public prisons are bound by the new 2023 Quality Framework and specifications.

553. Similarly, healthcare providers at the other two private prisons, Fulham Correctional Centre (also operated by GEO Group) and Port Phillip Prison (operated by G4S), are bound by the 2014 Quality Framework until at least 2027, or until the Department negotiates the implementation of the 2023 Quality Framework with the private prisons.

554. The Department has said that in order for the 2023 Quality Framework to be applied to private prisons, the contracts would need to be renegotiated, which is complex and costly. A Contracts Team Executive explained that the existing commercial agreement is based on the tender to the market at a point in time so when changes occur:

> … it's about nuancing the new specifications in a way that isn't overly impactful on them … it is really complex and really difficult.

555. In response to a draft of this report, the Department stated:

> [The Department] has commenced work to implement the 2023 Quality Framework in private prisons, prioritising Quality Domain 5 which supports enhancements in service delivery to Aboriginal people in prison. All private prisons have provided initial costings to support implementation of the changes and [the Department] is currently negotiating with these providers to ensure the changes delivered maximise opportunities to improve health outcomes.

Public prison contracts

556. Before July 2023, CCA held the primary health services contract for public prisons in Victoria. This contract was awarded to GEO Care, a subsidiary of GEO Group, in 2012, which was subsequently sold to Correct Care Solutions, and changed its name to Correct Care Australasia in 2015.

557. Services continued to be delivered through a subcontract arrangement between the GEO Group and CCA.

558. The contract was supposed to expire in 2021. At the end of 2020, in anticipation of the expiration of the CCA contract, Justice Health established a Health Services Review to review and recommission delivery of primary health services in Victoria's public prisons.

559. Although the contract was supposed to expire in June 2021, and despite community concerns about CCA following the death of Veronica Nelson, the Department extended CCA's contract by two years until 30 June 2023. A Justice Health Executive explained the extension was 'to support the opportunity to do a really fulsome review of the health model and look at what opportunities there were to make improvements'.

560. Ultimately the decision was made to stop providing healthcare in women's prisons through private providers and use mainstream public health providers instead. It was decided that healthcare in men's prisons would be delivered by a single private provider.

561. As Figure 16 shows, there were many relevant reviews and other events occurring around the time that the old contracts were expiring. This provided Justice Health with the opportunity, as well as lots of pertinent information and recommendations, to properly reconsider the provision of healthcare to Aboriginal people in prison. Given this, we have examined what it considered, and the process it underwent, to make decisions about the new contracts.

Figure 16: Timeline of new contract development and related events

Source: Victorian Ombudsman

New contract decisions and considerations

562. The Health Services Review, which was established to review and recommission health services in public prisons when the CCA contract expired, did not include a distinct review of Aboriginal healthcare provision. Instead, according to a Justice Health Executive, the team looked at the data that had been collected as part of the Aboriginal Health Risk Review.

563. The Health Services Review considered the data from the Aboriginal Health Risk Review in order to identify 'the barriers for Aboriginal people in accessing healthcare in prison … including how could the health service best build trust with Aboriginal people in custody'.

564. According to a Justice Health Executive, the review process 'built on feedback from a range of stakeholders over a number of years including the development, implementation and evaluation of the *Aboriginal Social and Emotional Wellbeing Plan*; the work of the Justice Health Ministerial Advisory Committee; the work of the Women's Correctional Services Advisory Committee; and engagement with the Rehabilitation and Reintegration Collaborative Working Group'.

565. There were various options for delivering prison healthcare that the Health Services Review could have considered, including using ACCHOs to deliver Aboriginal-led healthcare services to Aboriginal people in prison. However, ultimately Justice Health made a policy decision to look for a single provider to service the whole prison system.

Figure 17: Aboriginal Health Risk Review

In 2021, Justice Health carried out the Aboriginal Health Risk Review using data from prison healthcare providers as well as its own records.

The review involved:

- reviews of the files of 659 Aboriginal people in prison, conducted by prison healthcare providers, to identify clinical risks and indicators for poor health outcomes
- a medical record review of a random sample of the records of Aboriginal people in prison, conducted by Justice Health staff.

This was the first time that a large-scale review of the medical records of Aboriginal people in prison had been conducted. More information on this review in included in the section on prison health data.

Source: Victorian Ombudsman

566. A Justice Health Executive told the investigation that it was a priority to have a single provider:

> to avoid having fragmentation of services, and that is particularly an issue in the men's system where there are so many more men, there are so many more prisons and they are moving so much more quickly around the system all the time and that it was considered that there would be a real risk in having multiple providers that would increase the risk that healthcare would be fragmented across the system and people would slip through the gaps.

567. The decision to use one provider for the whole system meant that using ACCHOs was not a viable option. It also ruled out moving the provision of healthcare to public providers, which was considered.

568. According to a former Director at Justice Health, after the deaths of Veronica Nelson at DPFC and Michael Suckling at Ravenhall, there was discussion within the Department about whether prison health services should be delivered by the public health system.

569. While the Health Services Review was being conducted, in August 2021, the Cultural Review began, which also considered this question.

570. The Department opened a tender on 5 January 2022 seeking a single healthcare provider for the entire public prison system.

571. A Justice Health Executive acknowledged that the Department's decision was at odds with Aboriginal community wishes to use ACCHOs:

> That is the [Aboriginal] community's expectation. So, well obviously GEO [Healthcare] has requirements in their contract to engage Aboriginal health practitioners, but I think the community has been very clear that [they want] Aboriginal-led organisations. Not GEO.

572. However, a Justice Health Executive emphasised that Justice Health considered it necessary to ensure that anyone who offered healthcare services should offer a culturally safe service:

> Our very strong view is that we have to make sure that our mainstream [healthcare providers] have services that are culturally safe. Whatever model we go to in the future, we have to expect that our mainstream services can provide them with a culturally safe service because they might always be the point for the more specialist service or they might be the entry point … But noting these concerns about the provisions of those services one of the things that we will do is measure that independently and [have] a really strong focus on that. And that's us having a new Aboriginal Health Unit.

573. GEO Healthcare was awarded the tender.

574. Various Aboriginal organisations expressed concerns about this decision.

575. In their submissions to us, both VALS and the AJC noted that GEO Group was the signatory for the previous contract when CCA had been a subsidiary of GEO Group and were concerned that GEO Healthcare would operate similarly to CCA. They pointed to GEO Group's statement, reported by the Australian Broadcasting Corporation on 12 January 2023, that 'all staff currently working at these service delivery sites as employees of Correct Care Australasia will be invited to join GEO Healthcare's team'. GEO Healthcare estimates that approximately 60 to 70 per cent of their workforce are former employees of CCA.

576. Two months after the tender closed, the coronial inquest into the death of Veronica Nelson began.

577. According to a Justice Health Executive, the inquest:

> obviously highlighted some really significant concerns about health care in custody in general, but in particular healthcare for women. And so while the tender was in place, it did prompt us to really consider, did we have the model right? Were there things that should be considered with new information and really particularly looking at the complexity of health needs that women are coming into prison with?

578. Although the Coroner's findings and recommendations were not made public until 30 January 2023, the Department responded to a second round of submissions by Counsel Assisting the Coroner on 6 September 2022. This is one day after it began contract negotiations with GEO Group, and one day before it approached public providers about delivering healthcare in women's prisons.

579. This means the Department was preparing information for the Coroner at the same time it was considering the contracts. There is conflicting evidence about how much interested parties would have known about the Coroner's findings at this date. Justice Health told the investigation it 'does not routinely receive drafts of the Coroner's findings' and was not advised of the findings until they were made public. The Department confirmed that the Coroner provided draft findings on 30 May 2022, prior to submissions by interested parties and Counsel assisting. The Department said these draft findings did not include any detailed reasons or discussion.

580. VALS also made submissions to the Coroner on behalf of Veronica Nelson's partner, and its June 2022 submission referred to draft findings, indicating that the draft had been made available to 'interested parties', which included both Veronica Nelson's partner and the Department.

581. A former Director at Justice Health said the decision to engage public providers in the women's system was driven by 'the Coronial inquest and the outcomes of the inquest':

> that was the catalyst realistically … It [had been] decided, no we'll stick with a private, and then suddenly it changed quite quickly.

582. The same person also said that the decision to move women's prison healthcare to another provider also considered:

> the angst that was in the community about CCA still delivering the service, [this] was realistically the catalyst that said, 'No, we're going to move it to across to the public health system'.

583. In response to a draft of this report the Department said with the way that these deliberations were characterised by the former Justice Health Director was 'factually inaccurate'. The Department also said that the reference to concerns regarding CCA was 'not an accurate reflection of the factors influencing the decision to engage public health providers in women's prisons'.

584. In October 2022, the Department saw the draft Cultural Review report which recommended that prison health care should be delivered under a public health model, on the basis that outsourcing it to a private provider is 'inconsistent with best practice and results in inconsistent and delayed healthcare for people in custody'.

585. The Department's decision to engage public healthcare providers in the women's prisons, despite its desire to have just one provider across the system, aligns with the research and evidence cited by the Cultural Review about the benefits of a public health model. In its response to a draft of this report, the Department indicated it has reconsidered its approach to using ACCHOs and will be working with the ACCHO sector with regards to engaging them in direct service delivery.

586. A former Justice Health employee told us that when Justice Health learned about the Coroner's finding in the Veronica Nelson Inquest, Justice Health approached the Victorian Aboriginal Health Service and asked 'if you had an ideal primary health service what would it look like?'. VAHS sent back a draft proposal to provide services at three sites.

587. A Justice Health Executive confirmed this, saying the Department was not able to proceed with this proposal 'within the budget envelope we have'.

588. Instead of negotiating with VAHS on cost, the former Justice Health employee told us:

> the Department made the decision, no we won't be going down that route, [it has to be] a partnership between the health service and the ACCHO sector, which is not what the ACCHOs wanted. The ACCHOs wanted to be contracted directly by the Department, but [Justice Health] didn't listen. So, they never actually put an official tender up through Tenders Vic, it was a conversation.

589. In its response to a draft of this report, the Department disagreed with the former employee's evidence, reiterating that the decision not to proceed with VAHS' proposal 'was based on budget availability'.

590. This interaction seems typical of the sort of consultation the Department engaged in, where it approached Aboriginal organisations for input but did not take follow-up steps to negotiate towards community-led solutions or share information to enable meaningful community participation. We discuss this more in the following section on engagement.

591. Similarly, there are provisions in the new contracts that refer to healthcare providers building relationships and partnerships with ACCOs, but VACCHO advised us that ACCOs were not consulted about this and do to want to enter into such arrangements:

> The Department of Justice appears to have signed a contract with GEO Group Australia requiring them to work with ACCOs without asking ACCOs if this is something they are willing or able to do. A three-way partnership is intended but only two parties were involved in discussing the parameters for it. This represents a certain disregard for the autonomy of ACCOs to determine how and if they should engage with GEO Group Australia and could create requirements of GEO Group Australia that they are unable to meet.
>
> The Department of Justice envisage GEO Group Australia subcontracting ACCOs to provide services, which recognises that GEO Group Australia lack certain expertise and capacity to fulfil all requirements of the service specifications. VACCHO believes that if their preferred provider could not meet all requirements itself, the Department should have contracted other organisations, namely ACCOs, directly to provide the services required. This way, the Department of Justice would retain a direct contractual authority to ensure these services are provided.

> ACCOs have multiple reasons why they do not want to enter into a sub-contracting arrangement with GEO Group Australia. Firstly, it places ACCOs in a subordinate role creating imbalances of power and authority to the detriment of ACCOs. ACCOs would have to operate within the strictures and models that GEO Group Australia decide, compromising their ability to provide services consistent with their own models of care. ACCOs would be giving up control of how to provide health and wellbeing support to Aboriginal people to a for-profit American-owned private provider.
>
> ACCOs must also consider the risks to their own reputation of becoming a sub-contractor to a company whose parent company in America has faced several lawsuits by inmates and families of prisoners over the years due to alleged conditions at its prisons and immigration detention facilities, and in the last few months has had a lawsuit filed against it for improperly using toxic chemicals to clean detention centres causing people to get sick. ACCOs may risk losing the trust of the Community which could affect use of other services beyond the custodial system.
>
> Furthermore, ACCOs may understandably recoil from assisting a private provider [to] profit from the substandard care of Aboriginal and Torres Strait Islander people while in prison.

592. The AJC also commented:

> ACCHOs should not, and do not want to be used to plug holes in the failings of for-profit healthcare providers. They should be empowered to deliver their services for Aboriginal people in prisons in the way they see fit.

593. The new contract with GEO Healthcare was executed on 6 January 2023, however since then questions have been raised about how the contract could yet be varied, to improve the provision of healthcare to Aboriginal people in prison.

594. In May 2023, the Yoorrook Justice Commission was taking evidence about public prison healthcare contracts. The Department's Acting Associate Secretary, Corrections and Justice Service was asked by Senior Counsel Assisting Tony McAvoy SC to confirm that the Government had capacity to vary the new public prison primary healthcare contracts to engage directly with an Aboriginal community health provider.

> MR MCAVOY: So … from the department's perspective … there's no contractual impediment to the department entering into some alternative arrangement with respect to Aboriginal prisoners for primary health?
>
> A/ASSOCIATE SECRETARY: The existing contract with GEO contemplates a role for Aboriginal service delivery. It doesn't go as far as the model in some other jurisdictions. So I think there would need to be some negotiations with the provider to make sure we could have that work under the existing contract. But certainly we see a lot of potential in the idea of direct service delivery by Aboriginal health organisations.
>
> MR MCAVOY: Well, you're aware that the whole reason for the existence of Aboriginal community-controlled health services is that Aboriginal people tend to go and have their problems seen to by an Aboriginal controlled organisation, and tend not to go to mainstream health services. You are aware of that?
>
> A/ASSOCIATE SECRETARY: Yes, we're aware of that.
>
> MR MCAVOY: So in a closed environment like a prison, if somebody is not inclined to speak to the doctor who is not from the medical service, their health needs might go unmet. Do you accept that?
>
> A/ASSOCIATE SECRETARY: We do accept that.

> MR MCAVOY: It would seem that there is a good case for engaging directly with the Aboriginal community health services.
>
> A/ASSOCIATE SECRETARY: Yes, and we have been having some discussions through VACCHO, who has helped build a relationship between us and direct service delivery community-controlled health organisations in Victoria to progress that conversation. There were – most recently the discussions occurred towards the end of last year, but I know the most recent Aboriginal Justice Caucus meeting, the desire for us to progress this as a priority was raised and we've committed to taking that conversation forward.
>
> COMMISSIONER WALTER: Yet you still signed this new contract for five years.
>
> A/ASSOCIATE SECRETARY: Yes, we have … it was at the end of a tender process that ran for multiple years. I think that there was the ability to make a decision to adopt a different approach for the women's system. The timing worked for us to be able to do that. There was certainly discussion about the men's system and what the options would be for public service provision there. The feedback from our colleagues at the Department of Health was that in a post-COVID environment … the pressures on the public hospital system meant that they couldn't cope with the demand pressures from the Correctional settings and we were told that that wouldn't be supported by Health at this time.

595. A Justice Health Executive reiterated this position, saying:

> there's definitely a scope within the contract, as long as we can work within … the available budget and the available contracting environment, which is GEO as the lead contractor. There is definitely scope to increase the role for ACCHOs.

596. Whereas GEO Healthcare signed its contract six months before its commencement date, the contracts for healthcare provision to the women's public prisons were not signed by Western Health and Dhelkaya Health until 30 June 2023. They took effect the next day. It was not possible for either of these providers to be ready to deliver services that met all the required standards of the contracts, within this timeline.

597. In response to a draft of this report, the Department said:

> While contracts were signed on 30 June 2023, both Western Health and Dhelkaya Health had been working intensively with Justice Health throughout 2023 to prepare to commence service delivery on 1 July 2023. As timelines for transition were very tight, Justice Health worked with the providers to triage transition tasks based on risk.

598. In mid-August 2023, Western Health and GEO Healthcare told us they were still in the process of building their capacity to deliver on the new contractual requirements. For example, neither organisation had yet been able to recruit the required number of Aboriginal Health Workers.

599. A Justice Health Executive told us:

> GEO indicated to us that they needed nine months for transition … we signed the contact at the start of January so there's some things that they haven't finalised, all of their policies and procedures. And we have agreed to work with them on the things that we see as the highest priority. So, some of these aren't completely finalised at this stage. They are operating without some of the details being completed.

Engagement with Aboriginal stakeholders

600. Given the importance of self-determination and the strength of various government commitments to it, we would expect Justice Health to engage with Aboriginal stakeholders about significant changes to prison healthcare. However, we heard from key Aboriginal organisations that engagement with them about the new contracts was lacking.

601. In its submission to the investigation, the AJC said:

> We are disappointed Corrections did not engage with the AJC throughout the recent procurement process to appoint a provider of custodial health care.
>
> ...
>
> The AJC see no reason why our perspectives (which are shared by many other communities) on whether for profit corporations or community health organisations could or should provide health custodial health services were not sought or considered by the Victorian Government. This is a clear example of 'self-determination' occurring only on government's terms ...
>
> We have raised these concerns with Corrections and Justice Services and acknowledge their commitment, and that of Justice Health and the Aboriginal Health Unit to early and extensive engagement with the AJC in future.

602. The Department's response to a draft of this report noted in relation to the AJC's reference to 'Corrections' not engaging with it throughout the procurement process, that the Health Services Review within Justice Health was responsible for the procurement process, not Corrections Victoria.

603. A Justice Health Executive told the investigation that consultation with Aboriginal stakeholders was limited due to 'probity'. They said that sharing the detail of the new 2023 Quality Framework for consultation would 'basically create the specifications for the tender'.

604. They said that this restricted consultation because anyone consulted could 'get a head start on responding to the tender, if they were able to see what we were thinking or what the service model might [be] before it went to market ... So it's about ensuring fairness in the market'.

605. In its response to a draft of this report, the Department said consultation with all stakeholders was limited and that different standards were not applied to Aboriginal stakeholders.

606. However, ACCHOs and other Aboriginal community stakeholders would not conceivably have tendered for primary healthcare contracts across the entire public prison sector. In this context, probity does not seem to be a convincing justification for failing to adequately engage Aboriginal stakeholders to design a healthcare model appropriate for Aboriginal people. The AJC noted that the:

> lack of engagement by government agencies is often justified on the basis of 'probity' and 'commercial in confidence' grounds, however there are many examples across the justice sector where AJC members have been involved in these activities (and the probity requirements satisfied).

607. The AJC said there was no reason it could not have been consulted about the healthcare model while still meeting probity requirements and that this was a 'clear example of self-determination occurring only on the Victorian Government's terms'.

608. A Justice Health Executive told the investigation that while the 'preference would always be for that expertise to be drawn from the Aboriginal community-controlled health sector,' the 2023 Quality Framework was designed internally by the Health Services Review team. That team collaborated with the Department of Health's Deputy Chief Aboriginal Health Advisor and 'worked with internal Aboriginal staff' including within Justice Health, the Yilam and Corrections Victoria's Aboriginal Justice unit. She added that the Clinical Advisory Committee, which includes representatives from VACCHO, was also consulted.

