INQUIRY INTO THE GOVERNMENT'S RESPONSE TO THE COVID-10 PANDEMIC

SUBMISSION

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Parliament of Victoria

FLAT OUT INC. & HARM REDUCTION VICTORIA

JULY 2020

FLAT OUT

HARM REDUCTION VICTORIA
The Authentic Voice Of and For Victorian Drug Users
NOTHING ABOUT US – WITHOUT US!

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"This work draws heavily on the work and words of dedicated volunteers and frontline workers who responded to the "hard lockdown" at the Flemington, Kensington and North Melbourne public housing towers. They provided the foundation for this advocacy work, because they deeply understand the vital importance of centring human rights in times of crisis. They ask that the knowledge of individuals directly affected is recognised as leading expertise in the review of these matters and hope that this submission serves to elevate and amplify the voices of those residents and their communities."

1. Flat Out Inc

Flat Out Inc. is a specialist state-wide advocacy and support service founded in 1988 for women who have had contact with the criminal justice system in Victoria. It is an independent, not-for-profit, community-based organisation that is managed by and for women. Flat Out Inc. leads and participates in research and community education, seeking to inform the wider community about the harms that occur for women in the criminal justice system. We build on the intrinsic connections between service delivery and social change work that have been present since Flat Out's inception.

Flat Out Inc. works directly with women who have experienced criminalisation, providing specialised support and advocacy. Flat Out Inc. has a strong voice in the prison abolition movement both in Australia and internationally. Our vision is that women are neither criminalized or imprisoned – and advocate that prisons be widely understood as reflections of deep systemic inequity and injustice. Flat Out seeks to work alongside diverse communities towards community-led responses to harm, by developing evidence-based alternatives to incarceration that ultimately keep women, their families and communities safer.

Flat Out Inc. receives government funding through the Department of Health and Human Services (State) and the Department of Health (Federal), for the purpose of providing individualised support and advocacy for women (with or without children) to address homelessness, drug and alcohol treatment, mental health and a range of other support and advocacy needs, in order to address underlying causes of criminalisation. Current grant funders include the Victorian Legal Services Board, Family Safety Victoria, Victorian Women's Trust and the Brian and Virginia McNamee Foundation.

2. Harm Reduction Victoria (HRVic)

Harm Reduction Victoria (HRVic) formerly VIVAIDS Inc. is the drug user organisation for the state of Victoria. HRVic has a range of funding sources but is primarily funded by the Victorian Department of Health & Human Services to deliver programs for, and represent people who use and inject drugs in Victoria. Incorporated in 1987 (as VIVAIDS), HRVic is a membership driven, not-for-profit organisation. HRVic played a key role in mobilising the IDU (injecting drug user) community in response to the threat of HIV/AIDS. Since the heyday of the HIV/AIDS epidemic, HRVic has taken on a wider brief of drug user health issues. Through peer-led harm reduction education, advocacy, workforce development and community development processes, HRV

addresses issues such as the stigmatisation of people who use drugs (PWUD), access to health for PWUD, hepatitis C, heroin overdose, amphetamine-type stimulant related harms, the drug treatment needs of Victorians, drug-related matters for young people and those in the dance-music scene.

HRVic is the only organisation in Victoria with a mission to represent the needs and perspectives of people who currently use illicit drugs. HRVic provides advice and input on drug-use issues to the community, strategic policy advice to government at all levels, and to agencies and service providers whose work impacts upon the health and rights of people who use, or have used, illicit drugs.

HRVic employs people with current and lived experiences of illicit drug use and/or drug treatment services, including pharmacotherapy programs. HRVic acknowledges these community members are uniquely placed with a high level of expertise and knowledge of the minutiae of drug use and therefore the specific harms associated with illicit, synthetic and prescription drug taking. Alongside formal training, this ideally positions HRVic employees to discuss and encourage harm reduction practices with their drug taking peers. HRVic is an active member of the national network of peer-based drug user health organisations, headed by the Australian Injecting and Illicit Drug Users League (AIVL). AIVL is the national peak body representing all state and territory drug user organisations across Australia.

