LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

# STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING

(Reference: Review of ACT health programs for children and young people)

**Members:**

**MR J DAVIS (Chair)**
**MR J MILLIGAN (Deputy Chair)**
**MR M PETTERSSON**

## TRANSCRIPT OF EVIDENCE

**CANBERRA**

**TUESDAY, 28 SEPTEMBER 2021**

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

**By authority of the Legislative Assembly for the Australian Capital Territory**

Submissions, answers to questions on notice and other documents, including requests for clarification of the transcript of evidence, relevant to this inquiry that have been authorised for publication by the committee may be obtained from the Legislative Assembly website.

# WITNESSES

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*Amended 20 May 2013*

**The committee met at 3.08 pm.**

**RHEESE, MS STACY**, Team Leader, Policy, Advocacy for Inclusion

**THE CHAIR**: Today, the committee is holding a public hearing of our inquiry into the ACT children and youth health screening programs and fetal alcohol spectrum disorder responses in the ACT. The committee has received and published 10 submissions, all of which are on the committee's website. These proceedings are public; they are being recorded by Hansard for transcription purposes, and they are being webstreamed and broadcast live.

Before the committee starts the hearing part of our program today, on behalf of the committee I would like to acknowledge that most of us are meeting on the lands of the Ngunnawal people, the traditional custodians of the land. We pay our respect to their continuing culture and the unique contribution that they make to life in our city and in our region.

I would like to welcome our first witness today, Stacy, from Advocacy for Inclusion. Stacy, could you please confirm that you have read and understood the privilege implication statement that was sent to you?

**Ms Rheese**: Yes, I have read the privilege statement.

**THE CHAIR**: Before we head off to questions, you are more than welcome to start with a brief five-minute opening statement for the committee if you wish.

**Ms Rheese**: Yes, thank you; I will. Thank you for the opportunity to appear before the committee today. Children and young people with disability can face an array of issues in accessing both general and specialised health and assessment programs. These include inaccessible and unavailable services, stigma and misconception, and low disability awareness. These barriers can contribute to diagnostic overshadowing, negative and traumatic experiences with health services, unmet health and disability needs, and exacerbations of conditions and needs. The flow-on effect of these barriers can have significant consequences for children and young people with disability, exampled in the over-representation of this cohort in our youth justice system, high presentation to acute services, and ongoing distrust and poor outcomes from interactions with health services.

AFI wants to emphasise the opportunity for substantial improvements in access and service provision which is presented in addressing these barriers. The most positive comments to be received by our organisation often relate to situations where health professionals and services work well, and a person with disability feels heard and has their needs met. These experiences can quite literally be life changing. In our submission, AFI has made several recommendations to support improvements to health access and to address these existing barriers. We strongly support a robust and effective disability health strategy, and emphasise that resourcing and implementation of this strategy must be prioritised in order to support significant improvement and fundamental change to systemic barriers.

Similarly, we encourage strong support for resourcing and implementation of health services, disability action and inclusion plans, and additional strategies to address systemic change. We highlight the need for comprehensive disability awareness across health services, increased disability skills and specialist services, and improved support and knowledge of disability adjustments, assistance and supported decision-making. Finally, AFI would like to emphasise the need to prioritise early support for disability, including identification and response, to reduce escalations and acute health crisis responses. Thank you.

**THE CHAIR**: Thank you very much, Stacy. In your submission, you discuss the impact of a prevailing dominance of the medical model of disability on the ACT government's approach to people with disability. Can you elaborate and explain a bit more to the committee the social model of disability and why you believe that to be more empowering.

**Ms Rheese**: The medical view of disability views disability as an impairment within an individual, and so looks at ways to treat or deal with and manage that impairment specifically as a way of treating the individual. In comparison to that, the social model of disability also considers social, structural and environmental barriers that people with disability experience, and the impact that has in actually disabling an individual. Think, for example, about a wheelchair user approaching a building that has stairs as opposed to a ramp. They are disabled by the impediment of stairs into the building. If there is a ramp there and they can access the building they are not experiencing that impact of disability as much, because they are able to access a building equally, along with everyone else. So, in terms of access to health services, what we are seeing is a real focus on that medical view of disability as an impairment just within the person, without considering those other existing societal and environmental barriers. And that can really have impacts on service delivery and provision. It can impact things like communication choices with someone with a disability and the relationship with the health professional. It can also impact things like accessibility of a service if those other environmental considerations are not being made. Someone might be coming and visiting a health service and they are experiencing overstimulation from environmental factors like fluorescent lighting or noises and that sort of thing, which might not be brought into consideration.

It can also impact on that holistic approach to addressing disability support aids if the only impairment being viewed is within the person with a disability rather than the additional social and environmental supports or lack of supports that the person is experiencing. That can also impact on treatment management plans and other holistic and wraparound supports that the person might be referred to. I would just add also that we find that that medical view is probably a really fundamental thing within the health profession as well.

**THE CHAIR**: Thank you, Stacy. I will move on to Mr Milligan.

**MR MILLIGAN**: Thank you, Stacy, for your submission to this inquiry. Within your submission you mention that some health staff have demonstrated an inadequate awareness of accessibility or adaptive communication, inclusive practices and supportive decision-making. Can you elaborate a little bit more on that and maybe a give a recommendation in terms of how the government can better equip our health staff in this area?

**Ms Rheese**: Absolutely, and I would also like to say that this might include—knowingly and unknowingly—making these choices or practicing in a way that is impacting on people with disabilities. With respect to that, we have seen several examples of clients who have interacted with health professionals who might refuse requests that a client has made for adjustments. This includes formal requests, written and verbal, to do something like speak with a representative or a support person with that person's consent, or to provide information by additional means—so, rather than just verbal provision of information, someone might request to have information provided to them in a written format. We have seen that not taken into account or not responded to. There can also be a lack of provision of disability supports, including things like mobility supports when a person is in hospital. And in terms of supported decision-making, we have a concern that in some areas this might be seen as a bit of a box-ticking exercise and there might not be a real practical knowledge and understanding of exactly what supportive decision-making looks like and how it can be implemented within a health services setting.

So we might have conversations with health professionals—and this is a really important element in things like decision-making capacity assessments and possible orders around guardianship and mental health orders and things like that, where this can be a consideration before orders are proceeded to. Those health professionals might say, "Yes, we have attempted supportive decision-making," and if that is explored further there is no evidence of any practical supports being implemented or there is no way that people can explain exactly how they have explored supported decision-making. Supported decision-making looks different for every individual, and we are not really seeing a thorough engagement with that from health professionals who are ready to explore and support a whole range of alternatives and able to implement the range of support provisions that a person might need to engage with supported decision-making.

