

**LEGISLATIVE ASSEMBLY FOR THE
AUSTRALIAN CAPITAL TERRITORY**

STANDING COMMITTEE ON HEALTH

(Reference: budget 2002-2003—service delivery)

Members:

**MS K TUCKER (The Chair)
MR B SMYTH
MS K MacDONALD**

TRANSCRIPT OF EVIDENCE

CANBERRA

MONDAY, 25 MARCH 2002

**Secretary to the committee:
Mr D Abbott (Ph: 62050490)**

By authority of the Legislative Assembly for the Australian Capital Territory

The committee met at 10.32 am.

DANIEL STUBBS and

KAREN NICHOLSON

were called.

THE CHAIR: This hearing of the Standing Committee on Health has commenced. We wish to welcome the representatives of ACTCOSS. As you know, this hearing is part of the budget consultation process, and the committee will present the views of the community to government.

The government did give us an indication that there would be some form of document to help guide your input, but that has not appeared yet, as you are aware. I still wish to thank you for your very comprehensive submission, as always. I think what ACTCOSS does is very important. You always put a lot of work into your submissions, and I appreciate it.

I should also remind you that these hearings are legal proceedings of the Assembly, and are protected by parliamentary privilege. This gives you certain protections, but also responsibilities. It means that you are protected from certain legal actions, such as being sued for defamation for what you say to us today. It also means that you have a responsibility to tell us the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter. When you begin your evidence, please state your names and the capacity in which you appear, for the record. Do you wish to address the committee?

Mr Stubbs : I am Daniel Stubbs, director of the ACT Council of Social Service.

Ms Nicholson: I am Karen Nicholson, a policy officer with the ACT Council of Social Service.

Mr Stubbs: I am going to break down our submission into a couple of different areas, with respect to health. The two main areas are the community and health sectors as service providers, and then the pointy end, attacking poverty, which is the theme of our submission generally, and of the specific work that we recommend to alleviate poverty in the ACT.

In the ACT we have an overburdened acute health system. We can see this reflected in headlines in the newspaper, on almost a weekly basis, which discuss different aspects of the hospital system that are not able to meet the heavy demands made of them.

We also have a situation in the ACT health-related community sector where services in that sector are overburdened because of the need to get people out of the hospital or keep them out of the hospital and in their homes. Most conventional wisdom suggests that we should try to keep people out of the hospital system, in their homes or in other settings.

The difficulty in which we find ourselves is that the health services in the community service sector are stretched, as is the hospital system. We need some way of investing in the community sector so that a transition can be made between the burdens on the acute or hospital system and the community service system. That should be a planned process.

I think that, despite what the government might be saying at the moment, we may be looking at some windfall gains in revenue with respect to real estate, stamp duty, grants commission funding and so on. We would suggest that money is required in the community service sector to fund the transition from hospital into the community. However, we cannot just take the money out of one sector and put it into another to assist that transition: it just will not work. We are suggesting that this structural change be properly resourced.

An example of a way we can deal with this kind of transition is the step-down facility, for people who are leaving hospitals and going back into the community. At the moment, people are leaving hospital without receiving a lot of support when they arrive back in their community or back in their homes. In many cases, they often end up back in the hospital, because they did not receive the care or support they needed. Step-down facilities would assist people who have to leave hospital, whose need is not as acute as that provided for in the hospital system, but who still require support.

I am happy to talk about some of those issues in more detail. I am going to discuss some issues related to disadvantaged people, and those living in poverty in the ACT. We believe that, if we are going to target health services anywhere, we will make the most gains with people living in poverty and those living on low incomes.

One area that we believe needs a significant amount of work is that of substance abuse. We have talked to the government, and will talk to them further, about the idea of a substance abuse task force, which we believe should be established to consider the broad range of issues related to addiction and substance abuse. At the moment, we have a prospective safe injecting place, which would assist in one narrow area of the substance abuse and addiction problem, but by no means would it solve the problem. It concerns just one extreme area of the problem.

We have talked to the sector that provides alcohol and drug services in this town, and those workers are very supportive of the idea of a substance abuse task force, because they recognise that they cannot meet all the needs. There are services such as education programs and resilience programs that they are not providing. They cannot provide them. Those services are at the difficult, after-the-fact end of things.

We strongly recommend the resourcing of a substance abuse task force. Something similar to the poverty task force that the ACT government invested in a couple of years ago would be very appropriate. Unfortunately, the ACT poverty task group could not get down to the nitty gritty of recommendations about addiction and substance abuse in the ACT. It covered a wide range of issues, but did not get down to the detail of that particular one, which of course affects people living in poverty constantly.

Another specific area of concern in the health sector is indigenous people in the ACT. We live in an urbanised setting, and people from indigenous backgrounds in this town live in an urbanised setting. Despite that, we have indigenous people in the ACT with much worse health outcomes than those of the rest of the community.

Okay, by some measures those health outcomes are better than those of their counterparts in other places, but only if we are comparing them with outcomes in outback Northern Territory, Kalgoorlie and so on, and we cannot do that. We should be comparing them with those of the local population. When you compare the health outcomes of the local non-indigenous population with those of the local indigenous population, the outcomes for the indigenous people are appalling.

We would strongly recommend that, in the first instance, this committee at least takes up the recommendations of last year's health committee's inquiry into Aboriginal health, and ensures that those recommendations are implemented. Those recommendations cover a wide range of areas, including health and housing, two very important and not unrelated issues for people from indigenous backgrounds.

We are concerned about the collection of data on indigenous people in the ACT. The ABS does collect some data, but not nearly enough for our purposes because the population is small. The ACT government should really supplement that data collection to improve our knowledge of what is going on in that community.

While we are on the issue of data collection, we think that the ACT should also continue the data collection that the poverty task group started just over 12 months ago now, collecting data on poverty. In the ACT, we have a different setting for people living in poverty. We have a situation where we have high average incomes and, along with that, a very high cost of living. Both those things affect people living in poverty. They create higher expectations for people living in poverty, and they create higher costs of living for people living in poverty. We should consider it as an ACT issue, not just an Australia-wide issue.

People with a mental illness are also, unfortunately, counted among some of our most disadvantaged Canberrans. We recommend that this committee considers taking up the issue of the several mental health reviews that have occurred in recent years. There is also currently a coronial inquest under way, which will make further recommendations. If just the recommendations from recent reviews and coronial inquests were taken up and implemented in the ACT, I think we would go a long way. One of the specific issues that needs to be taken up is the funding of transcultural services, which provide for people from culturally and linguistically diverse backgrounds with mental illnesses. It is an area that needs particular attention.

There is also a need for greater resourcing of NGO or community services in this area, not just those providing specific mental health services, but also those providing other services in the main stream. One of our findings in this area is that people who have a mental illness do not necessarily want to present themselves at a mental health service. There is often a need to resource other non-specific services that provide people with similar opportunities.

