LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING

(Reference: Inquiry into Annual and Financial Reports 2021-2022)

Members:

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

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 9 NOVEMBER 2022

Secretary to the committee:
Dr A Chynoweth (Ph: 620 75498)

By authority of the Legislative Assembly for the Australian Capital Territory

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

APPEARANCES

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Amended 20 May 2013

The committee met at 1.04 pm.

Appearances:

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

ACT Health
Moore, Dr Elizabeth, Coordinator-General, Office for Mental Health and Wellbeing, Mental Health and Suicide Prevention Division
Garrett, Ms Cheryl, Executive Branch Manager, Mental Health and Suicide Prevention Division
Arya, Dr Dinesh, Chief Medical Officer and Chief Psychiatrist, Office of Professional Leadership and Education

Canberra Health Services
Peffer, Mr Dave, Chief Executive Officer
McKenzie, Ms Katie, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services

THE CHAIR: Welcome to the public hearing of the Standing Committee on Health and Community Wellbeing inquiry into annual and financial reports for 2021-22. In today's proceedings we will examine the annual reports of the Community Services Directorate, Canberra Health Services and the ACT Health Directorate.

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

On the first occasion that you speak, could you acknowledge that you have read and understood the privilege statement, which is on the table in front of you? Today's proceedings are being recorded and transcribed, and broadcast and webstreamed live on the parliament's website. If you take a question on notice today, please say the words, "I will take that question on notice." That helps our secretariat to follow up with you after today's committee hearing.

We will move to our first session. We are joined by Minister Emma Davidson, the Minister for Mental Health and Minister for Justice Health. Welcome, Minister Davidson, and your officials. Before we begin, Minister, can you acknowledge that you have read the privilege statement?

Ms Davidson: I have read the privilege statement.

THE CHAIR: As chair, I will start with the first question. Minister, can you please provide an update to the committee on the work done over the last 12 months to establish the ACT's first residential eating disorders clinic?

Ms Davidson: Yes. It is good timing, because we have had some further developments since I talked about this in the last sitting week. We have now secured the block in Coombs that was the preferred site that we had been talking about. That means we will be going through a DA process towards the end of this year, and everything is still on track for the time line that we have been talking about to get our first eating disorders residential centre open.

It is the right location. We have a reference group that includes clinicians, academics, NGOs who work in this space, and people with lived experience. They have given us a lot of information about what kind of site we would need for this service. That block in Coombs is ideal in that it is in a residential setting and it has a beautiful outlook towards trees, the river and the pond. It will be a really good space where people can spend a few months getting into a recovery space and being able to continue that when they go home, being in a more home-like environment rather than a clinical inpatient setting.

THE CHAIR: Can you explain to me what will make this facility different from a hospital facility? What would constitute somebody who would qualify for this facility over a hospital visit?

Ms Davidson: Before I pass to Dr Moore, who can talk more about the model of care for this kind of facility, with respect to the only other facility of this type that is currently open in Australia, back in June-July I went up to the Sunshine Coast and had a look at Wandi Nerida. What we are looking to do in the ACT is very similar in style to that.

One of the key things that people who were receiving treatment talked about, when I went up there, was the importance of the peer group as part of their therapy, and the fact that it is in a very home-like setting, so that it does not feel like they are being further medicalised when they are trying to work through some of the socio-cultural and psychological elements of their treatment. I will pass to Dr Moore, who can talk more about why it is being done in this way.

Dr Moore: I have read and acknowledge the privilege statement. The model of care has been developed over quite a significant period of time to look across the continuum of care. This residential eating disorders centre is not for people that are acutely unwell. They require hospital care.

We have previously discussed who would be the service provider for this. It will be run by a non-government agency with appropriate clinical in-reach, and it will form part of the whole eating disorders continuum of care. We know that eating disorders are a chronic illness with very high mortality. It is important that, once people are treated clinically and are stable, there is a period of recovery. That is best done in a supported residential facility such as the one we are building in the ACT.

It is partly funded by commonwealth money. The commonwealth wanted us to follow a similar model to the Butterfly Foundation and their facility on the coast in Queensland. There is an emphasis there on peer support. There is an emphasis on recovery, and learning new strategies to deal with what is usually a chronic, long-term illness.

THE CHAIR: If the only other facility like this is in Queensland, and this facility is being jointly funded with commonwealth money and ACT money, how was it that the ACT came to be only the second place in the country to have such a facility? That might sound like a bit of a dig; you will probably tell me it is because the ACT is great. I am curious to know how the commonwealth came to that decision with our government to fund the facility here and not in New South Wales or Victoria.

Ms Davidson: There are facilities that are also being funded by the commonwealth in other parts of Australia, but we are further along the track towards having ours up and running. I expect that ours will be the second to open in Australia, after that Wandi Nerida one in Queensland, and there will be others that will come online in other parts of Australia over the next few years.

They will all be slightly different from each other, and that takes into account what is happening in different jurisdictions. This goes to the importance of having the Office for Mental Health and Wellbeing in the ACT and their ability to do the research and analysis, and have conversations and relationships with other parts of the health sector to take that deep dive and understand at a localised level what we need in the ACT and how best to make that work. Without having that there, it would make it a lot more difficult when we go into conversations like the bilateral negotiation with the commonwealth that we signed off in March this year.

THE CHAIR: How many people will this facility be able to accommodate at any given time once it is online?

Ms Davidson: That is still being worked out. I can pass to Cheryl, who can talk some more about the detail of what will go into that facility.

Ms Garrett: I have read and understood the privilege statement. The model of care that we have been working on for a couple of years looks at a facility of around 12 beds, or a minimum of 12 beds, to start with. We are looking at individuals who will be participating in the program at the residential treatment centre for a period of two to three months. Those detailed operational elements of the model of care will be subject to further consultation with a service provider, when that comes on board, and contributions from people with lived experience through our reference group and other mechanisms.

THE CHAIR: How does Canberra Health Services currently provide care to somebody with an eating disorder issue? Obviously, this will be, I hope, an improvement, but I am interested to know how we are supporting them now.

Ms Davidson: We have a range of different services for people with eating disorders in the ACT. We have an Eating Disorders Program. We also have a clinical hub for eating disorders, which opened in January this year, and it has made a huge difference regarding people's ability to access treatment.

The waiting list has changed from, in December last year, 644 days to now being 56 days. We also have an eating disorder early intervention service that is currently going through a procurement stage. I will pass to Katie McKenzie, who can talk some more about the range of services we have.

Ms McKenzie: I acknowledge that I have read and understand the privilege statement. Picking up from where Minister Davidson got to, we have our clinical hub for eating disorders. It is a life-span approach, meaning it targets children, young people and adults. It is a single point of referral. There is referral into the Eating Disorders Program or referral to other service providers who may help the person in their eating disorder recovery journey.

If the criteria are met, on entry into the eating disorder hub, that person will receive a single session intervention. If further criteria are met, they will be waitlisted for entry into the Eating Disorders Program. We currently have 76 people in the Eating Disorders Program. That includes young people as well as adults. Within the program they receive active therapy to treat their eating disorder.

MR COCKS: I am interested in hearing a bit more detail regarding how people with acute eating disorders are managed at the moment—in particular, their transition out of hospital. I have heard from, sadly, a number of parents with children with eating disorders who are concerned about the discharge process. They talk about a lack of support—and, in particular, with eating disorders being this complex amalgamation of physical and mental health issues, a lack of support for the mental health side of the equation. What is in place now when someone is discharged who has an eating disorder or who meets the diagnostic criteria for an eating disorder?

Ms Davidson: Before I pass to Katie, who can talk about the process for discharge and how we transition people to being supported to continue their recovery at home, I want to acknowledge how incredibly difficult it is for parents of young people who are going through this kind of treatment to see what they are experiencing. It can be a really hard journey for families. That is why it is so important that we also have the parenting group established in the ACT, to support the families and carers of young people who are receiving treatment for eating disorders. I will pass to Katie, who can talk more about that transition process and discharge.

Ms McKenzie: I want to pick up on the same acknowledgment. An eating disorder of a child impacts every aspect of their life and every aspect of their family's life. The experience that you are hearing from families is real. One of the challenges for eating disorder treatment is the coordination across that physical and mental health space.

With respect to what we are actively doing to address that, we have introduced our in-reach clinician. That in-reach clinician comes from the Eating Disorders Program. They are allocated to an individual young person. They attend the multidisciplinary therapy meetings that happen whilst that young person is an inpatient, and they help them to transition back into the Eating Disorders Program. That in-reach clinician is allocated to that young person for a four-week period, by which stage we hope that they will be picked up by the Eating Disorders Program to commence their therapy.

One of the challenges that families experience is understanding in that acute phase of nutritional deprivation that that is not the space for therapy. Therapy has to happen after some stabilisation has occurred, and the young person or adult is able to maintain some nutrition outside the hospital environment. It is a very complex space for families and young people to navigate. We hope that what we are doing, surrounding them at the points of transition, is helping them to navigate that.

MR COCKS: Absolutely. You are correct about the stabilisation period being essential. With respect to the protocol that I am hearing, the feedback—I am sure you have seen it in media articles—is about parents feeling that their kids are essentially being fattened up and sent back out, without the support that they need. What criteria do you use to assess eligibility for these services?

Ms McKenzie: For the service—

MR COCKS: For that four weeks of support that you were talking about.

Ms McKenzie: Anybody who has been admitted for treatment with an eating disorder will receive that four-week support on discharge. They then have to transition into the Eating Disorders Program, which is where the therapy starts.

MR COCKS: How long does that program last?

Ms McKenzie: A young person can receive up to 20 weeks of therapy. For a young person aged less than 18 years, they receive family-based therapy. The first phase of treatment is 20 individual sessions. For an adult, they receive cognitive-based therapy, enhanced, which again is a 20-session program. Once the 20 sessions have been delivered, it is then about what is the next phase of that journey for recovery for that young person or adult.

MR COCKS: Given that we are talking about something that is typically very much a chronic condition, what is the step after that 20 weeks?

Ms McKenzie: I will particularly reference family-based therapy. That is for young people, because we are talking about families and young people. They may then move to groups or they may move to less frequent therapy. An eating disorder treatment pathway is non-linear. It can take up to a number of years, and that young person, as they transition into adulthood, might need ongoing support. After the initial phase, it becomes a more individualised approach to meet the needs of the young person and where they are at in their life journey.

MR MILLIGAN: As part of the National Mental Health and Suicide Prevention Agreement, the ACT government committed to a range of actions under both the bilateral agreement and the commonwealth overarching national agreement. What existing data does the ACT government have on unmet psychosocial support needs for people with complex and severe mental health issues in the ACT?

Ms Davidson: Thank you for that question. Before I pass to Dr Moore, who can talk about what we know about unmet need and what we are doing about it, I would note that the bilateral agreement included an expansion of support for the Way Back service that is being delivered by Woden Community Service, in recognition of the fact that there were people who we wanted to be able to access that program, and that they needed some more resourcing to be able to do that. We now have Thirrili, an Aboriginal and Torres Strait Islander specific service, being established in the ACT. I will pass to Dr Moore, who can talk more about unmet need and what we are doing.

Dr Moore: Data continues to be one of our issues. We do rely heavily on research from other places, which includes the ACT data. From our data sources we have recognised that, certainly, there has been an increase in psychological distress, which is not surprising, given COVID and what we have gone through.

We also look at the access to services—not so much wait times, because wait times are dependent on acuity and they do fluctuate over time. This has been recognised nationally as an issue, and nationally there is work going on to look at how we can better improve our data sources. We also have some early data linkage programs. We are looking at data linkage with the commonwealth, and mapping, together with what we know about data. It is a work in progress.

MR MILLIGAN: What work has been undertaken in the ACT to meet the commitments under the National Mental Health and Suicide Prevention Agreement, and specifically in relation to the commitment to undertake a comprehensive state-based mapping of all current psychosocial support services outside the NDIS?

Ms Davidson: I might pass to Dr Moore, who can talk about that mapping work.

Dr Moore: The mapping work is being undertaken, coordinated by the national level, and it is at the early stages at the moment.

MR MILLIGAN: It is coordinated at the national level, but is there any contribution that the ACT government is making?

Dr Moore: Yes, but it is at a very early level. We will be looking at what we have available, as well as what we do not know.

MR MILLIGAN: Has there been any engagement by the ACT psychosocial support services sector with those with lived experience or other key stakeholders regarding the mapping of these unmet psychosocial support needs? Will that come later, down the track?

Dr Moore: It will. We will be setting up our governance structures.

MR MILLIGAN: When can we expect to see that? Is there a time line attached to it?

Dr Moore: There is a time line. I might pass to Cheryl Garrett, who is our representative.

Ms Garrett: There are national governance structures that have been set up to look at the psychosocial work and commitments under the national agreement, and time lines are being looked at. As part of those national governance arrangements across the whole national agreement, there are also members who are consumer representatives and carer representatives. There is a contribution from people with lived experience at the national governance level, and we will also be working locally with our stakeholders, as part of our contribution.

MR MILLIGAN: Is there a budget that has been allocated to cover the ACT's contribution for the mapping?

Ms Garrett: We would be undertaking that within the existing resources.

MR COCKS: I want to come to the Mental Health Workforce Strategy. Minister, in the few short months since I joined the Assembly, I have had well over 50 discussions with mental health stakeholders, from individuals with lived experience, their families and their carers, to territory and national representative bodies. I think that, without exception, these stakeholders have identified Canberra's mental health workforce crisis as the number one challenge facing Canberra's mental health system.

Minister, you tabled, fairly recently, the ACT's new and very highly anticipated Mental Health Workforce Strategy. The strategy is essentially one A4 page long, with a significant portion dedicated to illustrations. Is there more to this strategy somewhere?

Ms Davidson: Thank you for the question. I want to start by recognising that this is a national problem as well. That is why there is a National Mental Health Workforce Strategy as well. What we are dealing with in the ACT is not unique to us. There are things that we can learn from our colleagues in other jurisdictions as well.

In terms of that strategy, a strategy is, by its nature, a fairly high level document. People are really wanting to talk about what actions we can take. I might pass to Dr Moore, who can talk about the process for how we get to the stage of being able to work on those things.