I would really recommend looking at the United Nations General Comments on article 12, which really outlines the practicalities and considerations that need to be undertaken in terms of supported decision-making. In my experience, there would not be a lot of health professionals that I have worked with who would have a thorough understanding of what that implementation of supported decision-making looks like, or who have the resources available. For some people, it might be having a support person present, it might be communication assistance, it might be provision of information in different ways. We are just not really seeing a lot of exploration of all those different elements of what supported decision-making might look like.

In terms of a recommendation of what can be done to improve that, we would really, ideally, like to see all health professionals having a comprehensive understanding of what supported decision-making looks like, keeping in mind that the United Nations recommends supported decision-making as a way for people to exercise their equal recognition before the law. This is a really critical element of decision-making, particularly in health settings, that allows people to participate in their treatment and management plans, so it should be something that people have a fundamental knowledge of, and it should be something that we are seeing practically supported and run out in all health services. Especially, I have to emphasise the importance of this in decision-making capacity assessments, when that question is coming into play: will someone be considered to have equal recognition before the law, or not? We really need to see supported decision-making being thoroughly explored in those areas.

**MR PETTERSSON**: I was wondering if you could tell the committee whether there were ways that the ACT could improve the early identification of disability.

**Ms Rheese**: Again, that comes down to the fact that we have a lot of opportunities across the board. Keep in mind that people with disability, children and young people, are engaging with a lot of mainstream services that are not specialist disability services. There is a lot of opportunity for mainstream health professionals to be recognising emerging disability needs that might not have been picked up yet, so there should be a fundamental knowledge of disability and presentation amongst all health services that were working with children and young people.

We do see things like holistic screening taking place in schools. Is there an emphasis on understanding and picking up disabilities, developmental delays and those sorts of thing in that area? In areas like education, staff who are spending a lot of time with children and their families might also benefit from disability awareness and that ability to recognise emerging needs. We are seeing a lot of situations where maybe not ideal services or responses are coming to emerging disability needs. We see things like a very high rate of interaction with criminal justice, emergency services and the youth justice system for young people with a high prevalence of disability. So we should be looking at opportunities where this cohort is engaging with services—CYPS, additional youth services and things like that—where we could be picking up what might be a presenting or emerging disability need, a mental health condition or that sort of thing. We are picking up these young people, but they are being funnelled into inappropriate areas, like the youth justice system, as a result.

We really need to improve that identification of disability support needs and the response to that to ensure that disability does not put people on a track towards areas like youth justice. Sorry, can we just go back to the question again, because I know there was another area that I wanted to address there?

**MR PETTERSSON**: The question was: how can the ACT better improve early identification of disability? You have touched on, I think, a lot of different broad solutions. Just narrowing in on your mention of the justice system, are there any further places—you mentioned places like CYPS—where we could be engaging with these at-risk youngsters? Is there anything else that we could be doing or is it essentially just a matter of hoping that these programs for at-risk youths are going to catch them? I feel like maybe there is more we could be doing.

**Ms Rheese**: Absolutely. Those are the areas that young people with unmet disability needs are being pushed towards, but in areas like education young people with disability have a much higher suspension rate than young people without disability, and we are seeing that starting to be picked up in ACAT and areas like that. They also have a higher rate of disengaging from school. So there are certainly a lot of earlier opportunities where we could start recognising the signs of unmet needs and be responding to that before they start getting into that at-risk area.

Even going much earlier than that, in early childhood development, we could be doing more. Again, if we have children and families presenting to GPs who are lacking in disability awareness, or if there are not the available specialist disability services for people to access at an early age, then we are also missing opportunities there. And that was the other element of the question that I wanted to go back to. We are seeing increased demand on specialist services in the ACT, and we are lacking specialist services in the ACT to respond to the really early identification of disability.

The NDIS has also highlighted this as an area, as people are required to get diagnoses and evidence for NDIS access requests. We are also seeing a lot higher demand on autism services and assessments in the ACT that we are struggling to have the capacity for. So certainly, there is an area of specialist services that we are missing in the ACT, and not everyone has the ability to go interstate to access these services.

**THE CHAIR**: Great, thank you. Any follow up questions? There are not. Thank you so much for your time this afternoon, Stacy. We really appreciate it. When available, a proof transcript will be forward to you to provide an opportunity to check over that transcript and suggest any corrections. Once again, on behalf of the whole committee, I would like to thank you for appearing today.

**Ms Rheese**: Great. Thank you very much for the opportunity.

**Short suspension.**

**TITO WHEATLAND, DR FIONA**, consumer member, Health Care Consumers Association of the ACT

**THE CHAIR**: I would like to welcome our second witness for today's hearing, Fiona Tito Wheatland from the Health Care Consumers Association. Fiona, can you please confirm for the record that you have read and understood the privilege implications statement that was sent to you?

**Dr Tito Wheatland**: Yes, I have.

**THE CHAIR**: Wonderful. Thank you so much. Would you like to begin with a short opening statement for the committee?

**Dr Tito Wheatland**: Yes, that would be great. Thank you to the committee for inviting us to speak today. Health care consumers' experience of health services for ACT children and young people come from some of the specific research commissioned by the ACT government covering children and young people in interstate care. This research showed that for many people, children and young people, paediatric health services are currently not available in the specialist areas in the ACT. These children and their families spend much time travelling between Canberra and—usually—Sydney, but even Melbourne, to get access to services, and sometimes for assessments as well as treatment.

There were stories in the research of children where diagnoses were significantly delayed because families were moved from one ACT health professional to another without getting an accurate diagnosis. Not only was this costly, but it resulted in treatment and intervention delays, which had adverse impacts on the child's health as well as on the family. One that sticks in my mind was in relation to juvenile arthritis. This was particularly so with unusual conditions or where there was a need for thorough differential diagnoses because the symptoms were either intermittent or non-specific. In some cases, the diagnosis delay had resulted in permanent disability. Tests were often duplicated and results unavailable from either end of the journeys of the patients and their families. The interactions between treating teams interstate and in Canberra were generally poor, and this led to complexities with continuity of care. Families often had to meet high accommodation costs, and the practicalities in the COVID period have been even more diabolical.

We do not expect all speciality and sub-speciality services to be available in what is a fairly small health system, and neither did the families. What they needed was people who guided them and connected both parts—Sydney or Melbourne and Canberra—in the treatment of the child or young person, and systems that reduced the strains they already felt. Parents often said that they were, in the end, the only person who held the information at both ends. The communication and arrangement of services to meet people's needs is crucial for children and young people, as well as their families.