609. A Justice Health Executive told the investigation that the then Deputy Secretary for Aboriginal Justice was on the Health Services Review Steering Committee that governed the tender process. She also said the Department engaged a member of VACCHO to sit on the evaluation panel for the tender.

610. VACCHO stated:

> The Victorian Government invited VACCHO to provide a staff member to be on the panel selecting the new provider, and our [then] Executive Director for Corporate Services … filled that role. This involvement, however, began after tender submissions had been received. This meant that all documents including the service specifications released in the Invitation to Tender were prepared and published without any input from VACCHO.
>
> VACCHO's representative was only involved in reviewing the two shortlisted applications and due to rules of confidentiality was not allowed to discuss any matter, including the service specifications and applications, with anyone …
>
> VACCHO's representative was able to make suggestions for what should be included in the contract but the Government chose not to accept these fully.

611. The Aboriginal Justice Caucus told the investigation in its submission:

> While there is greater awareness of the need to involve the AJC in policy development and decision-making … often assumptions are made by justice agencies about which projects, or aspects thereof, require AJC consideration rather than the full scope of work being described so that the AJC can decide which elements are most critical for consideration.
>
> …
>
> In development of the new Quality Framework and Service Specifications … the AJC …were not engaged at the outset nor were we asked for advice or input on the process for developing the new Framework, reviewing the existing Aboriginal cultural safety standards and the associated procurement and performance assessment requirements.
>
> Once these development and review processes were underway, we were engaged on some aspects of the work, and understand that Aboriginal people in prison were also involved in the review (which we strongly support), but not others.

612. VACCHO told the investigation that after it made the decision to engage a private provider for the men's public system, the Department 'had opportunities to discuss with ACCOs how they could work alongside a private health care provider, but these have not been fully used by the Department'.

613. In September 2022, the Department and VACCHO jointly hosted a meeting with ACCOs to discuss how to improve healthcare in prisons. The meeting was attended by the Deputy Secretary for Corrections and Justice Services, the Deputy Secretary for Aboriginal Justice and senior Executives from Justice Health and the Department of Health. The Department's response to a draft of this report noted that at the time, the procurement process was underway and there were strict confidentiality requirements 'regarding offerers and likely outcomes'.

614. Documents seen by the investigation show that in the meeting, the Department advised:

- there was support for the concept of ACCOs providing healthcare for Aboriginal people in prisons
- the Department wanted to discuss with ACCOs what could be possible, subject to funding availability
- the Department would meet with individual ACCOs to arrange shadowing of existing health services in prisons and organise consultations with people in prison
- the Department would discuss with the Victorian Aboriginal Health Service how people in prison could access its Yarning Safe'N'Strong helpline.

615. Following the meeting, the Department advised it would provide a pack of information including existing service specifications to help inform ACCOs in their planning.

616. There was a follow-up meeting in October 2022 with representatives of the Department, ACCOs, and Winnunga, the ACCO that provides healthcare at the Alexander Maconochie Centre in the ACT. Winnunga presented its model of healthcare delivery and invited ACCOs and the Department to visit their service. The Departmental representatives 'advised they were keen' but 'undertook no action'. VACCHO said:

> [The Department] did not provide the pack of information, did not discuss Yarning Safe'N'Strong with VAHS, and did not provide information to enable a visit to Winnunga. In January 2023, VACCHO emailed the Deputy Secretaries who had attended the meetings but received no response.

617. VACCHO also participated in meetings organised by the Department and GEO Group in the weeks before GEO Healthcare began providing services. VACCHO was also contacted by GEO Group seeking assistance to contact ACCOs to discuss service provision in prisons:

> Simultaneously, GEO were approaching Aboriginal Health Practitioners and Aboriginal Health Workers to leave their jobs in ACCOs to work for them. This created mistrust among ACCOs regarding the intentions of GEO to work in transparent ways and as such ACCOs did not want to engage with GEO.

618. In response to a draft of this report GEO Group stated:

> The Statement by VACCHO that suggests GEO approached Aboriginal Health Practitioners and Aboriginal Health Workers to leave their jobs in ACCOs in order to work for GEO is incorrect. GEO Healthcare advertised its Aboriginal Health Workers and Aboriginal Health Practitioners positions on SEEK Recruitment Platform using a standard open recruitment process.
>
> GEO has been successful in attracting Aboriginal Health Workers and Aboriginal Health Practitioners to work in the Victorian prison system from various States in Australia. GEO believes these staff have been recruited based on attractive working conditions and with an organisation that demonstrates cultural sensitivity to the needs of Aboriginal people in prison and GEO staff — allowing them to provide an integrated and comprehensive health service.

619. VACCHO met with the Department on 3 July 2023 to 'discuss concerns held by ACCOs regarding expectations held by the Department' that ACCOs and GEO Healthcare would work together in a subcontracting arrangement. VACCHO said it advised the Department that ACCOs did not wish to enter such an arrangement with GEO Healthcare and would prefer to be contracted directly by the Department.

620. VACCHO said the Department advised in this meeting that it would be 'cost neutral' for the Department to contract ACCHOs to provide certain services rather than paying GEO Healthcare to do so. According to VACCHO, the Department said it would:

> investigate this in more detail and arrange a meeting with VACCHO and GEO. The Department never provided any information subsequent to this meeting nor did they arrange another meeting. VACCHO was advised, six weeks later after we inquired, that the Department of Justice and Community Safety had looked into directly contracting ACCOs and decided it wasn't possible.

621. VACCHO told the investigation that 'given the lack of communication' from the Department, it sought a meeting with the Minister for Corrections, which took place on 8 August 2023. In this meeting, Department representatives said they had not acted on the discussions held in September and October 2022 as they had been busy with the transition to the new private healthcare provider and establishing the new model at Cherry Creek Youth Justice Centre. VACCHO stated:

> In that meeting, we raised the Winnunga model of care, which the Minister had not heard of, and invited the Minister and his team to visit there. This was agreed to but despite [VACCHO] following up, [the Department] has not provided potential dates for the visit.

Workforce capacity

622. A key challenge in providing Aboriginal-led healthcare in prisons is recruiting and retaining trained Aboriginal staff.

623. The Coroner recommended that the Department, in partnership with VACCHO, take concrete steps to 'build the capacity of VACCHO to provide in-reach health services in prisons'. A Justice Health Executive said:

> [T]he work that we are doing largely through the Aboriginal Health Unit now is really responding to the Coronial recommendations about building capacity within the ACCHO sector to deliver services in custodial settings … the Aboriginal Health Unit is in the very early stages of some engagement with VACCHO and the ACCHO sector … to really understand what that looks like, what the capacity building is required and how we could … work towards a pathway of having those directly … engaged services.

624. When asked what barriers there were to engaging with ACCHOs to provide healthcare in prisons, a Justice Health Executive clarified that any capacity issue on the part of ACCHOs was a matter of workforce capacity, rather than of service delivery. They further stated:

> [W]e've been really clear that … we are … committed to working collaboratively with them at a pace that supports that capacity building … certainly they've expressed to us a desire to make sure that we aren't extracting [Aboriginal Health Workers]… from the community … not robbing Peter to pay Paul.

625. A Justice Health Executive clarified Justice Health's understanding of the capacity issues, stating:

> [ACCHOs] have been really, really clear with us that there is a capacity issue, just in the broader Aboriginal health workforce. And certainly we've had some good conversations with VACCHO and the ACCHOs and the broader AJF about … our desire to bring in more Aboriginal health practitioners into custodial settings … [that] can sometimes create some challenges … they've certainly floated with us concerns about, what does it mean if they're coming from community and how can we really work in partnership together to continue to invest and grow that workforce? And that is a workforce that … across Australia [has] a real shortage.

626. Current and former Justice Health staff told the investigation that ACCOs lack the capacity to deliver health services in prison. However, according to VACCHO's submission to the investigation, ACCOs have not been given an opportunity to assess for themselves if they have capacity to deliver prison healthcare, let alone been engaged by the Department to establish what capacity they may have. Their submission states:

> ACCOs should be given the opportunity to show how they can supplement the healthcare provided by GEO Group. This would require ACCOs having access to information about:
>
> - The number of Aboriginal people in prison and information related to frequency of arrival, departure and length of stay
> - The needs of people in prison
> - Existing models of service and levels of provision
>
> When provided this information, ACCOs would be able to produce accurate business plans for how they could provide services in prisons. ACCOs would reasonably expect contract duration to be the same as that provided to GEO Group (five years) which enables a service to be built up. Unfortunately, government funding to ACCOs has never been for periods this long and has been piecemeal.

627. The Aboriginal Health Manager from GEO Healthcare told us that workforce capacity issues were impacting their ability to recruit Aboriginal staff. The Department of Health confirmed there were only 44 qualified Aboriginal Health Practitioners with general registration in Victoria as at September 2023. Data on the number of Aboriginal Health Workers is not available. When the investigation met with GEO Healthcare management in late August 2023 it had six Aboriginal Health Practitioners and one Aboriginal Health Worker on staff with two more about to start. The Aboriginal Health Manager stated:

> Part of the recruitment was that we had to offer more money and it's not … just to persuade them to come over, but because of the environment they work in, it's very different to what they'll see in the community. And we also offered other incentives, like relocation … because we also didn't want to take from the Aboriginal ACCHOs here that serviced the community. We had to do a national recruitment drive and I think we've done two and exhausted that resource …

628. There are requirements in the new private contracts for GEO Healthcare to engage Aboriginal Health Workers and Aboriginal Health Practitioners. Both VACCHO and VALS noted that that means the ACCHO sector is now competing for staff with a well-resourced and government-funded private company, with implications for healthcare provision to Aboriginal people in and out of prison. VALS said:

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

629. VACCHO told the investigation that ACCOs are not able to compete with the incentives being offered by GEO Healthcare to work in the prison system. A September 2023 GEO Healthcare advertisement for Aboriginal Health Workers offered a starting salary of more than $90,000, well above the highest salary in the Award of $73,606.

630. VACCHO expressed concerns that this has the potential to drain the pool of appropriately trained staff away from ACCHOs and into private healthcare providers. If the Government wants to build the capacity of ACCHOs, in line with its commitment in the Victorian Closing the Gap Implementation Plan, it needs to reconsider its funding priorities. These should include more training places and accessibility.

631. In response to a draft of this report, the Department advised that it plans to progress an Aboriginal-led model of custodial healthcare, with healthcare to be delivered by ACCHOs.

632. It provided us with a draft project summary updated on 11 January 2024, which indicated that Phase 1 will include engaging key stakeholders including Aboriginal people in prison and ACCHOs, and will involve 'building the capacity of ACCHOs to deliver in-reach prison health services'.

633. The summary indicates that these activities will be undertaken within the Department's existing budget and that implementation will be dependent on additional funding. The draft document does not include timeframes for this work.

Public prison contract obligations

634. The new women's and men's primary healthcare contracts in the public prison system are largely similar. For the most part, they set out requirements for the provision of healthcare to Aboriginal people in the same way.

635. The contracts contain specifications, which set out the clinical requirements on the healthcare providers. They also contain the 2023 Quality Framework, which encapsulates the standards at which the specifications must be delivered.

636. Justice Health measures and oversees the healthcare providers' compliance with both the specifications and the 2023 Quality Framework.

637. The contracts set out the aims and principles of the contracted service:

> Three aims underpin the delivery of primary healthcare services in the Victorian prison system:
>
> ...
>
> The right to health care (physical, mental health and wellbeing)
>
> ...
>
> Improving the health of people in prison
>
> ...
>
> Improving rehabilitation outcomes for all and reducing the overrepresentation of Aboriginal people by:
>
> I) Addressing the health and wellbeing limitations that impact on a person's ability to participate in programs, education, training, and social engagement, ...
>
> II) Ensuring that services are culturally safe
>
> ...

Contract specifications

638. The specifications set out the technical requirements that the healthcare providers are required to meet.

639. The specifications state that the services must address the Department's five focus areas:

- Health Assessment and Planning
- Population Health
- Alcohol and Other Drugs Health
- Primary Care
- Tailored Response for Priority Groups – which includes 'Aboriginal and Torres Strait Islander people in prison'.

640. Focus area 5 outlines the way that 'the prison primary health experience will aim to remove the challenges experienced by Priority Groups in accessing and receiving care while in prison and on release to the community'.

641. It acknowledges that people from priority groups have 'unique and often complex needs', and that 'services will be tailored at the collective and individual levels and integrated across the services'. It acknowledges that a 'lack of workforce training, awareness, sensitivity, or knowledge' can lead to 'wellbeing and health harms' and 'might engender service avoidance, active declines, reluctance to disclose health concerns or history ... or create negative experiences for priority clients'. It recognises that health engagement of priority groups can be improved by 'providing services that are safe, culturally appropriate, gender appropriate, patient-centred, timely, and non-discriminatory', which in turn protects and promotes 'the dignity, health, mental health, and personal agency of Priority Groups'.

642. Focus area 5 states that:

> The provider will provide trauma-informed care based on five principles:
>
> a) Safety (physical, emotional, psychological, cultural)
>
> b) Trustworthiness
>
> c) Choice
>
> d) Collaboration
>
> e) Empowerment

643. The contract for the men's public prisons states:

> the State and the Contractor will work together to achieve incremental implementation during the Term [of the contract] to improve the quality and appropriateness of primary health services for all priority groups.

644. The exception to this is tailored responses for Aboriginal and Torres Strait Islander people in prison, 'which will be implemented from contract commencement'.

Figure 18: Requirements of Focus area 5 regarding Aboriginal people in prison

For delivery of Services to Aboriginal people in prison, the Contractor will:

a) Recruit, develop, and maintain a primary health Aboriginal workforce.

b) Build partnerships with Aboriginal community health service providers and Aboriginal cultural and social supports for in-reach services for Aboriginal people in prison and out-reach for continuity of care upon release to the community.

c) Create direct and indirect health, wellbeing, cultural wrap-around, and social supports for Aboriginal clients as fully integrated aspects of the services.

d) Recognise that addressing prejudice and discrimination and providing a culturally safe and appropriate care environment for Aboriginal clients is not a didactic model. The responsibility and the work to prioritise the physical, social, spiritual and emotional wellbeing of Aboriginal clients, and to do so in a manner that is meaningful, respectful, tailored and consistent with their cultural needs, will be embedded across the whole service.

To improve the health management and outcomes of Aboriginal people in prison, and contribute to reducing over-representation, the provider will at a minimum:

a) Undertake the service Specifications detailed for Aboriginal clients.

b) Provide services to meet the physical, social, emotional, spiritual, and cultural wellbeing needs for Aboriginal people in a culturally safe way.

c) Foster a trauma-informed, and inclusive environment that is responsive to the needs of Aboriginal people.

d) Partner and collaborate with other health services and partner and collaborate with the wider custodial service providers.

e) Create collaboration pathways with Corrections Victoria (including the AWOs and ALOs) and Justice Health through information sharing to support participation in cultural and other programs.

f) Recognise the impact of experiences of trauma and racism, continually build the cultural capability of all health staff, coordinating care with Aboriginal Wellbeing Officers and establishing meaningful partnership with Aboriginal Community Controlled Health Organisations (ACCHOs) to enhance health service delivery and to support transition and continuity of care for Aboriginal people leaving custody.

g) Create linkages to traditional healing and custodial programs designed for spiritual health and cultural care to support social and emotional wellbeing.

h) Make interpreter services available for Aboriginal people for whom English is not their preferred language.

i) Provide health information in plain English and or traditional languages.

Source: Public prison healthcare contract specifications

645. A number of Aboriginal-health specific processes not in the old contract were added to the specifications of the new contract:

- the provision of support for Aboriginal people at their reception medical assessment, including the attendance of a member of the provider's Aboriginal health team, or an AWO or ALO if the health worker is not available, offering support for the person at the point of reception
- involvement of an AWO in the development of risk management plans and ensure that the attendance of an Aboriginal Health Worker or an Aboriginal Health Practitioner is offered
- development of a process and tool that is equivalent to Medicare item 715. This must be reviewed and accepted as appropriate by Aboriginal health service providers
- provision of Integrated Care Plans for Aboriginal people within 29 days of reception, which includes providing access to cultural support and traditional healing, and in-reach by ACCHOs.
- face-to-face release planning appointments and liaison with ACCHOs to ensure continuity of care
- priority access for Aboriginal people with dental or denture needs.

Quality Framework

646. The previous public prison primary healthcare contract (held by CCA until 2023) required CCA to comply with the 2014 Quality Framework.

647. There is no data available to show that the quality or outcomes of Aboriginal healthcare improved with the introduction of the 2014 Framework, nor does it appear that Justice Health developed processes to measure its performance against it.

648. Recommendation 21 from the Coroner's finding was 'that Justice Health review and, if necessary, revise the Quality Framework'. The current 2023 prison healthcare providers are still operating under the 2014 Quality Framework. Appendix 6 contains a comparison of the relevant requirements in the Quality Frameworks.

649. The 2023 Quality Framework was reviewed by consultants. A Justice Health Executive told the investigation that they specialise in 'driving quality across … health service delivery', but do not have expertise in cultural safety.

650. The 2023 Quality Framework 'articulates the standard of care expected to be delivered by health service providers in prisons and the unique requirements of delivering care in a prison system'.

651. The purpose of the 2023 Quality Framework is to enable the delivery of reliable, safe and high-quality health services by:

- providing health service providers with a set of criteria and key requirements to implement, manage and self-monitor
- providing the Department … with a set of criteria and key requirements to monitor, audit and assess the health service provider
- providing people in prison and the community with information about prison health services.

652. The 2023 Quality Framework is made up of nine 'quality domains'. Commonly used in healthcare settings, quality domains are broad categories that group the aims of a healthcare provider and enable them to set actionable goals.

653. The quality domains included in the new primary healthcare contracts are:

1. Clinical governance
2. Safe practice for healthcare in prison
3 The rights and needs of people in prison
4. Person-centred care
5. Aboriginal people in prison
6. Health assessments and planning
7. Population health
8. Alcohol and other drugs
9. Primary care (including mental health, dental and allied health)

654. Several Quality Domains include actions relevant to Aboriginal people but Quality Domain 5 sets out 22 actions the healthcare providers are required to take that relate solely to the provision of healthcare to Aboriginal people.

655. Quality Domain 5 is a comprehensive description of what a health service would need to implement in order to provide an appropriate service for Aboriginal people. What it does not provide for or address are the difficulties in implementing this within a mainstream health service. In reality, Quality Domain 5 represents the type of service that ACCHOs already provide in the community, but it does not ensure the centrality of Aboriginal culture and the deep understanding of Aboriginal concepts of health that makes ACCHOs a trusted and effective healthcare provider for Aboriginal people. While there is no prescribed way to measure compliance with Quality Domain 5, the only way to determine whether a service is culturally safe is to ask the people receiving the service. There is no requirement for this to happen within the contract.