Dr Moore: It is important to note that the framework itself, the strategy, is very high level, but there has already been work going on in this area. For instance, Canberra Health Services has been developing a very good strategy for attraction and retention. We have been having conversations around the peer workforce where, unfortunately, the ACT has dropped behind. This is a workforce that I believe not only has the potential to improve quality and safety but also is an untapped workforce.

MR COCKS: We can come to the workforce. The first question is: this is the strategy, isn't it? Is this one page the strategy?

Dr Moore: The strategy was preceded by a discussion paper. The discussion paper outlined our own problems, as well as the national—

MR COCKS: But this is the strategy; there is not a report that sits alongside it, setting out any actions or anything like that?

Dr Moore: There was more than one page, but the one-pager is particularly what people are focused on, because I believe it encapsulates what we need to do. We need to then move on to the actions and the implementation plan. We have been waiting for the National Mental Health Workforce Strategy to be released, and we have been waiting for a resource to continue to implement the other areas.

Ms Davidson: It is important, too, to note that, in developing actions that result from a strategy like this, there will be significant consultation with people with lived experience, the peer workforce, unions and professional associations. There is actually quite a bit of work to be done, and that needs to be done in consultation with the people in the workforce.

MR COCKS: That is helpful, but let me say that New South Wales has a strategic framework and workforce plan for mental health which is in excess of 100 pages long. The commonwealth's original workforce strategy, as a relatively high-level document, was around 40 pages long. Victoria has a current strategy that is about 60 pages long.

THE CHAIR: I hope there is a question at the end of this, Mr Cocks.

MR COCKS: Absolutely. What makes you think that a single page, which looks like it could have been drafted by a first-year management student at UC, is sufficient to address the critical shortages and those issues that we have now?

Ms Davidson: What you are really looking for is the actions that we will be taking. Certainly, in all of the conversations that I have been having with people in the workforce, professional associations, unions, advisory councils, a community coalition and all of the people who have such a strong interest in this, what they are really wanting to talk about is the actions.

Having the strategy out is great, but we are working through the next stages in being able to take the actions that will help. It is great to see that CHS is already working on things like recruitment and retention, but we know that we want to have a lot more conversations with people about the peer workforce as well.

MR COCKS: Minister, given your comments about people being keen to talk about actions, they have been keen to talk about actions for a very long time. Indeed, your predecessor, Minister Rattenbury, at the time, in November 2018, provided probably more detail about actions that would be taken. Indeed the words he used provided more detail than this strategy. Why has it taken so long, from 2018 until now, to get to a stage where you are only now thinking about what actions you can take?

Ms Davidson: I think what you will find is that there has been a continuum of work over a number of years, and that work evolves in line with changes such as the National Mental Health Workforce Strategy coming out. As you noted before, that is not the first document that has come out that talks about our mental health workforce. But things do change over time, and it is appropriate for us to revisit that and to do that in consultation with those unions, professional associations and community advocacy organisations that are also working in this space. Just because we have some work that we are still working through, it does not mean that the previous work does not still have merit as well.

THE CHAIR: Minister, I want to refer to a media release that you issued on 31 July relating to the bilateral agreement between the ACT government and the commonwealth on mental health funding. There was one point in there that I found particularly interesting, "the establishment of a territory-wide hospital avoidance strategy". Are you able to update the committee a bit more on why that is necessary, what that means practically for someone in our community with an acute mental health issue and how we will help to keep them out of hospital and in community?

Ms Davidson: Yes, absolutely. That goes to the vision that we have for mental health in the ACT about a kind, connected and caring community that is looking out for each other's mental health and wellbeing, and also our focus on early intervention and prevention.

There are a number of aspects of our health system where, if we get things right earlier, it can mean that we do not have as many people coming into our hospital system in an acute state of mental health. Making sure that we have the right services in place includes things like outreach services. It means having more services delivered in the community, and it means having more alternatives to people having to present to ED, which is not a place that you want to be when you are experiencing a mental health crisis. Having places that help people to achieve those better outcomes is a big part of that. I might pass to Dave Peffer, who can talk a bit more about some of the services that we have as part of that.

Mr Peffer: I have read and acknowledge the privilege statement. Along the lines of what the minister has been referencing, in terms of what the hospital has been seeing present to the front door, there has been a reduction in recent times of overall presentations but an actual increase in the ratio of admissions. We are seeing that acuity come into the hospital. It means that, for some people who otherwise would have presented to hospital, they are finding the care that they require out in the community, whether that be through NGOs or through their primary caregivers. I might ask Ms McKenzie to expand on that a little bit.

Ms McKenzie: It is important to recognise that a person's mental health recovery journey in hospital has the potential to be quite distressing and traumatising for them. If we can avoid hospital, or help them to discharge back to the community, back to their supportive environment and their own lives, where their recovery can take place as quickly as possible, that is actually in the best interests of the person. We do that through a range of services, particularly our services called Access and HAART. They are both focused on linkage early, as a hospital avoidance, and support on discharge. They provide a bridge to our community and adult community recovery services. This commitment will allow us to enhance those services.

THE CHAIR: For a layperson, would it be fair to say that this suite of investment in this space is almost the mental health version of the nurse-led walk-in-clinics? When the average Canberran thinks about keeping people out of hospital, this sort of investment is the mental health version of that; would that be a simple summary?

Ms McKenzie: I think it would be, with recognition that people with a mental illness who have spent time in hospital are quite unwell. It is about supporting them on their way home as well. I think it could be, for the layperson, a combination of the walk-in service, hospital at home and various other services which help people to recover in their home and community environment.

Ms Davidson: There is an interesting analogy there, because when you think about some of the things that walk-in-clinics do, some of it is about providing a service to people who otherwise might have had no alternative than going to an emergency department. Services like Safe Haven in Belconnen have proven to be very effective in people being able to get access to some support before things become so bad that they have no choice other than going to emergency. We had a report come out recently that showed the difference that Safe Haven has been making in its first six months of operation in the ACT. Clearly, that is the sort of thing that is helping people in distress.

It is also about system navigation, having services like MindMap for youth mental health and the holding service, which is a part of that. The report on the first year of operation of the MindMap service certainly shows that it is helping people to find the right services sooner, as well as supporting their carers or families to help that young person find the right services. If they have a wait time before they can access their first appointment with the service, Marymead's youth navigators are able to support people while they are waiting so that their condition does not deteriorate and they do not disengage from accessing services.

I refer also to the success of the Garran step up, step down after its first year of service and the number of people who presented to that who were actually stepping up from the community. It is not just about discharging from hospital and having that graduated transition back home; it is also about people stepping up to receive residential care without waiting for the need for inpatient care and admission to hospital. Once they go home, the four weeks of support from Woden Community Service, as part of their transition home, to keep them in a recovery state, has certainly helped in reducing the number of people having to come back again.

THE CHAIR: Can I play devil's advocate for a minute? If I read this cynically, and I wanted to be purposely cynical and glass-half-empty about it, I might say that a hospital avoidance strategy is an admission that we are bearing the brunt of the national workforce shortages of psychologists and psychiatrists. Because we do not have as many of those skilled workers as we might like in our hospital environments, we are instead resourcing more of these peer-to-peer, in-community services. What would you say to somebody who took a cynical reading of keeping people with acute mental health issues out of hospital and clinical environments?

Ms Davidson: We absolutely do have some difficult things that we are trying to work through, in terms of access to primary care for people. Being able to get an appointment to see a GP, get a mental health plan and see a psychologist cannot be the only way that we treat mental health and wellbeing. There is a whole range of services out there that people might need to access.

Navigating to find the right service and being able to get access to it quickly is not always easy. Making sure that we have well-integrated services is really important. We have also seen, over the last decade, that there has been a lack of investment in and support for primary-care services, and that has an impact on mental health and wellbeing for people. If it is really hard for you to get appointments to see a GP and have a GP who is well supported to be able to connect you to the right mental health service for what you need at that point in your journey, which is highly diverse across the community, it will be much harder for people to get the treatment they need at the right time.

All of these things have to work together. We are doing everything we can at the ACT level to provide people with more options, and to provide people with the support to navigate and find those options as well. Things like the Safe Haven and the MindMap service are important parts of that. Certainly, from what we have seen so far over the last year, it is making a real difference for people.

Mr Peffer: It would be our desire to have an empty hospital all of the time, if that was possible, but we understand that that is not the case. In the area of mental health, there is still considerable stigma attached to presentation and admission to our facilities. We have a wonderfully committed team that understands that. The balance regarding in-hospital and other supports that we offer is geared and designed to try and keep people out of hospital, wherever possible, and to intervene early to prevent that sort of deterioration.

MR COCKS: Minister, all the way back in 2002, the ACT government released its health action plan, which set the direction for health services in the ACT. That plan aligned with a lot of what you have been saying now around the objectives about early intervention, keeping people out of hospital and community care. How have things changed from between your vision now and a plan that was saying exactly the same thing 20 years ago?

Ms Davidson: We have a lot that we can look at over the last 20 years of the ACT's delivery of health services and the developments we have made in better understanding mental health and wellbeing, what kinds of services are needed for people, and the kinds of services that we have actually rolled out and that have proven to be effective. We have increased and expanded services such as the Way Back service, the PACER team, and step up, step down residential services. There is quite a lot that we can demonstrate that we have progressed over that period of time.

A big part of our ability to do that has been the establishment of the Office for Mental Health and Wellbeing, in order to deeply understand where there might be gaps for us to fill and how best we can do that in an ACT-specific way. The ACT will not do things exactly the same way as, say, Sydney, Melbourne or rural New South Wales; we are our own jurisdiction here, and we do have some unique situations that we are dealing with. I think that quite a lot has changed over the last 20 years.

MR COCKS: Do you not see any parallels between the current situation and the situation at that time, when the Mental Health Council of Australia considered that that plan failed to address the key problem—the shortage of services and clinicians to support those responses?

Ms Davidson: We have had national shortages of service across a range of different areas of health and wellbeing, including mental health and wellbeing, across the entire country over the last 20 years. These have been worked through in many ways by many different jurisdictions. The ACT is not unique in continuing to face challenges there.

What I can tell you is that we have made significant progress in the range of services that are available to people, in their ability to navigate to find those services, and the outcomes that people are experiencing by being able to access more of the right services at the right time. I am happy that we are able to continue working on that, and that we have an Office for Mental Health and Wellbeing that has such deep relationships with our community here in the ACT, with people with lived experience, and with clinicians and advocacy organisations who are working on these issues, so that we can work out what we need to do in the future and continue on that pathway towards more early intervention, more prevention services and making sure that we have a well-supported workforce.

MR COCKS: Given that you have just referred to those 20 years of challenges, it is worth noting that most other jurisdictions in the country already have some form of workforce plan or strategy, whereas the ACT has been foreshadowing one since at least 2005. Minister, why has it taken since 2005 to get to the point where we now have one plan on a page with less than 400 words?

Ms Davidson: As we were talking about earlier, the work on our Mental Health Workforce Strategy and the actions that will be taken as a result of that is ongoing, and it will be done in consultation with professional associations, unions, advocacy organisations and people with lived experienced who are stakeholders in this work and partners with us in making sure that we have a well-supported workforce in the ACT.

MR COCKS: But we are talking about 20 years. Why has it taken so close to two decades to get to one page?

Ms Davidson: As we were talking about earlier, there has been a significant body of work that has been ongoing in the ACT and nationally over that period of time, and it continues. Work has already been done. You were referring earlier to a 2018 report from the previous mental health minister. The work that has been done should not just be discounted, and you cannot say that it did not exist.

MR COCKS: I would hope not.

Ms Davidson: We have been working on it. We continue to work on it. The workforce has been changing rapidly over the last couple of years. They have been through quite a lot, and we have learnt quite a lot out of what we have been through with COVID. That all goes into what we are thinking about both at the ACT level, for our Mental Health Workforce Strategy, and with the National Mental Health Workforce Strategy as well.

MR COCKS: You are correct that the ACT workforce has been absolutely stretched. Maybe it would be useful for me if you could take me through the process of developing this plan—when it started and what that process has looked like. Can you step me through? Were there any consultants involved? What meetings have you held to get to this point?

Ms Davidson: We just had a conversation about the development of the current strategy and what will be done next, in terms of consultation and actions. In terms of what you were referencing there about everything that we have been through in the last couple of years with our workforce, we are currently doing a lot of work with that wellbeing and recovery fund. CHS has been doing some great work with the workforce on what it is that we can do to best support that workforce with their immediate issues that they are dealing with and the impacts that the last couple of years have had on them. It is quite a large piece of work, and I am really happy that the way in which we are doing that is by working with people in the workforce to design the solutions that will support them as we move forward.

MR COCKS: That is all well and good. I am interested in the steps and the process that you have been through to get to this document.

Ms Davidson: To get to the current ACT Mental Health Workforce Strategy?

MR COCKS: That is right. When did work on that strategy kick off, and what steps were involved?

Ms Davidson: Dr Moore can talk to the detail of that.

Dr Moore: We started thinking about this in about August last year and produced a discussion paper. A discussion paper was brought together by the Office for Mental Health and Wellbeing. There were no consultants involved. It was a literature search, and I am very happy to send that to you. It is in the public domain.

Following that, there was a motion passed in the Legislative Assembly which asked the minister to present a draft strategy to the Legislative Assembly. So, rather than disseminating the discussion paper and asking for people to come together, we disseminated the discussion paper, asked for help from various sectors, including the university sector, the education sector, the current clinical workforce, consumers and carers and non-government agencies.

The groups met, and we had to do most of this online—but I think that has actually been one thing that has been a boom from COVID. The ability to have separate rooms and to work in workshops whilst online was really quite interesting. There was a degree of consensus around the parts of the workforce plan. The consensus was around that there was actually a need to look at this from not only a strategy of attracting and retaining our current workforce but also making our workforce of the future industry ready in terms of being highly informed and understanding the mental health workforce needs. Of course, we always have evaluation as part of any of our strategies. We did not have a separate part for a peer-led workforce, because we thought all of the different parts of the workforce strategy actually related not only to clinical services and non-clinical services but also peer-led work services.

Following the strategies being delivered up to the minister, we continued to work with Canberra Health Service, who were already starting or continuing their workforce attraction and retention strategies. We had discussions with the major universities and with CIT, and the ANU is currently undergoing a curriculum review. So it is all around timing to get things into various curricula.

