LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING

(Reference: Inquiry into annual and financial reports 2019-2020 and ACT budget 2020-2021)

Members:

MR J DAVIS (Chair)
MRS E KIKKERT (Deputy Chair)
MR M PETTERSSON

TRANSCRIPT OF EVIDENCE

CANBERRA

FRIDAY, 26 FEBRUARY 2021

Secretary to the committee:
Mr A Snedden (Ph: 620 50199)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

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Amended 20 May 2013

The committee met at 9.30 am.

Appearances:

Stephen-Smith, Ms Rachel, Minister for Aboriginal and Torres Strait Islander Affairs, Minister for Families and Community Services and Minister for Health

ACT Health Directorate
Jonasson, Ms Kylie, Director-General
Coleman, Dr Kerryn, Chief Health Officer, Public Health, Protection and Regulation Division
Lopa, Ms Liz, Executive Group Manager, Strategic Infrastructure Division
Culhane, Mr Michael, Executive Group Manager, Policy, Partnerships and Programs Division
O'Halloran, Mr Peter, Chief Information Officer, Digital Solutions Division
Philp, Mr Alan, Executive Group Manager, Preventive and Population Health Division
Chambers, Ms Kate, Chief Finance Officer and Executive Branch Manager, Corporate and Governance Division

Canberra Health Services
McDonald, Ms Bernadette, Chief Executive Officer
Peffer, Mr Dave, Deputy Chief Executive Officer
Mooney, Mr Colm, Executive Group Manager, Infrastructure and Health Support Services
Coatsworth, Dr Nick, Executive Director, Medical Services

THE CHAIR: Welcome to the first of two public hearings of the Standing Committee on Health and Community Wellbeing on the annual and financial reports for 2019-20 and estimates 2020-21. The proceedings today will examine the annual reports, expenditure proposals and revenue estimates for the ACT Health Directorate, Canberra Health Services and ACT local hospital network in relation to budget statements C.

On behalf of the committee, I would like to acknowledge that we meet on the stolen lands of the Ngunnawal people. We respect their continuing culture and the contribution they make to life in this city and in this region.

Please be aware that the proceedings today are being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed live.

When taking a question on notice, if that happens today, it would be very useful if witnesses could use the words, "I will take that question on notice." This will help the committee and witnesses to confirm questions taken on notice from the transcript.

In front of you, you should see the privilege statement. Before you speak, please could you acknowledge that you have seen the privilege statement.

In the first session we are going to hear from the Minister for Health and officials. I ask you all to acknowledge that you have read the privilege statement and understand the implications.

Ms Stephen-Smith: I have read the privilege statement and acknowledge it.

Ms Jonasson: I have read the privilege statement and acknowledge it.

Ms McDonald: I have read the privilege statement and acknowledge it.

THE CHAIR: Minister, in the 2020-21 outlook for emergency department care, on page 327, it says that the emergency department will introduce a rapid assessment process. Can you explain what this rapid assessment process will look like?

Ms Stephen-Smith: I might hand over to Bernadette McDonald.

Ms McDonald: The rapid assessment process in our emergency department is one of the strategies in improving timely care and access across our organisation, across Canberra Health Services, with a focus on trying to improve access and timeliness, in the ED in particular, for our NEAT targets.

The rapid assessment process in the emergency department is about trying to streamline our flow through the emergency department. We have been looking at different models: models of whether or not we have a doctor at triage and whether we have a different triage process with multidisciplinary staff at the triage or at the front door so that people can come through. It is about focusing on that flow through the emergency department right at the very front door.

THE CHAIR: Do you know what percentage of people being assessed by the emergency department would be classified as seniors?

Ms McDonald: I would have to take that question on notice and go through our demographics to look at that.

THE CHAIR: No; that is okay. Have you considered the development of a seniors streaming?

Ms McDonald: In streaming through the emergency department, we are considering all sorts of streaming. You have to think about streaming at the front door and then streaming once a person has been triaged and brought into different parts of the emergency department. Yes, we have considered looking at people not necessarily by age as a demographic—that is one component you can look at—but by complexity. If we have aged care patients presenting, they often have comorbidities and complex care needs. Especially in the models that we are looking at for our new emergency department in our Canberra Hospital expansion, we have looked at whether we can stream in a different way once people have moved through triage.

Ms Stephen-Smith: I might just add that we have an election commitment around considering geriatric streaming. As Ms McDonald says, that may not be all older people, because there will be a range of healthy older people who will walk through

the door and be treated like any other patient, but it is about considering a more rapid pathway or a specific pathway for those frail aged. That is something we have committed to look at through an election commitment.

MRS JONES: In the last week or so it was brought to my attention that there are some systems where sometimes frail aged can go directly to care homes to seek their emergency care. Have you ever looked at that? For example, if the person is not responding properly, the medical staff may not think of checking for hearing aids or checking whether they have they brought their hearing aids with them. When that is happening in an aged care setting, all of those assumptions are part of the normal behaviours.

Ms Stephen-Smith: One of the really innovative things that the ACT has done at the Calvary institute is the GRACE program, the geriatric rapid acute care evaluation program. That is a program where they work, and it was expanded in the 2019-20 budget to all aged care facilities in the ACT. A nurse-led multidisciplinary team works with the aged care facilities: when a resident has an acute illness, they will go in, assess that—

MRS JONES: In that place?

Ms Stephen-Smith: Into the residential aged care facility. They will assess that person and maybe work with their general practitioner, if that is going to be the most appropriate response, or support them to get the health care they need in their residential aged care facility so that they do not need to come into hospital. If they do need to come into hospital, they also work with the emergency department to smooth that process into the hospital and the discharge back out again to the residential aged care facility. That is now working right across all our residential aged care facilities, as well as with Calvary and Canberra Hospital.

MRS JONES: Can you, on notice maybe, point me to the line item for the funding for GRACE.

Ms Stephen-Smith: Yes.

MRS KIKKERT: As recently as this week, on Wednesday, the discharge lounge was closed for an entire afternoon at the Canberra Hospital emergency department. On 1 February 2021, the ABC reported you, Minister, as saying that you will fix the emergency department wait times. It quoted you as saying:

> Our target—and the national target—is 70 per cent. We are nowhere near that at this point in time. We want to get to that target within nine months.

How is this going to be achieved when the solution you have so far provided was closed for the entire afternoon on Wednesday due to a shortage of staff, and how often will the discharge lounge be closed and how often will it be open?

Ms Stephen-Smith: Before I pass to Ms McDonald to talk about the discharge lounge, we need to clarify, as I have done multiple times in the Legislative Assembly, that what I was talking about with that reporter is what is called the NEAT, the proportion

of people who are either admitted into the hospital or leave the emergency department to go home, be discharged from the emergency department, within four hours. That is the figure that we are looking to get up to 70 per cent over the next nine months.

It is important that we talk about that with accuracy. The reason that the NEAT is a focus of attention across the country in terms of emergency department performance, is that it is about not just the waiting time to be seen initially but also how long you spend in the emergency department being treated before you are either admitted to hospital or discharged. That is an indicator of the quality of patient care. Evidence over time is that spending a long time in the emergency department has a negative impact on people's ultimate health outcomes.

In terms of the discharge lounge, I am not quite certain. I am assuming that Ms McDonald knows what you are talking about and can respond to your question.

Ms McDonald: You referred to the discharge lounge in the emergency department. Can I clarify what you mean by that? We do not actually have a discharge lounge in our emergency department.

MRS JONES: As part of the discussions in the public domain over the last couple of months, there was a discussion about there being a facility for people to wait, to leave emergency.

Ms Stephen-Smith: Not for leaving emergency; for leaving the hospital.

MRS JONES: There have been two different discussions. I would love clarification. On one end of emergency would be an additional doctor at the triage desk; at the other end of emergency there would be some kind of facility as people are waiting to either be put into the hospital or to leave. Is that correct?

Ms Stephen-Smith: Yes—not a facility; a medical navigator as opposed to a nurse navigator.

MRS JONES: What does that mean?

Ms Stephen-Smith: Who will be able to assess people more quickly and facilitate their admission into the hospital if they need to do that. It is not a place.

MRS JONES: It is not a physical location; it is within each of the pods?

Ms Stephen-Smith: No, it is not a place; it is a person.

MRS JONES: So that is within each of the pods? Is there a different person in each of the pods in ED or is there one person for the whole of ED whose job it is to do that?

Ms McDonald: Let me clarify about the discharge lounge within the hospital. We have a discharge lounge in the hospital that has been in place for a while. We have amped that up, I could say: it used to take only people who were mobile and could come and sit in a chair, but now we have extended it to an all-care discharge lounge.

People who are waiting for ambulance transport or just non-ambulance transport who need to remain on a bed or on a trolley can come down to the discharge lounge. It frees up—

MRS JONES: Which is at the end of their care?

Ms Stephen-Smith: Yes.

Ms McDonald: Which is at the end of their care before they go home or to their next destination.

MRS JONES: Out of the wards, basically.

Ms Stephen-Smith: Yes.

Ms McDonald: That is the discharge lounge.

Going to the emergency department, we are looking at multiple different models to manage flow within the emergency department. Many emergency departments have a stream where people get assessed early and the clinicians decide that this person is likely to be admitted or this person is likely to be discharged. Then the medical navigator role, which we are looking at implementing, is about focusing on those different streams. If we have a group of patients—about 70 per cent of our patients who present to the emergency department get discharged from the emergency department and not admitted—how can we streamline their care and make sure that they are not waiting more than four hours within the emergency department because they are likely to go home?

We are looking at models where we stream and we really focus on that group of patients, just as we focus on the group of patients that are likely to be admitted, which is about 30 per cent of our patients, to make sure that those patients do not spend too long in the emergency department, that they are admitted as quickly as possible into the specialist unit that is the right unit for their care.

MRS JONES: When a nurse said to me two days ago that an area of the ED had been closed, which was in her communication with me, and that that was about people leaving the ED, what area was that talking about? Do you know?

Ms McDonald: What we are doing in the ED at the moment—I think this is where there may be some confusion, and maybe that is a communication thing we need to look at within the emergency department—is looking at creating some new areas. We had an extra unit open for COVID, which was an extra number of beds for COVID patients during the COVID period. When we were getting a lot of patients that were query positive for COVID, we needed to separate people out.

At the moment we are looking at two things. One is a behavioural assessment unit. We have had an increase in mental health presentations to our emergency department—and quite significantly unwell mental health patients who require a behavioural assessment and medical management. We are looking at creating a collocated area in the emergency department.

MRS JONES: I do not think that that is what she would have been referring to as being closed on Wednesday, if it has not yet been created.

Ms McDonald: We have been moving beds around in the emergency department in order to create this. This is a work in progress at this point in time.

MRS JONES: So that is why there is this impression that something is open and then it is closed?

Ms McDonald: I think so. I think that is because we are moving beds and the function of beds around our emergency medical unit, our EMU, which is a short-stay unit. We are looking at that and the use of that. I think there may be some confusion in terms of what beds are open and closed.

MRS JONES: There are days when the emergency medical unit is open and there are days when you are focusing on something else?

Ms McDonald: No; the emergency medical unit is our short-stay beds, and those beds are open all the time. They are for people who require a longer length of stay. They are being discharged, but they might need more tests or a longer length of stay though they are not likely to require, or do not require, admission to the hospital. They stay in the emergency medical unit for a bit longer.

MRS JONES: Was that unit closed on Wednesday afternoon?

Ms McDonald: I do not believe that it was, but I can take that on notice and check that for you.

MRS JONES: Yes, very much so.

MRS KIKKERT: Can I just clarify? You mentioned that the discharge lounge is within the Canberra Hospital?

Ms McDonald: Yes.

MRS KIKKERT: Was that ever closed for an afternoon in the last week?

Ms McDonald: I do not believe so, but I can take that on notice. You would understand—it has been out on social media—a very busy week. Wednesday this week was very busy; we may have been moving staff around the hospital in order to open up more inpatient beds. If we needed to do that, we would have prioritised inpatient beds to be open for admissions rather than the discharge lounge. There may have been times when we moved staff, but I do not believe that it was closed for all Wednesday afternoon. But let me check that; it may just be that we were moving staff around.

MRS KIKKERT: That would be great. The discharge lounge is usually run by a registered nurse?

Ms McDonald: Yes.

MRS KIKKERT: Could we find out if there was a shortage of staff and that is why you could not keep it open for an entire afternoon? We are talking about patients who may require medications, who may require extra support at the end of their discharge. It would be wonderful if they could continue to have that care right up until they leave the hospital. If it was closed, it would be wonderful to know that, on notice.

Ms McDonald: Just to clarify, if the discharge lounge was closed for any reason, patients would remain on the ward receiving care until they went home. There would be no disruption in the continuation of their care; they would maintain their care on the ward where they had had their admission.

MRS KIKKERT: But there would be a longer waiting time for them if there were fewer staff on the ground.

Ms McDonald: Not necessarily.

MRS JONES: It slows down the bed flow.

MR PETTERSSON: The occupational violence strategy is mentioned throughout the annual report. Can you tell me what the strategy means for workers on the ground at the hospital?

Ms McDonald: Our occupational violence strategy was launched on 1 April last year. We launched it despite COVID because we felt it was really important and we were just really getting into COVID preparations and understanding what COVID would mean. The strategy has eight areas of focus: governance, prevention, training, response, reporting, support, investigation, and staff and consumer awareness. We have a steering committee that I chair that is, really, focused on developmental implementation of all the strategies. It is a three-year strategy.

For staff on the ground, this is really about keeping them safer. That is the focus. That has always been our focus and that is what we have communicated with staff. In terms of changes on the ground, we have changed our training for all staff across the organisation. We are undertaking an assessment of every single unit across our organisation in terms of risk of occupational violence in those units; and I do not just mean in our mental health units or in our areas that most people think you are likely to get occupational violence—we are doing it across all units in the organisation. We have an assessment tool. We have project people that work with staff in those areas to assess the risk of occupational violence.

We are also introducing an individual patient assessment tool for nursing staff or medical staff to assess the risk of a patient who may present and have risk factors that would indicate that they may be at risk of occupational violence with staff. That means staff can have a really good understanding of our patient cohort as a group but also for individual patients. We then work with each of the units in terms of what training is required and what sort of strategies can be put in place for patients to reduce their occupational violence risk.

We are also in the process of introducing what we call a code grey. This is when somebody is starting to escalate and people feel there is a risk but before we get to a code black, where it is a security response. It is about bringing some experienced people in for de-escalation. That is really helpful to staff who may not feel confident in de-escalating situations every time. Even though they have had training, it is quite confronting when you have somebody presenting with occupational violence in front of you.

We measure our occupational violence across the organisation. We have seen an increase in reporting, which we are promoting. We are looking at ways to make it easier for staff to report. We have an incident management system which staff report into. We are looking for simpler ways for staff to report so that we can measure as we go those incidents of occupational violence. It is really important for our staff to be able to report easily so they feel confident that we can respond and take action and that we are identifying risk as it occurs across the organisation.

In terms of our measurement, we measure our lost time injury frequency rate. For occupational violence in particular, we have set ourselves a target and we are under our target at the moment. So we are seeing positive signs that the strategy is working across the organisation.

MR PETTERSSON: You mentioned that the training has changed. How has it changed?

Ms McDonald: We are doing different levels of training. We are aiming to train individuals in teams. Often what has happened in the past is that three or four members from a ward might do training and then months later some others will go. So what we are trying to do is get teams of people to do their training around the same time and then put strategies in place so that if they need to respond to occupational violence in a ward, you have got a team approach to do that so people do not feel that it is individual.

We are reviewing our online training. Everyone has a basic level of training and then we do more advanced face-to-face training. We are also doing training for the code grey so that we have a group of people that can respond and are well trained to respond to de-escalate situations.

MR PETTERSSON: When you say that you are working with each unit, is the coordination of this strategy done centrally?

Ms McDonald: Yes. As I said, we have a steering committee. I have a work health safety team. We have dedicated project staff working just on the occupational violence strategy to coordinate it across the organisation and to report back to and work with the steering committee on the implementation across the organisation.

MR PETTERSSON: You said that you want to make reporting simpler. What are some of the ways to do that?

Ms McDonald: The emergency department has tried a simple method where the staff can just write a simple incident report—almost a Post-it note-type report—that is then

looked at by managers in the emergency department to pick up. We were finding that if we wait for staff to report it at the end of a shift and have to sit down and do lengthy incident management reporting, then they tend not to report. So we are looking at simple ways that they can report so that we can get a good feel for how often it is happening and is it verbal or physical. If it is verbal, that is what they are generally not reporting, so we really want to capture that as well.

It is a journey, and we are on that journey. I think that people are feeling safer to report and that it is worthwhile. The other thing that we need to do is respond to staff and provide them with support when they have these experiences. One of the real domains in the strategy is about responsiveness—us responding to staff and providing that support.

THE CHAIR: Can staff make these reports anonymously?

Ms McDonald: Yes. It is very difficult to follow-up on the incident if it is anonymous so we encourage staff to tell us and be open about that; but if they really want to, absolutely they can report anonymously.

THE CHAIR: Is that clear to staff that that is allowed?

Ms McDonald: Well, every time I talk about it, we talk about, "You can report however you want to report. Please report." We are encouraging reporting. I am not sure that it is in the policy that you can report anonymously, but people can report anonymously if they would like to.

MRS JONES: On the results of the violence we see, quite a few people talk to me about how they are coping with work in the hospital, and one of the areas that I have done a lot of work on here is post-traumatic stress disorder for frontline personnel, people who are dealing with the public and are sometimes in these violent situations. Does part of your strategy take into account people who are displaying signals that their mental health is deteriorating in their workplace? Is that part of the work or is it really just about getting the stats on what is happening to start with?

Ms McDonald: It is twofold. You are absolutely right—getting the stats on what is happening is vitally important so that we really understand what is happening, and that is where reporting comes in. As I said, the strategy has eight areas of focus, and one of those is staff support. We are certainly working on increased strategies for staff but particularly in areas where occupational violence rates are higher and where the risk of occupational violence is higher.

We have put out a staff wellbeing framework for managers, to look at how they can keep that open communication flowing with their staff so that they can be identifying if somebody is having problems, not necessarily just related to occupational violence but related to just coming to work anyway. You would understand that the work that our healthcare workers do, which is fantastic, is stressful. It is a very stressful job, and occupational violence often makes that worse and sometimes it is cumulative, so we have to be careful and watch and give staff all the support that they need.

We have staff feedback. We have introduced our new staff wellbeing and support

person, who used to be the employee advocate, and a lot of staff are going to that person and talking about situations where they are feeling stressed.

MRS JONES: I just want to drill down a little bit on one issue: in my study of this area I know that as people start to experience mental distress, they do not necessarily identify it. Is there something specific in the changed strategy, or the changes that are being brought about, that talks about people knowing what to look for? Also, is there any possibility in this additional training module of including a fairly new area of education essentially of pre-training people for post-traumatic stress signals? You do not know what to look for until it is quite late; that is the consistent view I have been getting from professionals.

Ms McDonald: In the current training, we have discussions about how to deal with occupational violence. We can certainly look at a module if we need to, but there are other strategies across the organisation. It is a complex area.

MRS JONES: I understand that. The interesting thing is that we so often get told something is complex. I know very well how complex this is because I have been studying it deeply for the police and emergency workers. So no-one is claiming that it is not complex. Nonetheless, one of the key things that has been shown to be effective in other workforces is pre-training in what to look for, what to expect, how to identify signals. I have my own personal experience in this space of mental distress which you do not necessarily pick up on until it is too late. The answers here are very careful; they always have to be, but I would love to see some sort of commitment—not today—to get that early training in.

When an ice addict loses their composure in the emergency department, that is one very obvious thing and someone might write a note about it. But it might simply be that this person has dealt with a child who looks like their child and it has started to crack something inside their head and their emotional and mental states start to deteriorate because they have been living under a certain amount of stress for too long. It has also to do with our staff shortages and so on. It is the whole pressure in the job; it is not just as simple as a big incident. That is why I am asking, please, is there some sort of scope for us to pre-train people for self-identification when things are starting to go downhill?

Ms Stephen-Smith: There are two elements to that—the self-identification for people to understand what to look for in themselves and also for managers and colleagues to understand what to potentially look for in their peers and the staff they manage. That is something we will look at now, put particularly in the context of the training that is being rolled out in response to the culture review. There is a whole lot of stuff around uncivil behaviour and speaking up for safety and all that.

MRS JONES: It is not just about that because the psychological state breaking down, as I said before, is not just about necessarily one big violent incident. Although those things have a big impact, for some people they are not even the main thing. Everybody will eventually break if exposed to enough distress; it is simply a matter of what kind, and for which person. I think that it is a really useful discussion for us to be having in the long term.

Ms Stephen-Smith: That is a really useful discussion, Mrs Jones. I was having a conversation with a couple of the ICU staff the other day on a very similar issue around how the ICU is a stressful place to work and they experience a lot of vicarious trauma from the families and the people they treat.

MRS JONES: The experts on this who have appeared before committees are Carmel Murphy and a doctor from St John of God Health Care. If you look at the transcripts from the JACS inquiry into our policing and the bushfire response, they appeared at one of those two inquiries. I can probably find the link for you. In that way you can see what the experts say about preparing people for this kind of stress. It is an area that the whole of government could get a lot better at and be on the front foot.

Ms McDonald: During COVID we put out a manager's guide to psychological safety, so it is a good first step in terms of managers being aware of what to look for. That was based on a small piece of research that came from the US in terms of what staff were saying that they needed during COVID in particular. We based our managers psychological guide for staff safety on that.

MRS JONES: Can I ask on notice for a copy of that document?

Ms McDonald: Sure.

THE CHAIR: Minister, on page 10 of the 2019-20 budget you outlined the total spend for hospital services. I am struggling to find specifically how much money within that is being spent on the Canberra Sexual Health Centre. More to the point, I am even more curious why it was not mentioned specifically in the annual report.

Ms Stephen-Smith: Canberra Sexual Health Services is part of the Canberra Hospital. It would be a very large report if it broke down every service in every ward. I am sure that if we have not got the number here, we can take on notice exactly what the cost is of the Canberra Sexual Health Centre.

THE CHAIR: Yes, identifying exactly how much money is spent on the Canberra Sexual Health Centre and what proportion that is of the overall hospital services budget. To the crux of my point, I would be interested to know whether that is going up or down or staying at level. Do you know if the Sexual Health Centre collects data on demographics of the patients in terms of where they come from? I have had it put to me by a number of constituents that the location being physically in Woden is becoming a barrier, particularly for a number of northside patients, to access that specialist service. I am interested to know if that anecdotal evidence is borne out through the data you collect.

Ms McDonald: We collect demographic data on all our patients. That goes into our system and our sexual health service patients are the same. We would have to run a report on location. We can do that by postcode and take that question on notice to provide that information for you.

Ms Stephen-Smith: On the broader issue, chatting with the staff at the inner north walk-in centre in Dickson I know they provide some sexual health services and they have welcomed the opportunity to provide that. It is one of the things that we are

looking at as we look at expanding the scope of practice in the walk-in centres and establishing the new walk-in health centres—better access to ACT government sexual health services. We are certainly conscious that while the Sexual Health Centre at Canberra Hospital does an amazing job—they will be moving into the new building 8 with brand new facilities—we need to also spread that geographically across the community.

THE CHAIR: What work has already been done to look at expanding the sexual health services at the walk-in centres? I ask that question in the context of I am conscious that—and I am sure you will agree—the sexual health centre is a specialist service and the practitioners in that workspace have a very specific and up-to-date understanding of that area of medicine. I have an acute concern that that might be diluted by spreading out those services. What work has been done there?

Ms Stephen-Smith: There is a range of sexual health services. Some of them are going to be highly specialised and require that specialisation; some of them are going to be more the kind of thing an advanced practice will understand what it is and how to treat it or the advice to provide to a patient and that might be to get more specialist advice from the Sexual Health Centre.

We can take on notice any work that has been done. It is something that we are looking at for the future more than something we have been working on today.

Ms McDonald: We are working on our clinical services plan at the moment. Sexual health services is one of our services. We are looking at different models across the board, what is the demand and need, how do we meet that, what is the model of care, is it best to have it all in one location with that specialist and everyone come to that or is it better to do different categories of care and then spread it out? At this point we have not made any decisions about moving sexual health services out into the walk-in centres, but it is something for us to consider in the light of our clinical services plan.

I know that the team are very excited to move into a brand new facility. Last year or the year before we increased the FTE of staffing for them, and we continually look at the demand and where the need is to prioritise that as well.

THE CHAIR: I have had it put to me that one of the distinct value-service offerings of the Sexual Health Centre has been its drop-in service. Naturally, like so many other parts of the health system, that has been affected through COVID. I have had it put to me that the lack of the drop-in service has limited the access of a couple of at-risk groups who would use the sexual health clinic perhaps more than others—young people, sexuality and gender diverse people—and that that could subsequently have an effect long term on their health care. What work, if any, is being done to reopen the drop-in services—even for a short time—and expand their hours to catch-up, for lack of a better way of putting it?

Ms McDonald: We are looking at all our services where we have had to make changes due to COVID, to try and understand the impact of that and what we might need to do to reboot, or get the services back online, particularly parts of services. We have always had the service open right through COVID but using a different way to deliver the services. We certainly will work with our sexual health team in terms of

what that might look like; but we are still in COVID. We are still screening people. We are still very careful about how many people come onto our site because we are one of the most vulnerable populations and we really need to still keep all our staff and all our patients safe as much as possible.

We take that very seriously. Every change in service that we have made, we have looked at and we continue to monitor. We certainly understand that some people will be feeling anxious about that, and that is not what we want. It is a balance at this point and continues to be so.

THE CHAIR: I am interested in getting the figures of how many presentations were made during drop-in hours in the last financial year as opposed to the number of presentations made by booking an appointment and coming into the Sexual Health Centre this year. That would be interesting data for us to see what the difference is. Anecdotally, I suspect that you would see a drop, which would inform what we might do next.

Ms McDonald: I will take that on notice.

MRS JONES: Given that the drop-in service may be somewhere people go if they have experienced a sexual assault, and they want to have that conversation, it was raised with me that there could be a possibility of a forensic and medical sexual assault care unit at Canberra Hospital—a mobile unit. There has been lots of media reporting recently about a high-profile sexual assault. People could call that team in. Has that ever been considered? What would it take to get forensic responses to sexual assault out into the community, instead of those people having to come into the hospital?

Ms McDonald: I cannot comment on whether it has ever been considered. It possibly has, before my time. Certainly, all of our services always look at different models, and meeting patient needs in the best possible way. I do not have a detailed understanding, but I can certainly take that on notice, from our forensic service. I do know that our forensic service is very carefully managed, and there are lots of reasons for that, in terms of the forensics that go with everything, and being very careful to ensure that the patient is extremely well supported and cared for. This service is located in the emergency department, but it is very separate, and there are very clear protocols that have to be followed. I am not quite sure how that would apply to a mobile service. It is something we could look at.

MRS JONES: Or whether that could be tacked on to the PACER model, for example. PACER is a bit about mental health, in a sense, and people who are maybe known to the system. It could be something of a similar nature, where there is a combined speciality that is going out into the community. By the time people come to report, as you all know, when it comes to sexual assault, it could be some time later. For example, an employer who has to work out what to do with a case could get excellent advice immediately.

Ms McDonald: That advice is available—maybe not on site, but that advice is always available. They can get advice straightaway.

MRS JONES: From the forensic unit? By phoning?

Ms McDonald: From the forensic team, yes. We always have someone on call for the forensic unit; absolutely.

MRS JONES: Where is that number available? If Joe Bloggs listened to this hearing or was an employer and had no experience in this area, which does happen from time to time, how would they find that? The discussion here is useful, because it can actually bring up the fact that this service exists, and we know that it is needed.

Ms McDonald: All of our services are on our internet site, so people can look up those numbers. They can call the switch and be put through to the—

MRS JONES: The Canberra Health Services switch?

Ms McDonald: Yes, if they need to.

MRS JONES: I did not know that it existed.

Ms McDonald: Canberra Hospital has a central number that the switchboard can put people through, obviously, and that happens. We get thousands of calls every day, and people get put through to the services that they require.

MRS JONES: They should ask for the forensic medical and sexual assault unit?

Ms McDonald: If they need to, yes.

MRS KIKKERT: That would be too much effort for somebody who was going through a trauma. Perhaps raising more awareness within the public, with a poster at a GP surgery or something like that—

Ms McDonald: I think you will find that most of these things do exist. There is information in GP clinics. There is information in centres. There is information in walk-in centres.

MRS KIKKERT: I have not seen it.

MRS JONES: No, we have never seen it.

Ms Stephen-Smith: On your phone or your computer, if you use your favourite search engine and search "Canberra Health Services sexual assault", you will come up with the sexual assault care information, which does give a direct phone number or Canberra Hospital switchboard number, and it has a range of fact sheets in relation to it.