The minister committed to address these issues before the last election and supported all of the recommendations from the research, but on the ground at the moment, achievement and change have been very small. We are happy to answer any of your questions.

**THE CHAIR**: Thank you so much, Fiona; I appreciate that. I will kick off with the first question. What is at the heart of the communication between the Canberra Hospital and hospitals in Sydney who share the care of children and adolescents? Specifically, what levers do you think the ACT government has to change these patterns?

**Dr Tito Wheatland**: Among other things, there is a lever in the fact that I think we pay for the services through the interstate arrangements. But the more important thing is for both teams to take a patient-centred care approach, I suppose, and to try and understand. There were situations which you looked at and thought, "This would have to be the most complicated thing you could imagine." People would have one set of tests done in Canberra that indicated they needed to go to Sydney. They would go up to Sydney and they would have to take a CD-ROM with them—one that they could then give to a person up the other end. If their technology worked, that was good. If it did not, they could not do any of it electronically. Sometimes you had people driving up and down a couple of times in a couple of days to do this—to repeat the refrain of that sort of thing.

You look at that and think that there could be ways of working out compatible systems at either end, or ways of reading it over the internet or something like that. I know from work that I have done in relation to remote area services, that quite often doctors can look at X-rays that have been done in the middle of central Australia down in Adelaide or somewhere like that. Yet we do not seem to be able to manage it between Canberra and Sydney. That is just a little practical example. But you need to have processes in place which say, if tests were done, "We recommend treatment for the child down in your other hospital," but then there is a formal way of making sure that that happens and that the parent does not have to come, wait until the child gets sick and then take their copy of the medical information to the Canberra Hospital and vice versa. It seems to me that it is a systemic issue, and if we know that we are not going to be able to provide the care on the ground here, we should have systems in place that make it easier for the patient and their families.

**THE CHAIR**: Great, thank you, Fiona.

**MR MILLIGAN**: Can you qualify the deficiency of paediatric services in the ACT and the delays experienced by securing appointments but also, you know, the delays in diagnoses of children that desperately need to see a paediatrician but at times might not be able to access one in Canberra.

**Dr Tito Wheatland**: I think if the child is acutely unwell that is probably not so much a difficulty, though I am not sure what it is like right at the moment with COVID and the hospital at Westmead being as busy as it is with people from Sydney. I think the delays in diagnosis were probably the ones that had the starkest issues. There was not a paediatric rheumatologist for a long time down in Canberra. I am not sure if they have fixed that yet. This research was done two years ago now, so some of the staffing things may have changed, but at that stage there was no paediatric rheumatologist. The symptoms of the disease of juvenile arthritis are very spasmodic. It will come, they will be really sick for a few days and then they will get better and then they go to the GP. The mum and dad say, "These are the symptoms," and unless the GP has actually had much to do with juvenile arthritis, they might put it down to stomach upsets, flu or whatever. But if they do not pick it up early enough, the child can go blind, so it is of one of those things where there is not a lot of wriggle room. I did not interview one of those parents, but I heard about that through the Juvenile Arthritis Association people. So it can be quite significant.

I think we do pretty well with the diagnosis of things like cancer, and the children often get in to see Sydney doctors without too much difficulty if they are in, as I said, a very difficult position. But it is another thing with diagnosis of things that are unusual or rare. The issue of genetic conditions is another one that came up, where some parents would be going to different doctors for four or five years before they got a diagnosis of a genetic condition that was not very common but where the child had all of the symptoms. That is how I see it. I know there are delays in clinics so some people say, "I can't wait," and they go to Sydney. The thing that they talked about was that when they came back to Canberra, sometimes they had trouble getting back into the clinic because the clinics say, "Well, you chose to go somewhere else." It seems to me that it is an unfair thing to say to parents. Parents are trying to do the best that they can for their children, often with not very much knowledge about what the child needs. They are frightened and the system at the moment does not really make that a seamless process so that the child gets continuous care.

**MR MILLIGAN**: Thank you.

**MR PETTERSSON**: Following on from Mr Milligan's question, for young people and their families that need to go interstate to access these essential health services, what is that experience like and is there anything that the ACT government could do to make that an easier process?

**Dr Tito Wheatland**: Thanks very much; that is a great question. The report that we did covered a whole lot of those experiences and how it could be made better. Some of it is about emotional strain, some of it is about financial strain, and some of it is about hard-to-operate processes and difficulties in finding information.

We did a really comprehensive set of recommendations in the document. I think you have a copy of the report that we did. That covered everything from helping people to be able to access budget accommodation—quite often people who have a house down in Canberra have to live for maybe 10 weeks or something up there. Often, if two parents have been working, one parent is no longer working, so there are financial difficulties. While they sometimes can get some help with that through charities, that is a bit iffy and often people do not know about it. There is no-one who can guide them. The social workers sometimes know about these things but, because there is not a paediatric social work team that looks after those connections, often the family can be in dire financial situations as well as dealing with a very sick child. If they have other children, they have to manage the looking-after of those children, often over an extended period of time. If they do not have family nearby, there are all of those complexities. Taking a very family-centric, child-centric approach in how people in the hospital system and the health system set up the supports and look at the individual circumstances of people is really important.

And we should try to have mechanisms so that people do not just despair. It was very sad sometimes seeing people who had no-one to talk to about what had been happening with their child. If the care was taking place up in Sydney and the parent needed some counselling assistance or something like that, to help them cope, then, because the patient had been up in Sydney, they could get the counselling in Sydney but they could not get counselling through the Canberra services, because they were not, at that stage, a patient of the Canberra services. It is very clunky and the needs of neither patients nor children are well met by it at the moment.

**THE CHAIR**: Thank you, Fiona. Mr Pettersson, Mr Milligan, have we got any further questions for Fiona?

**MR MILLIGAN**: No, I am fine at this stage.

**Dr Tito Wheatland**: I just want to make sure that you have a copy of the final report that we did. I think it was sent in with the submission, but I just want to make sure, because we can send it if you do not have it.

**THE CHAIR**: I am not certain, but we will get the secretary to confirm with you afterwards. And if we do not, yes, we are happy to take it and have a look at it.

**Dr Tito Wheatland**: Okay, thank you.

**THE CHAIR**: Thank you, Fiona. Our scheduled time has come to a close. When available, a proof transcript will be forward to you to provide you with an opportunity to check the transcript and suggest any corrections. On behalf of the committee I would like to thank you very much for your time in appearing today.