The other big issue related to mental illness is that we have a high proportion of people with a mental illness in our corrective services system, whether that be at Belconnen Remand Centre or interstate in the New South Wales system. We should circumvent that. It is creating enormous problems for people: it is creating an ongoing, almost circular process for a lot of people going in and out of the correction system.

Similarly, at the moment a reform process is occurring in disability services. We urge this committee to recommend that the government funds the outcomes of that process in this budget. That disability reform group will be making recommendations over time, and resources should be available to implement those recommendations. I do not think we would be pre-empting the report of the disability reform group by providing resources for the implementation of that group's work. It is urgent, and we have waited too long already.

A lot of the things we are talking about cost money, and there is no doubt about that. We recognise that, and we also recognise that the government is advising us that there is no money available. We will not know the actual facts until much closer to the day when the budget comes down.

Community services, however, save money for us in the long run. If we provide these services to people now, it means that we are not providing services to them because they are homeless in a few years time. If people have a drug abuse problem now, we should solve that problem now because, if we do not, they will end up in the correction system, which costs the territory an enormous amount of money. We are talking about investing in our community, not just expenditure and what is almost foregone income.

We see in this town that the ongoing attitude to business is that we can provide certain supports to bring businesses to town. We do not think that works. We do not think it really has the so-called trickle-down effect that creates employment for people living on low incomes and people living with disadvantage. What provides assistance to those people is getting them out of the homeless situation, getting them out of the corrective services system, and providing the mental health services that they need. Grants to business, which may or may not provide the multiplier effects that they are said to, do not help.

I want to finish up by thanking the committee for their time today. I am more than happy to answer any question on these or the other issues that we have raised in our submission.

THE CHAIR: Thank you very much. I have a few questions. Mr Smyth?

MR SMYTH: I will ask mine after you.

THE CHAIR: Thanks. In your submission, you talk about the people's charter, which was part of the poverty task force recommendations. How does that fit with Jon Stanhope's bill of rights idea, and is it such a different thing?

Mr Stubbs: We think the charter could be a significant part of a bill of rights. We think that, if we need to talk about anyone's rights in this town, it is those of people who are living with disadvantage. Because many people who are living on median incomes in

this town are, in general, not doing badly, their rights are less likely to be infringed than are those of people living with different forms of disadvantage. We think that the idea of a bill of rights fits perfectly with our recommendation on the charter, and we will be taking up that recommendation with the Chief Minister to ensure that it is a strong part of his bill of rights.

THE CHAIR: Do you see it as part of the bill of rights?

Mr Stubbs: I think it would be a very large part of it, too.

THE CHAIR: Is it basically the same concept?

Mr Stubbs: Yes, it is the same concept.

THE CHAIR: You previously talked about the need for planning discharges from hospitals so that the system works properly. We have been told over the last couple of years that the problems have been fixed, but I see that the need for a step-down facility has come up in a number of submissions once again. Could we have your view on how we approach support for aged people in our community?

We have, as a society, decided that institutionalisation is not okay for people with a mental illness, and it interests me that we do not seem to have thought of that in regard to older people. Our hostels, and particularly nursing homes, are basically institutions. I see that the step-down facility that you are asking for would be a transitional arrangement, and that sounds really sensible, but have you done any work—or have you seen work done—on how we could provide support for older people to reduce the need for these institutions?

I know that we are being told that that is already happening and that there is support in the home for those who are trying to keep aged family members at home, but almost every submission to this committee indicates that there is not enough community care, that it is not coordinated, and that the transition from hospital is not working. What is your comment on that?

Mr Stubbs: We are in an interesting situation in the ACT where a lot of people tend to retire to the south coast of New South Wales and then, once they are no longer able to look after themselves, they move to Canberra, because it is the nearest place with the support they need. As a result, we are seeing a huge rate of growth in demand for a range of facilities for older people in our community.

We think that what is needed to meet that demand is a planning process. It could come under a social planning framework, where we involve the consumers—whether it be older people and their representatives or advocates—the service providers and government. When I say service providers, that may mean home and community care providers, who actually provide assistance for people to remain in their homes or live independently, it may involve nursing homes, or it may involve a range of other combinations of those sorts of services and, of course, government.

ACTCOSS is currently in the process of developing a service planning protocol, which involves those different stakeholders, and some others. This will be a long-term process, not just about planning for this year. It will be an ongoing planning process, because the need changes as the population ages, and as new models of service delivery are developed. We need to respond to those different opportunities. We have developed a document that we are calling the service planning protocol, which works at a reasonably high level. We need to look at ways of applying the protocol, and we are currently talking to the home and community care sector to work out how we can actually apply it.

I would be happy to provide a copy of that to the members of the committee, if they are interested.

THE CHAIR: Thank you.

Ms Nicholson: I want to add that the work we have been doing on the SACS award is also very important because, if we do not value the work that these people do with the frail aged community and in the disability services area, give them the recognition they need, and provide professional structures and proper remuneration for the work they do, it will be very hard to attract workers and have good continuous quality care in any area of social service. Looking at the how people are employed, the awards under which they are employed and the conditions under which they can look forward to working is also important.

MR SMYTH: Under theme 4, the prioritisation of preventative health, sections b and c seem to be talking about solving the problems before they occur. You mention the schools as communities program, and you indicate that you want to see it applied across all schools in the ACT. You might not be aware of this, but this committee is going to look at the health of school-aged Canberrans, and what you are talking about here fits in rather nicely with that. How much of a priority is it?

Mr Stubbs: Again, I think it is something that we need to approach in stages. It is a priority, because we should recognise that our schools are themselves incredibly important social services. However, we call on them to take that role without always resourcing them as such. We think there should be a review of the schools as communities approach, with a view to expanding that program, and creating better linkages between schools and other services outside the schools. It is not always appropriate to provide those sorts of services within the school setting.

Sometimes you need to refer people to services outside the school system, and you have to have good linkages with those other services to do that effectively. We think you could pick up problems with health and other related issues much earlier if that system was better supported in the school setting.

MR SMYTH: Are you aware of the SUPPORTLink program?

Mr Stubbs: No.

MR SMYTH: SUPPORTLink is a program that has been developed by the Tuggeranong Community Service.

Mr Stubbs : Yes, I am, sorry.

MR SMYTH: Do you know much about it, or do you just know of it by name?

Mr Stubbs : I am well aware of the program.

MR SMYTH: Should we be doing that, providing points of reference that allow people to access all the assistance they need, without going from one point to the next?

Mr Stubbs : The SUPPORTLink model is, I think, something we could learn a lot from with regard to programs for schools. However, a school program must deal with young people who are often vulnerable, and so it may require something that is a bit more hands on.

Ms Nicholson: That lovely word “proactive” comes to mind.

Mr Stubbs : Maybe, yes.

MR SMYTH: Do you mean that it should be closer to the program at Canberra College at Stirling called the Bay?

Mr Stubbs : Yes. It should have a greater level of interaction between the services and the young people.

MR SMYTH: Do you think it is unacceptable for disability services to wait until September for new funding? If the government’s own analysis does not come down until September, it means that no new money will appear until the 2004 budget. Do you believe that there should be money in the coming year, the 2002-2003 budget?

