LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING

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

Members:

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

TRANSCRIPT OF EVIDENCE

CANBERRA

MONDAY, 21 FEBRUARY 2022

Secretary to the committee:
Dr D Monk (Ph: 620 50129)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

Privilege statement

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Amended 20 May 2013

The committee met at 10.05 am.

Appearances:

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

ACT Health Directorate
Moore, Dr Elizabeth, Coordinator-General Mental Health; Office for Mental Health and Wellbeing
Cross, Ms Rebecca, Director-General
Garrett, Ms Cheryl, Executive Branch Manager; Mental Health Policy and Strategy

Canberra Health Services
Peffer, Mr Dave, Chief Executive Officer
Rea, Ms Katrina, Executive Director; Mental Health, Justice Health and Alcohol and Drug Health Services

Community Services Directorate
Rule, Ms Catherine, Director-General
Pappas, Ms Helen, Executive Group Manager; Children, Youth and Families
Evans, Ms Jacinta, Executive Group Manager; Strategic Policy
Summerrell, Mrs Jessica, Executive Branch Manager; Social and Community Inclusion
Conway, Ms Sarah, Executive Branch Manager; Social Recovery

THE CHAIR: Good morning, guys, gals and non-binary pals; welcome to the first public hearing of the Standing Committee on Health and Community Wellbeing into the ACT government's annual reports for 2020-21. Today's witnesses comprise Minister Emma Davidson and officials. The minister will be appearing in her capacity as the Minister for Justice Health, the Minister for Mental Health and the Assistant Minister for Seniors, Veterans, Families and Community Services.

The committee wishes to acknowledge the traditional custodians of the land that we are meeting on, the Ngunnawal people. The committee wishes to acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region. We would also like to acknowledge and welcome any Aboriginal or Torres Strait Islander peoples who may be attending today.

When witnesses speak for the first time, could they acknowledge that they have read and understood the privilege statement that the secretary has already sent through? Should you take a question on notice today, it would be very useful if you could please state clearly that you will take that as a question on notice. This helps our secretariat and our witnesses to confirm those questions and follow up after today's hearings. Today's proceedings are being recorded and they will be transcribed and published by Hansard. We are also being broadcast and web streamed live.

I welcome Minister Emma Davidson, who will be appearing in this session in her

capacity as Minister for Justice Health and Minister for Mental Health. I remind all witnesses of the protections and obligations that are afforded to you through parliamentary privilege, and I draw your attention to that privilege statement.

I will kick off with our first question, Minister. I am picking up where we left off last time, around young people and the ACT youth portal. In the annual report, Minister, you note that the 2019 *Review of children and young people in the ACT* made that recommendation to establish the online portal for young people, for the purposes of triage and navigation. Could you please tell us what you discovered through the process of consultation and stakeholder engagement with young people in this process? Very specifically, I am keen to know what the main mental health issues are that you found are facing young people, and how this online portal will help them to facilitate appropriate services.

Ms Davidson: Thank you for the question. Before I pass over to the Coordinator-General from the Office for Mental Health and Wellbeing to talk in more detail about youth mental health and the portal, there are a lot of things that have changed between 2019 and today about what is happening with young people and their mental health, and the kind of stressors that they are experiencing.

We know that some of those are intensified by what they have experienced through the pandemic in terms of social isolation, economic insecurity and the impact on their education. We do need to take those things into account, but we do have very good, flexible health systems that can support young people through all of those things. I will pass over to Dr Elizabeth Moore to talk in more detail about youth mental health.

Dr Moore: I have read and understood the witness statement. That was a multipart question. What we discovered in the context of our new children and young person's review, which led to MindMap, as well as being a recommendation of the Youth Advisory Council, was that children and young adults wanted to understand more clearly the psychological issues that were affecting them, including anxiety and depression. We know from surveys that the ACT has a high rate of anxiety in its young people. The reasons for this are not quite clear. We have a highly educated population; of course, the recent pandemic has caused its own issues.

They were very clear, in the process of developing the MindMap portal, which was done in the co-design process, that they wanted to have control over the information that was on the portal. They wanted to be able to explore the various options for information. That included other applications, other sites, and they wanted to be able to see what services were available through the ACT and how that might be suitable for them. It was almost like online shopping, as they described it to us. You can place in various elements, like age, sex, what you are interested in, and then they wanted to have some recommendations. They also wanted the flexibility to look for themselves.

MindMap was co-designed. It was tested by members of our youth advisory committee. It was tested by members of our children and young person's community of practice, and it was launched by the minister in October last year. It has a back end, because the other thing that young people said was that they wanted also to be able to speak to somebody if they needed to. MindMap is a partnership with Marymead, who

have both clinical and non-clinical navigators at the back end.

The service itself has been accessed—and I will have to refer to my notes here—by many people, both by adults who are looking for information for their children, and children and young people themselves. There was one particularly heartwarming story that one young person, who previously had not accessed services, took advantage of what we call the "active hold". That is when a person is waiting for a service at another service; they can be supported by Marymead whilst accessing that service. It was the first time that that young person had actually accessed any service of any sort.

The other interesting thing is that we have a larger number of boys accessing the service than would be expected. I take this as a positive because young men do have some difficulty seeking help. That has been a positive in terms of MindMap, and we will continue to monitor it.

THE CHAIR: I have a quick follow-up on MindMap. There are a couple of figures that I would be interested in, and I am more than happy for you to take them on notice: the total number of young people that have accessed the service since it was launched; and a breakdown of any other data that the website collects, including an age breakdown, locality breakdown and gender breakdown, if there is any such information that we are making an effort to collect.

Ms Davidson: We can certainly take that on notice. With the locality breakdown, you will probably find that we can give you some accuracy about how many people are accessing the service from within Canberra; but once you get inside Canberra, I do not think that we can give you accuracy as to how many people are from Belconnen versus Tuggeranong, for example. It is a portal, a website; web analytics data and the geographic pinpointing can only go down so far while maintaining accuracy.

THE CHAIR: You know me too well, Minister; you know I wanted to find out how many Tuggeranong kids were using it, but there we go.

Dr Moore: If I could add to that, there have been over 5,500 page visits. Because we do not collect individual IP addresses, we do not know how many of those are return visits, unless the person actually says that.

Ms Davidson: The other really useful point, with reference to what Dr Moore was saying about young men and boys accessing the service, is that this complements nicely the prevention work that has been done through programs like Youth Aware of Mental Health. The feedback that we get about that program is that it helps to reduce the stigma about asking for help and knowing who you can talk to.

This is adding to that, and building on that. When you put all of these programs together, over a period of time we will start to see, hopefully, more young people, who previously might not have spoken up and said that they would like to talk to someone, finding that they can do that, and knowing where they can go to do that.

MR PETTERSSON: Is there any form of measurement of how many actual referrals from the website are taking place?

Ms Davidson: In terms of referrals to other services and what kinds of services people are being referred to; is that what you are looking for there?

MR PETTERSSON: I am trying to go beyond how many website page visits we have; do we have some measure as to what it actually translates to in the real world?

Ms Davidson: I will pass back to Dr Moore in a moment. You will probably get more useful information about this towards the end of the year, and I would be very happy to provide that, given that it only launched in October. We have not had a long period of time yet to see what is emerging. We do know that, in the ACT, there are peaks and troughs over the year, where people are looking for help of a particular type at certain times of the year.

In particular, with the influx of young people coming back for university in the ACT this year, some of them will be new students, and some of them will be coming back after not being able to do much last year because of the restrictions. If we have a conversation towards the end of the year about what we are seeing in terms of referrals, that will probably give you more useful information. Do we have any early indicators?

Dr Moore: We do not. Part of the process of MindMap is empowering young people to educate themselves to get strategies without referral to services. If you look at the continuum of care, we are trying to empower young people to look at their own strategies. If they need to access services, then those are the services they access. When we look at the evaluation of MindMap, which we are currently doing, we are looking at, first of all, the process of setting up MindMap; then we would look at the outcomes. As the minister says, we will be able to provide you with a bit more of that nuanced detail towards the end of the year.

MR PETTERSSON: That is fair enough. Have any service providers given any feedback about increased demand for their services?

Ms Davidson: I could probably take that on notice to see whether any particular services are talking about increased demand. We have a really diverse range of services, though. Some of the services that we have in the ACT target particularly at-risk young people who we know had a very hard time during the second half of last year. They may be experiencing higher demand and it may not be related to the kind of generalised issues that the broader community is seeing but to more specific things for young people that are experiencing a combination of mental health and homelessness, drug and alcohol and that sort of thing.

MS CASTLEY: While we are talking about youth mental health, the committee did an investigation into youth and mental health; 66 recommendations from the committee came out of that, with the government agreeing to 44 of them and noting 20. In October last year we found out that 16 of those recommendations have been completed. Could we get an update on how the rest of those recommendations are going?

Ms Davidson: Yes, we can provide you with some more information about that. I will pass to Dr Moore to talk in some more detail about those recommendations.

Dr Moore: With respect to the recommendations, we gave an answer to a question on notice last year, and the minister spoke to that. Because we need to go out to all of the different directorates, I am happy to take that on notice and provide that later.

MS CASTLEY: Wonderful; thank you.

MR MILLIGAN: Minister, I understand that you attended a meeting with the Aboriginal and Torres Strait Islander communities on 25 March 2021 to discuss the need for a board of inquiry to investigate the over-representation of Aboriginal and Torres Strait Islander individuals in our ACT criminal justice system. As I understand it, to date, the government has not said either yes or no to having a board of inquiry. It seems that you attended that round table and you were involved in those discussions. What pros and cons do you think there are in opening a board of inquiry on the over-representation of Aboriginal and Torres Strait Islander peoples in our justice system?

Ms Davidson: There are two things going on there that I think are really important for us to talk about. One is that broader issue of over-representation and how we can turn that around and make some broader changes there. Part of that is about having a conversation about what people's experiences have been and how that has impacted on the community. It is really important that we find ways of being able to do that which are supportive of people who have had those really difficult experiences and make sure that they are well supported through that process.

The other thing is to look at what we can do right now that improves the experiences that people have when they engage with the justice system—and, from my perspective, particularly for their health and wellbeing. Those are the things that we are looking at. We have been looking at how we can make improvements there and better support people.

We have made some changes over the course of the last year that we think will be helpful. Some of that has come about through what we experienced in the pandemic. For example, the restrictions meant that people in the AMC were not going to be able to have as many visitors, or have as much access to things in the community as had previously been the case. We provided some additional funding for both Justice Health and Winnunga to be able to better support the community—and, from Winnunga's perspective, also to make sure that they could support the family and friends of people in the AMC who they could not see.

There are things that we are doing at the moment to try and make improvements there. You will probably notice as well that in the last budget there was some additional funding for Winnunga to provide additional nurses and mental health care for people in the AMC, and that will also be helpful. We are always interested in having a conversation about what else we can do.

MR MILLIGAN: Since that meeting you had with the community back in March, have you had further discussions with the individuals that attended that meeting, in person?

Ms Davidson: Conversations are ongoing, and we will continue to work through that. There is a lot to unpack there. If we are going to do something that will have really far-reaching improvements, it is worth taking the time to have those conversations.

MR PETTERSSON: I saw the news over the weekend about the residential eating disorder clinic. Could you update the committee on what is next for the project?

Ms Davidson: I expect to be reporting back to the Assembly in more detail in the next month or so about the whole range of eating disorder services that we have in the ACT. As you know, we have also recently launched the eating disorders clinical hub, which is great, because that will bring together all of the different services to be able to exchange information and build skills across sectors in the ACT that are working on this.

The residential centre has gone out for a concept design. I am expecting that, over the next couple of months, work will continue on that concept design. That will include consultations with clinical health experts, as well as people with lived experience and the local community, to make sure that we are building something that will work well into the future to meet people's needs. Construction is likely to commence at the end of this year and we should have construction complete by the end of next year.

MR PETTERSSON: Has a clinical model been decided upon?

Ms Davidson: I will hand over to ACT Health, to Rebecca Cross, who can talk in more detail about that. This is part of the territory-wide model of eating disorder services. There was a reference group that included clinical experts; NGOs who have been working in this space; people with lived experience; and academic experts, all coming together as part of that reference group to talk about all of the different aspects of how we work with people who are experiencing eating disorders. That includes working with their family and carers, to make sure that they are well supported to stay in recovery. I will hand over to Rebecca to talk more about that.