**Dr Tito Wheatland**: That is all right; thank you very much.

**Short suspension.**

**BOWLES, DR DEVIN**, Chief Executive Officer, Alcohol Tobacco and Other Drug Association ACT

**THE CHAIR**: Welcome back to the Standing Committee on Health and Community Wellbeing public inquiry into health screenings for adolescents and young people in the ACT. I would like to welcome our third witness today, Dr Devin Bowles from ATODA. Devin, can you please confirm that you have seen and understood the privilege statement which has been sent to you?

**Dr Bowles**: I have, thank you.

**THE CHAIR**: Would you like to start off with a short opening statement for the committee?

**Dr Bowles**: I hope to focus my remarks today on just one of the terms of reference around fetal alcohol syndrome, or FASD. Congratulations to you for identifying such an important area of inquiry with potential for real improvement and clear return on the investment of society's resources. With the competing demands on your time right now, this is a good use of it—so, thank you.

Diagnosing FASD is not at all straightforward and involves a high degree of clinical judgement. It is also probably under diagnosed, in part because health professionals are not looking for it and in part because they may be reluctant to bring up a topic that is seen as stigmatising and uncomfortable. My own best estimate is that FASD probably affects one to two per cent of children born in Canberra. This is not my area of epidemiological expertise, but I would be very surprised if, in Canberra, it exceeded three per cent.

Does this mean that FASD is not a big problem? Far from it. FASD is a life-long disability, typically affecting cognition and often impairing impulse control. It forever impacts a person's ability to work and contribute to society. One relatively small study found that 85 per cent of people with FASD that it surveyed were unemployed. The potential combination found in many people with FASD of poor impulse control, reduced ability to communicate or verbalise their thoughts, and diminished cognitive ability or academic achievement, increases frustrations for people and constrains their ability to deal with these frustrations constructively. One result is that people with FASD are really over-represented in the prison population. While people with FASD make up a small proportion of the overall population, they have been estimated to make up over 30 per cent of the population of one Australian prison. American and Canadian studies indicate that it is almost certainly more than 10 per cent of the population in prisons there. So each time we can prevent FASD, we dramatically alter someone's life course. From an economic perspective, it is the difference between that person relying on disability payments and supports, maybe for all of their life or most of their life, and potentially spending some of their life in jail, with all of the cost that that entails, and, on the other hand, having a person who is able to contribute to society through employment and in other ways that most, or all of us, on this call have the luxury of taking for granted.

I am conscious that we are all men, but I think we can take it as given that no mother wants their child to have FASD. This is important to set out for two reasons. First, some discussions of FASD have either explicitly or implicitly blamed mothers. This is stigmatising and unacceptable, and it is also counterproductive, because it can hinder women seeking help when they need it. The second reason to highlight this is that it reminds us that women are the most important allies in any government or public health effort to reduce the incidence of FASD.

From this starting point, we can assume that the majority of cases of FASD happen in one of three situations—one, lack of awareness of FASD and/or awareness of the connection between drinking and risk; two, consumption of alcohol prior to being aware of pregnancy; and, three, consumption of alcohol during pregnancy by a woman who is dependent on alcohol and unable to abstain from drinking. Having set out these three broad situations, we can now ask: how do we best empower women to make choices that will reduce the risks for their babies?

Let us start on the third case: women who are dependent on alcohol. In the ACT, 42 per cent of presentations to alcohol and other drug services are for alcohol as the primary drug of concern. The AOD sector—the alcohol and other drugs sector—does a fantastic job in prioritising women who are pregnant, or might soon be pregnant, for treatment. But this does blow out the queue for others, and it also means that long wait times may mean that some women who do not identify as pregnant will wait longer than ideal or not seek treatment because of wait times, and this is a real missed opportunity. That is because of the way that drinking can cause, or not cause, FASD.

We have suggested a number of ways of reducing waiting times for AOD treatment at the inquiry into the Drugs of Dependence Personal Use Amendment Bill 2021. There are also a number of useful responses to the first two situations, including educating and motivating fathers and families to support women in abstaining from alcohol when pregnant or potentially pregnant. But the most powerful thing is to reduce alcohol consumed in society more broadly. You might think it strange for me to say that, given how vocal I have attempted to be in advocating for drug decriminalisation for currently illicit drugs. However, we base our policies on minimising the health impacts from all drugs, including alcohol.

This change in perspective is especially important because the NHMRC has changed its advice in December last year. Alcohol went from being like food—where you can have some, just do not have too much because then you will become overweight, or you will have too much alcohol and that will increase your risks—to the NHMRC saying that any amount of alcohol for anyone creates some level of health risk. So, now alcohol has shifted to be more like cigarettes. So it is not a question of over-consumption anymore.

There are many other benefits to reducing overall societal consumption of alcohol, because it causes so many other harms, including domestic violence. The ACT government has many means at its disposable to reduce alcohol consumption in Canberra, and I hope later we can discuss some options for this. Thank you.

**THE CHAIR**: Thank you very much, Devin. Would you believe that that leads straight into my first question, which I prepared earlier: noting the influence of cultural and social norms around alcohol consumption and the effect that that can have on people who are pregnant, would you mind elaborating a bit more for the committee on what role you see the ACT government having in shifting that culture around drinking and particularly drinking to excess in the ACT.

**Dr Bowles**: Yes. The ACT government—as all state and territory governments do—has a number of policy levers that it can pull to reduce how alcohol focused our society is. This can include earlier lockouts for clubs. It can include increased licensing fees. One really important step could be rolling back the availability of online purchase of alcohol and delivery—and there are some particular benefits to that. The government is able to constrain alcohol outlet density. It could also impose a minimum price per standard drink.

More fundamentally, though, I would hazard a guess that most of you and most of your colleagues would be embarrassed to be seen taking donations from the tobacco industry. Given that alcohol now, our top scientific body says, is similar to tobacco in that any amount of consumption includes some risk, I wonder, if in 20 years' time, there will be a similar level of embarrassment about accepting political donations from the alcohol industry.

I note that the alcohol industry is very heavily represented on the liquor advisory board in a way that we would not invite, I presume, the tobacco industry to the table for similar discussions. You may come to the view that it is inappropriate to have the alcohol industry at the table for similar discussions. So there are a lot of policy levers and there are a lot of benefits to those. One of these is that, according to the AIHW, alcohol consumption is, from memory, the fifth greatest contributor to the burden of disease in Australia. That is really important. It also contributes a lot to domestic violence. There has been increased community and public and political attention on domestic violence and what we can do to reduce that. Alcohol is implicated in a large amount of domestic violence. So doing things like rolling back the online purchase of alcohol—with delivery 20 minutes later, because you are too intoxicated to go get some more yourself—would be a really positive step in a number of areas, including FASD.

