



**LEGISLATIVE ASSEMBLY FOR THE
AUSTRALIAN CAPITAL TERRITORY**

**STANDING COMMITTEE ON HEALTH
AND COMMUNITY WELLBEING**

(Reference: [Inquiry into Raising Children in the ACT](#))

Members:

**MS J CLAY (Chair)
MR J MILLIGAN (Deputy Chair)
MR M PETTERSSON**

TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 21 MAY 2024

**Secretary to the committee:
Ms K Langham (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.

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Amended 20 May 2013

The committee met at 3.29 pm.

ALLEN, DR LIZ, Demographer and Senior Lecturer, Centre for Social Research and Methods, Australian National University

THE CHAIR: Good afternoon. Welcome to the public hearing of the health and community wellbeing committee for our inquiry into raising children in the ACT. Today we are hearing from a range of witness who made submissions. The committee wishes to acknowledge the traditional custodians of the land we are meeting on, the Ngunnawal people. The committee wishes to acknowledge and respect their continuing culture and the contribution they make to the life of our city and our region. We would like to acknowledge and welcome any other Aboriginal and Torres Strait Islander people who may be attending today's event or who may be watching from home.

We are recording and transcribing our proceedings today in *Hansard*, and we will publish them. We are also broadcasting them live. If you take a question on notice, you can say, "I will take that on notice." That will help us track down the answer. We recognise that some of the issues we are talking about today are sensitive. We have information on support organisations available for anyone who gives evidence today or for anyone who is watching. If you are affected by the issues that are raised in this hearing, please speak up, and our marvellous secretariat here will help with some support information.

First of all, we are hearing from Dr Liz Allen. Thank you so much for joining us. Have you seen the privilege statement?

Dr Allen: I have, yes.

THE CHAIR: Do you agree with the obligations and responsibilities set out in that?

Dr Allen: I do.

THE CHAIR: Excellent; thank you very much. We probably will not do opening statements unless—

Dr Allen: That is fine.

THE CHAIR: We tend to prefer the time for conversation—as a better use of it.

Dr Allen: Sure.

THE CHAIR: I will start with the first question and then we will work down the list. There were a lot of things, Dr Allen, in your submission that interested me, and it is great to hear from a demographer. One of the phrases I wanted to pull out is where you said:

... young people are seeing little to no action from governments on climate change and fear the future environment is one that makes it unethical to have

children.

We have heard a similar sentiment from a few people. Can you tell me where that comes from?

Dr Allen: There is certainly evidence within sample surveys. When young people are asked about their concerns for the future, climate change is mentioned and, indeed, surveys indicate that young people identify climate change and a lack of action on climate change as an impediment to having a child or having children. Certainly, that issue of ethics, and whether or not it is a moral thing to have a child and to bring a child into an uncertain climate future, features quite prominently, particularly among young women. For me as a demographer, I see that as one of the barriers preventing, particularly, young people from achieving their desired family size, whether that be one or subsequent children.

THE CHAIR: Yes, that is interesting. Is that something that you think is shifting over time? Is that something that maybe was not around and has arisen in more recent times?

Dr Allen: I certainly think it has grown. It is becoming more prominent in the way that we ask, so we are certainly asking about this now. Anecdotally, it is increasing, but, certainly, I would say, yes, it is a relatively newer phenomenon.

MR MILLIGAN: Thank you for coming along and putting in a submission to this very important inquiry. You have raised a number of issues in your submission, although you have not necessarily given us any recommendations. What do you think is the highest priority, and what should the government be doing to address that priority?

Dr Allen: In my submission I lay out a number of key areas. They relate to housing affordability, gender equality, climate change and financial security. Within that, I have set out a number of actionable items under each of those broad domains. The trouble with such an inquiry focused on investigating children and raising children in an area is that there is not one single item that we need to address; rather, we need to approach this as a systemic problem whereby a suite, or raft, of investments need to be made. The reason I came up with those four areas is that these are, generally, the biggest concerns that people of child-bearing age are experiencing and stating that they are experiencing. These are big-ticket items, and they are not easily solvable, but they can be broken down.

I also make mention in my submission that no baby bonus is going to get us out of this low total fertility rate, and the ACT has the lowest at 1.4, or thereabouts. Once you get below 1.6—and certainly at the level the ACT is at—it is going to be tricky to come back from that because it becomes an in-built social norm. We can look to, for example, Singapore, and the like, to see the situation. We are at this point now where, if you were to ask me what the one area is I would recommend you invest in, I think that it is a matter for data.

I would strongly urge that more data be invested in for seeking to understand the barriers to either having a child or having a subsequent child in the ACT. That

includes understanding the pressures from those that have already experienced raising a child or that are in the situation of raising a child. From that, we can have more of a data and evidenced-informed approach. It also signals that something is being done. Action and rhetoric are quite powerful, and the language and the leadership in this space is helpful. Sometimes there can be budget-neutral actions that really set the tone that children are welcome; there are family-friendly spaces; parenthood is not just about being a mum and a dad—there are a variety of ways to do family, for example.

They are my four main areas: housing, gender equality, climate change and financial security. If you were to look at the available data at the moment by way of survey responses, I would probably pick housing and financial security—that includes cost of living and so on. Climate change is one that you cannot get away from—that idea of, “Is it ethically okay?” Young people, particularly young women, are saying, “I am seeing no action, so I am going to take the action for you, and that means I am not going to have children.” These are desired families, so I would suggest investing in the easy wins that can gain traction quickly around housing and financial security, but do not forget climate change.

MR MILLIGAN: You mention that, ethically, some parents may choose not to have a child because of climate change—a very broad statement. What does that mean exactly? How is that going to either contribute to the issue or not, or how is it going to help improve the situation of climate change?

Dr Allen: From a functional point of view, when someone is thinking about having a child, they think, “What future would I be bringing a child into?” Many young people cite concerns about increasing climate disaster. “Climate boiling” is a term used now by large international organisations as the reality that we are in. This conjures up an image of a fiery inferno, and we are very aware of that kind of bushfire risk in Canberra. Those sorts of things are definitely at the forefront of young people’s minds, so they think, “Is it ethical to have a child to contribute to the possible depletion of the environment”, but also, “Is it ethically okay for that child to be brought into that uncertain future?”

MR MILLIGAN: Is there any evidence that suggests having one child will contribute to climate change or will contribute to rising of temperatures or anything like that? Apart from fear contributing to these thoughts or values, however you might like to title them, what evidence is there to suggest having children, or even one child, will make any difference towards our climate?