Mr Stubbs : Yes. We have waited a long time. We need to set aside the money now, so that we can implement new services and systems, and even new transition processes. Unfortunately, even restructures cost money, and we need to make money available in this coming budget so that we can hit the ground running in September or October.

MR SMYTH: All right. I want to ask you about the funding for the step-down facility. We actually have \$1.5 million in this year’s budget, of which the government has now spent about half a million, and they have said that they will roll the other million over into next year’s budget. Is that acceptable? The whole point of the funding there was to address a need whose existence even we acknowledged, and for which we had allocated funds this year and in the outyears. I have to say that I am confused as to why they would not use it this year. Do you believe that the need is there and that it should be met now?

Mr Stubbs : Yes, and the need has been there for quite a while. It is well documented, and I think the main argument in favour of providing this funding is that its absence is costing us, as a territory, a lot of money. People are having to go back into hospital for

extended periods, having to draw on other services, or having to stay in hospital for extended periods.

THE CHAIR: We are running out of time, but I want to quickly address your comments in the submission on the purchaser/provider model. I will not go through what you said, but I do have a question. You talk about how important it is to include many of the hidden costs of service provision that are not being included right now. Later, you talk about a community services industry development plan and, later on again, about innovation. I am interested in where innovation occurs, and if it can occur in this model.

I see that you have an idea for cooperative policy development and service planning, and that you are hoping that there would be the resources for all members of the community sector to work together to innovate. I can see that there could still be resistance to that initiative because of the fundamentally competitive nature of the purchaser/provider system. Do you have a comment on the need for innovation in this area?

Mr Stubbs: We are recommending a planned approach to industry development in the community services sector. A range of development processes is needed in the community services sector, and arguably this is one of them—the need to reform our service purchasing process. This government has already indicated that it will review service purchasing. Whether we think it is working or not, it is time we reviewed service purchasing. There is no doubt about that.

Other jurisdictions have moved away from that system. I think we have a lot to learn from the service purchasing approach. There are good things about it, but it can also be rigid, and some elements, including innovation, are stifled by having funding that is so specific. I think we have come to the point where we recognise that community services are not just like business contractors, where we purchase services such as cleaning, IT services or a whole range of other goods and services. There is a much bigger context: there is a two-way feedback, policy development process between the community service sector and the government.

We should recognise that this process exists, and also that the government and the community service sectors rely on each other, because they need each other to do things such as trying innovative service delivery models. I think we are going to see this particularly over the next 12 to 18 months in disability services. I think that would be a good example. We may also see this in the housing sector. Those sectors are really crying out for innovative processes, new methods of service delivery.

At the end of the day, if we can have a resourced industry development process for the community service sector, I think we could gain a lot out of it. A number of different things need to be resourced to develop this sector. I think that, rather than listing all the things that might need to happen over the next one, two or three years, what we should do is implement and resource a development plan, and then allow the government and the community sector to come together to identify the priorities for this year and the out years.

We should not try to review all the elements at once, such as service purchasing, data collection and a whole range of other things to do with the SACS award. If we try to review them all at the same time, we will overburden the sector and, indeed, the government departments.

Ms Nicholson: I want to point out to the committee the Productivity Commission's latest report on the Job Network. It actually said that the purchaser/provider system was not necessarily the best delivery model. It said that, when keeping long-term partnerships in the community is important, perhaps licensing was a better way to go. That is one area that I hope the committee will consider—that purchaser/provider is not the ideal model for all services, and that there might be a variety of models.

Mr Stubbs : I would also urge the committee to consider what Mick Reid is about to report, as a result of his review of the Department of Health. He will be commenting on our purchaser/provider system, and how it could actually be improved for this jurisdiction. It may even be appropriate for Mick Reid to speak to some or all of the members of this committee, because he is quite open about what he is developing. He is quite willing to talk about it. He is not interested in providing a report that is a surprise, or anything like that.

THE CHAIR: Okay, unfortunately I think we will have to conclude there. Thank you very much.

Ms Nicholson: Thank you.

Mr Stubbs : Thank you.

MARGO MITCHELL and

JO BOWEN

were called.

THE CHAIR: Thank you for giving time to the committee. This hearing is being broadcast and, if at any point in time you are not comfortable with that, you can let me know. You also need to understand that these hearings are legal proceedings of the Assembly and are protected by parliamentary privilege, which gives you certain protections but also responsibilities in terms of what you choose to say. I ask you to keep that in mind. Please both state your name and the capacity in which you appear.

Ms Mitchell: Margo Mitchell, Executive Director, Belconnen Community Service.

Ms Bowen: Jo Bowen, Director of Community Services at Belconnen Community Service.

Ms Mitchell: Belconnen Community Service, as you all know, provides a really wide range of coordinated services: family support, behaviour support, volunteer services, services to people with a disability and the frail aged, and arts community access programs. The services we provide are there for the whole community, but we particularly target people who are isolated; people experiencing family breakdown, violence or unemployment; people on a low income, often with little information or education; people with a disability; and people who are frail aged.

As all of you know, Canberra is at times a very hard place for those people. Community capacity and resilience are what we are aiming to achieve, but we strongly believe that it is important first of all that people's basic needs are met. That is the kind of thing that you want me to talk about this morning. In our budget submission we have identified an increased demand for the services that we provide and, from what we have heard anecdotally, for the services that other people provide.

The response that we have is two-pronged: top down and bottom up. Top down, we support the notion of a social plan for the ACT and the targeted, coordinated planning of service delivery. When resources are scarce we think it is really important that that happen, and we believe that organisations such as the Belconnen Community Service can play their part. As a regional service we can provide data, forums, community consultation and also analysis, which will assist government to better target and coordinate the services that we deliver. Bottom up, we are really keen to see increased targeted resources go into the community sector to deliver services.

Today we want to focus on mental health and home and community care. In the mental health area we see a number of people use our services—through family support and our home and community care areas—who have low to moderate level mental health problems. They are people the health system, as it is set up, does not deal with very often. You need to have got to the point where your mental health issue is quite severe before you can actually get the service.

We are keen to propose a comprehensive service whereby, through a number of strategies, people whose problem is low level—before the point that it gets severe—can get assistance. The strategies we would like to see increased resources for involve workshops where people can find out that what is happening to them is happening to other people as well. Then they can then work on developing information skills that can improve outcomes for them.

We are really keen to see some low-level clinical intervention as well, which happens through the private sector and a small amount of it is happening through the government sector. We are arguing that it is important to have an approach that is community based, which does not exist at the moment.

Ms Bowen: People who have been through the mental health system in some form or other are often very pleased to be able to access a community facility for clinical intervention rather than have to get into a hospital situation or even an outpatient's situation at a hospital. We run a moving on from depression program, which until now has been funded through the Healthpact service. The feedback we get from people who access our community health programs is that they would much rather be accessing a community centre than a medical facility.

Ms Mitchell: It removes the stigma; it can seem far more normal.