**MR MILLIGAN**: You mentioned applying certain restrictions or penalties or raising the cost of alcohol as, mainly, a deterrent. But wouldn't the focus be better spent on the government running awareness programs and maybe putting more support or funding towards service providers like yourself to get out in the community, to our schools, to speak with mothers-to-be and what no, to talk about the effects of alcohol or even other drugs on a newborn or a baby to be born. Isn't it better to educate first?

**Dr Bowles**: Well, first of all, some of those proposals are really good, and certainly our sector would not mind additional income. However, I would not see those options as being mutually exclusive. So better education would be great, but you might recall that in my opening statement I suggested that one of the three primary reasons that women might be ingesting alcohol in a way that endangered their future baby, is because it happened before they knew they were pregnant. That happens; people do not always know as soon as they are pregnant. They may know about reducing alcohol consumption once they are aware that they are pregnant, but it may be too late once they learn that they are pregnant. So there you want to just reduce the general baseline level of alcohol consumption throughout society as the best way of protecting those women and enabling those women.

So, in that, we are positing that women are making decisions in an unconstrained way, but anecdotally what can happen in families or relationships where there is a lot of alcohol and perhaps other drug consumption, is that a woman who is attempting to limit her alcohol consumption may be socially sanctioned by her partner saying, "I don't want to spend the night with you because I want to have a good night," which means drinking a lot. So she is placed in the really invidious position of choosing between the alternatives of consuming alcohol, knowing that it is not going to be great for her baby, or estranging herself from her partner. And neither of those is in the baby's best interests. So I think the most parsimonious route would be reducing alcohol consumption overall throughout society. But, certainly, the suggestions or the ideas that you made just then all have merit as well.

**THE CHAIR**: Tremendous. Thank you, Devin. We will move onto Mr Pettersson for a substantive question.

**MR PETTERSSON**: Thank you. I have some questions regarding access to specialist alcohol treatment services in the ACT. In your opening statement you said that pregnant women are prioritised for these services. I was hoping that you could expand. Is there anything that the ACT government could do to further enhance access or better provide these services in the ACT?

**Dr Bowles**: Yes, there are a number of options available to the ACT government. Right now we know that many people wait a long time in queues, effectively, for AOD treatment. For residential treatment—which may be a good option for someone who really needs to reduce their alcohol consumption quite quickly, depending on other circumstances—those waiting times can be months-long. Services are well aware of the risks to pregnant women from the consumption of alcohol or other substances, so those women are prioritised when the service knows, and to the extent that that can happen, but the fact is that because there are often queues, even if you go to the front of the queue for residential services, it might mean that it is still going to be a few weeks before there is a spot.

So increasing funding generally to AOD services would be really useful, not just because of that but also because our concern is that a number of people in the community do not access AOD services because of perceptions of waiting times. It is not hard to imagine a woman realising she is pregnant, realising she has an issue with AOD—or alcohol in particular—feeling at great risk of being stigmatised for that and being somewhat emotionally conflicted. And because she believes she may not get access for a number of months she may not proactively seek the treatment, even though, in fact, she would be prioritised. So I think there are some options for active outreach by AOD services into the community, but I have not canvassed those specifically with my members.

**MR PETTERSSON**: Thank you.

**THE CHAIR**: Thank you, Devin. Were there any further questions, members?

**MR MILLIGAN**: No, all fine for me, thanks.

**MR PETTERSSON**: I had one more. With regard to the National Alliance for Action on Alcohol and the nine policy areas for state and territory governments to reduce the population's risk from alcohol harm, I was wondering if you could comment on the things that the ACT government is doing well when it comes to reducing alcohol harm and some of the things where the ACT government could be doing better.

**Dr Bowles**: The ACT government has funded things like Pregnant Pause, which has been, I think, good. However, my memory of the National Alliance for Action on Alcohol's most recent jurisdictional report card was that the ACT's positioning had declined rather precipitously, and we were now towards the bottom. So there are a lot of areas where we could be doing better. Lockouts would be quite helpful. This is before the National Alliance on Alcohol has made some of those assessments, but with the recent development of the whole world moving to the online purchase of everything, if we do not do something to stop online purchasing of alcohol, that is going to be a real problem. And particularly in the area of domestic violence, because we know most domestic violence happens behind closed doors and we know that alcohol is a major contributor. How major a contributor? Well, ask yourself why Endeavour Drinks group—which is to say BWS et cetera, from memory associated with Woolworths—is a major sponsor of White Ribbon, or has historically been. So White Ribbon has perhaps not articulated the link with alcohol and domestic violence as much as they might have. It is a really important link.

Effectively, what has happened with COVID is that a lot of our society's drinking has shifted back to home, and that has likely increased the risk of domestic violence. In the home-delivery-in-20-minutes model of alcohol purchasing, we are really heightening those risks. So that is one key thing where we could arrest a problem before it got too big—before there were too many vested interests on the Liquor Advisory Board, for instance, telling us not to do something; before big problems happen.

**MR PETTERSSON**: Thank you.

**THE CHAIR**: Great, thank you very much, Devin. We might leave it there. On behalf of the committee, I would really like to thank you for appearing before us today and answering our questions. A proof transcript will be forward to you to provide an opportunity to check and suggest any corrections. Once again, on behalf of the entire committee, I would like to thank you for appearing today.

**Dr Bowles**: Thank you very much.

**Short suspension.**

**GIORGI, MS CATERINA**, Chief Executive Officer, Foundation for Alcohol Research and Education

**THE CHAIR**: Welcome back, guys, girls and non-binary pals, to the ACT Legislative Assembly Standing Committee on Health and Community Wellbeing's public hearing into health screenings for children and adolescents in the ACT. Welcome, Caterina. Before we kick off with questions, would you like to start with a brief, no more than five minutes, opening statement for the committee?

**Ms Giorgi**: I would.

**THE CHAIR**: Thank you.

**Ms Giorgi**: I would like to start today by acknowledging the traditional owners of the land on which we meet, the Ngunnawal people, and to pay my respect to elders past and present. Thank you for the opportunity to appear today to talk about fetal alcohol spectrum disorder and ensuring that there are adequate systems and services in place to prevent FASD and support people with the condition. The COVID-19 pandemic has shown us that our health and wellbeing is the most important thing and the health and wellbeing of our families and communities should be at the forefront of the development of policies and programs to prevent FASD and to support people with FASD and their families.