3. Introduction

We acknowledge that on Wednesday 29 April 2020, the Public Accounts and Estimates Committee agreed to the following terms of reference, to:

Review and report to the Parliament on:

a) the responses taken by the Victorian Government, including as part of the National Cabinet, to manage the COVID-19 pandemic and
b) any other matter related to the COVID-19 pandemic

We would first like to acknowledge that there are a multitude of examples that would positively illustrate the Victorian Government's response to the COVID-19 pandemic and we do not seek to detract those good examples. However, this submission focuses specifically on the decision to implement a "hard lock down" and impose a detention order on approximately 3000 people whose homes are contained in 9 public housing towers in North Melbourne and Flemington, and

the subsequent events and impacts that this action resulted in. This submission is informed by the workers of both HRVic and Flat Out who had direct involvement in the health and welfare response at the public housing towers and thus being well positioned to report. The issues arising at the towers raise important questions about governmental decision making processes that have a far reaching impact relevant to the fullest scope of this inquiry.

Flat Out and HRVic welcome this opportunity to respond to the Inquiry into the Victorian Government's response to the COVID-19 Pandemic.

4. Background

At 15:00 on 4 July 2020 approximately 500 Victoria Police officers ('police') were deployed to detain 3,000 residents of the public housing towers in Flemington, Kensington and North Melbourne in their apartments under what was publicly referred to as "hard lockdown" measure and, technically, Detention Directions ('Directions'). These Directions were made by undefined powers via the *Public Health and Wellbeing Act 2008* (Vic) (the 'Act').

The Victorian Government announced that resources such as Personal Protective Equipment (PPE), food and essential medicine would be supplied and that support services would be made available to residents during the lockdown period. Residents reported a significant period of time elapsed between police implementing the Directives and the establishment of accessible communication with residents. Workers and residents reported that up to 48 hours after the police arrived at the flats, many residents were unaware what was going on or why. The written directives which were written only in English and thus not able to be read by residents from non English speaking backgrounds. This delay impacted the time it took for health and community services to respond and make resources and support available. The delays resulted in acute deprivation of the residents' human rights, including the right to health. Staff from HRV and Flat Out provided response in the form of frontline outreach support and remote telephone support. Alongside other community organisations, they provided highly specialised health and welfare support during the lockdown period, such as welfare checks, assessments, care coordination and alcohol and other drug harm reduction. This workforce identified persistent barriers and significant impacts to service delivery. These concerns were corroborated by additional feedback from an alliance of advocates, volunteers and frontline workers who provided on-the-ground and remote services including Mental Health, Allied Health, Alcohol and Other Drug (AOD) and Family Violence support to residents during this period.

It is understood that this public health crisis is a moving landscape and that the Victorian government is rapidly responding to unprecedented circumstances. The legislation and infrastructure guiding this response was developed years before COVID-19 and powers in the Act have been evoked for the first time during this crisis. COVID-19 indiscriminately places all public systems under immense pressure. While this is appreciated, the recent 'hard lockdown' has highlighted that as public officials make critical decisions in response to the crisis, marginalised Victorians are vulnerable to underrepresentation and systemic discrimination. This at a time when equitable access to health and welfare services is more vital than ever.

As advocates, health experts and community members raise their voices and draw attention to these widening cracks, the urgent call is to prevent this public health crisis from further becoming a human rights crisis. Failure to do so has devastating consequences for individuals, families and communities. The "hard lockdown" of the Flemington, Kensington and North Melbourne public housing towers demonstrated this impact all too clearly. This submission will outline key concerns raised directly by frontline workers and draw on relevant evidence-based frameworks (Community-Led Response Models, Decarceration and Harm-Minimisation) to make appropriate recommendations for the Committee to consider.

5. Submission Framing

Decarceration refers to strategies focused on reducing the numbers of people being criminalised, including entering the prison system. Many of these strategies involve investing in communities and individuals to ensure that everyone has equal access to housing, healthcare, education, employment, and support. Decarceration strategies also require government policy and legislative change, including an end to prison expansion whilst ensuring alternative sentencing options like community-based orders and suspended sentences.

The majority of people in prison are from structurally disadvantaged communities, and prisons can worsen the preconditions for poor mental and physical health, drug and alcohol misuse, homelessness, violence, and poverty that lead to criminalisation. Prisons are expensive, diverting resources from necessary social services and impacting not just those who are imprisoned, but their families and the wider community. Furthermore, almost half of those imprisoned in Victoria have been in prison before and research shows that rather than deterring crime or providing rehabilitation, prisons may increase the chances of a person committing an offence after they

are released[1]. Decarceration broadly focuses on restorative and sustainable responses to social issues centred on reducing harms, rather than punitive, harmful criminalisation.