The other area of mental health where we would be really keen to see some expansion is that of children and young people. There is a pilot program running northside, which is very much about people getting access to low-level clinical counselling, but most importantly to some activity so that they can join in the kind of thing that the rest of us do as a matter of course. They might join in an art class; they might join folk dancing. It could be anything but, along with that, they have support. If there is a need for clinical intervention, then it is there—side by side—so you can have the two things happening. The program we are talking about is called Bungee, and it is working very successfully northside. We believe that that kind of model can be used for young people and children.

Ms Bowen: Bungee has a psychologist component as well. Young people often initially access the youth workers but, if there is an ongoing mental health issue, they are referred to the psychologist, whose services are free for them. We are targeting families who are mostly financially disadvantaged and who also have a mental health issue. There are a whole lot of different strands that Bungee picks up and addresses.

THE CHAIR: But at the moment this only applies in the north Canberra area?

Ms Mitchell: Yes. There is the possibility of extending it across the ACT. It is short term; the program has only been going about six months. But research shows that people who have access to this kind of support in the community develop a better sense of wellbeing and better resilience so that, down the track, their coping skills are increased as well as their ability to connect with their community.

THE CHAIR: In your submission you also focussed a fair bit on home and community care. Because we are running out of time, can you address that quite quickly? I am interested in the waiting times that you have listed in your submission, and you have said

all that. What I am interested to know is whether transcultural or multicultural access is an issue and whether indigenous people are finding these services.

Ms Bowen: The multicultural community tends to be accessing the HACC program more. We actually have a migrant services worker as part of BCS anyway, and that settlement worker often serves as a pathway to the more defined HACC services.

THE CHAIR: Would the general concerns you are expressing here apply to that group in our community? They are accessing it, if they can, as much as the rest of the community.

Ms Bowen: That is right.

THE CHAIR: What about Aboriginal people?

Ms Bowen: We have very few. The Aboriginal population of Belconnen is quite small, but we are aware that we need to put in more energy. We have connections with some of the services. The family support area and our Good Beginnings program are picking up more to do with indigenous families. Two indigenous families have been connected, and there is a volunteer who comes from an indigenous background. I believe we are starting to make inroads into that area, but it takes a long time to establish a program that they become comfortable with and can trust.

MR SMYTH: The concentration of indigenous Canberrans is in the south.

Ms Bowen: Yes, it is not a very high number.

THE CHAIR: Yes, but there are still some of them everywhere, and they all need services.

MR SMYTH: They are scattered all over.

Ms Bowen: I agree. And our service is certainly available for them, except that all services need to be more proactive about engaging with that particular community.

Ms Mitchell: But this concern is very general. Often people who are in the HACC target group need assistance in accessing services because there is a multiplicity of services. They often need somebody to help map things out and to work with them on what their actual needs are and then on where they are likely to be able to get them met.

What we are seeing is more complex people—bearing in mind that Belconnen has the highest percentage of people over 65 in Canberra. It is because of the sheer numbers of people in Belconnen that that is the case.

Ms Bowen: It is interesting. The latest stats show that Belconnen has the highest number.

Ms Mitchell: At 23 per cent. It will be interesting to see what the new census does.

MR SMYTH: This will be my serial question for the day, Madam Chair: does that call for a support link out of Tuggeranong where you might otherwise access the police? If people are having difficulty with housing and also need mental health or other support, they would be directed by support link to multiple forms of assistance rather than have to deal with one problem and then move on to the next.

Ms Mitchell: It is important to have a range of ways that people enter programs, and support link is one them. People go to a variety of places to get their information and, certainly regionally, a lot of people go to their regional community service.

Ms Bowen: Because there is a whole range of programs right across the board.

MR SMYTH: How do we make sure they get all the assistance they need—through case management, through the personal persistence of those they are in touch with or through their personal persistence?

Ms Mitchell: Case management is extremely important: when people make contact they then have a road to travel down and some facilitation to do that. That is quite important and so is a good level of information in the community—through things like the *Contact* book, which is now on the web. There is a variety of sources for people to refer to in order to come to the service. They do not all come through the one gate; it just does not happen that way.

Ms Bowen: If they contact BCS, they are coming through an intake system where their needs are assessed very quickly, and they are then referred to the appropriate area. If they are referred to case management, contact or referral to other services will be set up for them. But the person remains a client of BCS. Other services are supporting them as well, but BCS would have the overall role of monitoring the clients.

THE CHAIR: You have stressed housing, and I see that housing has come up in just about every submission. But before we conclude, can you talk briefly about housing for people who are vulnerable—for example, who have a mental health or addiction issue?

Ms Bowen: The mental health issue is a concern in accessing housing. Another concern is that they really do not want to have single parents with their children in a private rental market, and a concern we raised the other day was emergency accommodation. For older people who are still in a couple there is nowhere available for them to go in a domestic violence situation. Our HACC area and migrant services area certainly recognise that. For older people and people from multicultural backgrounds it is very difficult to access housing.

Ms Mitchell: And, of course, people with a disability may be able to live alone but find it very difficult to access accommodation and would find that almost impossible in the private rental market.

Ms Bowen: Yes, that is the case.

MR SMYTH: How urgent is the need of homeless secondary school students for housing?

Ms Bowen: I am not familiar with that. Are you familiar with the programs, Margo?

Ms Mitchell: No. I understand anecdotally that it is quite an issue but cannot comment directly. I know that Bungee are seeing some people in that category, but I cannot give you—

Ms Bowen: any figures on that.

MR SMYTH: It is just that in your submission you mentioned people on low incomes, especially homeless secondary school students. Perhaps you could provide more information to the committee if you have determined the level of problem in Belconnen.

THE CHAIR: It would also be good for our inquiry into the health of school-aged children.

Ms Bowen: There is a problem.

MR SMYTH: I am aware that there is, but how big a problem is it for you? Have we got any numbers of students?

Ms Mitchell: We are happy to provide that information.

THE CHAIR: Thank you very much, and thanks for your submission too.

MARIE BENNETT,

KATIE PEARCE and

MARITA MAHONY

were called

THE CHAIR: Thank you for coming and talking to the committee and for your submission. For your information, this hearing is being broadcast. If at any point you are not comfortable with that, you can let me know. These are legal proceedings of the Legislative Assembly and are protected by parliamentary privilege, which gives you certain responsibilities as well as rights. I ask you to have regard for that. Could you state your names and the capacity in which you appear before the committee?

Ms Bennett: My name is Marie Bennett. I am the executive director of Lifeline Canberra Inc.

Ms Pearce: I am Katie Pearce, manager of telephone counselling at Lifeline Canberra.

Mrs Mahony: I am Marita Mahony, and I am Katie's assistant.

THE CHAIR: Thank you.

Ms Bennett: Thank you very much for the opportunity to speak to you this morning. I would like to provide you with some more information about Lifeline and the proposals outlined for you in our submission. Lifeline is a reputable organisation that has served the Canberra community for over 30 years through the provision of a 24-hour crisis telephone counselling service. We have a proud reputation, and we seek to continue to improve on our high-class service.