Dr Allen: Many people will look at population; there are some that will espouse the view that there is a carrying capacity of the population. There are some that will even say that Australia is already overpopulated. I will park that to the side for a moment and go back to the main issue.

If you look at the depletion of climate and non-renewable resources, we have an ability to look at the impact of a person per capita. We can look at per capita responses. In a place like Australia, we generally have a very high rate of depletion, so that, I think, features, and certainly that is the evidence that is often cited. But I would suggest it is probably more from an ethics or moral point of view: not so much the contribution that child would make but, rather, is the future certain for that child or

those children? Uncertainty features quite heavily in housing affordability—that financial security—but also in that issue of climate and the fear of an uncertain future. From what I am starting to see, I can see in a series of datasets that uncertainty breeds fear and fear then contributes to a fraying of social cohesion. If we can tackle this feeling of uncertainty—and that can even be as easy as using budget-neutral type of language and rhetoric and publishing a stance that we seek to actually do something and we are committed to action—we can perhaps start to address those fears of uncertainty. At the heart of it, if you look at all the items, perhaps bar gender equality, that notion of uncertainty is at the core.

MR MILLIGAN: There might be uncertainty and fear, and the like, but it does not necessarily mean that that is accurate or correct. That is obviously their own personal view of this position—

Dr Allen: I cannot comment on that, but I will say that perception is more powerful than reality, generally. If we look at crime rates in an area, for example—crime rates are generally a lot lower than locals fear and say they are. While we can argue, and I do not have the expertise to argue about whether or not climate science is real, the evidence is that if climate problems increase, we will be in a state of climate boiling. Whether or not we agree on that, the reality is that perceptions are more powerful than reality, so if we have a population with concerns and a perceived risk, we do need to address that.

MR MILLIGAN: What evidence is there to suggest that Australia is already overpopulated or at the maximum? I do not know if you have this data or the details on you. What is the population growth like in Australia and around the world? Are we increasing, or is the population decreasing or are we stabilised? I do not know if you have those answers, but it would be interesting to know.

Dr Allen: Australia’s population is growing. In the last window of 12 months to, I think, September 2023, which is the latest data that we have on hand, the rates are quite high from a historical point of view; however—and I could spend all afternoon talking about the nuts and bolts of this—there is no cause for alarm, particularly with concerns around immigration. In fact, in the ACT it is immigration that is driving the bulk of the ACT’s population growth. It is across the country as well, but very pronounced in the ACT.

MR MILLIGAN: You don’t see an issue with that?

Dr Allen: I will come to that in a moment. I will address the main issue you have about what the optimum population size is. The answer is: there is none. That is very controversial. There will be those that will say that there is a magic figure and perhaps that figure was reached 10 million people ago in Australia; that is known as a “carrying capacity”. Carrying capacity, I would argue, as would many demographers, is a very limited view of the quantum of a population. I would instead say that it is not so much size that matters; it is the distribution of the population, the health and wellbeing of the population.

I will come back to that issue of the concern on immigration. Australia has an ageing population. The ACT has the same. We are living longer. The ACT has the longest

life expectancy of any jurisdiction. That is a fabulously wonderful thing. We also have the lowest level of total fertility rate. Those two things together put enormous pressure on our workforce. We are not replacing our workforce. In the ACT we have difficulty attracting and retaining people—for example, paediatricians. I understand there are jobs going on the ask, and they are not being filled. That is highly problematic. Immigration and net internal migration are essential to help us offset the deficits that we currently have in the local workforce.

MR PETTERSSON: There is a particular line in your submission, and it has come up a couple of times:

The Australian Capital Territory (ACT) has numerous demographic challenges, mirroring the national context but worse.

How much worse?

Dr Allen: It is really tricky because, in addition to the issues of the increased life expectancy—a more pronounced, ageing population—and the lower total fertility rate, we also do not necessarily have good, reliable intercensal population data. We can see that with the last census. Our intercensal estimation of population in the ACT did not reflect reality until the 2021 census. In other words, we really do not understand on a yearly basis what population difficulties, challenges or opportunities we have, because of the issues around the reliability of that data. That relates to when people move and do not tend to update their addresses and so on, and when students come to the ACT but do not feel themselves to be an ACT resident, for example. So that is one issue: data.

From a demographic and theoretical point of view, I say that it is much worse because we have what is considered a low-low total fertility rate. The total fertility rate is the average births a woman is expected to have given age-specific fertility rates at the time. It is a synthetic measure. That 1.4 may seem meaningless and very abstract, but it is generally the threshold. If you want to encourage people to be having the desired children they wish to have, it is very difficult to get above that low-low fertility, and if it goes down to 1.2, we are in deeper trouble. It is something, I think, that coincides with other demographic characteristics in the ACT: we have a higher level of education and higher incomes. There are a whole range of other socio-economic factors that make the barriers to having a child, or having a subsequent child, truly insurmountable: you have to put your career on hold; the domain of having a child is generally that of a mother, not of parenting. There are all of these issues that go towards that and make it a very complex situation. As I said, it cannot be really addressed with just one pick of a thing. It needs to be a suite of approaches.

MR PETTERSSON: I want to touch upon a couple of things that you have mentioned. It has been put to me that fertility in the ACT is a function of a range of these things. The one I hear most commonly is that the ACT is a very wealthy jurisdiction and with higher incomes comes lower fertility.

Dr Allen: Yes.

MR PETTERSSON: Is that the story of the ACT, or is it that and other things?

Dr Allen: There are a number of factors, but, as you say, generally, we will see total fertility rates lower where we have a higher socio-economic situation. I want to make a comment on the high socio-economic status of the ACT. We are talking about aggregates here, and we have a high degree of hidden poverty in the ACT that I do not think we have really grasped, and that contributes to child and family wellbeing and so on.

I will come back to the issue of what is going on in the ACT. Survey data generally points to the fact that we might start out our life as young adults saying we desire to have X number of children, but, as life happens and the barriers to living life become very apparent, the reality of having a child, or having a subsequent child, becomes difficult. Our barriers make us then realise that we cannot achieve our desired family size. I would not be concerned with a low fertility rate if it was a choice people were making and not because life was getting in the way. Life is getting in the way. By that I mean that what is happening is that the age at first birth, the average or median age at first birth among women, is increasing. That means your potential window of opportunity to have a child and have subsequent children is constrained even further.