Figure 19: Sample of requirements from Quality Domain 5 of the 2023 Quality Framework

5.5	Health service providers must engage and establish meaningful working relationships with ACCHOs in local communities to enhance health service delivery and to support transition and continuity of care for Aboriginal people leaving custody
5.9	Health service providers must with informed consent, engage family, a nominated support person, service provider or a community Elder or navigator to be involved with the Aboriginal person's release planning to increase the chances of maintaining health gains post release
5.12	Health service providers must foster an organisational culture and service that is culturally safe, inclusive, welcoming, and responsive to the needs of Aboriginal people in prison
5.18	Health service providers must actively monitor the nature of complaints lodged by Aboriginal people in prison, their families or nominated representative, and Aboriginal health staff to identify and address any evidence of systemic deficiencies that negatively impact the cultural safety of the health service
5.21	Health service providers must provide health staff with regular cultural capability training that increases their understanding of Aboriginal social and emotional wellbeing concepts of health, as well as the physical manifestations of trauma

Source: Healthcare Services Quality Framework for Victorian Prisons 2023

656. In its response to a draft of this report, the Department noted that Quality Domain 3 ('The rights and needs of people in prison') requires providers to:

- meet the NSQHS Partnering with Consumers Standard: Partnering with consumers in organisational design and governance
- involve a representative group of people currently in prison, advocates of people in the prison system and/or people with lived experience of prison in the governance, design, measurement and evaluation of the health care delivered in Victorian prisons.

657. However, this does not address the issue that compliance with Quality Domain 5 will need to be measured in a way that differs from evaluation and assessment of mainstream health services.

658. The Department's response also noted it is developing a Cultural Safety Audit Framework to measure health service providers' performance against Quality Domain 5.

659. It is clear the public prison healthcare providers are working to meet the expectations of Quality Domain 5. For example, Western Health has half day drop-in clinics that mean that women do not need to wait for an appointment or worry about missing appointments. Acknowledging the shortage of Aboriginal Health Workers, Western Health negotiated its contract to include three Aboriginal Health Liaison Officers who attend appointments if requested, assist women with accessing services and work on improving health service engagement and building trust with the providers. The Aboriginal Health Liaison Officer service is available seven days a week.

660. GEO Healthcare has allocated Aboriginal Health Workers or Aboriginal Health Practitioners for each site. Satellite clinics are conducted on units, so Aboriginal people do not need to visit the clinic if they would prefer, and unit clinics are more private and less formal. Aboriginal Health Workers at Metropolitan Remand Centre are developing patient feedback forms which include social, emotional and wellbeing questions to better inform healthcare providers of a fuller range of needs of Aboriginal people they are treating. GEO Healthcare has also allocated up to four Aboriginal Health Worker or Practitioner positions to trainees.

661. Both healthcare providers offer cultural supervision for their Aboriginal healthcare staff and have regular meetings where they are able to feed back their experiences to each other and the managers of Aboriginal healthcare provision.

662. While these initiatives are positive there are still limitations with the 2023 Quality Framework and accountabilities to ensure its domains are achieved. As well as not being designed or implemented by Aboriginal people, the contracts do not require compliance with Quality Domain 5 to be measured or evaluated with tools designed by Aboriginal people.

Monitoring Aboriginal healthcare outcomes

663. The Cultural Review found that Victoria's 'systems for collecting and analysing health data do not provide adequate insight into the health of people in custody'. It stated:

> Currently, Justice Health does not collect or disseminate comprehensive, system-wide data on the health profile of people in custody, or the availability and uptake of healthcare services offered in Victorian prisons. For example, comprehensive data about the dental health, substance use history, cognitive disability and transgender, gender diverse or intersex status of people in custody is not available.

664. Because of this, 'the objectives set out in the Justice Health Quality Framework are not supported by information systems, data monitoring and reporting processes that can ensure accountability of the custodial healthcare system'.

665. Justice Health has taken some steps to improve its monitoring of health outcomes for Aboriginal people. For example, in 2015 it released the *Aboriginal Social and Emotional Wellbeing Plan* (detailed in Appendix 3) which led to the creation of the Aboriginal Clinical Governance Officer role in 2017.

666. In January 2023 it also created an Aboriginal Health Unit, led by an Aboriginal Director. As of January 2024 it is developing a Cultural Safety Audit Framework to measure health service providers' performance against Quality Domain 5.

667. Justice Health also undertook the Strengthening Aboriginal Custodial Health Care Project in 2021 (detailed in Appendix 3). The project aimed to:

- develop a comprehensive, long-term plan of action that is evidence-based and targeted to need
- ensure the full, inclusive participation and self-determination by Aboriginal people in prison in all aspects of their health care
- prioritise culture, address trauma and support healing
- address racism and promote cultural safety.

668. Several actions were planned as part of the Strengthening Aboriginal Custodial Health Care Project, however, with the exception of the Aboriginal Health Risk Review (see below) it does not appear the project progressed. Justice Health said:

> Enhancements to Aboriginal health care included in the Health Services Quality Framework for prisons (July 2023) … will be measured through patient experience data and the implementation of the Aboriginal cultural safety audit framework, which will be developed by the Aboriginal Health Unit in 2023 … Justice Health will report to the Aboriginal Justice Forum (AJF) on this work on a quarterly basis.

669. Other actions Justice Health is currently undertaking include overhauling its electronic records system, JCare. However, we note that the issue of data quality and the capacity of JCare was raised by both Western Health and GEO Healthcare. Both indicated that their Aboriginal Health Managers were maintaining spreadsheets in order to track health interventions and engagements with Aboriginal people. The new Aboriginal Health Check form is still completed on paper and healthcare providers told us JCare did not allow them to enter all of the relevant data in the electronic form.

670. A Western Health Executive told us that 'the current JCare medical record system is really kind of, well, one or two steps beyond chiselling in stone'. They said they usually rely on data to inform their work but that information is not 'readily available out of JCare'.

Prison health data

671. Good healthcare is informed by reliable and comprehensive data, however Victoria does not collect good quality prison health data.

672. Australian prison health data is collated every three years by the National Prisoner Health Data Collection which captures data relating to prison entries and discharges over a two-week period, clinic attendances and medications administered.

673. Victoria did not provide data to the most recent collections in 2022.

674. The most meaningful attempt to collect data about the health of Aboriginal people in prison in Victoria was the Aboriginal Health Risk Review, which Justice Health conducted in 2021.

675. The only document Justice Health could provide the investigation about the Aboriginal Health Risk Review was a PowerPoint presentation.

676. The Aboriginal Health Risk Review examined the clinical risks and indicators for poor health outcomes of 659 (of 765) Aboriginal people in prison recorded by the healthcare providers. Justice Health also conducted a medical record review of a random sampling of the records of Aboriginal people.

677. The Aboriginal Health Risk Review made three 'key findings':

- Aboriginal people in prisons have higher and more complex health needs than non-Aboriginal people in prison.
- Existing health services had a low rate of referral to culturally appropriate services.
- Aboriginal people in prison have lower engagement with mainstream health services than non-Aboriginal people in prison.

678. According to a former Justice Health employee, the Aboriginal Health Risk Review was the first time that medical records of Aboriginal people in prison who had not made a complaint about their healthcare had been reviewed.

679. A former Justice Health employee who explained the review process to us said that limitations of the Jcare system meant Justice Health officers had to physically attend each prison to manually examine individual medical records.

680. It is unclear whether Justice Health has retained the relevant data or analysis. There is no evidence that Justice Health has a systemic approach to the collection and review of health data regarding Aboriginal people in order to assess their needs as a priority group and develop appropriate responses.

Deaths of Aboriginal people in custody

681. The deaths of Aboriginal people in custody give us some insight into of the state of Aboriginal people's health and healthcare in prison.

682. According to AJC, between the 1991 Royal Commission and the implementation of the 2014 Quality Framework, nine Aboriginal people died in Victorian prisons.

683. Since 2014, a further 15 Aboriginal people have died in Victorian prisons. AJC highlighted that of nine Aboriginal deaths in custody between 2014 and 2020, two were considered at inquest and the remaining seven had findings issued without an inquest. In those cases, the deaths were determined to be of 'natural causes', but AJC stated:

> It is clearly unnatural for young Aboriginal men and women in their 20s, 30s and 40s to die in custody from medical conditions that are preventable, and … which … could have been managed and addressed during their time in custody.

684. AJC stated that referring purely to clinical causes prevents us understanding what other health factors may have been present and contributing to the death of an Aboriginal person in custody. AJC said that where a cause of death is found to be from natural causes:

> … additional attention [should be] given to the physical, social and emotional health circumstances of the individual, how these might have changed over time, and whether institutional or systemic racism may have contributed to their death.

685. We considered the Departmental reviews conducted after Veronica Nelson's death, as well as those conducted after the death in custody of Michael Suckling. While both reviews acknowledged the Aboriginality of the people who had died, there was no consideration of whether their Aboriginality impacted on their healthcare experience, or of wider factors that form part of a holistic model of health.

Monitoring outcomes under the new public prison healthcare contracts

686. Justice Health is responsible for monitoring healthcare providers' performance and their compliance with their contracts.

687. Healthcare providers are measured against 16 key performance measures ('KPM') that 'describe the State's expectations regarding compulsory monitoring against the provider's Service Agreement'.

688. Each of the 16 KPMs measure the delivery of individual healthcare processes in a specified timeframe. Two of the KPMs focus on Aboriginal people; the Aboriginal Health Check and the Integrated Care Plan for Aboriginal people. However, none of the KPMs relate to health outcomes, cultural safety or the quality and safety of care.

689. This issue was noted by a Western Health Executive who said:

> I think Justice at the moment is very much … counting the beans in a way … throughput, how many people we're seeing, are we kind of ticking off things from a percentage perspective, but from our perspective if you were looking at the outcomes, just because that thing has happened doesn't necessarily mean they're going to have a good outcome … if you were to look at it evolving, you would look at trying to measure those outcomes.

690. In addition to the KPMs, the health care providers are required to report against Additional Data Requirements ('ADR') which relate to factors like prisoner complaints, workforce information, population health tests and alcohol and other drug treatment programs. As with the KPMs the ADRs do not measure health outcomes, cultural safety or the quality and safety of care.

691. Through the KPMs and the ADRs, the contract specifications are reported on at specified times.

692. The women's contracts further include a set of outcome measures, designed to capture women's experiences of the health services, including whether health services are culturally safe for Aboriginal women and support self-determination.

693. A Justice Health Executive said that these additional outcome measures would potentially highlight the differences between public and private providers. It is not clear how this data could be used to compare public and private providers, given the men's contract does not include any outcome measures.

694. In its response to a draft of this report, the Department said it intends to:

> work with all providers on the development and implementation of an evaluation framework, potentially including those same outcome measures. The evaluation framework will help to demonstrate any differences in outcomes between public and private providers.

695. Healthcare providers are also required to comply with the 2023 Quality Framework, however the contract does not set out how actions under the 2023 Quality Framework are measured. In practice, the Department is relying on the accreditation process (discussed below) rather than independently monitoring compliance with the 2023 Quality Framework. The Department's response to a draft of this report indicated that it regards accreditation requirements as an additional layer of oversight rather than a replacement for Justice Health's responsibilities.

696. There are no requirements in the contracts for compliance with the contract, including the provision of culturally safe healthcare, to be evaluated by means that are culturally valid, meaning they are designed and undertaken by Aboriginal people with the relevant expertise.

Accreditation

697. Under the contracts, healthcare providers are obligated to be accredited to the National Safety and Quality Health Service Standards ('NSQHS Standards'), which are administered by the Australian Commission on Safety and Quality in Healthcare. This brings public prison healthcare providers in line with all Australian public and private hospitals, day procedure services and most public dental practices.

698. The accreditation process involves an assessment by an independent accrediting agency which 'examines evidence of actual performance by reviewing hospital performance data, documentation and records, observing clinical practice, inspecting resources, testing high-risk scenarios and interviewing the workforce, patients and consumers'. The contracts require that prison healthcare providers make accreditation reports available to Justice Health.

699. However, there is no requirement for accrediting agencies to have expertise in assessing whether healthcare has been delivered in a culturally safe way.

700. Each of the nine Quality Domains in the 2023 Quality Framework are linked to one or more sets of national health care standards, primarily the NSQHS Standards. Quality Domain 5 relates solely to Aboriginal people and requires health service providers to meet a range of clinical governance standards.

701. The NSQHS Standards have a User Guide for Aboriginal and Torres Strait Islander Health which defines six actions. Justice Health has indicated that prison healthcare providers are required to implement these six actions, which broadly align with Quality Domain 5. However, Quality Domain 5 goes further than the user guide in outlining requirements for healthcare providers.

702. Justice Health is relying strongly on the accreditation process to ensure compliance with the requirements of the 2023 Quality Framework. A Justice Health Executive said:

> the key aspect of the new [2023 Quality Framework] is that it links very clearly to the national standards. Which means that every section is that you need to comply with the national standards. That gives us the ability to say, 'can you show us how you're complying' … it means that then is an external party that does that accreditation as well as what Justice Health can do. And I think that is really key in the health sector because whilst we have a really, really critical role … there is some aspects of our contracts that don't go to that level of detail … we create this expectation that our providers ensure that they are maintaining their registration.

703. In its response to a draft of this report, the Department said:

> Justice Health's view is that the accreditation requirements add an additional layer of oversight, rather than replacing [Justice Health] role in contract management and clinical oversight, including [Justice Health's] own audit process.

704. A Justice Health Executive responsible for health service delivery was unable to tell us in August 2023 how Justice Health is specifically monitoring compliance with the requirements of Quality Domain 5, beyond relying on accreditation and KPMs. In response to a draft of this report, the Department said that this statement 'infers that the absence of detail at the time [of the meeting with investigators in August 2023] meant that Justice Health is not positioned to ensure providers compliance with this domain'. Further:

> Justice Health will continue to identify other mechanisms to support more detailed reviews of how individual requirements are being delivered and whether they are achieving the intended outcomes. This is a continuous process and the absence of a defined list of all measures should not be inferred as an absence of capability.

705. However, given that Justice Health extended CCA's contract by two years during which it undertook the Health Services Review, we consider that Justice Health should have been in a position to plan in detail how it would audit and measure compliance by mid-August 2023, a month and a half after the new contracts came into force.

Audits

706. One of Justice Health's clinical governance roles is to audit health service delivery. The auditing it performs can either be based on fulfilment of KPMs or ADRs, or onsite audits that engage with the way health services are delivered.

707. One of the recommendations made by the Coroner in the Veronica Nelson Inquest was that:

> 18. .... the Victorian Government revise the system for auditing and scrutiny of custodial health care services to ensure that it is:
>
> 18.1. independent;
>
> 18.2. comprehensive;
>
> 18.3. transparent;
>
> 18.4. regular;
>
> 18.5. designed to enhance the health, wellbeing and safety outcomes for Victorian prisoners;
>
> 18.6. designed to ensure custodial health care services are delivered in a manner consistent with Charter obligations; and
>
> 18.7. that the implementation of any recommendations for improved practice identified by the system for auditing and scrutiny is monitored.

708. A Justice Health Executive confirmed that the process of revising their audit system is ongoing:

> ... I think the comment that the Coroner made was 'don't ask, don't tell'. So, ... how do we make sure that we are asking the really hard questions ... about what we see as the high-risk areas and ask [our providers] to tell us what audits they are planning ... we are just working through more detailed, more robust processes for completing those audits.

709. In response to a draft of this report, the Department stated that Justice Health does not only rely on audits undertaken by service providers, and engages in an ongoing process of revising its audit system with 'a particular focus on auditing the service elements that present the highest risk.'

710. To support the development of an audit process, Justice Health seconded staff from elsewhere within the Department, none of whom had experience or expertise in Aboriginal health care or Aboriginal cultural safety. When asked whether Justice Health had sought Aboriginal community input into designing the audit tool, a Justice Health Executive said:

> [W]hat we've worked through at the moment is an interim approach. We will continue to refine it ... working on ... more robust governance arrangements which will include consultation and oversight from external parties.

711. A Justice Health Executive stated that there is an expectation that healthcare providers will also undertake audits, both to demonstrate their compliance with the NSQHS Standards, and as part of their own clinical governance and quality assurance processes.

712. A Justice Health Executive stated that as part of their response to the Coroner's recommendation regarding their audit process, Justice Health was working on a tool to audit cultural safety. In its response to a draft of this report, the Department clarified that the Aboriginal Health Unit is leading the development of the tool.

713. Regarding auditing Aboriginal experiences of cultural safety and healthcare delivery, a Justice Health Executive stated:

> Justice Health doing this work should always be an add-on to our providers … we need to feel really confident that our health service providers are also actively engaging with the men and women in custody and hearing them and we really are doing that audit and check that actually what they're hearing matches our expectation, so that we can keep pushing and challenging them in different directions.

714. Shortly after the new contracts commenced, Justice Health sought input from the healthcare providers in developing its audit schedule for 2023-24. In the document sent to providers, Justice Health indicated that the audit schedule would focus on known risks:

- clinical service delivery
- known issues
- patient and workforce experience
- data management and health information
- service integration and collaboration.

715. The description of the 'patient and workforce experience' focus area stated audits 'may include dedicated focus areas, such as complaint handling and Aboriginal cultural safety'.

716. However, there is no requirement in the contract for healthcare providers to audit cultural safety or healthcare provision to Aboriginal people and Justice Health has never done this itself.

717. Justice Health could not give details about how or when it might audit specific aspects of healthcare provision to Aboriginal people.

718. Neither Western Health nor GEO Healthcare have yet developed or scheduled cultural safety audits.

719. In its January 2024 response to a draft of this report the Department stated:

> Since the [investigation met with Justice Health Executives in August 2023], the [Aboriginal Justice Caucus] has been consulted on the broader work on system oversight, and further engagement has been planned for 2024. Further engagement on the cultural safety audit framework is also planned for 2024.

720. The Department's response also included an overview of Justice Health's audit program for custodial health services in men's and women's prisons in response to the Coroner's recommendation, which stated:

> …the Aboriginal Health Unit will develop a cultural safety audit framework informed by Aboriginal stakeholders and patient voice research conducted with Aboriginal people in custody… Initial cultural safety audits will be conducted with [health service providers] at publicly operated prisons, focusing on Domain five of the 2023 Quality Framework, 'Aboriginal people in prison'. Equivalent cultural safety audits will extend to existing [health service providers] as they transition to the 2023 Quality Framework and where required, may incorporate cultural safety elements of the 2014 Quality Framework.

721. The overview stated that audit topics would include:

> whether custodial health services are designed and delivered to meet the physical, social, emotional, spiritual and cultural well-being needs of Aboriginal people in prison in a culturally safe manner. This will also include the patients' experience of all services available to Aboriginal people in custody, not just services provided by Aboriginal health practitioners.

722. However, the audit methodology, which was outlined as follows, did not refer to qualitative data collection from Aboriginal patients:

> The approach to conducting audits will be varied depending on the nature of the topic, including but not limited to:
>
> - Desktop audits
> - On observations
> - Qualitative data collection through interviews and surveys with [health service providers] and stakeholder staff
> - Quantitative data analysis.

Committees

723. A key part of providing culturally safe and responsive healthcare is ensuring Aboriginal representation at all levels of healthcare delivery and governance.