Community-Led Response Models have long existed in the health and welfare sector as a guiding principle "nothing about us without us". In a public health context, including the current context of COVID-19, extensive research advocates for community led response models as the most effective in prevention and response. A recent research paper titled "*First Nations people leading the way in COVID-19 pandemic planning, response and management"* is drawn from data collected during the 2009 H1N1 pandemic as well as COVID-19 data from March and April this year, in consult with the Aboriginal and Torres Strait Islander Advisory Group on COVID-19. This paper outlines the principles of Community Led Response as *shared decision-making, power-sharing, two-way communication, self-determination, leadership* and *empowerment* and robustly demonstrates the effectiveness of this model in managing the COVID-19 pandemic.
A Community Led Response Model has already been proposed by a representative body of residents of the towers, very similar to the model referenced in the above paper, where a committee of health experts and community representatives are directly involved in all decision making.

Harm Reduction is a framework for developing 'policies, programmes and practices that aim to reduce the harms associated with the use of drugs and/or alcohol. The defining feature is prevention of harm over the prevention of drug use itself, focusing on reducing the adverse health, social and economic consequences for consumers of alcohol, tobacco and/or other drugs. Harm reduction has been a foundational principle of Australian governments' approach to drug use for several decades, since the early 1980s when the first needle syringe program was first introduced. The evidence is quite clear that harm reduction programs such as needle and syringe programs or opioid replacement therapy (ORT) do not lead to an increase in drug use. In fact, ample research demonstrates that such programs can actually lead to a decrease in drug use. Needle and syringe programs (NSP), a cornerstone of Harm Reduction, have seen the most cost effective use of government money in Australia's history. $27 is returned for each $1 spent. The money we spend on policing and prisons for drug related offenses is far less economical. Decriminalisation of substance use allows governments to redirect funds towards prevention, support and treatment, resulting in improved social and economic outcomes for individuals and communities. Harm Reduction philosophy is consistent with Decarceration and Community Led Response Models.

[1] http://www.flatout.org.au/wp-content/uploads/2018/10/FO_AR_2017_Draft_WEB.pdf

These frameworks identify that carceral, punitive responses to issues of health and welfare cause significant personal and social harms, up to and including the loss of life. The Recommendations of this submission are the direct result of integrating these frameworks with the findings of the following thematic report.

6. Detention Directives or "Hard Lockdown": Frontline Perspectives

This content is drawn from the observations of first responders and frontline workers employed by mental health, alcohol and other drug (AOD), family violence and homelessness specialist services who attended the public housing blocks at North Melbourne, Flemington and Kensington during the "hard lockdown" period. In collating the feedback from surveys, interviews and focus groups a number of core themes were identified.

1. Service delivery was significantly impeded by the police presence

Workers reported police obstructed the delivery of food, essential medicines, mental health, AOD and FV support and impeded access to emergency services. Several incidents involving issues with ambulance access were reported at the Flemington site including an ambulance being prevented from transporting a child to hospital under paramedic directives and a premature infant who was transported by ambulance to hospital without her mother as the police refused to let her leave.

> *"the whole thing was such a breach of the residents human rights…. and once the community legal teams arrived we learned that the barriers (to emergency services) was a breach of the detention order itself… people were legally allowed to leave in the case of emergency! That just wasn't happening. Even later in the week once that had been flagged as a serious issue there was no consistency or clear process… the ongoing risks to residents were enormous"*
> *- Outreach Worker (AOD)*

> *"we met so many people there who were stuck there… they weren't even from the blocks. because they'd been visiting friends or family when the order came down and then weren't allowed to leave to go home… we met a couple of kids who'd been*

sleeping in the hallway"
- Caseworker (Family Violence)

"how is it that even in a health and welfare response, people defer to police. Who puts an AOD or a paramedic in a room with a police officer, and then gives the officer authority over the outcome of the assessment? Who decided that a police officer can stop a paramedic taking a child to the emergency department?"
- Support Worker (Family Violence)

2. The PPE, resources and supports reported as available to residents were not accessible or adequate

It was consistently reported that the DHHS number residents had been given to request services and resources including food and medicine was not accessible: People Frequently reported there was no answer when the line was called, or that they had lengthy wait times and failure to follow up in a timely manner, or at all. A number of significant incidents were reported including:

- A woman with premature eight-month-old twins who had no infant formula;
- An elderly gentleman who had been without insulin for 48 hours and was exhibiting symptoms of shock; and
- A young man who was withdrawing from prescribed benzodiazepine and assessed as high risk by the attending AOD clinician.