We have then got to this point where we need dual incomes to service a house, whether that be renting or whether that be owning a home. One of those in the household gives up a wage or lowers it, often going part time. It becomes very tricky. We have the cost of child care, accessibility of child care and the career impact of taking time out of the workforce. Unfortunately, in many workplaces having a child is seen, particularly for women, as a deficit. Evidence shows it is the opposite case for men. Men are considered more loyal and more of an asset if they have a child. So there are very fixed gender issues that we need to confront as well. All of these things compound, and you can see now why a baby bonus is not effective. It is a piddle in the pond, essentially, in addressing these major, lifelong issues when it comes to the impact of having a child on individuals.

MR PETTERSON: The other thing that I hear commonly is that the ACT is quite a transitory place. People come to work and do their time, commonly in the public service, and they leave to go home. To me, as a layman trying to understand this, surely that means we have more people of, I guess, family-starting age here. What is going on?

Dr Allen: You are right. Historically, the ACT was most definitely a transitory kind of place. You would come here, you would work, you would do your time and you would go home to have your family, so the ACT was not really considered as a place to have and raise children. That is changing. We are more and more, particularly with an ageing population, seeing the need for aged-care homes. We are seeing ageing in place. We are, importantly, seeing generations stay in the ACT. We also do not have a lot of data on that. There has not been a lot of recent research to understand that, so we are kind of flying blind, with our eyes covered. I think, again, that would be a space that we could understand, within that idea of understanding the experiences but also the preferences and behaviours, and intended behaviours. There are a range of survey questions that are tried and tested that we could easily do in a population-based survey in the ACT to understand this, and that would be an element of it.

THE CHAIR: Thank you. Dr Allen, this is fascinating. I could listen all day.

Dr Allen: I could talk all day!

THE CHAIR: Awesome! We probably only have time for one more point, and I want to put it to you that I am interested in your comments on the need for public housing adequately serviced by public transport. Alternatively, what data do you think the government should be gathering that would achieve that? Can you run me through whichever of those points you think is most important?

Dr Allen: There are a range of issues here that sit within housing affordability. Yes, we need greater investment in social and affordable housing. We need to also, in my opinion, increase rental rights in the ACT, because we see generation on generation having lower rates of home ownership, so that is an important thing to consider as well. But it is not just the home. Some of the schemes that we have in the ACT for first homebuyers, particularly, do not actually equalise income. I know this is taking us off the track, but if you look at the requirements and the eligibility for getting into these schemes, they assume there is a couple and, where there are children, they assume there is only one income earner. These first homebuyer grants have not kept pace with contemporary lives. We do not see equalised income as the basis determining factor of eligibility. We are instilling an inequality by way of these schemes.

I will go back to your main point. Appropriate social, economic and physical infrastructure is required for population wellbeing. That means active transport. We are a very car reliant, car-dominant city, and we are quite dispersed. We are not building up; we are generally building out. That needs to be considered. If you are asking people to have children, or that desired child or subsequent desired child, show them the infrastructure. That is, essentially, what it is, and that means reliable, safe and accessible infrastructure—accessible logistically, as well as financially and physically.

THE CHAIR: The notion that somebody under the age of 30 might buy a house with one income is quite extraordinary, I think.

Dr Allen: We will see the structure of our households change in response to housing affordability. We will see more people living in intergenerational or multigenerational households. We will also see multifamily households as a way of coping with these pressures. That raises questions, particularly from the multifamily perspective: is it conducive to wellbeing? Is conflict going to increase, and so on? As I said, we really do not have a lot of necessary data. We cannot collect and analyse data with a hope to prove that the government's actions are good. We need to actually have a scorecard of how we are doing from a population perspective so that we can understand what is needed to plan for tomorrow.

THE CHAIR: Is someone doing that kind of scorecard?

Dr Allen: I do not believe so.

THE CHAIR: So, in the ACT we are not, but are other jurisdictions doing that kind

of data-gathering exercise?

Dr Allen: Yes, there have been ad hoc approaches to this. There have been population policies developed in Tasmania and South Australia. South Australia has very pronounced population ageing. Tasmania is quite the same. Tasmania, though, is having a lot of exits and so on. There has been quite a lot of attention in those areas to understand why people move—in the Northern Territory also. That could help inform knowledge about the net interstate migration, intentions to stay and so on.

In terms of a scorecard, definitely the framework that the ACT government has is moving towards that kind of wellbeing framework. The wellbeing framework is certainly the bounds that you want to be doing such a thing within. The trouble is, I do not think the data exists that is required to properly inform such a framework.

THE CHAIR: Yes, I think you are right. Dr Allen, thank you so much for your time today. This was really interesting. Is there anything that you need to add before we come to the end?

Dr Allen: No.

THE CHAIR: On behalf of our committee, thank you so much for your time and expertise today. We did not have any questions on notice. You will get a copy of the transcript from our secretariat, and you can have a quick glance over it and let us know if we have got anything wrong.

Dr Allen: Excellent; thank you.

REED, MX KAT, Chief Executive Officer, Women with Disabilities ACT
NEWMAN, MX PIPPA, Policy Officer, Women with Disabilities ACT

THE CHAIR: We are pleased to welcome our witnesses from Women with Disabilities ACT. We have a pink privilege statement which, hopefully, you have had a chance to read. Do you agree with the responsibilities and obligations to tell the truth that are set out in that privilege statement?

Mx Reed: Absolutely, yes.

Mx Newman: Yes.

THE CHAIR: Excellent. We were not planning on taking opening statements, but I will check whether you have prepared one.

Mx Reed: We do have one prepared.

THE CHAIR: Would you like to read it or table it?

Mx Reed: I would like to read it, if that is okay.

THE CHAIR: Yes, sure. Please go ahead.

Mx Reed: Women with Disabilities ACT is run by and advocates on behalf of women, non-binary and gender-diverse people with disabilities in the ACT. We are a human rights based organisation, and we recognise the right of all people to be parents and to raise children under the Convention on the Rights of Persons with Disabilities. All people deserve support to parent, and our input to this inquiry highlights ways that the ACT government can provide this support to parents with disabilities.

We have made a number of recommendations in our submission, but we would like to highlight a few from the outset, as they are important to consider. Formal and informal parenting supports are essential for all parents; however, they are not always accessible for parents with disabilities. Parents might not know what supports are available or the services might have limited information on their physical accessibility or disability awareness. Parents might also be unaware of how these parenting services interact with other supports that they use, such as NDIS.