Ms Cross: I have read and understood the privilege statement. We have two officials here who can take your questions on the eating disorder centre—Liz Lopa, who is managing the build, and Cheryl Garrett, who is looking at the model of care and all of that other work. I might ask Ms Garrett to take your question first, and see where we go from there.

Ms Garrett: I acknowledge that I have read and understood the privilege statement. The minister referred to the territory-wide model of care for eating disorders. This is a stepped care model that will incorporate all of the new services that are being established to support people with eating disorders. There is a draft model of care that has been developed for the residential treatment centre. It is in draft, acknowledging that there is some further work to be done as the design concept is progressed and there is further consultation undertaken through the reference group and the steering committee.

MR PETTERSSON: Seeing that we have a draft model, do we have any idea who the service providers will be? Will they be CHS employees or an outside provider?

Ms Davidson: That decision about exactly who the service provider will be has not been finalised yet. The reference group for this piece of work did talk about the differences between when some services might be best delivered by public health services like CHS and when they might be best delivered by NGOs who have experience in that aspect of that particular type of service delivery.

The territory-wide model for eating disorder services incorporates a whole range of different services—sociocultural, psychological and clinical services. Some of those are services that CHS has been delivering for some time and has experience in. Some of these services will be new to the ACT. We might want to bring in some expertise and build our skills and knowledge so that we are able to do something that meets people's long-term needs and keeps them in a recovery state for as long as possible.

MR PETTERSSON: Is there a risk to the continuity of care if we have an outside provider providing these services?

Ms Davidson: This is one of the great benefits of having the eating disorders clinical hub that was launched in January. I think that started on 25 January. It provides the ability for the people who are working across the different types of services to be able to exchange knowledge and integrate that care in a way that we have not been able to do previously. That means you can get the care that you need at that point in your journey with your mental health condition from the right service provider who can deliver the right type of service for where you are at right now, while still maintaining that continuity across the entire journey.

MR PETTERSSON: When do you expect a decision to be made about who the service provider will be?

Ms Davidson: I might pass back to Cheryl to talk about the time line for when that decision will be made.

Ms Garrett: We do not have a time frame for the delivery of the finalisation of the model of care. It is happening this year, so we will be working through the steering committee, reference group and the design consultant as that process happens for the design of the residential treatment centre, and provide advice to the minister and government about the final model of care.

MS CASTLEY: Minister, can I just confirm that the residential centre will be open, did you say, by the end of next year, 2023?

Ms Davidson: We are expecting construction to start at the end of this year, at the end of 2022, and construction to be complete at the end of 2023.

MS CASTLEY: Opening, we would expect, in early 2024?

Ms Davidson: I would expect so. This is all in line with the previous time lines that have been talked about. As you know, this is a piece of work that was funded using some money provided by commonwealth.

MS CASTLEY: Has the site been confirmed yet? Is it Coombs? I am just unsure of

that.

Ms Davidson: We have a preferred site. The process of confirming how much of that site that we need for the eating disorders residential centre will be part of the work that is being done with this concept design.

MS CASTLEY: When will we know that?

Ms Davidson: We should have the concept design complete by sometime in late May, I believe. Then I understand the work on securing that site and how much of it is going to be used for the eating disorders residential centre will happen after that.

MRS KIKKERT: My question is in regard to smoking cessation at the prison. Since 2015 the government have been talking about banning or phasing out smoking within the prison. However, the inspector observed that they are still smoking outdoors and also indoors regularly after prison. Has the smoking cessation pilot been attempted recently?

Ms Davidson: Yes. Before I hand over to Canberra Health Services to talk in more detail about the work that is being done on the smoking cessation pilot and how that work is progressing, this is one of those areas of work that requires Justice Health working collectively with the corrections officers to find a solution that is going to work in practice and within the constraints of the workplace that they are in. It is really important that we make sure that it is a safe and healthy workplace for everyone who is working there and also that we are well supporting people who are in the AMC and who might be using smoking to manage the stress that they are experiencing.

There has been quite a lot of disruption happening over the past year, with public health restrictions making it harder for people to do some of the things that they would normally do to manage their stress and anxiety—going through changes to programs. We may find that there are some things that have not been able to progress quite as fast as we would like but we are continuing to work on that. I will pass over to Canberra Health Services to talk in more detail.

Ms Rea: Thank you for the question. I acknowledge that I have read and understood the privilege statement. There has been a pilot study that did occur on smoking cessation with a number of detainees last year at AMC. There was a small number who engaged in that program, and a small number who, I guess, completed that program as well. Canberra Health Services, along with corrections, are very committed to harm minimisation in this space. But it is, as the minister has suggested, something we need to work collaboratively on with our corrections colleagues. A lot of the challenges attributed to managing COVID in the environment, as well as staffing implications that that has had over the last year, has made that a challenging pilot to progress.

However, as suggested, we are always supportive of harm minimisation strategies. It is important to understand as well that it is obviously not just the wellbeing of our detainees that is impacted, it is also the wellbeing of people working in that environment.

There are other strategies that we put in place as well when staff are going to care for individuals. We try and ensure that there is a time period of smoking cessation prior to providing treatment in other health centre environments where our staff work, to mitigate any of the passive smoking risks as well in that space.

MRS KIKKERT: If it is a priority for corrections officers' wellbeing as well as detainees' wellbeing, why is it that smoking is allowed indoors?

Ms Rea: I would have to refer to our corrections team but my understanding is it is because it is a human rights prison and that that is supported in the ACT at the moment. Corrections would need to comment on the longer term strategy for smoking cessation in that environment.

MRS KIKKERT: In this case, human rights trumps the health of corrections officers and detainees?

Ms Davidson: I think what we are trying to pass on is that, if you want to talk in more detail about why smoking is permitted in some indoor environments that are not part of the health centre, you are probably best off asking that question of the Minister for Corrections.

MRS KIKKERT: The annual report states that the WorkSafe improvement notice was issued to corrections services and that the notice indicated that there was a failure to adequately enforce compliance with the corrections management smoking policy. Why did WorkSafe believe this was the case?

Ms Davidson: That sounds like a good question for the Minister for Corrections.

MRS KIKKERT: Have you been given an evaluation report about the pilot of the smoking cessation?

Ms Davidson: I can pass over to Canberra Health Services to talk about whether there has been an evaluation of that pilot.

Ms Rea: The evaluation has not been concluded for that pilot, but I am more than happy to provide some time frames on notice in terms of when we can expect to see the data that has come out of that pilot study.

MRS KIKKERT: Have you received any complaints from corrections officers of smoking indoors regularly because it interferes with their health?

Ms Rea: Complaints from corrections officers, you are looking for—

MRS KIKKERT: And detainees.

Ms Rea: To Justice Health?

MRS KIKKERT: That is correct, about smoking indoors regularly.

Ms Rea: I can take that on notice. We can check whether we have received any of

those.

MRS KIKKERT: Also, how many.

Ms Rea: Yes, how many.

MS CASTLEY: I am keen to talk about and understand workplace culture. I refer to the final report of the independent review into workplace culture. This happened in March 2019. The former health minister responded that the government would implement all 20 recommendations over a three-year period. That means they should all be implemented by May this year. Minister Stephen-Smith said only five recommendations had been completed. I am just interested if you could talk me through the recommendations and how many related to mental health.

Ms Davidson: This culture reform work takes place across a number of areas that cover ACT Health, Canberra Health Services, as well as Calvary. I might pass to Rebecca Cross to talk about this in a moment, but work has continued to progress and, even with all the increased pressures and workloads that have happened over the past two years, but last year in particular, I can tell you only about the things that I was there for.

Work has continued to progress through that working group—and I think it says a lot about people's commitment to wanting to have better workplace culture—they have continued to come together and talk really openly about the ways in which they are trying to improve things, and learning from each other's experience about things that have been implemented in different parts of our health systems across Canberra to try to do that. I will pass to Rebecca Cross to talk in more detail about those recommendations.

Ms Cross: I think, as a broad statement, all the recommendations of the culture review are aimed at improving the health and wellbeing of our staff in the health services and, whether they are specifically identified as mental health or not, the overall intent was to improve that mental health and wellbeing.

Of the recommendations, there are a number of actions that sit under each recommendation. Of the recommendations, there are also 92 actions. The last advice that I have is that 65 of the actions have been completed, there are a further six pending closure, 13 are on track and 14 that we are actively managing so that they should be finished by 30 June this year. Again, if you pick that up to the recommendations, we are expecting all of them to be completed by 30 June.

MS CASTLEY: The report talked about bullying and workplace culture in CHS. Can you tell me how many of the 400 submissions were from mental health workers?

Ms Davidson: I will pass to CHS to talk in more detail about how many were from mental health.

Mr Peffer: I acknowledge and have read the privilege statement. We will be able to take that on notice and provide an indication of the survey results. We got in the order of 4,000 people to fill out our most recent survey. We will be able to break that down

into divisional representation so that we will be able to capture what proportion of the 4,000 came from mental health.

MS CASTLEY: Minister, I am just wondering if you could tell me what specifically you have been involved in, in improving the workplace culture for our mental health workers. I am not sure whether this needs to go on notice but just exactly how many recommendations of the 20 related to mental health?

Ms Davidson: When we are talking about workplace culture, it all relates to mental health; it all contributes to people's mental health and wellbeing. It is all important. We are very committed to making sure that we can do everything possible to improve that.

We have continued to meet regularly as part of the oversight group for that to make sure that the work is continuing to progress well. The reports that we hear back at those meetings demonstrate that people are implementing real actions within their workplaces that are making a real improvement to how people are feeling about the way they are going about their work and reducing the risks of things like occupational violence, as well as people's feeling of their place within the system and the impact that they are having on people's lives. It has been a really positive thing to see.

I know that when I happen to be visiting a health service or visiting ACT health offices, I can see in action some of the things that we have talked about in those meetings. You can actually see it in action, where people are using different language or different ways of relating to each other to improve that workplace culture.

MR PETTERSSON: Whilst we are talking about wellbeing in the workplace, I was hoping that all the different entities could talk the committee through how they are implementing the government's union encouragement policy. CHS, Justice Health and the Office of Mental Health and Wellbeing would be wonderful.

Ms Davidson: Sorry, implementing which policy?

MR PETTERSSON: The ACT government's union encouragement policy.

Ms Davidson: I might pass to Rebecca Cross to speak first.

Ms Cross: I can take on notice the detail of what we have been doing, but we have recently engaged with another directorate that has had a very successful union encouragement policy. We are looking at the strategies that they have put in place to see whether there is anything more that we need to do in the directorate.

In general, it is part of our induction of staff. It is part of encouraging people, if there are meetings, to take time to attend those meetings. As I said, we are currently looking to see if there is more that we should be doing.

Mr Peffer: From a CHS perspective, I guess, it is a similar answer. Recently we did re-design our induction process in terms of structuring out people's day—they have joined the organisation—and the various modules that they work through during the day. We did that in collaboration with union partners in designing it, and our unions

do participate in that induction process.

MR PETTERSSON: In the context of Justice Health specifically and in the case of the Office of Mental Health and Wellbeing, that would be great too.

Mr Peffer: In terms of Justice Health, that is obviously one of the teams that are within CHS. So our induction process applies to all team members who are joining, irrespective of which particular stream they may end up working in. In CHS they still do go through the same mandatory training at the same time as we provide, I guess, the mass induction each month. We are onboarding in the order of 700 to 800 team members a year.

It has been the case that COVID has disrupted to some degree the process that we previously followed. We have not been able to have hundreds of people in auditoriums, as we used to, in terms of presentations and then structured stalls outside the auditorium. So we have had to get a little bit creative about how we do that month to month with the induction process.

Certainly, Justice Health is covered under the umbrella of Canberra Health Services and experiences the same induction process. In the organisation and within the various streams there would be induction processes particular to a ward, or a workplace, or a stream of service delivery.

Ms Davidson: I think you will find that, for the Office for Mental Health and Wellbeing, that would be covered by the same processes as ACT Health.

MS CASTLEY: I am here for information today. I am just interested in what exactly is the union encouragement policy. You said that you are looking at doing more to encourage people to join. What does that mean?

Ms Davidson: I might pass to CHS to talk about what that means.