FASD is the leading preventable developmental disability in Australia and is caused by alcohol exposure during pregnancy. It is a lifelong disability which results in behavioural, emotional and developmental challenges. No two people with FASD have the same support needs, and many people with FASD and their families struggle to get a diagnosis. Most have challenges navigating and receiving supports and many experience community misunderstandings and prejudice. The earlier a child with FASD gets an accurate diagnosis, the better their lifelong outcomes.

The ACT government has shown a strong commitment to preventing FASD. Minister Rachel Stephen-Smith was instrumental in progressing mandatory pregnancy health warnings on alcoholic products in Australia and New Zealand. The ACT government has also supported FARE's "pregnant pause" campaign through the health promotion grants program. That campaign has raised community awareness of the need to support alcohol-free pregnancies. The ACT government's support of "pregnant pause" also allowed FARE (Foundation for Alcohol Research and Education) to work with communities to understand the best ways to engage with people on alcohol and pregnancy. Lessons from this allowed FARE to seek federal funding for a multi-year campaign on alcohol and pregnancy which will launch later this year across Australia, including in the ACT.

While the ACT has a strong focus on prevention, greater supports are needed for people with FASD. For people living with FASD and their carers, having access to diagnosis, disability support, funding, services and early intervention results in better outcomes throughout their lives. However, the ACT does not have a FASD diagnostic clinic or support services. Children and young people with FASD are also over-represented in the criminal justice system, with a study undertaken in Banksia Hill in Western Australia showing that more than a third were diagnosed with FASD.

We commend the ACT for committing to raise the criminal age of intent in the ACT. In working towards this, it is important that children and young people in the criminal justice system are screened for FASD and that the opportunity for diagnosis is provided and supports are made available in the community. With the high prevalence of FASD in the criminal justice system, routine screening and diagnosis are critical to ensuring that people get the supports that they need.

Across the education, health and child protection sectors, a greater awareness of FASD is also needed. This will ensure that children and young people with FASD are supported to reach their full potential. This inquiry presents the ACT government with the opportunity to build on the work in prevention to improve the lives of people with FASD. Actions taken now can make a difference to the health and wellbeing of children, families and the broader community.

**THE CHAIR**: Tremendous. Thank you so much, Caterina. I will start us off with questions. My first one is: are you aware of any specific interventions that the ACT government has taken to implement the Senate inquiry's recommendations for an effective approach to prevention, diagnosis and support of FASD?

**Ms Giorgi**: Yes. The ACT government supported the prevention initiative of "pregnant pause" which FARE ran across the ACT. Most recently, we wrapped up a campaign which reached out to community heroes and encouraged and supported people to have alcohol-free pregnancies. The main things around action on FASD with the ACT government have been around prevention and also leadership around progressing alcohol pregnancy health warnings. More work needs to be done in diagnosis and screening, particularly in the criminal justice system, as I said in my opening statement. We think that there are some really great areas where the ACT government can take some action to be leading in that space now.

**THE CHAIR**: Thank you so much for your answer, Caterina. I will pass onto Mr Milligan.

**MR MILLIGAN**: Thank you, Chair; thank you, Caterina. Your submission mentions that the ACT does not have a FASD diagnostic service or support services. How important is it, do you think, to have this type of diagnostic service, given that in your report you make reference to the fact that particularly with young children at school sometimes their behaviour might be put down to them having ADHD? They are two quite different things. Obviously, FASD may interfere with learning difficulties. Can you elaborate a little on how important it is to have a diagnostic service and the support services around it?

**Ms Giorgi**: It is really important that there are health professionals who are FASD-informed, so that they have a really good understanding of what FASD is and a FASD diagnosis can be made. We do not have a FASD clinic in the ACT. There are child health clinics that can look at a range of different developmental problems and examine whether it could possibly be FASD. Having a specific FASD clinic would mean that we know that the health professionals that are involved in a diagnosis—and there are lots of different health professionals that are involved: an OT, a paediatrician, a psychologist—are all FASD-informed and are making a diagnosis and then referring people to get the supports that they need.

The closest specific FASD clinic is in Sydney. That clinic operates one day a week. We also know that getting access to supports, particularly through the public system—when you think about accessing paediatricians—does take time. The more people that we have who are aware of FASD—if you can make a diagnosis—the better it is and the easier it is for people to get an earlier diagnosis so that they can have better life outcomes and better opportunities throughout their life.

**MR MILLIGAN**: Just as a supplementary. If Sydney has one diagnostic clinic and operates one day a week, what type of level do you think would be required for the ACT—half a day, a day, a week?

**Ms Giorgi**: That is a really good question. We know that there are definitely not enough clinics across Australia. That is the first thing to say. The clinics that do exist are not operating enough and the waitlists are really long. We have heard of waitlists that can be a year. A year, particularly at those pivotal moments in a person's life, can be far too long. We would need to look at a potential pilot in the ACT, where they could model and try it for a short period and see whether it worked and what the demand would be. Starting with one day a week, like Sydney, would be a good starting point to ascertain the demand and to make sure that the staff are upskilled to be FASD-aware.

**MR PETTERSSON**: Caterina, can you tell the committee what role you see for the ACT government in improving the access of people with FASD to the NDIS?

**Ms Giorgi**: That is a great question. There was a lot of concern from people with FASD and their parents, carers and families about the possible exclusion from the NDIS earlier in the year and also concern around moving to individual assessments. What we know is that to get a good diagnosis or to get the supports that people need it is good for them to have a relationship with the person who is helping them to understand what FASD is. Then they can better understand the sorts of supports that the person needs. It is really important that the ACT government does not support those individual assessments. It is also really important that people who work within the NDIS and other systems that have interaction with people with FASD have a good understanding of what FASD is so then people who are accessing those support services get the range and scope of support services that they need.

**MR PETTERSSON**: In terms of data collection, are any jurisdictions doing data collection for FASD well or at all?

**Ms Giorgi**: We need a better system for collecting data. There was a recommendation that came out of the national strategy to have a look at a prevalence study. The Australian government is looking at how that would be done. It is difficult for a range of reasons. One is that we do not routinely assess prenatal alcohol consumption. Another is that, when it comes to diagnosing FASD, if there are not a lot of diagnostic clinics, then there is not a lot of diagnosis that is happening. We spoke a little in our submission about the over-representation of people with FASD in the criminal justice system. We think that this is a really good opportunity for the ACT government at the moment, particularly as they are looking at increasing the age of criminal intent, because of the over-representation of children and young people with FASD in the criminal justice system.