We wanted to have discussions around how we could drive consumer-led and peer-led services in the ACT. We were a little constrained in that the National Mental Health Workforce Strategy had been completed and was awaiting release, and we did not want to duplicate what might be done in the National Mental Health Workforce Strategy. We try to align our strategy to the National Mental Health Workforce

Strategy. I believe it has either just been released in the last couple of days or is just due for release. That was going to be our next phase in terms of kicking off our implementation and consolidating our actions, many of which are already under way.

MR COCKS: According to the Mental Health Advisory Council communique of 3 March, the strategy was expected to be tabled on 21 March this year. What was the cause of the six-month delay?

Dr Moore: That is a good question. I am trying to think back to—time is a very abstract concept for me these days—what has happened between March and now. There has been quite a lot happening, and the Assembly, as you know, has been extremely busy.

MR COCKS: It is a fairly important document.

Dr Moore: It is a very important document and we wanted to make sure that we can have the time to actually discuss it in the Assembly as well.

Mr Peffer: One of the constraints on progressing a range of work within the health portfolio has been the ability to consult with our clinical workforce. They have been deployed, obviously responding to the pandemic. That has taken quite a toll on the workforce and has put the brakes on our ability to engage in a range of activities and consultations, slowing some things down.

DR PATERSON: This morning we heard from the Office of the Official Visitor Scheme and were talking to them about complaints made in Corrections. The lead and key complaint was around access to health services within AMC. I am interested to know what we could be doing to improve our health services offered in correctional facilities.

Ms Davidson: We absolutely recognise that getting access to good health services while you are in the AMC is really important for planning for that transition back to the community, reducing recidivism and reducing overrepresentation for Aboriginal and Torres Strait Islander people. I am really glad that people in the AMC have a choice of who they can get their health care from, whether it is from Winnunga or from Justice Health Services.

But there are actually some limitations and some constraints that we have to work in that are quite unique to the AMC in terms of the layout of the facility and people being able to get into the Hume Health Centre and get access to services. That is why we are working on a Justice Health Strategy at the moment. I can pass to Katie McKenzie, who can talk a bit more about the process for getting that Justice Health Strategy.

Ms McKenzie: We are jointly developing the Justice Health Strategy with the Office of Mental Health and Wellbeing. We have included the Official Visitor into that process as well as Winnunga. We have had two meetings—I think that is correct—and they have gone very well. One of the key things that we are focusing on is access to health care.

I think it is also worth noting that one of the points of constraint in there is about access to nursing. Nursing has been very severely impacted by the COVID activities in the AMC. That is a contextual facture that is a really important thing in that setting.

DR PATERSON: When is the implementation of the Justice Health Strategy and when may we start to see improvements in access in the AMC?

Ms McKenzie: The strategy will be completed in March next year. We are already concurrently working to improvements as well, including having a look at our workforce and looking at how we can deal with our vacancies. The break from COVID activities, with no COVID in the AMC, is a welcome break. That is giving us the opportunity to really focus on our operation improvements.

DR PATERSON: What will be the key focus in the operational improvements to ensure that detainees do have access to medication and access to health care?

Ms McKenzie: The key things that we are going to focus on are telehealth, access to specialists, how we can ensure that detainees get their specialist appointments and quicker access into nursing. They will be the key focus areas.

DR PATERSON: Thank you.

MR COCKS: Minister, noting that your comments around time been an abstract concept, I will not push too much more on the time frames, but I want to come to the content of this workforce strategy. Fewer than 400 words, as I said before, and essentially four dot points with accompanying clip art—cover what you will do with your workforce goals. That includes gems like the dot point which states, “attraction, recruitment and retention”. Minister, literally every employer in the world aims to attract, retain and recruit staff. How is this any different from what you should be doing anyway?

Ms Davidson: I think what people are really going to be wanting to talk about are the actions in how we attract and retain staff. If I take, for example, the thin markets that we see and the workforce pressures that we see in disability services, we are dealing with quite different things there to what we are dealing with in the Mental Health Workforce Strategy. In order to deal with the workforce pressures that we see in disability services, there are some structural issues in how services are paid for and financed. That has a real impact on the ability to get the right kind of allied health professionals into some parts of Australia.

For the Mental Health Workforce Strategy, attracting, recruiting and retaining staff is actually a key part of what we need to do there, and that is why it is in there. So I am not sure why you are asking about that.

MR COCKS: As I said, it is a fundamental part of what every business and every employer does. It is unclear to me that the extent to which you addressed attraction and recruitment is to say, “Yes, we are going to do it.” There is nothing in there that goes to how. There is nothing that goes to tangible actions that you are going to take. And it has taken a very long time to get to a point of saying, “Yes, we are going to attract staff.”

Ms Davidson: A strategy generally does not answer the detail of how we do a thing. It tells us at a broader level what it is we are going to focus on. But, if you want to answer the question of how, that is in an action plan.

MR COCKS: Perhaps you would like to have a look at a couple of those national level strategies. Quite often they do go to that sort of detail. But let me follow that up. Another dot point in that section refers to data driven planning, monitoring and evaluation. Precisely what sources of data are you referring to?

Ms Davidson: I might pass to Dr Moore, who can talk a bit more about our data sources.

Dr Moore: Thank you, Minister. Some of the data sources we have and some we need to create. We have data sources, as you know, with the AIHW, which gives you a percentage, per 100,000 population, of psychiatrists and of psychologists. We also have some data through different services around peer led—for instance, Mental Health Services Australia—on the number of consumers that we have.

We are actually above the average in Australia for psychiatrists, and definitely above the average for psychologists in the ACT. However, that does not negate the fact that we do have overwhelming need and we do need to continue to attract and retain our staff.

The data that we would like to continue to collect is the number of people that we actually train locally who stay within the ACT. We do have some data around that for psychiatrists. We do need to get more data in terms of nursing. I will be working with the Office of the Chief Nursing Officer to see if we can do that.

MR COCKS: Do you have targets yet for what the mental health workforce should look like in the ACT?

Dr Moore: Targets depend on how much investment you have in your different sectors in—

MR COCKS: Let me rephrase that. Do you have any idea of what it would take to meet the need in the ACT?

Dr Moore: Again, that depends on where you put your investment. I would like to come back to a point the minister has said. We are continuing to put our emphasis on acute services. If we do not put some of our investment into promotion and prevention, we will continue to drive acute service delivery.

So some of our workforce has to be in that prevention area. It has to be teaching our population and also encouraging our population to be able to manage what I think is a range of mental health issues. Anxiety, as I said before, is something that is normal. It only becomes something that you need to see somebody for if it overwhelms your life where you cannot manage it. So we need to continue to put our money into our prevention activities.

MR COCKS: Thank you.

THE CHAIR: I am going to move on with some more substantives, to make sure everybody gets a go. I want to pick up on Mr Peffer's point before that the ideal is an empty hospital. I love that. I want to talk more about the things that we are doing to keep people out of hospital in general. In particular, I would like an update on the Step Up Step Down Program in Garran. Is that delivering as we intended, and what do those deliverables so far look like?

Ms Davidson: I think Katie McKenzie, will be able to provide you with that detail. One of the things that I am really excited about with the Garran Step Up Step Down is that it is a real partnership of a number of different services. We have got STRIDE, who are running the Garran Step Up Step Down; we have got Woden Community Services, who are supporting people when they go home; and we have also got CHS going into the Step Up Step Down to provide services where needed as well. That partnership approach is making a real difference for people, and it is also really helping to expand our skills in the community and support our whole sector. I will pass to Katie, who can talk about—

THE CHAIR: Katie might be able to answer this question. I appreciate I went straight to tintacks and there might be people joining us who have no idea about the Step Up Step Down Program. So let us start from the beginning. What is it? Who would go to the Step Up Step Down program? Then we will get the figures on how it is working.

Ms McKenzie: Step Up Step Down is exactly what it means. So you can step up from the community. It is a supported environment. It is not a clinical environment, but it is about ensuring that you have support at the time that you need it. That support can be given as you step up from the community or as you step down from the inpatient. It is just a phase of supported living in somebody's mental health recovery journey.

THE CHAIR: Tremendous. How many people have we supported in this program since it was established?

Ms McKenzie: I may have to take that as a question on notice. I can say 100 per cent occupancy. It works very well. It is a very important part of our discharge and admission journey. One of the things that we have done this year to really strengthen that partnership and the interface that we have with Step Up Step Down and various providers in that space is introduce a mental health link team. Housing is such a critical part of somebody's recovery journey. The mental health link team pulled all of our conversations about housing into one team who are able to help both our program areas and consumers navigate into where the best place is for them. That can be as they are discharging or as they are stepping up from a community recovery service.

THE CHAIR: Ms McKenzie, you said that it had 100 per cent occupancy. Would I be right taking from that that there is actually a demand that outstrips the service's capacity at the moment?

Ms McKenzie: I think there is a well-known demand for sub-acute housing within the ACT for mental health consumers.

THE CHAIR: Step Up Step Down was a new program, not unlike some of the other programs we have spoken about today—sort of national firsts. What are some of the key findings so far from this investment? Firstly, are we getting a good return on the investment and, secondly, what are some of the key findings?

Ms McKenzie: I could not put a figure or an exact amount to that investment. If you would like that, I can take that as a question on notice. What I can say, though, is that any investment—and this goes back to early intervention and support outside of the acute setting—in stable and secure housing is a good investment for somebody who does not have that.

Ms Davidson: I actually have the annual report from Garran Step Up Step Down open right now. So, if there is anything that you want to ask me, I could probably give you some numbers. I can tell you, for example, that they had 142 individuals who were supported in the 2021-22 financial year and that they had only a 10.6 per cent re-admission rate within 14 days of exit from the Step Up Step Down, which is quite low. It means that people were able to get in there and get the help they needed and then be able to continue their recovery at home.

THE CHAIR: This is a cheeky question, Minister, because you cannot make future policy announcements, but it sounds like Step Up Step Down is working and we have just one in Canberra.

Ms Davidson: We actually have a number of them in Canberra. The Garran one is the newest of them. We have five Step Up Step Down services in Canberra, and they all meet slightly different demographic needs. We have some Step Up Step Down services that are specifically for young people as well as Step Up Step Down services for adults as well. We are certainly looking at what else might be needed.

The annual performance report from the Garran Step Up Step Down has a bit of breakdown in terms of gender—how many male and female participants they had, how many First Nations people and how many from our multicultural community. Of the people who accessed the Garran Step Up Step down in the last financial year, 21 per cent were from our LGBTIQ community. It is actually really reassuring to me to see that people in our LGBTIQ community are finding that that is a safe place for them to be able to access services. I think that is something we should be proud of in the ACT.

THE CHAIR: Great. So there are five in the ACT. Is Step Up Step Down an ACT model or are there Step Up Step Down facilities in the rest of the country we have modelled ours off? I suppose that might be a question for other governments, but no doubt we can compare and contrast to other jurisdictions.

Ms Davidson: I am sure Dr Moore will be able to talk about what has gone into our thinking of why Step Up Step Down is something we are doing in the ACT and comparing that to other jurisdictions. But something that I think is also really worth noting is that a proportion of the people who use the Step Up Step Down service are stepping up from the community. About one-third of the people who used the Garran service in the last financial year were stepping up from the community.

So it is not just being used as a transition home from hospital; it is people in the community who are realising they need all the support that they can get from seeing their psychologist or group therapy programs they are accessing in the community and are being actually referred in there by services like the Home Assessment and Acute Response Team, the HAART team, that Katie McKenzie was talking about earlier, the Gungahlin mental health team and Tuggeranong and also from Access Mental Health.

That is why being able to invest in those hospital diversion programs that we were talking about earlier, things like HAART and Access Mental Health, actually helps us to get people to the right services at the right time and reduce the risk that they end up in hospital. I will pass to Dr Moore who can talk about comparison with other jurisdictions.

THE CHAIR: That would be great. Thank you.

Dr Moore: Thank you, Minister. Yes, most other jurisdictions do have Step Up Step Down. They call them different things. In Victoria, there is the Park Model. Most Step Up Step Downs have both a component of stepping up as well as stepping down. It is that idea of the continuum of care; so people can choose the level of care that they need.

Post-hospital, Step Down is a really important part. I think Garran is unique in that not only do they get the time in the Step Up Step Down but also they get more intensive follow-up for a couple of weeks post-discharge from the Step Up Step Down. We know that transitions between care are a difficult time for people and it puts them at increased risk. So this is something that I would encourage.

MR COCKS: Minister, those services are really valuable. They have been proven effective across the country. Do you know how many people have been turned away from the service in Canberra?

Ms Davidson: From our Step Up Step Down services? I do not think I would be able to put a number on that. But we do know that it is really important to have a diverse range of services available to people—for example, having things like Safe Haven open as well, and seeing how well that has gone in its first six months of operation and the difference it has made. As an example, there was a woman who has been accessing that service regularly since January of this year and has told me that she has been able to reduce the number of additional appointments she has needed with a psychologist or with her NDIS plan because of being able to go in and access that service. Certainly when people are having difficulty waiting for a service, having a range of other services available to them as well does help to reduce that pressure.

MR COCKS: Thank you, but I am very keen to understand what the turn-away rate is. If you are able to provide that on notice in any way, that would be really useful because they are not the same model and they do not have the same evidence base behind them.

Ms Davidson: Yes; I will take that question on notice.

MR COCKS: Minister, going back again to the workforce strategy, the largest and final section of this strategy sets out the outcomes that you are aiming to achieve, essentially. These are the ways that you are going to measure your success. I would like to run through a couple of those quickly. One of those outcomes says the ACT mental health system is considered an attractive place to work. How are you measuring that and why is it not yet an attractive place to work?

Ms Davidson: I would not necessarily say that it is not an attractive place to work. For example, the last financial year, as we were preparing to open ward 12B, which is a sub-acute mental health ward, we found that there were people from interstate applying for jobs, wanting to come to Canberra specifically to work in that ward and to work in that model of care. I think that really says a lot about how attractive the ACT actually is to people outside the ACT as a place to work. But I will pass to Dr Moore, who can talk a bit more about how we are going to measure the outcomes.

Dr Moore: Thank you, Minister. As with all outcome measures, it is getting the right outcome. As to having somewhere that is attractive to work, there could be a number of things we could measure. That is a piece of work that we will be doing. We already do surveys of staff, but we only do them in certain areas. What I would like to see us do in that section is actually have a much more thorough way of looking at how we will measure that. So it is a work in progress, Mr Cocks. I am very happy to take any advice from you.