724. Both the women's and men's contracts set out committees that are responsible for overseeing healthcare delivery. There is no requirement under the contracts that the committees include Aboriginal stakeholder, consumer or community representation.

725. Western Health has its own committees that provide oversight of the delivery of healthcare at DPFC. The Aboriginal Health Steering Committee, which concerns all Western Health service delivery, and is not confined to the healthcare it is delivering at DPFC, is made up of 40 members, 29 of which are Aboriginal. At the end of August 2023 only one meeting of the Aboriginal Health Steering Committee had taken place since Western Health's prison contract began. Western Health stated that it was still working on ways in which it could incorporate feedback from DPFC into that Committee.

726. Western Health has reinstated Aboriginal Health meetings at DPFC. They are attended by AWOs, the Western Health Aboriginal Health Liaison Officers and DPFC representatives, with plans to include VAHS.

727. Under the men's contract, GEO Healthcare is required to establish four committees to ensure the delivery of services in compliance with the contract specifications and the 2023 Quality Framework. A Justice Health Executive explained that the Committee requirement for GEO Healthcare differs from the women's providers because 'they are folded into a much broader organisation. So they will fold it into their existing clinical governance structures'.

728. GEO Healthcare has implemented the Risk and Quality Committee at each location as the Health Service Safety and Quality Committee.

729. When asked whether Justice Health would oversee these GEO Healthcare committees, a Justice Health Executive was unable to tell us, and said Justice Health was still finalising the committees' terms of reference. In its response to a draft of this report, the Department said:

> The [Executive's] statement was intended to convey that Justice Health and providers were still finalising arrangements for which committees Justice Health would attend as observers. However, Justice Health maintains oversight of the clinical governance arrangements of all providers, regardless of whether or not it attends as an observer of individual committees.

Feedback

730. Because cultural safety is determined by the Aboriginal person receiving the service, we asked Justice Health how it sought feedback from Aboriginal people in prison. Justice Health told us it had a complaints process and had run 'patient voice' focus groups in mid-2023.

731. The new contracts require healthcare providers to comply with Justice Health's *Complaints Handling Framework 2018: Victorian Prisons* and to have systems to obtain, record, respond to and escalate complaints. They are also required to develop processes to actively seek feedback and must report to Justice Health on complaints and feedback quarterly.

732. The contracts make no specific references to ways in which Aboriginal people can be encouraged to make complaints. There is no recognition that complaints regarding cultural safety, or a failure to provide culturally responsive care, may require alternative complaint handling processes.

733. A Justice Health Executive said that many of the complaints that come to Justice Health are those where 'the person hasn't felt comfortable to engage with the health service provider and has talked to their family on the outside and that's when we've become aware that there's been some issue'.

734. Justice Health was not able to explain how it uses the complaint information it collects to inform healthcare improvements for Aboriginal people. In its response to a draft of this report, the Department said:

> Justice Health and health providers both use complaint information to inform improvements to healthcare. Complaints received including key themes and actions taken in response are discussed at contract management meetings.

735. To hear what Aboriginal people's experiences of healthcare in prison have been, Justice Health's Aboriginal Health Unit conducted a series of 'patient voice' focus groups with Aboriginal people at six prisons.

736. We understand that these focus groups were not intended to measure cultural safety so much as to understand Aboriginal people's experience of healthcare in prison. The focus groups took place around the time the old contracts ended and there is no formal plan to conduct further focus groups in future. While these focus groups may be useful to help individual prisons understand the lived experience of Aboriginal people in the different prison locations, they do not replace cultural safety assessments designed specifically to improve the experience of Aboriginal people when accessing prison healthcare as part of a systematic cultural safety plan.

737. Sometimes Justice Health seeks feedback as part of particular projects. For example, the Aboriginal Clinical Governance Officer who took the position in 2020 and was responsible for finalising the Aboriginal Cultural Safety Standards conducted a series of consultations with Aboriginal people in prisons to hear about their health care experiences.

738. However, the former Aboriginal Clinical Governance Officer, who gave permission to be identified by title in this report, told the investigation:

> In theory, the cultural safety standards for prison health service providers [are] embedded in the Quality Framework, and then there's a contractual obligation, but that's reviewed by white people … the cultural safety standards tell them how to tick a box. That's basically all they are and I said that from the start when I was working on this project, that I didn't like them and I don't think they're appropriate, they're not holistic, they're not fit-for-purpose and I don't feel like our prisoners' voices was appropriately heard through this process, but I was told very quickly, 'Just get the … thing out. It's been since 2017'.

739. In its response to a draft of this report, the Department disagreed with its former staff member's account:

> Development included consultation processes to establish an understanding of best practice in the community and identify appropriate Cultural Safety Standards. This process was an initiative under [the Aboriginal Justice Agreement Phase 3].
>
> The Cultural Safety Standards were endorsed by AJC in July 2018.
>
> A desktop review of the Cultural Safety Standards was conducted in 2021, including consultation with Aboriginal people in prison, VACCHO and Naalamba Ganbu and Nerrlinggu Yilam. The outcome of this review was that the Standards were still appropriate, and they were incorporated into the 2023 Quality Framework. At the time of this review, it was noted that VACCHO was in the process of developing Cultural Safety Standards for health services and that any further consultation and updates should not be undertaken before this work is completed.

740. Healthcare providers seek feedback from Aboriginal people in prison in various ways.

741. GEO Healthcare's Aboriginal Health Manager stated that the Aboriginal Health Practitioners at the Metropolitan Remand Centre are designing patient feedback forms to use in conjunction with the Aboriginal Health Check. The goal is to capture information in addition to clinical matters, including social and emotional wellbeing issues and practical concerns such as accommodation within the prison.

742. Western Health are currently collecting feedback from Aboriginal women at DPFC via the Aboriginal Health Liaison Officers as well as through the Aboriginal Health Liaison meeting. Western Health's Manager of Aboriginal Health Policy and Planning stated that there are also 'mainstream' methods of collecting feedback, like the Western Health patient feedback process. They noted that the Department of Health has a health experience survey that is sent randomly to patients at discharge but acknowledge the low rate of response.

743. Currently there is no bespoke survey for Aboriginal people. Western Health's Manager of Aboriginal Health Policy and Planning noted that in such a survey:

> [W]e need to really tailor things to be basic terminology … layman's terms of how we speak. I've looked at some [health experience] surveys and stuff like that and people go, 'Oh this, this is the layman's terms', and I'm like, 'But it still doesn't go to how we speak in community'. You know, something as simple as, you know, digestive system, well, that's your gut in community.

Justice Health's oversight of healthcare for Aboriginal people

744. As the managing entity of the new public prison healthcare contracts, Justice Health has a considerable role to play in ensuring that healthcare delivery incorporates all government policies and recommendations. Justice Health needs to lead by example and demonstrate that it understands what is involved in delivering culturally safe healthcare.

745. There have been some recent positive developments in response to the Cultural Review and Coroner's findings, notably the creation of an Aboriginal Health Unit. The Director of this unit is a 'designated' position, meaning it must be filled by an Aboriginal person.

746. However, the Unit is still in a formative stage and it is unclear what approach to cultural safety and responsiveness it intends to adopt. According to a Justice Health Executive at a meeting with the investigation in August 2023:

> They've been around for six months now … they're really looking at what is the best use of their space. I think we haven't really finalised a very detailed work plan … what we're trying to work through is … what are the biggest areas of concern and then how do we measure those changes … we should always be seeking feedback directly from men and women in custody …

747. In its response to a draft of this report in January 2023, the Department advised:

> The Aboriginal Health unit workplan and priorities for 2024 include:
>
> - Develop and implement the cultural safety audit framework
> - Commence engagement with Aboriginal Community Controlled Health Organisations (ACCHOs) to design Aboriginal led models of custodial healthcare
> - Continuous quality improvement of Aboriginal Health Checks in custody
> - Patient voice focus groups

748. The Department did not provide us with a copy of the workplan, despite being provided an opportunity to do so.

749. The response also said that since we met with Justice Health Executives in August 2023, Justice Health has developed a draft strategic plan – that was to be finalised in February 2024 – which includes 'self-determination' and 'cultural safety' as two of five pillars to guide its work to 2027.

750. In practice, Justice Health receives little feedback from Aboriginal people in prison, and does not seem to fully understand their experience.

751. For example, the specifications in both the men's and women's public prison contracts include the aim of:

> reducing over-representation of Aboriginal people [in prison] by … ensuring services are culturally safe through: a trauma-informed approach that recognises the impacts of racism and trauma on health and mental health

752. While Justice Health has worked with DPFC to begin to integrate a trauma-informed approach in the women's system, it is less clear how this is being implemented in men's prisons. When asked whether work was being done to implement a trauma-informed approach to healthcare in the men's prisons, a Justice Health Executive stated that women in prison 'have much, much higher rates of trauma' which must mean 'there is some reason why it isn't being applied in the men's [prisons]' and that the issue was a 'question for custodial [services]' rather than Justice Health.

753. The idea that Justice Health does not need to be working on a trauma-informed approach for Aboriginal men in prison is at odds with what Aboriginal men in prison told us about their own experiences of trauma and a lack of services to address it.

754. It also fails to recognise the widely acknowledged phenomenon of intergenerational trauma impacting Aboriginal people of all genders, or acknowledge that culturally safe healthcare provision involves understanding the impact of intergenerational trauma on Aboriginal people and their health.

755. In its response to a draft of this report, the Department stated that this section of the report 'is not a fair or accurate representation of Justice Health's understanding of trauma in the men's prison system' and noted that trauma-informed services are one of the over-arching aims of the primary health service model. The response outlined the relevant requirements in the 2023 Quality Framework and contract Service Specifications for public prisons in the new contracts – which have been detailed elsewhere in this report.

756. However, we regard the comments about trauma as relevant to this section of the report, which deals with Justice Health's capacity to oversee the requirements of the contracts, rather than the contents of the documents.

757. When asked whether Justice Health had done any work on the impact of systemic racism on the provision of healthcare in prisons, a Justice Health Executive pointed to the expectations of the specifications and the Quality Framework. They said:

> … fundamentally we're starting from the individual's perspective … do they feel confident that the service that is available to them is culturally safe and respectful of their needs? … [T]hat can be both about overt or underpinning racism, but it can also just be that they feel like people understand how they may want to engage as well, and so definitely going much further than something that … fits into … racism.

758. In its response to a draft of this report, the Department said that this comment does not reflect Justice Health's position on cultural issues in healthcare provision and stated:

> [The Department] acknowledges that there is still a lot of work to be done in addressing stigma, discrimination and racism and is committed to this work. Justice Health is also working to implement relevant recommendations from the Cultural Review.

759. While a focus on individual patients is a standard aspect of healthcare delivery standards and can be a positive thing, this approach means that broader issues, like systemic racism, can go unaddressed. More importantly, an understanding of and critical reflection on the way in which racism impacts on healthcare provision is a central practice of culturally safe healthcare delivery. A person-centred approach also risks overlooking the centrality of culture in Aboriginal peoples' identities and their experience of healthcare provision, and does not necessarily accord with Aboriginal models of healthcare.

760. When asked to describe how Justice Health would improve the provision of culturally safe healthcare alongside the commencement of the new prison healthcare contracts, a Justice Health Executive told the investigation that Justice Health believed that this would happen by improving healthcare services generally. Justice Health was:

> trying to increase our expectation that everything that the health service providers did would be better tailored to meeting the needs of the person who was in front of them, including providing a more culturally safe service for Aboriginal people … the whole service model is really about very person-centred care which then means that when the person in front of you is an Aboriginal person, that we have to operate in a way that best meets their needs.

761. In meetings with Justice Health Executives in August 2023, and in the Department's response to a draft of this report in January 2024, the Department emphasised that its oversight focus across 2023 was on actively monitoring and supporting the transition in of new primary healthcare providers in the public prisons.

762. The Department's response said:

> the commentary in the draft report on the expected pace of change in response to the findings of the [Cultural Review] and the [Veronica Nelson Inquest] fail to reflect the long lead times required to embed changes of this scale, including the timeframes necessary to support robust procurement processes and enhancing internal and external capacity to support service delivery changes.

763. However, as noted above, the men's contracts required the new healthcare providers to implement tailored responses for Aboriginal people in prison at the point that the new contract commenced on 1 July 2023. By implication Justice Health should have been prepared to oversight this at this point, which would mean having a prepared audit schedule, an updated and Aboriginal community-approved Cultural Safety Framework, Aboriginal designed and delivered assessment and evaluation tools and processes, and demonstrating a thorough and meaningful understanding of culturally responsive healthcare provision.

764. Indigenous Allied Health Australia ('IAHA') has noted that organisations are the 'critical drivers in creating culturally safe and responsive systems'. Its resource *Cultural Responsiveness in Action: An IAHA Framework* states:

> Considerations at the organisation level require reform of the cultural and historical factors affecting the governance, policies and procedures of services and organisations. It requires respect for, and inclusion of, Aboriginal and Torres Strait Islander self-determination, cultures and cultural practices, education and training, critical reflection at an organisational level and awareness of the history of non-Indigenous institutional control over Aboriginal and Torres Strait Islander people's lives and contemporary consequences.

765. In February 2024 the Productivity Commission released its *Review of the National Agreement on Closing the Gap*. In the report it said:

> real change does not mean multiplying or renaming business-as-usual actions. It means looking deeply to get to the heart of the way systems, departments and public servants work. Most critically, the Agreement requires government decision-makers to accept that they do not know what is best for Aboriginal and Torres Strait Islander people.

766. It is clear that Justice Health's intent in the newly drafted contracts was to create provisions that would ensure culturally safe and responsive healthcare for Aboriginal people. However, we did not see evidence that this change was rooted in an organisation-wide shift at Justice Health.

767. Currently, Justice Health lacks Aboriginal clinical governance expertise and an evidence-based understanding of culturally responsive care, which limits its ability to consider healthcare delivery through the lenses of cultural safety. In effect, this means the elements of the new contracts intended to improve healthcare provision to Aboriginal people are not supported by an understanding of the type of change they are intended to bring about.

768. The Department's response to a draft of this report stated that in addition to the new Aboriginal Health Unit, Justice Health draws expertise from a range of external sources, including ACCHOs and Aboriginal people in custody. As detailed elsewhere in this report, the investigation found that to date, this has not been adequate to ensure Justice Health meets oversight obligations with respect to healthcare for Aboriginal people.

769. While acknowledging that there is work underway, the investigation did not find evidence that there has been a meaningful change in how Aboriginal healthcare is understood by Justice Health.

Conclusions

770. Over the years, Australian and Victorian Governments have made many commitments to supporting Aboriginal peoples' self-determination. The Victorian Government's Aboriginal Affairs Framework embeds self-determination as the principle underpinning all policies relating to Aboriginal people, because 'it works', 'it is what community wants' and 'it is a human right'.

771. When it comes to healthcare for Aboriginal people, the *Victorian Closing the Gap Implementation Plan* specifically acknowledges that for Aboriginal people, health is holistic and that culturally safe healthcare must include physical, mental, social, emotional and spiritual dimensions.

772. The Victorian Government has also recognised that this should be delivered by well-resourced Aboriginal Community-Controlled Organisations, as they are best placed to deliver culturally safe healthcare and they achieve better outcomes for Aboriginal people.

773. But these commitments to self-determination, consultation and evidence-based health policy appear to stop at the prison gates.

774. The prison population overall experiences significantly poorer health and higher rates of disability and mental illness than the general population and Aboriginal people in prison fare even worse. Aboriginal people are over-represented in the justice system, have more complex health needs and die preventable deaths in custody at higher rates than non-Aboriginal people. Moreover, it is well-established in research and accepted by the Australian and Victorian Governments that Aboriginal people as a collective have a different understanding of health and wellbeing, and that they require holistic healthcare that encompasses cultural, social, emotional, spiritual and physical needs.

775. The World Health Organisation describes lived experience as a form of expertise and health services now widely accept that it is vital to understand the lived experiences of patients and consumers in order to better meet their needs. It is also accepted that cultural safety is defined by the recipient of care, not the caregiver. This means that it was crucial for us to listen to the experiences and concerns of Aboriginal people in prison. We are grateful to those who entrusted us with their stories and gave permission to include them in this report on the basis that their identities be kept confidential.

776. The Department and some of the healthcare providers expressed concerns about the inclusion of anonymised quotes and case studies. We acknowledge that people's experiences are subjective and that the need for us to protect the identities of vulnerable people in prison limited healthcare providers' ability to respond to this aspect of this report.

777. For this reason, none of the conclusions or recommendations in this report are based solely on the information provided by people in prison. As detailed below, and throughout the report, the evidence we relied upon included:

- documentary evidence, including information provided by the Department and healthcare providers
- oral evidence from current and former Justice Health and Corrections Victoria staff
- academic research
- policy statements, standards and other publications by national and international public health bodies and healthcare professional organisations
- the findings of previous inquiries
- submissions from Aboriginal community stakeholders
- Government policies and commitments.

778. This investigation set out to answer three questions about healthcare provision to Aboriginal people in Victorian prisons. Ultimately, we found a system that is failing to meet the needs of Aboriginal people and is not ensuring their best health outcomes.

779. The investigation took place during a transitional period in the way prison healthcare is provided. It is clear that some of the changes made by the Department during this period have the potential to improve healthcare for Aboriginal people, including the creation of an Aboriginal Health Unit within Justice Health and new contracts in the public prison system. The contracts include increased requirements regarding the provision of healthcare to Aboriginal people. In particular, the new Quality Domain 5 acknowledges that Aboriginal people have an increased risk of chronic and complex medical conditions. It also emphasises that for Aboriginal people, accessibility and effectiveness of health services are dependent on culturally safe and competent healthcare. It also acknowledges the centrality of connection land, culture and community to Aboriginal peoples' wellbeing.

780. However, these changes were made without meaningful input from the key Aboriginal community representatives who should have been involved, including the Aboriginal Justice Caucus and the Aboriginal community-controlled health sector. They were made in a way that undermined Aboriginal stakeholders' trust and did not deliver a system of healthcare that is Aboriginal-designed and led, even though it is well understood that Aboriginal people in the general community need and are entitled to this. As a result, these changes cannot be expected to bring about the substantive, system-wide change that previous inquiries and Government commitments have acknowledged is required to ensure that Aboriginal people in Victoria's prisons can access continuous, equivalent and culturally safe healthcare.

To what extent does healthcare provided in Victorian prisons meet the needs of Aboriginal people?

781. The healthcare currently provided in Victorian prisons does not meet the needs of Aboriginal people.

782. The way healthcare is currently provided is at odds with the evidence established by numerous reviews and the wishes of Aboriginal communities. It is also at odds with Government commitments to Aboriginal people's self-determination, equivalency and continuity of healthcare, and improving health outcomes in prisons to reduce the over-representation of Aboriginal people in prisons.

783. The Veronica Nelson Inquest, the Cultural Review and the Yoorrook Justice Commission all found that healthcare provision in Victoria's custodial system does not meet the needs of Aboriginal people.

784. The testimony we heard from Aboriginal people in prison echoed these findings. Aboriginal people in prison spoke of healthcare that did not meet their basic physical needs, let alone address the cultural, social and emotional elements of health.