WWDACT, along with other organisations, have consistently highlighted the need for a parent navigator in the ACT to connect parents with disabilities to the information and support that they need. It is also useful for parents with disabilities to have access to tailored community supports and to connect with others who are facing similar experiences.

These supports in the ACT do not receive ongoing funding from the government, and programs become tied to grant funding, leading to inconsistent availability of things like social groups for parents with disabilities. If ongoing funding to disabled persons organisations in the ACT were increased, DPOs would be able to provide ongoing community supports to parents. Moreover, there is no formal support service available

for parents with intellectual disabilities in the ACT, and we call for this service to be funded by the ACT government.

We have seen our members face difficulties across their parenting journey, even when attempting to access assisted reproductive technology—IVF—or information about trying to conceive. Systemic ableism, unaffordability and inaccessibility are huge barriers for members in our community who are trying to access support to conceive. Funding assisted reproductive technologies, accessible information and training for practitioners is essential to ensure people with disabilities have their reproductive rights respected.

We are happy to elaborate on these issues or any of the recommendations we raised in our submission to this inquiry.

THE CHAIR: Thank you, Kat, for that excellent framing of the issues today. I was struck by quite a lot of things in your submission, including the fact that there is a lack of support for parents with intellectual disabilities and a lack of funding for the parental navigator. If that was done well by government, what would it look like?

Mx Newman: The parenting navigator is something that we have elaborated on, along with other disability organisations, in our submission to the ACT budget. Essentially, it would be a service that would be able to connect parents with disabilities. They would have a good knowledge of what services are available in the ACT—basically, the accessibility of those services, so whether they were physically accessible, whether they were particular support groups for parents with particular kinds of disabilities. They would have a good understanding of how that integrates with things like NDIS supports and other supports that are available—kind of a one-stop shop for parents, so that they know what services are available.

We have heard a lot from our members that often they do not know what kinds of things are available across the board in terms of support for their disability while managing their parenting responsibilities, and social supports and community supports that are so important. Having someone that has all of this information, who is also able to collate the information and have it available in accessible formats like easy read and braille—we see that as something that would help a lot, if parents had one place that they could go to access that information.

THE CHAIR: It makes a lot of sense. Probably a helpline or a well-publicised place that has some human beings working there; is that—

Mx Newman: Yes. There are similar navigator processes in other systems and in other sectors, similar to the healthcare navigation that is being talked about at the moment. It is something that has come up when we talk about things like foundational supports under the NDIS; navigation services generally are something that is being looked at. That would be a really useful tool.

THE CHAIR: It makes good sense, particularly with the difficulties people have on the NDIS journey. I know it is easy for state governments to say that it is not our responsibility; actually, if it affects your people and if you can help people to navigate between the federal and the state issues, maybe it is your responsibility.

MR MILLIGAN: You mentioned that children with disabilities should have the right to access mainstream preschools and schools, but that it has not been realised in the ACT. Can you elaborate a little on how that is the case, and how we could possibly address this matter to better equip our schools to be able to work with students with disabilities?

Mx Newman: Something that has come up in a few conversations we have had with members involves children trying to access early childhood education. With the additional supports needed, if they need to be watched all the time, given the nature of their disability, there are fewer formal supports than in primary and secondary education systems. Often they will be turned away, rather than giving parents and children the opportunity to access early childhood education.

It is something that we have heard through stories, but I have also seen it in the media, and I know it is a problem across multiple jurisdictions. There are multiple levels where that is an issue, but it continues through into primary and secondary schooling. We mentioned in the submission that funding—I think it is federal funding—tends to be tied to particular diagnoses, so children who do not have diagnoses or children with diagnoses that do not fall under the ones that are funded miss out on additional classroom funding and supports. This limits their ability to access education and limits the ability of teachers in that classroom to be able to give well-targeted education to everyone in that classroom.

Beyond more funding, and looking at ways in which the ACT government can give additional supports to teachers in the classroom or additional learning supports, I know that it is something that sits between federal and state responsibilities, as the NDIS does. With respect to the ACT inclusive education strategy that has been put forward, it is important to move towards having enough supports available in all classrooms so that all students have the ability to access the same classroom and do not have to go elsewhere or be locked out of particular spaces because they are not getting the supports they need.

MR MILLIGAN: In other words, we could be looking at how we further support and better equip, train and educate our teachers to be able to work with students with a disability in our public education system?

Mx Newman: That is absolutely one arm of it. Also, having additional support people in classrooms can be incredibly helpful, especially if you have multiple students that need individualised attention. It is very hard for one teacher to do that, even if they have all of the training and education behind them.

MR MILLIGAN: With students that are on the NDIS and have full-time carers, obviously, that carer support could go to the school and work with and provide the support for that student, and be there to support the student.

Mx Newman: Yes. It is also the case that lots of children that are not on the NDIS experience barriers to getting on the NDIS. It is something that WWDACT advocates on; Advocacy for Inclusion does a lot of advocacy on it as well. It is not our area of expertise, but it is something that came up when we spoke to parents about the

submission.

MR PETTERSSON: You have a recommendation for a government-funded inquiry into forced or coerced sterilisation, contraception and abortion experienced by women with disabilities. How commonplace are these practices in the ACT?

Mx Newman: It is something we do not know a lot about, because it has not been looked into. In the most extreme cases, it is reported, but in cases such as where women are placed on medical sterilisation—the contraceptive pill—that can happen without their consent. We do not actually know the prevalence and how often it happens. We know that it happens but there are no formal reporting requirements to gauge a picture of what is going on.

We know that legislation in the ACT would allow permanent forced sterilisation to occur under certain circumstances. We would encourage the ACT government to inquire further into this, consider whether that legal loophole should be closed, and look at the prevalence more generally of coercion and sterilisation practices across the ACT.

MR PETTERSSON: I appreciate that there have not been any studies done. Verbally, is this reported to your organisation?

Mx Newman: It is much harder to track, especially the medical chemical sterilisation, where it might just be a GP that is prescribing the contraceptive pill, for example, and that might be done without the consent of the person with disability. Potentially, consent is given on their behalf, but they do not have an understanding of the medication that they are taking. We would also consider this to be forced sterilisation. It is very hard to say whether that is recorded anywhere and who has the information about where that has been recorded.

THE CHAIR: That was a quite disturbing thing that I looked at in your submission. Are there other states or territories that have good reporting schemes in place, so that they have a better understanding of forced sterilisation that is going on within their borders?