MRS JONES: Yes, that is good, and maybe that can be picked up on by our amazing media, to get that out there as well. That would be great.

MRS JONES: I want to go to something that is a bit more general about funding. If we compare the budget expenditure with the ROGS data, there is an unusual trend that

is rather clear in our funding. It shows that since 2016-17 non-admitted patient presentations have increased by an average of 2.5 per cent per annum, while expenditure actually decreased by an average of 2.5 per cent per annum in the areas that are reported on by the ROGS data.

The ACT is the only jurisdiction where there are such significant opposing trends of increasing presentations and decreasing expenditure. Nationally, the increase in expenditure was 4.8 per cent, on average. It is a question for the directorate, in a sense. Is it not the case that the underlying reason for the ACT reaching the lowest level across the country in the four-hour target is inadequate funding—in fact, a cut in real terms at a time of increasing presentations?

Ms Stephen-Smith: The short answer is no. There are a whole range of things that are going on with the funding. I must admit that I am still trying to get my head around the data that is reported in ROGS in relation to spending; then, when I look at our budget, it seems to indicate a much more significant increase in spending across the health system than ROGS does. With respect to one of the things that we have seen in the ACT, there has been discussion for some time around the relative efficiency of the ACT hospital system, and we have been becoming more efficient in terms of cost per NWAU. What does that stand for?

Ms Jonasson: National weighted activity unit.

Ms Stephen-Smith: National weighted activity unit. I will hand over to Ms Jonasson to provide some further information.

Ms Jonasson: I will ask Peter O'Halloran to talk in detail about the ROGS data. He will have some detail for you, Mrs Jones.

MRS JONES: Thank you. Ms Jonasson, you have not appeared before me until now. Can you remind me of what your exact position is?

Ms Jonasson: My apologies. I am the Director-General of the ACT Health Directorate.

MRS JONES: Excellent. I possibly should have known that.

Mr O'Halloran: I acknowledge the privilege statement. As the minister has outlined, a lot of work has been going on through the system in the last few years, trying to make the health services and the system as a whole more efficient. That, largely, is enabling additional services to be delivered at a reduced price. That, in essence, is why there is that difference in those figures.

Historically, there has been some question as to which of the ACT Health Directorate functions should have been captured in that calculation for health services. If you look at the structures in other states and territories, it is much clearer where you have, for example, a local hospital network, an LHD or HHS, based on which jurisdiction you are sitting in, very separate from the rest of the health system. In the ACT we did not have such a distinction. That means that, historically, some of the costs that have been attributed to the hospital services may in fact have been some of those public

functions that are not counted by other jurisdictions.

MRS JONES: So it is a realignment?

Mr O'Halloran: Indeed. It is not necessarily showing that there is fundamentally a drop in funding. It is demonstrating that, as we are going through and cleansing our data—as you are aware, we have been doing a great deal of work in the last few years on actually cleaning our data—that is ensuring we are much more accurate in what we are reporting and how the costs are apportioned across the system.

As I said before, and as the minister said, there has been significant work in Canberra Health Services and Calvary in being more efficient in what they do. That is enabling them to deliver more services.

MRS JONES: Can I ask, on notice, for which items have therefore been removed from the data in that cleansing process, line by line? Can you provide that on notice?

Mr O'Halloran: We can provide that information on notice, yes.

MRS JONES: Also, do we use a resourcing framework for taking into account the different drivers—demand, complexity, wage costs et cetera? Is there a specific framework tool that is used?

Mr O'Halloran: There is a whole lot of work that is done around the costing, but in essence the allocation of costs against the public health services, or the health services provided in the acute and subacute settings, is guided by national guidelines as to what should be included in that calculation and what should not. Those guidelines and those frameworks are issued by the Independent Hospital Pricing Authority and the National Health Funding Body, and they are tied under the national health reform agreements and the underpinning legislation, both in the commonwealth and in the territory.

MRS JONES: Understood; but that is not how we decide how much money to spend on something from the ACT government.

Mr O'Halloran: No, and that is part of the health funding envelope in the broader budget for health.

MRS JONES: What framework is used to make the decisions about the ACT government expenditure that takes into account those factors that I mentioned?

Ms Stephen-Smith: The way that, for the last few years, the budget has been organised in terms of health funding is what Mr O'Halloran has described as the health funding envelope. There has been a specific provision for growth in health funding at around 4.15 per cent per annum over the forward estimates.

MRS JONES: Including the federal and the ACT funding?

Ms Stephen-Smith: Yes, that is right—total health portfolio funding. When we come to the budget process, we determine how that funding will be allocated for that budget

year and for the outyears that are associated with those new measures. You will see in the budget papers that there remains a line called "central provision"—

MRS JONES: Which is the ACT.

Ms Stephen-Smith: which is the remaining unallocated funding.

MRS JONES: What I am asking is: earlier on in the decision-making process, when it is decided how much money will be spent by ACT government in order to create that envelope, is there a framework in place that takes into account drivers, including demand, complexity, wage costs et cetera? Is there a tool that is used to make that decision about what we are going to do, from the ACT perspective, from the health funding?

Ms Stephen-Smith: I was not around when they originally set the health funding envelope, but I understand that it was more a question of rebalancing from what had been a very high rate of growth to what was considered to be a more sustainable rate of growth, given the proportion of overall budget that is spent on health.

MRS JONES: It is not so much going into the detail and saying, "In this bit we are going to need this much more and in this bit we are going to need this much more." It is more about asking: are we growing it? Is it increasing? Is it increasing in relation to the federal money?

Ms Stephen-Smith: Yes, and how we allocate that growth. We are doing some work at the moment to look at the sustainability of that overall health funding envelope, and how we calculate that into the future. That is work that is happening with Treasury.

MRS JONES: Do you think that that is possibly slightly flawed, in the sense that it looks at the overall input but not necessarily, at the decision-making point, at what the growth needs will be on the ground over the next X period of time?

Ms Stephen-Smith: There is also work that Treasury and the directorate do that looks at what we project demand to be. That feeds into both our territory-wide health services planning and our infrastructure planning, as well as the clinical services plan that Canberra Health Services is doing. That is what guides the prioritisation of the expenditure from the health funding envelope.

MRS JONES: But that is after the decision is made about how much the expenditure will be. My question is: is it a bit chicken before egg, or egg before chicken?

Ms Stephen-Smith: This is part of the reason that we are currently looking at those issues around health funding sustainability, and whether we will continue this approach, going forward, whether we will take a slightly different approach or whether we will retain the envelope approach but change the envelope. We are still working through those positions.

MRS JONES: Can I ask, on notice, whether the department or your office can work out when that decision was taken historically to go to that envelope approach, where we look at the overall growth of the bucket rather than the specific projection per

service, let us say, for the growth of the population?

Ms Stephen-Smith: It is probably a Treasury question, but we can take on notice what year that decision was made.

MRS JONES: I think it would help a lot with some of the—

Ms Stephen-Smith: It was quite a long time ago.

MRS JONES: Yes, but some of the discourse is, obviously, by people from some time ago. I would like to pinpoint when that change occurred so that I can understand it.

Ms Stephen-Smith: Sure.

MR PETTERSSON: What impact did COVID-19 have on hospital services, particularly on elective surgeries performed in 2020?

Ms Stephen-Smith: Obviously, there was quite a significant impact. There were a range of impacts, but the most significant one was the decision by the national cabinet to pause category 3 and most category 2 elective surgery, to ensure that we had capacity across the system to respond if we saw a wave of COVID-19 cases, to ensure that we were managing effectively what were, at the time, constrained supplies of personal protective equipment, and ensuring that we had sufficient intensive care unit capacity et cetera. That is why we invested significantly in growing our elective surgeries for this financial year, to make up for that backlog. I will hand over to Ms McDonald to talk in more detail about that.

Ms McDonald: I might hand over to Mr Peffer to talk in more detail.

Mr Peffer: I acknowledge the privilege statement. As the minister said, COVID caused quite a disruption to a range of services that were delivered by the health services in the territory and nationally. That was primarily around elective activity. It impacted, in the elective surgery space, largely category 2 and category 3. This determines the time frames in which people require surgery. Category 1, obviously, had to continue throughout that time period, as well as emergency surgery. There was no impact on emergency surgery and category 1, but there was a significant impact on category 2 and category 3.

The $30 million that the minister mentioned was invested by the government has supported the health services to attempt to catch-up on some of that activity that was missed during the slowdown as a result of COVID. I will step the committee through the particular components of what was funded and how we are actually tracking on that activity.

The first impact is around elective surgery, categories 2 and 3. With the impact of that, at 30 June 2020, because of the slowdown and a variety of factors, we had 1,505 patients that were outside bounds or overdue to receive their elective surgery in the two categories, category 2 and category 3.

MRS JONES: When was that?

Mr Peffer: 30 June 2020. Against that program of work that has been funded, and we are working to move those patients through the system, as of 21 February, a few days ago, we had 223 patients still remaining, to receive their care. Across the range of specialties, particularly orthopaedics and ENT, as well as paediatric, which were the largest components, we have accelerated quite well within the system, attempting to catch-up 100 per cent of those patients.

The second element that was funded is around dental services. Oral health services, of course, were affected as well. This is quite an important component of the program because, by and large, we are talking about under-served members of our community. It could be people within the prison. It could be people with a range of conditions and, generally, a low socio-economic status. Against that program of work, we undertook to catch-up 1,900 procedures. As of 4 February, we had completed 1,692 of those procedures. So we are on track with that part of the program, to close out that particular element.

The next part of the program related to endoscopy—scope procedures. The minister committed to an additional 664 scoping procedures being undertaken. All of those scopes have now occurred. These were patients impacted through COVID. All of those scopes have been completed, and we completed that work through both public and private facilities.

I should mention that a critical component for the delivery of this particular catch-up activity has been partnerships with the private sector. If you consider that the health system as a whole is operating generally towards capacity, the public system itself does not necessarily have the capacity simply to accelerate activity by an additional 15 to 20 per cent for a full year. There is a limit to what we can ask the workforce to do. A consideration always has to be sustainability and the wellbeing of our workforce. If you have people working seven days a week for a year, that is completely unsustainable and it is not what we wanted to do. We have leaned very heavily on the private sector partnerships that we had in place with hospitals and dental facilities, which has certainly aided us with that work.

The final part of the program related to outpatient services. These are specialist non-admitted appointments. This was always going to be a challenging part of the program in terms of what it is that we could actually get through. We were funded to undertake an additional 14,000. There were packages of work put out to the private sector to see what we could actually catch-up on, as part of that program.

Internal to Canberra Health Services at this stage, we had undertaken, by the end of January, 1,738 additional appointment; but the public sector was only going to be able to lift so much. We had to rely on the private sector. We went out to market. We had two responses to those packages of work. One was put forward by a consortium of general practitioners with special interests. These are GPs that have particular training or scope of practice that allows them to do some of that specialty work in a particular specialty. The second was a group of FACEMs—emergency physicians—who would utilise a telehealth platform to tackle some of the cat 3 appointments.

At this stage, the numbers that have been completed by the emergency physicians have been somewhat limited—much smaller than we would have hoped. Again, that is a workforce that is equally under pressure. The GP consortium, at this stage, have notified us that they will not be able to undertake the additional work, in working through the practicalities. Again, it is a workforce that perhaps felt that it had some capacity to do this work. As we were coming out of the COVID shutdown, I think there was some capacity across the sectors, but, very quickly, work levels resumed to BAU. Again, you see a workforce that is committed—

MRS JONES: Business as usual, yes.

THE CHAIR: We will adjourn for our morning tea-break.

Ms Stephen-Smith: Chair, could I quickly respond to a question that Mrs Jones asked earlier in relation to the GRACE program, when the expansion occurred and the reference for that? That reference is on page 52 of the 2018-19 budget review. So it was the 2018-19 budget review, not the 2019-20 budget, and that measure description is on page 52.

THE CHAIR: Thank you, Minister. The committee will reconvene at 10.45.

Hearing suspended from 10.30 to 10.46 am.

THE CHAIR: If I could have everyone's attention, we will kick off again, the time being 10.45. We will continue with Minister Stephen-Smith in her capacity as Minister for Health. There may be new officials present; so can I remind witnesses of the protections and obligations afforded via parliamentary privilege and draw your attention to the privilege statement. We do not have anybody new? That is all good. We are now going to proceed to questions.

Ms Stephen-Smith: Just before we do that, Ms McDonald has some further information in relation to the discharge lounge questions that were asked earlier.

THE CHAIR: I would appreciate that, thank you. Ms McDonald.

Ms McDonald: In relation to the question on notice regarding the closure of the discharge lounge on Wednesday of last week—

MRS JONES: Wednesday this week.

Ms McDonald: Wednesday this week, I can confirm that the discharge lounge has not been closed.

THE CHAIR: I remind members that we are on output 1.1, Healthy Communities. I will start us off. Minister, noting the outlook for 2020-2021 on page 74 of the annual report, I see that the directorate intends to complete the LGBTQ health scoping study this year. What is the scope of the study exactly?

Ms Stephen-Smith: I invite Michael Culhane to come and talk in more detail about that.

THE CHAIR: You can trust I will not just have one question on this subject.

Ms Stephen-Smith: I am pretty sure that you will have some supplementary questions. You will be aware that last year we released an LGBTIQ+ health survey as part of this work and that is informing the development of the further work. I ask Michael to talk more about it.

Mr Culhane: I acknowledge the privilege statement. The scoping studies were intended to identify how, in essence, we can make the health system better attuned to meet the needs of LTBTIQ+ folk. In terms of the process, it was a little disrupted by COVID but the key elements of it were a literature review, the survey that was open to all Canberrans and promoted through various channels as well, and a few workshops. We did not have the opportunity to run all the workshops we wanted to because of COVID interrupting that process.

In terms of the scope of the study, I do not think anything was precluded from the scope of the study. It encompassed the full LGBTIQ+ spectrum; it encompassed mental health, physical health, access to health, barriers to access to health, what people felt was missing from the health system in Canberra and, of course, in some instances what people thought was working really well in the health system in Canberra. It encompassed all that.

THE CHAIR: I understand that there was only one focus group run for the study, though. Do we believe that that was sufficient?

Mr Culhane: As I indicated, we would have preferred to hold more focus groups but COVID made that quite difficult to do; so we settled on one limited focus group.

THE CHAIR: I have had representations made that there were concerns about the inclusion of intersex people and intersex policy more broadly, in the scope. Is the directorate satisfied that the "I" was sufficiently covered through the consultation?

Mr Culhane: I think we are reasonably comfortable with it. I think that is one of the more difficult groups to engage with. As I understand it, some members of that group do not readily identify and it is difficult to actually identify people to engage with in relation to that. It is always possible to do better. We feel that we have done the best that we can in engaging with that group.

Ms Stephen-Smith: I might just add that I think A Gender Agenda have been very strongly advocating in terms of ensuring that intersex people's needs are well represented. They obviously have a range of people within their advocacy. They have also been talking to their members, who identify as intersex, about their views and needs and representing that up.

In addition to the focus group, there has been ongoing conversation with key stakeholders, including A Gender Agenda, to identify some of those gaps that might have come out because of the restrictions in the consultation around COVID and what we can do to ensure that we address those.

Mr Culhane: Just as the minister was talking, I realised that I had not talked about the focus group. This is not a piece of work that was done by the directorate in isolation. We engaged with the LGBTIQ+ Ministerial Advisory Council and we also had a focus group that worked with us through the process. The most recent meeting of that focus group was earlier this week but we met with them on a range of occasions through the process.

THE CHAIR: When do you expect that the report will be complete?

Mr Culhane: I would anticipate that the report would be complete in the next quarter or so. It is not a long way off.

THE CHAIR: Minister, do you intend making the report public once it is complete?

Ms Stephen-Smith: Yes, absolutely. I have seen a draft of the report. As you have probably heard, there was some feedback on that draft from those key stakeholders, including the ministerial advisory council and the steering group representatives. There has been some revision to that draft. When the final report is finished and provided to me, I absolutely intend to make that public.

THE CHAIR: You said "next quarter".

Mr Culhane: Yes.

THE CHAIR: Is that correct?

Mr Culhane: I would hope, yes.

MRS JONES: With regard to output 1.2, I wondered if we could go to the hydrotherapy pool, the commitment?

Ms Stephen-Smith: We can go to the hydrotherapy pool.

MRS JONES: I am sure that you expected that there would be some questions.

Ms Stephen-Smith: I ask Ms Lopa to join us here.

MRS JONES: The minister is so excited about this promise, I am sure.

Ms Stephen-Smith: I am absolutely thrilled to have been able to make the commitment to the development of a hydrotherapy pool on the south side.

MRS JONES: Can we start with an update of where we are actually up to since the commitment was made? Do we have a scoping study or a project outline? There is probably some money attached to the commitment but do we have that budgeted yet et cetera?

Ms Stephen-Smith: Yes. There was some scoping—

MRS JONES: There is a group of people who are very keen.

Ms Stephen-Smith: There was some scoping work done, which led to the election commitment. As you are aware, there was an expression of interest process that went out and also some internal work to look at potential existing public facility options. That is what informed the commitment to develop the south side hydrotherapy pool at Tuggeranong, at the Lakeside Leisure Centre, with Erindale as a backup. I will hand over to Ms Lopa, about what has happened since then.

Ms Lopa: I have read the privilege statement and I acknowledge it. In regard to the hydrotherapy pool, we did a lot of work leading up to the commitment that was made last year. Originally there was the Nous report that looked into all the hydrotherapy options that were available throughout Canberra. Then my infrastructure area took on the project to start looking at it from an infrastructure point of view. Where would be the best place to build a hydrotherapy pool? Where were the existing ones? We went out and we spoke to user groups, we spoke to the Disability Reference Group, about their use of hydrotherapy pools and what they need.

What I learnt in that time is that hydrotherapy is a much more complex issue than what I thought it was.

MRS JONES: I think we all learnt that last year.

Ms Stephen-Smith: I think we all learnt that.

Ms Lopa: There is a lot out there around temperatures of pools and what they need to have in them and all those things. It was a bit of a learning journey. Do you have—

MRS JONES: Pods or a big pool?

Ms Lopa: changeable depths and all those things. We learnt a lot. We looked at a few different options. As the minister said, we looked at do we extend an existing facility, the existing public pools, or do we build a new facility? And if we built a new stand-alone facility, how would that link up with other services?

We looked at some greenfield site options, just a very high desktop analysis, and we looked at the costs associated with those. We went to government with the advice. We also went to a market sounding process and we put it out to the community and said—

MRS JONES: When was that? What was the time frame for when that was done?

Ms Lopa: That closed in February last year, that market sounding, and we got the consultancy—I cannot remember the dates—around that same time as we started the consultancy. The consultancy also looked at the responses that we got as part of the market sounding as well so that we had the full suite of options to advise the minister on.

The suite of options that we put up to the minister did recommend looking further at Tuggeranong and Erindale, for a number of reasons. One was around financial matters. It is cheaper to expand an existing facility, there are economies of scale around change rooms and administration et cetera. We also looked at where the existing

hydrotherapy pools are. There are about 15 in Canberra but not that many right down on the south side.

Since that time, and since the commitment has been made, we know now that we are looking at Tuggeranong as the main commitment but we are also keeping Erindale as a live option just in case we come across something at Tuggeranong that we are not expecting, because that happens, under the ground in particular.

We have formed a good governance group. We have got Property Group on that governance group. They run and own our pools. We have got Sport and Recreation on that governance group because they obviously have expertise in pools and all things about running pools and how to do it. We have been meeting with them to scope out what those next steps look like. We know that we need to do some community consultation and talk to the community about how they access and why, and in particular around Tuggeranong and Erindale.

I should also add that education are also on our governance group because Erindale is actually owned by the Education Directorate and has an interesting operating model as to how they operate that pool. There is a complexity there.

We know that we need to do some more due diligence and we know that we need to do community consultation. They will be the next steps that we will be looking to undertake in the short term, in the coming months.

MRS JONES: I guess the only other question that I have on that is: given that there is a group of people out there who may be able to access the service now who were accessing it when it was at Canberra Hospital and who are having their own pain and medication issues as a result, and I am hearing from them, of course, a lot, but can we give them—I do not want you to give me a date because I know that it is very difficult for government; you do not want to set yourselves up—an envelope of time in which your intention is to get this pool open, because I think that is something that people need to plan around and set their expectations around?

Ms Lopa: I think, you are right. We are always reticent to give an actual opening date before we have done the design of the pool et cetera. But if all goes to plan, we get all that due diligence done this year and everything, and we get funding to then build it—

MRS JONES: Minister.

Ms Stephen-Smith: Treasurer.

MRS JONES: Chief Minister and Treasurer, are you listening?

Ms Lopa: I would think 2024.

MRS JONES: Open in 2024?

Ms Lopa: That would be what we would aim for.

Ms Stephen-Smith: Yes. Obviously, if we can do it more quickly than that, we will

do it more quickly than that.

MRS JONES: If you cut the ribbon before the next election, I will say it is wonderful.

Ms Lopa: We want to get it done as soon as we possibly can. We know that there are people out there who want to use it—

MRS JONES: There will be some people in that group who have passed away by then. But as quickly as you can, of course.

MR PETTERSSON: Minister, what support was provided, by the ACT government, to Winnunga during the COVID-19 pandemic to help protect Aboriginals and Torres Strait Islanders in Canberra?

Ms Stephen-Smith: There was some specific support provided to Winnunga among a range of supports to non-government organisations generally. Some specific support was provided to Aboriginal and Torres Strait Islander organisations specifically. For Winnunga, it was $200,000 in COVID funding to ensure that it was able to continue delivering its services safely throughout the year and also $145,000 in infrastructure costs to help them establish the separate waiting area for their respiratory assessment clinic. The clinic itself is funded by the commonwealth but we provide some capital funding to ensure that they could do that safely and continue to have their other clients coming through a separate entrance with a separate waiting area.

MR PETTERSSON: You said that there was funding for other Aboriginal and Torres Strait Islander groups as well?

Ms Stephen-Smith: Yes. I do not actually have all those figures at my fingertips—I could probably look up my media release—but we provided some additional funding to Gugan Gulwan Youth Aboriginal Corporation and we provided a pool of $65,000 for some flexible funding for community to respond. We were particularly conscious in relation to that funding that there was a lot of stress on the community at multiple levels but in particular the importance of Sorry Business for the Aboriginals and Torres Strait Islander communities and the restrictions that were placed on people being able to attend funerals and that kind of thing. We were very conscious that we wanted to be able to support people who were struggling in that space. I think that we provided some additional funding to Tjillari and to Yeddung Mura as well, but I can have a look at that and get back to you.

MR PETTERSSON: You mentioned $200,000 to deliver services safely. What exactly was that money used for? How did they deliver the services safely?

Ms Stephen-Smith: Really, it was supplementary funding for them to ensure that they could continue to provide services. I do not know if there is an official who has more detail on what they actually have spent the funding on? No, not at this point.

MRS JONES: Page 165 of the annual report, under "Community engagement", says:

> … $300,000 to inform the development of a culturally appropriate residential service supporting drug and alcohol rehabilitation for Aboriginal and Torres

> Strait Islander people. Winnunga Nimmityjah Aboriginal Health and Community Services developed a draft culturally appropriate Model of Care for the proposed service and consulted on the draft with the ACT Aboriginal and Torres Strait Islander community.

Can you advise when the drug and alcohol residential rehabilitation service for Aboriginal and Torres Strait Islander peoples will be funded? When is the plan for that to be funded?

Ms Stephen-Smith: We are continuing to work with Winnunga on the development and finalisation of that model of care, and—

MRS JONES: Again, do you have a general time frame for what you are hoping to achieve in getting it open, essentially?

Ms Stephen-Smith: Obviously, we want to do that as quickly as we can. It is dependent on having the material to take to the budget process. My hope is that we will be taking that to this upcoming budget process; but that is dependent on whether we get an agreement with Winnunga around what it is that we would be taking and we have enough information to take to the budget process to be able to reasonably accurately estimate the funding requirement.

MRS JONES: Maybe Mr Philp could tell us where we are at with the information that is required for the budget process.

Ms Stephen-Smith: Before we do that, I will go back to Mr Pettersson's question. In addition to the Tjillari Justice and Yeddung Mura Aboriginal corporations, which each received $20,000, we provided some additional funding to Canberra Rape Crisis Centre's Nguru program. They received $75,000 for culturally appropriate counselling for people who experience sexual assault and their families, and Relationships Australia's Dhunlung Yarra program received an additional $100,000 to increase its capacity to provide counselling and conflict resolution services through COVID.

Mr Philp: I acknowledge the privilege statement. Thank you for the opportunity to speak to this particular item, Mrs Jones. With the Winnunga work, we are now at a stage where we are finalising the model of care with them. That has been a particularly important bit of work in terms of how the organisation and the facility are run. Using the model of care will direct—particularly about the cultural appropriateness of it. We believe that the work that we are doing with Winnunga—and we are about to do some further community consultation around that model of care—will be finalised this calendar year. Then we will be talking with Winnunga and with the government about what the future looks like in terms of the resourcing for the capital build of the facility.

MRS JONES: That means that it would presumably then go to the budget requests for the budget after the one that is being delivered in July?

Mr Philp: Yes.

MRS JONES: That is good to know. Obviously, we have some less than ideal statistics on Aboriginal health in the ACT. I do not want to take up all your time reading them all out, but 57 per cent of the Aboriginal people in the ACT have one or more selected chronic conditions compared to the national average of 45 per cent; 53 per cent had three or more current long-term health conditions compared to the national figure of 36 per cent; and it goes on. Under maybe four out of five major statistical categories we have the worst health outcomes in the country. Minister, do you have any information on why there is such a disparity between the health stats of Aboriginal people in the ACT compared to the rest of the country, especially for a population that is entirely in the urban setting?

Ms Stephen-Smith: Part of it is probably that, being in the urban setting, we have more data and more accurate information. So when people access health services, you know that they are accessing health services and that they are unwell.

MRS JONES: You know more about them.

Ms Stephen-Smith: There is probably an element of that. But—

MRS JONES: But there is still lots to do.

Ms Stephen-Smith: There are a whole range of reasons why, as you said, Aboriginal and Torres Strait Islander peoples have poorer health outcomes, going back to the impact of intergenerational trauma and past policies and practices, but—

MRS JONES: True, but I am saying that this is compared to the other cohorts within Australia, essentially.

Ms Stephen-Smith: Again, I do not think that we have really strong evidence in relation to why that might be. Access to drug and alcohol services and trauma services is key across a range of other areas, like engagement in the justice system as well. So it is something that we are very focused on, as is access to mainstream health services. People have access to a fantastic service at Winnunga but it is a primary healthcare service. We are really conscious of the need to ensure that our mainstream ACT government health services are culturally safe and—

MRS JONES: So when people go up into the more tertiary services—

Ms Stephen-Smith: I will ask Bernadette in a moment to talk a little about what we are doing to ensure that Canberra Health Services is as culturally safe as it can be. Ms McDonald and I met with the new Aboriginal reference group late last year. They are now going great guns, providing some fantastic advice to Canberra Health Services about some quick wins to improve services and then some things that are going to take longer.

In relation to the drug and alcohol space, the increase in services overall in response to the implementation of the Drug and Alcohol Court is also providing another way for people to access services and encouragement for them to do that.

Ms McDonald: We have a very clear strategy called Together Forward that we have

developed in collaboration with our Aboriginals and Torres Strait Islander consumer reference group which, as the minister said, we formed last year. We have met with that group. That group continues to meet on a regular basis. We have also formed an Aboriginals and Torres Strait Islander staff network. So there is not only consumer input but also our staff input. That is providing staff with opportunities and support from that network.

On our Together Forward strategy, I can give you a lot of detail. I can ask Mr Peffer to come and talk through that. In terms of a strategy that is based on real data and what is really happening, we have done a health needs analysis of our Aboriginals and Torres Strait Islander communities and then how we are meeting or not meeting those needs within Canberra Health Services. So our strategy is very data based. The Elected Body has given us very clear feedback—

MRS JONES: Can you give any examples of change that is occurring?

Ms McDonald: Looking at presentations to the emergency department and Aboriginals and Torres Strait Islander patients who did not wait—we are looking at the percentage of those who went home, did not wait, because that is unfortunately not uncommon. That is an example of a measure that we have done our baseline on and now are working on different strategies to make a change to that.

Other examples of activities that are happening are simple things like our Aboriginal liaison service and our Aboriginal and Torres Strait Islander room, which were nowhere near the main foyer of the hospital. We are now moving it into the main foyer of the hospital so that Aboriginal or Torres Strait Islander people feel welcome, know where to go, feel safe and feel that it is culturally sensitive to their needs. I will let Mr Peffer add to that because he has been attending to the strategy.