MR COCKS: I might come to another measure or outcome that you have got there, which is that the ACT community is able to access safe and responsive care. Again, how are you looking to measure that one and what is the current situation—what is the baseline we are working from?

Dr Moore: Again, that is part of the strategy that we will look at. We look at safe care in a number of ways, and I am sure that Katie can help answer this question. Access is an issue that we want to measure. Is it getting the right care at the right time? Is it having the number of available services? We are going to be taking that to, once again, a multidisciplinary group with consumers and carers. We have already started some of that work on outcome measures with the MHCC, the Mental Health Community Coalition. We are awaiting a report from them.

MR COCKS: Just to wind up on this, the strategy does seem underdone and that there is more work needed to turn it into something where we have got practical actions that we can move forward with. What processes and what governance arrangements do you have in place to make sure we have input from the relevant stakeholders for the next implementation stage, including people with lived experience, the community, the mental health sector and registered training providers?

Ms Davidson: Your question highlights the difference between a strategy and an action plan. It goes to what I was talking about earlier. The detail of exactly how you deliver something is something that you see in an action plan. That is why we will be doing that consultation. I will pass to Dr Moore, who can talk about what the consultation process will be, with the next steps.

Dr Moore: For all of our implementation plans, all of our work plans, we form a steering group. The steering group has representatives of consumers and carers, as well as the relevant stakeholders. In this case it will be clinicians, service providers, the universities and the other educational institutions. We will have that steering group. They will also need to have their own ability to coordinate input from their relevant stakeholders.

The action plans that we have done in the past have all been very collaborative and co-designed, and I see no reason to change that. We would also include in that the commonwealth government, because of the National Mental Health Workforce Strategy.

In terms of reporting back, we report back to the minister on a regular basis on all of our action plans to ensure that she has visibility and that we are not missing another element.

It is important to say that we have other stakeholders here. We have an inter-directorate committee. That goes across the whole of the ACT government. Much of the work that we do is not just in the health portfolio. With a mental health workforce strategy, we have psychologists, for instance, in education who also deal with mental health issues, and it is important that they have input into this. We also have private practitioners and unions that we consulted when we put together this high-level strategy, and we would also be making sure that they were involved in this.

MR COCKS: When do you expect to have that action plan ready for public consumption?

Dr Moore: We are, of course, now going into the DHR and the Christmas period. I would hope that we would be able to get something to the minister by April next year.

THE CHAIR: Minister, referring back to that agreement with the commonwealth for the $37.5 million package in mental health supports, one of the things I was interested in getting more information about was the extension of the second Police, Ambulance and Clinician Early Response team. What do we know of that team over the first 12 months since it was established, and what evidence base are we drawing on about its success or otherwise to support re-funding and expanding the program for another 12 months?

Ms Davidson: Before I pass to Katie to answer the detail of what we have learned so far, certainly, all of the feedback that I have been hearing from people in the community, as well as from services, including the police, is that they are very happy with the results that they have been able to achieve with that PACER service. It has been very good at supporting people to reconnect with the right services in the community and not have to go to hospital unnecessarily. It has given police an alternative to having to take people to the emergency department, when they get a call from someone who is actually in a mental health crisis. I will pass to Katie, who can talk about how that has gone so far and what we have learned.

Ms McKenzie: PACER is one of our real success stories. It is well celebrated and it is a really good example of our commitment to work across agencies. We are actively evaluating PACER at the moment. We have a process open and we are looking at data; we are seeking consumer feedback and carer feedback.

One of our main measures of success for PACER is how many of the attendances result in hospital diversion. Fifty-nine per cent of the call-outs in the morning shifts resulted in hospital diversions and 79 per cent of the p.m. shifts were hospital diversions. They are able to de-escalate, support the person through what is happening for them in that moment and ensure that they are supported—they have supports in place for the next part. That is our main measure of success. It is working very well, from our perspective, and we look forward to the outcome of the evaluation, which we are hoping will be completed by the end of January or early February.

THE CHAIR: Those are incredibly high figures. When the PACER team does divert somebody from hospital, where are they diverted to?

Ms McKenzie: There is a range of services. They may be diverted to private services that they are linked in to, or back to their GP. They may also be diverted into our intake services, which I mentioned a little earlier—our access or HAART teams. They may be linked in to their community team, either through CAMHS or the community recovery team. There are many things. It is about diverting them and supporting them with a service that is right for that person.

Ms Davidson: It is also worth noting that when we started PACER, we did not have a Safe Haven. We now have a Safe Haven as well as PACER. Both of those things are providing services to people who might be experiencing distress in different ways. They provide services in different ways. There are opportunities now for us to look at how we get all of our services working well together and make sure that people know there is a full range of places where they can go for help.

THE CHAIR: Are we aware of any PACER program or PACER-like program in any other jurisdiction in the country?

Ms Davidson: I might pass to Dr Moore, who can answer more about what else there is around Australia.

Dr Moore: Yes, there are a number of PACER programs around Australia, and in Scotland. It is about learning from other jurisdictions and what has worked there, but we need to contextualise it for the ACT.

THE CHAIR: Are there any particular ACT contextualisations that we have had to do to implement our PACER program? I suppose I am giving you a bit of a kick here, Dr Moore: what makes our PACER program special, and to be getting the kind of figures that Ms McKenzie pointed to?

Dr Moore: Of course, it is our clinicians. It is the coordination between the three services. Also, it is to do with tailoring the times of day when PACER is available. We originally started with one shift and we have gone to two shifts, in response to that.

THE CHAIR: The intention is that that will be extended even further, with the funding announced a few months ago; would that be correct? That is for another

PACER unit?

Ms Davidson: We currently have two PACER units. As with anything that you are trying for the first time, you pilot something, you look at where you might need to pivot, expand or change the way in which you deliver it, and you have evaluation processes that give you some good advice about what that might be.

With respect to one of the other things that we might need to look at, you were asking before about where people can be diverted to. In some cases people might actually need to go somewhere for a short period of time before they return home. It might be that hospital is not the appropriate place for them, but having somewhere else that they can go to that is a place of safety is really important. That is part of the reason why we are also doing things like opening Safe Havens. We also need to look at what happens in other jurisdictions and whether that might be applicable to the ACT, for future plans.

DR PATERSON: I have questions in respect of the Chief Psychiatrist's annual report. Is that for this session?

Ms Davidson: Yes, you can ask them.

DR PATERSON: In table 62 of the annual report, under the apprehensions and the apprehending professional, the figure for authorised ambulance paramedics apprehending people has decreased very significantly, but it seemed to have risen over the last three years, pre-COVID through COVID. I am wondering why there is such a decrease in ambulance paramedics as apprehending professionals.

Ms Davidson: I will pass to Dr Dinesh Arya to talk some more about that decrease and what might be driving it.

Dr Arya: I have read and understand the privilege statement. The key driver that brought those numbers down was an amendment made in February 2021 that allowed ambulance officers and police officers to bring people in if they agreed to come in. Prior to this amendment, whenever ambulance and police officers were called, they were bringing people in, irrespective of whether the person changed their mind and agreed to come. That, I think, is the significant driver. As the minister was saying before, and as Ms McKenzie was outlining, PACER has also been a key influence in terms of making appropriate supports available for people. People do not necessarily need to be brought in for apprehension or an assessment.

DR PATERSON: Going to the involuntary detentions, those numbers have not changed. They continue to remain, I would say, fairly stable. But a thousand people is still a high number for involuntary detention for up to three days. From speaking to constituents who have been involuntarily detained, it has been a very traumatic process for them. My question is: what are we doing to actively reduce that number and how are we working with the community so that people are not involuntarily detained?

Ms Davidson: That goes to the heart of that aim we have around investing in earlier interventions so that things do not reach that level of acuity before someone is able to access help. It is about making sure that people have an awareness of what services can help them, that they can be referred into them quickly and that we have enough of those services at that earlier intervention point to meet the demand. That will be helpful for us in reducing the number of people who reach a level of acuity where they end up in hospital or with an involuntary admission.

DR PATERSON: When would you expect to start to see a decrease in that number?

Ms Davidson: I might pass to Dr Moore, who can talk in more detail about where we are headed with earlier intervention and what kind of data we might have about that.

Dr Moore: It is important to understand that, if a person requires involuntary admission, they are fairly significant and severe in their illness. We do not have a crystal ball, but we have been undertaking a program with the Brain and Mind Centre called "Right care, first time, where you live". This is a modelling tool that is under development, and we are the first jurisdiction to undertake that. That is looking at interventions that will make a difference. You can plug in your intervention and see in five to 10 years time what will actually influence mental health and wellbeing. We have had three workshops on it. The model is coming together. We hope to have a report that will be of use in our future planning.

In terms of the absolute numbers of people that require involuntary detention, I cannot crystal-ball gaze as to whether or not that will go down, but we do know that we have checks and balances to make sure that that is an appropriate level of intervention. What the minister has spoken about, in terms of early intervention and trying to make people aware of what they can do before it becomes so difficult that they require involuntary detention, is something that is still going on. It is a work in progress. I am sorry; I cannot give you a definite answer.

Ms Davidson: I can tell you, though, having seen that modelling tool recently at one of the workshops, that that tool is unlike anything else that I have ever seen in terms of being able to quantify what would be the impact of being able to provide some of these services to people at an earlier stage. I think it will be incredibly helpful for us in understanding where is the best place to invest in mental health services to have the greatest impact on those with the most acute need.

DR PATERSON: I have spoken with the Public Advocate in hearings before and they assess every application for involuntary detention, and oversee them, but they are very stretched in their resources to evaluate all of these applications that come through. Is that something on which you are working with Minister Cheyne to ensure that, where people are involuntarily detained, there are adequate checks and balances on whether that was an appropriate course of action?

Ms Davidson: One of the great things about the different kinds of oversights we have in the ACT is that there are a number of ways in which people can ensure that their human rights are respected and supported, and that processes are working the way that they should be. It is not just the Public Advocate; we have Official Visitors and we have the Human Rights Commission. There are a number of ways in which we can make sure that we are doing things the right way and we can address any issues that might be occurring.

DR PATERSON: What sort of oversight is there? Are you comfortable that we have adequate oversight, when people's human rights are actually being taken away, that it is an appropriate course of action for these individuals?

Ms Davidson: What I was just saying goes to why I feel that, yes, we do have good oversight mechanisms in the ACT because we have a diversity of them. We are not reliant on a single point, and I think that really helps us. We want to make sure that each of those oversights, whether it is the Public Advocate, the Official Visitors or the Human Rights Commission, are all properly resourced to be able to do the work that they are doing. I really value the fact that we have a variety of them, so that there are a number of ways in which people can have their needs addressed.

MR COCKS: I would like to come to the digital health record, MyDHR, and the potential unintended consequences which could arise. I have been hearing from a number of people who are worried that their previous mental health diagnosis will appear in this system and could impact their symptom treatments in the future in relation to both mental health and physical health concerns. What protections are built into the system to look after people so that they are not discriminated against, even subconsciously or unconsciously, regarding previous diagnoses?

Ms Davidson: I am glad that you asked that question. Having previously worked in social research and advocacy, mostly for women's health but including mental health and wellbeing, having previously worked at the AMA when digital health records were being rolled out at a federal level, dealing with the questions and making sure people were adequately trained and supported, and having worked in software development, I had a pretty strong interest in making sure that we were doing this right. I will pass to Dave Peffer, who can talk about what we are doing to make sure that people's privacy is respected within that DHR system. Yes, we have been looking at this carefully, and making sure that we are doing the right things.

Mr Peffer: As I answer, I might not respond exactly to what it is you are looking for, so please guide me if I am not on the right track here. The digital health record essentially will displace many of the existing primary business systems that we use within the health service to provide services. For any of the patients that we have on current treatment plans, or for any who may be inpatients with us at the time of cut-over, which commences this Friday, we will transition—"cut-over" is the term that we are using—those patients, treatment plans and so forth, from the existing business systems into the digital health record.

The benefit that that brings in an area like mental health, which interfaces with many other areas within the health service, is that you do not get that dislocation of care when it comes to the technology and the information stored across disparate business systems. I have spent time myself with teams in the emergency department who are perhaps admitting a patient to the mental health short-stay unit, where they have to physically print out from EDIS, the emergency department business system, the patient's information and physically walk it 10 metres to the short stay, where registrars or others will load that information into the next business system, to continue that care.

One of the underpinning reasons that we are bringing in the digital health record is essentially to eliminate that dislocation of care when it comes to business systems.

MR COCKS: Maybe an easier way to ask would be: will there be any visibility to administrative staff, or even low-level medical staff, of someone's previous mental health diagnosis when they present to the ED?

Mr Peffer: To the extent that that information is visible now, we would expect that in the future that will be visible. But that is an important part, I think, of the continuity of care.

In terms of the information that flows, it is kind of the lifeblood of our organisation. We need that information to be able to provide care and support people as they come into our facilities. We have a range of policies and procedures that govern, incredibly tightly, who can access what information and for what purpose. From time to time it may be that people breach those procedures, and we respond to that accordingly. All of that transitions with us into the DHR.

The business system that is being delivered is an Epic platform. It will sit inside a very secure health enclave, which will itself sit within a secure ACT government server environment.

MR COCKS: Okay; you have probably covered that part of it. The other concern I have heard is that I understand there is an impact on prescribing. I am interested, particularly, in the sense of psychiatric conditions. I understand that there is a barrier that prevents interns from writing scripts for outpatients, to do with legislation. Can you talk about what is happening in that space?

Mr Peffer: Yes. A range of challenges, as the program has rolled forward, heading towards our Friday night, Saturday morning, go-live, have been identified, as there are more and more eyes on the system. We have had hundreds of our team members or our subject matter experts who have helped to design every workflow, every button and the terminology that is used. It is an incredible process that we have been through to customise the system.

As we have brought it into a pre-production environment, and people could essentially get in there and play—run through workflows and determine how it will actually work for their teams in their work environment—we have identified some constraints or challenges within the system. But as each of those has been identified, they have been logged and teams have then responded to that to make any amendments that are required, so that the system essentially functions as we need it to function.

I do recall some issues being identified around prescribing, and not just limited to what you have raised today. At this point in time my understanding is, and certainly from the briefing we had earlier this morning, that there are no longer issues that would impact go-live.