Mr Peffer: In terms of the policy itself, this is a whole-of-government arrangement that was reached through the strategic board. We have had a number of discussions, as relevant heads of agencies, about how that policy is to be implemented, with some guidance from CMTEDD. It is not a recent policy; it has been in place and it is really in an implementation phase.

At this point in time I think we are reasonably confident that we are executing against what we have to as part of the policy. From our perspective, I think we are confident in the induction process that we have got and we are satisfied with what we need to have.

MS CASTLEY: And what is the policy?

Ms Davidson: Effectively—and I just very quickly looked up the internet so that I could quote for you—executive managers and supervisors are required to adopt a positive and supportive role, not simply passively accept membership recruitment and representative activity by unions. It is actually some of the positive things that we can do to support that engagement with the unions.

THE CHAIR: Can I remind those speaking that on the first occasion they speak they should acknowledge the privilege statement. Throughout today we might have missed a couple of people. If that was you, feel free to acknowledge the privilege statement. That would be great.

Minister, we are back to me. I have got a question for you regarding the new Indigenous suicide prevention service. I note that the establishment of that service is a key goal for this current financial year. Can you provide an update on the work to date and let us know when you expect that service to be up and running?

Ms Davidson: Before I pass to Dr Elizabeth Moore to talk in more detail about the establishment of that service, one of the things that I have been really impressed by in the work that has been done so far has been the engagement with the community, with people with lived experience and with Aboriginal and Torres Strait Islander organisations to make sure that what we are setting up there is something that is going to be a real partnership between ACT government and the community, and is able to deliver a service that really acknowledges and understands the relationships between people who are experiencing that level of distress and their family and broader community; that it is not just one person we are talking about; it is a whole community. I will pass to Dr Moore who can talk in more detail about how that work is progressing and what the next steps are.

Dr Moore: It was one of the key recommendations of the Aboriginal and Torres Strait Islander Suicide Prevention Working Group, a passionate group of individuals that really have changed some of our thinking around this space. I am actually going to pass to Cheryl Garrett because she has all the details of where it is actually up to now.

Ms Garrett: The procurement process for the Aboriginal and Torres Strait Islander Culturally Appropriate Suicide Prevention Service has been completed. There were four out of five people on that tender panel who were Aboriginal or Torres Strait Islander; so it has been very much led by the community.

A contracting process is underway now with the preferred provider and, once that contracting negotiation is completed, an announcement can be made. The Aboriginal and Torres Strait Islander Suicide Prevention Working Group that Elizabeth mentioned will be involved in terms of implementing and assisting the provider in terms of culturally safe and appropriate practices and processes to establish the service.

THE CHAIR: Probably the key takeaway, if I could, is a date. I will not hold you to it but what is our ambition for when this should be up and running and we are able to provide the service?

Ms Garrett: It is very much an as soon as possible date; so we are working as quickly and efficiently as we can to get the service established as soon as possible and to streamline those negotiation processes in terms of the contract.

Ms Davidson: Because we are talking about a service that is quite new and is going to be delivered in a way that has a big difference to other suicide prevention and

postvention services that we have seen before, it is worth taking the time to make sure that we get it right and that we build those good, strong relationships with community.

THE CHAIR: Tremendous, thank you, Minister. I will move onto Mr Milligan for a substantive question.

MR MILLIGAN: Minister, in your Canberra Health Services annual report, table 14 on page 75, it talks about the number of work health safety incidents that have occurred. In 2018-19 there were 1,972 incidents; then in 2020-21 there were 2,555. So, my question is: what can you contribute that increase to? It is almost 25 per cent over the last three years.

Ms Davidson: Before I hand over to Canberra Health Services to talk in more detail about what has been contributing to it, I would just like to point out that one of the pieces of work that has been happening with that workplace culture program of work is the implementation of safe ward practices, which has been really helpful in a lot of services. We will start to see the impact of that over time on things like occupational violence and how safe people are feeling in their workplace. I will hand over to Canberra Health Services to talk in more detail about what has contributed to that.

Mr Peffer: Despite the number going up, which, at face value, looks concerning, this is actually a bit of a success story for us in terms of a lot of the work we have been doing around injuries and occupational violence in particular. This has been a real focus for our organisation. I think we can understand how critical it is that people feel safe at work and that they have a supportive environment. Wherever someone feels dissuaded from reporting an incident as it occurs, that obviously means there is no opportunity for us as an organisation to improve and to potentially ensure that that injury or incident does not happen again.

What we did see was an increase in reporting rates, which is very, very positive. At the same time, we saw a decrease in lost-time injury frequency rates. This is a measure of the severity of injuries that are occurring both psychologically as well as physically. We are seeing that the reporting rate is going up strongly, but that the severity of injuries is reducing. The reduction exceeded 20 per cent in that year. That is exactly the story that we wanted to see.

That proves the effectiveness of the initiatives that we had in flight and the measures that we were introducing—as the minister said, initiatives like safe wards. I might get Ms Rea to talk through some of those in just a moment. That is the ideal situation, where you are building a stronger culture of people having confidence that they can report, knowing that something will be done about it. That really does provide us the ideal opportunity to improve. It is also reflective of the results in our most recent culture survey. We did see the incidence of people filling out that survey, who had been subjected to some of these incidents, falling quite considerably, which is a great positive story for folks working in Canberra Health Services.

I acknowledge that we still have a lot to do. Those numbers are far too high. They are far too high above what we would like them to be. We know there is a level of risk when you run a tertiary health service like ours. There are very high-risk elements to providing care to people at risk in the community who pose a risk to themselves and

to other consumers as well as to the workforce. Nevertheless, notwithstanding that number going up, we actually see that as a positive in terms of greater levels of reporting in the workplace. I will just hand to Ms Rea to talk through some of those initiatives.

Ms Rea: Yes, thank you so much. Certainly, we have seen a mimicked trend within mental health, Justice Health, and alcohol and drug services as well, where, although our reporting rates have increased, our lost-time injury has significantly reduced to similar rates of greater than 20 per cent as well in that environment.

As the minister mentioned, the implementation of safe wards has been a really key success factor in that space. That is a strategy that provides our staff with some training, education and ongoing strategies that are implemented in inpatient mental health environments to improve situational awareness; relationships and rapport with our consumers; and the language to de-escalate situations and share, for example, mitigating bad news and doing that in a way that reduces any potential escalations of behaviours.

That has been implemented across a number of our mental health inpatient units. We have also implemented strategies such as a Broset violence checklist, which is a checklist that allows us to identify, within the previous 24 hours, what was an at-most-risk behaviour that an individual has had. The team uses a traffic light system to be able to really quickly identify the risk posed by those individuals. That is really important because, again, it allows them that situational awareness, before they are stepping onto the ward environment, around what the occupational violence or escalating behaviours might be in that environment.

To be able to support not just the acknowledgement or the understanding that those things are occurring, but also what we are doing about it, we have implemented a wardsperson pilot, particularly in our adult mental health unit, which increases the number of wardspersons in that space. We have found that it has had a really positive impact on consumers as well. Having someone who is not seen to be a clinician creating some relationships and rapport, but also supporting our broader multidisciplinary clinical team, has been really effective.

We have seen the correlation in that lost-time injury around the implementation of that pilot as well. We have invested in that in the long-term, so that will be a long-term implementation in that environment. We have also implemented some other services such as a concierge assistant in nursing. That is a nurse who plays a rotating and floating role to really support the immediate needs of any consumers in that space—whether that be access to a cup of tea or answering a question rapidly. We found that there was a lot of frustration at times around timeliness for individuals to have some of their needs met, or their perceived needs met. The person in that role wears a little visor so that their team know who they are, and the consumers know who they are, and they can play that role in really mitigating situational issues really quickly.

We have also had an incredible focus on our seclusion and restrictive practice strategies as well. A lot of these mimic one another. We have seen a huge decrease in the seclusion of restrictive practice over the last 18 months in particular. That in itself

also supports that early identification of risks and escalating behaviours, but equally acting when behaviours are escalating. The reduction of seclusion and restraint has also correlated with the reduction of occupational violence in that space. Obviously, ongoing education, training, debriefs with our teams, and establishing clinical governance structures around these reviews of all of these processes and incidents of OV or seclusion restraint are helping to keep those reduced over time.

MR MILLIGAN: I find it a little bit strange that you refer to the increase in the number of incidents being a success. I guess that is through people reporting it and because you are maybe putting in different mechanisms for them to report these incidents. But I think real success would be lowering the number of incidents. Do you actually have a target, or do you have an expectation on when these numbers would start to subside?

Ms Davidson: It is really important when we are talking about safety in the workplace, and people's experiences, that we look not just at the numbers but also at the qualitative information we have about what they are experiencing. That is where the importance of the reduced time lost and the severity of the impact of what they have experienced is really important. So if you are experiencing an increase in reporting but a decrease in the severity of what is being reported, then that is telling you that the culture is changing, and people are talking about what they are experiencing and they are wanting to engage in the process of making those workplaces safer. That is a really positive thing.

Mr Peffer: I can add to that, Mr Milligan. I think when you construct measures that you are going to focus attention on within the organisation, and really drive some focus, you have to be very careful about what might be the unintended consequence. If the measure that you focus on driving down is the number of notifications about incidents, it can actually lead to a situation where it becomes harder for people to notify, and those numbers do start going down. But that is not actually reflecting what the experience of our healthcare workers is within a ward, a clinic or a community-based setting. So, by focusing on the severity of that injury, and knowing that it is going down markedly, we have seen quite a significant reduction. That is what is key, because encouraging reporting allows us to make the improvement so that we can avoid future incidents. At a point in time we will expect to see those numbers go down. They have to. They should track—albeit a lag indicator—a few years later, the actual severity in injuries sustained by our workforce.

MS CASTLEY: Somebody mentioned psychological support for staff. WorkSafe ACT issued one health and safety improvement notice to CHS in September 2020 to update the procedures and processes for the psychological support of team members. It was satisfied and lifted that on 12 October. I am just wondering if you could explain to me what this was about and give me a bit more detail on the psychological support for staff.

Ms Davidson: Yes, I will pass over to CHS in a moment to talk in more detail about that. We are talking about something that happened in late 2020 so it is a bit of a way back and we may have to take some of the detail of that on notice. In general terms, we have improved, continued to improve and will continue to improve the support that we provide to mental health and Justice Health workers in their workplace for

their mental health and wellbeing.

Mr Peffer: We will take that on notice, and we will come back to you with some further detail on exactly what was undertaken under that notice.

MS CASTLEY: Thank you. Could you also take on notice the metrics from staff and what staff are saying about the psychological disorder as well. How are they rating that?

Mr Peffer: Yes.

Ms Davidson: Yes.

MR PETTERSSON: Following up on the reference to the Adult Mental Health Unit, I have had reported to me that there has been a significant increase in code blacks. I was wondering if you have some measure of that.

Ms Davidson: Yes. Before I hand over to Canberra Health Services to talk in more detail about code blacks, one of the things that happens with our mental health services is that it is not like there is a steady stream of people who are coming in and needing to access those kinds of acute care services over a period of time. There are peaks and troughs. Some of those can be somewhat predictable. For example, there was a decrease in people coming in during the peak of restrictions in 2021, when more people were staying at home, and then we saw an increase after people started going out more again, after restrictions started to ease.

But some really unpredictable things can happen. Everything can be tracking along okay and then you can have a really busy weekend, for example, that you were not expecting. We have really good, flexible services in the ACT that are able to flex up and down as those needs change over time. I think that is one of the real strengths we have within ACT's mental health services. For a city of only 420,000, we have to provide services across the complete range, from prevention and early intervention and delivering care in the community, right through to the most acute care situations. You just never know what is going to be coming next. But we have the ability within those services to flex up and down. I will pass over to Katrina to talk in more detail about code blacks.

Ms Rea: Code black, of course, is a strategy that we deploy in those situations where there is increased risk. It is to get a rapid response to a certain emerging issue. As the minister has accurately articulated, it is not necessarily a trend that is consistent over time. It relates to, at times, a very unwell individual, and we often see those spikes attributed to their presentation and their needs in terms of their acuity.

All the strategies that I was speaking to regarding occupational violence also apply in terms of short, medium and long-term strategies. In a situation where we might see a certain individual escalating their behaviours, there are a number of things that the clinical team put in place to address that, to ensure both consumer safety and the safety of our staff. That includes clinical roundtables to review, with a multidisciplinary team—within and often with external members from the team, to ensure that there is a good breadth of independence, as well as expertise around the

table—the current treatment plans for individuals and maybe augment those, depending on the risk.