Mr Peffer: The organisation has been on quite a journey with our Aboriginal or Torres Strait Islander consumers, and with the Elected Body as well, dissecting a tremendous amount of data to really understand not just within the territory's context how we perform as a health service in terms of access and the quality of care that our consumers are receiving but also right down to the disaggregated level within our health service where we need to focus our attention.

What we have discovered is that if you look at the Closing the Gap national indicators, the territory can differ in some respects to those indicators and then, even within the territory, Canberra Health Services can differ somewhat again. Pleasingly, as we have done that analysis, we have identified a range of areas where we are providing really good care to our Aboriginal or Torres Strait Islander consumers. In particular quality indicators, such as pressure injuries or falls, we are performing much better with our Aboriginal or Torres Strait Islander consumers than—

MRS JONES: But not across the board—that is the point. We can talk here all morning and I am sure there are other people, but what is practically happening? What are the outcomes; what are the changes? Bernadette touched on some. Do you have any more on what actual actions have been taken by Health to change this situation?

Mr Peffer: Perhaps if I give you a really practical example on the ground, an

on-the-ground shift in focus of attention in terms of service delivery is around our ENT—ear, nose and throat—surgical program—

MRS JONES: Which is a key area.

Mr Peffer: I am sure committee members would be aware that for kids that perhaps have problems hearing, if you are in your first year of school and you cannot hear—

MRS JONES: The wait times are quite long at the moment, yes.

Mr Peffer: within a month, that puts you a year behind. If that is the situation over a longer time period, then that can set you on a particular life trajectory, so it is a critical point of intervention. So we commenced a targeted piece of work. This is being led very ably by our head of territory-wide surgical services, who has invested a lot of time in this, working with our ENT surgeons to commence a priority program of fast-tracking ENT surgery for Aboriginal or Torres Strait Islander children. I am very pleased to say that at this point in time we are a considerable way through that program. I am hopeful that in the weeks ahead we will have cleared all our Aboriginal or Torres Strait Islander kids off that list for receiving ENT surgery.

You are quite right: this is a specialty where there is a shortfall across the country and it does lead to waiting times, but it is a focused area where we have identified that we can make a real difference—

MRS JONES: So you are getting grommets in, you are getting tonsils taken out and all that kind of stuff.

Mr Peffer: That is right.

MRS JONES: Good.

THE CHAIR: Minister, noting the government's response to recommendation 19 of this committee's report from the last annual reports hearing, will ACT Health be running STI testing at festivals this year?

Ms Stephen-Smith: I am not sure there will be any festivals this year, Chair.

THE CHAIR: Let me broaden the question then. Will ACT Health be running STI testing at locations outside of the sexual health clinic or walk-in-centres?

Ms Stephen-Smith: I am not sure if we have that. Dr Coleman will be very happy to come and talk about STI testing, I have no doubt.

MRS JONES: Dr Coleman is usually the star of the show.

Dr Coleman: It is one of my favourite topics.

Ms Stephen-Smith: A real passion.

THE CHAIR: We are going to spend a lot of time getting to know each other,

Dr Coleman.

Dr Coleman: Once we finish with COVID.

THE CHAIR: That is right.

Dr Coleman: I acknowledge the privilege statement. Sexual health screening testing at music festivals was a big topic well before COVID. I am casting my mind back; that was a year and a half ago now. We have spent quite a bit of time liaising particularly with New South Wales, who have this fantastic model of providing in-reach testing at sexual health centres at music festivals, including Groovin the Moo. In 2019 we had reached out to GTM to see if we could get sexual health testing at that music festival but, unfortunately, due to what else was happening—and I believe there were conversations about pill testing as well at the time—there was a bit much happening. Then we also looked at Spilt Milk later in the year and that was not a very successful negotiation. Then, of course, COVID hit. So at this point in time we still have an understanding of what it would involve and what those plans would look like, and we will certainly look to re-engage on that issue once we know more about what music festivals will look like in the near future.

THE CHAIR: Putting to one side the conversation about a static pill-testing site in the city, is that the kind of model that you think could work for STI? Yes, we are not going to music festivals this year but we do still have nightclubs open and people are still converging on the city. Do you think that a similar framework could work for STI testing?

Dr Coleman: What we have noticed over many years is that STIs, sexually transmitted infections, are increasing in our young people. Young people is where we need to be focusing, regardless of sex, gender and other aspects. Music festivals is one of the places in which they all congregate but there are other places. That is one of the reasons we have been looking at walk-in centres as an opportunity to expand that testing, as that is a drop-in kind of place.

Screening is a really easy "pee in a jar" kind of prospect, so the baseline sexual testing is actually really easy. So I am not sure that we need a specific, unique sexual health testing clinic itself. I think young people get—I am not young anymore but I do not like to feel that everyone sees that I am dropping in to have an STI test; I like to go somewhere where a range of things are on offer. We are looking at how we can integrate it into as many services as possible. Lots of young people do have a family GP or do have a GP, so we are spending some time working with ASHM and other training providers about how we can continue to work with GPs to, once a year, just ask that question of all of your patients and clients coming in: "Do you need an STI test? I would like to offer you one."

THE CHAIR: We will move on now to output 1.4.

MRS JONES: We are up to continuous improvement.

THE CHAIR: Thank you, Mrs Jones. I note your obvious interest in the subject.

MRS JONES: I am very interested in continuous improvement of the health system.

Ms Stephen-Smith: We are all about continuous improvement.

MRS KIKKERT: My question is in regard to the junior doctors. A recent medical training survey by the Medical Board of Australia found that junior doctors are overworked, underpaid and also bullied. One in five survey respondents had personally experienced bullying, harassment or discrimination in their workplace. Another 15 per cent had witnessed it. Junior Aboriginal or Torres Strait Islander doctors reported higher levels of abuse. Half reported that senior medical staff, their own supervisors, were apparently responsible. Seventy-eight per cent did not report the incident they witnessed, unfortunately. So what are you doing to keep our junior doctors safe and make it safe for them to speak up?

Ms Stephen-Smith: You may recognise Dr Nick Coatsworth from national television advertisements—

MRS JONES: YouTube videos et cetera, yes.

Ms Stephen-Smith: but Dr Coatsworth is here in his role at Canberra Health Services.

Dr Coatsworth: I acknowledge the privilege statement. This is a critically important survey for junior medical staff around Australia. The specifics that you outlined, Mrs Kikkert, are of significant interest to me and the health services as employers and in our desire to become an employer of choice for junior medical staff around Australia.

I would like to address the issue of bullying and harassment first. In terms of specifically addressing that, prior to the release of the medical training survey, I conducted a workshop myself with a junior medical officers forum, where I sought their opinion on bullying and harassment in the workplace and the sorts of things that we could do to address that. The feedback I got included developing a formal mentoring program, which we actually already have within the organisation. About 65 junior staff participate in that.

There was also substantial interest in the Speaking Up for Safety program, which is best described as a graded assertiveness program that is run by the Cognitive Institute, which is a well-known healthcare improvement institute. That will provide a common language for all staff in Canberra Health Services, including junior doctors, to be able to raise patient safety issues in a way that is far less likely to engender any sort of feedback that might be perceived as bullying and harassment. That is going to be a key centrepiece of our cultural reform this year in Canberra Health Services.

MRS KIKKERT: Will that boost the confidence of junior doctors to speak up?

Dr Coatsworth: I am hoping that it will boost the confidence of junior doctors. We have recently seen how important the confidence of nursing staff is in the recent vaccination incident in Queensland, to be able to challenge a practice. So we are confident that this program, which is going to be rolled out across all staff and which I am the executive sponsor of, will assist with that.

MRS KIKKERT: What are you doing to address the heavy workloads, more than 40 hours a week or sometimes over 60 hours a week?

Dr Coatsworth: Specifically to address the heavy workloads, I have asked my staff in the medical training and rostering unit to provide monthly reports to me on workload, including any trainee who has exceeded 100 hours—I believe the threshold is 100 hours; I might have to take that on notice—per fortnight of work; and I have issued a direction that no junior medical officer in their first or second postgraduate year is to exceed more than three rostered overtime shifts in a fortnight period. Finally—

MRS KIKKERT: Is that happening right now, or is that what you are projecting for the future?

Dr Coatsworth: No. There was some concern that a small number of trainees had experienced that in December of 2020 and January of 2021. When we investigated that, it was related to the trainees themselves picking up those shifts. However, we do not give that as an option to trainees now. There can be a tendency for medical staff to want to overwork themselves, I guess—

MRS KIKKERT: As overachievers, right.

Dr Coatsworth: The final piece in that puzzle is to ensure, and this is the final report that I get, that any outliers—there is rostered overtime, where we ask people to cover the after-hours shifts; and then there is unrostered overtime, where the home unit itself, like cardiological or general surgery, calls them in. That can be a particular issue with surgery. Many of our surgeons do their rounds before theatres, so most of the junior medical staff on surgery actually start earlier than 8 am. So we have to pay attention to that unrostered overtime load because that could easily push people well over the 100 hours a fortnight.

MRS KIKKERT: What are you doing to address the underpayment issues?

Dr Coatsworth: The underpayment issues—I was made aware of those last year. I will open the relevant piece of documentation.

Ms Stephen-Smith: I think the issue around payroll and payment is about inaccurate payment as much as it is about underpayment. Some people are likely to have been overpaid and some people are likely to have been underpaid as a result of errors in the payroll processing. Ms McDonald can talk more to that.

Ms McDonald: Shared Services provides payroll for all our staff at Canberra Health Services. We are working together with them to make sure that the entitlements in the medical practitioners enterprise agreement are being applied correctly. There were a couple of payroll issues that were highlighted to us, and we say thank you to the junior doctor who identified it in her pay. She has worked closely with us and Shared Services to make sure that all those interpretations of the medical practitioners enterprise agreement are being applied to the payroll correctly. So we have been working with them closely and in consultation with our junior medical officers to let

them know what is happening in that space.

As the minister has said, sometimes payroll is not correct but it goes both ways. Sometimes people will be underpaid and sometimes people may be overpaid. These are payroll corrections. We have thousands of pays going through this service and we are used to correcting any incorrect applications of the enterprise agreement in payroll.

Shared Services has assured us that they have implemented an internal tool, a quality tool, to calculate the entitlements and to make sure that they are being applied correctly. They have basically gone backwards to do a retrospective audit of junior medical staff employed by us to make sure that there is nothing outstanding retrospectively and make sure the system works prospectively, going forward.

We have been talking to our junior doctors about this all the way through, in particular a couple of junior doctors who are very good at making sure that everything is applied correctly. We absolutely want to make sure everyone is paid correctly. That is our ultimate goal.

MRS KIKKERT: Have they been compensated for being underpaid?

Ms McDonald: We have corrected it. We have made corrections wherever there is a correction required, retrospectively as well.

MRS KIKKERT: Did you find your paper, Dr Coatsworth?

Dr Coatsworth: I did, and I can confirm that Ms McDonald has accurately described everything.

MRS KIKKERT: Can you outline the way the pandemic has disrupted their training?

Dr Coatsworth: Yes, I can. I think the way to frame that question is to look at how it has substantially interrupted or disrupted training for all trainees around the country and specifically look at what Canberra Health Services has done about it as well.

Probably the main concern for junior medical officers has been that when they were moving to the next stage of their training and they required exams that would usually be conducted face to face with patients, they had to be delayed. Nearly all the colleges had to have new mechanisms. That created a substantial degree of uncertainty. For the record, that is largely the responsibility of the specialist colleges to manage; but it is then the responsibility of the health service to provide the pastoral care for those trainees.

I will use the example of physician trainees. One of their last exams does actually require real patients coming in and obviously that could not happen. That has transitioned to tele-exams. You do them on the telephone now, so it is substantially different. They were six months delayed, but we were able to provide a high degree of training and supervision from our senior medical staff to ensure that our physician trainees were well supported. I cannot give the exact exam results, because the trainees have not quite finished the second part of the exam; but I can tell the committee that we are very satisfied with the results so far from our physician trainees.

There has been a lot of helping to adjust to that uncertainty, offering pastoral care.

The final comment to make is about the younger medical staff, the interns and the first-year residents, who rely on the face-to-face teaching program to actually learn their trade and how to operate within the hospital environment. That has been shifted to an almost entirely online delivery mechanism, headed by our deputy director of postgraduate education, Dr Luke Streitberg, who was recognised in the *Canberra Times* recently for his work in that space. It is a very innovative approach and it has been welcomed by our junior medical staff.

MRS JONES: When will those pass marks be known—the level of passing of those delayed exams?

Dr Coatsworth: I am afraid I cannot say accurately, because the exams are conducted over a series of weekends. I would anticipate—

MRS JONES: Can you take that on notice?

Dr Coatsworth: We can take that on notice, yes.

MRS KIKKERT: There is a negative impact when people hear about the current state of the ACT Health, as you can understand. What are you doing to retain junior doctors and to attract interstate junior doctors?

Dr Coatsworth: Just to emphasise the statistics there, we have about a four to one ratio in terms of applicants to jobs available in the early junior medical staff years. So we are a popular destination. Moreover, some of our recent consultant appointments have been home-grown junior doctors who have been through the ANU Medical School and through our own health service and are now coming back as consultants. So there is growing evidence that, despite some of the reports that we hear and some of the issues that we want to address, we are considered a growing health service of choice for our medical staff.

MRS JONES: There is a very different opinion from various colleges.

Dr Coatsworth: Which ones in particular, Mrs Jones?

MRS JONES: I will have to seek their advice as to whether they would like to be named. It is just interesting, is it not? Obviously, application rate is important, but the CV building that goes on between the initial two years and the entry officially into the college training programs apparently is quite hard to get through here. It is hard to get that build-up of experience and skills within the ACT. That is what I am being told. You shake your head, but these are experts in their fields who are telling me this. So that is something worth considering and looking at as well.

Dr Coatsworth: We do have very frequent discussions with the colleges. Nearly every college representative is a close colleague of mine. I am not specifically aware of those concerns, and I do take the view that they would raise them with me if—

MRS JONES: I do not think you should assert that they are raising something with

me that they are not concerned about because they have not raised it with you. That is very unnecessary.

Dr Coatsworth: Well, it would be helpful to know specifically to be able to respond to the question—

MRS JONES: I am very happy to write a very long and detailed letter.

Ms Stephen-Smith: I was just going to suggest, Mrs Jones, that you may like to write to me and outline the concerns that have been raised with you.

MRS JONES: Absolutely. I think it is a good conversation to have.

Ms Stephen-Smith: We will certainly respond to those. But there is an issue around being able to respond to assertions that are made to others—

MRS JONES: Of course.

Ms Stephen-Smith: if they have not been made to us. In relation to some of the conversations that Dr Coatsworth has had previously, and he alluded to one of these earlier, sometimes concerns are raised and then when they are explored, it turns out that the explanation for the occurrence is quite different to what has been assumed about that. The overtime is one example of that.

We are always happy to take on board that feedback and to explore what is happening. We do have a professional colleges group as well, which I have not met with for a while but do intend to meet with soon, so I certainly want to get their feedback. One of the things that I have been talking to our industrial representatives and the colleges and professional groups about is that this is all a shared responsibility. We all need to play our role in improving the circumstances for the hospital and for junior doctors.

MRS JONES: It is like the idea of a place to practise suturing on cadavers, right? That is a discussion that has been had with the College of Surgeons, and that that does not exist. It is also a conversation about hybrid theatres and the fact that we do not have any in the ACT, and there is no other place in Australia where a tertiary hospital, to my knowledge, does not have a hybrid theatre. There are all sorts of things going on.

THE CHAIR: Mrs Jones, we are having a conversation. There was not a question there. Minister, I will allow you one final reply but then we will move on.

Ms Stephen-Smith: We are moving into acute services in the next session, so I will just reply to that in that context to say that obviously we are having ongoing conversations with the Royal Australasian College of Surgeons about their advocacy around training. The new building 8 will create some additional training capability and simulation facilities. The type of overall excellent training facility with cadavers capacity, with the capacity to use animals and with a whole lot of other things, is the type of facility that is only available in two or three other places in Australia. So it would not be fair to say that we are the only place that does not have that facility—

MRS JONES: I was talking about the hybrid theatres when I said "nowhere else in Australia".

Ms Stephen-Smith: Yes—just to clarify.

THE CHAIR: I will allow Mr Pettersson to ask a question on output 1.4 before we move on.

MR PETTERSSON: One of the central themes of the election was working to better integrate health care in our city. What work is underway to better integrate health care?

Ms Stephen-Smith: There is a range of work. We have committed $2 million to feasibility for the walk-in health centres. Part of that work will be about how they help to integrate services across our existing walk-in centres, our community health centres and our acute and tertiary services, and work with general practice and other primary care services. That will also build on the outcomes of our Canberra Health Services integrated care project, which I will hand over to Ms McDonald to talk about a bit more in a moment.

Another commitment that we made around this was a patient navigation service. That was not funded in this budget, which was a pretty constrained budget, but we have been working with the Health Care Consumers' Association for some years on developing a model of patient navigation across the service. We have indicated that the first element of that will be patient family navigators for very sick children who are requiring care interstate. The Health Care Consumers' Association did an excellent report for us, consulting with families of children who need care interstate about some of the barriers, pressures and challenges that they face. The Chief Minister and I have also met with one of the families that provided feedback to HCCA through that process. Navigating the care system between an interstate service and an ACT service and then ensuring that they are getting appropriate care when they do come into contact with ACT services is a key challenge there.

That is a priority, going forward. The current work that Canberra Health Services is doing on integrated care, Ms McDonald can talk about.

Ms McDonald: There is a lot of work going on, and it is great work, in terms of working closely with our NGOs and really looking at how we can have that continuum of integrated care across the system.

Mr Peffer: We have a range of infrastructure projects which the government has announced through the election campaign and provided some initial funding for through this budget that will start to demonstrate the reform work that is underway now in integrated care. There are two in particular. One is the evolution of walk-in centres. Then we have also got a pilot in Coombs with the co-op, where we are looking at a partnership model between our MACH services that will be relocating there in the coming months and the existing GP offering that is on site.

I will use that as a sort of explanation of the path that we are taking within that team. We have a really passionate team working on this that has both medical representation

and some great strategic thinking. It is bringing partners together, not just Canberra Health Services but right across the service provider spectrum—GPs, community, our NGOs. It is treating everyone as a partner to start to unpack and think about what a model in Coombs could look like—not just for MACH services that sit there in isolation and are provided by themselves but looking at a particular demographic, unpacking a lot of data and looking at what the services are that these individuals, young families and young kids access, not just through Canberra Health Services but also through other providers, through their GPs, through NGOs.

So we have a discovery phase underway at the moment. We are in commercial negotiations with the co-op to stand up that project. There is a lot of design work and design thinking going into this, motivated by both the team and our NGO partners, about what opportunity we can create here to provide a true wraparound service.

In terms of then delivering on the ground, the sorts of issues that we have to tackle are around clinical governance, ownership and care pathways. What would be an ideal situation is if we had someone come in—perhaps they are having an early childhood health check. We have identified a range of services that would be useful—perhaps diabetes, diet, exercise, respiratory, asthma or whatever it might be—and we can provide that wraparound service and easy handover between the service providers. So that it does not have that clunky feel where service providers and the design of services are really around which tier of government funds it and then what the speciality is or which specialist provides it. It is much more patient-centric, taking the patient and thinking about the list of services that we could construct, bring together and integrate for a truly seamless experience, irrespective of whether it is funded by the ACT government, by the commonwealth or by some other source.

THE CHAIR: Thank you. We are 10 minutes late, but I will keep us honest. We will move to the next output stage. I have a question, Minister, about cancer screening. The Cancer Council has said that cancer screening has gone down during COVID, as to be expected. On page 229 of the CHS annual report, it states that women in the age 50 to 74 cohort participating in breast screening is seven per cent under target. Has the government kept data on the screening rates for other cancers during the COVID period?

Ms Stephen-Smith: I do not know who is going to answer that. Some of those other screening processes are run by the commonwealth, so we would not necessarily have data on those. I am thinking particularly of bowel screening.

Ms McDonald: We can ask Cathie O'Neill to talk specifically about breast screening and give you some more information on that. Cathie is also our executive director for cancer services, so she might have some more input on screening in general.

Ms O'Neill: I acknowledge the privilege statement. I am sorry, but in that transition I missed the question.

THE CHAIR: That is okay. I can summarise my question. I was simply pointing out that breast screening for women aged 50 to 74 is down by seven per cent. I am just curious to explore any other data you might have about cancer screening rates reducing through COVID and then, I suppose, exploring what CHSs' strategy is to

boost those numbers back up and catch-up on the shortfall.

Ms O'Neill: I can advise the committee that this financial year we have made up the shortfall from last year. We are ahead of target at the moment, which is good—not by much, but we are ahead of our current target. The ACT actually performs quite well in terms of screening rates for breast screen compared to the other jurisdictions. The national target is at 60 per cent. We perform around 56 to 57 per cent of our screening target, whereas most other jurisdictions are much lower down in the 50s.

MRS JONES: It is better than it used to be.

Ms O'Neill: Yes. The biggest drop-off for us has been a reduction in our promotional activities. Normally, we would have stalls at festivals and home shows and those sorts of things. We have not found that attracting women back into the service has been an issue. Our biggest deficit is around getting people to come back in the appropriate time frame for their subsequent screens, which is between 24 and 27 months. It is a narrow window from a statistical point of view. Often we find that women come back at 28 or 30 months but, from a data perspective, that shows it is a bit of a deficit for us.

THE CHAIR: If that is where the gap seems to be, that women are not coming back for supplementary appointments, is there a strategy in place to try and shorten that?

Ms O'Neill: We do mail-outs. We give them fridge magnets when they come for their first screen. We do try to keep them on track, but people's lives are busy and sometimes these things slip. It does not take much for a month to slip by.

THE CHAIR: We are talking about breast screenings specifically, but I want to broaden it to cancer screenings more broadly. Those rates would not actually be down during the COVID period. Sorry, in relation to your answer, when you were giving me those stats, was that specifically on breast cancer screenings?

Ms O'Neill: Breast screening, yes.

THE CHAIR: Okay.

Ms O'Neill: That is the only screening program I am responsible for. I do not know whether somebody in—

MRS JONES: You can take it on notice, perhaps?

THE CHAIR: Thank you, Mrs Jones. I am happy to take it on notice.

Ms O'Neill: Alan can probably address those, so if you have any other questions about cancer—

MRS JONES: I wanted to ask a question about cancer, if that is all right—it is very small—while Cathie is still here.

THE CHAIR: Yes, of course, Mrs Jones.

MRS JONES: I have someone in my electorate whose blood cancer treatment was stopped during COVID and it was some time before it recommenced. What exactly happened there with the cancer unit? There were obviously impacts on people's health from the treatments having ceased for a period—and not much can be done about that now—but what can we measure about having caught back up at all?

Ms O'Neill: We did not stop cancer services through COVID. The doctors individually assessed patients for their risk status to determine whether or not having treatment would put them at a potentially higher risk if they were to get COVID as against the risk of not doing the treatment in time.

MRS JONES: Well, hers was stopped.

Ms O'Neill: As a service, we certainly did not stop the treatment.

MRS JONES: Right. Are we back to normal now or do we have a backlog to sort out?

Ms O'Neill: I am not aware of a backlog. Those decisions were made on an individual patient level, not on a service level.

MRS JONES: During the conversation I had with her, she literally said to me, "There are a lot of people who need to get back in, so I am waiting until a bit later." It distressed me that that was the conversation she was having. That could have been individual choice—I am not saying it was not—but I was concerned.

Ms O'Neill: I am not aware of any delays to treatments. If you have specific details, I am happy to take those on notice.

MRS JONES: I might grab your contacts, if the minister says that is okay.

Ms Stephen-Smith: You will write me another letter, Mrs Jones, so that we can look into it.

THE CHAIR: Thank you. We are just waiting on the cleaning during the changeover. Then I want to go back to that question more broadly about cancer screenings in the broadest sense.

Mr Philp: Thank you very much for the question. As we know nationally, the COVID pandemic has affected people's access to and use of health services such as cancer screening programs. Many of the healthcare providers suspended or changed the way they delivered the service. We have heard a little bit about breast screening this morning. The Australian government is also responsible for bowel and cervical screening programs, which are administered by Telstra Health.

The data shows that breast screening numbers had been affected by the COVID. If we look at April last year, there were only 1,100 mammograms conducted; whereas normally and for the previous year there were something like 70,000. You can see the impact there. The Australian Institute of Health and Welfare say that all states and territories experienced a lower number of screening mammograms performed per

month in April and May than previously. We think that the decrease was only around that April, May period and that it is coming back up.

There was no pause to the national bowel screening program. The Australian Institute of Health and Welfare says that there was no direct impact of the pandemic on bowel screening cancer. However, there was an initial delay in posting out some of the screening kits. In the ACT, participation numbers pretty much stayed on track, which is very encouraging. It is my understanding, and my notes say, that all public colonoscopies referred to the bowel screening program were delivered in compliance with the clinical guidelines.

In terms of the cervical screening tests conducted, they were lower in 2020 than 2019. That shows that for us—it is hard to compare the years—the numbers are looking pretty similar. However, according to as yet unpublished data from the Australian Institute of Health and Welfare, on a month-to-month basis there were fewer screens than in 2019 across all jurisdictions. Again, April was the lowest.

We have been made aware that the National Cervical Screening Program was informed by the department and Telstra Health that in February this year there was an apparent malfunction in the system and three-quarters of a million letters did not go out to remind people to go in for cervical screening. For the ACT, that number was nearly 11,000 people. They usually send a letter out in five years to bring people back in, but due to an error in the way that the data was calculated three-quarters of a million people across Australia were not notified. But, like I said, from Telstra Health's perspective, it looks like nearly 11,000 women have subsequently been followed up. It goes from a six-month delay for some women to around 40 months. They have now understood the error and have—

MRS JONES: Caught up.

Mr Philp: followed through on getting the letters out.

THE CHAIR: What about skin cancer? What about those screenings during COVID?

Mr Philp: Often it occurs at a primary care level. The skin cancer rates are often at the GP level and they are not necessarily Cancer Council data. It would be at a primary care level with skin cancer.

MRS KIKKERT: The Productivity Commission report on Health Services shows that the ACT's emergency department waiting times are the longest in the country and performance across several categories has deteriorated in recent years. On 23 February this year, Canberra Health Services issued a reminder on Facebook that the ED should be for genuinely urgent matters only and that Canberra Hospital's ED was under pressure. My question is: has not emergency always been for genuinely urgent matters only and why did it need to be posted up on Facebook as a reminder?

Ms Stephen-Smith: We do take the opportunity to remind people when the emergency department is particularly busy that there are alternative options, including walk-in centres or going to your GP during their opening hours. That is when our emergency department is busy, because people do turn up to the emergency

department for things that could be treated by a GP or could be treated in a walk-in centre. We do not want those people turning up to a particularly busy emergency department and having an extended wait. We are just trying to get information out to the public about what is going on—

MRS KIKKERT: Right. So other than Facebook reminders—

Ms Stephen-Smith: and giving them a genuine choice.

MRS KIKKERT: what else are you doing?

Ms Stephen-Smith: I am sorry?

MRS KIKKERT: Other than Facebook reminders, what else are you doing to remind people?

Ms Stephen-Smith: On those days when we particularly want to get the message out to people about their alternative options, we also contact mainstream media. You will often hear on the radio news, for example, that Canberra Health Services is just reminding people: "We're having a busy day. Can you please think of an alternative if you don't need to come to the emergency department at this particular time?"

We also have the ACT Health app. We are continually looking at ways to better promote the availability of the app and encourage people to download it so that people can get real-time information about the waiting times both at Canberra Hospital and Calvary, as well as across the walk-in centres. The app also includes information about what can be treated at a walk-in centre. It is a useful source of information for people. Of course, the app also does the COVID screening for people who are turning up to Canberra Health Services or any of our other health services across the city.

MRS KIKKERT: So Canberrans were advised to go to neighbouring walk-in centres. But are they equipped to deal with a potential emergency? What happens when they reach capacity?

Ms Stephen-Smith: When the walk-in centres reach capacity?

MRS KIKKERT: Yes. They were advised to go to walk-in centres.

Ms Stephen-Smith: Walk-in centres generally have pretty good wait times. Obviously, sometimes it will be a little longer than others, but they do not—

MRS KIKKERT: Are they equipped to deal with potential emergencies?

Ms Stephen-Smith: If it is a genuine emergency, I think our messaging to the community is always: "If it is an emergency and you need to go to an emergency department, please come to the emergency department. We are never closed and we will treat you."

MRS KIKKERT: But they were advised to go to a walk-in centre.

Ms Stephen-Smith: For a minor injury or illness of the kind where people often go to the emergency department. I know myself that, in the past, I have been to the emergency department with an injury to my finger that I got at the stables on a rusty thing. I went to the emergency department to get a tetanus shot. That was before we had walk-in centres. Now we have walk-in centres. That is exactly the kind of thing that you would go to a walk-in centre for, rather than going to an emergency department.