Workers reported that access to the buildings was inconsistent and unclear. Often police refused them entry. At other times, towers were unguarded. When not able to access buildings or prevented from doing door-to-door welfare checks, workers reported concern that they were not able to deliver the essential services they had been sent to provide. Other issues of concern were the lack of available interpreters and translated written information and inadequate PPE provided for residents.

"we were there to provide AOD and mental health support… but not only were we not able to really do that, the windows where we did have access we needed to prioritise that people didn't have food, or nappies, or essential medicine… you can't do an assessment or give mental health support when someone hasn't got enough food"
- Support Worker (Mental Health)

> *"people were trying to leave for medical emergencies but were prevented – refused by police, or they didn't get a response from the 1800 line… an ambulance was held up for hours trying to take a child to the ED"*
> *- Support Worker (Mental Health)*

> *"we were reading what was coming out from the press releases on the promised health and welfare responses… and thinking hang on that's us! That's not what we are able to offer them!"*
> *- Outreach worker (AOD)*

> *"so many people we spoke to said they couldn't get through to the DHHS number – it didn't work, they couldn't get through or waited for hours, then didn't get any call back or follow through…*
> *- Support Worker (Mental Health)*

3. Operational risk issues

Workers reported significant issues with operational risk management, including the absence of policies or processes regarding management of family violence and AOD concerns. Workers deployed with police and swabbing teams to do welfare checks in some towers reported a number of significant health risk issues including:

- The presence of large amounts of spoiled food at the bases of the towers and in the hallways;
- Poor or absent cleaning service and supplies; and
- Failure of police personnel to use PPE or observe social distancing as instructed.

Several clinicians reported performing emergency mental health and AOD assessments that led to the provision of pharmacotherapy by a prescribing doctor, only to be prevented from delivering the prescribed medicines to residents by police. A number of family violence workers reported that they were prevented from direct access on overnight shifts and so were unable to assess for or respond to reported family violence. There was no clear process of authorisation for access to the towers and this led to significant delays in the provision of essential services such as pharmacotherapy and risk assessments.

"there was no clear process around family violence response, and the police were enforcing the detention order so as to prevent people from leaving, even in emergencies… that is so dangerous. If someone goes to leave, thinking they can, and then is prevented… that makes them so much more unsafe. That could be fatal"
- Case Worker (Family Violence)

"I got sent on a goose chase all over the compound, to look for someone who could authorise me to deliver this prescription… I mean, I did the assessment myself! it was his own script from his own doctor… so I'm trekking all over the grounds thinking of him stuck up there… thinking please don't seize, please be ok"
- Outreach Worker (AOD/Mental Health)

"I saw that the police and department response actually created further health risks… police not in PPE, not social distancing, not using hand sanitiser correctly… just walking around in groups… piles of rotting food everywhere, at the bottom of each tower…"
- Outreach Worker (AOD)

4. Issues of police misconduct

Workers consistently reported concerning police conduct including inappropriate and derogatory comments and intimidating and discriminatory behaviours towards residents and volunteers. this included a senior constable overheard joking about residents committing suicide, and police escorts sent with a door to door swabbing team joking about residents' needs and requests, including making fun of drug and alcohol withdrawal and suggesting that a resident without toilet paper use cat litter. Workers also reported that police personnel had negligent adherence to PPE and social distancing and generally seemed confused and unclear of their own processes and responsibilities.