There are two key areas I would like to make representation on in the time I have this morning. The first is our request for a short-term face-to-face counselling service. From the front line of our telephone activity and in response to community concerns we have identified a gap in community services: there are no face-to-face crisis counselling services in Canberra.

Callers referred to generalist services by our service are usually faced with a two- to six-week waiting period before their first appointment. For people in crisis this is too long to wait. We propose a service that takes the pressure off the existing services, allowing them to do what they do best: offer quality in-depth or specialised counselling to people with medium- to long-term needs in a timely way.

The model for a short-term crisis counselling service, as outlined in our submission, is in line with the model proposed by Professor Nick Glasgow at the recent government sponsored health summit. The model is of competent generalists who provide community health services and refer to specialist services only when necessary.

By offering a crisis service we would assist people to resolve crises before they become long-term entrenched issues or before they suffer escalating mental health problems. Mental health services are only available to people with fairly severe mental health issues. Currently, the main avenues of support available for people with mild to moderate mental health problems are medication from their GP or our crisis line. We know that crisis intervention can stop the escalation of mental health problems. Access to a crisis service for these people would take the pressure off existing mental health services, and we are the service best disposed to fill this gap—in line with Professor Glasgow’s model of competent generalists. That is the first issue.

The second issue I would like to address from our submission is suicide intervention skills training for health care workers within the ACT government. The applied suicide intervention skills training, which is known as ASIST, is a two-day workshop brought to Australia from Canada by Lifeline Australia. It is the most widely used intervention training program in the world.

Statistics tell us that every year 6 per cent of the population considers suicide. In the ACT this equates to 18,300 people. ACT health care workers are what we would call emergent care givers, the type of people most likely to first hear of a person’s suicidal thoughts. These workers need the skills to recognise people at risk, estimate that level of risk and make an appropriate intervention.

Through the ASIST component of our submission, funding of \$30,000 will provide this workshop to 250 ACT government personnel, with the focus on health care workers. This proposal has the enthusiastic support of Ms MaryLee Sinclair-Vogt, head of the social work department at Canberra Hospital. Ms Sinclair-Vogt has long been a strong advocate of ASIST for all community health care workers. Suicide is a whole-of-community problem and must be tackled by a whole-of-government and community approach.

In conclusion, the ACT government has an opportunity to provide the community with a significant number of people trained in suicide intervention. These are the people on the ground who are the first to encounter the person at risk of suicide. Lifeline is the logical choice for providing immediate, accessible and low-cost face-to-face counselling to people in current crisis in order to attend to their immediate need and to forestall these people becoming regular long-term users of an already overwhelmed community mental health infrastructure. Thank you.

THE CHAIR: Thank you. You are asking \$200,000 for face-to-face counselling?

Ms Bennett: Yes, we are.

THE CHAIR: Is that for two counsellors, 24 hours?

Ms Bennett: That will provide us with two counsellors, five days a week.

THE CHAIR: So, people do not need counselling on the weekend?

Ms Bennett: It is not that they do not need it on the weekend; it is pretty difficult to get generalist counsellors who will work on weekends. Our gambling counselling service at the moment offers afternoon and early evening appointments, and I am sure that is something we will get into. A large number of our callers say, "I can't make it during the day. The thing that's holding me together is my job, and I need to continue to go to that." We would probably offer something late afternoon/early evening.

THE CHAIR: I am interested in your statement on Youthline that you do not feel it is meeting the need.

Ms Bennett: Youthline has an opportunity to really expand its services to the community. What we are constrained by is the number of hours of professional support we can offer. Until December we had 20 hours a week for our Youthline coordinator. That has now gone up to 30 hours by virtue of the community capacity building grants, and we are very grateful for that. In our experience, the number of calls that we take on Youthline can be directly attributed to the amount of hours that we can put into promotions and support for young people. We are very keen for Youthline to grow and expand. It is minimally funded and could definitely use an injection of funds.

THE CHAIR: Do you get a sense of what age the young people are? Are they school-aged people or just young? How do you define youth? Is it up to 23?

Ms Pearce: Youthline is a targeted service for people from 12 to 25. Most of the people who call are in the senior secondary school bracket: college aged people between 15 and 18 or 19; people older than that tend to ring Lifeline. We also get a lot of parents and people who support young people calling Youthline.

THE CHAIR: Do you ever get a sense that they do not feel they can get that support within the school system?

Ms Pearce: A lot of school students want somebody they do not know and who is not going to have a direct impact on their school life.

THE CHAIR: Confidential.

Ms Pearce: They want somebody they can speak to who is anonymous. They do not have to say exactly where they come from or who the people involved in the problem are. They want somebody who is not going to have a direct impact on what they do.

THE CHAIR: Would the face-to-face counselling also apply to young people?

Ms Pearce: Definitely. Yes, we identified a need. I talked to some people in community services and youth centres, and they said that there is a real need for an increased face-to-face counselling service for young people because they are not meeting that need at the moment.

THE CHAIR: I am interested in Youthline in particular and might invite you to speak on it later to this committee, since we are conducting an inquiry into the health of school aged children. The mental health of children and young people is obviously very

important. I won't pursue it now because we can do it later. Does anyone have any questions?

MR SMYTH: Is it proven that the suicide intervention training program actually helps reduce the number of suicides?

Ms Bennett: Yes, it is proven. Speaking anecdotally, I would get calls on a fairly regular basis from people that I have trained—so far we have trained about 2,500 people here in Canberra—saying that they had used their skills with somebody who was experiencing thoughts of suicide and helped them.

All of our telephone counsellors are trained according to this model, and on a very regular basis—I would venture to say once a week—we have a call from someone who had rung our crisis line, been assessed by using the ASIST program and had an appropriate contract put in place. Those people have rung back a few days later and said, “Thank God you were there, and thank God you did what you did for me.”

Ms Pearce: It also assists when our telephone counsellors use their skills to assess somebody as emergency, high-, medium- or low risk. It helps them to work with the police and the emergency services team. If we ring and say that somebody is an emergency risk, they know what we are talking about and will respond a lot better.

MR SMYTH: Do we know how many people actually attempt suicide in the ACT each year?

Ms Bennett: Yes; my guess is around 500-600.

Mrs Mahony: I cannot recall off the top of my head. But what I do know, from the field trials that were done when ASIST was first brought to Australia, is that the other way it helps save people's lives is by giving the caregiver the confidence and the willingness to go down that track and explore the issue of suicide with the person. The kind of feedback we get from people who do the course is, “Now that I know what I need to do, I feel confident and I feel comfortable about doing it with people who are thinking about suicide.”

THE CHAIR: I know this is a radical idea, but why not? Could it be integrated into first aid training? It is just that not so long ago it happened to me that I felt totally incompetent in a situation. If people generally have the opportunity to do first aid training, why not the opportunity to be taken through this training? It is first aid in a way; it is just not something a citizen would normally go and get training in. Yet more and more of us, sadly, are being confronted in our personal lives with situations involving the suicidal.