We also do huddles with our team to make sure that the team are aware of the risks and how they might be changing, depending on different strategies. We also implement behavioural support plans for that individual. That is a guide that gives our treating teams the things that we need to look for in terms of escalation of risk and behaviour for that individual, but also the things that really work effectively for that individual. It may be utilising some of our safe ward strategies. Maybe we did not articulate a change in their visiting restrictions and we could have done that in a calmer way. In that situation, this individual might like to do that with their support person or we will use certain strategies for that individual. It might be anything right up to reviewing their medication regimes, for example. Although we track and review them, they often are attributed to an individual presentation at that time.

Another thing that we have done is in terms of the Broset violence checklist that I spoke to earlier. That gives us an indication of that person's risk of violence within that 24-hour period. It has also been implemented within the ED environment. That is really important in terms of clinical handover. Often we see increased code blacks at that transfer between when a person has presented to the ED environment and when they are admitted into a ward environment. That allows us to have the same shared understanding and same language around the risk to that individual. That is something that we have implemented recently as well, to reduce the risk of OV ongoing.

MR PETTERSSON: Thank you. Just circling back to my original question, is there some measure of code blacks and their frequency over time?

Ms Davidson: I think it is really important, when we are talking about incidents that are occurring in relatively low frequency, that we are looking at the qualitative information about what was contributing to that individual's circumstances at the time, rather than getting too caught up in whether the number went up or down in a particular year. There could be a particular individual who is having a really, really difficult time who might cause that number to look as if it is going up or down by a greater percentage, but when we are talking about a relatively small number of actual incidents, the qualitative information is really critical to changing the situation.

MR PETTERSSON: I understand that very fair observation. But I have had reported to me that there has been an increase in code blacks. You also recruited new personnel into this space, the Adult Mental Health Unit, so I am just hoping that you can provide some data or measure, maybe not of how many of these incidents occur but what the staffing profile and the unit look like as a result.

Ms Davidson: Yes. I can take that on notice. Is there a particular time period you have in mind?

MR PETTERSSON: The past two years would be great.

Ms Davidson: Okay; thank you.

MR PETTERSSON: Also, the staffing profile would be wonderful.

Ms Davidson: Okay; thank you. I will take that on notice.

MR PETTERSSON: Thank you.

MS CASTLEY: Can I add to that something to take on notice? I am interested in exactly whether you measure the code blacks, yes or no. If so, could we go back five years? Please take that on notice. With notifiable injuries, there were 13 work health and safety incidents. I am wondering if you could let me know what those were about. Thank you.

Ms Davidson: Yes, we can take that on notice.

MS CASTLEY: Thank you.

THE CHAIR: Great, thank you, Ms Castley. Mr Pettersson, I think that means you are on a roll, and it is your turn for a substantive question.

MR PETTERSSON: Thank you. The Office for Mental Health and Wellbeing work plan is currently dated 2019 to 2021. The year is 2022; I was wondering if there were plans for an updated work plan?

Ms Davidson: Yes, thank you. That work is in progress and before I hand over to Dr Moore to give an update on where that is up to, it has been really impressive to see how much that work has progressed, even despite all of the disruptions and what was experienced over the past year with people having to work from home for significant periods and not being able to engage as much with the people they would normally see face to face. I will hand over to Dr Moore, who can talk about the timeline for the next work plan.

Dr Moore: Thank you, Minister. So we talked to the Mental Health Advisory Council, and we talked to our major stakeholders about what we should do at the end of this work plan. We have the work plan 2019 to 2021, and the consensus was that for 2022 we should concentrate on some of the enablers to ensure that our work plan was embedded, and, at the end of 2022, look at another three-year plan.

Part of the reasoning for that was that all of our stakeholders were tired. They said that they would appreciate some time to be able to think about strategic planning, and there are a number of national plans that need to be incorporated. So we have done some work on the strategic approach to mental health, which actually looks at some of the work that is being done by the National Mental Health Commission around suicide prevention. It looks at some of the work that is being done around the national mental health workforce plan, which is, alas, not yet available. We are concentrating this year on some of the work that is required to be done, and that includes reporting back to the Legislative Assembly, on a workforce strategy. People around this table have been involved in that, and we will be reporting that up through the minister.

We have a number of pieces of work that still have to go through the final stages, including a report on what is colloquially known as the "missing middle". That was part of our children and young person review, looking at what needed to happen for

those children who, in the stepped care model, were deemed too complex for primary care but did not meet the threshold for our tertiary services. That piece of work is just about to come to its conclusion. It is going back to stakeholders to see whether or not we can accurately represent it, their thoughts and how we can move forward from that.

We also have an older-person strategy that was created—gosh it seems so long ago now—in 2020 to 2021. That is also being refined because we need to put more input into that, now that things have changed. There are a number of other pieces of work that are going on in terms of data. So one of my hopes is to actually have mental health outcomes data across the whole of the continuum of care—that is, from the non-government services through acute care to rehabilitation and recovery—so that a person can be tracked. That tailors very nicely with the commissioning process that the ACT Health Directorate and other directorates are currently undertaking in the non-government space.

MR PETTERSSON: Wonderful, I look forward to following all of them.

MRS KIKKERT: The Official Visitors have noted a lack of qualified staffing, which has impacted both psychiatric services and Aboriginal and Torres Strait Islander support services at the prison. In a year that has seen both immense pressure on mental health and highly distressing incidents involving Aboriginals and Torres Strait Islanders, why are both of these areas seeing a distinct and ongoing lack of support?

Ms Davidson: Before I hand over to Canberra Health Services to talk more about the supports that are being provided, I would like to note that we have increased the resourcing and support for people's mental health and wellbeing while they are in AMC. We did part of that through the announcements in the September 2021 mental health support package, with increased justice health and Winnunga resourcing to look at people's mental health and wellbeing. We also increased quite significantly the resourcing for Winnunga in the most recent budget to provide additional nursing support and psychological support for people in the AMC. We expect that that will have some improvements for people's experience while they are in there. I will pass over to Katrina, who can talk in more detail about the services we are providing.

Ms Rea: In the AMC environment, our justice health services and forensic mental health services team provide a number of supports by way of primary health care and population health care. We have an acute mental health service in that environment as well. That enables everything from the primary health assessment, looking at any urgent needs or requirements from a physical health perspective, as well as a mental health care perspective. Based on those needs, they can be addressed within an appropriately triaged time frame or referred to specialist tertiary services across CHS.

We also have access, as part of the mental health and justice health portfolio, to Aboriginal and Torres Strait Islander liaison officers. Those individuals go out into the AMC environment to provide culturally safe care for those who would like to access their services. In addition, we work really collaboratively with Winnunga. We have a nurse administrator whose role is to ensure appropriate liaison and continuity of care between Canberra Health Services and Winnunga in that environment. We work collaboratively with them to ensure that detainees get the most culturally appropriate care for their needs at that time. Depending on the services that Winnunga

are able to provide, we ensure that continuity occurs. That requires some shared care arrangements in certain environments, and we facilitate that where clinically appropriate.

MRS KIKKERT: How have you increased the mental health services in the prison? Is it extra nurses or extra psychiatrists? How many psychiatrists are currently working onsite?

Ms Davidson: I think it is really important to note that, when we are looking at people's experience while they are in the AMC, a lot of people who go in there experience stress just from going into that environment. That is quite a difficult thing in itself and that is not necessarily something that is best dealt with by a psychiatrist. We are looking at the totality of supporting people's wellbeing, maintaining their connections with their community while they are in AMC and the social determinants that contributed to how they ended up there in the first place. Having more access to nursing care is really important as part of that. Winnunga will tell you that that is their experience as well, that access to that nursing care is critically important for maintaining people's wellbeing and managing the stress and anxiety they are experiencing while they are in there. I will pass to Katrina, who can talk more about the services we are providing.

Ms Rea: Specifically in the current environment, some of those enhancements that we received really enable us to leverage other skills, not just across the current AMC environment but across the rest of the mental health and justice health portfolio, particularly acknowledging some of the challenges over the past 12 to 18 months around COVID.

Access to care is also increasing. We have provided some more comorbidity clinicians. They are nurses or senior allied health professionals who work across both mental health and alcohol and drug services to make sure that people with comorbidity needs are met. At times when the team has been under a huge amount of pressure, we have enabled more drug and alcohol nurses to go into that environment.

We also closely monitor our current services in terms of our mental health and forensic mental health services that provide that acute tertiary level care. That is predominantly very experienced nursing, allied health professionals and also psychiatrists, who can provide appropriate supports for those people who are deemed at risk in terms of their mental health presentation.

Ms Davidson: One of the unique things about the way we deliver services in the ACT to people in the AMC is that they actually get a choice of healthcare provider. That is a unique thing. I think that really reflects our human rights-based approach to people's health and wellbeing while they are in there. They can go to justice health or they can go to Winnunga. While you can access all of the health services that you need through both of those places, some people will have a preference for one versus the other, and we support that.

MRS KIKKERT: There were a lot of complaints regarding the justice health service that was delivered there. What is the waiting list for the dental service?

Ms Davidson: I will pass to Katrina in a moment to talk in more detail about access to dental services. We do support people being able to access both routine and emergency care, to deal with an emergency, if it comes up, with dental care. Sometimes that requires people to come out of AMC, particularly for an emergency procedure, and to be supported through that. I will pass to Katrina, who can talk more about dental services in AMC.

Ms Rea: By way of dental services, there are zero detainees on the urgent wait list at the moment. Detainees triaged as urgent require a dental appointment and are seen as a critical priority. By way of non-urgent appointments, there are currently 64 detainees on the general dental wait list. The longest wait was recorded in early 2020. That is something that the team continue to manage, ongoing. Access to non-urgent urgent dental services, obviously, has a relatively long wait list and it is something that we are working collaboratively on at the moment.

MRS KIKKERT: Are you looking at increasing the amount of time a dentist attends the prison onsite? At the moment I understand that they are currently visiting three times a week. If you have a wait list of 67 inmates to see a dentist, are you looking at increasing the amount of time a dentist attends the inmates at the prison?

Ms Rea: That is one of the factors. There are a number of other factors as well, in terms of access to equipment, dental chairs et cetera in that environment that also contribute to access. It is one of the factors that we are looking at.

MRS KIKKERT: What is the hurdle for a dentist to come to the prison in those two days of the week that they are not able to attend?

Mr Peffer: There are constraints on the workforce. There are only so many healthcare professionals that we have. We need to balance wait lists for the community as well as a variety of other settings. We have some long-stay patients as well who may require dental care in our different healthcare facilities. The team do a good job of balancing and triaging need. They respond as quickly as they can to urgent dental appointments across the city, because we are providing a service not just for inmates but for the broader community. If we were to increase the days at the AMC, necessarily that has to come from somewhere else. A lot of the support provided by our dental team is provided to particularly vulnerable members of our community and also to folks with particularly high needs where the complexity of undertaking dental procedures is not something that is typically done in the private system. Some of these individuals, for example, require a surgical theatre and general anaesthetic for a procedure to be done.

MRS KIKKERT: Why can AMC not have their own dentist instead of borrowing one from the community? Therefore, they could work there five days a week. Is it a funding issue?

Ms Davidson: There is quite a bit of planning work that would have to go into that, because we are not just talking about a staff member there; we are also talking about the space that they work in and making sure that that is right and how that fits into all the other services that are being provided. It also involves talking with corrections officers about how that works in the physical space, in terms of people being able to get to and from the clinic while participating in all of the other programs and activities

that are happening at the same time. It actually takes a bit of planning to be able to do something like that. It is not just as simple as employing one more person.

MRS KIKKERT: Is the justice health hub at AMC too small for it to reach its demand?

Ms Davidson: The Hume Health Centre?

MRS KIKKERT: Is that what it is called?

Ms Davidson: Yes, the Hume Health Centre. I would expect that, for the period of time that the Hume Health Centre has been operational at the AMC, there would be reviews that we would undertake in the process of looking at our overall strategy for how we deliver services, how that has changed over time—the number of people that we are providing services to has also changed over time—and also the nature of the services that they are accessing. It is not as simple as just going out and employing one more person. This actually needs to fit into a whole bigger strategy about health services within the AMC.

MRS KIKKERT: And you are looking at doing a review on that, Minister?