MRS KIKKERT: Can the scope of practice of every nurse-led walk-in centre be published and included in the ACT Health app?

Ms Stephen-Smith: The Health app does include information about what can be treated at a walk-in centre.

MRS JONES: There is a difference, I believe, between different walk-in centres, about their scopes. For example, you are getting X-ray at Weston Creek.

Ms Stephen-Smith: When we open the imaging service at Weston Creek—the capital funding has been allocated in this budget, but it is not yet open—that will be included in the app. We have also made some commitments around expanding the scope of service at walk-in centres, including additional nurse practitioners.

MRS JONES: Yes.

Ms Stephen-Smith: One thing that can change from walk-in centre to walk-in centre is the availability of nurse practitioners to prescribe at particular times of the day. It may be that you turn up to one walk-in centre and they say, "We don't have someone who can prescribe right now, but if you go to another walk-in centre, you might be able to get that service." That is one of the reasons we have made a commitment to increasing the number of nurse practitioners at walk-in centres—

MRS JONES: Who can.

Ms Stephen-Smith: to ensure that that scope of practice is available for that wider length of hours. Is that accurate?

Ms McDonald: Yes. Cathie O'Neill, who runs all our walk-in centres, can give more detail on the scope of practice and the difference between our walk-in centres, which is not great, really.

Ms Stephen-Smith: No.

Ms McDonald: They are very similar in their approach.

MRS JONES: I think Coombs is planned to be slightly different again.

Ms Stephen-Smith: Coombs is not going to be a walk-in centre. Obviously, there is a walk-in centre at Weston Creek. It is not going to duplicate that service which is very close by.

MRS JONES: So it is not a walk-in centre?

Ms Stephen-Smith: We have called it a walk-in health centre. It will provide some immediate services, and we are still working through that. Mr Peffer talked about the model of care.

MRS JONES: There is some confusion about that.

Ms Stephen-Smith: It will also provide specific maternal and child health services. Those were going to be the services that would move back into Weston Creek Community Health Centre. Weston Creek was planned to be a collocated walk-in centre and community health centre. Obviously, it has been dedicated to COVID almost since it opened, to do testing. Now we have said that we are going to put an imaging service into Weston Creek—

MRS JONES: So it is more of a health centre.

Ms Stephen-Smith: and the maternal and child health services will collocate into Coombs. We are looking, as Mr Peffer talked about earlier, at the broader model of care for Coombs and how we integrate care and what other services might be available there. Ms O'Neill?

Ms O'Neill: Thank you. There is no discernible difference in the scope of practice between our current nurse-led walk-in centres. Whilst there may not be a nurse practitioner there at all times, the amount of prescribing that happens in those walk-in centres is pretty minimal. The advanced practice nurses that are on duty at all times are able to start what we call a starter pack. For example, if they diagnose a definitive infection, according to their protocol, they can start the person off on antibiotics without having to have the nurse practitioner—

THE CHAIR: So then they have to follow up with a GP?

Ms O'Neill: Yes.

MR PETTERSSON: I refer to the budget, page 44, table 14. I am looking at alcohol and drug services' community contacts. The target was not met, well and truly. Can someone explain why that target was not achieved?

Ms Stephen-Smith: Page 44?

MR PETTERSSON: Table 14, alcohol and drug services' community contacts.

Ms Stephen-Smith: The footnote says:

> The under achievement is related to a reduction in occasions of service due to health professional vacancies and the ongoing challenges of fulfilling those vacancies.

MR PETTERSSON: Recruitment; indeed.

Ms McDonald: Yes.

Ms Stephen-Smith: I do not know if Karen is here.

Ms McDonald: Karen is not here. She will be here this afternoon for mental health and justice health. This has been an ongoing issue in our mental health services across the board in terms of recruitment of staff for services. I know that explains why we have not been able to maintain the service, but we did see a drop-off with COVID in terms of people coming in for services. We had to adjust how we were doing that. There are definitely ongoing issues with staffing. We have very clear recruitment strategies, but there is a national shortage of mental health staff, both medical and nursing, and other health practitioners in mental health across Australia. It is an issue for us that we are taking seriously and working on recruitment seriously.

Ms Stephen-Smith: This applies across both alcohol and drug services.

Ms McDonald: Yes. Alcohol and drug services sit under our mental health services, so it is across the board.

MR PETTERSSON: You would not happen to know, I guess at a somewhat specific level, what the vacancies are?

Ms McDonald: Yes, but I would have to take the question on notice in terms of the numbers.

MR PETTERSSON: Wonderful. Thank you.

THE CHAIR: Dr Coatsworth reminded us earlier that we have four applications for every one position for junior doctors, proving that, on some level, our health system is a system that people really want to work in. What are we doing right to promote employment opportunities to junior doctors that we are not doing to promote these vacant opportunities so we can get these numbers down?

Ms McDonald: I think that it is a question of the number of graduates that are coming out. Junior doctors are from a different pool than our senior medical staff pool. There is a national shortage of mental health psychiatrists—for example, senior psychiatrists—across Australia. All mental health services are experiencing shortages. There are also a number of psychiatrists who prefer to work in what we call visiting medical officer locum positions. They travel around and do short stints around Australia rather than being employed as a staff specialist within an organisation.

There are a large number of medical graduates across Australia, and we are attracting them, which is great, but we do not have the same large number of senior medical staff psychiatrists that we can attract as well. For us, our recruitment strategy for senior medical staff is about the work environment and the experience they can get. It is also about Canberra: come to Canberra; it's a great place to live; let's make it attractive: those sorts of things. In terms of salary ranges, we are competitive with the rest of Australia. So that it is not the issue. There is a shortage of psychiatrists and mental health practitioners around Australia nationally.

Ms Stephen-Smith: If I can just add to that? I think that applies across the nursing workforce in mental health as well. It is a specialised area of nursing, as is drug and alcohol. There are shortages across all levels of the workforce in those spaces.

Ms Jonasson: If I can just add: this is something that all the states and territories have raised with the commonwealth, our minister and other state ministers. In terms of workforce shortages, it is an area that has been identified as a priority reform area out of the negotiations from the last national health reform agreement. It is certainly something that we are very keen to progress, but it has to be done bilaterally or cross-jurisdictional with the commonwealth government.

MRS JONES: With the universities as well, I presume.

Ms Jonasson: The universities as well.

THE CHAIR: On that note, what can we do that we are not currently doing, in terms of filling these positions, to encourage and support people who want to work in the medical profession—it seems that we have a surplus; there are more than we have the demand for—through a professional pathway to fill these kinds of positions long term?

Ms McDonald: Dr Coatsworth, if he is here, might talk more about this. With any speciality training program, for us it is about creating the environment where we work closely with our psychiatry registrars to ensure that they have a good training experience with us, that they go on—

MRS JONES: To stay.

Ms McDonald: to become consultants, and then would like to stay and work with us in future. So it is creating that pathway all the way through and creating that positive experience. Having said that, with a lot of our doctors it is actually good for them to do their junior training with us and then go somewhere else to work and then come back. It is about trying to create an environment that they want to come back to, because experience external to Canberra is very valuable and good. It is trying to create that positive experience with them while they are with us, and then attract them back or, in some cases, get them to stay and complete their whole training with us. I might ask Dr Coatsworth to talk more about that.

Dr Coatsworth: Just one other observation, which is going to be self-evident: as a smaller jurisdiction, we are going to be more vulnerable to these supply shocks, having worked also in the Northern Territory. That means we have to work hard to address them. It is about salary. We know that we are matching salary. It is about providing a great training environment. We know where we are doing well on that and we know the areas that we need to improve, as I responded to Mrs Kikkert earlier, about junior medical officer culture.

In the medical sphere it is often about word of mouth as well. In this day and age, things that happen in a jurisdiction, particularly with COVID, are across the country with WhatsApp in a matter of seconds. We need to have sufficient critical mass of people talking about us in a positive way, to be able to get ahead of places like

Sydney, Melbourne and Brisbane. As someone who has worked there, they are like Jupiter in terms of their gravitational pull for clinicians.

THE CHAIR: The root of my concern is that I am really struck by the four to one ratio that you gave earlier for junior doctor applications. In that respect, we have a gravitational pull there of medical professionals—

Dr Coatsworth: We do.

THE CHAIR: that do want to work in our system.

MRS JONES: Well, they apply to many places.

THE CHAIR: I am curious as to what scope we have to encourage them into entry level positions in other parts of our workforce, not unlike drug and alcohol rehabilitation services, where we know we have a shortfall. I respect that we need the high-level specialists, I imagine, to lead those teams.

Dr Coatsworth: Yes.

THE CHAIR: But is there scope to even fill or create positions for entry level medical professionals?

Dr Coatsworth: Thank you for the clarification. There is a concrete answer to that, which is that the number of accredited junior medical staff positions in psychiatry, which includes drug and alcohol, has increased over the past year. I am afraid I would have to tell you on notice specifically what that is. I signed off on two junior medical staff positions two weeks ago. There is an increase, aligning with the suggestion that you are making.

THE CHAIR: Tremendous. Great minds think alike. Thank you, Dr Coatsworth.

MRS JONES: I want to go to cross-border arrangements in our acute care. Just to paint a picture, I would like to understand better the precise nature of the repayments that we get from the New South Wales government for treating people from outside the ACT, which is a good and important part of what we do, so it is not a criticism. I would like to understand better how that functions. Are we being paid back at the national efficient price or are we being paid back at the cost of delivering the services? What is the time frame for the repayment of that money?

Ms Stephen-Smith: It is basically the national efficient price, but I will get Ms Chambers to talk more about that. It is also important to remember that, while we treat more New South Wales patients than New South Wales probably treats ACT patients, there is a two-way flow. There is obviously—

MRS JONES: When we are away on holidays.

Ms Stephen-Smith: a range of ACT patients who go and get treatment in Sydney for things that we cannot treat here because of our population base and the inability to have every specialty available for a population of 426,000 people, or whatever we are.

Even our regional population of 800,000 to a million that we might treat overall is not enough to support some specialties. Ms Chambers?

Ms Chambers: I acknowledge and have read the privilege statement.

MRS JONES: Thank you.

Ms Chambers: On page 62 of the ACT Health budget booklet, I will just draw your attention to the line item where we allocate our cross-border revenue. That is on page 62. For 2021, we anticipate $200 million for cross-border revenue. That is across all states and territories.

MRS JONES: As in recouping from, say, a Northern Territory patient who is here as well?

Ms Chambers: All interstate patients—

MRS JONES: Right.

Ms Chambers: that are treated in the ACT. That is our revenue line. The funding comes through our state pool accounts through the national health reform agreement. For New South Wales, as to the actual break-up of that quantum of the $200,000, I could take it on notice and get the actual specific. I did not bring my annual report booklet with me, but there is a good blurb in the financial reporting section about what our cross-border revenue is.

Also, we have cross-border expenses, of course. Those are measured on an annual basis. We calculate, through the National Health Funding Body, reconciliations about how many interstate patients we have treated and how many ACT residents have been treated interstate. We provision the New South Wales proportion monthly. We are transacting monthly provisions through our financial statements and back through to our providers to obviously recognise the services that they have delivered to our visiting residents. We also reconcile that every year in arrears. We are currently reconciling 2019-20, and that will be determined in March 2021.

MRS JONES: How many staff are engaged in the business of managing and collecting the data on how many people we have served or, let's say, the things they have had done to them in our system and then how much? Is it like a 10-person team? You may have to take that on notice.

Ms Jonasson: We would probably have to take that one on notice, Mrs Jones.

MRS JONES: Yes.

Ms Jonasson: What I would say is that the staff are in different areas of the directorate.

MRS JONES: Right.

Ms Jonasson: We use some data team people. We have also got a team that is doing

the negotiations with New South Wales around the new MOU agreement. There will be people from across a bunch of different areas. We will see what we can do.

MRS JONES: Can I just ask for an FTE equivalent—maybe that is the easiest way—

Ms Jonasson: Yes.

MRS JONES: of people who are engaged in getting us to that point of getting the money back or dishing money out, but, I think, generally getting it back?

Ms Jonasson: Yes.

MRS JONES: Thank you.

Ms Stephen-Smith: To that point, Mrs Jones, in relation to the detail of understanding, one of the things that we have been doing in terms of the territory-wide health services plans and CHS clinical services is having a better understanding, at a granular level, of who is going to Sydney or Melbourne for treatment—

MRS JONES: And for what.

Ms Stephen-Smith: and for what.

MRS JONES: Yes.

Ms Stephen-Smith: Because it may turn out that the volume has now increased to a point where we could actually sustain a service in the ACT.

MRS JONES: That is right.

Ms Stephen-Smith: But we have not realised that that is happening because they are going interstate. So there is quite a lot of work going on to better understand that granular detail around the cross-border flows.

MRS JONES: Excellent. Thank you.

MR PETTERSSON: I understand the new Northside Opioid Treatment Service has recently commenced. Can you provide an update to the committee on its work?

Ms Stephen-Smith: It opened late last year. Given that Karen is not here, I do not know how—

Ms McDonald: We can give a broad update. The service is going well; that is probably as much detail. There are no particular issues with it. It has commenced. It is actually a great service. We have the southside service, which has been in practice for quite some time. My understanding is that the northside service is going extremely well. If you would like more detail, I can take that on notice, or we can answer it this afternoon in the other session.

Ms Stephen-Smith: Yes.

MR PETTERSSON: I will come back to it then.

MRS JONES: Page 290 of the ACT Health Directorate annual report reveals that the expansion to the Centenary Hospital for Women and Children has been further delayed with the completion date now of September 2023. In a media release on 1 June 2017, the then health minister, Meegan Fitzharris, announced the centenary hospital expansion with a completion date of 2020-21. Then it was delayed to 2021-22, and now it is delayed again to 2023. What are the exact reasons the project has been delayed from 2020-21, to September 2023?

Ms Stephen-Smith: I think there are a range of reasons, and Colm Mooney will talk about that in more detail. The original extension of time frame is around the redesign of the expansion; for example, the inclusion of the adolescent mental health unit into the expansion of the Centenary Hospital for Women and Children as opposed to being a stand-alone unit. Project issues come up, as they do, but Colm can talk more about that.

Mr Mooney: I acknowledge the privilege statement. The women and children's expansion project is an exciting, complicated project for Canberra Health Services, complicated by the fact that it is being done essentially in a live hospital or adjacent to a live hospital.

MRS JONES: All of our hospital expansions are like that.

Mr Mooney: Indeed, but this particular one has been challenging. Going to the original dates, we have had a number of issues. The adolescent mental health ward that the minister touched on was originally a stand-alone building; it is now being connected into the main building at level 2 to integrate with the paediatric adolescent ward.

MRS JONES: Is that going to take over a space currently used for something else or is it a new building?

Mr Mooney: It is a new building.

MRS JONES: So it will be on the second floor but there will be a corridor?

Mr Mooney: The specific location of the adolescent mental health ward is the corner of Hospital Road and Gilmore Crescent. It is a triangular block. It is a very, very constrained site, constrained by area but also what lies beneath it.

MRS JONES: Is this outside the front door of the women and children's hospital on the right?

Mr Mooney: Correct.

Mr Mooney: There is a statue of a boulder with a bird and a fish on the top. That is now enclosed and that is exactly where it is. That building is coming to its final stage

of design at the moment. We have a contractor, Richard Crook Construction, on board since last year.

MRS JONES: How many beds will it have?

Mr Mooney: The paediatric adolescent ward and the new adolescent ward, what springs to mind is eight beds, but I have to confirm that.

MRS JONES: Can you take that on notice?

Mr Mooney: I will.

MRS JONES: And then can you compare that to the other adolescent beds that will still be available?

Mr Mooney: I will take that on notice, just to confirm that. There has been redevelopment in that space. Going back to the original scope that we had taken on board, one of the key elements was the relocation of the Ronald McDonald House.

MRS JONES: What is going on there?

Mr Mooney: The physical Ronald McDonald space was to be relocated to a new space. The new space had to be outside the footprint of the hospital but had to be close. To meet the requirements of Ronald McDonald House, there was more than a bit of a disconnect in terms of the scope and the time frames that could be achieved and, indeed, the dollars. So we had to reconsider the design completely without relocating Ronald McDonald.

MRS JONES: So they will stay in the building where they are?

Mr Mooney: They will fully stay in the building where they are. There is no impact on Ronald McDonald. With that we had to then look at the restaging of the project in its entirety. There are eight elements of the project and within them we have already completed the paediatric high-care unit. That was opened the middle of October of last year.

MRS JONES: Is that within the building, upstairs on the far other end?

Mr Mooney: Yes, close to the Yamba Drive side. As I touched on earlier, the complication of this project is that it is like one of those puzzles with the missing space and you are moving it around. So we cannot do a whole lot of activities in parallel. A key thing you will see at the moment with the structure going up is the new modular administration block. It is a modular building and typically modular buildings have a life of 10 to 20 years; but modular buildings now are improving.

MRS JONES: Where is that?

Mr Mooney: That is right outside the main set-down area at the women and children's.

MRS JONES: On that piece of concrete that was never used?

Mr Mooney: Correct. There is a substation there, so it is being built above that. It is a rectangular building, two storeys. That will allow for the relocation of admin.

MRS JONES: Is that the admin that is in the wing between the women and children's and the old hospital?

Mr Mooney: It is on that side of the building, yes. So there is one at level 2—

MRS JONES: And will that then become a ward—

THE CHAIR: Mrs Jones, I am cognisant that we have only 10 minutes left for this item. Is this a line of questioning you could get a briefing on?

MRS JONES: No, it is really important because this project has been put off by two years. The staff are crying out for help and there has not been much explanation for the public about why and how. I do not mind if it is summarised, but I think that it is an important line of questioning.

Mr Mooney: The current admin block will be relocated and that will allow for the redevelopment of that admin block, which will also allow for the—

MRS JONES: Patients.

Mr Mooney: That is for patients. And that will allow for the redevelopment of what is known as block F, level 3, which was an undeveloped space but was always future-proofed for expansion. But, obviously, in order to do it we need to do a lot of disruptive work. So it is moving the pieces around the table.

Our original completion date was June 2022; that has moved out to September 2023. Within the time spent to repackage the works in order to arrive at an end outcome as quickly as possible within the funding envelope we have, which is just over $50 million, along the way we have incorporated new elements that were not originally in scope. I make particular reference to the early pregnancy unit, which was the subject of a separate committee in terms of recommendations and those recommendations were taken up. We worked very specifically with one of the consumers who had raised those concerns and that eventuated in a recommendation coming out of this report. They have all been incorporated into the new scope that is being delivered.

MRS JONES: Okay. I just have to correct something. I said in my question that, in a media release on 1 June 2017, then Minister Fitzharris said it would have a completion date of 2020-21. That is really important—it is going to be two years beyond that when it is completed.

Mr Mooney: I was working on a date of when we started it and it was to be completed by June 2022.

Ms Stephen-Smith: To go back to one of your earliest questions, the centenary

hospital expansion newsletter from July last year indicated that the adolescent mental health unit would be integrated with the existing adolescent ward, as Mr Mooney has indicated. The facility will include a six-bed adolescent mental health unit that is connected to the eight-bed adolescent ward with shared services.

MRS JONES: So can they scale up those beds into the adolescent unit if it is needed and vice a versa?

Ms Stephen-Smith: Yes.

MRS JONES: Has the staffing plan been drawn up? The question from nurses who have worked in that unit is that we currently have adolescent mental health patients sometimes occupying beds that are not adolescent mental health beds and the staffing for that is not quite what it could be. Is there a plan to have a significantly increased staff in that specialisation?

Ms McDonald: Yes, the model of care has been worked on with staff and our mental health services. The current adolescent beds are often filled by either children or paediatrics with mental health issues or behavioural issues, not necessarily diagnosed mental health issues. That is under the remit of women, youth and children. We are bringing mental health services in to run and staff the adolescent mental health unit so that those paediatric patients who are currently in general beds being looked after by paediatric nurses will be in a specialised unit, not necessarily in the adolescent mental health unit but in the adolescent paediatric unit. That will have the benefit of mental health staff across the board.

MRS KIKKERT: Is the adolescent mental health unit the same as what the government has promised with the eating disorder facility?

Ms Stephen-Smith: No.

MRS KIKKERT: So it is completely different?

Ms Stephen-Smith: Yes.

THE CHAIR: The ACT drug strategy is mentioned on page 70 of the ACT Health annual report. How has the Drug Strategy Action Advisory Group been evaluating the action plan 2018-21? Noting, of course, that my question has an assumption that some evaluation has been done, given that the action plan is nearing the end of its life.

Mr Philp: We have recently put out a one-year summary of the work undertaken with the drug strategy plan.

THE CHAIR: Is that publicly available?

Mr Philp: Yes.

THE CHAIR: When exactly was that put out?

Mr Philp: It was released towards the end of the year.

MRS JONES: Perhaps you could give the committee a copy?

Mr Philp: Yes. The work of the drug strategy action plan is due to expire, as you know, by the end of this year. We are carrying out an overall evaluation plan to link to the new plan. A monitoring and evaluation group has been established to drive the work. It includes cross-sector representation and is chaired by a professor from the ANU.

They will be meeting in the next period of time to progress where we are with the evaluation. We believe we can feed into the committee's report because it has been included in the scope of terms of reference for the ACT Legislative Assembly and so will be coming back into that inquiry by the end of 2021 to reaffirm the actual work within the evaluation.

THE CHAIR:. Is it the government's intention to develop another action plan, noting that this expires?

Ms Stephen-Smith: Yes. The action plan responds to the national drug strategy, so under the national drug strategy.

THE CHAIR: Is it our intention to develop our own strategy rather than responding to the federal government's drug strategy, particularly taking in context that the legal and policy framework around drug use in the ACT is substantially different to the national average?

Ms Stephen-Smith: There are some differences in the way that we approach this with the forward-leaning approach we take to harm minimisation compared to some other jurisdictions, including the commonwealth. That is probably fair to say. But I would have some reluctance around establishing a new strategy for the sake of establishing a new strategy because I think the principles around harm minimisation are clear across the national strategy and the existing action plan.

What is more important to me is what are we doing rather than let's have another round of 18 months of consultation to think about setting a set of principles that will end up being exactly the same principles that we have already identified and are already identifying actions against.

This will probably be a part of the conversation the committee has in relation to looking more broadly at drug and alcohol policy across the ACT, and we welcome that conversation. A colleague recently described a state you can get into of death by framework, where people talk about what you should be doing without actually doing what you should be doing.

THE CHAIR: Let me stress this: in my line of questioning my intention is not to burden our officials with a duplicate framework. That is definitely not my intention. Rather, I have concerns that basing our work on—knowing that we are a forward-leaning jurisdiction and we have legislative and policy framework that treats drugs very differently to the national average, responding to the national framework, which is arguably behind the times with the ACT act, does not seem quite as

responsive. Would you agree with the assessment that we may be meeting the lowest common denominator across the national average rather than leading?

Ms Stephen-Smith: I think we can lean forward in our action plan, recognising that all jurisdictions, from a health perspective and from a national drug strategy perspective, see harm minimisation as a key element of drug and alcohol policy. Within that priority of harm minimisation, we can identify actions that go further than other jurisdictions would want to do. I do not know that revisiting the principles is something that would necessarily have value; but, again, if the committee has a different view, then that will come out through the inquiry.

Just in relation to the progress report, probably the reason people did not necessarily notice this being released and uploaded onto the website was that it was updated on 9 September, two days before caretaker. The progress report came out just before the caretaker period started so it did not get a lot of publicity. If you look up the drug strategy action plan website, the progress report is up there.

MRS JONES: My question is about this whole investigation we are going to be doing in the ACT about change led by Mr Pettersson's bill. The feedback I have had is about people trying to get into rehabilitation services. I presume that is touched on by this plan. Do you have any statistics about the number of beds in residential rehabilitation, the number of places in non-residential rehabilitation for drug use, and other options that are available to people for recovery? The casual feedback I have had is that it is really hard to get in.

THE CHAIR: Mrs Jones, there are a fair few more questions there to answer than we have time for. Would you be comfortable taking those on notice?

Ms Stephen-Smith: Yes, I think we would have to take that information on notice in terms of the number of beds across different—

MRS JONES: It would be helpful for us, in the next few months of debate, to have that information for the Assembly as well.

Ms Stephen-Smith: I think it will be important to break those down, because there are a range of different types of detox and rehabilitation. We have supported Karralika's non-residential detox service. So we will try to find a way of summarising that information for the committee.

MRS JONES: There are some interstate ones as well that are used by people in the ACT, so I would love to know all of that.

THE CHAIR: I remind witnesses that if you have taken any questions on notice today, please provide the answers to the committee secretary within five working days. That would be close of business Friday, 5 March.

Hearing suspended from 12.31 to 1.30 pm.

Appearances:

Stephen-Smith, Ms Rachel, Minister for Aboriginal and Torres Strait Islander Affairs, Minister for Families and Community Services and Minister for Health

Community Services Directorate
Wood, Ms Jo, Director-General
Sabellico, Ms Anne-Maree, Deputy Director-General
Pappas, Ms Helen, Executive Group Manager, Children, Youth and Families
Murray, Ms Christine, Executive Group Manager, Inclusion and Participation
Bassett, Dr Louise, Executive Group Manager, Strategic Policy

THE CHAIR: Welcome back, everyone. In this session we will hear from the Minister for Families and Community Services. I remind our new participants to familiarise themselves with the privilege statement and to acknowledge that privilege statement when they first speak.

MRS KIKKERT: My question is on the external merits review. One of the budget priorities for 2020-21 is to strengthen oversight in Child and Youth Protection Services. Can the minister update the committee on what the government is doing to make sure that child protection decisions are subject to external merits review?

Ms Stephen-Smith: Mrs Kikkert, you might be aware that we held an online forum with a number of stakeholders, with both Victorian and Queensland representatives, last year, prior to the election, to talk about both the findings of the discussion paper and that process we went through to think about what a model for external merits review might look like and to hear from other jurisdictions about their experiences with external merits review with a range of stakeholders, including the Human Rights Commission, legal advocates et cetera. Subsequent to that there was another forum which I think took place during the caretaker period—certainly I did not participate in it—to talk through the lessons learned from that.

One of the things the director has been working through with those stakeholders is the need for an integrated approach to these issues, where we look at how decisions are made in the first place and communicated to people, what the internal review processes look like, and how that integrates with the external review. I will hand over to Anne-Maree to talk a bit more about that whole process.

Ms Sabellico: I acknowledge the privilege statement. In terms of the work around the external merits review, as the minister said, we have held a number of forums. The first forum brought together people who have experience of implementing external merits from other jurisdictions, to get an understanding of what the issues were for them, what the considerations were and how that all fits together for them in their process. The second one was validating what we heard from the sector as part of those conversations and progressing the discussion in terms of what we want to see in the ACT context.

A number of key things came out. One is that the capacity to engage appropriately from first contact is really important in being able to manage a more restorative

approach to casework and casework decisions going forward and including people throughout that process. Another was looking at how we make sure people have a level of advocacy and support outside of either the internal review participants or to support them in the external review process. All of that needed to come together to provide a unified approach.

So once we knew what it was we wanted to do externally then we needed to go back and have a look at what we were doing internally around making sure that we were capturing all of the elements and we had consistency between the two processes.

A lot of work has been occurring within Child, Youth and Family around looking at their internal processes, and I will ask Helen to talk about that in a moment. But that then goes with the principles: how we include people earlier, how we put in place a more restorative approach and how we make sure that people are absolutely aware of the decisions being made at the point in time and having a say around that.

MRS KIKKERT: Just before you move on to Helen, I would like to hear about the internal process as well. Was that all of the recommendations from the jurisdictions who are currently implementing external reviews, or are there more? If so, could you provide the committee with that?

Ms Sabellico: We can certainly provide the committee with the overview of the discussions from those sessions.

Ms Stephen-Smith: I think that was shared with stakeholders, yes. One of the important things that came out of that conversation though—and this provides the context for handing to Helen to talk about internal decision review processes—is that, for both Queensland and Victoria, the number of decisions that go to external merits review is very, very small.

At least one of those jurisdictions—I think it was Victoria—indicated that they have quite a lot of examples where the decision is going to the external merits review process but is also being considered by the Children's Court. This is one of the things we have been trying to work through—how do you line up what goes where without duplicating and without extending time periods for decision-making for children in care? They highlighted that the existence of an external merits review process also drives improvements in internal processes, and they were quite supportive of the view that one of the key things we need to do is improve our internal processes.