MR COCKS: I understand that this is not a system issue so much as a legislative barrier. I am happy for you to take on notice what actions and impacts we are looking at around intern prescribing.

Mr Peffer: Yes, why don't I take that on notice?

Ms Davidson: Having attended one of the go-live presentations at an early stage—it might have been at 60 days—and having seen some big software development rollouts in my previous career, at this stage, before something goes live, before deployment and the system becomes active, to see how prepared people are, the types of issues that have been identified and the plans that were already in place to address those issues, it has given me great confidence that this will be a very successful implementation.

There are always things that come up that you were not expecting, but there are really good backup plans in place and lots of support available to staff as the system goes live to make sure that they are able to continue to do their work well, as they work through it. Certainly, with the number of staff who have been trained during a period of time when there have been those workforce pressures, and everyone has been incredibly busy, the fact that so many staff are putting their hand up and saying, "Now I want to be trained and I want to be a superuser," indicates how much staff recognise that this will help them in their day-to-day work and relieve a lot of those frustrations that they have when they cannot get the information that they need as quickly as they want it.

MR COCKS: You have a very strongly stated commitment to the peer workforce. How many peer worker positions are funded under ACT Health and are they all filled?

Ms Davidson: I might need to take that on notice for exactly how many positions are funded. I would also note not all the peer workforce positions within the ACT are going to be in ACT government funded services. There are other arrangements in place as well that might result in people working in peer workforce in mental health.

MR COCKS: Okay. Well perhaps you can tell me, do you know how many are currently engaged?

Ms Davidson: I will take on notice the question of how many peer workers are currently employed in arrangements funded by ACT Health.

MR COCKS: Thank you. Following on from that. I understand people with lived experience who want to gain their certificate in mental health peer work, to take up these positions, cannot get that training in Canberra at the CIT. Is there any reason we do not have training available for that workforce?

Ms Davidson: I might pass to Dr Moore to talk about training and what is available in the ACT. But certainly this is part of the reason why, when we are working through consultation towards the action plans that result from a strategy, it is so important we are engaging with a range of people including education institutions, which we have already started doing.

Dr Moore: Thank you, minister. Yes Mr Cocks, there used to be a Cert IV available at CIT. We are not sure, except that there did not appear to be demand for it and CIT dropped it. Obviously we would prefer to home grow our own and we would look to have that as part of our implementation strategy.

DR PATERSON: Minister, my question is in respect to the ACT Aboriginal and Torres Strait Islander suicide prevention intervention and after care service. It says in the annual report this is a new service funded and the first of its kind. Can you speak to what this service is, how many people are engaging with it and how it is being delivered?

Ms Davidson: I am really glad you are asking about this service. I think it is great the ACT is able to get this service established here and to be able to provide this to the community. The way in which it was established, the co-design with the community, with organisations that have experience as well as with people with lived experience, has been a really key part of that process. I will pass to Dr Moore who can talk more about what this service is able to do and how it is working.

Dr Moore: Thank you. Thirrili is the provider of the service. We had an Aboriginal and Torres Strait Islander forum at which time the community said it wanted to have more input into how this service would work. So Thirrili at the moment is consulting with community around the service provision particularly for the ACT.

DR PATERSON: So it has not started yet?

Dr Moore: No.

DR PATERSON: What is the extent of the consultation and how long will that run for?

Dr Moore: I will have to pass you to Cheryl for specific answers there.

Ms Garrett: We really are being guided by the local Aboriginal and Torres Strait Islander community when it comes to providing their feedback. As Dr Moore said, we are responding to feedback we received through the forum that the community would like a longer lead up time in terms of implementation. There are some staff on the ground and being recruited by Thirrili at the moment. So there are positions that are being recruited to, including the partnership Thirrili is progressing with Woden Community Services and the way that support program at Woden runs. Thirrili will be partnering to assist in upskilling around Aboriginal and Torres Strait Islander culturally appropriate supports and responses to the existing service as well. So there is a couple of parts to the work they are doing.

DR PATERSON: When will the service start to be delivered?

Ms Garrett: We will be guided by the community in the feedback we receive from them and the feedback Thirrili will take on board. At this stage, there is not a date but the community is very much driving and involved in that. There are also strong relationships being built between Thirrili and Winnunga Nimmityjah. So the local community will be helping with that.

DR PATERSON: So no timeframes on anything there at all?

Ms Garrett: Only that there is work already progressing and there is very good engagement. Thirrili is already onboarding staff to start with relationship building and further co-design in terms of what the community would like to see.

DR PATERSON: Okay. Thank you.

MR COCKS: I would like to come back to adolescent eating disorders. It is good to see a little bit of progress around the centre today. I understand it will provide psychological and therapeutic recovery services. Is there anything happening in the ACT hospital system that is equivalent now?

Ms Davidson: Is the Eating Disorder Residential Centre what you are asking about?

MR COCKS: Yes, that is right.

Ms Davidson: The Eating Disorder Residential Centre is a first for the ACT. We do not currently have a residential centre and that is why we worked with the commonwealth to get the funding to establish this one. In fact, there is nothing like it anywhere between here and that other one I was talking about earlier on the Sunshine Coast. This is an area of work that a number of jurisdictions around Australia are getting up and running at the same time. It looks like ours will open before some of the other states are able to open theirs. We can expect to see that there will be quite a high level of initial demand. But we have been doing the work on the understanding that there will be other residential centres around Australia as well. I am sure we are all going to be learning a lot from each other’s different models of how we are providing the service.

MR COCKS: The Butterfly Foundation, when I spoke with them earlier this year, really drove home the importance of having the right workforce. We are going to be competing with other jurisdictions for a fairly limited pool of people who are skilled in this particular area. As attractive as it is, there is a really high turnover of mental health workers in these facilities. How are you looking to address that particular part of the equation? Or will that be entirely up to whoever comes in to run the place?

Ms Davidson: I recently saw the Wandi Nerida facility and had the benefit of being able to have a conversation with the workers there, as well as with some of the participants in the treatment program, about how important the peer workforce is as well the recovery navigators that they have there. I also spoke with some of the staff about what it was that attracted them to wanting to work there and why they had chosen to stay. As with a lot of healthcare professionals, people really want to be able to work to the top of their practice, to be able to see that what they are doing is meaningful and to be engaging in critical best practice. The same thing is going to apply with the new service like the Eating Disorders Residential Centre.

In that respect, I am really excited about what this means for the ACT mental health workforce in that we have another type of service in which people can practice in a different model of care to what they might practice in a hospital setting or in a day program or an early intervention service. This is a different kind of service. There will be people who are really looking for the opportunity to be able to engage in this kind of work. It will actually make us very attractive to people interstate where they do not have an eating disorder residential centre to work in yet. So this is a really great opportunity for the ACT. I am really proud that people in Coombs are going to have this in their local neighbourhood.

MR COCKS: One of the key issues is that it is an extra service competing for the same workforce. There are not magically going to be people there ready to go, I would assume. Unless there is something in the hospital system already where we can draw from?

Ms Davidson: So knowing what kind of service we are looking to get up and running in the ACT, how that differs slightly from the types of services in other states and territories and what they are preparing to open in the next few years, I do believe the ACT service is going to be really attractive to people who want to work in that kind of home-like environment, providing residential centre treatment to people that is not like hospital in-patient care. What we are doing in the ACT and the way we are delivering it, our residential centre is going to be a really great place to work as well as a great place to receive care.

MR COCKS: That is great. What will you do to equip those people coming to work, with great intentions, to deal with what is a really high stress, difficult place to work?

Ms Davidson: That probably goes, in some way, to some decisions that are still to be made about exactly who and how the service will be delivered. This is also part of the reason why we established the Clinical Hub for Eating Disorders in the ACT. So we have an opportunity to bring together the different services that operate across the continuum of care, for professionals to have more opportunities to talk with each other about what their services are doing and to engage with each other about what they can learn from each other's practice. It really helps us to support and grow that workforce and develop their skills.

MR COCKS: The capacity of the facility? I think you said 12 full time beds?

Ms Garrett: 12 beds.

DR PATERSON: If you have answered this before, I will go back to Hansard, but how will the model of care we offer be different from other jurisdictions?

Ms Davidson: Each of the jurisdictions that has been funded to develop an eating disorder residential centre is going to have a slightly different model of what their centre is going to do. That is going to reflect what their local needs are and what other services might already be in their area, in terms of how it all fits together. We have a Territory-wide model of care for eating disorders and we have a number of different services. The service we are specifically needing to provide in the ACT is very much about a home-like environment. It is about providing care in a residential setting that does not feel like a clinical in-patient environment. It is very similar to what we saw in Wandi Nerida on the Sunshine Coast and the model the Butterfly Foundation have implemented there.

DR PATERSON: Okay. So it is not going to differ from that model?

Ms Davidson: There will be some localised differences. Part of it is also about how you integrate the residential centre with the other services we are running. So having the clinical hub is a really key part of our range of services in the ACT to make sure we are providing integrated care for people with eating disorders and that people are able to transition from one service to another and be supported well.

THE CHAIR: I would like to talk about MindMap in our remaining five minutes. My curiosity in my first annual reports hearings, as a new member, came across as being spicy but I was just genuinely curious how this new platform was genuinely going to support young people. There seems to be a lot of different resources, websites, links and platforms thrown at young people to support their mental health. What reflections do we have on MindMap so far, on its take up and its effectiveness?

Ms Davidson: I will pass to Dr Moore in a moment who can talk in more detail about that. One of the things that I think makes this service really unique is that it is not just a directory or a portal, it is a service Marymead are providing in those youth navigators. They can really hold the space for someone. So if they are going to have to wait awhile before they can have their first appointment with the service they connect with, there is someone who can support them until they reach that point. So it reduces the risk of that young person disengaging with mental health services and it reduces the risk of their health deteriorating while they are waiting. That is really critically important.

The youth navigators can help people to navigate to find the right service, either by text, chat or phone, every day. So even if you are not looking for someone to hold the space while you are waiting for your appointment, if you are someone who is finding the whole experience of finding the right service overwhelming and you want to talk to a human being, there is someone there who can help you to do that. That is quite unique amongst navigation services online and something I think we do really well. It demonstrates the value of the partnership between ACT government and our NGO sector who really understand the local community at a deep level. I will pass to Dr Moore, who can talk about that MindMap service.

Dr Moore: The minister has covered the basic premise of MindMap, which is to give young people, their parents and any carers the opportunity to see what is available. There are two elements to it. You can either go and look around yourself or you can actually be directed to various services. There is a chat there. The chat function is really useful. What we found is most parents will look at the service for what they need. The kids will perhaps chat. The parents will ring. So a difference in what is done.

Since its launch MindMap has had, and these are figures from a question time brief, 18,000 users, 85 per cent user profiles, so some people come and repeat and 15 per cent of visitors have returned to the page multiple times. There were 50 per cent under the age of 17, 23 per cent were between the ages of 18 and 24 and 27 per cent were nominated as parents or carers. The key issues raised by the youth selecting the MindMap sites were around anxiety and depression and that is similar to other services. But other topics also related to psychosis, mood and personality disorders, self-harm, suicide prevention, emotions, trauma, abuse and family violence.

Neurodiversity and eating disorders and body image all came up. There were some users that were seeking a dedicated support for Aboriginal and Torres Strait Islander services.

Since the launch of MindMap you may have seen the bus. There is a bus with MindMap on it. We have found the usage of MindMap goes up as we advertise. So it is a learning for us, we need to keep the advertisements up.

The evaluation framework has been developed for the short-term outcomes and for the first-year impact and we are currently awaiting that evaluation. Marymead and ourselves are looking at what we can do to continue our stakeholder engagement. We have had some very good narrative stories from Marymead around the active hold. Although not data per se, the stories show people are coming to accept Marymead can offer an active hold. So this is where a person has been accepted for a service, is waiting for a service and Marymead will not provide so much clinical intervention as a support, allowing the young person to know that they have not been forgotten, that there is somebody out there that cares. One particular young man accessed a service, completed that service and came back to Marymead while waiting for another service. The statistics there are the ones from September. I will just check and see if we have any more.

Ms Davidson: I think it really demonstrates, if someone has accessed the service and then comes back and accesses it again, it shows this is a service that works for people, that they are willing to come back again.

THE CHAIR: Absolutely. Dr Moore, if you do not have those, I am happy to take them on notice.

Dr Moore: I do. The latest statistics are from September 2022. So those were the statistics available.

THE CHAIR: Tremendous. Thank you, Dr Moore. On behalf of the committee, thank you Minister Emma Davidson and all of your officials for your attendance today. For those of you that have taken any questions on notice, if you could please provide those answers to our committee secretary within five working days.

Hearing suspended from 3.01 pm to 3.30 pm.

Appearances:

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

Community Services Directorate
Rule, Ms Catherine, Director-General
Wood, Ms Jo, Deputy Director-General
Evans, Ms Jacinta, Executive Group Manager, Strategic Policy
Bassett, Ms Louise, Executive Branch Manager, Strategic Policy
Lapic, Ms Silvia, Executive Group Manager, Children Youth and Families
Saballa, Ms Melanie, Executive Branch Manager, Next Steps

THE CHAIR: Welcome back, guys, gals and non-binary pals, to the afternoon session of the Standing Committee on Health and Community Wellbeing's continued inquiry into annual and financial reports 2021-22. This afternoon we will hear from Minister Rachel Stephen-Smith, in her capacity as the Minister for Families and Community Services.

On the first occasion that you speak, please acknowledge that you have read and understood the privilege statement. Should you take a question on notice today, please do acknowledge that and use the words: "I will take that question on notice," to assist our committee secretary in following up with you after today's hearing.

There are no opening statements, so we are going straight to questions. Minister, I joined you and other members of the Assembly for the opening of a new facility in Waramanga, as part of the Safe and Connected Youth Program. I was wondering if you could give the committee a bit of the background on the work that led to the opening of that new facility and the government's ongoing relationship with the providers of the facility?

Ms Stephen-Smith: Yes. That has been a fantastic project the whole way through. It is very much a try, test and learn. We looked at the Ruby's model in South Australia that was set up in the context of the youth homelessness sector, recognising that there needed to be an alternative approach for young people who are at risk of homelessness, disconnecting from their families, to give them an opportunity to have a safe place of respite, for want of a better description. There is also therapeutic support for them and their families to work through the issues that are challenging them and to enable young people to stay safely at home with their family, rather than ending up in homelessness or, if that is not going to be an option, to provide a safe pathway into alternative support for that young person.