Ms Bennett: That would be ideal; that would be fabulous. Part of our campaign has been to talk to the Coroner's Court and try to get the coroner to say that all police, all paramedics, and all ambulance officers ought to be doing this training. Marita is right: it gives people the skills and the confidence to know how to deal with someone. That is often the biggest thing.

For a while we had quite a spate of calls being put through to us from the offices of members of parliament. People were ringing members of parliament and saying to staffers, “I need help, I am not getting help and I can’t get help, so I’m turning to you and I expect you to help me,” and they would patch them through to us because they also felt inadequate dealing with people who were experiencing thoughts of suicide.

MR SMYTH: Would \$30,000 train 250?

Ms Bennett: Yes.

MR SMYTH: So in multiples of \$30,000, we could do 500, 750, 1,000—

Ms Bennet: Yes.

MR SMYTH: We could and extend it to school counsellors—

Ms Bennett: Absolutely. We certainly could.

MR SMYTH: community services and all those areas.

Ms Bennett: Yes. Some schools have been fabulous. The principals of Dickson College and Canberra College attended the ASIST program that we ran and said, “All of my staff need to do it.” There are some places where it has already been put in place and where a commitment has been made by the school hierarchy or organisational hierarchy to have staff trained.

At the moment, the best we can do is with some support from Tobin Brothers. They help us subsidise the course, but it costs us \$200 per person to put the course on. Although I consider that a very cheap two-day program, a lot of community services and a lot of groups simply cannot pay that.

MR SMYTH: Cannot afford it.

THE CHAIR: We will have to wrap it up there. Thank you for your submission and for speaking to us today.

MEREDITH HUNTER and

ALEXANDRA CAHILL

were called.

THE CHAIR: Welcome to the Youth Coalition of the ACT. Thank you for coming and addressing the committee. I need to let you know that these hearings are being broadcast. If you aren't comfortable with that, just let me know. These hearings are legal proceedings of the Assembly protected by privilege. That gives you certain protections but also responsibilities which I ask you to have regard to. Please state your names and the capacity in which you appear before you speak. I say thank you once again for the work you've done in providing a submission to this committee and other committees. It's very important for us.

Ms Hunter: I am Meredith Hunter, Executive Officer of the Youth Coalition of the ACT.

Ms Cahill: I am Alexandra Cahill, Project and Policy Officer of the Youth Coalition of the ACT.

Ms Hunter: I will give an overview. As we've said in our submission, the information and statistics regarding young people's health are often focused on the incidence of death, injury and accidents. It's great to hear what you've just said—that there will be an inquiry into school-aged young people's health, because there are a whole range of issues that come in. We see mental health as a priority in the health area.

It's also vital to understand the health implications of changes in the social/economic climate that restrict young people's access to housing, income support, education, training, recreation and employment. This is particularly so for marginalised and disadvantaged young people.

As you can see, we have a number of recommendations in the health part of the submission. They cover things such as indigenous services. The incidence of drug misuse with young indigenous people is on the increase. This has been identified by Gugan Gulwan and by Winnunga Nimmityjah. That's an area where we have recommended programs and a detox. A detox has been opened in the last 12 months or so, but there are some cultural issues that still need to be addressed. They may be best addressed by a detox run and controlled by the indigenous community.

Dual diagnosis was highlighted at the recent health summit. This is an area that still needs quite a bit of work. Alex might say a bit more about that later.

Mental health is a very large area. Picking up on what Lifeline said, there is definitely a lack of generalist counsellors for young people. It's great that we have a counsellor at the Junction Youth Health Service, and the hours, I believe, are increasing. But we've again put in our submission that there needs to be more at Junction but also more generally.

There's a problem with young people being able to pay for psychological and psychiatric services. Because we have pushed prevention and early intervention, having access to counsellors available through youth centres, the Junction Youth Health Service or other established agencies, is absolutely essential to pick up those young people.

We have also put something in our submission about CAMHS, Child and Adolescent Mental Health Services. They have clients up to the age of 18 years, so there is a gap for people between 18 and 25, who are expected to access adult services, but that's not always in their best interests or is not the best outcome for them.

Another issue is funding to re-establish the adolescent outreach program. Many of our members have mentioned that that was a very valuable program they sent a lot of young people to. We would urge the committee to look at that recommendation.

We've also raised early intervention. Mainly that has been in connection with the Junction Youth Health Service. I have mentioned the provision of counsellors and advocates for children and young people, but there is also a need for more health promotion. A growing number of young people are being diagnosed with STDs and a range of other health conditions. We believe that more health promotion will be that prevention program, will be that education program.

Finally, we mention young carers. It's great to see that Cyclops has been funded and is up and going. One of the issues they have identified is children and young people and families affected by drug dependence. We would urge that further investigation and work in looking at services in this area be done. We also recommend that research be conducted to explore young carers issues, including service gaps, interagency collaboration, child protection and poverty and strategies to respond to these. We have thousands of young carers in the ACT. They deserve services to assist them to reach their potential.

That's a bit of an overview for you.

THE CHAIR: When did that adolescent outreach program fold?

Ms Cahill: It was, I believe, some time last year. When I spoke to one of the workers from the adolescent program, she said it was very beneficial but they hadn't had the funding to continue the service.

THE CHAIR: I didn't realise that it had stopped.

Ms Cahill: Yes. They're very keen to get it up. A lot of other services that were referring young people are keen to have it back on the ground as well.

THE CHAIR: You wanted to talk a little bit more to the dual diagnosis issue?

Ms Cahill: I guess the main issue around dual diagnosis—and we're getting a lot of anecdotal evidence through our services and providers—is that many young people are attending with complex drug and alcohol issues and complex mental health issues. I guess when you're on the ground working with young people and they come to you at

a crisis point it's really hard to define which area to deal with first. Often the drug and alcohol sector and the mental health sector aren't working together on the one issue, so often children and young people are being sent to several different services.

We're trying to bring that together and have central organisations working around the area of dual diagnosis rather than having the separation. We're also getting a lot of anecdotal evidence from the sector saying that a lot of young people have been turned away from the child and mental health crisis service, possibly due to their funding levels but also the crisis level of young people in the ACT accessing their services.

I spoke to a previous client of mine just a week ago. She attended the psych ward voluntarily. She was there for three days. She was then discharged. She went back two days later. They basically didn't address the issue. She was then returned to her flat. To me, there's a really huge issue there. If at 11 o'clock at night a young person is accessing a mental health service and is not being taken in, then we really need to be highlighting that issue. We're then putting services back on to our outreach workers, who are inundated already with young people with mental health issues.

MR SMYTH: But is the psych ward not taking them in because they don't believe they need the care or because they don't have the resources?

Ms Cahill: Could be a combination of both. I couldn't say exactly what it is.

MR SMYTH: It's a comment the police often make. They pick these people up and they take them to the hospital, and the hospital says, "You're fine. Go home."

Ms Cahill: Yes, exactly, and they're discharged.

MR SMYTH: And the cops come back six hours later, and there is this endless routine.