Ms Pappas: I acknowledge the privilege statement. As Ms Sabellico said, we have been running a consultation process external to our directorate but also internal with our staff about how we can reset the mechanisms and the way case managers and team leaders and operations managers engage in a request for a review of a decision. That is about how you initially make a good decision and how you communicate that decision so that people understand clearly—and sometimes you have to do that multiple times and with different people—and then how do you work with people who are not satisfied with the initial decision to get their voices heard through other mechanisms, independent of the people that made the decision.

We have talked at hearings before about the almost hundreds of decisions

caseworkers make every day with families, and it is not possible to have all of those reviewed and reviewed and reviewed. There are consequences for children and young people when that happens but also for families. We need to review the key ones, where there is the controversy and where there is always the complexity—things like contact, placement options, outcomes of appraisals, for example. There are a number of things that we see over and over again in terms of people not understanding how to engage in the conversation with the system.

We did a pretty comprehensive consultation process with everybody that made a submission to the discussion paper that was released some years ago. We met with them, provided them with some draft internal operation policy and sought their feedback—what works, what does not work, are there any unintended consequences we had not thought about, is it clear enough, does it communicate in simple terms that everybody can engage in a review system internally? We are at the final stages of that now and we will make sure everybody is still happy with that and make sure we have positioned the policy properly. Then we have to align that with the external process so that it is a really coherent system. We have to make decisions about do you have to do one before you do the other or can you do both?

All those things need to be resolved and worked through. But we want to get on internally to start a really good conversation with our staff around why you make decisions, how you make good ones and how you communicate them. That needs to happen regardless of an external system anyway. We are looking at practice guidance and pretty detailed, comprehensive training for people. We will do that this year, in readiness to align with an external process.

MRS KIKKERT: The committee report tabled last year specifically recommended that amendments creating a review process be modelled after Victorian law, which provides that the child, a parent of the child or any other person affected by the decision may apply to their tribunal for review of a decision. Will the external merits review in the ACT replicate this right?

Ms Stephen-Smith: One of the things that came out of those conversations with Victoria and Queensland was that we have an opportunity to improve on their processes. That is what I was saying about how they go to their Administrative Appeals Tribunal, I understand. That can result in parallel processes between the Administrative Appeals Tribunal and their Children's Court processes, which means that the Administrative Appeals Tribunal process is effectively put on hold while the matter is considered in the Children's Court.

There was a conversation in that group about: can we improve on that process by better understanding how things move through an external system where you have decisions that could be reviewed in the Children's Court and in this other external process? So it is unlikely that we will completely, 100 per cent replicate the Victorian model because they have identified that it can be improved on, and we have the opportunity to do that.

MRS KIKKERT: In the hearing last week, the Children and Young People Commissioner mentioned that the CSD was in the process of putting out a tender in relation to this matter. Can you, Minister, please explain specifically what this tender

is for. She said it last week when she appeared before the committee.

Ms Stephen-Smith: Dr Bassett needs to answer that.

Dr Bassett: I acknowledge the privilege statement. Would you please repeat the question for me?

MRS KIKKERT: The Children and Young People Commissioner mentioned that CSD was in the process of putting out a tender in relation to external merits review. Can you please specifically talk about what this tender is for.

Dr Bassett: As you heard the minister outline, we have had a number of consultative processes to examine models. The tender process is around the examination of models that exist in jurisdictions in Australia, the identification of which aspects of them would be applicable in the ACT, and customising the proposed model for the ACT.

It is around making sure that it takes into account our own jurisdiction's legislation with respect to the Childrens Court and our Children and Young People Act; making sure that the model that is proposed would actually work in the ACT from a legal perspective, in sync with the internal processes that Helen mentioned earlier; and making sure that whatever is proposed is really effective and does not have the issues that Victoria and other areas have identified with their existing processes.

The piece of work is really about unpacking all the aspects of a proposed model and making sure that before we propose anything formally, there is analysis of all of the intersecting parts. As you have heard already, it is quite a complex piece of work. We have that tender process in place. It has not yet commenced, but it will commence soon. It is to examine all the aspects of proposed models for external merits.

MRS KIKKERT: Do you know how soon you are talking about?

Dr Bassett: We did discuss this, didn't we?

Ms Wood: It will be within the next month. It could be slightly quicker than that. It is just going through the procurement process to put the tender out.

MRS KIKKERT: Will it be an open tender?

Dr Bassett: I think it is a select tender, but we have constructed the list of organisations that will be approached from a range of people's views. We have sought the views of the executives in JACS and CSD and other interested parties, such as the Human Rights Commission, to put together a select group that we think will be able to respond well to that procurement. That is the proposal at this stage.

MRS KIKKERT: Is there a limit to how many of those selected people could—

Dr Bassett: No, I do not think there is a limit as such.

MRS KIKKERT: So it is unlimited?

Dr Bassett: It is just that one of the things that—

MRS KIKKERT: It is quite select.

Dr Bassett: Yes. A determination needs to be made about the capacity of organisations to respond to the request, so we have tried to ascertain whether the organisations on the list could actually respond and have the capacity and the capability or use their expertise to give us exactly what we need. That is part of the consideration in how that list is put together.

MRS KIKKERT: I am sure you also discussed how long this tender will take for them to do? Once they get the job, what is the deadline? What time limit are you giving them? Is it a year?

Dr Bassett: It is not a year. The specific details will be worked out, as we now have the approval and we have the list together. The next stage is determining exactly how long, what their deliverables are, and how soon they will get it to us so that we can have a look at it.

MRS KIKKERT: What would your expectation be?

Dr Bassett: I think it will be within this calendar year.

MRS KIKKERT: Within this calendar year they will be ready with the result of their research delivered to the department or delivered to the minister?

Dr Bassett: I think that is our expectation, yes.

MR PETTERSSON: I have heard really good things about the Inclusion and Participation Division's implementation of the union encouragement policy. Could someone outline for the committee how that is being implemented?

Ms Wood: I will invite Ms Murray to respond to that. And I belatedly acknowledge the privilege statement.

THE CHAIR: Thank you, Ms Wood.

Ms Murray: I acknowledge the privilege statement. I initially had the opportunity to join the Inclusion and Participation Division for a short period, but I have now been there for a longer period. As a team, we wanted to work really hard on building a culture that mirrored the work that we do in the community. Inclusion and participation are what we are all about; we are all about trying to hear the voices of all of our staff, and our staff as they represent the community and represent the conversations that they have in the community.

One of the mechanisms that we have used to help bring that voice of everyone in the division to the table has been around really ensuring that the representatives of different areas—health and safety representatives, respect and equity and diversity contact officers and union representatives—are brought to the table. We are working on an individual workplan with the people we refer to as our contact officers as a way

of making sure that everyone has a voice to participate in their workplace. We are uniquely placed in Inclusion and Participation, because we work really hard with our community and we need to hear the voices of everyone in our community to inform the policy development that we do. For me, it is almost a no-brainer in terms of making sure that we give an opportunity for all the perspectives to come to the table.

I am really excited about the workplan that we have been able to develop with all our contact officers. We are really open about the conversations around the importance of unions and the diversity that they can bring to the table. We always invite unions to participate in our divisional meetings. There is no wrong voice to be heard. After so many years in people management, everyone knows me well enough to know that a real passion of mine is to make sure that people have their voices heard at the table and to make sure that everyone feels they can fully participate.

In trying to make that participation available, I have tried to work on a flatter structure where everyone has a conversation and that voice heard, but I am really cognisant of the fact that there still is a hierarchy and that some people need support to continue to participate, particularly in raising concerns. It is a really important role that the unions are playing in supporting people to bring any concerns to the table. Does that help? It is not a step-by-step plan A, plan B, plan C; it is just opening the doors and being open and honest in our dialogue.

MR PETTERSSON: It sounds wonderful, and the feedback I have received is that you are doing a very good job. It is nice to hear it explained.

Ms Murray: Thank you very much.

THE CHAIR: Minister, reporting on strategic objective 8 in the CSD annual report on page 53 shows that over five years the proportion of children exiting care with no more than two placements in care has steadily decreased. What are the main reasons for this trend?

Ms Stephen-Smith: I will get Ms Pappas to come and talk about that. I think one of the reasons is that, because we are doing more work to ensure that children and young people only come into care when that is necessary—so more work to ensure that children and young people can stay safely at home—we have a higher proportion of children and young people staying in care for a longer period of time and so the likelihood is that they will experience a higher number of placements. It is obviously something that we are cognisant of, but I will hand over to Ms Pappas.

Ms Pappas: In strategic objective 9, we think the decline in the number is driven by three key areas of practice. Kids who are in care tend to stay in care for a long time, as the minister was describing. Some children come in at 12 months old or two years old and stay up to the age of 18 in care, in some circumstances. You can expect that, over the course of that time, kids will move. Sometimes that is not a bad thing; it is about kids being in the right placement for them. Sometimes kids come into care and no families have presented themselves; then after a period or some years, a family presents itself and that is a better option for those kids. A change in placement should not necessarily be seen as a backwards step or the wrong move for kids; for some kids, it is the right move.

THE CHAIR: Just to clarify, in that instance, if a child is taken from care that is being administered or arranged through CSD to a family member or even back to their parents, for reporting purposes that would not be considered their second placement or their next placement; that would be back to family. Correct?

Ms Pappas: Back to the biological parent is not considered a placement, but back to extended family is—aunts, uncles, cousins, grandma, grandpa. All of them are what we call kinship carers in our service. We assess them and we support them financially and otherwise to look after kids that are their extended family members.

THE CHAIR: In this figure that I am concerned about, about children who have experienced more than two placements, would you know how many of those kids or placements were in kinship relationships rather than just with foster carers?

Ms Pappas: In terms of how many kids are in kinship arrangements?

THE CHAIR: No; the figure that I am looking for is this: of the children that experience more than two placements in care, how many are moving back into or from kinship care arrangements and not just from foster home to foster home?

Ms Pappas: That data does exist. I do not have the data in front of me, so I will have to take that one on notice.

THE CHAIR: That would be great. I would appreciate that.

Ms Stephen-Smith: Another thing to recognise with this indicator—correct me if I am wrong, Helen—is that because the indicator is based on children exiting care, that is a relatively small number of children and young people in any one year.

Ms Pappas: That is right.

Ms Stephen-Smith: So the individual experiences of that relatively small number of children and young people will have an oversized impact on the group.

THE CHAIR: That makes sense.

Ms Pappas: There are another two drivers. One goes to the restoration efforts. Sometimes when birth families are actively seeking to have their children returned to them, kids can move in and out of the system. You do the work to get kids back to their parents and then something goes wrong and those kids have to come back into care. It is a really small number, but that does impact on this data as well.

The third cohort that impacts on this data is our teenagers in residential care. They are a very mobile cohort. They, as we want them to, make their own decisions. Sometimes they make decisions that are good—

Ms Stephen-Smith: Sometimes we would prefer that they did not!

Ms Pappas: Sometimes the decisions they make for themselves put them at risk.

Young people move in and out. When you leave a residential care placement, that bed closes down and then when you come back in there is a new bed and that is considered a new placement. That sort of in and out of the residential care system can also impact on this data.

THE CHAIR: That makes sense.

Ms Stephen-Smith: With your indulgence, Chair, can I just clarify that?

THE CHAIR: Please; it is all useful for me.

Ms Stephen-Smith: A decision to go from residential care to supported adolescent placement—a sort of semi-independent placement—would also be counted as a change in placement, but it is part of the transition to independence for those young people who are leaving care.

Ms Pappas: A change in placement, just to reiterate, is not necessarily a bad thing. It could be about that child's pathway into independent living, pathway back home or pathway to another arrangement. We like to see that kids have as few changes as possible. We know that kids do better when they build positive relationships with people that care for them. That is an indicator for us. If a young person is having lots of moves, obviously there is something wrong and we need to try something different to stabilise them.

THE CHAIR: You have noted those three main reasons why they would experience that, and I appreciate that there would be a different body of work required for particularly older young people who are transitioning out of care, in large part of their own accord, but I am interested more in the children who would be in classifications 1 or 2—that their length of care or restoration efforts have failed. What is the support framework in place, accepting that these young people probably need additional supports and care, based on their multiple placements that create a certain new level of challenges to that young person? Is there a specific framework to support them?

Ms Pappas: Each child and their family that comes to the attention of our system has unique and individual circumstances. We try hard not to take a menu approach. We use the process of care teams. When children come into care, we bring together both the people who have established relationships with the children and the families and some agencies that have something to contribute. It is quite an individualised response.

Our out of home care providers—ACT Together, for example—have the Australian Childhood Foundation, who bring some therapeutic expertise into residential care. They work one on one with carers and they do some work with young people to try to find that thing that helps kids settle. Usually it is not one thing. We know that it takes a long time for kids to recover from trauma and we know that some kids do not recover from trauma, but the work of the Australian Childhood Foundation is to try and stabilise those kids, connect with them, help their carers understand what their triggers are, and put a plan around that so that when they are seeing a young person escalate, they can recognise that and they can respond in a way that the experts have recommended.

That is the residential cohort. We also have the younger cohort. We have a trauma recovery centre, Melaleuca Place. It has been in place for a long time. It does therapeutic work with children under the age of 12. Again, it is around recovery from trauma, working with carers or the people that are caring for those kids to understand triggers, to understand how to respond to them, to set a plan and actually do therapeutic work with those kids. It is intensive work, it is specialised work, and it is work that takes a long time. Some of our kids in Melaleuca Place can be there for 18 months for treatment; then they step down from that and there is ongoing support to carers as they need it.

There are other programs. Uniting Children and Families runs some intensive family support programs—that is in house, kids who live with their parents—to manage behaviour, to change the way parents are parenting, to support them to do things differently.

There are a range of other programs. There are child and family centres. There is a whole network that sits around vulnerable children and families to offer some expertise. There is no one service that can do it all; we bring a collective together. We are able to share information and be quite fluid around how decisions are made through those care teams.

THE CHAIR: That answers my questions around points 2 and 3, those restoration efforts and older young people. In terms of the young people where length of care is the reason why they are transitioning through multiple placements, I am curious to know if you keep data on the difference between those young people coming to you or another provider through the course of their supports to say that the placement is not suiting them and their needs, as opposed to people providing the care saying that the placement is not suiting their needs. I am interested in the split there.

Ms Pappas: That is not data that we can extract easily out of the system. You are right that they are two triggers. It is either a young person saying, "This is not working for me," or it is a carer or a family member saying, "This is too hard for me." The data we capture identifies the change in placement. To get the reason why or information on who made the approach, we would have to go to individual client records. I will take that on notice and make sure that is right.

THE CHAIR: The reason I ask and the reason I stress that I feel that that would be important data to collect is that it is important to ask—I am sure I am telling you how to suck eggs here—whether, for children who are experiencing more than two placements, the issue is that the carers are not adequately prepared for the young people that they have been asked to provide care for and they are the ones ending the placement or there is more work to be done with the young person, who is just trying to get out of having care provided, with greater degrees of frequency, which is distorting their care overall. I suppose that is more of a comment.

MRS KIKKERT: I have a follow-up question on kids exiting care, those who have turned 18. It is probably a question on notice. Can you tell me how many of those kids have exited care in the last two years and how many of those kids received a care plan when they exited? Also, can you tell me how many of those exit plans were quite successful in providing housing, employment and support for that young adult?

Ms Stephen-Smith: The number of children and young people exiting care is in the snapshot report that is tabled in the Assembly every six months. The current snapshot report goes back to 2016-17. That data is available through those snapshot reports.

MRS KIKKERT: In regard to the care plan when they exit? If you do not mind providing answers to those questions on notice, that would be great.

Ms Pappas: When you say "care plan", do you mean the transition plan for young people? There are two things. Not all children that exit care are 18; there are some kids that exit care prior to 18, although generally that is the group.

MRS KIKKERT: Yes; all of those kids.

Ms Pappas: Do you mean the transition plan that is established to help that transition and then beyond their 18th?

MRS KIKKERT: Into society, whether they are under 18 or over 18. It would be wonderful to get a group shot of how many of that cohort of kids that leave care, no matter what age they are, are receiving a care plan to settle into society.

Ms Pappas: Okay.

Ms Stephen-Smith: Mrs Kikkert, I can answer the first part of the question; we have the data for the last financial year. The figure for exit from care was 105 children and young people for 2019-20. Ms Pappas can provide the data on the care plan on notice.

MRS KIKKERT: Is it mandatory that each of those kids that exits receives a transition plan?

Ms Pappas: The legislation requires planning to start at the age of 15. That is not a set and forget plan; it is an iterative plan, depending on the circumstances of that young person. At 15, it is about "Where do you see yourself when you get to 18? Do you see yourself staying in your existing care arrangements or do you see something else for you? Do you see yourself going home?" It is really trying to get young people to think beyond 15. We use the same process. At 15, they are reviewed annually. Beyond 18, young people have to consent. They might choose to walk away from whatever planning we or ACT Together had been doing with them and go out on their own.

MRS KIKKERT: Do you keep data on young people who decide not to receive those care plans?

Ms Pappas: We know the young people that exit and we know if they come back. They are always able to come back, up to the age of 15, for some ongoing support, case management, brokerage funding. They can dip in and out of that as they please. If they are in a foster care or in a kinship care arrangement, some young people just stay there—just as our children do. My 22-year-old is still at home with me. It is a very natural thing for kids just to stay, and that is true for kids who are in foster care and kinship care as well as other kids. Some of those arrangements just continue and

become really normalised, natural arrangements. Other kids make some other decisions about independent living, supported accommodation and other arrangements that they might choose to make. If they want to come back, that door is open for them. If they choose not to, that is what happens.

MRS KIKKERT: One of the budget priorities for 2020-21 is to increase permanency and stability for children in out of home care through increased enduring parental responsibility and adoption orders. That is on page 5. The annual report notes that 24 permanency orders were achieved in 2019-20. How many of these were adoptions and how many were EPRs?

Ms Stephen-Smith: Page 5 of which document, Mrs Kikkert? Sorry, but we are doing budget and annual reports.

MRS KIKKERT: The annual report.

Ms Wood: For 2019-20, the number was 16 permanency, enduring parental responsibility and adoptions, of which two were adoptions.

MRS KIKKERT: I have a statement from CYPS, issued by ACT Together this month, that states that all adoption matters need to be temporarily withdrawn from the ARC. As I understand it, this is due to the current uncertainty regarding the new legal threshold, and this is being tested in the Supreme Court. Minister, can you explain what this is about and what the government is doing to address this matter?

Ms Stephen-Smith: You will recall that we made some amendments to the Adoption Act last year to make sure that we were putting the best interests of the child front and centre in the consideration of the Supreme Court when making decisions about the dispensation of parental consent in adoption matters. The way that legislation and court processes work is that when you change legislation that provides guidance to the court. The first time that is tested in court will indicate how the court is going to interpret that legislation. We have a small number of adoption matters on foot in the Supreme Court at the moment, but one of those in particular will test the Supreme Court's interpretation of the legislative changes that were made by the Assembly in September last year.

There is work being done by CYPS and the legal representatives of the ACT government to work with the Supreme Court to help them to interpret the legislation in the way the Legislative Assembly intended it to be interpreted. So there is effectively a test case currently before the Supreme Court that will determine whether the Supreme Court is going to interpret that legislation in the way that we intended, which is what we hope is going to happen.

The decision about putting these other matters on hold until we get that outcome is what the Community Services Directorate and CYPS want to do. When they take matters to the Supreme Court and seek the dispensation of parental consent and an adoption order as the territory parent—the director-general as the territory parent seeking that order—they want to have as high a likelihood of success in that legal process as possible. In order to make an argument in that legal process that is the most likely to succeed, it is important that the directorate and our legal representatives

understand how the court is interpreting what the legislation says. The decision was made that it would be unfair on families to progress to the next stage of the consideration process and to start down a path when there was—

MRS KIKKERT: There is a possibility.

Ms Stephen-Smith: I do not want to describe it as uncertainty; it is just that this is the process when courts need to interpret legislation. When that interpretation is clear, we want to be able to progress with the next lot of adoption cases with the clearest possible understanding of the arguments and the evidence that are going to be required by the Supreme Court so that those cases can be successful.

In the past—this is one of the reasons that we moved to change the legislation, apart from other policy feedback—there have been instances where the directorate, and the director-general and the legal representatives, have proposed and supported the dispensation of parental consent and made that argument in the court and the judge has not supported or agreed with the directorate's position. That is a very difficult situation for families to then find themselves in.

I absolutely recognise that this is incredibly frustrating for families who are in a permanency process and who are waiting for decision-making. It is really important to stress that the children involved in these situations are safe; they are in secure family arrangements. The action that is being taken is to ensure, to the greatest extent possible, that as those permanency processes progress and they are given the greatest chance of success. Have I summarised correctly?

Ms Wood: Beautifully done.

MRS KIKKERT: You mentioned the bill. Are you in a position to state which part of the bill is being challenged in court?

Ms Stephen-Smith: It is not that it is being challenged.

MRS KIKKERT: The family is going to court because they are not happy with the decision.

Ms Stephen-Smith: No. Adoption decisions can only be made by the court. Child and Youth Protection Services has no capacity to make an adoption decision.

MRS KIKKERT: Let me clarify my question. What is the judge looking at? With the bill, how is he interpreting it that is different from how the director-general is interpreting the bill that was passed last year?

Ms Stephen-Smith: My understanding is that she is considering and seeking advice on how to interpret the clause around the dispensation of parental consent being necessary in the best interests of the child or young person.

MRS KIKKERT: The bill last year was debated in May?

Ms Stephen-Smith: It was passed in September.

MRS KIKKERT: What sort of consultation did people have concerning this bill, especially the foster parents who would be involved and affected and who would be deeply impacted by the bill?

Ms Stephen-Smith: I might get Louise to talk about that, but there was extensive consultation in the preparation of the bill, not only with the parents and families who are interested in adoption policy and pursuing permanency processes but also with the Human Rights Commission—and with the Aboriginal and Torres Strait Islander community, given the very strong views expressed by the Our Booris, Our Way committee about permanency of Aboriginal and Torres Strait Islander children.

Dr Bassett: The question is about the consultation arrangements prior to the amendments to the Adoption Act that were passed in the Assembly?

MRS KIKKERT: Yes, and before you answer, I want to know whether people who would be impacted by this bill were sufficiently notified about the timing of it all. It was implemented in September. Did they have enough time to get themselves prepared?

Dr Bassett: The amendments that were passed came as the very last action out of the Domestic Adoptions Taskforce work, which had been going for four years prior to the recent change to the act. So yes, they had a long period in the sense that there has been work on adoptions, the framework and the permanency arrangements in the ACT for a really long period.

We did three separate consultation processes about these amendments. There were plenty of opportunities, and lots of the people who have current matters in consideration in adoption were involved and provided us with lengthy personal submissions about their particular circumstances. We had consultation processes which also went to people who had been adopted. And we had a public consultation process where people could either write to us and tell us what they thought or call us and talk to us on the phone. We had a number of ways in which people could talk to us about what we were proposing.

We then had a process where the Human Rights Commission were engaged. When we are talking about permanently changing the legal identity of a person, human rights are one of the primary considerations. They were actively participating in our discussions and in our consultation processes. The Children and Young People Commissioner as well as the other human rights commissioners were all engaged in this work.

So there were a number of ways in which people could have their say. There was a piece of work finally in the third-round consultation where we took the synthesis of all those views and put them together in a paper that was then published. There is a lot of material available about how we consulted and who we consulted during that process.

MRS KIKKERT: Currently a lot of the foster parents are a bit confused about what is happening. If they want to adopt, everything is on hold. Is there current consultation

about that? Are parents being notified about exactly what is happening so that they do not get the shock of their life when these things spring up?

Dr Bassett: I cannot talk to operational matters, but the minister may like to comment on those matters.

Ms Stephen-Smith: We have had a number of conversations about this in the last week. I have asked the directorate to speak directly with the families who are involved in the adoption matters.

As you noted, Mrs Kikkert, that email came from ACT Together. We have identified a shortcoming in the process in that, quite appropriately, ACT Together is speaking with the foster carers they support. But it results in the Community Services Directorate, CYPS, providing information to ACT Together, who then provide information to the carers and then cannot necessarily answer all of the carers' questions because they do not have that detailed background. As a result, I asked the directorate to make direct contact with the person who has written to me—I am sure it is the same person who has written to you—to really explain, in more detail, what is happening with the court processes, the conversation that we have just had, essentially, and establish a more direct line of communication with the families who are awaiting and pursuing adoption processes so that they can get the box and dice detail about the legal process directly from CYPS rather than it being a matter of "CYPS told me this and I am telling you this" and then back through—

MRS KIKKERT: When was CYPS aware of this case appearing before the court?

Ms Stephen-Smith: This case has been in train for a little while. The time frames in the Supreme Court do move around, though. There was an expectation that the case would be resolved earlier than it is now likely to be.

MRS KIKKERT: When did you decide to freeze all the other decisions about adoption?

Ms Stephen-Smith: I think the decision was taken late last week not to progress some of the conversations in the ARC this week.

MRS KIKKERT: So you decided last week to put all the adoption decisions on hold?

Ms Stephen-Smith: I do not know that that is an accurate way of describing it. It probably is in some ways an accurate way of describing the process, but not to take it to this particular application review committee process while further work is done in relation to this.

MRS KIKKERT: The court case has been around for a while now. When did CYPS decide to put all the adoptions on hold?

Ms Pappas: I will clarify on the decision to progress to an adoption: five matters are already lodged with the Supreme Court. There will need to be some work once we know the decision of the judge. We will have to review those five to see if they are

still going to meet the court's expectations. And if my data is right, there are five matters pending, five children, so relatively small numbers.

The decision was a couple of weeks ago and, as the minister was saying, the decision was to wait for the outcome of the precedent or the test case and then hold an out-of-session application review committee to progress those matters. If the decision of the court is as we hope and as the legislation was intended then those matters will move quickly through and there will be out-of-session meetings to make sure they move relatively quickly. We think it is just a temporary, short-term hold on those matters.

I think it was a couple of weeks ago that the decision was made, with advice from the Government Solicitor's office, around the very serious responsibility we have to take in terms of progressing matters to the Supreme Court that will meet the court's expectations. The advice was that it would be irresponsible for us to continue when we were not sure whether those matters were going to be successful.

MRS KIKKERT: I am concerned that ACT Together was left in the dark about all these decisions. When did they find out about this? Do you think there is a lack of communication between CYPS and ACT Together in delivering this service? They are the ones providing information to the foster parents.

Ms Stephen-Smith: I am not sure that "left in the dark" is the right way of describing it.

MRS KIKKERT: Well, they did not know what was happening until after—

Ms Stephen-Smith: They provided the information to the foster carers.

MRS KIKKERT: Finally. But do you think that was sufficient? Do you think CYPS could have contacted them earlier and let them know what was happening?

Ms Pappas: CYPS and ACT Together have very regular meetings—I think they are monthly—that talk about each assessment matter—whether it is adoption or enduring parental responsibility—to make sure there is no drift in those matters. They have not been kept in the dark. What I will say is that there was probably a lack of clarity in going to the issue of the judgement and the test case and the consequences of that on families who are progressing down that road.

ACT Together understand; they are very familiar with the adoption process. They do all the assessments; they do all of the communication with carers. Our role is to take the matter forward to court, as the as the territory parent. So they were not left in the dark, but I accept there was probably a lack of clarity in the message and understanding of what the issue is.

MRS KIKKERT: I want to ask about Safe and Connected Youth, or Ruby's. The annual report shows $470,000 in funding this year for the four agencies that are delivering the Safe and Connected Youth project, but there is nothing in the budget to show that this funding will continue. What is happening to this program after 30 June?

Ms Stephen-Smith: We are absolutely cognisant of that. The way this budget was put together was prioritising measures that required new funding, and if you look through the budget almost all of the measures required funding in this financial year. Very few things that came forward in this budget start from 1 July next year.

But the other factor as to why there is not specific additional or ongoing funding in this budget in relation to Safe and Connected Youth, or Ruby's, is that the evaluation of the project is ongoing. As you would be aware, $1 million was put aside in the COVID infrastructure funding to do the refurbishment of a house to provide accommodation for young people eight to 15 who are at risk of homelessness—the respite part of what has been delivered through Safe and Connected Youth in a rather limited way—but on the basis of the lessons that have been learned from Ruby's in South Australia and the lessons learned even early on in the Safe and Connected Youth project—that having that residential part is key. We were not quite in a position to understand exactly the service model that needed to be funded ongoing when preparing this budget.

Ms Sabellico: The Safe and Connected Youth program has been operational for a while and it was always intended as an action research approach so that we could work with the young people to understand what they need in the service system, rather than predetermining. That information has been gleaned from their discussions with all the young people who have gone through. The model has a number of elements to it which go to the youth work, the respite and the family work, which is why it also has a relationship with family reconnection programs. The intent is that the young people are reconnected back with family and they are able to be sustained in the family unit without having to enter the crisis and tertiary services.