Mx Newman: I am not sure. It would go to the Human Rights Commissioner, I think, in each individual state, and that is for permanent, irreversible sterilisation or surgical procedures. I would have to look into whether that is the case in other states and territories. I would assume that there is no clear way of getting reporting of what is going on.

THE CHAIR: We are speaking to the Human Rights Commissioner. It is a difficult concept to imagine how a report would end up, how a complaint would end up, with the Human Rights Commissioner in these situations, because who would be bringing the complaint? That is a bit tricky, I think, if it was complaints based, which is where you want the need for some better information about how prevalent it is.

I was interested in your comment that we do not have a lot of data about parents with disabilities in the ACT. Is that because we do not have a good handle on who our people are and what they need? Is that where we are at?

Mx Newman: I would say so. In looking at raising children generally and targeting services or policies to the people that need them most, it is difficult. This is a problem generally across disability, where disaggregated data is not always available, so it is hard to pull out the experiences of people with disability from the broader picture. For issues like parenting, where people with disability have really specific experiences, it is quite hard to know if the data that we are drawing on for other areas is not disaggregated by disability. That is an ongoing issue across multiple areas. It did impact our ability to know how prevalent all of the issues that we talked about in our submission actually are in the ACT.

THE CHAIR: It is difficult, too, because with people with disability, everybody has different experiences of life and different needs, and that is also true of parents. It is probably compounded. If you do not have a particularly good understanding of where people are at and what help they need, it might be quite difficult to know if you are providing useful services, I would imagine.

Mx Newman: Yes, absolutely. That is why we advocate for universal design of services so that they can respond to parents, whatever their needs are, and, as those fluctuate, whether you have a diagnosed disability or not. People's needs fluctuate over time and the services that are provided should have an understanding of that.

THE CHAIR: You have unpicked that a little bit in the education setting. Do you think our healthcare setting is doing that better or worse?

Mx Newman: I know there is a lot going on at the moment and a lot of discussions are happening around the ACT Disability Health Strategy. There is certainly more to be done. A position like a healthcare liaison officer could function as a parenting navigator, as someone in the healthcare system that is able to give people with disability the information they need and advocate on behalf of them to other healthcare staff.

Health care is a huge area and the parents that we spoke to raised perinatal mental health as a massive concern—how that is treated in the ACT health system. That intersects with women with disability in that they are more likely to have their children taken away by child protection services. Also, more complex mental health conditions like perinatal psychosis were raised by a couple of our members as something that does not have adequate understanding or treatment in the ACT health system. This leads to inappropriate treatment or understanding of what is going on.

THE CHAIR: You mentioned that anxiety and postnatal depression were better understood but postnatal psychosis was not particularly well serviced here. I was quite alarmed to see child protection fears come up in this area; that is obviously something that your members, your community, are talking about.

Mx Newman: Yes, and it is something that we have raised and done some inquiries in the community about, given the child protection act reforms in the ACT recently. That is something that comes up time and again: women are scared of seeking help because of the risk that their children will be taken away. There is a very real risk; the over-representation can be seen through the statistics.

MR PETTERSSON: You highlight in your submission some of the barriers to accessing fertility treatments. An example in the submission is that one of your members was forced to sign a legal waiver when attempting to access fertility services. How commonplace are behaviours and practices like this in the ACT?

Mx Newman: It is another statistic and data that we do not necessarily have, because it is not always recorded. We do not know how many of our members try to access fertility treatment and get knocked back or get coercive genetic counselling. Unfortunately, there does appear to be a widespread belief, especially when practitioners do not necessarily have the education about disability, that people with genetic disability should not have biological children. That is an incredibly problematic but pervasive belief, and one that our members have come across when trying to access those services. They have had to do things like sign legal waivers in order for the practitioner to feel comfortable continuing with a process like IVF.

MR PETTERSSON: What does the solution look like? Is it that practitioners should just know better and that, in their schooling, they should be made better aware of these issues? Is there a legislative fix that is required?

Mx Newman: I think disability awareness training for practitioners would be really beneficial. My understanding is that the ACT government is looking at ART in the ACT and how to make it accessible and affordable, given recent inquiries. Something that should be kept front of mind is that people with disability do not have equal access and do need additional supports to be able to access this. It needs to be normalised. People with disability should be able to be biological parents in the same way that everyone else is.

THE CHAIR: Housing has come up a lot, from a lot of different people, in a lot of different contexts in this inquiry. It also came up in your submission. You mentioned there is no affordable rent in Canberra if you are on a disability pension; of course, that would be the case, as our rents are far higher than that. You mentioned the need for more public housing and gold standard public housing. Can you open that up a bit for me?

Mx Newman: Gold standard public housing refers to the accessibility requirements of that housing—all single-level housing, wheelchair-accessible housing, housing that is able to be adapted to people's needs. This is something on which we have done a lot of joint advocacy with Advocacy for Inclusion, and around the upcoming budget as well. There are more details in that, and that organisation has a lot more of that information off the top of their head.

We think it is incredibly important that new public housing is built to the gold standard of accessibility, to be available for people with disabilities. It is really hard if even the public housing that might become available is not appropriate because it does not allow your wheelchair to fit through your front door.

THE CHAIR: We have moved to silver standard construction in the ACT, but not gold standard. I know that our public housing waitlists have a higher proportion of people with a disability on them than our general population. There is obviously a

need to move to that higher level. I have heard evidence from Advocacy for Inclusion on this before. Is that one of the particular barriers you would see to parents, or potential parents, with a disability having a child or having another child, if they do not have adequate housing?

Mx Newman: Yes, absolutely. If you do not have appropriate housing or you are not confident in your ability to find housing that would suit the needs of a growing family, that is a huge barrier.

MR MILLIGAN: The gold standard is renamed, isn't it, from class C?

Mx Newman: I would have to take that on notice.

MR MILLIGAN: No, it is all right. I am pretty sure that they renamed it from class C, in terms of requirements for housing to meet the needs of people with a disability. I think they have changed it to gold standard. I am not sure why; maybe it is a marketing thing or to make it sound more attractive.

THE CHAIR: Do you think there is room for improvement in our disability discrimination laws here, in a way that would assist parents or potential parents with a disability? Is this mostly a service problem or is this a legislative reform problem?

Mx Newman: I see that the main issues for parents accessing services are a lack of awareness about disability generally and attitudes of ableism. Whether a legislative change would actually go towards changing the attitudes and education of people in the community is another issue. It might help. I am not sure where the gaps in current disability discrimination legislation are that might stop some of the service gaps that parents with disabilities are experiencing.