785. While the Department's response to a draft of this report emphasised that changes have been made to healthcare provision (mainly in public prisons) since we spoke with Aboriginal people in prison, the current model itself does not align with Government commitments around self-determination, or with the Aboriginal communities' wishes. Moreover, the changes to healthcare provision since 1 July 2023 relate mainly to public prisons, excluding the nearly 40 per cent of the prison population held in private facilities.

To what extent is the healthcare system in Victorian prisons adequate to ensure the best health outcomes for Aboriginal people?

786. The current healthcare system in Victorian prisons is not adequate to ensure the best health outcomes for Aboriginal people because it does not reflect the evidence regarding the most effective and appropriate models of healthcare for Aboriginal people. The evidence is that Aboriginal people need holistic healthcare that attends to cultural, spiritual and social dimensions which is designed and delivered by the community.

787. The Department has not engaged with Aboriginal stakeholders in a way that allows them to have meaningful input into outcomes, despite government commitments to Aboriginal peoples' self-determination.

788. The investigation did not find any evidence that the views of Aboriginal people in prison were sought or taken into account in relation to the new healthcare service model or contracts.

789. Research shows that ACCHOs have expertise and a strong track record of providing culturally safe healthcare in the community. Aboriginal community representatives believe that contracting ACCHOs to deliver healthcare in prisons could provide culturally responsive care and promote continuity and equivalency of care when people exit prison.

790. While the Department had conversations with the ACCHO sector, we saw no evidence that the Department gave serious consideration to directly contracting ACCHOs to provide healthcare to Aboriginal people before deciding to engage a single mainstream provider.

791. Despite Justice Health telling the investigation that ACCHOs currently lack the capacity to deliver healthcare in prisons, the evidence is that the Department did not sufficiently assess the sector's capacity. This would have required the Department to provide ACCHOs with information about what delivering prison healthcare would involve as well as a meaningful and ongoing conversation about what ACCHOs and the community believe is required. The Department's rationale that ACCHOs lacked capacity ignores the fact that the new mainstream providers also currently lack capacity to meet all the requirements relating to Aboriginal health in the new contracts.

792. Instead, Justice Health began a major Health Services Review of the prison healthcare system in late 2020 in anticipation of the expiration of the contracts. However, this review did not systematically analyse the most appropriate way to deliver healthcare to Aboriginal people. Justice Health also told the investigation that it did not consult key Aboriginal stakeholders about changes to the prison health system for 'probity' reasons. The Aboriginal Justice Caucus told the investigation there was no reason it could not have been consulted about the healthcare model while meeting probity requirements.

793. Justice Health acknowledged that its decisions not to contract ACCHOs to provide healthcare directly, and to contract GEO Healthcare in the men's public prisons, went against the advice of Aboriginal communities.

794. Aboriginal organisations said that this not only meant that the overall model was against community advice, but that the new contracts – including the specifications, KPMs and 2023 Quality Framework – do not reflect Aboriginal perspectives. They also do not measure the cultural responsiveness of health services or the health outcomes for Aboriginal people.

795. The current contractual arrangements for healthcare provision in the prison system cannot guarantee equivalence or continuity of healthcare to Aboriginal people. They also create inconsistency, with some providers operating under the old 2014 Quality Framework and others using the 2023 Quality Framework.

796. There are now also public providers in the women's system (fulfilling part of the Cultural Review's recommendation that a public health model be adopted urgently across the prison system). Justice Health told the investigation this will improve clinical governance. But these changes have not been made in the men's system, where healthcare services are provided by a range of private providers.

797. The new public prison contracts include a greater number of Aboriginal health-specific requirements and processes. These include the introduction of Aboriginal Health Checks intended to be equivalent to those available in the community, the option for Aboriginal programs staff to attend medical appointments and family involvement in healthcare plans.

798. The 2023 Quality Framework and specifications in the contracts are an improvement. The 2023 Quality Framework links healthcare provision to Aboriginal people to national standards and Quality Domain 5 reflects a holistic approach to Aboriginal health, to an extent.

799. However, Quality Domain 5 is not supported by the means to operationalise this approach, and the contract does not require compliance with Quality Domain 5 to be measured or evaluated with tools designed by Aboriginal people. The lack of culturally appropriate evaluation of healthcare provision means Justice Health cannot know if Aboriginal people experience culturally safe and responsive healthcare.

800. Moreover, the KPMs in the new contracts measure quantity of services provided to Aboriginal people, but the quality of these services is not measured and nor are health outcomes.

801. Aboriginal organisations expressed concerns that measuring quantity alone will not address the complex health needs of Aboriginal people in prison and may impact on the quality of services – for example by creating an incentive for providers to offer short appointments or different staff – and do not reflect the time and care needed to build trust in a prison environment. They also raised concerns about the lack of KPMs related to improvements in health outcomes for Aboriginal people.

802. While the new contracts may deliver some improvements, they came into force before the new requirements could be fully met by the providers, or by Justice Health.

803. For example, Justice Health's audit schedule had not been completed and health service providers had not been able to recruit the required number of Aboriginal Health Workers.

804. In private prisons – which include some of the largest men's prisons in Victoria – healthcare contracts are managed by the company that operates the prison, rather than by the State.

805. This subcontracting of healthcare services by private prison operators impedes the State's ability to ensure consistency of healthcare services across the prison system and to require health services at private prisons to operate in accordance with Government policy and priorities.

806. For example, the Department is currently negotiating with three private prisons to modify their contracts to require them to comply with the new 2023 Quality Framework. At the time of publishing, they were still using the 2014 Framework, now 10 years old.

807. Similarly, the Department intends ACCHOs to subcontract to private prison operators, but VACCHO has said that ACCHOs do not wish to do this. ACCHOs regard such an arrangement as culturally unsafe and have said they would only consider directly contracting to the State.

808. There are also workforce capacity issues. There is a shortage of qualified Aboriginal Health Workers and Aboriginal Health Practitioners in Victoria, and a shortage of Aboriginal people in clinical governance, leadership, auditing and policy roles.

809. Justice Health said these workforce capacity issues were impacting the ability of the new providers to recruit Aboriginal staff. This is an issue across the State and affects both the ACCHO sector and the prison healthcare providers, who are recruiting from the same limited pool of workers.

810. Given the workforce capacity issues across the board, Justice Health does not seem to have considered that the Department could have chosen to invest in ACCHOs' capacity to deliver prison healthcare, rather than investing in private providers.

What is needed to ensure that Aboriginal people in Victorian prisons can access healthcare that is culturally safe, continuous, and of an equivalent standard and quality as that which is available to people who are not in prison?

811. Despite some recent positive developments in response to the Cultural Review and Coroner's findings, and its work to establish an Aboriginal Health Unit throughout 2023, Justice Health currently lacks Aboriginal clinical governance expertise. This limits its ability to consider healthcare delivery through a cultural safety lens.

812. Justice Health did not demonstrate a strong grasp of health from an Aboriginal perspective, cultural safety and factors impacting the health of Aboriginal people in prison. This means that Justice Health lacks a well-developed understanding of the evidence relating to culturally responsive provision of healthcare to Aboriginal people in prison. This poses risks and limitations to Justice Health's ability to oversee healthcare delivery to Aboriginal people.

813. An example is that Justice Health did not provide evidence that it made meaningful changes to improve healthcare provision to Aboriginal people for years following Veronica Nelson's death. The decision to contract a public healthcare provider for DPFC was made once it became clear that the Coroner would make negative findings, nearly three years after her passing.

814. Justice Health's confidence that a person-centred care approach will necessarily lead to the provision of culturally safe care does not accord with an understanding of cultural safety and the central role that culture and collective identity play in Aboriginal peoples' health and wellbeing.

815. That culture and collective identity are central to Aboriginal peoples' health and wellbeing has been accepted by the Victorian Government and embedded in the *Victorian Aboriginal Affairs Framework*. This framework identifies prioritising culture, addressing trauma and racism, and promoting cultural safety as among the 'self-determination enablers [identified by Aboriginal communities] which government must commit to and act upon over the next five years to make Aboriginal self-determination a reality'.

816. Justice Health's responses to the investigation did not demonstrate a good understanding of this evidence and suggest it may lack the capacity to properly oversee healthcare providers' compliance with requirements in the new public prison contracts.

817. In contrast, both GEO Healthcare and Western Health gave evidence demonstrating an understanding of the ways in which culturally responsive healthcare should be delivered to their Aboriginal patients. This includes an awareness and a stated commitment to incorporating trauma-informed practice in their service delivery.

818. While this is positive in terms of the providers and their stated approach, it is a risk that the delivery of culturally responsive healthcare appears to be currently reliant on the expertise of individual service providers. Ensuring culturally responsive healthcare requires systemic change, and this has to be driven by Justice Health, not by individual providers.

819. Justice Health has demonstrated a limited capacity to oversee the system and ensure providers meet the prescribed standards, despite some work underway including the development of a cultural safety audit framework and plans to establish an external oversight board.

820. It is clear from the Aboriginal people in prison who spoke with us, public health research, the extensive evidence compiled by previous inquiries, the submissions of Aboriginal community representatives and the Victorian Government's own commitments, that for Aboriginal people in prison to receive culturally safe, continuous and equivalent healthcare, more work needs to be done.

821. The Government needs to work with Aboriginal community representatives to implement an Aboriginal-designed and Aboriginal-delivered model of healthcare for Aboriginal people in prison. This will, by its very nature, require a holistic approach to health and involve greater integration between health services and prison authorities for its delivery.

822. Healthcare provision for Aboriginal people needs to include evaluation and assessment with an Aboriginal lens as to its cultural responsiveness. It needs a qualitative focus on user experiences and on health outcomes.

823. Justice Health needs to develop an evidence-based understanding of the health and healthcare needs of Aboriginal people in prison. It needs to build its capacity to monitor and provide effective oversight of whether these needs are being met by health services.

824. One aspect of this is improving its information systems. Existing systems currently fail to capture meaningful data about prison health outcomes and fail to support effective clinical practice. Another aspect is the need for Justice Health to engage Aboriginal staff with clinical governance expertise to improve its understanding of cultural safety and Aboriginal health needs.

825. The Department has pointed to the various steps it has taken and those it plans to take, as evidence that it is making progress towards delivering culturally safe healthcare for Aboriginal people in prison. However, our investigation showed that despite the Department's plans, little progress has actually been made and little has changed for people in prison.

826. Whatever actions the Department has taken to date, these have not been effective and are not sufficient.

Opinions

827. On the basis of the evidence obtained in the investigation, the Department of Justice and Community Safety's recent changes to healthcare provision for Aboriginal people were 'wrong' within the meaning of section 23(1)(g) of the Ombudsman Act, because they were made without adequate involvement of Aboriginal community stakeholders, which is inconsistent with:

    - the Victorian Government's own commitments to self-determination under the *Victorian Aboriginal Affairs Framework, Victorian Closing the Gap Implementation Plan* and *Aboriginal Justice Agreement* Phase 4
    - the recommendations of the Coroner and Cultural Review.

828. The Department's decision to solely offer mainstream health services to Aboriginal people in prison is 'improperly discriminatory' within the meaning of section 23(1)(b) of the Ombudsman Act as:

    - it is inconsistent with Victorian Government policies and commitments acknowledging that Aboriginal people have a different understanding of health; experience disadvantage and inequity in access to health and health outcomes; and have better health outcomes when able to access culturally safe healthcare delivered by Aboriginal Community-Controlled Organisations
    - the lack of Aboriginal-designed and delivered, culturally responsive healthcare in prison means that the current system denies Aboriginal people, as a cultural group:
        - equivalent care between prison and the community
        - continuity of care between prison and the community.

Recommendations

Pursuant to section 23(2) of the Ombudsman Act, the Ombudsman recommends the following actions.

The *Victorian Aboriginal Affairs Framework* and the *Aboriginal Justice Agreement* commit the Government to enabling Aboriginal peoples' self-determination. Our investigation found, as have many others, that the Aboriginal community wants healthcare delivered by ACCOs. Under the *Victorian Closing the Gap Implementation Plan 2021-2023* the Government committed to boosting formal partnerships and shared decision-making, and to building the ACCO sector. Given the Government's commitments and the Aboriginal community preference for healthcare provided by ACCOs, work should begin as soon as possible to enable ACCOs to deliver healthcare in prisons, where necessary by varying current healthcare contracts.

That the Department of Justice and Community Safety:

Recommendation 1

Work with key Aboriginal Community-Controlled Organisations ('ACCO') to design and deliver holistic custodial health services that are culturally safe and responsive to Aboriginal people, culture and rights. The community engagement, service design, implementation and outcomes should:

a. be conducted in accordance with Aboriginal community protocols and wishes
b. be embedded in Departmental policy and strategy
c. be evidence-based
d. be supported by an increase in relevant and diverse workforces
e. be enabled by effective IT systems, record-keeping and data-sharing
f. be formally evaluated by Aboriginal experts in cultural safety
g. include ongoing opportunities for Aboriginal patients to provide feedback and participate in service design.

To enable this, the Department must provide ACCOs with the necessary resources to ensure their participation in this process.

Department's response:

Accepted in principle noting that implementation will be reliant on funding.

Under the *National Closing the Gap Agreement 2020*, the Victorian Government committed to transforming Government organisations. Our investigation found that while Justice Health has taken some steps to improve the provision of healthcare to Aboriginal people in prison, we saw no evidence of a significant organisational shift at Justice Health in how it understands cultural safety and responsiveness. The following recommendation is drawn from the evidence around how organisations effect internal cultural change. It is in line with the Australian Health Practitioner Regulation Agency's definition of cultural safety and Indigenous Allied Health Australia's definition of cultural responsiveness. It is also in line with the Productivity Commission's recent finding that systems change involving deep reflection is essential for meeting the Closing the Gap commitments.

That the Department of Justice and Community Safety:

Recommendation 2

Increase Justice Health's capacity to oversight the delivery of culturally responsive healthcare to Aboriginal people by developing and implementing a capability building plan. The plan should be informed by the Australian Health Practitioner Regulation Agency's definition of cultural safety and Indigenous Allied Health Australia's framework for cultural responsiveness and include strategies to build individual and organisational capability. In developing the plan, the Department of Justice and Community Safety should:

a. embed processes for Justice Health staff to engage in critical self-reflection in relation to cultural responsiveness and cultural safety
b. embed Aboriginal health expertise, including Aboriginal clinical governance and cultural safety expertise, within Justice Health
c. support Justice Health's leadership team to manage this process through tailored cultural responsiveness training that addresses the impact of racism and trauma on healthcare provision and outcomes for Aboriginal people in prison.

Department's response:

Accepted in principle noting that implementation will be reliant on funding.

Under the *National Closing the Gap Agreement 2020* the Victorian Government committed to addressing inequities in health outcomes by ensuring access to culturally safe healthcare. Our investigation found that access to healthcare and the quality of it across the prison system varied and that it did not meet the standards of healthcare available outside prison.

That the Department of Justice and Community Safety:

Recommendation 3

Consider ways in which current custodial primary health contracts can be varied to provide oversight that is more culturally safe and responsive to Aboriginal people, such as but not limited to:

a. applying the *Healthcare Services Quality Framework for Victorian Prisons 2023* to all prisons
b. embedding key performance measures that measure:
    - Aboriginal people's health outcomes
    - the delivery and impact of trauma-informed services and culturally safe services
c. embedding requirements for Aboriginal cultural safety expertise in clinical governance structures.

Department's response:

Accepted in principle noting that implementation will be reliant on funding.

Under the *Victorian Aboriginal Affairs Framework* and the *National Closing the Gap Agreement*, the Victorian Government committed to promoting access to culturally safety services. Under the Aboriginal Justice Agreement it committed to meeting the needs of Aboriginal people through a more culturally informed justice system. Our investigation found that Justice Health is not effectively assessing whether prison healthcare is meeting Aboriginal people's needs. This was also reflected by the Coroner in the Veronica Nelson Inquest, who recommended that Justice Health revise its system for auditing and scrutinising custodial health care services.

That the Department of Justice and Community Safety:

Recommendation 4

Ensure Justice Health develops an audit framework to regularly assess the clinical effectiveness and cultural responsiveness of the health care delivered to Aboriginal people across all of the prisons in Victoria. The framework must be:

a. evidence-based
b. designed with input from experts in Aboriginal health and cultural safety
c. designed to capture the experiences of Aboriginal patients.

Department's response:

Accepted.

Research evidence shows that Aboriginal health professionals play a critical role in improving the health outcomes of Aboriginal people. The Department and ACCOs agree that there is currently a shortage of suitably qualified Aboriginal health professionals in Victoria. The Department of Justice and Community Safety needs to work with the Department of Health and the Department of Jobs, Skills, Industry and Regions to increase the Aboriginal health workforce capacity, especially in prisons.

That the Department of Health, the Department of Jobs, Skills, Industry and Regions and the Department of Justice and Community Safety:

Recommendation 5

Invest in education and training to increase the number of Aboriginal Health Workers, Aboriginal Health Practitioners and other Aboriginal health professionals in Victoria, and better support their career development.

a. provide support for students, to improve enrolment and course completion rates
b. allow delivery of training in rural and regional areas
c. provide opportunities for training in prison environments with additional support and culturally appropriate supervision.

Department of Health response:

Accepted in principle.

Department of Jobs, Skills, Industry and Regions response:

Accepted in principle.

Department of Justice and Community Safety response:

Accepted in principle noting that implementation will be reliant on funding, and that only part c of this recommendation is within the Department's direct control.

Appendix 1: The investigation

Authority to investigate

829. The Ombudsman's jurisdiction to investigate administrative action taken by or in an authority is derived from section 13 of the *Ombudsman Act 1973* (Vic).

830. In addition, section 13(2) of the Ombudsman Act provides the Ombudsman the power to enquire into or investigate whether the administrative action is incompatible with a human right set out in the *Charter of Human Rights and Responsibilities Act 2006* (Vic).

831. The Department of Justice and Community Safety is an 'authority' by virtue of section 2(1)(a) of the Ombudsman Act.

832. This investigation was conducted under section 16A if the Ombudsman Act, which provides that the Ombudsman may conduct an 'own motion' investigation into any administrative action taken by or in an authority.

What the investigation involved

833. On 7 November 2022, the Ombudsman notified the Minister for Corrections and the Secretary of the Department of Justice and Community Safety of her intention to investigate this matter.

834. The investigation analysed:

- written information provided by the Department (some of which was provided centrally by the Department and others by Corrections Victoria, Justice Health and the Naalamba Ganbu and Nerrlingga Yilam)
- publicly available material including public health research, Coroner's findings, and reports of previous reviews, inquiries and investigations

835. The investigation held meetings to assist its understanding of the issues including:

- healthcare provision to Aboriginal people
- oversight and contract management arrangements
- changes to healthcare provision resulting from the Cultural Review and Coroner's findings regarding the Veronica Nelson Inquest.

836. The investigation met with executives from Justice Health and Corrections Victoria, and some former Justice Health employees. The meetings took place in August 2023 and were recorded with the participants' consent. Participants were offered the opportunity to provide written responses to questions or attend formal interviews but opted for recorded meetings and were advised that information they provided may be quoted or otherwise included in a public report.