Ms Cahill: Exactly. If there's no room within the hospital system, often young people are taken to Quamby for the night. Quamby is not seen as an appropriate place for a young person who is suffering mental illness.

MS MacDONALD: One of the previous submissions highlighted a need not just for crisis or acute care for mental health but also other sorts of services at a lower level to stop it escalating into an acute care situation.

Ms Hunter: Exactly. That's the point we put. They are focused on that acute end and not on early intervention/prevention or on moderate mental illness.

THE CHAIR: Dual diagnosis, on one level, takes the approach of the boxes. You could easily argue that there's triple diagnosis or quadruple diagnosis. If they don't have a house to live in, I'd say their homelessness is as big a factor as their substance abuse in terms of their capacity for wellbeing. I think you argue this. I've heard you speak to it before. We need to have a sense of the whole person.

Ms Hunter: A holistic approach. I think Melanie Greenhalgh will be appearing later today, but the Junction statistics from when it was first opened show that young people do not come in with flu, a cold or some illness. When the workers sit down and start

talking, they find that there is a housing problem and maybe some sort of debt problem. It can go through to problems with nutrition and not having the living skills to be able to shop and cook—a whole range of things.

THE CHAIR: So the choice some people may make in that circumstance to use a drug to make them feel better is a reasonably legitimate choice, you could argue, if nothing else is working in their life.

Ms Hunter: Completely, yes.

THE CHAIR: The issues you've raised are really important. We are going to see Melanie later. I was going to ask some specific questions about Junction, but I won't. We'll do that then.

MR SMYTH: Why are STDs on the increase? Do we know why?

Ms Hunter: I haven't seen the research as to why. It is just that it is on the increase. There could be a range of factors. I think there is some concern that use of condoms by young people is dropping back or not being taken up the way it should.

MR SMYTH: So the grim reaper generations have moved on and the younger generations haven't got the message?

Ms Hunter: Yes. It worked very well for a while and then there was a gap. I think there are a lot of health promotion services around the country looking at this issue to try to get up some more campaigns. There would be young people who would say, "Well, it's okay because my partner is on the pill so she won't get pregnant." It's all about pregnancy, not necessarily also about STDs. There is a growing problem there, and it does need to be addressed through campaigns, also through good sex education in schools.

MR SMYTH: I heard one report that said it was mainly on the rise in young females.

Ms Hunter: I'm not sure, but that could be the case. It's also an issue within the gay community.

MR SMYTH: Although you don't mention it, I understand that smoking among young females is on the increase. Do we have effective counters to that? Is that something you deal with?

Ms Hunter: Again that should be part of some good health promotion campaigns. We do have the children and young people's tobacco coalition here in the ACT working on a number of things. Alex has attended. She'll be able to tell you all about that.

Ms Cahill: Yes, it's through Healthpact. They're just working around developing programs to address the issue of young people smoking, going back to campaigns, advertising, education within schools. They're highlighting that as a very serious issue, yes.

MR SMYTH: Is the message about STDs in the gay community of concern?

Ms Hunter: I guess the number of AIDS cases has been increasing slightly, and people not practising safe sex. There would be AIDS action councils around the country, no doubt here in the territory too, picking up on that issue and looking at strategies and ways to address it.

Ms Cahill: For direct client contact and statistics it would be best if you speak to Melanie Greenhalgh from the Junction Youth Health Service. She has direct client contact.

THE CHAIR: On the question of housing and mental health, I think we had a protocol between police and Mental Health, and I thought we had something happening between Housing and Mental Health. But according to your submission that is not really making any difference. Is that correct?

Ms Hunter: I'm unsure whether the protocol still exists in that area. I know that it took a long time to get one in place. I'm not sure what stage it's at at the moment. But obviously that is a big area. If people with mental illness are not being supported, then they're unlikely to maintain their tenancies. Havelock Housing Association has run a program for some years which has been highly successful. It is a small program, so it has enough resourcing to do that. That has been working with the Richmond Fellowship. The Havelock Housing Association provides the housing, looks after the maintenance and collects rents, and Richmond Fellowship provides support. That has been quite a successful model. We're recommending that more of that happen.

It can also happen with the public housing system now that there are specialist housing managers and the linkages program has got up. Hopefully that will be used to its full potential to identify those people at risk of losing their housing because of their illness.

THE CHAIR: And how is that working?

Ms Hunter: The linkages program has only just gone out to tender, and I believe last week the YWCA received the news that they had got that tender. So it is early days, but we'd be hoping that this would be a client group that they would very much focus on.

THE CHAIR: I was told yesterday by someone in the mental health community that Havelock and similar accommodation options do not have a list now. They're not accepting people on to a waiting list. Is that your feeling as well in terms of need?

Ms Hunter: Many of the organisations have closed waiting lists. There's a point where it just gets too long. Because the community housing sector is quite small, you have to weigh up whether you keep a long list going or cut it off at some point so people have some chance and some realistic timeframe to get in. I think there were submissions to the Community Services and Social Equity Committee the other day around increasing community housing.

MR SMYTH: Which you would be supportive of?

Ms Hunter: We're supportive of an increase in community housing. Our issue is that it should not rely completely on stock transfers, because really it's just robbing Peter to pay Paul and we're not actually building the social housing sector; we're just shuffling the chairs around. There is consultation going on at the moment on future directions for community housing. Hopefully that will look at some ways to grow that sector that don't necessarily rely on stock transfers.

Public housing has moved away from being about just bricks and mortar and now sees itself as having a broader role. I think the public housing system can be quite a good one to house people and to bring in supports from community services. I think all social housing has a role to play.

There are mental health issues in youth refuges. These have been ongoing right across Australia. The National Youth Coalition for Housing got some money from the Commonwealth and did a report a couple of years ago on strategies and ways to address this. We can also go back to that if anyone wants to look at that report. But it is an issue when you have, say, 10 beds in your refuge and you may only be able to fill six on the night because there may be one or two young people who have quite critical mental health issues. One youth refuge worker just can't manage it.

THE CHAIR: And there's often only one overnight.

Ms Hunter: Absolutely, one overnight, which obviously raises it's own occupational health and safety issues.

THE CHAIR: It's been a problem for a few years too, unfortunately. None of this is new. Thank you for speaking to the committee.

JAMES KEITH PURCELL was called

THE CHAIR: I welcome you to this committee hearing on the budget. These hearings are being broadcast. If you're not comfortable with that, let me know. These are legal proceedings of the Assembly, and they're protected by parliamentary privilege, which gives you certain protections but also responsibilities in terms of what you say.

Please state your name and the capacity in which you appear before you address the committee. I thank you for your submission and for giving your time. You're probably aware that the government was going to give a framework for people to respond to its budget, but that didn't happen, so we see this as a consultation exercise, without knowing quite what the priorities of government will be. Would you like to address the committee?