I think it is a broader issue than just legislative change. It even goes to organisations, where services are available, not having the disability awareness or knowledge and not being able to or knowing how to provide services that are accessible for people in the community. I would see that as a broader project than legislative change.

THE CHAIR: Is there anything we did not get to that you think we should talk about or that you need to tell us?

Mx Reed: I think we have spoken about most things.

THE CHAIR: Thank you so much, Kat and Pippa, for your time today, and for sharing your experience and the experience of your members and your community.

Mx Reed: Thank you very much for the invitation.

THE CHAIR: Our secretariat will send you a copy of the transcript and you can suggest corrections to anything that we got wrong.

GRIFFITHS-COOK, MS JODIE, Public Advocate and Children and Young People
Commissioner, ACT Human Rights Commission

TOOHEY, MS KAREN, Discrimination, Health Services, Disability and
Community Services Commissioner, ACT Human Rights Commission

THE CHAIR: I welcome witnesses from the ACT Human Rights Commission. You have both seen our pink privilege statement. Do you understand the rights and responsibilities there, and are you happy to comply with those rights and responsibilities?

Ms Toohey: Yes, I am.

Ms Griffiths-Cook: Yes.

THE CHAIR: Excellent. Thank you for coming in to give evidence and thank you for your submissions. We have heard from our first couple of witnesses, and we have had a lot of submissions to this inquiry. We have had about 80 submissions, so we are hearing an awful lot.

I am interested in a few of the health discrimination strands that we have here. We have some comments about the shortage of psychologists and psychiatrists and of paediatric streaming. We heard comments from our last witnesses about navigation services, particularly for people with a disability, but I imagine that is for a number of things. Can you talk about some of the problems that you are seeing from those issues?

Ms Toohey: Obviously, a lot of my work comes from people making complaints to the commission. I acknowledge that lots of people have a good experience in these services, and the matters that we see are generally where something has not gone according to the person's expectations.

We have had some issues, and I think there have been some quite significant changes, particularly with how our emergency departments and our paediatric hospital-based services have approached service delivery over the last 18 months to two years. Certainly, earlier on we saw a number of matters where it was quite difficult, particularly in those emergency situations, for parents to get traction on their concerns about either a deteriorating child or getting access to specialist services if a child was brought into the ED.

One of the things that we see—and I know that in some of the submissions there were some comments about this—is fragmentation of continuity of care because of issues around GP services and their accessibility, the walk-in services and those relationships with our hospital services. We have certainly seen—again, as was mentioned in a couple of submissions—that there is a paediatric navigation service for complex matters. It was set up with very good will. The matters that I have seen have been where there are complex child presentations. I think there is an underlying assumption that people self-refer to some of those services, whereas when people are presenting with a sick or deteriorating child, or a child with very complex health issues, they are trying to get the service. They are not looking around at what the options are. One of the things that we certainly discuss with our colleagues in some of

the health services is the need to actively promote those services; otherwise they are being underutilised and therefore there is a perception that they are not needed, or they are not performing their function and the wear and tear again falls back on the parent or family.

In a number of matters where we have seen, for example, coordinated care between Canberra and Sydney, for some of the more critical situations, the parents have had to navigate that whole arrangement themselves. We have certainly seen that mean part of the family was in Canberra and part was in Sydney, and they were endeavouring to navigate all of those health services themselves.

I completely acknowledge that there has been a lot of effort put into trying to improve those services for children. Particularly, last year there was an expert panel on health services for children and young people, and paediatric services, which identified some of those gaps and pathways forward. My sense is that there are some assumptions made that parents, families and carers are much better equipped to navigate those systems and services than we see.

Disability would be another space where parents, carers and families will say there is a lot of onus on them to navigate those services, and they are information-heavy. It is difficult to find the right service and there is a lot of wear and tear on families in those situations. I think that is something that particularly comes through in the complaint work that I do.

THE CHAIR: It strikes me as an unfortunate problem for government not to have addressed, if we have a good navigation service that is under-used, and we also have hospitals that are sending people away when they would perhaps be better served by a referral. What recommendations came from the expert panel work last year? Has the government followed through on any of those?

Ms Toohey: Part of the panel work was around building that capacity and capability between Canberra and particularly some of the services in Sydney—around making those pathways clearer and more accessible for people. We know there have been improvements in that space; we have heard that. Again, I get the matters where it has not worked. For example, we have had some quite complex, particularly paediatric presentations where the parents are trying to navigate for themselves who to see in Sydney, what services to access and what they do on returning. As I said, we have had a number of matters where we have ended up with part of the family in Sydney and part in Canberra, because we have not been able to coordinate that.

Again, I acknowledge that there is a lot of work going into that. Certainly, people will bring a matter to us to try and get it resolved. Obviously, if they have that sort of experience in their family, that is what they are focused on. It then becomes a matter for us to try and work with our colleagues in the health services on what we are doing to try and improve, particularly, information flows.

The paediatric navigation service is a service that was set up as a result of consumer feedback about that experience of Canberra-Sydney. In my experience, there seems to be a lack of visibility about that service, even for some of our practitioners. For example, we have had matters come to us from GPs, where they have had that

difficulty and they have not known about the service.

I am probably just flagging for my colleagues at Health that we will be coming back to them again to say, “Is there more we can do to promote some of these excellent services that do not have enough visibility,” and certainly in the spaces that we see.

MR MILLIGAN: I refer to page 3 of your submission, where you mention that some parents—carers as well—are fearful or reluctant to engage with government services to seek supports for parenting or children’s services because of fears about engaging with these services, the scrutiny that contact can bring and the potential for separation or removal of children, and with a particular focus on parents with a disability. Can you elaborate a little more on that? Is that perceived or is there evidence of this type of outcome occurring when parents contact government services?

Ms Toohey: Again, I acknowledge that my space is around when things do not work well. Jodie will talk about when things work well.

Ms Griffiths-Cook: No, I get the “don’t work well” stuff, too!

Ms Toohey: They are certainly the sorts of matters that we see. Certainly, what is expressed to us is a fear about, “Once we’re on the radar, we’re on the radar and we can’t get off the radar.” It is a small jurisdiction. It is very difficult to get off the radar once you are on it. I acknowledge that a lot of our colleagues, particularly in Community Services, are working very hard to support children and families. Certainly, the matters that are brought to our attention are when perhaps there have been a lot of assumptions made about parent capability, the nature of the supports that those parents need, and the onus put on them to comply with particular requirements which are beyond their capability.