837. The investigation also met with representatives of GEO Healthcare and Western Health, while CCA chose to provide written responses to questions.

838. To ensure our investigation was culturally informed, we engaged two experts specialising in issues relating to the health of Aboriginal people in the criminal justice system, Professor Megan Williams and Jack Bulman.

Appendix 2: Aboriginal organisations' proposals for change

839. Each of the organisations that made submissions to the investigation set out recommendations for changes to prison healthcare provision for Aboriginal people. Their proposals are quoted below.

Victorian Aboriginal Community Controlled Health Organisation

- The Government implement all recommendations from the Royal Commission into Aboriginal Deaths in Custody.
- Fund Aboriginal Community-Controlled Health Organisations (ACCHOs) Ito provide healthcare in all Victorian prisons and custodial settings.
- The Government implements all recommendations made by the Cultural Review of Adult Custodial Corrections System 2022.
- Increase the Aboriginal health workforce.
- Increase access to culturally appropriate programs within prisons.
- Mandate cultural safety in all Victorian prison and custodial settings for all prison and custodial workforce.

Victorian Aboriginal Legal Service

- The Victorian Government should create and resource a legal service dedicated to providing legal advice and representation for people in prison, and properly resource Aboriginal Legal Services to provide such services to Aboriginal people in prison.
- VALS telephone numbers should be free and accessible to all people in prisons in Victoria.
- Responsibility for prison healthcare should be transferred from the Department to the Department of Health
- The Victorian Government must end privatisation of healthcare in prisons, including by cancelling the new contract with GEO Group, and transferring all prison healthcare services to the public healthcare system.
- The Victorian Government should properly fund ACCHOs to develop a model of care and provide their services in prisons.
- The Federal Government must ensure that incarcerated people have access to the Pharmaceutical Benefits Scheme (PBS) and the Medicare Benefits Schedule (MBS). The Victorian Government should advocate with other States and Territories and the Commonwealth to enable this access.
- Justice Health should immediately carry out a meaningful consultation process on the [MATOD] Guidelines, including all relevant stakeholders such as addiction experts and relevant ACCOs.
- The [MATOD] Guidelines should be immediately amended to ensure that individuals cannot be rapidly and involuntarily withdrawn from the [MATOD] Program, as a disciplinary measure, including for failure to comply with the Program Contract of Consent and Agreement.
- People in prison should be able to access harm reduction services available in the community, like needle exchanges and addiction specialist services.
- The Victorian Government should make further changes to the Justice Health and [Justice Assurance Review Office] Death in Custody Reviews, to ensure that they meet the requirements set out in Coronial Recommendation 36 from the Veronica Nelson Inquest. Stakeholders views, including from VALS, should be incorporated into this review process.

- The Victorian Government must urgently revise the system for auditing and scrutiny of custodial healthcare services, to ensure that there is a robust oversight and accountability system for all providers of prison healthcare (both public and private).
- The Victorian Government should significantly reform the system for monitoring prison healthcare services, to ensure that prison healthcare outcomes are the primary mechanism for measuring the delivery of prison healthcare services.
- Prison complaints, including complaints against private prisons and contractors, should be handled by an appropriately resourced independent oversight body with sufficient powers to refer matters for criminal investigation. The body must be accessible to people in prison and complainants must have adequate legislative protection against reprisals.

Aboriginal Justice Caucus

- The Victorian Government fully implement all Royal Commission into Aboriginal Deaths in Custody recommendations relating to custodial healthcare.
- All Aboriginal deaths in custody are subject to thorough coronial inquests with no exceptions for deaths considered to be due to natural causes.
- The Victorian Government, in partnership with the Aboriginal Justice Caucus, establish an independent, statutory office of the Aboriginal Social Justice Commissioner, to provide oversight for Aboriginal justice in Victoria, including implementation of coronial recommendations and recommendations from the [Royal Commission into Aboriginal Deaths in Custody] and associated inquiries. This office should be properly funded, with appropriate powers (including powers to conduct own motion inquiries), and report directly to the Parliament.
- Mandate regular training in Aboriginal cultural awareness, systemic racism and unconscious bias for: a) All agencies and bodies involved in the design, delivery or administration of programs and services across the Corrections system (Corrections staff, Justice Health, healthcare professionals, all staff involved in organisations currently delivering custodial healthcare).
- The Victorian Government fully implement all coronial recommendations relating to custodial health care in Victoria. Decisions about whether coronial recommendations have been fully implemented must reflect Aboriginal perspectives and decisions, and there must be a documented and consistent process for sharing information on the implementation of coronial recommendations with bereaved family members and the broader Aboriginal Community.
- Provide people in custody with healthcare (including mental healthcare) that is the equivalent of that provided in the community. This means that their physical and mental health needs must be met to an equivalent standard; not just that there is an equivalence of services available.
- Enshrine the right of Aboriginal and Torres Strait Islander peoples to self-determination in the Charter of Human Rights and Responsibilities Act 2006 (Vic) and other relevant justice legislation like the Corrections Act 1968 (Vic).
- The Victorian Government must fund and support Aboriginal organisations and Aboriginal Community Controlled Health Organisations to develop an Aboriginal-led and operated model of health care in Victorian places of detention.
- That there be early and ongoing engagement with the Aboriginal Justice Caucus in the development, implementation and review of frameworks and standards relating to custodial health care delivery and accountability.

- The Victorian Government must reform funding arrangements with Aboriginal Community Controlled Organisations and Aboriginal Community Controlled Health Organisations (in line with the recommendations of previous reports and commitments under the National Agreement on Closing the Gap) to provide sustainable, and ongoing support for all aspects of Aboriginal-led service delivery (from design to implementation, workforce development, data collection, and evaluation.
- There must be greater transparency of information on custodial health care provision and outcomes for Aboriginal people. Data needs to be collected and accessible to Aboriginal people and organisations.
- Collect and publish data on critical health incidents, adverse events and near misses for Aboriginal people in custody and those recently released from prison.

Appendix 3: Relevant government commitments

National and State level agreements

National Agreement on Closing the Gap (2020)

840. All states and territories have endorsed the *National Agreement on Closing the Gap* (2020), the latest iteration of an agreement first signed in 2008. The agreement commits the Australian and State Governments to address 'the fundamental divide between the health outcomes and life expectancy of the Aboriginal and Torres Strait Islander peoples of Australia and non-Indigenous Australians'.

841. The agreement has 17 target outcomes, including that Aboriginal people enjoy 'high levels of social and emotional wellbeing' and that Aboriginal people are 'not over-represented in the criminal justice system'.

842. It also commits the Victorian government to four priority reform areas designed to change the relationship between governments and Aboriginal people. These include boosting formal partnerships and shared decision-making; building the Aboriginal community-controlled sector; and transforming government organisations. On 3 July 2023, the Victorian government announced $3.3m in funding for Aboriginal organisations over four years to 'put them at the heart of [Closing the Gap] reform work'.

Victorian Closing the Gap Implementation Plan 2021-2023

843. The *Victorian Closing the Gap Implementation Plan* outlines the actions Victoria will take to achieve the objectives of the national agreement. It repeatedly emphasises that self-determination and culturally safe services are at the heart of addressing poorer health outcomes. It also supports Aboriginal models of social and emotional wellbeing and positions Aboriginal organisations as being best placed to deliver holistic and culturally safe health services to Aboriginal people.

844. The plan commits to ensuring that service systems are culturally safe:

> As the provider or funder of services intend to benefit the entire community, it is crucial that the Victorian Government ensures its systems, institutions, and the services it funds, are culturally safe and responsive to the needs of Aboriginal and Torres Strait Islander people.

845. The Plan also states:

> Victoria acknowledges that Aboriginal and Torres Strait Islander community-controlled services produce better, more sustainable outcomes for Aboriginal and Torres Strait Islander people and their communities. They achieve better results, employ more Aboriginal and Torres Strait Islander people, and are often preferred over mainstream services.

846. In relation to outcome 1, that 'people live long and healthy lives', the Plan states:

> The health and wellbeing of Aboriginal people is affected by several risk factors including the experiences of racism and discrimination, especially within the health system. As a result, Aboriginal people continue to experience poorer health outcomes than non-Aboriginal people…A well-resourced ACCHO sector is crucial for addressing the underlying factors that contribute to Aboriginal life expectancy rates and ensuring that the Aboriginal community has access to culturally safe care that reflects their definition of health and wellbeing. Social and cultural determinants of health including connection to Country, culture, community and family provide strong protective factors for Aboriginal people. Increased focus on preventative strategies and timely access to culturally safe services are ways the health system can contribute to improved health and wellbeing for Aboriginal people. Strong, holistic wraparound models of care that are based in Aboriginal ways of being, knowing and doing can provide additional opportunities to improve health and wellbeing for Aboriginal people and families.

847. In relation to outcome 1 – that 'people live long and healthy lives' – the Plan states that self-determination – including via a well-resourced ACCHO sector – is key to improving health outcomes for Aboriginal people in Victoria:

> A well-resourced ACCHO sector is crucial for addressing the underlying factors that contribute to [lower] Aboriginal life expectancy rates and ensuring that the Aboriginal community has access to culturally safe care that reflects their definition of health and wellbeing. Social and cultural determinants of health including connection to Country, culture, community and family provide strong protective factors for Aboriginal people… Strong, holistic wraparound models of care that are based in Aboriginal ways of being, knowing and doing can provide additional opportunities to improve health and wellbeing for Aboriginal people and families.

848. It also states:

> The Victorian Government is committed to improving health, wellbeing and safety outcomes for Aboriginal Victorians. At the very heart of this change is self-determination, whereby Aboriginal people take ownership, carriage and responsibility for designing, delivering and evaluating policy and services on their own terms.
>
> On July 2017, the Department of Health and Human Services launched the 'Supporting self-determination: prioritising funding to Aboriginal organisations' policy (the policy) with the overall objective of supporting Aboriginal self-determination and improving the health, wellbeing and safety outcomes of Aboriginal Victorians. The policy aims to prioritise Aboriginal-specific funding to Aboriginal organisations who provide services that address their communities' health, wellbeing and safety needs and aspirations.

849. Elsewhere, in relation to outcome 14 – that 'Aboriginal people experience high levels of social and emotional wellbeing' – the Plan states:

> Many Victorian Aboriginal people and their communities are strong and rich in their culture. However, Aboriginal people generally experience significantly poorer mental health, wellbeing and safety outcomes than non-Aboriginal people. The legacy of trans-generational trauma and experiences of systemic racism and discrimination are key drivers of these poorer outcomes. It is important that Aboriginal Victorians have access to Aboriginal-led services that are appropriately resourced and trained to respond to mental health care needs, as well as culturally informed mainstream services that understand Aboriginal concepts of social and emotional wellbeing.

> 'Social and emotional wellbeing' is the term preferred by many Aboriginal Australians to describe the social, emotional, spiritual, and cultural wellbeing of a person (Henderson et al. 2007). While acknowledging mental health as a critical area of wellbeing, social and emotional wellbeing emphasises the importance of individual, family and community strengths and resilience, feelings of cultural safety and connection to culture, and the importance of realising aspirations, and experiencing satisfaction and purpose in life.

Victorian Aboriginal Affairs Framework 2018-2020

850. The *Victorian Aboriginal Affairs Framework 2018-2020* ('VAAF'), developed through extensive consultations with Aboriginal communities, is the government's overarching framework for 'working with Aboriginal Victorians, organisations and the wider community to drive action and improve outcomes'. It 'sets out whole of government self-determination enablers and principles, and commits government to significant structural and systemic transformation'. It aims to provide a consistent framework for – rather than replace – the numerous existing strategies to embed self-determination and improve outcomes for Aboriginal people in Victoria.

851. The VAAF states that self-determination is the guiding principle in Aboriginal affairs, because 'it works', according to national and international evidence; because 'it is what community wants', and because it is a human right:

> We acknowledge that the way government enables Aboriginal self-determination will continue to evolve over time, based on changing community expectations and needs. However, community has identified four self-determination enablers which government must commit to and act upon over the next five years to make Aboriginal self-determination a reality:
>
> 1. Prioritise culture
> 2. Address trauma and support healing
> 3. Address racism and promote cultural safety
> 4. Transfer power and resources to communities.

852. It also acknowledges that Aboriginal peoples' self-determination 'involves more than consulting and partnering with Aboriginal Victorians' and that government should continue to strive towards transferring decision-making control to Aboriginal peoples and community on the matters that affect their lives.

853. Like the *National Agreement on Closing the Gap*, the VAAF sets out objectives and goals in key domains including 'Health and wellbeing' and 'Justice and safety'.

854. Goal 14 is that 'Aboriginal Victorians enjoy social and emotional wellbeing':

> It is important that Aboriginal Victorians have access to Aboriginal-led services that are appropriately resourced and trained to respond to mental-health care needs, as well as culturally informed mainstream services that understand Aboriginal concepts of social and emotional wellbeing.

855. Goal 15 – to eliminate Aboriginal over-representation in the justice system – acknowledges social and structural barriers such as racism and entrenched social and economic disadvantage as factors leading to higher rates of imprisonment.

856. Goal 16 – that 'Aboriginal Victorians have access to safe and effective justice services' – notes the need for intersectional response between a range of services, including health services, in prevention and early intervention to keep Aboriginal people out of the justice system.

Burra Lotjpa Dunguludja – Aboriginal Justice Agreement

857. While self-determination is at the heart of the VAAF, the AJA embeds these principles in the justice system.

858. The AJA is a long-term partnership between the Victorian government and the Aboriginal community. The first AJA (2000-2006) was developed in response to recommendations from the 1991 Royal Commission into Aboriginal Deaths in Custody, and is currently in Phase 4, which began in 2018.

859. Signatories include the Aboriginal Justice Caucus, Regional Aboriginal Justice Agreement Committees, key Aboriginal organisations, and representatives of the Victorian Government including the Minister for Corrections.

860. The AJA commits signatories to 'working together to improve Aboriginal justice outcomes, family and community safety, and reduce over-representation in the Victorian criminal justice system.' It consists of a number of levels, including domains reflecting critical areas in which outcomes need to be achieved, goals that are considered achievable within the current phase, and outcomes reflecting desired changes for individuals, families, communities and the justice system as a result of actions implemented under the agreement.

861. Under Domain 3 – 'a more effective just system with greater Aboriginal control', with the goal of meeting 'the needs of Aboriginal people…through a more culturally informed and safe system', Justice Health has committed to partner in 2023 with the Aboriginal Justice Caucus, the ACCHO sector, people in custody and subject matter experts to build the cultural safety of custodial healthcare, focusing on three priority areas:

1. Aboriginal-led Models of Custodial Healthcare:
    - develop Aboriginal-led custodial and post-release healthcare models across Victoria.
2. Strengthen the cultural safety of health care service delivery:
    - Develop and implement the Aboriginal Cultural Safety Standards Audit Framework.

- Monitor feedback and complaints, identify trends and themes to improve accessibility and quality of health service provision to Aboriginal people in custody
- Support custodial health service providers with the implementation of the Justice Health Aboriginal Cultural Safety Standards
- Build staff capabilities to work within the Victorian Aboriginal Affairs Self-Determination and Closing the Gap Frameworks

3. Knowledge and Evidence
   - Develop the evidence base to continuously improve the quality and cultural safety of healthcare for Aboriginal people in custody.

Departmental plans and initiatives

862. The Department has implemented a series of initiatives that seek to improve the cultural safety of Aboriginal people in custody.

Justice Health Quality Framework

863. In 2014 Justice Health adopted the *Justice Health Quality Framework* which set standards of primary healthcare in Victorian prisons and formed part of the contractual requirements of both public and private prison healthcare providers.

864. The 2014 Quality Framework includes a number of the Royal Commission recommendations relating to corrections healthcare, including: the right to receive healthcare equivalent to that available to the general public; that prison healthcare staff receive training about issues that relate to Aboriginal health, including history culture and lifestyle; and that Aboriginal prisoners receive a medical assessment within 72 hours of reception.

865. There is no data available to show that the quality or outcomes of Aboriginal healthcare improved with the introduction of the 2014 Quality Framework.

Aboriginal Social and Emotional Wellbeing Plan

866. The *Aboriginal Social and Emotional Wellbeing Plan* ('ASEWP') was developed by Justice Health and Corrections Victoria as part of the *Aboriginal Justice Agreement* Phase 3. It recognises the role of culture, community and spirituality in health and wellbeing for Aboriginal people, and aims to improve health and justice outcomes for Aboriginal people in prison. It supports a range of programs that aim to provide connections to culture, community and Country and support partnerships with Aboriginal organisations to provide direct social and emotional wellbeing support to Aboriginal people in custody.

867. The ASEWP was released in 2015 and expired in 2018, and focused on five priority areas to improve the mental health and wellbeing of Aboriginal people while incarcerated and upon their release:
   - prevention and health promotion
   - culturally capable workforce
   - culturally safe and responsive services
   - continuity of care
   - working from and building an evidence base.

868. A 2020 evaluation found that good practice underlined the design of the ASEWP, as well as individual initiatives pursued under the plan such as the Continuity of Health Care Pilot.

869. This pilot operated from 2017-18 until 2020 at Dhurringile Prison, DPFC and Fulham Correctional Centre, and involved local ACCHOs providing in-reach health services from an Aboriginal health care worker. The program aimed to build connections with prisoners prior to release, schedule appointments at ACCHOs and follow ups post-release to increase the likelihood of successful transition of health care.

870. The 2020 evaluation report made recommendations to capitalise and extend improvements to cultural safety and the social and emotional wellbeing support available to people in custody. These included recommendations that the Department develop a next-phase Plan that:

- recommits the Department to improving social and emotional wellbeing as a priority within the corrections system
- continues to build culturally appropriate programs and services for prisoners, developing a culturally competent workforce, ensuring a culturally safe system and strengthening partnership with community
- explores opportunities for innovative service delivery partnerships between ACCHOs and Health Service Providers to provide regular in-reach services by Aboriginal Health Workers to all or most prisons
- funded partnership with ACCHOs to provide for regular in-reach by Aboriginal Health Workers to work with health services staff and with Aboriginal Wellbeing Officers, building on the Continuity of Health Care Pilot
- explore a partnership-based approach in which the Department and Aboriginal community organisations jointly co-design Social and Emotional Wellbeing program needs, implementation and monitoring
- enables equitable access to Social and Emotional Wellbeing strengthening programs for remanded and protection prisoners
- strengthen clinical governance of Aboriginal health within the prison system by establishing a reference panel of Aboriginal people with clinical expertise to guide and advise Justice Health and contracted Health Service Providers

871. A 2020 Evaluation Report noted Justice Health had implemented many of the actions prescribed by the ASEWP. Recommendation 7 of the report read:

> To support and assure the delivery of culturally appropriate clinical care, Justice Health should continue to strengthen clinical governance arrangements governing service delivery to Aboriginal prisoners. This should encompass:
>
> - strengthening clinical governance of Aboriginal health within the prison system by establishing a reference panel of Aboriginal people with clinical expertise to guide and advise Justice Health and contracted HSPs
> - continue to embed clinical standards, supported by operational policies, procedures and tools that provide specific guidance to health service staff on the practical delivery of culturally appropriate clinical care
> - continue the function of the Clinical Standards Review Officer within Justice Health to audit and assure the implementation by HSPs of the clinical standards.