In the ACT there was some strong advocacy from Rotary, in particular, around the success of that model in South Australia. They worked with the Youth Coalition, among others. They were advocating to government, and the Youth Coalition at the same time was very much talking about youth homelessness for young people under the age of 16.

Members might be familiar with the fact that the homelessness sector is really only funded for young people from the age of 16 and over. But what many providers were seeing was that young people under the age of 16 were becoming homeless and there were no real support options for them. They then either become engaged with child protection or they might become engaged with the youth justice system, because they are on the streets, they are not eligible for income support and they are not eligible for homelessness services.

In the ACT there was consideration of what model we needed to use to support young people under the age of 16 who are at risk of homelessness as a result of disengaging from their families, family conflict, disengagement from school et cetera. Taking that Ruby's model but thinking about how similar kinds of services could work in the ACT, we started a few years ago—and others can probably give you the exact dates if you are interested—looking at: did we actually need a residential service in the ACT or if we provided some more wraparound pathways to therapeutic supports, with maybe a little bit of purchased respite for those families where that was really required, would that do the job?

We did a try, test and learn project with Safe and Connected Youth, led by the Youth Coalition but with a number of community partners, including the Conflict Resolution Service, Northside Community Service and Woden Community Service—if memory serves me correctly about which community services were involved—and Marymead providing some of that residential accommodation on an as needs purchase basis.

As a result of that pilot program we determined that we did need a residential solution. Housing ACT were able to identify a property that could be refurbished to suit this purpose. We got some funding through the COVID shovel-ready projects fund to support the refurbishment of that property into a six-bed property to effectively set up something very similar to the Ruby's model but for younger young people. Down to the age of 10, young people can engage with this service, as opposed to the Ruby's model in South Australia, which I think only goes down to 15 and then goes to older young people. It is a unique service as a result of that. It is unique in that it sits within the youth services sector, rather than in the child and family services sector and rather than in the homelessness sector.

When we developed the service to include a residential component, and funded it in last year's budget, we went out to a procurement process. The successful partners in tendering for that were the Conflict Resolution Service and Marymead, working together to deliver the residential element of that alongside the therapeutic, family-centred response to help young people re-engage, reconnect, with their families, to help families work through the conflict that they were experiencing and to provide a safe pathway for children and young people to either stay at home safely or, again, if that is going to end up not being appropriate, to provide a planned pathway into alternative supports through Child and Youth Protection Services.

It has been really great community partnership. The house itself, in terms of the refurbishment, was co-designed with young people who have an experience of homelessness and residential care. They provided some really valuable insight into the feel of the place, the actual design. Interestingly, one of the comments was that they did not want the complete refurbishment to include individual ensuite bathrooms. They thought shared bathrooms were fine and in fact safer. So they had a real insight into the safety of young people and the decisions that young people would take in an environment like that. One of the pieces of feedback was that they did want a bath that was in a separate bathroom. They did want one of the bathrooms to have a bath as a sort of therapeutic thing for the young people, and so that was factored into the build. There were a number of other things that they gave feedback on.

As you would have seen when you visited, Mr Davis—and it was fantastic to see so many people there at the official launch—the house is fantastic. The service is unique. I was recently in South Australia and visited one of their Ruby's houses, which is quite a different set-up. They were really excited about the fact that we had brought the model to the ACT. They were also excited about the fact that we were doing something a little bit different in the youth space, rather than in the homelessness space. They were going to learn from us as well. It is a really good example of interjurisdictional collaboration but also real community leadership in advocating for the establishment of that program in the ACT.

THE CHAIR: Great. I have a couple more questions, but here is a clarifying one, Minister. You used the phrase, in the answer to your question, "purchased respite". I have not heard that before. What is that?

Ms Stephen-Smith: It was on an as needs basis. Marymead has residential accommodation that is already available to it, so it was about the capacity for—there is a word that is escaping me at the moment. Essentially, with the services that were provided, Safe and Connected Youth were funded to purchase respite on a nightly basis from Marymead if they needed that service.

THE CHAIR: Okay. That makes sense.

Ms Stephen-Smith: Brokerage. That is the term. That is the one I was looking for. Yes.

THE CHAIR: Perfect. Obviously, this facility has only been around in the ACT for a little while. We have got some good insights from South Australia and you noted some pretty strong—

Ms Stephen-Smith: I am sorry, Chair. I forgot to acknowledge the privilege statement earlier. I have read and acknowledge the privilege statement.

THE CHAIR: I forgot to remind you. I can feel the committee secretary's eyes in the back of my head. I am interested in what early findings we have. Obviously, it is a new service, so I expect a full evaluation has not been done. Would it be safe to assume that, at the moment, even one facility is not meeting the demand? What are the findings that we have already, preliminarily, and how are they informing our next decision-making in this space?

Ms Stephen-Smith: I am not sure; I will hand over to someone else. I have only got some positive anecdotal feedback. What I can tell you is that I recently spoke at a Rotary conference and on my way in I was lobbied for another facility to be established on the north side.

THE CHAIR: Those Rotarians don't muck around.

Ms Stephen-Smith: No. Jacinta.

Ms Evans: Thank you, Minister. I have read and acknowledge the privilege statement. Just in response, it is important to note that there are a couple of elements to the program. We have the early preservation outreach part of the program, as well as that therapeutic respite accommodation and the post-exit outreach part of the program. That is quite critical.

One thing I can tell you about how well the program is going is that about 80 per cent of the young people engaged in the program so far have been able to remain at home after accessing that therapeutic accommodation part of the program. I think 80 per cent is a really good percentage. These are obviously young children, young people, who are in conflict situations. So that is pleasing.

We do know that three in four families engaged with the program have been current or previous Child and Youth Protection Services clients. That is a really great part of the positive engagement with those families. And all of the families participating in the program we know have been impacted by mental ill health. We are starting to see some themes and trends in terms of the sorts of young people and families that are being engaged. Evaluation was a critical part of this program in the pilot phase that the minister mentioned. It will be, again, another critical part of the program ongoing. I look forward to being able to tell you more about the outcomes as the evaluation is completed.

THE CHAIR: Great. Just step this out for me. You said 80 per cent of the young people return home. So their period of stay with the Safe and Connected Youth Program is essentially what—just to provide a bit of break from the family to allow those relationships to work out?

Ms Evans: Absolutely. Yes, the break and the accommodation is that therapeutic support for them to step away and also for their family to receive the counselling and support they need to re-establish the relationship or to work through what it is that is causing the issues for them.

THE CHAIR: That makes sense. And while the 80 per cent is great, what happens to the 20 per cent? Are these young people who have spent some time in the Safe and Connected Youth Program who have not been able to reconnect with family or go back home?

Ms Evans: There could be a range of different responses for those young people. Depending on their age, they may have already been staying with friends, rather than family, or had some other arrangement in place. It is not to say that they would never be able to, but it is just after that short period. I am talking about a number of months that we have had the program running, and some of the children were not able to immediately return to their home.

THE CHAIR: Okay. That makes sense.

Ms Stephen-Smith: I think it is important to recognise, in terms of the model, that the house is not a place where young people would stay for an extended period in one go. It is about working with the family and maybe providing two nights a week in a planned way, or two or three nights a week for a few weeks, not staying solidly for four weeks at a time.

THE CHAIR: Okay. Great. Thank you.

MR MILLIGAN: The annual report states that the consultants' final report for the external merits review of the child protection decisions is due in September. When will this report be released to the public?

Ms Stephen-Smith: In terms of when it will be released to the public, I will hand over to Ms Bassett to talk about where we are up to with receiving the report, and then I can respond to when it is going to be released.

Ms Bassett: Thank you, Minister, and thank you for the question. I have read and acknowledge the privilege statement. The report has been somewhat delayed. Part of that is the delay in the consultation scheduling. We had some COVID-related delays to those roundtables and the other workshops with stakeholders. We have been working to finalise the report with our consortium partners, Monash, Curijo and the Centre for Evidence in Melbourne, but we are yet to finalise the report.

Ms Stephen-Smith: When the report is finalised it would be my expectation that it will be publicly released. We will have to see the report before making a decision about the timing of that. It may be that we need to take that report for further consideration by cabinet or a cabinet subcommittee before we release it so that we can release it with a response.

One of the things that has become clear through this process—well, it was already clear, but I think it has been confirmed through this process—is that there is no clear agreement between stakeholders on what an external merits review process should look like. At some point, government is going to have to make a decision and it is not going to be necessarily a consensus decision from all stakeholders that this is the path we should be going down. In that context, it may be more appropriate to take the report to cabinet to have that conversation and then be able to release it with a clear direction to community, rather than releasing another report that says we need to do more work.

MR MILLIGAN: Okay. The annual report states that the final report will include a recommended external merits mechanism model. What is the recommended model?

Ms Stephen-Smith: That is exactly what we are working through and that is part of the reason the report has not yet been finalised. The consultants are working through what those recommendations will look like. I do not want to speak for them, but from the information that I have about the process to date, as I said, there is no clear consensus view that could be brought together into a recommendation that all stakeholders are going to support about what the right model is for the ACT.

What we clearly know from other jurisdictions is that there are challenges in all of the models in other jurisdictions. None of them are perfect. What we have been trying to do is ensure that we have a fit-for-purpose model for the ACT and also a model that integrates between the external decision review and the internal decision review processes that have been considerably strengthened over the last 12 months.

We are now in a try, test and learn pilot process to test out a new model of internal decision review, which I am sure somebody could speak to—Ms Lapic—if you are interested in where that is up to. It is really important that we have an integrated response that then also takes into account the existing role of the Human Rights Commission in receiving complaints about child and family services as well. One of the challenges that we have had throughout this process, as I have discussed with Mrs Kikkert before, is that we do not want to end up with four parallel streams of people being able to seek a review of decisions, which ends up really slowing down decision-making about the lives of children and young people. That is, in itself, detrimental for the children and young people involved.

MR MILLIGAN: Okay. As part of the recommended model, will it allow a review of decisions regarding such things as frequency and length of contact visits?

Ms Stephen-Smith: Contact is one of the things that have frequently come up as something that would be part of the decision review. I think it is also important to recognise that that is something that should initially be pursued through an internal process, if people are unhappy with the decisions of caseworkers and CYPS, and indeed the courts. Sometimes contact is a decision that is made by the Childrens Court. That is part of this complexity: if a contact decision is made by the Childrens Court, it would not be appropriate to have that then subject to external decision review in ACAT, for example, because that decision has already been taken. A review of that can be requested, and that can be requested via parties to a child protection order as part of the decision-making of the Childrens Court. So that is part of the complexity. I do not know if Ms Lapic would like to add anything in relation to how those decisions now would be reconsidered if someone had a concern about contact.

Ms Lapic: I acknowledge that I have read the privilege statement. In terms of the internal review of decisions, an affected party may be a parent or a carer, so I will refer to them as affected parties. When an affected party is seeking a review of a decision, the first point of contact is with the casework team themselves. We are looking for local resolution and some good conversations to occur with that local team in the first instance. If resolution is not reached at that point, it is referred to a senior officer who has not been involved in the decision-making at that point. So there is the senior level independent review of all the materials. At that point there can be a conversation as well with the affected person, who may be saying that certain information has not been considered in the first instance.

In that process, we have the decision clearly outlined in a decision-making statement. So there is clear documentation about a decision that has been asked to be reviewed and the rationale behind that decision-making. The affected party may feel that perhaps information was not considered or there is new information that needs to be considered as part of the decision, and that senior officer can then review that information. So there are multiple opportunities for resolution at that point. If it is still not resolved, it can go to an independent panel that then will review those decisions about the rationale and any other information that needs to be received. That is the process from end to end, in brief.

Ms Stephen-Smith: Just on that panel, one of the things that needs to be clear is that a decision-maker needs to be a person. So the panel, to my understanding, would make a recommendation back to the decision-maker.

MR MILLIGAN: And that is part of the internal review?

Ms Lapic: That is correct.

MR MILLIGAN: How many requests have been made for internal reviews recently?

Ms Lapic: There have been no internal review decisions that have gone through that entire end-to-end process. In the early stage, with the initial casework team there are opportunities that continually are sought, in terms of reviewing the decision. Through the internal review of decision formal mechanism there have been two requests. One was ineligible. With the second one, the resolution occurred outside of the process and therefore did not have to proceed.

MR MILLIGAN: Thank you.

DR PATERSON: On the internal review process, with the pilot that has been launched, what will be the difference in that process, in comparison to the old process? What has been piloted, basically?

Ms Lapic: What we had before was an informal procedure in terms of where to go and how to access the review of decisions. Now that this has been formalised it means different stages of development, and there is independence throughout this process. So there is quite a unique difference here around an officer who has not had an initial decision-making opportunity in that first instance.

The try, test and learn project is the oversight mechanism. That is what is most important here. We have stood up an internal review governance arrangement to look at some learnings. We have external bodies on that group as well, to look to how we can strengthen our decision-making throughout the next 12 months. We have also embarked on a program of strengthening our decision-making with our workforce. We are looking at it from both ends: how do we strengthen decision-making in the first instance, but, if it is not being resolved, how do we ensure timely, good decision-making from a restorative justice view?

Ms Stephen-Smith: And I think the other thing is—and I feel like I am stepping into what I am just about to warn people about here—there is often a conflation of the complaints process versus the decision review processes that are part of normal case management, where people might not agree and then go back and say, “Well, hang on, there is some more information you did not consider. Can you please reconsider that decision?”

There is also an independent group that takes complaints in relation to Child and Youth Protection Services. There has also been quite a lot of work done in that complaint stream to develop a more restorative complaints process and to work more closely with the Human Rights Commission when they receive a complaint—to ensure that CSD is supporting those mediation processes with the Human Rights Commission.

So, we are taking quite a different approach to the consideration of complaints than maybe complainants might have seen a few years ago, in terms of really trying to take that restorative approach and mediating complaints. My understanding is that when that has occurred, that has gone really well. They sit on a continuum but also are separate processes.

DR PATERSON: Sure. With the stakeholders that were engaged in the feedback for the pilot, were there people with lived experience of the system engaged in that process—like carers in particular?