Sometimes there are a lot of assumptions made about people’s capability to comply with some of those requirements and, again, some of that navigation expertise. I think we included one example of a mother who had a 13-year-old that was quite challenging; it was really difficult to get support at school that provided any continuity into the home or into the other settings. Once the child was not attending school, the only thing we could find to help her was a phone call to a parent line, which was not really helpful for her in trying to address some of the behaviour supports that she was looking for.

The other aspect that we see, which you mentioned, is really long lead times to get in to see, particularly, health professionals—psychologists and psychiatrists. If you do not have an existing relationship, it is very difficult, particularly in the private sector, to try and get those appointments and those supports. And it is expensive, at the end of the day. There are a lot of assumptions that you can go and get some support or see a psychologist when, actually, that is just not available to you.

Meanwhile, the child’s behaviour in that case had deteriorated in terms of her engagement with her family, her mother and the school, so she was coming into contact with the justice system. As we know, that can be a one-way trajectory. There were some quite obvious interventions that we thought could have been provided. The parent was very concerned about getting on the radar, if I can use that terminology,

with our child protection colleagues, because of the fear that (a) it is not short term, it is a long-term process, and (b) she had another child and she was very concerned that there would be assumptions made about her parenting abilities more generally, because of the older child's behaviour.

MR MILLIGAN: Can you elaborate a little bit more on these “requirements”? Is it right that parents need to meet a certain requirement to support their child? Is that accurate?

Ms Toohey: Jodie can probably comment more fully, but some of the matters we see are where there is this issue about engagement, so there is an obligation on the parent to make contact or to bring a child to particular appointments or services for engagement. In that scenario, that parent was not capable of assisting that child to engage. In that one particular matter, it reflected really badly on her, and there were cultural aspects to that, because it then flowed into her community; there were these assumptions about the mother and her parenting abilities within her community, who withdrew support as well.

Some of those obligations often sit more in the formal situations that our colleagues in CYPS are dealing with. Even in those situations where there might be a light-touch involvement from child protection services, there are assumptions about the child needing to do this or that. As the parent, you are the one who has to facilitate that, and if you are working and supporting another child, that becomes a really difficult scenario for people that are already in a complex and often depleted resource situation.

Ms Griffiths-Cook: Sometimes we see shifting goalposts: “We need you to do this by this time,” or there is the inflexibility of, “We need you to be here at this time.” Again, that sometimes fails to recognise the complexity of the circumstances that exist around those family units.

Some of what we see is where there is an intergenerational history of child protection involvement. It may well be a perceived fear, but it is premised on some very real life experience. There is that feeling of, “If I don't toe the line, if I don't do things perfectly,” and what is that definition of “perfect”? Sometimes we know that that intergenerational pathway does permeate, and we do see young parents in particular who have had a care experience themselves. There is that layer of scrutiny that is upon them almost from the time their child is born, if not before.

MR MILLIGAN: Do you think that there needs to be a bit more flexibility, and working with the parents and the child to meet those requirements and to assist the child to attend? Does there need to be a bit more recognition and support from the government and those other services that it might be challenging for those parents?

Ms Griffiths-Cook: I was really pleased to see the direction in which the government is heading in terms of the legislative changes that will make active support a requirement before there is any form of statutory intervention, other than in more extreme cases, obviously, of deliberate harm. I think that is important. We need to be looking and reaching in, if we see that a family is struggling, like some of the examples that Commissioner Toohey talked to. It is about asking what we need to do to bring the supports to the family, to the child or young person, so that we are not

actually creating a greater risk of their situation spiralling into a crisis point. It becomes far more costly to deal with crisis than it does to get into the preventive space.

MR PETTERSSON: My question is to Ms Griffiths-Cook. Is the ACT a child-friendly place?

Ms Griffiths-Cook: That is a good question. As a parent I would answer that and say it is a great place to raise a child, but I hear from young people that there are limitations to that. I think it is very hard to make a blanket statement. I think that, as a city, we do pretty well.

What I do hear, though, from young people in particular, is that not all of the spaces are welcoming for them. We heard through our play consultation last year that if you have an adolescent at a playground, they have often encountered circumstances where parents of younger children have effectively said, “This isn’t the space for you, you need to go.” There is some of that attitudinal, cultural stuff around where a young person hangs out, how that is actually viewed and through whose lens. Certainly, we heard from young people that there is a need to explore more spaces for recreation where young people feel welcome and where that is not seen through a negative lens.

MR PETTERSSON: Is it from the community that young people do not feel that sense of inclusion or are there wider government decisions that might lead to those young people not feeling that they are welcome?

Ms Griffiths-Cook: I frequently argue for the need to put a better focus on engaging directly with children and young people through processes like this. I know you would have seen that in our submission as well. Where we look for opportunities to involve children and young people in all of our processes of decision-making, we will ultimately get better polices, better strategies and better frameworks.

While some of that is attitudinal, from a community perspective, I also think there is a responsibility on the part of committees like yours to lean in and find out what it is that we are hearing from our children and young people that will make things better for them. It is certainly part of my role, obviously, but I think it is incumbent upon all of us. It is part of not only upholding their rights but also looking for ways to ensure that we have the appropriate protections there for them.

MR PETTERSSON: There is a section in your submission which I thought was remarkable; I had no idea that this was the case. The Australian Early Childhood Development census notes that there has been:

... a significant negative change and, most shockingly, the ACT has a higher rate of children and young people who are developmentally vulnerable in one or two domains than the national average. Nationally 22% of children are developmentally vulnerable in one domain but in the ACT, it is 26.7% of children.

What is going on?

Ms Griffiths-Cook: Certainly, it shows that you cannot take your finger off the pulse.

We have seen recently through the expert panel into literacy and numeracy that they identified room for improvement in that space. We can look at our Wellbeing Framework. I remember commenting, back when it was being developed: where is that children and young people's lens? How are we utilising that framework to make sure we are understanding how we can improve things and make things better for kids in that space?

Certainly, with the data, we are not alone; we are not the only jurisdiction that showed decreases between 2018 and 2021, the period covered by that census. We need to keep looking at opportunities for change. The health space is part of that; the participation space is part of that; the education space is part of that. Importantly, for me, it is around: how does that all come together?

Often the cases that we both get are the pointy-end cases where things are not going well. Often it is because systems are not necessarily talking well to each other; there is that disconnect and the siloing that occurs. That is often where those gaps emerge. There is the complexity of having to navigate systems, to tap into various different supports and services to address what is often a complex interplay of needs. If those services either are not available or there is a time delay in being able to access them, there are those cumulative and compounding impacts.