872. However, it is not clear what action was taken on this recommendation.

Yarrwul Loitjba Yapaneyepuk – Walk the Talk Together Koori Inclusion Action Plan (2017-2020)

873. The Department's *Koori Inclusion Action Plan* aimed to ensure that 'structures, behaviours, culture and values reflect respect for the Koori community, the Traditional Owners of the land upon which we all live and work as Victorians'. According to the Plan, it envisioned a department committed to Aboriginal peoples' self-determination and principles of:

- partnership with Koori communities – with relationships built on understanding, trust and continuous learning
- incorporating Koori business into everyday business – by actively demonstrating commitment to Koori inclusion
- improving Koori outcomes – by making the Department services respectful and responsive to the Koori community, supporting Koori economic development and meet departmental commitments to improving justice outcomes for Kooris.

Strengthening Aboriginal Custodial Health Care Project

874. Justice Health's Strengthening Aboriginal Custodial Health Care Project was designed in 2021. The projects aimed to:

- develop a comprehensive, long-term plan of action that is evidence-based and targeted to need, and is capable of addressing the existing inequalities in health services in order to achieve equality of health status and life expectancy between Aboriginal and/or Torres Strait Islander and non-Indigenous Australians by 2030
- ensure the full, inclusive participation and self-determination by Aboriginal people in prison and their representatives in all aspects of addressing the health need
- prioritise culture, address trauma and support healing
- address racism and promote cultural safety.

875. The project was endorsed by the Aboriginal Justice Caucus. The project set five priority areas for action and had a comprehensive range of projects intended to fulfil it.

Figure 20: Priority areas of the Strengthening Aboriginal Custodial Health Care Project

Priority Area One – Quality Improvement and Research

- Aboriginal Health Risk Reviews and Audit Planning
- Health Service Providers Aboriginal Health Action Plan
- Aboriginal Prisoner Health Workshops
- Jurisdictional Review – into Aboriginal Prisoner Health Care
- Advance Care Planning, Journey to the dreaming
- Review of health promotion information and fact sheets to ensure cultural relevance

Priority Area Two – System Improvement

- Implementation of the 715 Aboriginal Health Check
- Integrated Care Plan Tool – Review
- Mental Health Recovery Plan - Review
- Aboriginal Cultural Safety Standards for Prison Health Service Providers
- Cultural Safety through art
- Continuity of Aboriginal Health Care Program

Priority Area Three – Stakeholder Engagement

- Stakeholder Engagement and Promotion Plan and Pack
- Aboriginal Mental Health Reform – Clinical Consultation Group

Priority Area Four – Staff Training

- Cultural Wellbeing Program
- Cultural Mentoring Program
- Digital Story Telling Project
- VACCHO – Cultural Safety Training
- Culcha Camp – Mulana Kaalinya
- Justice Health, Tertiary Scholarship Fund – Reimplementation

Priority Area Five – Workforce Enhancement

- Health Services Review – Aboriginal Healthcare Enhancements 2023
- Health Service Provider fostering partnerships with ALOs and AWOs

Source: Department of Justice and Community Safety

876. The Project aligned with recommendations from the Royal Commission into Aboriginal Deaths in Custody, the *Aboriginal Justice Agreement* Phase 4 and the *Victorian Aboriginal Affairs Framework.* As part of this, Justice Health met with 237 Aboriginal people in prison and identified five consistent findings:

- Conscious and unconscious bias
- Lack of communication
- Dental appointments
- Care without care
- Lack of Aboriginal health staff or staff with limited cultural knowledge

877. The Aboriginal people who spoke to Justice Health also recommended:

- Aboriginal Health Liaison Meetings – to build rapport and include prisoners in quality improvement
- Lived experience video – prisoners explaining their views on engagement and culturally safe healthcare, to educate clinical staff
- Medical appointment notification – prisoners work on a process with health staff to have appropriate notification on internal appointments
- Aboriginal health promotion and screening – information sessions on health information and different health screenings
- Culturally appropriate and holistic care – need for a more holistic approach to healthcare needs that includes therapeutic approaches
- Recruitment of Aboriginal health staff with cultural knowledge, because of the impact of this on their social and emotional wellbeing.

Other standards and frameworks for corrections

Guiding Principles for Corrections in Australia (updated February 2018)

878. The *Guiding Principles for Corrections in Australia* are a set of outcomes or goals to be achieved by correctional services. They were endorsed by the Corrective Services Administrators' Council which comprises the heads of Corrective Service agencies in each jurisdiction in Australia and New Zealand, including the Corrections Victoria Commissioner. The Principles are not enforceable, but a 'statement of national intent, around which each Australian State and Territory jurisdiction must continue to develop its own range of relevant legislative, policy and performance standards'.

879. The Principles recognise the continued and increased overrepresentation of Aboriginal people across the criminal justice system and include specific principles relating to Aboriginal people across the three outcome domains of respect, health and wellbeing and rehabilitation and reintegration. These include:

> 4.1.10 Holistic health services are provided to Aboriginal and Torres Strait Islander prisoners that encompass mental and physical health; cultural and spiritual health needs; and recognise how connection to land, ancestry, and family and community affect each individual.
>
> 5.1.6 Interventions for Aboriginal and Torres Strait Islander prisoners/offenders are culturally specific or adapted to cultural needs. They acknowledge the impact of Stolen Generations and emphasise indigenous healing and wellbeing.

> 5.2.4 Aboriginal and Torres Strait Islander prisoners are provided with culturally relevant reintegration and post release services.
>
> 5.4.4 Meaningful community partnerships are developed and maintained with Aboriginal and Torres Strait Islander organisations, Elders, other respected persons and the broader community to support the successful reconnection and reintegration with their community.

Correctional Management Standards

880. The Correctional Management Standards for Men's Prisons in Victoria and the Standards for the Management of Women Prisoners in Victoria set out specific standards for the management of Aboriginal men and Aboriginal women in custody.

881. The Standards recognise that the safety of Aboriginal people in custody requires the consideration of a range of factors, including connections to family, community and Elders and ensuring that staff have the capability to understand and respond to the needs of Aboriginal people in custody.

882. The intended outcome of the Standards is that:

> prisoners who identify as Aboriginal or Torres Strait Islander are managed in a manner that is sensitive to their cultural needs and provided programs and services that focus on increasing protective factors and decreasing risk factors with a view to reducing the likelihood of reoffending.

883. The Standards provide that prison General Managers will do a number of things, including:

- comply with the principles and directions outlined in the Aboriginal Justice Agreement, including the recommendations of the Royal Commission into Aboriginal Deaths in Custody
- provide Aboriginal prisoners with access to an Aboriginal Wellbeing Officer
- accommodate Aboriginal prisoners together, where possible and appropriate
- train all staff members with the aim of their developing an understanding of the cultural needs of Aboriginal prisoners and ensure that staff:
  - are aware of the particular needs of Aboriginal prisoners
  - have regard for their life experience
  - manage them with dignity and respect
  - facilitate their access to appropriate support services.
- provide opportunities for Aboriginal prisoners to have access to recognised Elders and participate in celebrations and ceremonies of cultural importance
- facilitate assistance and support for families to visit Aboriginal prisoners.

Indigenous Strategic Framework

884. The 2016 *Indigenous Strategic Framework*, endorsed by the Corrective Services Ministerial Council (which includes the Victorian Minister for Corrections) in July 2016, sets out guidelines for the management of Indigenous people in corrections in Australia and New Zealand.

885. The Framework recognises that 'Indigenous people have experienced high levels of trauma through the loss of land, culture, language and the breakdown of traditional lore', which has been passed down through generations. It requires that 'decisions makers … when managing and processing Indigenous offenders … determine if their decision has increased or reduced the potential for a death in custody'.

886. The Framework also states:

> To ensure Indigenous deaths in custody do not increase, the health and wellbeing of Indigenous prisoners and offenders needs to be a major consideration in managing Indigenous prisoners and offenders.

887. It sets out considerations relating to the health of Indigenous people in prison, including:

- To ensure deaths in custody do not increase, appropriate integrated health services need to be made readily available to Indigenous prisoners and offenders.
- Staff should be provided with appropriate training to manage Indigenous prisoners and offenders with complex needs including health needs.
- An adequate health care plan needs to be developed for Indigenous prisoners and offenders, linking to appropriate internal and external health care providers to improve health outcomes.
- Training needs to occur to increase staff awareness of health issues that impact on Indigenous prisoners and offenders to ensure identification and early detection of health emergencies when they arise.
- Health plans and medical history needs to be accessible for Indigenous prisoners and offenders entering and exiting the criminal justice system.
- Programs need to improve Indigenous prisoners and offenders wellbeing by addressing issues such as intergenerational trauma, grief and loss, institutionalised behaviour, education, mental health, skills development, employability skills with the aim to successfully reintegrate them back into the community.

Operational requirements in prisons

888. The Department issues operational instructions for custodial staff in Victoria's prisons, known as the Commissioner's Requirements and the Deputy Commissioner's Instructions.

889. The Commissioner's Requirements are a high-level set of operating instructions that apply to all Victorian prisons, both public and privately operated. The Deputy Commissioner's Instructions are a set of specific standards applicable only to public prisons. In lieu of the Deputy Commissioner's Instructions, private prisons have sets of Operating Instructions that are specific to each prison, which are reviewed by Corrections Victoria and the Department for consistency with corrections legislation and contractual requirements.

890. Underneath these policies, each prison typically has its own Local Operating Procedures that prescribe operational procedures for corrections staff specific to each prison.

891. Commissioner's Requirement *2.7.1 Aboriginal and Torres Strait Islander Prisoners* establishes minimum standards across all prisons for the management of people in prison who identify as Aboriginal. Its requirements include:

- staff training to develop an understanding of the cultural needs of Aboriginal people in prison
- during initial reception into a prison, Aboriginal prisoners are to be observed every 30 minutes until a mental health assessment is undertaken
- within 24 hours of an Aboriginal person's reception into prison or identifying as Aboriginal, Aboriginal prisoners are to be given access to an appropriate contact person, such as an Aboriginal Wellbeing Officer or an Aboriginal Liaison Officer, unless there are exceptional circumstances
- a person's Aboriginal status must be recorded on eJustice
- the General Manager of a prison to provide programs for Aboriginal people in prison which reflect their culture and which incorporate links to community programs

892. Other Commissioner's Requirements that are wholly dedicated to Aboriginal people in custody include:

- *CR 1.2.8 Funeral attendance of Aboriginal prisoners* – which stipulates the process and requirements for Aboriginal prisoners to attend a funeral of an Aboriginal person in the community
- *CR 4.5.1 Aboriginal Art Program* – which establishes guidelines for the management of artwork produced by Aboriginal prisoners participating on the Statewide Indigenous Arts in Prisons and Community Program ('The Torch Program').

893. There are also general Commissioner's Requirements which apply to all prisoners but prescribe specific requirements in relation to Aboriginal people in prison. These include:

- *CR 3.4.1 Living with Mum Program* – which stipulates that the Living with Mum Program (for children remaining with their mothers in prison) must be sensitive to the maintenance of cultural and community links for Aboriginal women
- *CR 2.3.1 Management of 'At Risk' Prisoners* – which makes the General Manager of a prison responsible for the development and implementation of procedures for prisoners 'at risk' of suicide, and must ensure that wherever possible, an Aboriginal Wellbeing Officer (or equivalent) is involved in the development of risk management plans for Aboriginal prisoners
- *CR 1.3.3 Reporting and Review of Prisoners Deaths* – which provides that the response and reporting of the death of an Aboriginal or Torres Strait Islander person must be managed in a culturally sensitive way and must be in the best interests of the person, their family and the broader Aboriginal community.

894. Relevant Deputy Commissioner's Instructions include:

- *DCI 2.07 Aboriginal and Torres Strait Islander Prisoners* – which stipulates that prisoners who are Aboriginal should be managed in a manner sensitive to their cultural needs, and largely mirrors the requirements established in the Commissioner's Requirements
- *DCI 1.02 At Risk Prisoners* – during the initial reception process, Aboriginal prisoners will be automatically deemed a significant (S2) risk of suicide/self-harm until an 'at risk assessment' is completed by a mental health professional, and requires prison staff to consult with the Naalamba Ganbu and Nerrilinggu Yilam / Aboriginal Wellbeing Officer regarding the ongoing management of an 'at-risk' Aboriginal and Torres Strait Islander prisoner
- *DCI 2.03 Offender Management* – which requires Aboriginal Wellbeing or Liaison Officers to assist a prisoner's case worker to develop the Local Plans of each Aboriginal prisoner, which stipulates the prisoner's goals while in custody
- *DCI 1.20 Deaths in Prison* – which provides notification processes in the event of a death of an Aboriginal person in custody, and largely mirrors the process established in Commissioner Requirement 1.3.3 Reporting and Review of Prisoner Deaths
- *DCI 1.11 Reception, Care and Control of Prisoners* – requires reception staff to ask all prisoners if they identify as Aboriginal and advise prisoners how to contact the Victorian Aboriginal Legal Service, and further requires the local Health Service Provider to assess the physical and mental health of all people in custody within 24 hours, to assign a medical risk rating to all Aboriginal prisoners and complete a medical risk and an integrated health care plan.

Appendix 4: Previous reviews

895. For more than 30 years, numerous national and state-based bodies have investigated the causes of poor Aboriginal health outcomes and deaths in custody and made recommendations about how to address these issues.

1991 Royal Commission into Aboriginal Deaths in Custody

896. In 1991 the landmark Royal Commission made 339 recommendations, at least 200 of which were about improving the health of people in prisons. Several times the Royal Commission recommended that Aboriginal health services be funded to provide leadership and care for Aboriginal people in prison.

897. Twenty recommendations outlined how Aboriginal health services could self-determine improvements in prison health services. It was recommended that governments invite Aboriginal health services to deliver prison health services in areas where they already operate, or where Aboriginal people are particularly over-represented. This recommendation has rarely been implemented.

898. The Royal Commission also recommended that Aboriginal health services be included in health planning decisions, including:

- reviewing and guiding prison health standards, including on cultural matters
- training for prison health staff and police
- developing protocols for transfer of health information
- integrating Aboriginal health care with mental health and psychiatry
- operating early intervention programs to reduce numbers of people incarcerated.

899. Regarding the health of individuals and families, the Royal Commission recommended Aboriginal health services be used in health assessments, drug and alcohol rehabilitation, counselling and mental health care, including through national leadership.

900. The Royal Commission called for Aboriginal people to be involved in every level of research and to be funded for evaluation to assist with program development.

901. To achieve these things, the Royal Commission recommended 'funding arrangements necessary for them to facilitate their greater involvement'.

902. The AJC told the investigation it is currently undertaking a project to assess Victoria's implementation of the Royal Commission's recommendations. It believes that 'whilst some recommendations have been implemented … robust implementation of these recommendations would have gone a long way to improving justice and health outcomes for Aboriginal people.'

Ombudsman investigations

903. The Victorian Ombudsman has previously investigated issues relating to prison healthcare, programs for people in prison and the experiences of Aboriginal people in custody.

904. In 2014, the Ombudsman released her *Investigation into deaths and harms in custody*. The report identified that 38 per cent of all prison cells still had hanging points, which failed to comply with Corrections Victoria's Cell and Fire Safety Guidelines and the Royal Commission's recommendations to removing hanging points from cells. The Ombudsman also recommended eliminating all possible hanging points in cells. To improve reviews of deaths in custody, the Ombudsman recommended establishing an independent custodial inspectorate, with monitoring and oversight responsibilities for Victorian prisons, which would report to Parliament.

905. In 2015, the Ombudsman completed her *Investigation into rehabilitation and reintegration of prisoners in Victoria*. The investigation considered the efficacy of rehabilitation and transitional services in Victoria's prisons, and whether the system was working to reduce reoffending. The investigation concluded that rehabilitation programs had not kept up with demand and that few rehabilitation programs are available to people in prisons. The report also concluded:

- that culturally specific programs for Aboriginal prisoners were run haphazardly
- that drug treatment programs are inadequate to meet demand, and there are significant barriers to access, including for people on remand
- there are too few Aboriginal Wellbeing Officers and Aboriginal Liaison Officers to provide adequate support for rehabilitation and reintegration.

906. In 2017, the Ombudsman concluded her investigation *Implementing OPCAT in Victoria - report and inspection of the Dame Phyllis Frost Centre*. The investigation involved Ombudsman staff visiting DPFC over the course of seven days and speaking directly to women inside the prison. The main issue Aboriginal women raised was the lack of access to culturally safe healthcare, as well as barriers to participating in the Mothers and Children program.

Cultural Review of the Adult Custodial Corrections System

907. The Cultural Review was established by the Victorian Government to 'inquire into and report on culture, safety and inclusion, and integrity within the Victorian custodial corrections system'. It commenced in August 2021 and provided its report to the Minister for Corrections in December 2022. The terms of reference included to 'support a safe prison system that is free from breaches of integrity, sexual harassment and discrimination and promotes Aboriginal cultural safety and self-determination'.

908. The Cultural Review received direct testimony from 214 Aboriginal people in 12 prisons and engaged with Aboriginal corrections staff and community organisations. It made many findings about Aboriginal people's experiences of healthcare in prison, noting:

> Without exception, every Aboriginal person in custody that we spoke to reported serious challenges in accessing medical treatment including an overwhelming sense that they had no control over their health needs.

> We heard many stories of people living in custody with chronic pain that was poorly treated, under recognised, dismissed and which over time, in addition to the physical pain, resulted in anxiety, depression and emotional instability. Aboriginal people in custody are more likely to experience health issues and chronic disease. Aboriginal people are also likely to experience further barriers to accessing healthcare given the impact of trauma, dispossession, family separation, systemic racism, and stigma.

909. Of Aboriginal conceptions of health, the Review stated:

> Understanding health from the perspective of Aboriginal people helps explain the importance of access to culture, community, Country and family to the mental health and wellbeing of Aboriginal people. It also explains clearly why incarceration, which demands separation from family, community and usually Country, is so damaging to the health of many Aboriginal people. For this reason, the delivery of healthcare to Aboriginal people in custody cannot be a variation or a more "culturally safe" version of mainstream health services. It should be designed to support a holistic conception.

910. The report also highlights the importance and significance of ACCHOs in relation to healthcare provision for Aboriginal people in prison, stating:

> ACCHOs are rooted in the community – the term 'community-controlled' is very real, with board members and staff drawn from local communities. In that way, ACHHOS can be more responsive to needs of Aboriginal people than mainstream health services.

911. The Cultural Review found that Aboriginal people in prison do not feel culturally safe accessing mainstream prison health services. People who described experiences of racism and discrimination said they were afraid to access healthcare because of fears of dying in custody. They identified the impact of intergenerational trauma and the related fear of medical intervention or sharing information that might result in separation from other Aboriginal people, their families and communities.