"there was (sic) about 8 police officers ringing this young woman… she was just standing there (not trying to leave)… and one of them came running and announcing "that's an active case! right there!" really loudly and pointing at her and I just thought, you can't say that! She's not a case she's a human being… that's so scary and dehumanising…"

- Outreach Worker (AOD)

"once we started working with the community liaison teams i really noticed the difference... the police were pretty dismissive of us... but the way they treated the residents and volunteers was worse and so much more overt"
- Support Worker (Family Violence)

5. The residents and community volunteers were the most effective supports

A number of workers reported that the mobilised community based response to residents' needs such as food and essential medicine was highly effective, provided culturally appropriate food, had access to translators and were more accessible for workers and residents. They also observed that the teams of community volunteers had better PPE adherence than the police personnel or department representatives. Workers also reported that the community liaison team members were a primary source of information and access, proving essential over the course of the lockdown.

"we just shouldn't have been there... the community was clearly more than capable. And if it needed to be services it should only have been services with existing ties and relationships to community..."
- Outreach Worker (AOD)

"most of the engagements I had where I actually got someone something they really needed, that was because of the community liaison teams, because someone let us know directly"
- Support Worker (Family Violence)

"I learned that the residents had requested additional cleaning and more resources for PPE and sanitiser and masks month (sic) ago, because they knew the risks and wanted to stop this from happening. It didn't happen... how can we advocate so that doesn't happen again, so that we resource and support first of all?"

- Outreach Worker (AOD)

"the community had the answers... they knew what they needed to avoid this in the first place... but weren't listened to in time."
- Team Leader (AOD)

"It was just so obvious, from the moment we got there, that the community liaison teams were running rings - around department, around the orgs, around the police – in terms of the level of response and support they were capable of providing to the residents... it was clear that, given the resources, those communities can look after themselves."
- Outreach Worker (Homelessness)

7. Recommendations

Recommendation 1 – We recommend the *Public Health and Wellbeing Act 2008* (Vic) be reviewed by a Parliamentary Committee.

1.1 Referring to Hansard, the Act was passed without going to committee. While we appreciate this part of the process is optional when passing a Bill, it does provide an opportunity for feedback and scrutiny. We believe a review by any Parliamentary committee now could prevent the significant social and economic fallout that our workers observed arising from the Detention Directives imposed during the 'hard lockdown' from occurring again. A review of the Act, would provide an opportunity to review what refinement and amendments may be necessary to better deliver on the Act's stated purpose (as follows) for all Victorians, especially those most exposed to the harms of this pandemic.[2]

1.2 The purpose of the Act (as stated therein at s1) 'is to enact a new legislative scheme which promotes and protects public health and wellbeing in Victoria'.[3] It is our assertion that the manner in which the Detention Directives were implemented – that is primarily through police intervention rather than health or community-based response – was in breach of the Act's own stated purpose and principles in that it did not 'promote or protect public health and wellbeing' for the 3,000 Victorians subjected to the Directives and, in our observations, had the opposite effect.

Further we argue that the Detention Directives issued abrogated a number of provisions within the Act, including s111(a) and (d), s112 and s198 – details as follows:

S111 (a) and (d)

The following principles apply to the management and control of infectious diseases:

(a) the spread of an infectious disease should be prevented or minimised with the minimum restriction on the rights of any person;

[2] Parliament of Victoria, Parliamentary Debate (Hansard), August 2008, https://www.parliament.vic.gov.au/downloadhansard/pdf/Council/Jul-Dec%202008/Council%20Extract%2021%20August%202008%20from%20Book%2011.pdf

[3] Public Health and Wellbeing Act 2008 (Vic), s 1.

> (d) a person who is at risk of contracting, has or suspects he or she may have, an infectious disease is entitled—
>
> (i) to receive information about the infectious disease and any appropriate available treatment;
>
> (ii) to have access to any appropriate available treatment.[4]

It is our assertion that Detention Directives cannot be considered the control of infectious diseases with the 'minimum restriction on the rights of any person', nor did those persons at risk receive adequate information or appropriate access to treatment.

Examples from workers on the ground that give rise to these assertions include that:

- Residents were not provided with reasonably accessible information about the process, and there was no pathway for appeal.
- The international human right to health was also undermined.[5] For example, residents could not access health services, on reasonable grounds, compassionate grounds, or when experiencing a health emergency.[6]
- Residents were denied access to food, medicines, fresh air and exercise, and non-discriminatory health information. The places of residence that were directly impacted by

[4] Public Health and Wellbeing Act 2008 (Vic), s 111(a), (d)(i)-(ii).