You asked earlier about time delays and things like that. If you are waiting for a diagnosis and you need that diagnosis to be able to get the right supports, either in the family space or in an education space; waiting for two years to get your autism diagnosis means you have two years where you are not potentially getting the right mix of supports to attend to the needs that that child might be evidencing, in an education environment, for example.

THE CHAIR: I have a very specific question, Commissioner. Thank you for pulling us up, quite correctly, and saying that we had not yet received any evidence from anybody under the age of 18. What would be a good and useful way for a parliamentary committee to do that? Would the Youth Advisory Council be well placed? You can probably suggest a number of ways that we might get evidence from children.

Ms Griffiths-Cook: I have been turning my mind a bit to this. You might not be surprised to hear that. The Youth Advisory Council are a useful source. They have certainly provided submissions on different topics over the last few years. The first one on which I recall the council providing a submission was when we were in COVID and they provided a submission at that time.

One of the things I have been talking about with my team, though, and I am certainly happy to put it on the table before the committee today, is the idea that if the Assembly were open to funding a dedicated position within my office, we could work to create child-friendly versions of some of the terms of reference or other inquiry documents, and facilitate consultations around those issues in order to be able to present those findings back to committees on relevant issues.

The reason that comes to my mind as a thought is that we are doing some work at the moment on the draft national autism strategy with the federal government. We asked

us whether we could make a version that would be accessible for a nine-year-old, because we had a nine-year-old who came along and said, “I’d like to be able to put my views forward but the survey has a minimum age limit of 14.” We then created a child-friendly version of that; we are doing a small-scale consultation and will feed that input back to the strategy in its draft development to help inform the final version. That was where the idea came from: if we can do that for a national draft strategy, we could do that here.

THE CHAIR: Thank you. Commissioner Toohey, I want to check something that disturbed me in our last hearing. We heard a bit of evidence from Women with Disabilities that there was forced sterilisation going on in the ACT. They suggested that there was not particularly good data, that nobody was collecting data on this. They were not quite sure from where we would get good data, but they mentioned that, presumably, if somebody were making a complaint, they would go to the Human Rights Commission. That worries me a bit, regarding somebody who may be under guardianship. They were mostly talking about medical sterilisation, prescription sterilisation, and probably not surgical sterilisation. Do you have any information on that or any concerns about that?

Ms Toohey: Generally, obviously, in those circumstances neither the guardian nor the individual will bring a matter to our attention. There are circumstances in which a guardian may seek to get an order, because health decisions may be subject to a guardianship order if there is a guardianship order in place. They are complex situations and there may be particular reasons why someone might be prescribed, for example, contraception or something along those lines.

We have certainly had a number of matters where we have suggested to guardians that they get assistance through supported decision-making in supporting a person to access those health services. That might have been through Sexual Health and Family Planning, for example. There are a number of matters where we will have suggested to families, rather than just making these decisions, that they get that support. Again, I would be surprised if there was evidence of surgical sterilisation in the ACT.

THE CHAIR: I do not think that was the concern. I think it was contraceptives.

Ms Toohey: Yes. It is a complicated space, both for the health practitioners and for the families, because there is a protective element in some of that decision-making. Certainly, we are working with our colleagues, again in health settings and health services, to encourage the use of supported decision-making in those processes rather than making a whole bunch of assumptions. That is work in progress. It is not something that will happen immediately.

The issue can be that it requires a situation of trust between the individual, potentially their carer and the health service provider. As you know, there is a vast range of health providers who will or will not make particular decisions, with or without the person’s consent, sometimes irrespective of what their capacity is. It is a complicated space, but it is a space that is actively being engaged in, certainly with some of those providers that work in the sexual health space, particularly with recent discussions, as you are aware, around fertility rights and access to sexual health services in the ACT.

Certainly, in the disability space, again, it may depend on the scope of a particular guardianship order, if there is one. If those matters come to our attention, they might be under our vulnerable person jurisdiction, for example. If someone is being required to take particular medication by a guardian in a coercive situation, that would certainly fall within our neglect, abuse or exploitation jurisdiction. They are the sorts of matters that we can deal with.

We have found that, in the small number of matters that we have seen, getting the family and the individual to engage with some of those services with that expertise has led to a good outcome.

THE CHAIR: The bit that disturbs me the most on this line is how often you get involved versus how often it might be happening, and nobody is involved. Complaints-based systems are great when we have strong complainants.

Ms Toohey: Sure.

THE CHAIR: Is it something that you think is prevalent? You may not have the information to be able to answer that question.

Ms Toohey: I would query whether anyone would have the data explicitly on that. There is work going on at the moment by our colleagues, particularly in the Public Trustee and Guardian, to develop resources to help private guardians, in particular, understand the scope of their obligations and what a guardianship order actually means, because there is not much information in that space. Understanding the obligations for supported decision-making and consultation with the person about those decisions is the focus of that work, as is, again, the scope of an order. Certainly, in some of the matters that we have dealt with, not explicitly about that issue, people assume that if there is a private guardian in place, they have control over everything, down to clothing and how much food you can have. That is clearly not the scope of the order. Our colleagues are doing some work in that space to develop resources so that we can educate guardians at the front end of the process, not at the back end, when they get to me.

In the health space I would suggest that a lot of our health practitioners are very cognisant of those issues around supported decision-making, particularly with people with disabilities. I think we struggle with it with older people as well, and capacity and fluctuating capacity. I did not see a submission from Capital Health. Certainly, some of my health colleagues would be able to answer some of those questions.

With the matters that we have dealt with in that space, it may be a service provider who has brought it to our attention rather than family or a carer, because the family or carer may have made the call that it is an appropriate thing to do, in consultation with the health provider, but there will be a concern raised potentially, as you may be aware, particularly around NDIS providers and coordinators.

Clearly, for a health practitioner, it would be a breach of their code of conduct if they were actively prescribing medication for someone when clinically it was not necessary, without that person's consent and understanding.

THE CHAIR: Is there anything that we did not cover that you think should be covered?

Ms Griffiths-Cook: No.

THE CHAIR: Thank you for attending, and for your submissions and advice. It was all well received. Thank you for your time and expertise. I do not think you took any questions on notice. Our secretariat will send you a copy of the transcript, as usual; please let us know if we have got anything wrong.

Hearing adjourned at 4.55 pm.