Ms Davidson: What I am saying to you is that if you are asking us to just employ one more person that is not necessarily a simple answer to a bigger, complex problem.

MRS KIKKERT: I am beginning to understand the mechanism in hiring an extra staff member at the AMC health hub. It seems to me that it does need a review, because the wait list is quite staggering when you have over 60 inmates waiting for a dentist, plus people wanting to see the podiatrist and to access other health services that they are in need of. A review sounds pretty good to me.

Ms Davidson: Over a period of time we do look at the feedback that we get from people like the Official Visitors, as well as the inspector of corrections, and our own internal feedback that we are receiving. We take all of those things into account. Services do change over time as needs change.

MS CASTLEY: Can you give us the exact number of how many nurses and psychiatrists you have working across all of the mental health units in the ACT?

Ms Davidson: We can take that on notice. I think it is important to note that psychiatrists are not necessarily the clinicians that treat every single mental health and wellbeing issue that comes up there. The nurses are really important, as are psychologists, as are other programs that people might be accessing that look at their overall wellbeing needs, as well as managing emotions and stress while we are in that place.

MS CASTLEY: Thank you; and if that could be over five years for psychologists, psychiatrists and nurses.

THE CHAIR: Minister, you might want to take this on notice. I would like to know how many positions the government has currently funded that are yet to be filled for

mental health professionals across the system. I understand that there were some additional funds allocated in the last budget, but you have highlighted the challenge of recruiting some of those staff. If we could just get the number of how many staff we are trying to recruit right now, that would be wonderful.

Ms Davidson: Across all of our Canberra Health Services that number does fluctuate quite a lot because we are talking about large numbers of people across a really diverse range of different fields. There are also peer mental health workers that are working for some of our NGO partners where we are funding the service but it is actually delivered by a partner organisation. That could be quite complex. Can you give a bit more detail on what it is you are looking for?

THE CHAIR: I could probably help by being more specific. How many psychologists and psychiatrists we want to employ as government employees; so how many positions you have available across the health system.

Ms Davidson: I can take that on notice.

THE CHAIR: Wonderful.

MS CASTLEY: I would like to chat about the Dhulwa Mental Health Unit and learn a bit more about that. It was built in November 2016 for $43 million. It is a significant facility. I understand that there is no female wing. I am just wondering why that is.

Ms Davidson: I will hand over to Katrina in a moment to talk in more detail about how the wings are set up and how they are used. One of the key things that make our ACT mental health services work as well as they do, given the complexity of different services people might need for a relatively small population, is that flexibility to enable people to access the right care wherever their clinical need is. That includes people who might have vulnerabilities for a whole range of reasons. It may not just be about their gender; it might be about the clinical symptoms they are presenting with; it might be other aspects of their identity that make them more vulnerable; or it might be age. There are a whole range of reasons why someone might be in a particular situation. We have the flexibility across a range of our different inpatient mental health services to be able to provide care to those people in a way that is safe and treats their clinical need but also recognises that they may be more vulnerable. I will hand over to Katrina to talk about the wards at Dhulwa.

MS CASTLEY: Can I just add to that: is it best practice to have a dedicated female wing, especially in light of the fact that some patients would have suffered domestic violence and things like that? Could you talk about that whole situation.

Ms Rea: Thank you so much for the question. Dhulwa is one of our acute inpatient units. It is a secure environment, so it is a locked environment, and it is legislated under the secure facilities act. That unit has the capacity to care for up to 25 individuals. We are funded for 17 and we generally run close to capacity, with around 17 consumers being admitted to that space at any one time. We divide the unit based on clinical acuity, not based on gender. One side of the unit cares for people who are quite acutely unwell and the other side of the unit cares for individuals who are more subacute and need more time for their care and treatment plans to be put in place

before they can be discharged to a less restrictive environment. At the moment there are a very small number of females in that environment, but we do assess their needs from a sexual safety perspective in that space, as well as balancing that with their clinical needs.

As the minister has appropriately reflected, we have the capacity across a whole array of different acute environments to care for people as may be required, based on their individual vulnerabilities. Segregating consumers by gender, although it can be one approach, is not always best practice and does not necessarily assure sexual safety either. There are a number of different approaches that we can take within the Dhulwa environment as well. There are smaller spaces within that unit that can allow us to separate individuals if we think that there is a clinical risk or, indeed, a perceived risk for that individual.

MS CASTLEY: Is that happening now for the females that are in Dhulwa? Are they being treated in those special areas?

Ms Rea: In the current environment they are not separated based on gender.

Ms Davidson: It is really important, too ,that we do not segregate people and put them in a situation where they cannot engage with other people. Just because someone is more vulnerable does not necessarily mean that you want to completely separate them from other people that are also receiving treatment at the same time. There might be clinical reasons why it is actually good for people to have a bit more engagement with others in the same space.

MS CASTLEY: I understand. Thank you, Minister. My question goes back to: we have a female wing at AMC. Why would we not have a female wing here? It is not really about segregation; it is about protection. That is my concern.

Ms Davidson: We are also talking about a massively smaller number of individual people who are receiving care within Dhulwa, compared to the number of people who are receiving care within the AMC. The ways in which we go about delivering that care are necessarily going to be different because of the numbers, as well as the clinical needs of people. It is a really complex group when we are talking about people in Dhulwa.

MS CASTLEY: Has there been an independent review of the operations in Dhulwa since it was opened in 2016?

Ms Davidson: Before I hand over to Canberra Health Services to talk about what reviews have taken place since 2016, I would like to note that we have oversight from a number of different bodies in the ACT who regularly go in there and report back to us on what they are seeing. They will also engage with us early if they are receiving feedback about something that we can change quickly. So we do not necessarily always have to wait for a review in order to make ongoing improvements. It is because of that good relationship that we have with those independent oversight bodies that we are able to do that. I will pass over to Katrina to talk about reviews since 2016.

Ms Rea: There has not been a specific review of Dhulwa since 2016. However, as the minister has accurately reflected, there are independent bodies who currently review certain parts of the services that we provide. In addition, we review other operational planning within that space. We have just gone through a review of our operational procedures within Dhulwa. We do that internally as well. We are also going through the process, particularly in line with nurse ratios coming on board, to review our model of care, to make sure that that is contemporary and provides appropriate safe and clinical care in that space.

MS CASTLEY: I have heard some reports that staff are fearful for their safety at Dhulwa. Have any assaults been recorded in the last year? How many have been reported?

Ms Rea: There have been a number of occupational violence incidents at Dhulwa this year. I can get you the exact number on notice in terms of how many there are. Certainly that environment, not unlike any other environment across any other health service, does impact our staff culture and their feeling of safety. We have done a lot of work with the team out there to ensure that they have the right skills and tools and support to ensure that they are feeling safe to provide care.

We have increased the number of senior skilled staff across our services and are providing modelling of different skills and techniques in that environment, as well as having that senior person there that the team can call on. We are doing regular debriefs and clinical roundtable discussions in that environment. There are opportunities for staff to come and talk to us about the clinical behaviour management plan for individuals and how they are feeling about their safety in that environment. In a really open and transparent way, we are encouraging reporting and having an ongoing review of what that looks like to pick up on any key themes or trends.

There has been an increased level of OV attributed to one unwell individual at the moment. That is why we are seeing a more recent increase in that space. That speaks of some of the things we were speaking about earlier, around whether it is code blacks or other mechanisms that allow us to identify that. Our RiskMan reporting has enabled us to go in and put some really specific strategies in place. We look at the behaviour management support plans and discuss their clinical management. In terms of staff safety and wellbeing, it is about the presence of our senior management team, our local management team, on the floor to have those conversations with staff to understand what they uniquely might need for them to feel safe. That is something that we do regularly in that environment.

MS CASTLEY: Thank you. Minister, in light of all of these, there seem to be a few different reviews going on internally. Is it time, do you think, to call for an independent review?

Ms Davidson: As I was saying earlier, we have a number of independent oversight bodies that report to us regularly. I very much appreciate the feedback and honest advice that they give us about where they are seeing potential for improvement. I always welcome their advice and their input. If they feel the need to look at a particular issue, they do, and we then make changes on the basis of that.

MS CASTLEY: Have you been out to visit Dhulwa yet, Minister?

Ms Davidson: I have indeed, yes.

MS CASTLEY: You mentioned training and things like that. I noted that there was a death out at Dhulwa last year, which is really sad. What is the policy when a patient dies? Is there a policy for the nurses to work through in events such as that?

Ms Davidson: Are you talking about in relation to understanding the contributing factors to what occurred or are you talking about supporting the staff who might have been providing care for someone for quite a long period? Which aspect is it?

MS CASTLEY: That death last year, for instance—were there policies for the staff to know how to handle that?

Ms Davidson: Yes. Katrina can talk in more detail about how we supported the staff through that.

Ms Rea: Thank you for the question. Certainly, that is one of our highest priorities in that environment. It is an incredibly distressing time, particularly when an individual has been cared for by a team for a very long time. We have very specific policies that guide our psychological safety in those circumstances and some of the reporting in that space. Basically, it starts by doing some hot and cold debriefs with the team who are involved in that incident and the death itself, because you really need to target those individuals. Then the colder debriefs really talk about the ongoing and broader debriefs that we have with our team.

Everyone experiences those situations differently, so it is really an ongoing strategy. It is not something that we do once. We do it over and over again and make sure that we are available to our staff. We make sure that we have the employee assistance program deployed. Also, members of that team can provide either one-on-one or group sessions with our staff. We also have an employee advocate within Canberra Health Services who provides incredible support to those teams. That individual is a social worker in their own right and is able to provide really targeted support.

It is something that we have allowed the staff to continue to bring up as they need, as well as to engage in their own forms of recognising this individual. They have done some lovely things such as writing memories of the individual and making sure that the family have access to some of those, because it means a lot to those individuals who have cared for them for a long time. It is certainly something that we continue to ensure that our team have access to. Our staff always have access to EAP and other support services whenever they might need them.

MS CASTLEY: You are confident that at that time the staff had a specific policy to follow on how to deal with the death, and with the other patients, and what to do with the body? There was a specific process nutted out for the staff to follow?

Ms Rea: By way of the psychological safety, absolutely. There is a specific policy that deals step by step with how we support our team. Equally, in those events there are other clinical policies that support the other practical stuff.

Mr Peffer: I would just add, in terms of the response to that, Ms Castley, that that is obviously done in partnership with the police and then the coroner.

MS CASTLEY: You can take this one on notice. Can you give me some figures about the violence and the number of attacks that have occurred with staff since it opened?

Ms Rea: Since it opened, yes. I would be happy to take that on notice.

MRS KIKKERT: Katrina, you mentioned that the staff were encouraged to report violence. What sorts of skills are they being taught for self-defence? Are they allowed to defend themselves if a patient gets quite aggressive and tries to attack a nurse? What sort of skill must they have in order to protect themselves?

Ms Rea: We have very specific training in place, called VPM training, in the Dhulwa environment. That is a specific tool that allows a team, at the beginning of their shift, to identify who is on the response team, and we have a response team of five. It does not necessarily have to be clinicians. That response team can be made up of allied health nursing, medical and security officers as well. They have specific roles, so in that environment where they need to deploy, whether it be a restraint on an individual who is potentially at risk of assaulting someone or is in the process of it, they can deploy that team to be able to support that. They also all carry mobile duress all the time that can trigger that. If anyone is feeling threatened, they can click their duress and that response team responds immediately to their needs.

There is also, if they are concerned about ongoing violence, an opportunity for them to call Canberra Health Services assert team, as we call it. That is a more assertive team in that environment, with some of our other trained security professionals who can provide that level of situational security in those extreme circumstances. I guess more extreme than that would be the AFP, but locally they do absolutely have that occupational violence training.

Across Canberra Health Services we are rolling out new occupational violence training as well that makes some other mechanisms available to them. It is consistent across all of our units, which is really important when staff are rotating through different environments. That has been rolling out since the end of last year. We are hoping to have that implemented for March this year, but until we are confident in the critical mass of staff in that environment who have had that new training, we will continue with the old VPM training—until we are at that critical mass point where we can take on the new techniques.

MRS KIKKERT: Okay. Have any staff complained or given some feedback about the VPM, and can onsite guards try to help a situation if it gets out of control between a patient and a nurse?

Ms Rea: By way of the second question, onsite guards are able to do that. They are not allowed to lay a hand on a consumer until there is that situation where there is occupational violence occurring.