[5] Henry Shue, *Basic Rights: Subsistence, Affluence, and U.S Foreign Policy* (Princeton, New Jersey: Princeton University Press, 2nd ed. 1996) 13; United Nations Committee on Economic, Social, and Cultural Rights, *General Comment 14* (11 August 2000), E/C12/2000/4; The right to health is not the right to be *healthy*, but it 'provides the rational basis for a justified demand' (Shue) relating to the determinants of health. The 'right to the highest attainable standard of health' is explained with authority in General Comment 14, which was a collaborative output involving the WHO, and was adopted by the United Nations Committee on Economic, Social, and Cultural Rights (CESCR) in 2000. General Comment 14 sets general obligations on states to ensure the availability, accessibility, acceptability, and quality, of health services. These are mutually reinforcing concepts that relate to the economic, social, and cultural context that determines health. The Victorian Carter of Human Rights 2006 protects rights for Victoria, such as the right to health.

[6] On plain reading the Detention Directives, condition 5(2) was breached, as you only need to 'have been granted permission' to be granted to leave the premise for reasons 5(1)(a)-(c), that is, it's reasonably necessary to do so, like compassionate grounds to go to a funeral; and not for 5(2), namely, '…unless…there is an emergency situation'.

the Detention Direction are not designed to enable a centralised catering system. Even if food and health services were onsite, they were not reasonably accessible.

S112 of the Act requires that the 'least restrictive measure' be chosen: 'If in giving effect to this Division alternative measures are available which are equally effective in minimising the risk that a person poses to public health, the measure which is the least restrictive of the rights of the person should be chosen'.[7]

Recommendation 3 (below) provides evidence that less restrictive measures were available, and that measures may have been at least equally effective and, data suggests, more effective than the chosen path, as well as significantly more cost-effective to implement (i.e. activating a community-led response).

S198 of the Act was evoked for the first time during the recent 'hard lockdown' and has raised concerns about the lack of transparency about what powers are available to government officials,[8] the limitations on those powers, and accountability mechanisms if breeches occur.[9] Section 198(1) reads: 'The Minister may, on the advice of the Chief Health Officer and after consultation with the Minister and the Emergency Management Commissioner under the *Emergency Management Act 2013* ['EM Act'], declare a state of emergency arising out of any circumstances causing a serious risk to public health'. This raises questions; for example, to what extent did the Minister consult with the Chief Health Officer ('CHO') and Emergency Management Commissioner, before declaring a 'state of emergency' at those places of residence?[10] The definition in the Act is 'a state of emergency under section 198'.[11] The EM Act

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[7] Public Health and Wellbeing Act 2008 (Vic), s 112

[8] In the EM Act, s 22, 'The Emergency Management Commissioner has power to do all things that are necessary or convenient to be done for or in connection with the performance of the functions of the Emergency Management Commissioner'.

[9] Justice Connect, 'Who can use the Emergency Powers during the State of Emergency?' (23 July 2020) <https://justiceconnect.org.au/resources/how-the-victorian-governments-emergency-restrictions-on-coronavirus-covid-19-work/#_ftn5>

[10] We note that priority three in the Emergency Management Strategic Plan 2019-22 is to 'enhance inclusion and empower and build the capacity of communities' (accessed July 2020), <https://www.emv.vic.gov.au/sites/default/files/embridge_cache/emshare/original/public/2020/07/a2/0d4efb567/EMV%20Strategic%20Action%20Plan%2019_22.pdf>.

[11] Public Health and Wellbeing Act 2008 (Vic), s 3.

defines Class 1 and Class 2 emergencies, and the examples given highlight 'fire' and 'terrorism'.[12] The detained residents were not given the opportunity to follow plain language instructions. Why was the official response assuming that residents would be non-compliant to an extent that the Directions were resorted to in the first instance?

There are more questions to consider when reviewing how the Act's legislative scheme was applied. What data was used to inform the advice given by the CHO to the Minister? Was it only epidemiological data? What was the whole advice given to the Minister? What was the process between determining a state of emergency, issuing Detention Directives, and the Standard Operating Procedures (SOPs) given to police who deployed ~500 police officers, including mounted police, and those officers did on several occasions (as though part of their SOPs) did not allow residents to exit their individual apartments and would not escort those residents to the health services on site when requested. Were police onsite considered 'appointed officials'?[13] Could community leaders not have been offered greater agency throughout the entire process?