As a starting point for data collection, for example, a prevalence study of FASD within a criminal justice setting and then moving towards making sure that those people get supports for their FASD and access to NDIS and supports in the community to stop people going into and out of the criminal justice system would be a good start. Other examinations of FASD in settings like the child protection setting or out of home care are other environments to have a look at the prevalence of FASD, because we know that there is an over-representation of people with FASD in those different settings.

**MR PETTERSSON**: Thank you.

**THE CHAIR**: I note that we are five minutes ahead of schedule, which is rare in these things, so it does give me an opportunity to ask another question. You made a recommendation regarding the improvement of data collection on the rates of drinking during pregnancy. Can you talk us through what sensitivities you are considering in the approach to collecting this data and how you would expect these surveys to take into consideration the risk of stigma or discrimination?

**Ms Giorgi**: That is an excellent question. This is something that we are really conscious of. It is really important, when we are talking about fetal alcohol spectrum disorder, to understand that we all want the best for our babies and that, when people find out that they are pregnant, they do all they can to try and make sure that that pregnancy is healthy and that that baby is healthy. What we need to do in the systems that we create and the supports that we provide is to make sure that they are enabling people to get supports, rather than creating stigma.

It is important that alcohol questions are routinely asked in the way that other questions are routinely asked during pregnancy. It is really important that it is not just a yes-no question. What happens is that you can ask questions in a range of ways. You can ask, “How many drinks are you currently having?” to really unpack the situation that the person is in. It is important that that information is voluntary.

It is also important that, when that information is disclosed, the health professional understands the range of pathways that are available to help the person get support. I have, unfortunately, heard too many stories from people who have indicated that they disclosed alcohol use during pregnancy and the health professional either said to them, “Well, you probably shouldn’t do that and stop,” or was not quite sure where to refer them or the help that they needed. Often it is that one point where someone is reaching out to help that it is really important that that help is provided.

In thinking about support services that are available, we also have to think about support services for women who might be alcohol dependent. That includes support services that allow them to have their child with them and also make sure that, if they disclose information about their alcohol use, they know that it is to help them to get help and help them to get the support they need, and for no other reason than that.

**THE CHAIR**: Caterina, thank you again for appearing before the committee today and answering our questions. When it is available, a proof transcript will be forwarded to you to provide an opportunity to check the transcript and suggest any corrections. Once again, on behalf of all members of the committee, thank you so much for making time to appear today.

**Ms Giorgi**: Thank you for having me and thank you for including FASD in the terms of reference.

**Short suspension.**

**DEAN, MR LACHLAN**, Programs Manager, Ted Noffs Foundation

**THE CHAIR**: Welcome back, friends, to the final portion of the Legislative Assembly's public hearing into child and young people health screenings here in the ACT with the health and community wellbeing committee. Lachlan, can you please acknowledge that you have received a copy of the privilege statement and understand it?

**Mr Dean**: Yes, I have, and I understand it.

**THE CHAIR**: If you would like to start with a short, no more than five minutes, opening statement for the committee, we would appreciate that.

**Mr Dean**: We work with young people in the ACT through the ages of 12 to 25. We have been doing it for the last 20 years or so, working around drug and alcohol support for young people. We work with young people from a whole heap of different backgrounds. I guess one of the things that we notice is that drug use probably does not discriminate against where young people are born, how they are raised or anything like that. One of the things that we are seeing for young people is that the issue does not tend to go away. With each generation that comes along the same problems come up. Being able to address that on a much broader scale is pretty important for young people.

When I first started working in the drug and alcohol field 14 years ago we were doing a lot of support with schools. We were doing a lot of education stuff with schools around supporting young people and trying to get better health outcomes. About 10 years ago we stopped doing those support services in schools. It is part of our funding contracts that we are not allowed to provide any drug and alcohol information into schools; it is actually written into our contracts.

That, I guess, leaves schools in a predicament where they are relying on their teachers to provide that drug and alcohol information. We probably get close to 40 requests every term from principals and teachers seeking support for their young people around drug and alcohol support. The other aspect is that parents and teachers want support around how to work with young people who have drug and alcohol issues. There is some significant stuff that could be done in the education system around supporting young people in terms of using a harm min approach to drug and alcohol use in the ACT, but this sort of gets left undone.

The other thing that I would raise is that there is a strong need for greater access to drug and alcohol counselling support in the ACT. We are generally full to capacity all the time for young people. We have two drug and alcohol counsellors that are specialists in the field. That is across the whole of the ACT. We work with close to 40 young people at a time but are constantly doing assessments and reassessments. The referrals come in pretty thick and fast. There is a pretty big scope to increase that level. Since the pandemic, since we have shut down this time around, the actual demand on our service has gone up incredibly. So there is definitely a need for actually putting in some support for young people around drug and alcohol use.

**THE CHAIR**: Thank you, Lachlan. I will start with the first question. Both your organisation, the Ted Noffs Foundation, and ATODA have recommended the development of a strong drugs education policy in ACT schools. There have been other forums that the Assembly has hosted where we have heard similar evidence about the need for increased drug education. What is the opportunity that you see here and, importantly, what are some of the risks or challenges in implementing a drug education program in ACT schools, from your experience?

**Mr Dean**: I think the opportunities are that we have staff that are already engaged with schools across the ACT, so counselling support one on one with young people in school settings. We are on pretty good terms with a hell of a lot of principals and deputies across the ACT. I have met with the education department around what supports we can put in place. It does not require much—this is probably the important thing—and it is not like it is a huge investment for what you get out of it.

I think that, in terms of the impact, not every kid that goes through school is going to use drugs and not every kid is going to need drug and alcohol counselling to the level that we offer. But there are accidents and things that happen that can be absolutely avoided through education. I think that we have young people who do not actually know what they are using, the effects or the long-term effects, or have any resilience around being able to talk about drug use, this hidden thing in our society that we just cannot be named.

In terms of the challenges, I think there is a worry that it might condone drug use. That is probably an aspect that comes up with this. But it is also around at what age do you start providing information and education for young people. That is also a challenge that could probably have some debate around it. I would be pretty keen to suggest that year 7 onwards is that age range, just because it is where we start to see a pretty big pick-up in drug use. We also see it in year 6, but I think that might be a bit harder to sell.

**THE CHAIR**: Thank you, Lachlan. Mr Milligan.

**MR MILLIGAN**: Thank you, Chair; thank you, Lachlan. My original question was, in part, the same as Mr Davis's. Just to extend on that, providing that extra education through our schools here in the territory, currently you have two counsellors; is that correct?