MRS KIKKERT: Are they allowed to stand back and yell at them and tell them to stop?

Ms Rea: If the situation had escalated to that point, they would be able to lay hands on them, based on the VPM training that they have experience in. Prior to that, though, they would not. They would need the team to be able to call that response. So that is the second part. Could you repeat the first part of the question that you had for me?

MRS KIKKERT: Have you received any feedback about whether VPM training is effective or not for nurses and whether they need extra training?

Ms Rea: We always support extra training that any individual may need in that environment. What was identified through VPM, and I have not had any specific complaints that VPM is not an effective tool, was about moving to the new OV training: ensuring that that the transition of learning and skills into the new type of training is seen as effective for that individual and that they still feel empowered to protect themselves and their team members if they need to. I think that is the bit of work that we are working collaboratively on with our staff at the moment but, as I mentioned, it is really important that we do transition to this more consistent way of supporting occupational violence strategies across Canberra Health Services.

Dhulwa is the only environment that uses VPM as a specific kind of occupational violence and situational security training. That does create some other opportunity cost and risk, in that it is really hard to supplement other individuals coming into that environment to make sure that they have that training. It is an approach to ensure that we can maintain their ongoing safety, regardless of where people work within our organisation.

MRS KIKKERT: Just to clarify: you did say that the guards are allowed to use their hands to stop a situation, where it gets out of control, between a patient and a staff member, like a nurse?

Ms Rea: Yes, once that response team has been engaged; correct.

MRS KIKKERT: Right. Okay. But before then, if they are not there but the guard is available and at the scene, they cannot use their hands and stop the fight or whatever is happening; is that correct?

Ms Rea: I think it is getting a little bit situational. We are trying to come up with some—

Mr Peffer: We might get Dr Riordan just to expand on this, but if a situation arises and escalates to the point where there is physical engagement, then the answer is yes. Dr Riordan, do you want to expand on that?

Dr Riordan: Thank you. I acknowledge that I have read and understood the privilege statement. I just want to add a couple of comments to the dialogue that is happening here that I think are really important. It is really important to remind ourselves that, for mental health consumers and for our staff, violence is not the norm. The vast majority of interactions that take place within all of our mental health units are not

driven by violence. The vast majority of responses that staff are making in situations are not in response to violence. Obviously, in situations where there is the threat of or risk of escalation in relation to violence, we absolutely take that very seriously.

One of the first things that we do, right from the get-go, is to think about de-escalation techniques. Katrina has mentioned the importance of safe wards and the approach to safe wards, which we roll out across all of our areas. An important component of that safe wards approach is that a member of the nursing staff who is doing their orientation to the unit will sit down and identify with that consumer what are the things that might make that person agitated, what are the things that help them when they are agitated. So we start right from the beginning, where somebody is able to engage in that. That is the vast majority of our clients and consumers. We really start from a position of working collaboratively, of thinking about what it is that might make you agitated and what it is that we can be doing right from the beginning, as a care team, to support you.

MRS KIKKERT: I understand that, Doctor; thank you. I have a family member who has been in a mental health institution and I have seen violence against him and I have seen him being violent towards others, so it does exist. There is a lot of talking before that is necessary, but we also know that, in reality, they can get out of control and hit someone. What I would like to know is: if a guard is present but the response team are not, are they not allowed to stop it physically from happening?

Dr Riordan: Personally, I acknowledge what you say—that, yes, there are acts of aggression within our unit, but I do just want to clarify that. I am sorry to hear about that experience. In terms of the specific question, there will always be nursing staff around, on the unit, in the Dhulwa situation, so the nursing staff would be able to activate the duress response for the VPM team, who would then be able to get the guard to support them if that was what they needed to do. We would not have a situation—

MRS KIKKERT: I understand, Doctor. A VPM response requires a team to attend. However, if the guard attends there first, if he is the quickest out of a group that comes in as a response team, is he not allowed to physically stop the fight from happening until the others attend? Is that the case?

Ms Davidson: Mrs Kikkert, would you like me to take on notice to provide you with all the steps that we would go through in various situations where this might occur? Would that be helpful?

MRS KIKKERT: I know what happens before. It is just a simple answer, Minister: can a guy can step in and stop it from happening before their colleagues attend? That is a simple no or yes.

Ms Davidson: I think what you are asking about there is situations in which there would not be clinical staff or nursing staff around, and there are always nursing staff there. That is the nature of being in a facility like that. But I can take on notice to provide you with more detail about the steps that they go through before the guard engages in the situation.

MRS KIKKERT: I would like to know if they can or cannot. That is all: a simple yes or no.

THE CHAIR: Thank you, Minister. Mrs Kikkert, you have asked the question a few times and the minister has endeavoured to take it on notice.

MS CASTLEY: I have a question on notice, if possible. Can you please let us know how often the assert team and the AFP have been called in over that five-year period? That is going back to my last question on notice.

Ms Davidson: Since 2016, how many times the AFP have gone out on site to Dhulwa? Yes, I will take that on notice.

MR PETTERSSON: Has anyone ever escaped from Dhulwa?

Ms Davidson: Not in the last year, that I know of, but I have not been doing the job since 2016. I could hand over to Canberra Health Services to provide you with an answer on whether anyone has ever escaped.

Mr Peffer: Dhulwa is a custom-built, secure facility. I am not aware of anyone escaping since it opened.

MR PETTERSSON: Has anyone ever escaped from the Adult Mental Health Unit?

Ms Davidson: I can take on notice to provide some more details about when and how many times someone might have left the Adult Mental Health Unit. What period of time are you talking about for that one?

MR PETTERSSON: I am curious about how frequently it occurs.

Ms Davidson: Okay. Thank you. I will take that on notice.

MR PETTERSSON: Also, when the most recent escape was would be useful.

Ms Davidson: The most recent one?

MR PETTERSSON: Yes.

Ms Davidson: I will take that on notice.

THE CHAIR: Thank you, everybody. I am very cognisant of the time and that we have the minister and her officials for a three-hour block, so I think we are all due for a quick break—bathroom, water and that sort of thing.

On behalf of the committee, I would like to thank Minister Davidson and officials for your attendance today. The secretary will provide you and your office with a copy of the proof transcript of today's hearing to this point, when it is available, for you to check for accuracy. Minister, could your office or your officials please liaise with the committee secretary to provide answers to those questions that you have taken on notice.

Mr Peffer: Sorry, Chair, if I may indulge the committee just very quickly: I did undertake to respond to a question from Ms Castley, I think, on the number of survey responses from the Mental Health Division. We distributed 797 surveys and 356 responses were received from that team.

MS CASTLEY: Thank you. Just quickly, may I have one more question, or are we done?

THE CHAIR: Ms Castley, we can fit it in. I just want to make sure that everybody has a moment over their lunch break.

MS CASTLEY: Sure. It is about government funding for mental health services for students in non-government schools. There was a bit of a report done, and the government said that they would do a review. The next update we received was that the work will commence in 2021-22. I am just wondering: did the government undertake a review of the funded mental health services for students in non-government schools and, if not, why not?

Ms Davidson: That might actually be a question for the Minister for Education and Youth Affairs. I think that one might be part of the education portfolio, but Dr Moore may have some more information for you.

Dr Moore: Ms Castley, we are doing a couple of things in that space. One of them is looking at appropriate programs for eight to 12-year-olds that may help with mental health and wellbeing. The other one is the Youth Aware of Mental Health program, currently funded by the commonwealth, that is going out to year 9s. Currently, 4,000 students have gone through that program.

MS CASTLEY: Thank you. Do you know about this, Minister—the funding for non-government schools? What do you know about that?

Ms Davidson: Can you tell me a little bit more about which program you are talking about there? I am just trying to work out: is that a mental health services program or is it an education program?

MS CASTLEY: Table 13; it is pages 94 and 95 of the report. It refers to the government's response to the inquiry into the appropriation bill. It was back in 2017-18. The recommendation said that the government would do a review, and then the update in this current report says that the work will commence for non-government schools in 2021-22. The government said that they would do the review. Has that happened and are we ready to go with that?

Ms Davidson: Has the work commenced? I can take on notice to provide you with some details about the work—whether the work has commenced and what the time line is for that.

MS CASTLEY: Thank you.

MR PETTERSSON: Just one quick thing, Mr Davis.

THE CHAIR: You are testing the friendship, Mr Pettersson, but off you go.

MR PETTERSSON: I was hoping to expand those questions you have taken on notice about escapes from the Adult Mental Health Unit. I was wondering if you could outline the details of any escapes, the circumstances, in the past two years, as well as if escapes have been by people that have been sent there by courts.

Mr Peffer: Mr Pettersson, we will endeavour to provide some useful information on that. It is a secure facility, so we have to be mindful of outlining how those escapes occurred, but we will endeavour to put something useful together for you.

MR PETTERSSON: Wonderful. Thank you.

MS CASTLEY: Can I be clear on my question? Did the government do the review? That is my question on notice. Thank you.

Ms Davidson: Yes. Noted; thank you.

THE CHAIR: We will take that 10-minute break and we will resume with the minister in her capacity as Assistant Minister for Seniors, Veterans, Families and Community Services at 12.10 pm. This session of the committee's hearing is suspended.

Hearing suspended from 11.59 am to 12.12 pm.

THE CHAIR: Welcome back, everybody. In this session we will hear from Minister Emma Davidson in her capacity as the Assistant Minister for Seniors, Veterans, Families and Community Services. I remind all witnesses of the protections and obligations that are afforded under parliamentary privilege, and I draw your attention to the privilege statement. In the first instance that you speak at today's hearing, can you please confirm that you have read and understand the implications of the privilege statement.

With that housekeeping covered, we will go to questions. As chair, I will kick us off. Minister, I want to ask about the government's plans to raise the age of criminal responsibility and the implications of that for justice health. Can you talk me through some of your work, as minister, on that policy reform and what services and policy changes you have already identified may need to change to facilitate that work?

Ms Davidson: Yes. Thank you for the question. There are indeed pieces of work that are happening in the process of looking at how we go about raising the minimum age of criminal responsibility, and that includes making sure that we are providing the right services and supports to young people, and their families and carers, who might be at risk of ending up in the youth justice system.

That might look at some of the other things that are going on in their life, such as homelessness, drugs and alcohol, mental health, domestic and family violence—those kinds of factors that might be impacting on them. It is a really good opportunity for us to look at where the gaps are in the system, not just for 10 and 13-year-olds but for

younger age groups as well, before they even reach that age, so that we can make sure that our young people are not engaging in those harmful behaviours or, if they are starting to, we can change that.

One of the things that we have done is a pilot of functional family therapy in the youth justice space. I will pass over to Catherine Rule, who can talk to us more about how that has been going and other work that we are doing.

Ms Rule: Thank you, Minister. I have read and acknowledge the privilege statement. I might throw to Helen Pappas or Catherine Furner to give an update on that trial.

Ms Pappas: Thanks, Catherine. Hi, everybody. I have read and acknowledge the privilege statement. The Functional Family Therapy—Youth Justice program is an evidence-based program. It targets young people and their families, young people from the ages of about 12 to 17. The program is designed to improve the family dynamics, communication and supportiveness within the family network, while decreasing the intense negativity and dysfunction that can occur in patterns of behaviour within families. It is really to work with young people who are at risk of or are on youth justice orders.

The program commenced in January 2021 and started taking referrals from 1 February. From February to December 2021 there were 62 referrals made to the program. Of the 62 referrals, 34 young people disengaged or were discharged at intake. What that means is that those young people either did not consent to participate, their families or their parents did not consent to participate, or both, or the conditions in which that young person was living were not suitable for entry into the program. They may not have been spending enough time within the family unit or there may have been other issues that needed to be resolved before the program could commence.

Of the 28 families that were accepted into the program, nine completed treatment in February to December of 2021. We have a further nine young people in the program as of January 2022, and they are continuing to work through their treatment program.

I guess what I could do is talk about some of the outcomes that OzChild have identified for those families that are in the treatment program or have completed the treatment program. The numbers are quite small still, but the early signs of outcomes include a decrease in or a change in the illegal behaviour demonstrated by the young person in that family unit; less running away from the family home; improved school attendance by those young people; improved school participation and performance by those young people; and a slight decrease in the use of alcohol and drugs by that young person in the family home, as reported by the professionals that are involved with those families.