As part of that, the discussion has gone to looking at establishing a Ruby's-like model. That is part of the build, but we are still working through what the model looks like for the ACT, bringing together what we have learned from the Safe and Connected Youth program, what is in place through the Ruby's model currently in South Australia, how we blend those and what would be the cost of running it to be able to inform any further applications.

MRS KIKKERT: Let me clarify this: the Safe and Connected Youth program will still continue after June this year?

Ms Stephen-Smith: That is certainly the intention; it may not continue in the exact form that it currently is. For example, Youth Coalition has already effectively pulled itself out of the consortium and handed over management of the Safe and Connected Youth program to Conflict Resolution Service to coordinate the program. That was Youth Coalition very deliberately getting involved to identify what might need to be done to get it up and running, but they are not a service provider. They recognised that they do not have a service provision role and it was better that a service provider take over the management of that program.

MRS KIKKERT: So let me get this clear: Ruby's house, once that is established, will that take over the Safe and Connected Youth program?

Ms Stephen-Smith: That is what we are working through at the moment. Obviously,

I cannot pre-judge what decisions might be made in the budget process.

MRS KIKKERT: How long will it take for Ruby's house to be completed? Have you identified a block or is it renovation of a house?

Ms Sabellico: Louise can provide the detail on that one.

Dr Bassett: The house is identified and it is an ACT government property which is being refurbished. It needs quite a lot of work. A tender process was put out for that restoration and repair and refurbishment work. I understand that that is out and will close shortly and then work will commence. There is a period of time in which that refurbishment and refitting of that property will occur. The purpose-built nature of it means that that process will take a reasonable time, to ensure that the safety is managed and that there are sufficient facilities.

The structure has a number of bedrooms; it is quite a large property and it has a lot of communal spaces. Most of the effort is about making sure that those communal spaces are able to be used as they are intended for the young people so that they have an opportunity to have that familiar environment that feels like a home environment. But there are also places inside the property where they can have access to services and they can have their own families there—counselling and working with families, the Conflict Resolution Service and other sorts of supports delivered within that property.

It quite an extensive process to refurbish and refit the house. That work is underway at the moment with the tender process for the refitting and then the design work. I understand some young people will be engaged in assisting on the design and they will be able to input into the final look and feel of the place. That will go a long way to making sure that it is fit for purpose.

MRS KIKKERT: I am assuming it will take months and months for it to be completed. I do not think it will be ready by 30 June.

Dr Bassett: I do not think so.

MRS KIKKERT: I do not think so. What happens then? What happens with the Safe and Connected Youth program if nothing is funded beyond June and the house is not ready?

Ms Stephen-Smith: That is what we are working through at the moment. Because this budget and the next budget have been delayed, the budget itself will not be handed down until August, but there is capacity to make early decisions in the context of the budget process. Obviously, we cannot pre-empt the decisions that might be made in this budget process, but we certainly acknowledge the very high value that the Safe and Connected Youth program has delivered and the very strong support for it in the sector. Safe and Connected Youth is probably the one program that is called out in the administrative arrangements in my portfolio. So I think you can be confident that the service supports will continue. Over the next couple of months we will be working through exactly what that looks like after 30 June and how that transitions into a longer term arrangement over time.

MRS KIKKERT: What you are saying is that it is going to be in limbo: the kids who a need the support through the Safe and Connected Youth program will still be supported somehow but you do not know how?

Ms Stephen-Smith: I am definitely not saying it will be in limbo, but I am also telling you that I cannot pre-announce budget decisions that have not yet been made.

MRS KIKKERT: So you are saying that the kids that need support through the Safe and Connected Youth program will not be in limbo; they will be provided some kind of care?

Ms Stephen-Smith: Yes.

MRS KIKKERT: You just do not know how?

Ms Stephen-Smith: Yes.

Ms Sabellico: We will work with the organisations that are currently part of that group that are supporting the young people to look at what is needed for each and every child and be able to make sure they are linked appropriately. Part of the program has a brokerage component, which means we can still pay for accommodation outside of whether the building is completed by a due date at this stage.

MRS KIKKERT: That is what I wanted to hear—whether you were still going to be working with the organisations that are currently delivering the program at the moment and getting their feedback on what they can do to support and move forward with it.

Ms Sabellico: We will.

Dr Bassett: The work is due to be completed in late May, bearing in mind that that might blow out a little bit depending on how long it takes for the work to be completed.

MRS KIKKERT: It is quite early.

Dr Bassett: It is actually a bit sooner than that.

MRS KIKKERT: You mentioned you have not decided on what model of care to deliver at Ruby's house but you have some form of idea. Will there be an open tender for services to operate the model of care?

Ms Stephen-Smith: We have not committed any funding to this at this point and, again, I cannot pre-empt the budget decision around that. But, should we go down this path—obviously the refurbishment of the property indicates that is what we are intending to do—we would then need to work through what that procurement process would look like, bearing in mind both the requirements of the Procurement Act around tendering and that there is effectively one provider of this service that has a

proven and successful model that we want to build on. So, in line with the Procurement Act, we would need to work through the most appropriate procurement mechanism for that. We have not done that work yet.

MRS KIKKERT: Funding for the Safe and Connected Youth project is $470,000. What is the expectation of funding for operating Ruby's house?

Ms Stephen-Smith: Obviously that is a more expensive proposition because it is a full-time residential care facility and there will also need to be the ongoing outreach and support and intensive family services that are provided currently through the Safe and Connected Youth project. One of the things that has been drawn out through Safe and Connected Youth is some of the other services that are available.

Ms Sabellico mentioned Youth Reconnect, which is a commonwealth-funded service. Conversations are happening with CatholicCare, the provider of Reconnect in the ACT, around the connection between the programs and whether there are opportunities for them to slightly adjust their model of service delivery, still in line with their commonwealth contract but to address some of the issues that have been identified through the Safe and Connected Youth pilot and the Action Research project.

MRS KIKKERT: You mentioned that the Youth Coalition pulled out from the Safe and Connected Youth program. Can you tell us why?

Ms Stephen-Smith: As I said earlier, they are not a service provision organisation. They drove the development of the project; they brought the other providers together—Conflict Resolution Service Woden and Northside—and set it up. But it was their decision to then step back from the project and hand it over to an organisation that is a service provider. The purpose of Youth Coalition is as the peak body and support for the youth sector, not as a direct service provider to young people.

MRS KIKKERT: Previous annual reports included a list of all government contracts over $25,000. Why does the latest annual report not include this table? I have an example. In the 2018-19 report there are 10 pages of government contracting, but in this annual report there is only one and a half.

Ms Wood: Mrs Kikkert, could you point us to the page in the current annual report you are referring to?

MRS KIKKERT: Yes, it is on page 465. The heading is different, so maybe it is just on a different page. On page 465 the heading is "Contracts executed in 2019-20", and it is just one-and-a-half pages, but in the 2018-19 annual report "Community Services Directorate and Housing ACT contracting over $25,000" is 10 pages long.

Ms Wood: I do not have the 2018-19 in front of me, but probably the key difference is that in 2018-19 we went through a process of extending existing contracts for a whole range of services under a number of programs. So there was a very large number of contracts in 2018-19 because those service funding contracts were extended. That is likely the explanation for that.

MRS KIKKERT: Once it is extended, do they need to sign a new contract?

Ms Wood: It is not a new contract; it is an extension, but yes, they sign it and we sign it.

MRS KIKKERT: They sign a new agreement, right?

Ms Wood: That is right.

MRS KIKKERT: But you do not add that into your annual reports as a new agreement?

Ms Wood: It would have been in the 2018-19 report but not in this one. So these are only the new ones. And if there were extensions here I think that would be included, but we had done that in the previous year.

MRS KIKKERT: So you are saying you do not add agreements and new contracts into the annual reports?

Ms Wood: No, I am just saying there was a large number in 2018-19 and a much smaller number in 2019-20, hence the fewer number of pages.

Ms Murray: The extension went for multiple years, so there would not be a duplication or reprinting of the reissuing of that contract for multiple years.

MRS KIKKERT: So you do not need to write it into the annual reports table?

Ms Wood: No.

MRS KIKKERT: During the reporting period, how many contracts did the directorate let with a value between $25,000 and $200,000?

Ms Wood: That is in that table. I do not have the total, but we can count them up. Everything we need to report in terms of contacts within those thresholds is as reported on pages 465 and 466.

MRS KIKKERT: Some contracts are exempt from the quotation requirements. Why is that? From what I understand, if there is a contract between $25,000 and $200,000, you would need three quotes on that, and anything beyond $200 has to go to an open tender; is that correct?

Ms Wood: Yes. Under the Procurement Act and the Government Procurement Regulation, thresholds are set for the way we approach the market. If it is under $25,000, it is at least one quote; if it is $25,000 to $200,000 at least three written quotations are required, and we usually call that a select tender; and then for $200,000 the default setting is that we go to public tender. But, within the act and under the regulation, provisions allow the director-general or the director-general's delegate to exempt a procurement from those specific requirements if satisfied that the benefit of a different approach outweighs the benefit of, for example, an open tender.

There are a range of circumstances in which we would consider that. Even if we are doing a single select tender—going direct to a provider—we always consider value for money and probity and ensuring that we are always complying with the procurement regulations. There may be circumstances in which a limited number of suppliers have particular specialist knowledge—in a jurisdiction the size of the ACT that can sometimes be the case—and we could go to a public tender, but there are only maybe three providers that have the expertise to deliver that, so we go to those directly.

Sometimes we would consider a different approach where we are looking to achieve, in addition to an outcome in terms of procuring a good or service, the social outcomes the government has committed to. For example, we have different arrangements around procurement with Indigenous suppliers. There may be circumstances in which a particularly urgent procurement would work against a public tender being called. There are a range of circumstances where we can do that. It is under the Government Procurement Regulation and there is a process we follow to assess each case to determine if that is an appropriate approach to the market.

MRS KIKKERT: In the 2018-19 financial year, 91 per cent of the procurement contract budget worth more than $208 million was awarded without the directorate going to the open market to tender. Do you see that as quite concerning to the taxpayers who are paying for this? Would they not want an open tender and fairness for providers who would like to be participants in providing support and service?

Ms Stephen-Smith: As Ms Wood indicated earlier, in 2018-19 a lot of contracts were extended for our existing community services program providers. Those existing community services that are funded under that program effectively had services they are already providing extended to June 2022 for a range of reasons.

I understand the point that you are making, but if we had put a lot of those services out to tender at that time you and your colleagues would have been standing up in the Assembly and saying, "Why aren't you funding this service? Why aren't you funding that service? Why are you not funding this service?" That is done where services that fill very specific niches in our local community have really strong local connections and where there is only one service, effectively, that provides that outcome.

As Ms Wood said earlier, the very long list of contracts in 2018-19 reflected the number of rollovers in relation to that year. And even for this year, just looking at the list, for example, the ACT services access card project was a single select tender with Companion House. They are the current provider of that service and it is an expansion of that service. So you would not go to tender for an expansion of an existing service where they logically make sense as the continuing service provider.

There is another contract that is single select for McKillop. That it is a lot of money, but they were identified as having the expertise that we absolutely required to deliver a very highly specialised service in this particular space. There are a range of reasons that it might be a single select process. But in 2018-19 there were some specific reasons for that.

Ms Wood: Those extensions to contracts are counted in the single select category.

They are always done in accordance with the Procurement Act and the Government Procurement Regulation. For example, for the programs you are talking about we had a tender process originally to establish those funding agreements. The funding agreements were established with extension options, so they might be a three-year agreement with a capacity for a two-year extension, for example. When we activate those extensions they are counted in data as single select, but they are still within the same procurement framework and they have followed on a procurement process.

MRS KIKKERT: Before you extend a contract or an agreement with a service provider, is there any evaluation process?

Ms Wood: We are always focused on ensuring that we are assessing as we go. Under our funding agreements, reporting from providers is required, so we have visibility of their performance. That would be a factor we consider when we look at contract extensions.

MRS KIKKERT: So you are saying that the assessment or the evaluation happens way before the agreement is expired and the extension happens?

Ms Wood: We actively monitor performance of the services we fund. Where we seek to do a formal evaluation as opposed to monitoring performance, that would be for a program: is that program achieving what we intended to achieve? But we look at whether individual providers are achieving the outcomes under their funding agreements. We do that on an ongoing basis, and we would obviously look at that at the point of contract extension to see if there are any performance issues.

MRS KIKKERT: What happens where a service provider wants to deliver a service and they know full well that another service provider is providing that service but their contract is coming to an end? Do those service providers sitting on the sidelines, thinking they could do a better job, have a fair hearing on their case being brought forward to the director-general to deliver that service? If you do not have an open tender, how will they know?

Ms Wood: That is something we are always balancing across all services of government purchases. But in the human services and the social services areas the organisations that deliver those services in the ACT, many of whom are quite small, need some stability and some knowledge that if they recruit people to deliver the service they have enough certainty in their funding agreement and the length of it to invest in doing that and setting up that service.

We know new people will be coming in and we encourage new providers coming into the ACT who want an opportunity to also participate. That is why we have to always balance certainty in funding agreements and how long we contract for before we go through a new procurement process with providing opportunities for new providers. We continue to look at that.

We now have a number of funding agreements across a number of sectors that extend until June 2022 and we are doing a whole lot of work collaboratively with the community sector. It covers children and family programs, specialist homelessness services, some of the community health programs and also some justice programs. We

are looking at, based on our joint experience of government but also the community sector, whether we have the right services.

We would not necessarily do a procurement process for exactly what we are doing now. If we have learnt some things, and we have found some gaps, we might want to change the services that procure. But we also work collaboratively with the sector to look at how we fill gaps and the right procurement process for the types of services.

As the minister said, there are some very specialist services where there may be only one provider in the ACT. There will be other types of services where there are a broader range of providers and there may be some providers from outside the ACT that would like to offer their services here. So it is not a one size fits all. A public tender may not be appropriate for every type of service, but it might be appropriate for some types of services. That is something that we will work through for the next round of funding agreements.

MRS KIKKERT: When you are looking at extending a contract, is it possible to have a select tender for possibly another service provider to deliver the service that is currently delivered?

Ms Wood: At the point at which a funding agreement is coming to an end, we always have a choice to make about whether we have scope to extend that particular contract because it was set up to allow that extension or if we want to change the service or if there are concerns about the performance. At that point we could choose to open that to other providers, and a select tender could be something where we invite a number of potential providers to put in a tender. That would be a lesser number than you would get necessarily through a public tender. But sometimes the select tenders are useful because if there are only a limited number of potential providers we are not wasting everyone else's time when we know the expertise we require.

THE CHAIR: Is CSD aware of any providers who have approached you directly to say that they would be interested in tendering for the provision of services that CSD has already made the determination to run the select tenders for? Does CSD believe there is a huge appetite from other organisations that want to provide services that those who have won select tenders are doing? Do we know that for sure?

Ms Wood: Providers often come to talk to us about wanting to innovate in what they are doing already. So they may want to extend what they are doing and they are looking at options for doing that. We have those kinds of conversations all the time. We do not very often have conversations with a completely new provider that is not already delivering services in the ACT that says they want to come in, but that may happen from time to time.

We hear a lot from the sector about wanting more certainty. When we look to the next round of funding agreements, the providers across a sector would be seeking longer funding agreements than they have had in the past. This happens in other sectors and not just the human services space. Some contracts for some kinds of government services can be quite long term.

There is reform happening in other jurisdictions as well that we are looking to learn

from. We are using a commissioning approach, which is really about binding the services together in partnership and looking at how you structure the funding agreements. Part of that is often to provide more certainty. So you look at the time frames for funding agreements moving beyond, say, a three-year agreement. Different jurisdictions have looked at five and 10-year funding agreements. You may establish a seven-year contract with a two-year extension and another one year. There are different models for how you do that.

THE CHAIR: Forgive me if this sounds hostile—it is not my intention—but as a new member I am picking up what I am hearing in the conversation and I sense that there does not seem to be a strong appetite or enthusiasm—for lack of other adjectives—for new service providers to engage with CSD for the provision of services that those who have won select tenders are already doing.

If I am providing such a service in another jurisdiction and I am confident that I am doing a good job, based on this conversation I am not sure I would be very enthusiastic about reaching out to CSD to promote or to try and engage in a dialogue about my new innovative service model I am running in another jurisdiction. What would you say to organisations that feel they are doing good practice and they would like to do it here but they are finding that the current tender process does not facilitate their engagement?

MRS KIKKERT: And is your decision based on money they are asking for? New innovations sometimes require more money, so do you sometimes base your decisions on what is the least cost?

Ms Stephen-Smith: Decisions are based on value for money, not least cost. As a former procurement minister I had a lot of conversations about what value for money means. One of the things I have been concerned about that we see in commonwealth procurement a lot is basing decisions on least cost and seeing large national providers come in to deliver a service in a local jurisdiction where they have previously had no presence whatsoever and no connection with the local community. They then expect the smaller local providers to pass the work to them because they do not have those existing local connections. There is a risk in contracting purely based on the lowest cost. That is not the way we want to approach our contracting in the human services sector. We genuinely want to value existing local connections and existing social capital. That is very important.

To your question, Chair, that may sound like you would see interstate providers being even further discouraged by those comments. But we also want to hear from those who are doing good things in other jurisdictions. The example I can point to in our annual report is in relation to McKillop—not an existing service provider in the ACT—that had been doing something really innovative in another jurisdiction. We identified that a service we thought could work for a particular form of sanctuary model care in the ACT. We contacted them and had a conversation with them about: "We are really interested in the innovative thing you are doing in another jurisdiction."

If people wanted to come and talk to us about that, we would very much welcome those conversations but would be really conscious of the fact that for some services

existing local connections and existing social capital are really important parts of service delivery. We need to balance those things when we are talking about interstate providers that have no existing presence in the ACT. I will not say anything about NDIS.

THE CHAIR: You highlighted McKillop which, again, we identified as doing good things and we approached. Can you take on notice the framework you would introduce an interstate provider to if they wanted to, in an unsolicited manner, introduce us to their program that they think would have a place here? This gets to what I imagine Mrs Kikkert's line of questioning was—it would be great if we encouraged a culture of: "Come to us if you've got a good idea."

I remind everybody that for any questions taken on notice answers should be provided to the committee secretary within five working days—that is by close of business Friday, 5 March.

Ms Stephen-Smith: For the record, Chair, we will take that last question on notice.

THE CHAIR: Thank you.

Hearing suspended from 3.03 to 3.29 pm.

Appearances:

Davidson, Ms Emma, Assistant Minister for Families and Community Services, Minister for Disability, Minister for Justice Health and Minister for Mental Health

ACT Health Directorate
Jonasson, Ms Kylie, Director-General
Arya, Dr Dinesh, Chief Psychiatrist
Moore, Dr Elizabeth, Coordinator-General, Office for Mental Health and Wellbeing
Ord, Mr Jon, Acting Executive Branch Manager, Mental Health Policy Branch
Grace, Ms Karen, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services
Coleman, Dr Kerryn, Chief Health Officer, Public Health, Protection and Regulation Division

Canberra Health Services
McDonald, Ms Bernadette, Chief Executive Officer

THE CHAIR: Good afternoon, guys, girls and non-binary pals. We are into the home stretch. Welcome back to the public hearings of the Standing Committee on Health and Community Wellbeing on annual and financial reports 2019-20 and estimates 2020-21. This afternoon we will hear from the Minister for Justice Health and Mental Health. Please be aware that all our proceedings are being recorded and transcribed by Hansard. They are also being broadcast and webstreamed live.

When taking a question on notice, it be useful if you could use the words, "I will take the question on notice." It helps our wonderful secretary, Andrew, to keep a record of those things. I remind all witnesses of the protections and obligations afforded to them by parliamentary privilege and draw your attention to the privilege statement. If you come up and you have not yet presented today, do be sure to note that. We will now proceed to questions.

Minister, I will kick us off. I refer you to page 228 of the CHS annual report where you explain that some mental health clients of CHS are transferred or discharged interstate. If clients are discharged interstate, what is the process that ACT Health has to ensure that they still receive follow-up in their home state—not just being discharged and sent away but that we are still ensuring that they are getting care?

Ms Davidson: I will refer that one to Bernadette to answer, but I can assure you that there is a process there to make sure that there is a proper follow-up and that all the right things are done.

Ms McDonald: I call Karen Grace to come and talk it through. Karen is our Executive Director of Mental Health, Justice Health Services, and Alcohol and Drug Services. I just reiterate that, in relation to any patient that is discharged from our services, we follow up with them in terms of discharge planning but also then, especially from mental health services in particular, there are processes around

follow-up.

Ms Grace: I acknowledge the privilege statement. When we have patients within our services who transfer interstate, the usual process would be that, as with all patients, a comprehensive discharge summary would be completed. That discharge summary is provided to the patient's local GP. It does not matter in which jurisdiction the patient resides. A copy of the discharge summary will be provided to the patient's GP.

If we are concerned in terms of requirements for follow-up care in relation to mental illness, we would contact the local mental health provider within the jurisdiction that they reside, usually New South Wales, and we would ensure that there was a referral made to that mental health service in their locality, who would then follow up with them personally. It would be dependent on the individual patient and their needs, as it is with local residents that are discharged. The same process exists for interstate.

THE CHAIR: Just to clarify, in the instance that the patient does not have a relationship with a local general practitioner, where would that referral go to, exactly, in the first instance?

Ms Grace: It would go to the local mental health service.

MRS JONES: Chair, was your question about Dhulwa or about the AMC?

THE CHAIR: Neither and both. More broadly, when we are discharging people in our care and they are going interstate, how we are ensuring that their care continues or that they are still connected to services?

MRS JONES: I just wanted to ask about a similar situation. The women who are coming out of jail and who want to go into detox, how is that transportation arranged?

THE CHAIR: I think that might be a substantive question, given that it does not pertain to an interstate transfer, rather a transfer to a connected service.

MRS JONES: Although some of them are interstate. I visited one this week.

THE CHAIR: It is still pertinent to the relevant question on whether we have a process for how that discharge would work interstate.

Ms Grace: Yes, sure. We do have a small number of people who are transferred to interstate drug and alcohol services primarily. Those detainees in this case, I guess, would be referred to the relevant alcohol and drug service interstate. They then need to go through an assessment and acceptance process. That process can happen whilst they are still within the ACT. If a decision is made to admit them directly to detox from the prison there are a number of ways that that can happen, dependent on the circumstances of the detainee. It would be our preference to discharge them, or release them, from prison, which is the corrections component, so that they are actually released from the AMC and they are free people on the outside of prison. Then there is a referral to the service. What we have found is that we have better success with some of these ex-detainees if we facilitate the transfer directly—

MRS JONES: I was wondering if that was happening.

Ms Grace: Ideally, what we would do is expect them to use their own supports on the outside in order to get there. However, when that does not exist we have, on several occasions, provided transport to the border usually. Ordinarily what we would do is tee up the transfer with the provider in New South Wales. We would provide a staff member to transfer the person by vehicle, usually to Yass and then at that point there would be somebody from the New South Wales Health Service that would meet us there. Then that service provider would take over care at that point.

MRS JONES: Depending, obviously, on the service and what they can achieve as well?

Ms Grace: Yes. Because they are then a free person who is accessing a service interstate, whenever possible we would ask that they organise their own transport. But if that is not possible—

MRS JONES: I guess it is not always possible.

Ms Grace: Yes. We would facilitate that.

MRS KIKKERT: How many inmates are currently signed up to receive health services from Winnunga?

Ms McDonald: That is something that Karen can answer for you.

Ms Grace: I got the updated numbers this morning, so please bear with me for a moment.

Ms McDonald: We might give a little bit of context. The relationship with the Winnunga health service is going very well, from our perspective. We are moving more towards a shared care model in the AMC, rather than an MOU and a full transfer across to them or back, and that sort of thing—a shared care model, especially for patients that require psychiatric care. Those numbers keep moving around. Karen has the latest updated numbers.

Ms Grace: Since the Winnunga health service commenced in January 2019, a total of 83 clients have been cared for by them. Fifty-four of those clients are no longer in custody. Eight clients have had their healthcare services transferred back to Justice Health. As of yesterday, there are currently 21 detainees receiving health services from Winnunga within the AMC.

MRS KIKKERT: Have any of those 21 detainees had to wait for Winnunga's health services?

Ms Grace: There is a transfer process. There is no waitlist as such for the transfer of detainees to Winnunga health services. The way it works is that, on induction into the prison, all detainees are advised of Winnunga health services and are offered the opportunity to transfer to their health service. Justice Health services, under the Corrections Management Act, is responsible for that induction assessment.

We do all of the induction assessments on all detainees initially. If a detainee requests, at that time or subsequently, to transfer their care to Winnunga, we would make that referral to Winnunga. Winnunga will then consider the referral. They have access to the Canberra Health Services clinical records, so they can review the records of that detainee. They will then make a determination as to whether they are able to accept care of that person; then the care transfers across.

In the original MOU there were a number of inclusion criteria, which meant that anyone who required specialist mental health services or alcohol and drug services, particularly the opioid replacement treatment program, was excluded from Winnunga health services. In recent months we have moved towards, as Bernadette has described, a shared care model in its purer sense. That means we have had successful transfer of detainees that have accessed forensic mental health services under shared care with Winnunga, and more recently opioid replacement, which is for people that are not initiating OMT at this point in time but are already stable and maintained on the program. They are able to access care through Winnunga.

MRS KIKKERT: When an inmate is registered and receiving service from Winnunga, they can also receive services from the other health providers?

Ms Grace: The specialist services from Canberra Health Services, yes.

MRS KIKKERT: Has there ever been a time when Winnunga wanted to provide a specific health service within AMC but they were denied?

Ms Grace: In the early months of the establishment of the service, the exclusion criteria were seen as a barrier for Winnunga. I would absolutely acknowledge that that was the case. As a consequence of that, since we went through the process to review the MOU, we have moved towards the shared care model, which would mean there are very few, if any, exclusion criteria for Winnunga. The decision about whether to provide care or not will sit with Winnunga themselves when they do that initial assessment. There are some patients within the AMC that are very complex and difficult to manage from a clinical perspective, and that require a lot of expert input that Winnunga may not be able to provide. But that decision would be made by Winnunga rather than by us, as was previously the case under the MOU.

MRS KIKKERT: If Winnunga is unable to provide that service, it will be provided—

Ms Grace: Yes, we provide it.

MRS JONES: For everyone.

MRS KIKKERT: You will be able to provide that?

Ms Grace: Yes.

MR PETTERSSON: Looking at page 44, Justice Health services community contacts are down. In the footnote it is explained that COVID-19 restrictions impacted

the availability of doctors. Could someone expand on how, firstly, doctors were impacted in the ACT in terms of providing those services?

Ms Davidson: I will leave it to one of the officials to explain in more detail, but I want to acknowledge that 2020 was a very unusual year. We could not have possibly predicted all of the things that were going to impact on health services over the course of that year. Certainly, at every point during the year, people were making decisions with the aim in mind of trying to protect those most at risk in our community. I will hand over to Karen.

Ms Grace: The outcome of community contacts for the Justice Health service is multifaceted, and the availability of doctors is one of those. Primarily, the main driver of the reduction in community contacts is the success of the implementation of Buvidal as part of the opioid replacement program within the prison. For every detainee on Buvidal, they will have one monthly injection, as opposed to daily doses. They are counted once over a period of 30 days, rather than 30 times, in terms of dosing. That is the main impact.

In terms of the COVID impact on doctors, we have some senior medical staff within the prison who are on visiting medical officer contracts who reside in other jurisdictions, and primarily in New South Wales. There was a period of time when it was difficult, if not impossible, for us to bring those doctors in from New South Wales due to the border restrictions.

During that time, however, what we did—and it was primarily related to forensic mental health as opposed to primary health, which was impacted to a lesser degree—was that, for some periods of time, they were able to come into the ACT but not into the prison because it was a high-risk setting. That is when telehealth came into play. They would fly into the ACT and provide telehealth consults into the prison and Bimberi during that time. Primarily, that was the issue; we could not get them into the jurisdiction because of the restrictions.

MR PETTERSSON: It will sound like a bit of a strange question, but why were we transporting them to Canberra to provide telehealth services?

Ms Grace: Because it is easier when they are in the ACT to get access to the clinical records on the network. It is difficult to access clinical records outside the ACT government network.

MR PETTERSSON: Interesting.

Ms Grace: So it was easier. It was easier for them and it was easier for us.

MRS JONES: I want to go to drug services in the AMC. Is Buvidal the buprenorphine replacement?

Ms Grace: Yes.

MRS JONES: This is the injectable version. Is it the same active ingredient or is it something that people have to transition onto?

Ms Grace: They have to transition onto it. They go through a Suboxone transition. Somebody that was on methadone previously would go through a short period of receiving Suboxone; then they would be able to—

MRS JONES: Is that a liquid or a tablet?

Ms Grace: It is the sublingual—in a wafer under the tongue.