**Mr Dean**: Yes.

**MR MILLIGAN**: How many would you see that we would need to cater for the demand, to cater for providing that support that is needed for our students here in the ACT, and what additional cost of funding would that require?

**Mr Dean**: To meet the need for outreach counselling, so just doing counselling for those clients that need it, probably another two counsellors across the ACT would quite easily meet the need for young people who are at that pointy end who need the intervention. In terms of school support, that can be done with two staff. In terms of something that we currently get from the ACT government, it would probably be an extra $200,000 a year—around that.

**MR MILLIGAN**: That would provide two additional counsellors and also meet the current needs?

**Mr Dean**: If we factored in all the admin stuff and everything like that, maybe three, but not a huge expense, if that makes sense.

**MR MILLIGAN**: Thank you, Lachlan.

**MR PETTERSSON**: Lachlan, one of the things that caught my eye in the submission—and I am putting on my hat as member for Yerrabi—is that you highlighted the lack of youth services in some of the newer or younger regions of Canberra—that is, Gungahlin. What services would you recommend for a region like Gungahlin?

**Mr Dean**: We have experimented with a whole heap of engagement services at Noffs as an organisation. The model that I would suggest is an engagement model. We have got a Street Uni that operates in the city. It has really strong impacts around reducing crime and reducing drug use for young people but also building, I guess, community amongst young people. It is about having a space that is not set up as a youth centre; so the place where you actually go to do things, as opposed to just going to hang out.

It also needs to have an element of treatment involved. You need to have counsellors attached that can jump into brief interventions and across a spectrum of people. So it is about knowing that we are going to have young people that come in who just need to build community and are able to interact with other young people in a safe setting all the way through to really problematic, troubled teenagers who need a lot of intervention and support.

By being able to cater across that, you do not stigmatise it. Street Uni has got a bit of a front; we do a lot of hip-hop and dance and a whole heap of other things. No-one would ever know why you are going into the Street Uni. You do not go there because you need drug and alcohol support; the reasons are unclear. We are a health service, but we do huge amounts more work than just that. Young people do not feel a sense of stigma when they go there. Also, there are things happening in those spaces that teach skills that are productive. Young people are expected to participate in things and it is not just a passive service, I guess.

For Gungahlin in particular, there is the light rail going out there, but Canberra has some big divides of young people. If you really get down to it, we are a pretty well-off city, but there are some young people that are out on the fringes. When I say that, they are out in those further areas that do not have access to support. They do not have someone that they can talk to. As much as we can say that public transport is fantastic, even though it is pretty good in the ACT, it is still not really accessible. We do a lot of our outreach to schools in those areas because young people just cannot make it in.

**MR PETTERSSON**: Thank you.

**THE CHAIR**: Lachlan, you kind of answered it in your answer to the last question, but I would like to elaborate on it a bit further. In saying that there is a shortage of youth, alcohol and drug counsellors in the ACT, one of the risks I find associated with this question, particularly from the broader electorate, who may not be as across the issue as you are, is that they say, “There’s a problem. Government should throw money at it.” But if there is one thing this committee keeps hearing in the health space, it is that there is a shortage of specialists in a whole range of areas of health provision. Is that your experience of alcohol and other drug counsellors? Essentially, are you confident as a professional in the sector that, if we funded those positions, we would be able to recruit and retain appropriate staff?

**Mr Dean**: Absolutely, yes. We have got rehab that we run out at Watson. We have 30-odd staff that are employed in the ACT. Drug and alcohol staff are actually notoriously hard to recruit in the ACT for adults. We take a different approach around the drug and alcohol stuff; it is about the relationships that you build. We need counsellors that can connect with young people. If they can do that, the rest sort of follows.

With the age group that we are working with, drug and alcohol use is generally a way that they are dealing with the issues that are coming up. It is probably like 10 per cent of what we are working on. It is absolutely the visible aspect of the trouble that the young person is going through. We want people who can actually support a young person through a whole range of supports.

In doing that, we have got training modules and a whole heap of stuff that we do with our staff to upskill them. I do not think we would find it hard in terms of our recruitment staff that we have had for the last 10 years. I think the longest we have gone in not being able to fill one of those adolescent family counsellor roles was probably about three weeks. So it is not hard at all for us.

**THE CHAIR**: That is surprising and encouraging.

**MR PETTERSSON**: Can you talk me through maybe some of the common pathways that a young person that is experiencing harm from alcohol use might proceed through in the ACT in trying to get help?

**Mr Dean**: Just alcohol or drug and alcohol?

**MR PETTERSSON**: Just alcohol.

**Mr Dean**: For someone who has problematic drinking or has some concerns around it, depending on their age and their circumstances, normally an intervention is going to come from outside of that young person. It is going to be a family member, a friend, an aunt, an uncle or sometimes police—some police liaison referrals come through about young people being intoxicated out in the street—CYPS or school counsellors.

Generally, the young person is using it to manage whatever is going on for them. Young people do not drink excessively every night because everything is wonderful; there is generally something else going on. They are probably not seeing that drinking as the issue. They know that there is an underlying thing there that is probably what they need to deal with. So it is probably going to come external from them.

We normally would get a phone call. It would come through from family, a carer or whoever it was. We would then ask that they encourage that young person to give us a call. We would have a quick, probably 10- or 15-minute chat with them just to make sure that they are in the right age range and that there is some substance use stuff going on there, whether it is their substance use or somebody else's.

We then get one of our counsellors to book in a session with them to do a further assessment, which would probably take about 45 minutes, and that is when we are looking at that whole-of-life stuff. Then it would just be straight into the counselling. From start to finish, we could probably have that process done within 24 hours at the longest. Normally we would get a referral. If we were going to a school, for instance, we might book in to see that young person in the next week. But if there are pretty big concerns, we would make some calls and action that up pretty quickly.

**MR PETTERSSON**: Thank you.

**THE CHAIR**: Lachlan, thank you for your time this afternoon, for answering our questions and for your submission. When it is available, a proof transcript will be sent to you to provide you an opportunity to check and suggest any corrections. Once again, on behalf of the whole committee, thank you very much for appearing today.

Before we conclude, I remind everyone who appeared today that if you undertook to provide any further information or took questions on notice during the course of the hearing that, while the committee has not set a deadline for the receipt of those responses, answers to questions would be appreciated within two weeks of today's hearing. I thank everyone who has provided one of the 10 submissions and appeared before us today.

**The committee adjourned at 4.39 pm.**