Ms Davidson: I think it is also useful to know that we are going to need a range of different responses for young people and their families, to change engagement in harmful behaviours, if we are going to have the minimum age of criminal responsibility raised to a higher age. Some of those solutions might need to be very individually tailored to meet a specific young person's complex needs. We are engaging in work at the moment to look at what are the possible ways in which we

could do that, knowing that some of these young people aged 10 to 13 who are currently engaging in the youth justice system are not from families that have previously been engaged with the CYPS system or with police. Clearly, there are areas in which we can improve service delivery before young people engage with the youth justice system, and we are looking at flexible ways in which we can do that.

THE CHAIR: Great. Thank you, Minister.

MRS KIKKERT: Minister, I understand that this pilot will cease mid-February. Is that going to continue or will it stop and another program commence?

Ms Davidson: Because it was a pilot, the funding for the pilot was for a limited period of time. We are going through the process of ensuring that funding for that pilot can continue until the pilot is able to be completed, and also to make sure that we are getting some good evaluation information about how that pilot is going that can then feed into the wider discussion we are having about what services we might need in an ongoing, permanent way in the ACT.

MRS KIKKERT: Okay. Thank you. Has the review happened?

Ms Davidson: That pilot is still ongoing, and there will be a review at the end of that pilot program.

MRS KIKKERT: When will it finish?

Ms Davidson: I will pass over to Helen Pappas to talk about the time line for the Functional Family Therapy—Youth Justice pilot.

Ms Pappas: Thanks, Minister. We are working on the basis that those families who are currently involved will continue to be involved until midyear, at which time OzChild, who are delivering the program, will finalise their evaluation and provide us with a report that goes to those issues that I talked about, such as the outcomes, what was achieved and what were the challenges, particularly in the context of referrals and engagement.

It is a program that requires consent, so OzChild will have some insight into what worked and what did not work in terms of getting young people and their families to participate, and what were the challenges for their own workforce in securing properly trained and qualified staff to deliver this sort of program in the long term. All of those things we will use to understand, as the minister said, whether the program hit the mark and what else we need to think about in the context of raising the minimum age.

MRS KIKKERT: Thank you.

MR MILLIGAN: No doubt COVID has had a significant impact on the veteran community in the ACT. My question is: how has the directorate delivered services to the veteran community over the last two years?

Ms Davidson: Before I pass over to Catherine Rule to talk in more detail about what services we have delivered for the veteran community over the last two years, I would

like to note that it has not just been the pandemic; it has also been the timing of what has happened, particularly with outbreaks in the ACT and the public health restrictions that were necessary to manage that, as well as what has been happening with things like events in Afghanistan and how that impacts on our veteran community.

They have been through some really difficult periods, particularly over the last year and a half, where the combination of some of those things has made it harder for people to get access to the kind of support they would usually do. Our ESOs and VSOs have been really creative in finding flexible ways to maintain people's sense of connection and access to support services during that period of time.

That is one of the reasons why it would be great to have a veterans wellbeing centre in the ACT. We have seen those implemented in a number of other cities around Australia. That has been a really good way of services being able to come together to provide support in a shared location and to better integrate and interconnect with each other, as well as providing services to people in the community.

During a Senate estimates committee hearing last Thursday, the ADF confirmed that they spent $32 million a year on marketing the ADF to potential new recruits, and particularly targeting 17 to 24-year-olds. Nationally, since 2001, we have lost one veteran per fortnight to suicide. In March last year I noted that we believed that that had gone up to one per week since October 2020. We could reduce that loss and provide better care for our veterans through a one-off investment that is just a fraction of that annual marketing budget to bring in new recruits, if we had something like a veterans wellbeing centre in the ACT.

In the meantime, we are continuing to deliver support to veterans, including while they are going through the process of that royal commission. I will hand over to Catherine, who can talk more about that.

Ms Rule: I would note that we have ongoing and very strong relationships with the local veterans community. Through the ministerial advisory council for veterans, there is lots of engagement with key stakeholders in this space to hear about some of the issues and challenges facing the local veteran community.

We are very aware of the fact that Canberra has a higher number of veterans than most other places in Australia, so we are very keen to make sure that we are working closely with that community to support them. We have a number of initiatives underway where we are reaching out directly to the veterans community to make them aware of services and supports that might be available. They are certainly a group of stakeholders that are very vocal and really good at telling us where they think the gaps in service supports might be, and what further things we can do to support them.

Ms Davidson: I would also note that, with the veteran wellbeing grants, we are currently in the process of assessing grant applications. They have a particular focus on responding to the impacts of COVID-19 and social isolation for veterans. It is a really good way of providing support to some of our smaller organisations in the community that work with veterans with particular shared life experiences or interests in a way that really engages with them and meets their needs.

MR MILLIGAN: How many issues specific to the veterans community have arisen, especially across services such as counselling and support groups? What has been done to address these issues?

Ms Davidson: Can you ask that question again?

MR MILLIGAN: What specific issues have arisen from the veteran community across services such as counselling and support groups? What is the government doing to help deliver those services to the community?

Ms Davidson: Some of what they are experiencing is that there were groups that they used to attend in person—say, coffee mornings and things like that—that they could not attend in person during public health restriction periods. They moved to online participation in events.

There were people who found that their need for social connection increased because of what they were hearing, with news about events in Afghanistan that coincided with public health restrictions. It meant that they could not go to some of the places in the community that they usually go to. People in our VSOs and ESOs were able to go out and see people one on one and provide support, as well as over the phone.

A range of organisations have been providing different services to different people in the community. I think that reflects the huge diversity of veterans in Canberra. It is not just people who have retired from service; we also have active, serving members in Canberra, and we have their families. Sometimes their families are impacted by these things as well. It is about making sure that we are looking at the diversity of different ways in which we might need to provide support.

Ms Rule: Mrs Summerrell can give you a bit more information on the specifics, if you would like, Mr Milligan.

MR MILLIGAN: That would be great. It is quite alarming that we are seeing an increase in suicides, particularly over the last 12 months. You mentioned the veterans wellbeing centre; is that correct?

Ms Davidson: Yes.

MR MILLIGAN: What sort of support would they potentially offer to the veteran community? Also, what is the hold-up? If the government is supportive of this type of centre, what are you doing to actually implement it?

Ms Davidson: We are actively engaging in conversation with the federal government around this. This is a commonwealth government program that we have seen implemented in a number of cities around Australia. That experience of seeing what has happened in other places like Nowra and Townsville has been really helpful for us to look at and understand what is possible in the ACT.

We have a high number of veterans per capita in this city and a real diversity of veteran experiences. Having a veterans wellbeing centre would be a place where

ESOs and VSOs could deliver services to people and could engage with people, and engage with each other as well, so that they are able to better support each other's work and reduce the duplication of services or be able to work well with each other.

If someone is posted to Canberra and they are looking at their plans for transition, we know that transition is one of those key times when a veteran's mental wellbeing is at risk. If we have people who are posted to Canberra and they are looking at transition, having a veterans wellbeing centre locally means there is a place where they can go and engage to find out what their options are.

If there is someone who finds that they are transitioning out of active service unexpectedly, through illness, injury or other circumstances, having a place where they can physically walk in and talk to someone and engage with services can be really important. That might not just be about managing the transition to new forms of employment—and the ACT public service has been doing a fantastic job of recruiting veterans into a number of different directorates; it might also be about accessing health services in the general community that they might not have accessed before.

It might be about services to support their family, their kids in school, and how to better engage in sports, arts and recreation activities that they have previously done within the service but where they are now looking to engage, now that they are leaving. Do they want to join, say, a veteran-specific group or do they want to engage with something in the broader community? That is a really good place to do that.

We have also seen veterans engaging really well in volunteering in the ACT. They have been very important in our response to what we have experienced during COVID, with things like food relief. Having a veterans wellbeing centre makes all of those conversations and partnerships between government and the community a little more frictionless, if we have a place to do that. We are actively engaging with the commonwealth government to talk about how we can get a veterans wellbeing centre up and running in the ACT.

MS ORR: I have a quick question on the Carers Recognition Act and how that is going, since it was passed in December. I believe that the commencement date is within six months of the bill, or a date set down by the minister. When are you looking to commence the act?

Ms Davidson: Before I hand over to Catherine Rule, who can talk more about the commencement of the act, I want say thank you for your engagement with us during the process of that really important piece of work. It was really great to see that happening.

With the implementation of the Carers Recognition Act, the directorate has been working with some of the organisations that will need to report on that to provide them with things like fact sheets and templates, to make sure that the implementation is as frictionless as possible and that people understand how best they can do that. I will hand over to Catherine, who can talk more about implementation and the time line.

Ms Rule: I will hand over to Jacinta Evans, who can give you some of the

information you are after more directly.

Ms Evans: I acknowledge the privilege statement. Thanks, Ms Orr, for your question. As you alluded to, we have to move to implementation within six months. We are progressing that work, and particularly looking to outline the obligations within the act for directorates, or the care and carer support agencies, that will be subject to the act. Those are the government directorates that manage or deliver supports for people in a care relationship or any non-government agency providing support to people in a care relationship.

The obligations, as you noted, are to uphold those care principles in assessing, planning, delivering, managing or reviewing support services, programs and policies in relation to people in care relationships. As the minister said, we are working with directorates to consider what information is required for them to be able to implement and work to those principles under the act. We are working closely with Carers ACT, who are our partner under the ACT carers strategy.

I would like to make particular note of recognition being one of the priorities underpinning the carers strategy. That is a really strong link between the Carers Recognition Act and the strategy. Basically, the bill was passed on 2 December and, as you know, commenced on 10 December; so work is now underway to implement it.

Ms Davidson: The timing of getting that Carers Recognition Act through is so relevant to what carers are experiencing right now with the economic impacts of COVID and the pressures about returning to work. They might still need to stay physically separated from large groups of people if the person they are caring for is particularly at risk. To have that Carers Recognition Act while people are trying to navigate how we protect those most at risk in our environment, with COVID circulating in the community and balancing that with the return to work recommendation changes, is really important.

MS ORR: Am I right in understanding that the commencement has already happened but you are looking now at how best to make sure that reporting obligations are met by the organisations of care and carer agencies?

Ms Davidson: Yes. We are very much looking at how we can practically support people to make sure that that implementation goes well.

MS ORR: I believe Ms Evans said that there is a lot of work going on across directorates and the not-for-profit partners around who is defined as a care and carer support agency. I am happy for you to take this on notice. Is it possible to get a list of who those organisations are?

Ms Davidson: Yes, we can take that on notice.

MS ORR: I appreciate that you might not be able to rattle that off in the hearing. You said there were a number of fact sheets and other things; what are the resources that you are providing to care and carer support agencies to help with their reporting? Can you provide a bit more detail on that?

Ms Davidson: I will pass to Jacinta to answer that in detail.

Ms Evans: Ms Orr, the fact sheets are around assisting the care agencies to understand what the principles are, what their role is in ensuring that carers are able to be recognised for their efforts and for the dedication they have, for the social and economic contribution they make to our community, to have their social wellbeing and health recognised in matters within the care relationship and to have the effect of their role as a carer on their participation in employment and education recognised and considered in decision-making.

In saying all of that, the most important part about what we are trying to bring to the directorates' attention is that carers can sometimes be a bit unseen within the work that each agency is doing, because they may be working with a particular person who is their client. The carer, as their support person, may not be as visible. We are trying to make clear for our support agencies how they should work to acknowledge the role and the contribution of carers in that relationship.

MS ORR: Would you be able to provide a copy of the fact sheets, on notice, to the committee so that we can see the good work that is going on there? Also, has any consideration been given to when the first reporting date will be for the obligations under the act for agencies?

Ms Davidson: I might pass to Jacinta, if she is able to provide the detail on that; otherwise we can take it on notice for the exact date.

Ms Evans: Minister, I do not have the exact date, but if the intention is to report within about 12 months, it is probably at the end of this year.

MS ORR: Part of the act requires consultation with carers or with a carer agency. Has any consideration been given to providing additional funding or resourcing to any of the peak groups to assist with meeting those obligations under the act?

Ms Davidson: Before I pass to Jacinta to talk about resourcing support for organisations that we are engaging with, I can tell you that we continue to engage with organisations like Carers ACT about a whole range of different issues. They have been really helpful in providing advocacy for carers and helping us to understand how we can better support them. I will pass to Jacinta, who can talk a bit more about what resourcing support we provide to those organisations.