MRS JONES: So that is the version of buprenorphine?

Ms Grace: Yes.

MRS JONES: Are you finding that this has a good take-up rate among those who were on buprenorphine, to avoid the diversion issue?

Ms Grace: Yes.

MRS JONES: That is excellent. We had such long discussions about it in the last term. Can I get an update on how many inmates are currently on methadone, broken down by gender, and how many inmates are currently on either buprenorphine or Buvidal?

Ms Grace: I can give you the numbers. However, I will have to take on notice the breakdown of gender.

MRS JONES: That is fine.

Ms Grace: As of today, there are 25 detainees on methadone and 74 detainees on Buvidal.

MRS JONES: And no-one on buprenorphine?

Ms Grace: No-one on Suboxone, no.

MRS KIKKERT: How many of those are female?

Ms Grace: I will have to take the gender issue on notice. I do not have that.

MRS KIKKERT: Okay.

MRS JONES: Are there any other opioid replacement therapies currently being used in the AMC?

Ms Grace: No.

MRS JONES: What is the population of the prison today?

Ms Grace: 408 at muster this morning.

MRS JONES: Thank you; that is good to compare.

THE CHAIR: Minister, the ACT Health Directorate strategic objective 4 comments on the impacts of bushfires on the mental health of Canberrans. A lot of Canberrans suffered psychologically during our most recent bushfires, particularly in my electorate of Brindabella, as it pertained to the Orroral Valley fires. How are you measuring and managing the impacts of climate anxiety?

Ms Davidson: That is a really interesting question. I will hand over to an official to talk in more detail about what we are currently doing. Certainly, that is something we will need to pay closer attention to over coming years, as the climate continues to change and we continue to see the effects of that throughout society. We have the Office for Mental Health and Wellbeing to help us to take that bigger picture view, plan for future changes that might be needed, understand what is happening and see what is being done in other jurisdictions as well.

Dr Moore: I acknowledge the privilege statement. In terms of the impact of not only the bushfires but the hailstorms and now COVID, there have been several surveys. The general health survey was done late last year, and the University of Canberra also did a survey monitoring the mental health and wellbeing of Canberrans generally.

One of the things that came out of the surveys was that there was a degree of anxiety. Of course, fear, anxiety and worry are naturally good reactions to a threat. All of the anxiety did rise, as we would expect, but we found that younger people had more anxiety; so that was one of the targets of some of our media campaigns.

In our children and young persons review, we found that there were a number of different services available for children and young people, but people did not know how to access them. There were 176 services that were available to children and young people, but the navigation of those services was difficult; hence the work that we are now doing on the youth navigation portal.

THE CHAIR: Do you mind explaining a little bit further the youth navigation portal, as you understand it, and how it pertains to your work?

Dr Moore: Yes. We were lucky to obtain some commonwealth money for it, in one of their grants. With the youth navigation portal, currently we have a request for quote for a provider, a non-government organisation, to help run the portal. We have done some of the groundwork in building the portal. With the non-government provider, the request for quote closes on Monday, and we should have them on board by the end of March.

THE CHAIR: Forgive my ignorance for not knowing more about this, but now I am very interested. Is the youth navigation portal a whole-of-government project or is it something that you are working on exclusively in the mental health office?

Dr Moore: We never exclusively work on anything in mental health.

THE CHAIR: That is good to know.

MRS JONES: But is it for services across government or just for mental health services?

Dr Moore: It is primarily for mental health services, but one of the values of having the portal is that you can link to other websites. We know that the social determinants are really important for people.

THE CHAIR: Without pre-empting the work that might happen as that portal develops, if it does present a great appetite from young people to use that portal to access and navigate mental health services, do you see it as having the potential to scale up to include more government services? Perhaps it could even be a one-stop shop for young people?

Dr Moore: That was in fact one of the original premises of it. We always co-design. In the children and young persons review it was co-designed with the Youth Advisory Council and the headspace Youth Reference Group, who told us that some of our methodology would not suit younger people. We were very happy to take that on board. They have been involved in the initial design of what they want. We would also like to have an area for parents and carers. They need something slightly different, but it is primarily for those children and young people.

THE CHAIR: Again, can I assume that that youth navigation portal will be more than just a learning page on the internet—that it will take up the form of an app?

Dr Moore: Yes. Young people have said very much that they would like an app.

THE CHAIR: If it is not in an app, I do not see it; so that is good to know.

MR PETTERSSON: How will the ACT's online youth navigation portal differ from existing portals, like the commonwealth's Head to Health?

Dr Moore: From our consultations, Head to Health was not seen as youth friendly, and it was seen as much larger than just the ACT. When we put in the bid for this, we wanted an ACT bespoke one. Young people have spoken very loudly and said they do not want it run by government. They will not look at anything run by government. They want a non-government agency to run that. We are working very closely with YouthCo, who already have a directory of services, to see what we can do to make it very accessible to them.

MR PETTERSSON: It will direct to the same services; it will just be provided by a non-government provider?

Dr Moore: Head to Health, unfortunately, does not capture all of the services. That is what we have been hearing. We want digital platforms to be captured. Some of the big ones are ReachOut and Beyond Blue. They are captured on Head to Health. We want some of the smaller, more bespoke ones in the ACT that might suit some people and that currently do not have visibility.

MR PETTERSSON: What are some examples of those?

Dr Moore: There are a number run by CatholicCare. This brings me to the missing middle, as it is called. These are the children that are not severe enough to need specialist child and adolescent mental health services but do not fit the criteria for primary health. That is one area that we need to look at. We currently have a project with Capital Health Network looking at what is the best service for that. Is that a new service? Is it a connecting service? Is it an enhancement of other services?

MR PETTERSSON: You said that kids want a non-government provider. The government is working it up. Are we handing this off to someone at some point?

Dr Moore: We will work in partnership with them. That is why we wanted the provider on first, and we are looking at the builder. Obviously, we would not build the portal without the provider being involved. The idea is that the non-government agency would run that in partnership with us.

MR PETTERSSON: Is there any idea of what the ongoing running cost of this website will be?

Dr Moore: We have not looked at the sustainability beyond two years. We should then know how much that would be, and whether it is successful. Everything we do has to be evaluated. If people do not use it, why continue with it? If people do use it then it is valued.

MR PETTERSSON: When do we expect it to be online?
Dr Moore: The builder will be on by June, and we are expecting it to be online, at least in its initial form, in September-October.

MR PETTERSSON: What is the difference between those two dates? The build is online—

MRS JONES: Not live.

Dr Moore: With respect to the person that is building the portal, the negotiations will be complete in June; then they will build it.

MR PETTERSSON: They will build it. Maybe I am not understanding this. When can I expect to be able to hop online and utilise this?

Dr Moore: September-October—maybe Mental Health Month.

MRS KIKKERT: What was the feedback that you received from youth that they did not want the government to run it?

Dr Moore: If you look developmentally, government is seen, obviously, as a parental figure. That might possibly have—

MRS KIKKERT: Is that what they said?

Dr Moore: something to do with it. They did not articulate it in so many words, but there definitely was that feel. Of course, with a bunch of middle-aged women—

MRS KIKKERT: Interesting.

Ms Davidson: That is consistent with other similar navigation portals and tools that are set up for young people in the ACT. They are looking for organisations that they know and trust in the ACT to be involved. They are looking for non-government organisations to be trusted providers of those navigation tools. We have seen a lot of success with other resources and portals that have been put together in the community for young people in the ACT in the past with a very localised focus, rather than just relying on national tools that might already exist but that may not have the nuance or all of the detail of services available in the ACT.

MR PETTERSSON: One of the things that I would observe quite broadly, and similarly one of the problems with accessing mental health services in the ACT, is the very long wait times. Is there a risk that we are just directing people to services that have incredibly long wait times?

Ms Davidson: One of the things we can see from navigation tools being available to people is people being able to have more control and choice over which service they will approach for help for their particular individual circumstances. There is more chance that they will find a service that perhaps they had not heard about before. That can be really helpful. Certainly, there should be no wrong door for mental health services.

THE CHAIR: In that context, would it be fair to say that if the observations that Dr Moore has made are right, with government seen as a bit of a parental figure, and a lot of these services being ones that young people feel they are directed into or managed towards, this will instead create more of a menu option for young people to be more self-selecting and identify their own pathways and their own health care? Would that be a fair assessment of what we are looking to do?

Dr Moore: Absolutely, yes. It is also about making them aware of the digital options which sometimes they are not aware of, and neither are the GPs or other practitioners.

THE CHAIR: Highlighting Mr Pettersson's point, if there are in fact long wait times for certain mental healthcare services, and if there are some young people with acute mental health concerns whose issues could be addressed through a digital platform, that might actually alleviate some of the pressure on some of those services. Would that be fair to say, too?

Dr Moore: Correct. There is also the idea that, in fact, waiting for a service actually makes people worse. If you take some autonomy and put yourself through one of the digital platforms, you actually create an opportunity to grow.

THE CHAIR: Minister, I understand that it is a focus of yours in the mental health space to be looking at more preventive mental health care. I assume this platform would also have scope for a toolkit or applications for young people to implement self-care, rather than necessarily needing mental health services as well. Is that an intention?

Dr Moore: That is an intention. We will not duplicate, though. There are other platforms that do that and we would direct them to those other platforms, like ReachOut, which are fantastic for that.

Ms Davidson: There are a whole range of other education, awareness and prevention programs that are being funded as well, including some that were announced in the February budget. I expect that there will be more over the next four years.

THE CHAIR: At the beginning of my question, on a completely different topic, we spoke about the general health survey and the UC survey that informed some of that anxiety that took us into this conversation. Was it those surveys that spoke to young people about this platform, what it would look like and what they would need? What was the work that was done there to solicit that feedback?

Dr Moore: No, we undertook a separate process for that. In the co-design process with the Youth Reference Group from headspace and the Youth Advisory Council, we undertook, during COVID, several workshops. We also used our non-government partners, such as the Youth Coalition, and their networks to understand what young people wanted from this.

THE CHAIR: What other things, in addition to mental health supports, did young people identify? Assuming that the conversation with young people was that this would be an access tool for them to government services, what other things did they identify that they would want to find on a platform like this, in addition to those mental health supports?

Dr Moore: They identified that what they wanted was what they called an online shopping list. Whether they were male, female or non-binary, what was their major issue? What was their degree of distress? Who did they want to see—particularly male or female? They wanted to be directed to that.

In terms of the other government services, because it is a platform up to the age of 25, we had identified things like employment services, support for employment and education.

Ms Davidson: Very reflective of the social determinants.

THE CHAIR: How much work, if any, has been done with the Education Directorate to link this in with young people and their relationship with their school communities, or supports they might be getting in school?

Dr Moore: We have worked very closely with the Education Directorate. The Education Directorate is part of our mental health and wellbeing interdirectorate committee. We have a number of projects with the Education Directorate. The main one is Youth Aware of Mental Health. They are aware of all of our projects. Out of the children and youth review that we did, that informed this work, the three main things that children and young people identified were anxiety, bullying and relationships—problems with friends and their parents.

THE CHAIR: Were these the three main things that they had identified as just their

issues in life?

Dr Moore: Yes.

THE CHAIR: What were they again? Anxiety—

Dr Moore: Bullying and—

MRS KIKKERT: Relationships—

Dr Moore: With parents and friends. The bullying was occurring online and at school. We worked with the schools on some of their programs. They have some very good programs but I will not speak to those.

MR PETTERSSON: Circling back to the online navigation portal, I understand the theory put forward that this helps people to better navigate it. I guess the crux of my question is: are there any services in the ACT that have no waitlists?

Dr Moore: I am not aware. It would be very difficult to find that, but I can try and take that question on notice.

MR PETTERSSON: I am happy to have an anecdotal conversation. At the start we acknowledged that there can be very long waitlists for certain services. I guess the flipside is: are there any services that have good—

MRS JONES: You can get straight into.

MR PETTERSSON: Yes.

Dr Moore: If you look at how people access services, if there is a significant degree of distress then the opportunity is there to be triaged. If there is a significant risk then you go up, in terms of triage level. You would be admitted or you would be seen by Child and Adolescent Mental Health Services.

For those children and adolescents who have less risk but still have distress, you would offer those other services. That could be Beyond Blue, in terms of their COVID hotline. What would be the nature of that? It is difficult to say, because headspace traditionally has had a waitlist, which is unfortunate. That was not the model when it first came in. But that is a commonwealth-funded service.

MR PETTERSSON: I would be curious if, on notice, someone could answer whether there is a mental health service with no waitlist in the ACT.

Dr Moore: I will try and take that question on notice.

Ms Davidson: I would expect, too, that the situation in the ACT would be not that different from the situation in other cities around Australia.

MR PETTERSSON: I completely agree. It is a national problem. My frustration here is that, seemingly, the thing we keep putting up as the answer is that we will more

efficiently allocate people to services. The follow-up question is: what are these services? I think every service is stretched.

Ms Davidson: I can absolutely understand that.

MRS JONES: Can I ask that you list, for the committee, the services that you are currently looking to add to this platform and link to? At least there is then a list that is being worked on at the moment and that is as comprehensive as you are able to make it.

Ms Davidson: Going to the reason why you have that concern, I can absolutely understand that concern. Certainly, that is something that we are continually working on. For young people in particular, if they are starting to experience a health condition for the first time in their life, understanding how to navigate the available services and what it means for them is quite a big thing to be working through. Being able to provide them with information about all of the services and how to access them is really helpful in terms of giving them back their own sense of agency and control over what is happening in their life. I see real value in being able to support young people in that way.

THE CHAIR: Dr Moore, would it be fair to say that any time in healthcare provision, when you make it easier for patients to communicate their issues and attempt to access services, you expect to see a greater number of presentations, a greater number of people in need, because you have lowered the barrier to entry in your communicating in their language? Will the data from the use of this platform not make it easier for governments to make decisions about what services to fund and, based on knowing, with clearer data, where the demand is?

Dr Moore: Yes. Data is very important. Also the level at which people enter—people might have a concern but at the moment they do not know what digital platforms are available. They do not know what low-level services are available. So that nuance of data will be really important.

THE CHAIR: Would it be fair to say that you would be expecting a greater number of people to be cared for in some way across the mental health system by virtue of the success, hopefully, of this platform? You will just be identifying more people who require care. Would that be fair to say too?

Dr Moore: That would be the vision—so that people that have any concerns are able to have somewhere where they can go. Parents particularly wanted this. What does this look like? What is happening to my child? What can I do about it? What can they do about it? So, yes, we would expect that those people would be able to access the appropriate level of care.

MR PETTERSSON: What data would be sought to be collected from the online portal?

Dr Moore: We are still in the nature of the build. But—and this is very early—we would want some sort of outcome data at the beginning and the end of their interaction with the portal. Did they actually become less distressed? Outcome data is

much more useful than output data. "We had 300,000 clicks" does not tell me much. What happened to those people? The usual demographics, if the person allows that—

MRS JONES: So a voluntary feedback sort of tool as well as number of clicks and stuff?

THE CHAIR: It is a bit like when you are online shopping, I suspect, at the end of the transaction: "How did you find your experience today?"

Dr Moore: Yes.

Ms Davidson: There is a lot that can be determined by good web app providers, based on the path people are taking through the app to get to the information that they are then sitting on the page for a long time reading through, and then exiting the site. Then you are able to look at what their path through was. What sorts of questions were they asking in order to get to that information? That can really give you some useful insight into what people are thinking about how they need to access information.

MRS KIKKERT: Speaking of data, do you collect any data on inmates that smoke cigarettes?

Ms Davidson: Is that a question about the AMC?

MRS KIKKERT: Yes.

Ms Davidson: There is some work that we have been doing around smoking within the AMC. I will hand over to Karen to explain that in more detail. There is some work that is being done and we are concerned about not only making sure that we are providing a safe and healthy workplace for Justice Health staff that are working there but also making sure that we are providing healthy, safe care for people who are in the AMC.

MRS KIKKERT: What would your position be on smoking in the AMC, Minister?

Ms Davidson: My position on smoking within the AMC is that we do need to make sure that we are providing both a safe and a healthy workplace for Justice Health staff who are working there and we do need to make sure that the health of people who are in care in AMC is looked after and that they are provided with support and options. I will hand over to Karen to talk about the programs that are in place there.

Ms Grace: We do not keep data on individual numbers of detainees that smoke. I am not sure whether that is something that corrections potentially collect, but from a health service point of view we do not have numbers of smokers within our data collection system.

What we do offer is smoking cessation programs. We have a dedicated drug and alcohol nurse and we have recently increased that FTE within the prison. One of the primary functions of that role is to work with detainees on smoking cessation strategies, including nicotine replacement therapies. We have that program in place

within the prison currently.

We found, anecdotally, as a result of Buvidal, that a lot of detainees that have transitioned onto Buvidal have expressed interest in smoking cessation, which is an unanticipated positive impact of the rollout of Buvidal. We think it is because there is such a close relationship between drugs of addiction and nicotine.

Recently we have entered into a significant body of work with Corrective Services on reducing the impact of smoking within the prison, with an aspirational goal of a smoke-free prison ultimately. At this point in time, we are working with them on ensuring that all the dedicated smoking areas within the AMC are utilised and enforced. There are a few areas within the prison where detainees have restricted movement, which creates significant impact for staff in terms of smoking exposure.

MRS JONES: At the management unit, yes.

Ms Grace: The management unit and the crisis support unit are the two. The crisis support unit is where our most unwell detainees are housed and the management unit is a unit used for detainees that need to be separated from the general population for whatever reason. They have less ability to move around the prison and access the smoking areas. So they are the two areas that cause the most concern to our staff.

MRS JONES: In the crisis support unit, are there open spaces for each detainee, or not? In the management unit there are the yards on each cell.

Ms Grace: I would have to take that on notice. I am not familiar enough with the—

MRS KIKKERT: They are probably too small to have—

Ms Grace: I think not, but—

MRS JONES: The management unit has yards on every single cell, but I am not sure if the crisis support unit does.

Ms Grace: I do not think so, but I will take that on notice and provide more detail. Over the last four months, I think, we have got to a position where now the crisis support unit detainees are not able to smoke between certain hours during the day. It is during those hours that the health staff will have access to most of their clinical work with those particular detainees. So we have managed to restrict the exposure of health staff to tobacco smoke when caring for the most vulnerable detainees within the prison. That has been a major improvement over the last few months.

As we move forward, the next area that we will tackle is the management unit. That will be the second dedicated area within the prison that we focus on in order to restrict exposure to tobacco smoke. And, as I said, we are working towards our aspirational goal of a smoke-free prison at some point, but that is a corrections thing.

MRS JONES: Is that restriction for hours rather than entirely because you have to take your health services to them in those units rather than them coming to the health centre?

Ms Grace: Yes. We have also implemented more movement of detainees into the health centre when that is safe and possible. So we would preferentially care for all detainees regardless of—

MRS JONES: In the health centre?

Ms Grace: Yes—whether they are in CSU or anywhere else in the prison. And we do that when we can, but there are some detainees in that area where it is safer for us to provide the services into the area. It is the same now in the accommodation units and particularly the management unit, where we are required to attend for satellite services and medication administration.

MRS KIKKERT: Did you mention before that you are working towards banning smoking in the AMC?

Ms Grace: That is an issue for corrections. That is a JACS issue.

MRS JONES: But that is their stated position as far as you know—is that what you were saying when you were referring to that before? Is that a Health position?

Ms Grace: We are working with them on the possibility.

MRS JONES: I want to ask about independent psychiatric assessments for inmates. Late last term, I was dealing with an issue of a particular inmate who has been written about a lot over the last few years. There were various incidents with this particular person. When I was advocating for him last year, he was attempting to end his life on at least a couple of occasions fairly close to each other. I was lobbying for him to perhaps be allowed to be housed at Dillwynia. It was an issue of smoking that was involved as well, which was given as one of the reasons why he was not sent to Dillwynia.

I then asked whether he could have an independent psychiatric assessment, and the minister last term said that they enabled a desktop psychiatric assessment from some other specialist. Have we moved anything in this regard for next time something like this comes up? Do we have the capacity to do in-person independent psychiatric assessments? There was a great deal of distress around this situation and the person was in and out of the hospital. But it seemed to be a reasonable request which was not facilitated in the fullest way it could have been. I do not know if you can have a position on it but I certainly want to get your thoughts.

Ms Davidson: We are talking about what sounds like a very complex individual case. Probably the best approach would be for you to come and talk to me about some advocacy on behalf of that individual person to make sure that their needs are being addressed. Is there a systemic issue that you are looking to—

MRS JONES: I think there is, in that I suspect that there is some sort of contractual arrangement with a psychiatric provider, perhaps through Health Services. Someone might be able to shed light on why that occurred.

Ms Davidson: You are asking what sorts of programs we are providing, or services for a complex—

MRS JONES: It is not that. This individual was at very much a crisis point and the systemic stuff—actually, in a way, that person may have been in less of a distressed state if we did not have smoking because the trigger for the particular meltdown was around a desire for more nicotine and the negotiations for it. But the thing that I walked out of it thinking, apart from the fact that there may be some benefits to banning smoking, is that it seemed like a very sensible suggestion that had been made to me by other people in the healthcare world that a different psychiatric provider be able to speak with and assess that person, because they just may have had something against the last one. Do you know what I mean? The health officials might know why we ended up in that situation.

Ms Davidson: When we are talking about a complex individual case, I would need to—we could talk separately and make sure that advocacy—

MRS JONES: Yes. Mrs Kikkert now has the role that I had last term, but I think it is still an interesting and important point that, when someone was at such a crisis point, that just seemed to be a non-option. I wonder if the officials are able to—

THE CHAIR: I do think the minister has answered the question as it pertains to a particular person's situation, rather than a broader—

MRS JONES: Yes, but my question is about whether we can have independent psychiatric assessment in the facility. It is a perfectly reasonable question and I think the officials are keen to answer the question. Let them answer.

THE CHAIR: It helps now that I understand the specific question. I am happy for the specific question to be answered now that we have got it.

Ms Davidson: Now that we are talking about what is available for psychiatric care, Karen can talk about that.

Ms Grace: I am confident that there is a robust and established process in place across the system for second opinions and reviews of complex cases. This was particularly complex and I am confident that a really robust review was undertaken in relation to that case.

We have a number of options available to us when it comes to opinions in relation to different views from different parts of the health system, or even objective opinions in cases that are very complex. So we can do a number of things, one of which is to get a very senior consultant to do a desktop review.

We can do face-to-face reviews if that is deemed to be the most appropriate approach. One of the challenges with face-to-face reviews is the importance of rapport, of establishing that rapport with the individual in order to undertake the comprehensive assessment. Sometimes it is deemed that there is risk associated with adding another person into the mix as well, in which case you would then ask someone to look at all the extensive case notes—and they were extensive case notes in relation to this

particular individual—and then make recommendations on the basis of that review. That could then potentially extend to a face-to-face review or some other decision in terms of future management.

But it is really important to remember that we need to be really careful when we are determining the appropriate pathway. We were confident that we had enough independence in terms of the review and enough information for that person to consider without putting the individual at further risk.

MRS JONES: Okay. That is excellent information which was not available at the time.

MRS KIKKERT: Going back to the smoking at AMC, the corrections management policy says that every inmate that is admitted into the AMC centre should be identified as a smoker.

MRS JONES: Health centre.

MRS KIKKERT: Are they just verbally telling the staff there or the guard there that they are smokers? You do not record them?

Ms Grace: It may be recorded within corrections information, not routinely as part of the health service data collection.

MRS KIKKERT: Are you aware that the Inspector of Correctional Services identified that inmates were allowed to smoke indoors or near cells?

Ms Grace: That is the issue that I have just been speaking to in terms of CSU and the management unit in particular.

MRS KIKKERT: Okay, so it is indoors; we are not talking about outdoor specific areas?

Ms Grace: Yes. There are some areas within the prison where it is more problematic than others. They are the areas, as I referred to earlier in terms of the crisis support unit and the management unit, where detainees have less ability to circulate through the prison, so less opportunity to move outside to the allocated smoking areas. That is where the problem is most difficult to manage. But we are working together with our corrections colleagues on improving the situation for the detainees and the staff out there.

THE CHAIR: Accepting what Mrs Kikkert just said, that corrections do in fact have a policy that they collect data on the inmates at AMC on whether they are smokers, would that not be useful information for Health to have when providing healthcare services to inmates at the prison?

Ms Grace: Yes. It would be recorded in their clinical notes but not in a way that is easily pulled out in terms of reporting on the data. I would imagine corrections could do that.

THE CHAIR: How—

MRS KIKKERT: They are able to share that information with you?

Ms Grace: Yes.

MRS KIKKERT: If you wanted to—

Ms Grace: They could. We would ask every detainee about their smoking habits. We would not necessarily capture it in a way that we could pull out easily and report on.

MRS JONES: Is it potentially in the initial screening when people first arrive?

Ms Grace: Yes.

MRS JONES: Then is that process undertaken by the prison rather than the health service?

Ms Grace: No, we do that. I will take it on notice and see if we can pull it out. I am not convinced that we collect it in a field within our system that can be pulled out in terms of number of smokers at any point in time within the AMC. When we are providing care to an individual, we would know whether they are a smoker and we would be able to talk to them about smoking cessation and other risks related to their smoking. It is just not a statistic that we report on.

MR PETTERSSON: In 2018 the ACT government released a position statement on eating disorders. Could I get an update on any action that has arisen from it?

Mr Ord: Good afternoon. I have read and acknowledge the privilege statement. There have been a few bodies of work underway which we have been quite busy on in the last year or two since the eating disorders position statement came out.

In the ACT government budget that immediately followed the publication of the position statement in November of 2018, in the following budget year, $2.2 million was invested in eating disorders over the course of four years. We are halfway through that program of work. That began in 2019-20 and 2020-21 in terms of the development of and enhancement of the clinical workforce, which involves the recruitment of things like the service coordination clinician and HP therapists. In this financial year we have also recruited a clinical health manager within CHS. There are two more years to go in terms of bringing it up to what the business case and the budget papers allowed for. But the recruitment activity for clinicians in 2019-20 and 2020-21 is already complete.

We are also working on the governance now for the clinical hub. Connected to that—and it was at a time when there was quite a lot of national publicity about the topic—in June of last year the ACT government signed a partnership agreement with the commonwealth government which allowed for $13.5 million to come to the ACT for the establishment and construction of a residential eating disorders centre. The first component of that funding flow is next financial year. It works on a basis of $5 million next year, $6.5 million the next and then, I think, $2 million the year after.

Since that agreement was signed, we have been extremely busy in the directorate and the local eating disorders sector in terms of developing what we think the territory-wide model of care should be for eating disorders.

It is important that the residential centre fits into a wider whole and fits into a wider system. It is also an opportunity to build something from the ground up, which does not come along very often. Particularly from about July to Christmas, we were very busy with an eating disorders reference group, which was heavily influenced by carers, consumers, clinicians, and particularly by parents of eating disorder patients, around what the key features of the model of care should be, as well as the key features of what the residential centre should be. That work is continuing into this calendar year.

MR PETTERSSON: When do you expect construction on the residential treatment centre to start?

Mr Ord: That is contingent on a few matters. If it is okay, I will take that on notice to get the precise timing—it is a year or two away yet. In terms of the ACT government, we are working at the moment on securing a suitable block. We are also working quite closely with carers and consumers, and particularly parents, around what the physical build will look like.

MR PETTERSSON: If you are taking on notice the question as to when the construction starts, can you also take on notice when you expect to be able to take patients?

Mr Ord: Of course.

MR PETTERSSON: Thank you.

MRS JONES: We can go to mentally healthy communities now, correct?

THE CHAIR: We can.

MRS JONES: I want to ask about emergency orders. I have been asked to seek some more information regarding the involuntary use of EOs, emergency orders, under the Mental Health Act when patients are willing to go to hospital voluntarily. There were some discussions about this last term. But the feedback I have just had in the last week is that there is still a bit of an issue there. Could someone explain what the criteria are for voluntary and involuntary admission, and who the decision-maker is?

Ms Davidson: Do you have more detail about the kinds of involuntary orders you are talking about happening?

MRS JONES: Basically it is somebody who could come involuntarily and perhaps claims once they are in that they wanted to come in voluntarily. I am not making any accusations. I simply want to understand what the process is so that, if I go back to ask more questions, I know what the norms are or what the expectations are of clinicians when they are making those decisions, and how the decisions are made.

Ms Davidson: Are these arrivals by ambulance or—

MRS JONES: Yes, I believe so. I think something came up last year about the access point, because the access point could be the back of emergency rather than the front door. That may have been resolved by now; I do not know.

Dr Arya: Good afternoon. I acknowledge the privilege statement. Mrs Jones, I think you are referring to the emergency apprehension order, which is the provision in the Mental Health Act that police and ambulance use to apprehend a person who is at risk. Previously the situation was that anyone who was seen by people from the police or ambulance was apprehended and taken to an approved facility for assessment. On 12 February this year an amendment came into play, which is what you were referring to: that someone who agrees to go to the emergency department now does not have to be apprehended.