912. The Cultural Review reported that Aboriginal people in prison spoke of:

- limited access to cultural practice, cultural spaces, and cultural programs, with little or no access to cultural supports reported at some prisons
- barriers to meeting cultural obligations, limiting opportunities to connect with family and community
- limited access to timely safe healthcare, and limited understanding of Aboriginal health and wellbeing in the delivery of healthcare services.
- limited access to culturally informed programs and supports, contributing to poor connections with community, impacts on mental health and rehabilitation outcomes
- the collective trauma experienced when learning of an Aboriginal death in custody.

913. They said that elements that contributed to better experiences in prison included:

- access to the support of an Aboriginal Wellbeing Officer
- access to cultural spaces and opportunities to practice culture
- access to cultural programs and culturally informed supports, including culturally informed rehabilitation programs
- opportunities to connect with family, culture, and spend time on Country and in the community
- support with health and wellbeing that is culturally informed and safe.

914. The Cultural Review called for an urgent overhaul of the way healthcare is provided to Aboriginal people in prison to ensure safer health services and continuity of care. It recommended that:

> The Department of Justice and Community Safety should commission a Victorian Aboriginal community-controlled health organisation, peak body or Aboriginal consultancy service to develop a model of care for Aboriginal people in custody. The model of care should:
>
> a) be developed via a funded process in consultation with Aboriginal people in custody and their families, service providers, and stakeholder organisations with understanding of the needs of Aboriginal people in custody
>
> b) take into account intersectional issues that may affect Aboriginal people in custody
>
> c) recognise the diverse roles and supports that might contribute to holistic health and wellbeing support for Aboriginal people
>
> d) support equivalent healthcare outcomes and continuity of care for Aboriginal people
>
> e) be clear enough to provide guidance across the state, but flexible enough to account for the local adaptations that will be required to suit particular facilities and communities.

915. The Cultural Review also recommended that:

- the Victorian Government 'urgently implement an adequately resourced public health model for delivery and oversight of health services across the adult custodial correction system'
- the Victorian Government include the right to equivalency of healthcare and health outcomes as a minimum standard in the Corrections Act
- contractual arrangements should specify training requirements for staff delivering healthcare to people in prisons, including on 'Aboriginal cultural safety, with a focus on key issues for Aboriginal people in custody' and trauma-informed practice
- the Department develop an outcomes framework to monitor and report on health outcomes for people in custody, as part of the development of a new public health model. The recommendation included requirements for the framework to:
  - recognise the specific health needs of Aboriginal people
  - be developed in consultation with people in custody, their families and carers, healthcare service providers, and the Victorian Aboriginal Community Controlled Health Organisation
  - be reported on publicly and compare outcomes for people in custody with those of the Victorian community, with results of the self-reported experiences of people in custody through the Healthy Prison Survey to be included in the assessment of outcomes.

Coronial inquest into the death of Veronica Nelson

916. Veronica Marie Nelson, a proud Gunditjmara, Dja Dja Wurrung, Wiradjuri and Yorta Yorta woman, died in the State of Victoria's custody on 2 January 2020. She was remanded in custody at the time of her death, having been refused bail for relatively minor, non-violent offences. She was 37 years old at the time, loved and respected, yet died alone in a cell at the Dame Phyllis Frost Centre, a maximum-security prison) after pleading for help for several hours.

917. An inquest into her death was held in the Coroners Court of Victoria, with the findings of Coroner Simon McGregor delivered on 30 January 2023.

918. The Coroner found that Ms Nelson's death was preventable and would have been prevented had the Victorian Government and its agencies implemented the recommendations of the 1991 Royal Commission.

919. The Coroner noted that Ms Nelson's death had not been adequately investigated by the Department of Justice and Community Safety and by CCA, who appeared to have a 'don't ask, don't tell' agreement, which the Coroner described as 'a matter of grave public interest and goes part of the way to explaining how so many continual and repeated systemic failings were permitted to occur in this case'.

920. The Coroner also noted that current approaches to reducing the number of Aboriginal people dying in custody are failing.

921. The Coroner's findings included that:

- health services available to Ms Nelson at DPFC were not equivalent to those available in the community
- that failure puts the lives of people in prison at risk upon their release, due to the risk of fatal overdose
- the treatment Ms Nelson received for her health condition was 'cruel and inhumane', and contrary to section 10 of the Charter
- the medical care of Ms Nelson was far from adequate, with physical examinations either of poor quality or not undertaken at all, despite being noted that they had been done
- Ms Nelson should have been transferred to hospital when she arrived at DPFC, and at many times afterwards, and the failure to do so contributed to her death
- Ms Nelson was culturally isolated and provided with no culturally competent or culturally specific care or support at any time from her arrest to her death
- multiple systems failures by the Department, CCA and the DPFC contributed to Ms Nelson's death
- Ms Nelson's treatment by some prison officers was 'inhumane and degrading'
- the formal DPFC debrief did not critically examine Ms Nelson's death, and minutes kept were 'inadequate and misleading'
- Justice Health's death in custody report was 'grossly inadequate and misleading'
- the Justice Assurance and Review Office review of Ms Nelson death was 'grossly inadequate and misleading'.

922. The Coroner made 39 recommendations, many of which relate to legislative change, Corrections Victoria, and to custodial health policy and service delivery. These include that:

- the Victorian Government revise the system for auditing and scrutiny of custodial health care services to ensure that it is:
  - independent;
  - comprehensive;
  - transparent;
  - regular;
  - designed to enhance the health, wellbeing and safety outcomes for Victorian prisoners;
  - designed to ensure custodial health care services are delivered in a manner consistent with Charter obligations; and 18.7. that the implementation of any recommendations for improved practice identified by the system for auditing and scrutiny is monitored
- the Department of Health and the Department of Justice and Community Safety:
  - consult to determine, from a clinical patient outcome perspective, which department should have oversight of custodial health services
  - consult with stakeholders (including peak clinical bodies, organisations representing the lived experience of prison, public health services, private health providers and Aboriginal community representatives) to determine what model of healthcare delivery will achieve the best health outcomes for people in Victorian prisons.
- Justice Health 'review and, if necessary, revise the Justice Health Quality Framework'
- the Department of Justice and Community Safety and/or Justice Health, in partnership with VACCHO, take concrete steps to build the capacity of VACCHO to provide in-reach health services in prisons.
- Justice Health and CCA and/or the Health Service Provider at DPFC ensure that all Aboriginal and/or Torres Strait Islander prisoners have the option during the reception medical assessment of consulting with an Aboriginal Health Practitioner or Aboriginal Health Worker, either in person or by telehealth, within 48 hours. The prisoner's response to this offer should be documented.
- CCA and/or the Health Service Provider at the DPFC, in collaboration with Corrections Victoria and Justice Health, develop and implement clear guidelines to assist custodial and clinical staff to identify a prisoner's clinical deterioration, including the indicators that must result in an escalation of a prisoner's care to clinical staff, a medical practitioner or transfer to hospital.
- Justice Health require custodial Health Service Providers to:
  - engage with Victoria's Aboriginal and Torres Strait Islander communities to learn how culturally safe and culturally appropriate principles can be embedded into their delivery of health services to Victorian prisoners. This process should be ongoing, guided by Victoria's Aboriginal and/or Torres Strait Islander communities and be conducted in the manner determined by these communities.

923. The Coroner separately recommended that CCA:

- engage with Victoria's Aboriginal communities to learn how it can embed culturally safe and culturally appropriate principles into their delivery of health services to Victorian prisoners. This process should be ongoing, guided by Victoria's Aboriginal and/or Torres Strait Islander communities and be conducted in the manner determined by these communities.
- report the deficiencies in care identified in this Finding to its current accreditation providers before it participates in any further tender for the provision of custodial health services in Victoria.

924. In its response to a draft of this report, CCA stated that one of the interested parties, who was a CCA employee at the time of Veronica Nelson's death, has appealed the Coroner's findings with respect to that individual and the appeal was ongoing as of 13 December 2023.

Yoorrook Justice Commission report

925. In September 2023 the Yoorrook Justice Commission handed down its *Report into Victoria's Child Protection and Criminal Justice Systems*.

926. The Commission 'received extensive evidence pointing to widespread failure in providing adequate healthcare to people in prison', including from Aboriginal people in prisons and organisations that work closely with Aboriginal people in prison. According to the report:

> Aboriginal prisoners told of significant delays in being able to see a doctor, a dentist or mental health practitioner, and of being denied medical care and medication …
>
> Aboriginal prisoners also told Yoorrook about lack of mental health support and care provided and the importance of receiving proper mental health care. This includes access to well-trained psychologists in trauma and cultural awareness.

927. In relation to the change in healthcare providers in public prisons in July 2023, which saw CCA replaced by public providers in the women's system and by a new private provider, GEO Healthcare, in men's public prisons, the report states:

> Simply substituting one for-profit provider with another in men's prisons is not good enough.

928. The Commission made a number of recommendations that go to the social and emotional wellbeing of Aboriginal people in prison, including that the Victorian Government:

- as soon as possible and after consultation with the First Peoples' Assembly of Victoria and relevant Aboriginal organisations, take all necessary steps to structurally reform the Victorian prison system based on the recommendations of the Cultural Review (in particular those relating to Aboriginal people)
- take all necessary steps to ensure prisoners, including Aboriginal prisoners, can make telephone calls for free or at no greater cost than the general community.

Appendix 5: Programs delivered by ACCOs in Victorian prisons

929. There are various programs currently delivered by ACCOs in prisons:

- Prison Support Programs delivered by Djirra at DPFC and Tarrengower prison, providing legal and non-legal support to women throughout their transition back into the community
- the Continuity of Aboriginal Healthcare Program – funded to operate at Fulham Correctional Centre and the DPFC until June 2024 to support access to culturally safe healthcare, the Program is being delivered by the Victorian Aboriginal Health Service ('VAHS') and aims to provide pre-and-post release support to engage in culturally appropriate health service in the community upon release.
- the Wadamba Prison to Work Program – delivered by Wan-Yaari, the program aims to provide a supported pathway to employment for Aboriginal men and women aged 18 to 35 who are remanded at the DPFC, the Metropolitan Remand Centre and Marngoneet Correctional Centre
- Yawal Mugadina Cultural Mentoring Program – a cultural mentoring program structured in three core stages providing cultural supports and care in the transition from prison to community
- Baggarrook – a partnership between Corrections Victoria, the Victorian Aboriginal Legal Service ('VALS') and Aboriginal Housing Victoria which supports Aboriginal women as they transition from prison. Each participant is provided with transitional housing and a model of holistic case management support
- Prison Support Program – delivered by Djirra, an ACCO that focuses on supporting Aboriginal women and children, providing legal and non-legal support to Aboriginal women in custody and supported throughout their transition back into community
- State-wide Indigenous Arts in Prison and Community Program ('The Torch Program') – focuses on the role of culture and cultural identity in the rehabilitative process of Indigenous prisoners by assisting Aboriginal artists in custody reconnect with culture, earn income from art sales, foster new networks and pursue educational and creative industry avenues upon their release.

930. The Department advised the investigation that it has also implemented the Kaka Wangity Wangin-Mirrie Cultural Programs Grants Scheme which has provided funding to several cultural programs for Aboriginal men and women in prison:

- Beyond Survival program – a holistic healing program provided by the Victorian Aboriginal Child Care Agency that supports Aboriginal men and women to reintegrate into family and community upon release from prison, incorporating yarning circles and visits from Elders and prominent leaders in the community
- Sisters' Day In – a program delivered by Djirra at the DPFC, with a focus on relaxation and wellbeing, with an underlying message of building resilience to family violence
- Dilly Bag – delivered by Djirra, the program encourages personal development by and for Aboriginal women

- Men's Healing and Behaviour Change Program – delivered by Dardi Munwurro, a specialist Aboriginal family violence service, focusing on assisting Aboriginal men understand and change their behaviour, develop greater resilience and foster positive relationships with their peers, families, their communities and their culture
- Marumali Program– a workshop delivered by Connecting Home, for Aboriginal men and women to deal with issues of removal and offers a culturally safe environment to discuss issues including grief, loss and the spiritual dimensions of healing and encourages re-affirmation and strengthening of their identity.

Appendix 6: Comparison of 2014 and 2023 Quality Frameworks

931. In 2023, the 2014 Quality Framework was updated to include a section specifically detailing the requirements for providing healthcare to Aboriginal people in prison. The 2023 Quality Framework incorporated all previous requirements for the delivery of Aboriginal healthcare in prisons and included a number of new requirements. Figure 21 sets out a selection of key requirements.

Figure 21: Quality Framework requirements related to healthcare for Aboriginal people in prison

2014 Quality Framework

Standard 5.2.1: Aboriginal and Torres Strait Islander, Cultural and Specific Needs

Health service providers will ensure that:

- Aboriginal and Torres Strait Islander Prisoners' physical, social, spiritual and emotional wellbeing is addressed in a manner that is consistent with their cultural needs.
- Aboriginal and Torres Strait Islander Prisoners are managed in accordance with Commissioner's Instruction 2.7 – Aboriginal and Torres Strait Islander Prisoners
- Information about health services and chronic conditions is provided to Aboriginal and Torres Strait Islander prisoners in a culturally sensitive style and language.
- Health services promote the employment of culturally appropriate healthcare staff and the choice of an Aboriginal and Torres Strait Islander Health Worker, where available.
- Access to traditional healing is available and facilitated where necessary.
- Aboriginal and Torres Strait Islander Prisoners are able to express their views and have those views understood through a consultative process to identify their needs and improve their physical, social, spiritual and emotional wellbeing.
- Aboriginal and Torres Strait Islander Prisoners are advised of the availability of the Aboriginal and Torres Strait Islander Wellbeing/ Aboriginal and Torres Strait Islander Liaison Officer/Aboriginal and Torres Strait Islander Service Officer in custodial settings.
- Consultation with Aboriginal Community Controlled Health Organisations is undertaken to enhance and further develop Health Service delivery for Aboriginal and Torres Strait Islander Prisoners and to support connection and engagement upon transition to the community.

Other relevant standards

- A Chronic Health Care Plan is initiated for a prisoner who is Aboriginal or Torres Strait Islander.
- Health services staff are provided with Aboriginal and Torres Strait Islander cultural awareness education and training to assist them to deliver healthcare to Aboriginal and Torres Strait Islander prisoners.

- Aboriginal and Torres Strait Islanders and Prisoners with specific needs receive comprehensive transition support appropriate to their cultural, health and specific needs (regarding discharge and release).
- Aboriginal and Torres Strait Islander cultural competencies must be developed and implemented with appropriate consultation.
- Aboriginal and Torres Strait Islander issues are considered and incorporated into planning processes for the training of staff and the delivery of health services to Aboriginal and Torres Strait Islander prisoners.

2023 Quality Framework

Quality Domain 5: Aboriginal people in prison

Health service providers must:

- Provide coordinated care to Aboriginal people in prison through collaboration and information sharing between health services and the Aboriginal Wellbeing Officer or Aboriginal Liaison Officer at all prison locations.
- Engage and establish meaningful working relationships with Aboriginal Community Controlled Health Organisations in the local communities to enhance health service delivery and to support transition and continuity of care for Aboriginal people leaving custody.
- Provide information to Aboriginal people in prison in a way that is accessible and meets their needs, this includes being provided with culturally appropriate literature regarding health information.
- Develop rapport with Aboriginal people in prison to improve cultural safety, health promotion, prevention, and early intervention.
- With informed consent, engage family, a nominated support person or in-reach ACCHO services to support Aboriginal people with health and mental health needs throughout their stay in prison.
- With informed consent, engage family, a nominated support person, service provider or a community Elder or navigator to be involved with the Aboriginal person's release planning to increase the chances of maintaining health gains post release.
- Have an ongoing process of implementing strategies, training, programs and initiatives to continually build the cultural capability of all health staff, including reflective practice, trauma informed care and training in unconscious bias.
- Employ, retain, and develop Aboriginal staff at all levels of the health workforce and provide evidence of an Aboriginal employment and retention strategy, including professional development and progression opportunities.

- Foster an organisational culture and service that is culturally safe, inclusive, welcoming, and responsive to the needs of Aboriginal people in prison.
- Provide cultural wraparound support for Aboriginal staff. This includes providing Aboriginal staff access to culturally appropriate places to practise their spirituality, culturally appropriate professional support, and embedding Aboriginal cultural values in its policies and operational practices.
- Have evidence of strategies, activities, and tailored health services and monitoring undertaken to improve health outcomes for Aboriginal people in prison.
- Embed Aboriginal cultural values in health programs and services for Aboriginal people.
- Improve communication and support for Aboriginal people from the point of reception to encourage them to engage with health services and to be involved in the planning for their release.
- Maintain a culturally safe process for handling complaints, incident reports, and feedback where Aboriginal people in prison, Aboriginal health staff and third parties feel safe when lodging a complaint and can receive timely and culturally appropriate support.
- Actively monitor the nature of complaints lodged by Aboriginal people in prison, their families or nominated representative, and Aboriginal health staff to identify and address any evidence of systemic deficiencies that negatively impact the cultural safety of the health service.

Other relevant standards

Health service providers must:

- [During medical reception assessment] seek the presence of an Aboriginal Wellbeing Officer or Aboriginal Liaison Officer, if available, when requested.
- [During at-risk assessment] ensure that Aboriginal people will be offered the attendance of an Aboriginal Health Practitioner or Aboriginal Health Worker, if requested and available.
- Ensure that all Aboriginal people are offered an annual Aboriginal health check that is equivalent to the Medicare item number 715 and considers the physical health and social and emotional wellbeing needs of the individual.
- Ensure that the Aboriginal health check informs the Integrated Care Plan.
- Ensure that the health check is conducted by or an Aboriginal Health Practitioner or Aboriginal Health Worker.
- Identify people who are eligible for an Integrated Care Plan, which includes all Aboriginal people in prison.

- Ensure that development of Integrated Care Plans for Aboriginal people are led by Aboriginal Health Practitioner or Aboriginal Health Worker.
- Identify barriers to accessing health care for diverse and priority groups.
- Plan and implement evidence-based strategies to reduce the barriers to accessing health care for diverse and priority populations.
- Identify workforce training needs to ensure the health service delivery is responsive to the diverse range of attitudes, cultures, abilities, genders and health needs of people in prison.
- Improve the cultural capability of the workforce to meet the needs of Aboriginal people in prison using a capability building resource approved by the department.
- Regularly audit and share health records with the department to inform continuous improvement.
- Ensure health programs delivered are based on contemporary practice and supported by documented research.
- Ensure a safe and welcoming environment for all people in prison accessing health services, regardless of their cultural background.
- Involve a representative group of people currently in prison, advocates of people in the prison system and/or people with lived experience of prison in the governance, design, measurement and evaluation of the health care delivered in Victorian prisons.
- Ensure communication and materials are tailored to the specific needs of prisoners.
- Deliver [alcohol and other drug] programs that are tailored to meet the specific needs of Aboriginal people and other priority populations in prison in a manner that is culturally safe and trauma-informed.
- Ensure that palliative and end-of-life care services are designed to meet the cultural, spiritual, and religious needs of Aboriginal people.
- Provide priority access to dental and denture care services for Aboriginal people.

Source: Justice Health Quality Framework 2014 and *Healthcare Services Quality Framework for Victorian Prisons 2023*

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