Recommendation 2 – That the Act (and any other applicable operating legal instruments) limit the role of police in the implementation of public health measures, so as to support health and community service workers and not impede the delivery of healthcare and welfare support.

2.1 We question the overreliance on police for public health response. The direct accounts of our frontline workers are consistent with and support the messaging from the Flemington & Kensington Community Legal Centre (FKCLC) 'Police Accountability Project (PAP):

> *'The presence of large numbers of armed police causes fear, stress, anxiety, confusion and can generate distrust in public health messaging. People are more likely to receive fines, charges and criminalizing responses rather than support. The choice to deploy large numbers of public order police as the government's frontline response removed agency, self-determination and control from residents, local community networks and health responses. The policing of the emergency lock-down takes place in the context of long-running and well documented community concerns and extensive legal action*

[12] Emergency Management Act 2013 (Vic), s 3.

[13] Emergency Management Act 2013 (Vic), ss 166-182.

to regard to discriminatory policing, documented racial profiling, policing operations targeting particular ethnicities and multiple incidents of severe human rights abuses over many years. Victoria Police and Victorian Governments have consistently failed to take adequate measures to address, monitor or prevent discriminatory policing'.[14]

2.2 Police Powers must be clearly defined in all contexts including health responses. Several health and community service frontline workers described interactions with police where the officers were not informed of services that had been arranged for the residents and, as such, were not permitted access to residents nor would police escort residents seeking help to the onsite health services. The FKCLC's PAP writes:'

'Police can often act in an arbitrary fashion if their powers are not clearly defined and articulated. This generates confusion between police and public and can result in rights infringements, altercations and use of force. There is currently a great deal of confusion between what is 'advice', 'directives' and actual legislated emergency powers provided to police. Differing state and Commonwealth's rules and restrictions and the rapid speed at which new restrictions are being announced are a recipe for confused interactions between police and public. The extent and limits of any new and unusual police powers must be clearly articulated and described in order to avoid misapplication by police members. In conclusion, the Victorian Government and Victoria Police must prioritise the public health needs, dignity and human rights of all people who live in Victoria and avoid unnecessary, harmful and abusive police interactions in the context of this pandemic'.[15]

Recommendation 3 - That the Community Led Response Model be centred in emergency health planning legislation, in all relevant protocols, procedures and standard practice.

3.1 The State Health Emergency Response Plan (SHERP) is based on a Community Resilience Framework for Emergency Management. A 'resilience-based approach' recognises that an emergency is 'not solely the domain of emergency management agencies; rather it is a shared responsibility between individuals, communities, business and governments'.[16] This approach is

[14] http://www.policeaccountability.org.au/racial-profiling/remove-police-from-public-health-responses/

[15] http://www.policeaccountability.org.au/policing/policing-the-pandemic/

[16] Emergency Management Victoria, 'State Health Emergency Management Plan' (version 4, 1 Oct 2017) (accessed July 2020, p. 13) <https://www2.health.vic.gov.au/-/media/health/files/collections/policies-and-guidelines/s/state-

advocated for in the SHERP because it is well-documented that mobilising local resources can provide a more efficient, appropriate and rights-based, and cost-effective response to an emergency. For those who may argue that our current situation is extraordinary and was unforeseeable, note this from the SHERP:

> *'...A communicable disease outbreak contained to a community or region for example, may disrupt a local vibrant economy due to employers and/or employees being unable to attend work, or community members being unable to leave their homes and purchase local goods and services as they normally would. A larger scale health emergency, such as a dangerous highly infectious disease like Ebola, may result in further consequences for the Victorian economy. Depending on the timing of the outbreak, for example, it may have a significant impact on major sporting, music or cultural events due to large numbers of people being unable to attend due to illness or the risk of infection. Events may be cancelled…'* [17]

Even with foresight of a 'communicable disease outbreak' the SHERP promotes an approach that involves the community. In practice, as witnessed in Flemington and North Melbourne, the key role of community was strictly limited by the Directives. The "hard lockdown" approach exacerbated the risk of viral transmission by mobilising a large, concentrated, and disorganised workforce and all other vulnerabilities among the detainees (residents). The police response was not equipped to meet the basic or significant health and community service needs of those detained.