MRS JONES: Fantastic.

Dr Arya: This is, I think, what you were referring to. It is too early to say how much difference this amendment is going to make, but the information from the first weekend was that almost one-third fewer apprehensions were made. I looked at the figures the weekend after the amendment came into play. On any given weekend there used to be almost 20 apprehensions previously. On that weekend there were only six.

MRS JONES: Are those that have not been apprehended still allowed to enter through the specific door for mental health?

Dr Arya: Absolutely. The only difference is that these people then come of their own volition, voluntarily, rather than not.

MRS JONES: When they have been brought in under an apprehension, when that does occur, is their entire stay in the hospital also under that apprehension?

Dr Arya: No. If someone comes in under apprehension then they are assessed. If they are assessed to be in need of involuntary treatment, only then would they stay—

MRS JONES: And the assessment is within the unit once the unit has the capacity to assess? It is not necessarily immediate, is it?

Dr Arya: It occurs in the emergency department. It has to occur within four hours.

MRS JONES: Right—it is the same thing. And it is that same measure that we are not succeeding at, the four hours. Our statistics show we sometimes—

Dr Arya: That is slightly different, because this is a requirement of the Mental Health Act.

MRS JONES: Do we know how good we are at achieving the four hours at the moment? Or can you take it on notice to get some data back?

Dr Arya: It is very rare that we are not.

MRS JONES: But I would love to see that in a statistical profile—

Dr Arya: Certainly. We can take that on notice.

MRS JONES: much as I am sure you are absolutely right. Has the PACER program made any difference to this, that you know of?

Dr Arya: It will and I think it is but, again, the amendment has come into play very recently and basically this is also relatively new. I think it will make a significant difference.

MRS JONES: On the PACER program, we have recently had an announcement of additional funds and support. How does that change the number of hours and the number of crews available? My understanding was that the initial funding was for part-time availability of PACER. How does the change to funding change the hours?

Ms McDonald: Karen would have all the details on that. Chair, while Karen joins us, can I give details on a couple of questions on notice?

THE CHAIR: Please do.

Ms McDonald: Regarding the gender breakdown for OMT, for methadone we have 24 OMT on methadone, 23 male and one female; for Buvidal, it is 75, 70 male and five female; and for Suboxone it is two, one male and one female. That is the gender breakdown.

On the outdoor space for the CSU at the AMC, there is an outside space but not for every cell. It is different to the management unit. They were two of the questions on notice.

MRS JONES: Is that a correction to the number of people who are on—

Ms McDonald: Yes.

Ms Grace: On Suboxone I said no because I had none in my briefing papers, but the subsequent gender-based data shows two. They would be transitioning to Buvidal.

MRS JONES: What were the numbers for Buvidal? What was the gender breakdown?

Ms McDonald: Seventy male and five female.

MRS JONES: Thank you. Karen was going to give some more info on PACER.

Ms Grace: When we initiated PACER in December 2019, it was for four days a week, 10 hours a day, from memory. In April 2020 we expanded that to seven days a week, with one car. What we are able to do with the funding that was announced in the budget in February is to maintain a car seven days a week, 10 hours a day. Previously the funding was reliant on the mental health stimulus package announced for COVID-19. In essence, we now have surety around continuation of—

MRS JONES: For two years? Is that right?

Ms Grace: No, I think it is four.

MRS JONES: Okay, great.

Ms Grace: For one car, at this stage.

MRS JONES: Which hours of the day is it operating? I think there was a peak demand period that it was built around.

Ms Grace: Yes. It started at four days a week, Thursday to Sunday, because that was the peak demand, and it was afternoon into the evening. It was from 2 pm through to 10 pm. That has now been expanded for those hours over seven days a week.

MRS JONES: For those who might be reading the transcript, what does the car have? Who is in it?

Ms Grace: The other thing that we will be able to achieve through this funding initiative is a purpose-built vehicle. We have been utilising an ambulance vehicle previously; now we will have a purpose-designed PACER vehicle. In that vehicle we have an ambulance officer paramedic, a police officer, and a mental health clinician. The idea of the PACER program is that the calls come through to the police call centre and if there is a sense from the caller that there is mental health impact in relation to the incident that is being reported, the PACER vehicle would be deployed initially to do an initial assessment.

The idea of having the three services is that the police can deal with the policing issues; if there are physical health concerns, the paramedic can address those; and in terms of mental health, the mental health clinician can do an assessment and make a determination as to whether that person needs to go to the hospital. And, if necessary, as they are a mental health officer under the act, they are able to put them under an EA.

MRS KIKKERT: What are the logistics behind it all? Where will the van be located?

MRS JONES: Does it work out of a police station or an ambulance station?

Ms Grace: Yes, it works out of a police station.

MRS KIKKERT: Would the paramedic be there constantly or do they go over and pick them up?

Ms Grace: They are rostered on shifts and the team attend the base to pick up the vehicle, which is at a police station in the north of Canberra. They meet there. They are rostered on. From our perspective, from a mental health service perspective, the clinician is rostered onto the shift and that is where they would go for their shift—to that police station. The team will meet there, and they are allocated their jobs through the police job allocation system.

Ms McDonald: Just to clarify the hours, I think it is midnight that—

MRS JONES: Through to midnight?

Ms Grace: That was the other change as well.

Ms McDonald: It was 10 pm originally.

MRS JONES: From two to midnight?

Ms McDonald: Two to midnight.

MRS JONES: Fantastic.

THE CHAIR: On page 340 of the 2019-20 ACT Health Directorate annual report, the office states that one of its aims is to "work with lead agencies to provide evidence-informed community and workplace interventions". I am particularly interested in the workplace interventions. What do those interventions look like? I am curious about how that comes to be and what those look like when they happen.

Ms Jonasson: We think that might be a question for Dr Moore.

Ms Davidson: Yes. It actually highlights, again, the value of having an Office for Mental Health and Wellbeing, to be able to connect up different directorates and agencies and to do that strategic kind of research work and help set the direction for future services and programs.

THE CHAIR: I feel as though I should know the answer to this question. Minister, but we are the only jurisdiction in the country with an office for mental health and a minister designated to it, aren't we?

Dr Moore: We are. Other places do have a commission.

THE CHAIR: We are punching above our weight once again. The question was about those workplace interventions.

Dr Moore: The principle of the office is that we do not duplicate, and we work with people. The workplace interventions can occur within government or outside government. We have been working with CMTEDD—Chief Minister, Treasury and Economic Development—who have the lead in terms of workplace interventions for the ACT public sector.

In terms of WorkSafe, WorkSafe have a website, which I am totally envious of, around some of the workplace interventions they have been introducing into non-government workspaces. In terms of the commonwealth, I have only had initial discussions, because there are a large number of ACT residents who are also within the commonwealth.

THE CHAIR: You mentioned you were envious of WorkSafe's website. What do

they have that you would like?

Dr Moore: It is a very well set out website and has lots of resources which are easily accessible.

THE CHAIR: I will jump online and check it out. In terms of workplaces more broadly, I am interested in how this work manifests itself in particularly vulnerable workspaces and workspaces that are not often picked up when we think of conventional work—caring labour, volunteers, the gig economy, people in the performing arts sector. How are we intervening in those workplaces?

Dr Moore: This is part of our work plan that we want to look at further. We have had a workplan for 2019-21. We are about to go out, in the second half of the year, to look at a further workplan over the next five years. When the office was originally set up, we did that consultation over what people wanted us to concentrate on in the first two years. We are now about to go into that second phase, reflecting back to the community what we heard that we could not do previously and asking whether they still want us to concentrate on that and looking at what else we need to do.

THE CHAIR: What appetite do you perceive there to be for greater supports in spaces where work is being done, but it is not work thought about conventionally in terms of earning an income—like that caring labour I spoke of?

Dr Moore: I think there is quite an appetite. We also meet with the peak non-government agencies for mental health every two months—Carers ACT, the Mental Health Consumer Network, the Mental Health Coalition and ATODA. Carers ACT have highlighted some of the issues that carers bring in terms of their own work stress. They are doing some work in that area, but it is something we can do more of.

THE CHAIR: What work have we done, if any, particularly over the last COVID year, in the context of the gig economy, which I am sure we would all agree is one of the parts of the economy that has been most affected and where the staff have probably received the most mental health impacts? What work have we been doing there?

Dr Moore: No specific work particularly for the gig economy. It has been covered under that wider umbrella through WorkSafe and through our media campaigns.

Ms Davidson: Also, a significant amount of work has been done in other areas of the ACT government in trying to relieve some of the social determinants on mental wellbeing in terms of making sure that people are able to still put food on the table, keep a roof over their head and deal with all of those kinds of stresses. It might also be useful to hear from ACT Health and Canberra Health Services about some of the work they have been doing for their workforce, particularly given all the pressures they have faced over the last year.

THE CHAIR: Certainly, particularly if there are good things we can use elsewhere.

Ms Jonasson: I invite Dr Kerryn Coleman to the table. She has done quite a bit in our emergency management team to ensure that people are coping with what we have

been coping with.

Dr Coleman: I have been asked to talk a bit about how we have been very aware of the potential impact of the COVID outbreak on our workforce. We have a workforce of around 70 to 100 public health staff—logisticians and people such as that—sitting within the emergency management centre. While we know a lot about people on the front line, such as frontline firefighters and healthcare workers, we do not know a lot about what a prolonged emergency looks like in people who are doing the behind-the-scenes work. It can be turned on a dime. You would have seen in the media sometimes that we have to announce a lockdown within an hour. That gets implemented really quickly. They are constantly talking to people stuck in a different town about how they are going to get home and all the quarantining issues.

We have had a mental health and wellbeing adviser embedded within our workforce for almost the entire time that we have been stood up. Dr Sarah Miller has done some amazing things with the team. One of the most important things she has done is to implement a survey to take measurements and a temperature check. The most recent ones were done in November and in January this year.

The three things that she has been measuring are compassion satisfaction—about whether they are getting satisfaction from their work; secondary traumatic stress; and burnout. Burnout is the one we are seeing. While there has not been a deterioration in the burnout, we are seeing that it is not getting any better. We are looking at things we need to do. That will link quite nicely into the cultural work that Jodie has been leading.

Going to some of the things that we are looking to develop in that space, we have seen that people, particularly our leaders and our managers—in Health we do not train them that well in how to do the skills of managing and leading. We all know very well what a public health measure is, but it is providing our teams with that support so that they do not get so stressed all the time. It is making sure that they take their breaks. We have had EAP on site.

We plan to do that survey every three months or so, just to keep a close eye on it. That is a snapshot of how we have been trying to learn from this experience, which is pretty unique, and also care and look out for those workforces.

THE CHAIR: Dr Coleman, since I have you in front of me, can I ask you a question lots of Canberrans would probably want me to ask you? How are you doing? Are we looking after you?

Dr Coleman: Thank you. I must admit it has been a bit up and down, but Monday was a fantastic milestone to reach, and it let off a bit of pressure this week to have the vaccine program rolling out. We have a fantastic team. I am not doing it alone—no way. Those guys keep me up and running. We are getting there together. Thank you for asking.

THE CHAIR: I saw your announcement on Facebook that we can go to Melbourne soon, so I am particularly delighted with your work.

MRS JONES: Earlier we were discussing with the Minister for Health—some of the officials would have heard it—the possibility of early detection of what might eventually lead to something like a post-traumatic stress disorder or post-traumatic stress situation for somebody. Have you done any work in this space, either with the current workforce or on the academic side, to talk about how people can identify when they are experiencing early signs? We know that in the broader health workforce it is not necessarily something we train people for. Have you got any suggestions or success stories in that space?

Dr Coleman: I will readily acknowledge that that is not my area of expertise. That is why I have embedded this mental health and wellbeing adviser within the team. We have taken two actions. One is to look after, in particular, people in quarantine. We do an interview intake questionnaire and we go through a range of interview questions with them to do an early detection if there is a problem or if there is a concern and decide whether we need to do something additional to assist them during their 14 days. They will use validated instruments and tools to do that. The second issue is that we have EAP on site. We encourage, and have normalised, having appointments.

MRS JONES: For the record, what is EAP?

Ms Jonasson: The employee assistance program.

Dr Coleman: I have a fortnightly coffee regularly noted in my diary. All my leads have that. We normalise it within our program. That is completely confidential. We get some feedback on the levels and the themes that are coming through that to assist us and work through that. With respect to your question, no. I am not sure if Elizabeth or Dinesh might have more specific information about that from a public health perspective.

Ms Davidson: I have heard from someone who has been through that quarantine in Canberra and did that survey that you were referring to. They noted on one of the days that they were not feeling so great and they got a call straight away: "Okay, how are you feeling? What can we do to help?" They really appreciated that quick response.

MRS JONES: A good friend of mine just went through 11 days but then was let out early. It is very up and down.

I am also interested in the workforce issues that go to people burning out, but the information we got in this committee room last year in the policing inquiry was that absolutely everybody has the capacity to break down if they are exposed to enough stress. That is a really interesting piece of information which I had never heard before. It is not that somebody will have a propensity; enough of the right type of stress and we are all going to end up with a trauma brain which operates best in a traumatic situation and not so well in day-to-day life.

Ms Jonasson: Mrs Jones, we completely agree, which is why we took the measures that we did very early in the emergency response. And I would like to make a plug, because I know Dr Coleman will not, to say that the mental health supports for people in quarantine in Canberra have been well recognised around Australia, by other states and territories, as nation-leading, with the ACT punching above its weight.

MRS JONES: Excellent. Thank you.

MR PETTERSSON: When did those mental health services kick in for people quarantining? I returned from overseas at the very start of the pandemic, and I had to do—

MRS JONES: But you were at home, weren't you?

MR PETTERSSON: Yes; I had to do 14 days at home.

MRS KIKKERT: You were one of the first ones.

MR PETTERSSON: I get that, but the question is: when did that kick in? Was it only with hotels?

Dr Coleman: I could not tell you an exact date, but we evolved our program over time. It was not available at the very start, when we got that rapid influx of all people coming home and in, but it was probably within the first three to four months, I would hope. If you need the exact time, I can get it for you; I just do not have it here.

MR PETTERSSON: No; it is fine.

MRS KIKKERT: It has been well reported in the community that there is a need for ongoing increased mental health support for young Canberrans with highly complex needs who are at risk of mental illness, criminalised behaviour and substance misuse. Minister, you have talked about the establishment of an intensive trauma service for adolescents to support their recovery. When will the service be up and running?

Ms Davidson: Is that the functional family therapy program that you are talking about?

MRS KIKKERT: I am referring to what you said in an article in the *Canberra Weekly*.

Ms Davidson: That sounds as though it is the functional family therapy program, which is being delivered through youth justice. That might be one we could talk more about in the committee next week.

MRS KIKKERT: We have already done community services today. You cannot talk a little bit about it?

Ms Davidson: There is community inclusion next week.

MRS KIKKERT: Yes; that is youth inclusion.

THE CHAIR: We will have the minister before the education committee next week, for youth justice.

MRS KIKKERT: But you are oversighting it?

Ms Davidson: I am. I am really looking forward to talking with you in detail about it during that committee.

MR PETTERSSON: I tried to ask some questions earlier but the right official was not here. I am hoping they are here now. Page 44 of budget paper C shows that alcohol and drug services community contacts have dropped and that this is due to there being a lack of health professionals. I was wondering if someone could expand on where the vacancies are that are leading to that decrease in contacts.

Ms Davidson: I will ask Karen to talk in more detail about that, but there was a COVID impact.

Ms Grace: As with the Justice Health contacts, there is a multifaceted answer in terms of the overall picture, a component of which is workforce.

To touch on some of the other impacts, again, it is the impact of Buvidal reducing the number of times that each individual needs to access care on the program. As in the prison, we have had a good uptake of Buvidal in the community which has seen a reduction in contact through that program.

There also was a COVID impact within the alcohol and drug service, particularly around drug counselling. In this area—in fact, in several areas across my portfolio—we struggle with the workforce, particularly around senior health professionals in counselling roles, particularly with drug and alcohol expertise.

We are carrying a number of vacancies in that part of the service in particular. At the moment, our vacancy rate for the alcohol and drug community program is 24 per cent. The majority of those are within the counselling service. We have 21 FTE budgeted within the health professional classification; at the moment, we are at 13.5 FTE. So there are 7½ FTE vacancies in that group. In nursing, we have an establishment of 22 and we are on 19.5, so we are a couple of FTEs short in nursing. Enrolled nurses are fully recruited. As for medical officers, we have one vacancy within our medical service, but that is due to long service leave.

Over the past 12 months, it is also important to remember that we have opened another opioid treatment service on the north side of Canberra, which has led to an increase in resource need. Another thing we have done is increase our resources supporting the drug and alcohol court, the DASL—drug and alcohol sentencing list.

In a jurisdiction the size of the ACT, given that alcohol and drug counselling is such a specialised area, we find that when we grow in one part of the service, we often contract in another part of the service as people move from one part of our service to another when we are unable to achieve a net growth in the overall workforce. The same is true in mental health and in justice health to a lesser degree. We have a workforce committee that is looking at a whole range of strategies, including increasing the availability of education to specialist drug and alcohol training locally. That has been problematic over the years; it is not something that has been readily available, so people have had to travel or undertake remote study to gain the qualifications within alcohol and drug services. We are working on improving the

availability of that locally as well as looking at a number of strategies to try and attract people to the jurisdiction to get a net increase in service.

MR PETTERSSON: What are some of the strategies to attract people to the ACT?

Ms Grace: As I said, we have a committee and they are working on the recruitment plan at the moment. We are looking at each of the different types of professional staff that we need across the division and targeting the recruitment to areas where we know that particular discipline will engage. It is particularly around professional colleges, popular conferences and other mediums that we know alcohol and drug nurses—in particular, in this example—or alcohol and drug counsellors access in terms of their personal and professional development and trying to target those with the ads to drive them to our website, where they can find the vacancies.

MR PETTERSSON: That sounds reasonable. How long have we been doing that for?

Ms Grace: You cannot overestimate the impact of COVID. People have not moved much over the past 12 months in this country. We found that, even if we were able to attract people from interstate, getting them here has been really problematic over the last 12 months. Not being able to predict where people are able to travel from and to has meant that people have buckled down and stayed put, I think. That is true across all of my services. It is definitely true.

The other thing we do is a bit of international recruitment, and that has been impossible over the past year as well. We have been working on this strategy for some time, but nobody could have predicted the broad impacts of COVID, and one of them for us has been our ability to attract talent to the territory.

MR PETTERSSON: But these vacancies would have existed before COVID?

Ms Grace: Yes, of course.

Ms McDonald: If I can just add something, as we talked about earlier today, there is a national and international shortage of psychiatrists and mental health practitioners. We are fighting everyone else. We had some recruitment strategies that worked beautifully pre COVID, for pharmacists in particular. We had great difficulty in attracting pharmacists. We have been to their conferences; we have had a true recruitment strategy. It has worked beautifully because there are pharmacists to recruit. It is the same with anaesthetists. We had a very clear recruitment strategy and we now have more staff specialist anaesthetists. But there are anaesthetists to recruit.

The difficulty we have in mental health, with psychiatrists in particular, is that there is a national and international shortage of practitioners, so it is very difficult to do this. It is one of those wicked problems we talk about and COVID has just added to the complexity.

MRS JONES: Have you considered a return of service type of arrangement with the education facility in this space? For example, in teaching once you did a certain number of years in a certain place which paid for your training. Have we looked into

that?

Ms Grace: We have a whole range of activities happening at the moment at both ends of the scale. There is the idea of opportunities for people to have flexible arrangements to return to the workforce or transition to retirement arrangements that are flexible and will enable people to stay in the workforce for longer.

We are also working with our university partners on postgraduate programs for all our high need specialties. In the last 12 months we have commenced an occupational therapist in social work internship program; we provide a 12-month supportive transition program for those specialties. That already exists for psychology.

MRS JONES: That is as they graduate?

Ms Grace: Yes. It is a particularly tailored graduate program to enable them to apply their skills within our workforce.

We are looking at a whole range of options. We are looking at workforce redesign options where we can move away from traditional ways of working and be more creative in how we utilise our workforce. What we are trying to do in that is to look at each practitioner's scope of practice and design roles to the top of their scope so that we are using all our professionals to the top of their scope. Then we can ensure that we are getting the best use of the expertise that they have trained for. Through doing so, you also create better job satisfaction for people.

MRS JONES: Do you get the impression that we have sufficient places in the ACT in those education facilities, or could there be more? I know that is a conversation to have with the federal government, but given the number of times this topic comes up, I am just wondering where we are at with being a part of that conversation, if anyone knows.

Ms Grace: The challenge here is with speciality training opportunities locally. There is some work that we are doing in partnership with the office of the chief nurse within the Health Directorate around establishing a number of postgraduate offerings for mental health that will give a range of different people opportunities to come and join our workforce. We are starting at entry level assistant in nursing or allied health assistant positions that have a particular focus on mental health or alcohol and drug or justice health and then going through enrolled nurses to registered nurses and beyond.

MRS JONES: That is taking people from the cohort who are training in nursing and medicine and trying to get them interested in these areas earlier in their training. Is that right?

Ms Grace: Yes. We have also reviewed the term descriptions of our junior medical officers, for that reason, to give them more of an in-depth experience of psychiatry when they do their rotations.

MRS JONES: Is there any idea that there are not enough coming in through the education system or is it simply a matter that not enough are considering this area?

Ms Grace: I think it is about choice. It is a similar challenge to the ones we have in a number of speciality areas within health; the ones that I am responsible for are just some of them. It is about early career exposure to speciality areas to make them an option for people. That is what we are focusing on: giving people exposure as students and as very junior professionals.

MRS JONES: Do you test the effectiveness of these strategies afterwards?

Ms Grace: We will be.

MRS JONES: It has not started yet?

Ms Grace: No. We will be ensuring that we are measuring—

MRS JONES: Can you give us an idea of the time frame for this approach that you are trying to implement?

Ms Grace: I would have been much further ahead if it was not for COVID.

MRS JONES: When we come back to estimates at the end of the year, will there be a bit more information?

Ms Grace: There should be more information by the end of the year. I am hoping I will be able to report a bit of success, but do not hold me to that.

MRS JONES: How long have you been trying to get this going for?

Ms Grace: Working with universities around course curriculum and course offerings is time-consuming because they have their own governance processes to get approval for courses. Whenever you want to change an offering that you have previously had, it takes time. We have been working with the University of Canberra on a postgraduate course.

MRS JONES: How long for?

Ms Grace: It probably has taken 12 months. We should start to see some of the benefits of that over the coming months. We have now got 12 months of a health professional graduate program under our belts, and we have just recruited to the second round. We should be able to start measuring retention of those staff. That is an important measure in all of this: to be confident that we are not just training people and losing them but actually retaining them in the system.

MRS JONES: It might be one of the upsides of the COVID situation. You might keep people.

Ms Grace: That is right. They do not have much choice at the moment.

Ms Jonasson: Earlier today I mentioned the conversation at the national level around workforce shortages. It was identified pre COVID, and work was well underway on national workforce reform. It is also connected and identified as a priority area under

the National Health Reform Agreement reform areas that will be progressed.

MRS JONES: Interestingly, it is something that I discuss with young people. Whenever I am in front of young people, I say, "Don't forget that psychiatry, counselling and mental health medical careers are going to get you a job."

Ms Jonasson: Obviously we are using as many local levers as we possibly can to train local and retain local, but we will also ensure that the pressure remains on the conversation at the national level so that we can encourage the commonwealth to do whatever they can to help us as well.

MR PETTERSSON: How many psychiatrists are employed by ACT Health?

Ms Davidson: That sounds like a question that Karen will be able to give you the answer to.

Ms Jonasson: Or take on notice.

Ms Grace: I think I have it.

Ms Davidson: As we have just heard, whatever the number is, we would love to have more.

Ms Jonasson: I will give Ms Grace time to get there. I can say that in the directorate we have two, both sitting in this room.

MRS JONES: That is good for the directorate.

Ms Grace: I will have to take it on notice; all I have here is the vacancies, not the actual FTE.

MR PETTERSSON: In the youth mental health inquiry, we discussed that there was one psychiatrist who is child and adolescent trained and they are working one day a week in the eating disorder program. I was wondering if that was still the case.

Ms Grace: For the eating disorders program, that is the case. That is not the total number of child and adolescent psychiatrists in the territory. There is a whole workforce of child and adolescent psychiatrists, but there is one currently allocated to the eating disorders program.

MRS KIKKERT: My question is on the safe haven cafe. It was reported this month that the construction of two safe haven cafes has been delayed, despite a rise in the number and severity of mental health presentations across the ACT's health services. Minister, why the delay, and how soon will these facilities be built?

Ms Davidson: I am very much looking forward to the first safe haven cafe opening soon. There has been a lot of work going on on the hospital campus with all the construction. It is really important that the first safe haven cafe is located near the emergency department, which is where there has been a lot of change happening. I will let Jon talk in more detail about progress on the project.

Mr Ord: The safe haven cafes were initially funded in the mental health support package that was announced in May 2020. That was circa $340,000, which was subsequently received in—

MRS KIKKERT: Sorry, how much?

Mr Ord: It was about $342,000 or $341,000. I can get the precise figure for you, but it was certainly the early 340s. And in the budget that was announced a couple of weeks ago there is an additional 80,000.

MRS KIKKERT: What was that for?

Mr Ord: That was also for safe haven cafes. That was a boost, effectively, to the funding. In the mental health support package, there was a commitment that there would be two safe haven cafes. There would essentially be the one that the minister has just referred to—at the hospital, preferably quite close to the ED—and one in a community setting.

MRS KIKKERT: Do you know where that will be?

Mr Ord: In the community setting?

MRS KIKKERT: Yes.

Mr Ord: No; that is something that we are working through in the steering group at the moment. In terms of a delay, we have undertaken a lot of work between the announcement and now in terms of what a safe haven cafe will look like. It is a real example of good co-design in how we developed it. I do not know how much you know about safe haven cafes, but there are a lot of models in different parts of Australia and different parts of the world showing what they do and what they are. It is fairly easy to talk about having a safe haven cafe, but there are lots of questions and considerations about what they do and, crucially, what they do not do—and what they are meant to support.

Minister Rattenbury, as the minister, made the announcement in May. We held an online webinar in July last year which heard evidence from two really successful safe haven cafes, one community based in the north of Brisbane and one just over the road from St Vincent's in Melbourne, in the CBD. We heard their experiences and their mixed experiences of what worked and what had not worked.

From the end of August or the start of September, up to about Christmas or thereabouts, we undertook a co-design process with the steering group around what those safe haven cafes would look like. We started from the bottom up in terms of how it would work. We heard from consumers. We heard from carers. We heard from clinicians in Ms Grace's division about how they would work and how they could connect to an emergency department, as well as how it could potentially in the future connect to things like PACER. We had two co-design teams. The Mental Health Consumer Network and Carers ACT contributed. They recruited a lot of their members to help with that co-design work.

Just after Christmas, into early February, we got our model for the safe haven cafe that would be in close proximity to the emergency department; currently we are working through possible locations on the hospital campus. In the deliberations in spring into early summer of last year, the steering committee were very clear that the ED one should be given priority in terms of developing the model. We worked on the basis that the steering committee were very clear that they wanted to concentrate on the ED safe haven cafe initially in the model. A safe haven cafe that services and sits close to an emergency department might look quite different in terms of the cohort and what it does compared to a community safe haven cafe. We are now at the point where our colleagues across the Health Directorate and Canberra Health Services are working on a location in Canberra Hospital.

The other steering committee meets next Tuesday to start in earnest identifying a site and talking about the key questions in relation to the community safe haven cafe.

MRS KIKKERT: When will the safe haven ED site begin to be constructed?

Mr Ord: I do not have a definitive answer for you, but as soon as possible.

MRS KIKKERT: Would it be possible for the committee to receive the discussion papers from your discussions in Brisbane and Melbourne?

Mr Ord: Yes, of course. It is actually online. The webinar is online. Also, as part of that co-design work, we had as an independent adviser and facilitator a lady who was the manager of the safe haven cafe in Brisbane. She was an independent facilitator and was able to talk us through some questions and experiences that they have had. We have a significant body of work that sits behind that that we would be happy to share.

THE CHAIR: The committee's hearing for today is now adjourned. On behalf of the committee, I thank the ministers and officials who have appeared throughout the day. If witnesses have taken any questions on notice today, please remember to get answers through to our wonderful secretary, Andrew, within five working days of receipt of the proof *Hansard*. If any members, including those watching in their offices, wish to submit a question on notice, they need to get those through by close of business on Friday, 5 March.

The committee adjourned at 5.23 pm.