Ms Evans: There has been no additional support provided since the implementation of the bill, since the bill was introduced. As you would be aware, any additional funding would be subject to the budget process. However, as we are looking at this kind of level of implementation, we are thinking about the existing supports that are in place and how they can be reflected better.

Many different directorates, for instance, may be gathering data on the way that they support their clients, so some of the implementation of the bill will be around getting them to reflect on when there are interactions with a carer as well. Some of that does not require additional funding; it is more around considering how we would change some of our reporting processes.

MS LAWDER: Minister, in the annual report there is reference to the age-friendly city plan. We have had a number of conversations in the chamber and elsewhere about dementia-friendly training. Are you able to provide any update on whether training has been provided, for example, to Access Canberra staff or other public-facing roles, and what the progress is?

Ms Davidson: Thank you for the question. Before I pass to Catherine Rule, I believe that the last time I talked about this in the Assembly would have been before Access Canberra's Belconnen service centre had reopened, so there may well have been some changes or progress since that date. I will pass to Catherine Rule who can provide more detail on dementia-friendly training for Access Canberra staff.

Ms Rule: Minister, you are right that we have been significantly disrupted by COVID and closures and the like. I am going to throw to Jessica to give you an update on this one.

Mrs Summerrell: Thank you very much for the question. I remember our talking about this at the last hearing as well. I understand the importance of this, and I am pleased to report that this is something that Access Canberra are really actively working on. They are exploring what dementia assistance training can be provided for service centre staff. That includes dementia-friendly principles and how they use that information in designing the spaces for Access Canberra. That includes considerations like quiet waiting areas, as well as not having dark flooring, and a range of principles that sit within that dementia-friendly model.

Access Canberra have commenced the construction of the new Belconnen service centre. That will include their further investigation of that training and what that looks like. That is really exciting. I believe that the minister will be providing a further update on the age-friendly city plan in the Assembly soon, which will provide some more information on that.

As with everything, of course, I will not deny that COVID has caused some delays in the progress on some of those things, but I am aware that some other areas are also engaging with dementia experts. This is very much something that is forming part of that overall consideration in new design principles. I think it is very exciting that that conversation is happening as we are looking at other spaces, like libraries and whatever it might be—whatever spaces that may include. It is definitely something that is being considered.

MS LAWDER: If I could follow up, Minister: will your report include areas like theatres, libraries, Access Canberra, buses, with regard to dementia-friendly design and/or training? Would that be the responsibility of each of the separate areas to report on?

Ms Davidson: Yes. When I provide that update on the age-friendly city plan I will indeed address what we are implementing to make service delivery in the ACT more dementia friendly. That will include training as well as service design, yes.

MS LAWDER: Across the government?

Ms Davidson: Across the government, yes.

Ms Rule: Chair, can I just take a moment to correct the record on something related to the Carers Recognition Act?

THE CHAIR: Yes, please.

Ms Rule: I just quickly want to state that the reporting against the Carers Recognition Act will not be by the end of the year, as was stated. It is actually going to be conducted by the annual reporting process for each directorate. So it will be in line for the timing of those annual reports.

THE CHAIR: Thank you so much.

MRS KIKKERT: The annual report notes the establishment of a whole-of-government ACT community recovery task force to advise on measures to address the collective impact of emergency events, including bushfires, smoke, hail and COVID-19. Minister , what community recovery and emergency relief can you briefly outline? What support and recovery services were provided to impacted residents, apart from those available at the information hub in Higgins, when the hailstorm happened on 3 January and west Belconnen residents were hit quite hard?

Ms Davidson: There is a really big piece of work going on at the moment around community recovery, and I will pass to Catherine Rule in a few moments to talk in more detail about it. But it is not just about the immediate situation of providing relief, say, during a storm or a bushfire, through an emergency evacuation centre or something like that. It is also about things like the food relief support that we provided throughout 2020 and 2021, and a lot of the things that we learned from that and how we can better support the NGO partners that we work with to continue localised delivery of those services in the community.

It is also about acknowledging the social impacts of what these things do to our community. We have had a lot of feedback from seniors in particular, but also from people throughout our community who have experienced greater levels of social isolation. We know that young people experienced a lot of social isolation, and that has ongoing impacts. Even after the immediate impact of the disaster has been dealt with, there is an ongoing impact on people's wellbeing and on social cohesion across our community. Part of what we are doing with community recovery needs to look at that and address that work. I will pass to Catherine, who can talk more about community recovery work.

MRS KIKKERT: In the interests of time, can we specifically focus on the hailstorm that happened in west Belconnen, please, and the directorate response to that event?

Ms Davidson: Yes. While we are doing that, can I also thank Mr Milligan for the motion that he brought forward in the last sitting week that will set up an inquiry to specifically look at that event—what we have learned from that and what we can do differently in future. It is always good to be able to do something that looks quite specifically at where we can make improvements and what we have learned from

those things.

Ms Rule: In the interests of time, I will get Ms Conway to talk specifically about the role of CSD in that particular emergency response.

Ms Conway: Thank you for your question. I have read and acknowledge the privilege statement. In response to the storm event of January, the Community Services Directorate did have a presence in the emergency coordination centre in supporting a whole-of-government response and, in particular, in supporting individuals who were impacted and individuals with additional vulnerability within that area. As part of that, we coordinated a food relief approach and worked really closely with our community partners who we had strong, established connections with from the Canberra Relief Network.

We worked across CSD with different line areas, including the offices for disability and multicultural affairs, to ensure that we were supporting those individuals who were reaching out to community partners that they had established connections with but also who were reaching out to government to access additional supports and connect them with those services as necessary.

We did also have a presence at the community information hub, and that was to provide support to those people who wanted to come face to face to talk through their situation and to ensure that they were aware of where they needed to go to access that support. So we had a variety of mechanisms that we put in place for that and were able to support the community.

I think, also, that it was a great example of community coming together to support each other. We really did see a number of examples, in different suburbs and locations, of community stepping into help people who were particularly impacted within their street or area. That is something that we will be taking forward into our work more broadly as we progress the social recovery direction, moving forward.

MRS KIKKERT: You mentioned that you helped out those people who reached out to CSD. What about those residents who could not reach out to you due to their phone being dead, or because they had no power? What steps did the ACT government take to identify which impacted residents were especially vulnerable and provide support to them? For example, were homes in affected streets visited by the community recovery team or were phone calls made? If there was anything else, could you specify it?

Ms Rule: I would just reinforce that that type of emergency response, dealing with the immediate crisis on the ground and reaching out to affected residents, is actually the role of the Emergency Services Agency. Really, the role for the Community Services Directorate comes in after the first days of those emergencies, to do things like food relief but also to look at the longer term community and social recovery aspects. The the immediate emergency response is not the responsibility of the Community Services Directorate.

MRS KIKKERT: Having said that, there were some residents who were without power for six days. In those six days you would have had access to streets which were

impacted by power loss. Did you not see it as fitting for the Community Services Directorate to doorknock and see if they needed any relief?

Ms Rule: No. That is not our role in an emergency response. That is the role of the Emergency Services Agency, and we work closely with them to provide whatever supports we are responsible for. It is really important in an emergency that there are not too many people out there doorknocking and falling over each other. We work closely with ESA in those circumstances, but that is not our role in the immediate emergency response.

Ms Davidson: One of the things that we see the effects of in our response to disasters is the relationship between different agencies and directorates and with our NGO partners, who might have particular relationships with people who are most at risk in our community. When we have those good working relationships then you are able to see the benefits of well-coordinated responses there. For example, I know that Access Canberra and Fix My Street were out there proactively looking for where there were trees down in the community and making sure that they were dealing with that and not necessarily waiting for everything to be reported individually. We know that there would be NGOs who would have people that they are working with in the community who are particularly at risk and they would have been in contact with those people as well.

We have also seen in our response, not just to things like storms but also to things like the mental wellbeing impacts of things like COVID-19, good responses across directorates as well, where we have recognised that something that is happening in one area will have impacts in another—for example, increasing mental health and wellbeing services, as we did in September 2021 in response to increased social isolation. That has included things like getting the first Safe Haven up and running before the Christmas period started, when we knew that there was going to be an increasing need for services, and getting a second PACER team up and running. That second PACER team has started working today.

We know that there will be effects of natural disasters that will happen across a whole range of different areas, and having a good, coordinated response where all the agencies are working together is what makes that work well.

Ms Rule: And for each emergency response, including this one, an emergency control centre gets established, under the leadership of the Emergency Services Agency. We in the Community Services Directorate are a part of those control centre arrangements, including the one that was in place for the west Belconnen storms. So there is a coordinated approach to reaching out to people and making sure that they are getting the help that they need but also that agencies are not falling over each other in that response.

MRS KIKKERT: Having said that there was a coordinated response between the different directorates, my understanding is that for six days there was hardly anybody on the ground doorknocking and letting people know that there was support for them. Did the Community Services Directorate receive notification from the Emergency Services Agency that these streets did not have power? Did anyone say, "What can we do to help them out, because we need help because we are attending other things?"

Ms Davidson: Yes, emergency services would have been responding to and dealing with the power outage issue.

MRS KIKKERT: That is correct.

Ms Davidson: We could talk some more about the work that we did to make sure that people could get access to food and to other things that they needed during that period while they were without power, if that is something that you are interested in.

MRS KIKKERT: I was just interested in what sort of discussion was happening between the Emergency Services Agency and the Community Services Directorate in regard to those six days without power. Why were there not any people doorknocking on those impacted streets and letting people—

Ms Rule: In the emergency control centre arrangements, which included us, ESA and the energy providers, amongst many others, there was visibility of which streets were out of power and we did coordinate relief efforts as people required them. It did not necessarily involve knocking on doors, but we certainly distributed food relief, for example, for people whose food had perished because their freezer was not on or their fridge was not on, making sure that people had access to essential supplies.

MRS KIKKERT: But I am speaking of those people who did not have access to either the internet or phones to call in that they needed support and help. A little bit of reaching out would have been helpful for them.

Ms Davidson: I think this is where a lot of the work that we have done over the past two years really comes into play: things like the know-your-neighbour cards that were distributed and a lot of the conversations that we have been having in the community about supporting each other, looking out for each other and understanding who might be at risk in your street, who are the neighbours who might be having a hard time if they are isolated. It is really important that people do have good social networks within their local neighbourhood and that they are able to support each other. We have seen that not just with things like this storm. I remember that, even back to the 2003 bushfires, I found out about them because a neighbour knocked on my door and told me.

These things are fundamental to being able to respond well in a crisis—that we have that good social fabric there. That is why, with things like the veterans grants and the seniors grants that we are assessing applications for at the moment, we have taken a COVID-19 lens to that in looking at how we can support community organisations and support our community to rebuild that social fabric, and to rebuild stronger connections so that, when things like this happen, nobody is left feeling like they are on their own with it. We know that we are all in it together and we can work collectively to recover from that.

THE CHAIR: I am conscious that there are only four minutes remaining and, as you pointed out, there will be a whole line of inquiry on this very issue, so there is plenty of time to have this discussion.

MR PETTERSSON: Following on from Mrs Kikkert's questioning, I was just hoping to get a bit more clarity about who the lead agency was at what point in time in responding to the emergency.

Ms Davidson: Specifically in relation to the storm, there were a number of key pieces of work that were happening there. Emergency services would be responding to issues like power outages and those very immediate situations, and CSD were responding to providing people with material supports and food relief.

MR PETTERSSON: Was there a lead agency or minister responsible for the response at certain points in time?

Ms Rule: Yes. There is a very detailed and clear framework for responding to emergencies that puts the control with the Emergency Services Agency. There is an incident controller appointed for every incident, including this one. We work closely with them but under the current established framework that coordinates all those responses, and under the direction of the incident controller. So it is ESA, not the Community Services Directorate.

MR PETTERSSON: Are you saying that ESA was responsible for the response the whole way through?

Ms Rule: Yes, as long as it is an emergency response under emergency circumstances. They maintain the responsibility and we work closely with them.

THE CHAIR: I would like to thank Minister Emma Davidson, officials and witnesses for assisting the committee today. I confirm that you will receive a copy of the proof transcript of today's hearings, when it is available, to check for accuracy. Please do liaise with the committee secretary if you have taken any questions on notice. Thank you, everybody. Today's public hearing is adjourned.

The committee adjourned at 12.59 pm.