The SHERP notes: 'Community connection Health emergencies have the potential to impact social connections, due to some methods for controlling the spread of disease such as restrictions on movements or public gatherings. Depending on the scale of the incident, individuals, communities or entire regions across the state may experience mental health (and other) challenges associated with a loss of community connectedness or independence. There may also be community concern and associated mental health challenges in circumstances where the nature and extent of illness from exposure to a biological release or radioactive

health-emergency-response-plan-edition-4-pdf.pdf?la=en&hash=B2AA0AFAD30854022645E4A9A2F3D1228E2E5AA3>

[17] *Ibid*, p. 11

substance is unknown. Physical and psychosocial impacts of an emergency can also exacerbate social problems in communities, such as drug and alcohol abuse or family violence.'[18]

3.2 We acknowledge that community capacity varies greatly across Australia, but all accounts confirm that the community advocates among those directly affected were well organised and able to operate to-scale. Requests for Governmental resourcing and support had been sought by residents for several months prior; such as requests for repairs to an elevator and more regular cleaning of communal areas. Further, at every stage of the Directives those community members were better placed to implement a response that did not deprive people of essentials like food or medicine. Their voices need to be heard and experiences believed and understood, in part as reparation, but also because they are the experts in regards to their own needs.[19] There are recent precedents in Australia of community-led responses being the most effective to controlling Covid transmission with First Nations-led interventions leading the way. The principles of the successful interventions are as follows; *shared decision-making, power-sharing,*

[18] Mukdarut, Bangpan, et al. "The impact of mental health and psychosocial support interventions on people affected by humanitarian emergencies: a systematic review." (2017).

[19] Residents asks from Voices from the blocks https://threadreaderapp.com/thread/1281352537744920582.html

1. For the Victorian government to implement infection prevention measures such as regular disinfection and cleaning of communal spaces, and distribution of masks, for the foreseeable future until a Covid 19 vaccine is available or an independent health body deems the Covid risk within the towers as not requiring such action.
2. For the Victorian government to allow residents deemed as high risk to relocate with family and friends located outside the towers, until the period the Covid 19 crisis is deemed under control by an independent health body with experience in this field.
3. For the Victorian government to create a committee made up of health experts, community members and residents, both under hard lockdown and in Stage 3, to coordinate the continued management of this Covid 19 crisis within the towers.
4. The establishment of clear two-way communication channels between residents in the towers and decision makers in government that have decision-making authority.
5. The appointment of an independent body of health experts made up of specialists from experienced in managing the complexity of the tower situation, with the ultimate aim of reviewing and providing guidance on all health and disease related matters undertaken by the Department of Human Services prior to implementation.

two-way communication, self-determination, leadership and *empowerment*[20]. This model is in line with the core principles of the SHERP (see 3.1), given as follows:

- Provide information to support best practice health care and to empower the community and responders to manage their own risk of exposure.
- Confirm and support effective governance arrangements
- Ensure a proportionate response
- support and maintain quality care
- communicate to engage, empower and build confidence in the COVID-19 plan
- provide a coordinated and consistent approach

3.3 Communication during an emergency is critical. Plain language should be used wherever possible. There should be transparency regarding important decision-making. Key messages need to be accessible for people from culturally and linguistically diverse backgrounds, and abilities. There was a serious need on the ground for translations of key materials, templates or other ways to deliver such communications could have been done in partnership with community. These values and practices were not actualised to a reasonable standard. The Victorian Government must ensure that any legislative powers and directives are clearly and accessibly recorded, and understood by both police and public.

[20] https://www.mja.com.au/journal/2020/first-nations-people-leading-way-covid-19-pandemic-planning-response-and-management

Flat Out and HRVic would like to thank the Public Accounts and Estimates Committee for convening to address these complex and pressing concerns. The Recommendations made in this submission are grounded in the observations of a skilled and dedicated workforce, supported by robust evidence-based frameworks that can and will, if implemented, prevent untold harms to the health and wellbeing of individuals, families and communities in Victoria.

Flat Out and HRVic would welcome the opportunity to elaborate on this written submission and provide a verbal presentation to inquiry committee members.

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[redacted]

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[redacted]