Ms Lapic: I will go back and look at the entire stakeholder group, but I do believe, and I do recall, that there were carers involved in that alongside other community agencies, our government partners and others—so, yes.

DR PATERSON: Thank you. Minister, the annual report notes the over-representation of the Aboriginal and Torres Strait Islander children and young people in child protection. Do you have numbers on hand about the extent of the over-representation in the system?

Ms Stephen-Smith: I do not have the latest data on that, but I am sure somebody does. I will be tabling in the next sitting of the Assembly the latest six-monthly snapshot that has been part of the process of Step Up for Our Kids. We have tabled snapshot data every six months on what that is looking like.

In reading that data, which is not up to date—there is always a bit of a lag—unfortunately, we do continue to see that about 30 per cent of children and young people in care are Aboriginal or Torres Strait Islander, which is very disappointing. Over time, we have seen the numbers flatline so where, probably, four or five years ago, we were seeing a trajectory up, both in Aboriginal and Torres Strait Islander children and young people and non-Indigenous young people, we have seen that really flatten out over the last couple of years. We have seen an uptick in overall numbers in the last 12 months as well which, again, is disappointing. We are still seeing those numbers of entries into care be pretty stable and lower than we would have otherwise expected without the reforms that we have put in place, but the number of exits has been lower in the last 12 months—just to get to the bottom of that issue. Ms Lapic might have some more information on that for the data.

Ms Lapic: I can share that the estimated population of Aboriginal and Torres Strait Islander children and young people aged zero to 17 years living in the ACT as at 31 December 2021 was 3,000, which is 3 per cent of all children and young people living in the ACT. In 2021-22, 28 Aboriginal and Torres Strait Islander children and young people entered out of home care, which constitutes 28 per cent, at the moment, of all children and young people who entered the care system.

DR PATERSON: Thank you. I note in the annual report that CYPS is actively seeking to provide culturally responsive services for Aboriginal and Torres Strait Islander children and young people. Can you give an example of the services that CYPS is delivering, or planning to deliver, that falls into that culturally responsive category?

Ms Wood: I think there has been a lot of work across all aspects of CYPS to look at all the touchpoints for families and where we need to bring a stronger cultural lens. For children who are in care, there has been really important work looking at the quality of cultural plans. Those plans are intended to ensure that Aboriginal and Torres Strait Islander children have really good, sustained and strengthened connections to family and culture while they are in care, whether they are in foster or kinship care, and ensuring they support children where there is a pathway to restoration.

That is for children in the care system, but there is also work looking at how we might receive reports into the system differently and look differently at the concern reports that come into the system and what the other options are for connecting families with support earlier. That is the really critical objective to ensure that children and families do not come unnecessarily into the system—looking at services like functional family therapy, and the other kinds of early supports we need in place under the next step strategy.

Ms Lapic: Another example of a program which is, I think, what you have asked for, is Family Group Conferencing—that is a specific program for Aboriginal and Torres Strait Islander families both engaged in or entering the child protection system. I am able to give you more detail, if you want, about the program.

DR PATERSON: Is there data on the average length of time the children and young people are in the care of a foster or kinship carer?

Ms Rule: I have read and acknowledge the privilege statement. We will have that data; I do not think we will have it with us today. We would be able to extract that data from our system, but we do not have it with us today.

DR PATERSON: The reason I asked is Legal Aid used a case study in their annual report around a family from a culturally and linguistically diverse background, and the children were taken into care overnight, while their situation went to court, and it was a domestic violence situation. Of the children in care, I am wondering on the number in care for just overnight, or very short periods of time, or is this long-term care arrangements?

Ms Rule: It is all of those things.

Ms Stephen-Smith: Yes. An average probably would not be particularly helpful, because there will be a number of children in long-term care who are in stable care placements, particularly in kinship care placements, where they will likely be in those family arrangements until they are 18. They might have been there for five years, three years or 10 years. If they are in a stable placement, that is the important thing.

It might be useful, depending on what you want in terms of being taken on notice, to find out the number of children and young people, particularly Aboriginal and Torres Strait Islander children and young people, if that is what you are interested in, who are on short-term orders. It is certainly the case that sometimes children come into care and are either restored to their family or restored to another family member as part of a family arrangement that is not an ongoing statutory child protection arrangement. That can happen quite quickly, or it might take a few weeks to sort through all of the issues and make sure that there is confidence that there is a safety plan in place for those children and that the family has appropriate supports. It can be quite variable. Certainly, the objective is to return children home when you can safely do that.

THE CHAIR: Minister, I want to get a bit more information about the charter of rights for parents and families involved in the child protection services system. First of all, where is that work up to? Secondly, how can parents, carers and people in the broader community participate in that discussion?

Ms Stephen-Smith: That has been out for consultation. I am not sure if the consultation is closed on that.

Ms Bassett: It is, yes. The consultation was on Your Say.

THE CHAIR: Ms Bassett, could you acknowledge the statement?

Ms Stephen-Smith: She did.

THE CHAIR: Go right ahead.

Ms Bassett: I will do it again, for the sake of completeness. I have read and acknowledge the privilege statement. The charter of rights consultation was in two parts. We had some face-to-face consultation with people with lived experience and we used some contacts that we have with the Red Cross birth advocacy service. We invited them to provide us with some names and contact details for some parents and carers, who were invited to the consultation on the charter as a piece of work.

We also had a Your Say session that was open for over six weeks. We have had a number of submissions from community groups, organisations and interested people, and we are in the process of collating all of that feedback at the moment.

THE CHAIR: Is there an intention to release a listening report once that is consolidated and when could people expect that to be released?

Ms Bassett: Yes, there is certainly the intention to release it as a listening report and a thematic analysis of what we have heard. Timing, I think, is a subject for discussion with the minister, because we have not yet finalised the collation of the information.

Ms Stephen-Smith: According to the Your Say website, we were intending to release the charter of rights following the consultation in December this year, for implementation in early 2023. Part of the parliamentary and governing agreement is to somehow embed that in legislation. We were also looking at how we would do that. That does not necessarily mean we would delay finalisation of the charter. It is then a question of whether or not we would legislate to give that some legal effect.

It will be important, in all of these things, to ensure that the charter can be used by everybody to understand the relationships that exist and the rights and responsibilities that they all hold, but not to be used as a tool to delay and disrupt decision-making that is part of the formal child protection process. That is the kind of thing we need to think about, as we think about potentially embedding this in legislation.

The time frame on Your Say is December 2022, for release of the charter, and early 2023 for implementation. It may be slightly delayed, given that it is a month until I go on leave. There is a lot to do between now and then.

THE CHAIR: How will this charter of rights intersect with the current charter of rights for kids in care and the charter of rights for carers? I should know this, but I will ask, because the right people are in the room: are either of those two other charters that I mentioned currently legislated?

Ms Stephen-Smith: No. As you mentioned, there is a current charter of rights for children and young people. One of the challenges is that the charter of rights for parents and families would extend beyond a period when children and young people are in care, whereas the charter of rights for children and young people is for children and young people who are in care. There is already a slight disconnect there.

We have not gone out for consultation on the carers one yet. No, the existing one, the children and young people, is not legislated. That is one of the other things we have to think about, as we think through the modernisation of the Children and Young People Act and the potential to embed the charter of rights for parents and families. If we are doing that, it would make sense to embed the rights of children and young people.

THE CHAIR: That makes sense. Without asking for a statement of future policy, with that charter of rights for carers, what work has happened so far to prepare that to go out for what I imagine would be a not dissimilar consultation process to this current charter consultation process?

Ms Stephen-Smith: I attended a meeting; I can never remember what it is called, because it used to be called the carer wellbeing working group, and that is still what I call it, but it has not been called that for years. We did start talking about that process, what that will look like, and what an appropriate way to engage carers will be. I might hand over to Ms Bassett again.

Ms Bassett: It sits between the two divisions, and we are working together on it. I will say what I know and my colleagues in children, youth and families may be able to elaborate further.

As the minister has outlined, the intersection of these charters is really significant, and it is important that they are not conflicting with each other and that they support each other to do what they need to do, for the individuals that are subject to the charter, both the responsibilities part and the rights part.

We have had some conversations internally about how they might work together and how they might be reviewed. At this stage that meeting that the minister referred to of the wellbeing group is the first time that it has been publicly discussed. We are in the planning stages for how we will engage.

MR MILLIGAN: Currently, there is a draft bill to establish a new Aboriginal and Torres Strait Islander children and young people commissioner. It has details about how the commissioner can participate in the court process, but no mention is made of how he or she will be able to participate in the internal or external reviews of CYPS decisions. Why is that?

Ms Stephen-Smith: My recollection of the bill—and I do not have it in front of me—is that the existing powers of the Public Advocate have been mirrored for the Aboriginal and Torres Strait Islander children and young people commissioner. The Public Advocate has quite significant powers to intervene in child protection matters in the interests of the child or young person.

I had a conversation with the current Children and Young People Commissioner and Public Advocate the other day about how that role intersects with a decision review role and whether it would be appropriate for the Public Advocate to have a role in decision review. But because they are potentially part of a decision-making process—so the Public Advocate can actually join a care team for a child or young person—that may create a conflict between those two roles.

In terms of the Aboriginal and Torres Strait Islander children and young people commissioner, and their direct engagement with Child and Youth Protection Services, there are elements of that that would not necessarily need to be legislated. The really important thing is that they have the same powers to access information and to have information shared with them that the Public Advocate does. My understanding is that those powers have been mirrored in the current bill.

DR PATERSON: Minister, table 15 of the annual report talks about complaints against particular business units. CYPS has had quite a substantial decrease in the number of complaints, from last year to this year. Are you able to give the committee an overview around the nature of those complaints and, if there are systemic issues, whether they are being addressed?

Ms Stephen-Smith: I am not, but I am sure that someone will be able to provide some information.

Ms Wood: We do not, Minister, have that detail with us. We can take that on notice.

DR PATERSON: Okay, thank you.

THE CHAIR: Minister, I am curious about the Next Steps for Our Kids plan that was announced in June. I have been looking at some of the action items there, in terms of Next Steps. There is one in particular. Item 5 in the actions says “establish a new ministerial council that will include community partners for people with lived experience”. Instinctively, I would think that is one of the things that you would do straight up to inform the work that is happening. Would I be instinctively correct, and what has already been happening to establish that ministerial council?

Ms Stephen-Smith: Yes, you would think that that would be an early action and, indeed, it is underway. We have had a couple of processes that have fed into this. This has been the subject of discussion for quite some period of time—how to best arrange your governance-advisory bodies and roles in this space. It sounds simple, but it is actually quite complex to figure out who you put on a relatively small group and what responsibilities you give them.

There have been two processes that have fed into this consideration. Last March I held a child and family services forum with a large number of attendees from across the child and family services sector, to talk about the range of reforms that we have in train. Next Steps is a key one.

Out of that—and Ms Evans can talk about the work that came out of that—a group came together to talk about how the sector can form an advisory body to provide advice to the government, to me, and to work together with the community sector to address some of the challenges that they are identifying. It is about how to feed the non-government sector into government, and how to get advice from the non-government sector on challenges that we see as being a priority.

There have been a group of people coming out of that forum who have been having a conversation about that. We have also had a critical friends group that supported the development of Next Steps, and I have had a conversation with them, as well, about what kind of group we want to establish and whether it focuses just on Next Steps or takes a bigger picture, and there are pros and cons with both of those. We have just about landed on a model on which we now have a discussion paper. We are scheduled to have another child and family services forum on 6 December. Post that, we will very quickly move to establish a council. Is that a fair summary, Jacinta?

Ms Evans: It is, Minister.

Ms Rule: The only other thing that I would stress is that that council is a formal, ongoing mechanism which, as the minister said, needs to be set up for the future. But it does not suggest that we have not consulted with the sector and key stakeholders in the development of Next Steps and the early implementation. It will be an ongoing, embedded mechanism for consultation, but in the meantime we have been very connected with the sector. There are what we call our critical friends who, all the way through the development of the Next Steps strategy, we have engaged with. We have sought the advice and expertise of others.

We do not have a council yet, but we are using our established networks and stakeholder relationships to make sure that this is a piece of work that has had contributions from all angles.

Ms Stephen-Smith: In terms of finalising the action plan, one of the envisaged roles of the council was to work with us to finalise the action plan, which we want to get done by the end of this year. We are not going to quite make that deadline. That forum that I spoke about on 6 December will explicitly be considering a draft action plan in at least two of the domains, if not across the whole of Next Steps. There are three action priority initiatives under each of the six domains, but there are a lot of other actions that will have to be taken over time to implement Next Steps. There is some really detailed thinking to be done about the order in which we do those things. Some of them provide a platform for others. We cannot do everything all at once, so we are engaging with the sector to talk about what we should do first and who wants to be involved.

The real step change with Next Steps is that it is about a partnership with our non-government sector organisations. It is about who wants to be involved in the implementation of each of these different actions over time, so that we are doing it together.

THE CHAIR: All right. But Next Steps is a comprehensive body of work. I imagine the reason we want a ministerial council, ongoing, is that it is not a small initiative and we have relied pretty heavily, particularly in this sector, it would be fair to say, on those stakeholder relationships and what the community sector are saying to us that they need. But this reads to me as another level up in terms of their responsibility and their time commitment, as well as partnering with government. Based on that preamble, will people get remunerated for their time on the ministerial council?

Ms Rule: Yes. We expect it will follow the normal processes of the government's appointment of members to these types of bodies. We will work with the Remuneration Tribunal on how much people will be reimbursed. It will be set up with all of those formal mechanisms in place.

THE CHAIR: Tremendous.

MR MILLIGAN: We have heard concerns that the care and protection intensive list is not well known and is under-utilised. The annual report states that over the years CYPS has supported a small number of children and young people through this process. What exactly was that small number and what is the presumed capacity of the alternative to care and protection proceedings?

Ms Rule: I suspect the reason that we have said it is a small number is that we, for privacy reasons, tend not to publish very small numbers because it can be easy to identify the people.

MR MILLIGAN: How would that be a privacy issue? By releasing the numbers you are not releasing who it is.

Ms Rule: Yes, but it is standard practice in almost every social services system I have worked in to not release numbers less than 10, usually. That is kind of the benchmark because it can be possible to identify people who might be involved in that, in a small community like Canberra. Our typical practice is not to publish small numbers, so the number that is in the annual report would be less than 10.

MR MILLIGAN: Right. Okay. The annual report also states that CYPS supports eligible children and young people, and their families, to participate. What makes families eligible to participate and who decides this?

Ms Lapic: The details in relation to eligibility go to our legal services branch, and they determine the pathway for which families are eligible. I am able to seek some further information for you around the eligibility criteria, but that is determined by our legal branch.

Ms Stephen-Smith: In partnership with the court, presumably, because it is a court-led process.

Ms Lapic: Yes.

Ms Stephen-Smith: It was the court that drove the establishment of what was originally called the therapeutic court and then changed the intensive list. So it is a process very much designed by, and driven by, the Childrens Court. It is one that I really welcome and that I think is very important. It means there is a joint responsibility.

MR MILLIGAN: Okay. So is there a mechanism for the therapeutic care court to provide feedback or influence CYPS decision-making?

Ms Stephen-Smith: Yes. My understanding—and I will throw to Ms Lapic because I am really outside my lane here—is that the therapeutic care court process or the intensive list process is an alternative mechanism for making the same decisions that the Childrens Court would usually make through its standard process in considering child and youth protection matters and care and protection order issues. So it is the court itself establishing a restorative process to consider those issues, in kind of a similar way that circle sentencing has the same result of a sentence being determined, but it is done in a different way through a restorative process. Now I cannot remember what your actual question was.

MR MILLIGAN: Can they provide feedback or influence the decisions that CYPS make?

Ms Stephen-Smith: Silvia, it might be useful to talk through how the court process considers the care plans that CYPS puts forward because it is often talked about publicly that X, Y and Z was a CYPS decision where, in fact, it was a court decision or CYPS is acting on an order of the court.

There are some decisions that are made by Child and Youth Protection Services, there are some decisions that are made by our partners in ACT Together and there are some decisions made by the court. Often those things become conflated. The role of the therapeutic court would be to support decision-making in the same realm that the Childrens Court currently has. But that does sometimes go into the decisions that would sit normally with CYPS.

We were talking earlier about contact, for example. It may be that a care plan involves a plan for contact with birth parents and that the court will consider that as part of its overall consideration in making orders. Silvia, do you want to quickly talk through how CYPS provides that information to the court and how that might be taken into consideration and even adjusted through that process?

Ms Lapic: Given the very small number that have proceeded through this, I am happy to take it on notice to give some real, concrete information about the court. It is really through our legal services branch, where we are briefed and we provide the information that is required. I will take it on notice to get some more concrete information for you.

MR MILLIGAN: Excellent. Thank you.

DR PATERSON: Minister, foster and kinship carers make a huge contribution to our community. What do we do to support foster carers who are at the beginning of the process, through the process of caring for a child or young person and then if that child leaves their care?

Ms Stephen-Smith: Yes, you are absolutely right: foster and kinship carers are the backbone of the child and youth protection system and particularly the out of home care system. A lot of the responsibility for supporting them sits with our partners in ACT Together, particularly for foster carers. I might hand over to Ms Lapic again.

Ms Lapic: Thank you. In terms of the supports, if we consider when a kinship carer, for example, enters the system, we have over the last six months developed a new orientation program, co-developed with our carer group—the group that the minister earlier mentioned, the carer wellbeing joint committee. This committee had nominations to be a part of this orientation program. It looks to provide some early supports or give some really good information when you become a kinship carer. It can be quite daunting, with a new environment, a new child. They are part of your family but there are a lot of different dynamics that need to be considered at that point.

The orientation program that has been delivered just this year has had some really positive feedback. The regular newsletter that we send out each and every month has quite a lot of information, updated information. We have a therapeutic corner, which gives some tips on things, and school holiday activities or different types of information that we think might be really helpful.

We work very closely with ACT Together on what we can do to support carers, both in the early stage but throughout the process as well. We do have a dedicated carer support worker in our CYPS team, as do the ACT Together staff as well. There are multiple opportunities to provide different types of support, depending on what the carers are seeking.

But this area needs to be strengthened, and we will be working really closely, particularly over the next year, with ACU and Curijo. We have partnered with them to look at what is a good model of care, what is the best practice model of care when we are looking at kinship carers, looking towards what can be done to strengthen our support in this space.

Ms Stephen-Smith: For the benefit of Hansard, and anyone else, ACU is the Australian Catholic University, which has a child protection specialty research area. The only other thing I would add in terms of carers is that we have renegotiated our agreement with Carers ACT that was established under A Step Up for Our Kids to provide carer advocacy that is slightly broader. Ms Saballa or Ms Wood might want to talk a little bit about this. It was based on the feedback from Carers ACT that by the time people came to them for advocacy support it was too late and the relationship with either ACT Together or CYPS or both, had already broken down. They wanted to broaden out the supports that they could provide to carers who were having difficulty in engaging with the system. Do you want to talk a little more about that?

Ms Saballa: Yes, I am happy to. Thank you, Minister. I have read and understand the privilege statement. To add to what the minister outlined: yes, we have entered into a contract with Carers ACT. In the discussions in the lead-up to executing the contract, we worked with Carers ACT on where they saw that they could really make a difference in their work. As the minister mentioned, it was around individual advocacy. That is the space that they were working in in the previous contract, but also we looked at how they can take a more systemic approach—how they can work with other funded partners and with CYPS to look at policies and processes and the broader system for carers. That is what we have in place now. Thank you, Minister.

DR PATERSON: And people have access to that information early on and are aware that there are those advocacy arrangements available if they do experience some challenges with the system?

Ms Saballa: Yes. I can confirm that that is part of that orientation program: giving really good information at the early stages. Carers ACT have also participated in that session, providing information and being available for support. Yes, at the very earliest point, we like to provide that information.

DR PATERSON: The program that you spoke about at the Australian Catholic Uni is focused on kinship carers. Is there more work that we need to do more broadly with foster carers as well?

Ms Saballa: I do think that there are always opportunities to strengthen our response. We need to respond to carers and the feedback that they provide to us. As part of the carer wellbeing joint committee, we have foster carer representatives who also bring issues to the table and we work through those. ACT Together are contracted to provide that level of support and continue to respond and receive that feedback.

Ms Stephen-Smith: I think, Dr Paterson, this is exactly why, in Next Steps, we committed to the charter of rights for carers, alongside the charter of rights for parents and families. We have very clearly heard the feedback from carers that there are some challenges in navigating the system, whether it is a foster carer or a kinship carer. A lot of that is around decision-making and feeling heard and having your expertise recognised—your expertise with the children and young people that you are caring for.

I think the process of establishing the charter of rights will be a process of engaging not only carers and people who have that care experience but also our own staff and the staff of our non-government partners in a conversation that helps to build joint understanding. All of these charters, for me, are about building a joint, shared understanding of the important role that everyone plays in the system. Rather than being a tool to beat someone over the head with, actually they are a tool for culture change.

DR PATERSON: Thank you.

MR MILLIGAN: Just on that, what steps does CYPS take to ensure that foster carers or kinship carers know exactly the history of the child and whether or not they may pose a risk to other members of their family?

Ms Rule: I think Ms Lapic has already said that, primarily, the role of dealing with foster carers is undertaken by ACT Together. Part of ACT Together's role is to work with CYPS to place children into placements with foster carers. That involves a process of sharing whatever information is available and appropriate to share about that child or those children with those foster carers. But you will appreciate that, under some circumstances, at the point in time at which a child is taken into care, they can be in crisis. We will learn more about those children over time. So it may be a process of sharing information with carers as more becomes available. For example, if we take emergency action and need a placement for a child at very short notice, we may not have a lot of information about that child and about issues that that child may have, but we will work that out over time with carers.

MR MILLIGAN: Okay. Finally, what concerns were raised by carers on the carer wellbeing joint committee during the reporting year, and what has CYPS done to address these concerns?

Ms Rule: I might share a little bit of feedback and then pass to others to contribute. I was really heartened, at the last meeting of the carer wellbeing committee, to hear the members of the committee talk about how optimistic they are for the future, based on Next Steps and some of the recent policy decisions made by government. Also, they reflected that they can see and feel a shift in CYPS and ACT Together practice over the last six months.

We have worked incredibly hard to make sure that the communication with carers is more effective and that our staff are empowered to work with ACT Together and with carers more readily on these issues. For that wellbeing committee to tell us that not only in their caring situations but in terms of the other carers that they work with they can see and feel a positive shift in the practice of the child protection system is great. That was a pretty good day, I think, when we had that meeting. Those kinds of committee are usually, in my experience, pretty good at telling you what is not working, so to hear some positive feedback about us having worked really hard with them to identify problems and solve them together and that they can feel that we are making progress is really as good as we could ask for.

MR MILLIGAN: Were there any concerns raised, though? Was it all positive or were there some concerns?

Ms Rule: No; there are always concerns. I can ask my colleagues to tell you about some of those specific concerns. But the concerns usually relate to things like information sharing, the timeliness of decision-making, review processes, the complexity of the system—all of the things that we have identified in the Next Steps work and are working on solving and improving. Part of that reflects the feedback that that group has shared with us. There are, absolutely, problems and things that we can fix, but it is good to take the good with the bad.

Ms Stephen-Smith: One of the other most frequently raised concerns is access to therapeutic supports for the children and young people that are in the carer's care. That crosses over a range of things. I am certainly very conscious of that with my Health portfolio hat on—how we better improve access to health services, including early intervention and support services for children and young people who are in care. That is a piece of work that I think we probably would have got cracking on a bit earlier, if not for COVID, but it is certainly something where, for me, there is an increasing priority to do better.

MR MILLIGAN: Okay. Thank you very much. In relation to permanency orders, 36 permanency orders were made in the reporting year. How many of these were adoptions and how many were 18-year orders?

Ms Stephen-Smith: Can you refer me to the page, Mr Milligan?

MR MILLIGAN: Ninety-four.

Ms Stephen-Smith: There will be some information on that in the A Step Up for Our Kids data update that I table in the next sitting. I cannot remember what the answer is.

Ms Lapic: Yes. I can confirm that that 36 is not in relation to 18-year orders. The 36—

MR MILLIGAN: Okay. Yes. Sorry; you keep going.

Ms Lapic: Sorry. I think that is what you asked. How many of those are—

Ms Stephen-Smith: The permanency orders; whether it is EPR or adoption I think is what they want to know.

MR MILLIGAN: Yes.

Ms Lapic: EPR and adoption are included in the 36, but not long-term care and protection orders to 18. That is a separate count.

Ms Stephen-Smith: I think he is after: of those 36, how many are adoptions and how many are EPRs?

MR MILLIGAN: Yes.

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

MR MILLIGAN: Okay. Thank you very much. The annual report also states that permanency orders exceeded the annual target for 2021-22, due to a number of matters being progressed through the courts. How have court proceedings been impacted by recent legislative changes on adoption laws?

Ms Stephen-Smith: Again, I have had discussions with and answered questions from Mrs Kikkert a number of times on this. There were some delays in the consideration of adoption matters through the Supreme Court. Some matters were effectively put on hold during and following the changes to the Adoption Act that we made to change the focus of the decision-making around dispensation of parental consent to adoption from being focused on the parent to being focused on the best interests of the child.

That needed to be tested in the court to ensure that the court was going to interpret the intention of the Legislative Assembly in making that change in the way that the Assembly had intended. As you can imagine, we do not have control over the time frames of Supreme Court consideration of matters, so it took a little bit of time for the first case using that new criteria to come to court. Once that case was considered and the justice had made a decision on how the court was interpreting those criteria, a number of other matters were able to be taken forward through the legal process.

I absolutely recognise that that whole process took a bit of time to flow through the system. It was a really important change and I genuinely think it has potentially affected the outcomes of some of these matters. It has certainly affected the way the court is considering the criteria for dispensation of parental consent in adoption cases in a much more positive way, in a way that genuinely is about the best interests of children and young people.

I think what you are then seeing is some matters starting to flow through, following that change. They have not all got to court yet, but they have started to flow through the system, which is quite a complex system of working out how and when to take things to court. As I have said to Mrs Kikkert before, there definitely has been a delay as a result of this, but also there is a better process at the end of the day.

MR MILLIGAN: So do you think that these permanency orders will continue to go up over the next couple of years until that delay is picked up?

Ms Stephen-Smith: Yes. The other thing is that we, a few years ago in the budget, committed specific resources to the adoptions team, which considers EPRs as well as adoptions, and there has been a bit of turnover and staff change in that. Ms Lapic might want to talk about how that team is now resourced and focused on getting this work done.

Ms Lapic: There are six staff members as part of that team. They have specific functions across EPR adoption. Adoption is then also considering intercountry adoption, step-parent and known children adoption, as well as out of home care. So there are different parts of the adoption process, as well as an information service that we are able to provide. The small team are able to work very closely with ACT Together and work with our government solicitors to progress those matters.

Ms Stephen-Smith: There is a new process, particularly on the adoption side, of much more regular joint meetings with families, between CYPS, ACT Together and the family, to update them. I think part of the challenge in the processes previously, with ACT Together's responsibility, was a little bit of a Chinese whispers process, which is no-one's fault and totally unintentional. Legal providing information to the CYPS case manager, providing information to the ACT Together case manager and then providing that information to the family was not always necessarily being interpreted a hundred per cent accurately as it went down that chain. The process of everybody meeting together regularly I think is a significant improvement.

MR MILLIGAN: Okay. Thank you, Minister.

THE CHAIR: Do you have any further questions, Mr Milligan?

MR MILLIGAN: No. I think the other questions can be put through on notice.

THE CHAIR: Tremendous.

Ms Stephen-Smith: If you have them and you want to ask them now and avoid us having to answer them on notice, we are happy to stay till five.

MR MILLIGAN: I think Mrs Kikkert is probably best positioned to put those through on notice.

Ms Stephen-Smith: Okay.

THE CHAIR: It would appear that we accommodated the expectation of Mrs Kikkert's time here today and thus we are finishing a bit earlier than we might have. Thank you very much, Minister Stephen-Smith and your officials, for appearing today. If you took any questions on notice, please provide the answers to those questions to the committee secretary within five working days. To other members of the Assembly watching in their offices, if you wish to lodge a question on notice, please also get those through to committee support within five working days of today's hearings. Today's hearing is now adjourned.

The committee adjourned at 4.43 pm.