Mr Purcell: I'm Jim Purcell. I'm the Executive Director of the Council on the Ageing (ACT). COTA welcomes the opportunity to appear before the committee. You will have had the opportunity to have a look at our submission. There are, we believe, a couple of very important health issues we need to be considering in relation to older Canberrans. We've entitled our submission "Investing in Older Canberrans" because we believe that governments need to start looking at older Canberrans and the opportunities they present as vital members of the community, and they need to invest in older Canberrans rather than spending on older Canberrans. We believe an investment in older Canberrans will reap significant rewards as time goes by.

I'd like to address specifically some of the issues that we have raised in our submission. The first is convalescent care. We believe that the lack of a convalescent facility in the ACT is a significant gap in health care services for older people. This issue has been around for a significant period of time. You will recall that convalescent care homes were a part of the Australian community landscape some time ago, but they disappeared in the 1960s and 1970s.

We've had a significant change in the way hospitals work as well. These days hospitals try to get people out of hospital as quickly as possible. I don't necessarily want to comment on that, but there are consequences associated with that. In a community such as ours where we do have a rapidly ageing population, a number of those people being discharged from hospital are older people and they don't necessarily have the care that they should have at home or they can't access care in the community.

We believe that the establishment of a convalescent care facility where people can go in transition from acute care to home will allow those people to achieve a better health outcome in the longer run. They will be able to do this by going to a convalescent facility where they'll be able to regain their confidence and also improve their health a little. We would envisage people going to a convalescent facility for a number of days, maybe up to even two weeks. During that time they would be able to regain their health and to regain their confidence.

I'll give you an example. An older woman who breaks a leg will go into hospital. It's not a particularly life-threatening situation, but it is something which can be severely debilitating. They will only be kept in hospital for a day or two, but they don't know how

to function effectively at home with their leg in plaster—simple things like getting out of bed, going to the toilet, answering the telephone, answering the front door, using crutches and all of those sorts of things. They'll get some little help from hospitals to achieve those things, but if they could spend just a couple of days in convalescent care learning about how to do those things, then health outcomes would be tremendously better for them.

If they go home and they suffer an adverse effect at home, like falling, they can end up back in hospital, and the cost to the community is significant. That's not the only scenario. There are lots of scenarios where people would benefit as a result of going to convalescent care. We all know that there are a lot of people who are discharged from hospital without a discharge plan or with an inadequate discharge plan. I'll address that issue a little later. But the issue of a convalescent care facility is important. We had some money—

THE CHAIR: Is that the same as the step-down facility? It's just a different term?

Mr Purcell: It's the same thing. That's exactly right. You can call it a step-down facility, convalescent care facility, transitional care facility, whatever you want to call it, but it's a non-acute care setting where people can regain their health.

MR SMYTH: A discharge plan may or may not include the use of the step-down facility?

Mr Purcell: That's exactly right, yes.

MR SMYTH: The step-down facility tends to be part of the process in many cases, but it might not be essential in all cases?

Mr Purcell: No, it's not in all cases. No, we wouldn't envisage that all cases would go to convalescent care. We would envisage a reasonable proportion of them. It would be in consultation with the discharge planning people, and the discharge plan would have to require admission to convalescent care. You wouldn't be able to get into convalescent care without it being a requirement of your discharge.

THE CHAIR: If you were lucky enough to have a discharge plan.

Mr Purcell: That's right. I can press on with a couple of other issues, but if you've got questions about convalescent care I can address them now or later.

THE CHAIR: No, continue. This has come up with other submissions, you'll be interested to hear, but they called it a step-down facility. It's coming up as the major one.

Mr Purcell: Yes, it is. One of the problems we face at the present time is that there was some funding made available in last year's budget for it. Some of that money has been used for another transitional care facility which is quite a different facility. There's a partnership with the federal government. People who have more complex health needs are going through the transitional care program. It can't be accessed by people other than through an aged care assessment team assessment. Therefore, they're theoretically eligible to go to residential aged care, a nursing home or hostel, but instead go to

Morling Lodge and stay there for up to 12 weeks, with the hope of their health improving to the extent that they are able to go home. It's a pilot program and it's being evaluated at the present time. Some of the money has gone there. The rest of the money is still unused in the budget.

We had identified a site in Chapman. The facility exists. It needs refurbishment. The proposal was to build a 16-bed convalescent facility there, but at the present time the government is reconsidering that because Calvary Hospital has put forward a proposal that they may be interested in providing convalescent care services as well. I don't have any problem with Calvary Hospital putting a proposal forward, but while we step back and evaluate how good that proposal is nothing is happening. If that proposal turns out not to be viable, then we've lost six months or 12 months. My other concern is that every time another proposal comes forward we will continue to do nothing. We've got to get on with the process and get something on the ground.

In relation to discharge planning, COTA have recently done a considerable amount of work with a large number of older people within the ACT. One of the questions we talked about was discharge planning. Our concern was confirmed in that survey. The majority of older people leaving hospital do not receive a discharge plan. I haven't got the figures in front of me, but on average about 35 per cent of people get a discharge plan on leaving hospital. That leaves a significant gap in the number of people who do get a discharge plan.

The relevance and importance of a discharge plan can't be underestimated. A discharge plan provides older people with a plan for the things they should do and the services they should access to regain their health and to maintain them as an integral independent person within our community. If they don't get an adequate discharge plan, the consequences are more often than not that their health will deteriorate and they'll end up again in an acute care setting, which is not what anybody wants.

THE CHAIR: The committee can ask for the current figures on that, but I've asked for readmission figures. I have been hearing this kind of evidence for a few years and it has never been shown that there was that much of a problem.

Mr Purcell: I don't know. I think it depends on the definition of readmission.

THE CHAIR: Yes, it could be.

Mr Purcell: And how quickly that might occur. Readmission, they might say, is something that needs to occur within a specific timeframe, but it may not necessarily be within that timeframe. If a person is readmitted within a couple of days, then it's an obvious related incident, but if a person is readmitted three weeks later or two months later it's not necessarily a related incident. The research we have done would tend to suggest that older people use hospitals more than the rest of the community generally and that over a period of time the average older person will access a hospital service at least once a year.

Not everybody will need a discharge plan if they're accessing some services within the hospital, but where they have a stay in hospital they ought to have a discharge plan. One of the problems associated with a discharge plan, of course, is that whilst there might be

a range of services identified on the discharge plan, the person can have difficulty accessing those services, because there's a lot of pressure on home community care services to provide the level of services that demand requires of them anyway. You can't just address the discharge planning issue without addressing the whole question of the provision of services more broadly through the community care sector and the home and community care program.

THE CHAIR: If the majority of older people do not have a discharge plan, what's happening to them, apart from readmissions. Who's picking up the slack? Is anyone?

Mr Purcell: It's generally the community sector that's picking up the slack somewhere. Anecdotal evidence would tell us that when people leave hospital without a discharge plan they will try to access the services they think they need, which may not necessarily be the most appropriate services. Often people will try to access a service, be unable to do so and then take the next step down to access some other service. Eventually they will get a service provided to them, but it may not be exactly what they require.

They may need, for instance, help at home with personal care. They may not be able to access personal care services, but they may be able to access something that isn't quite as relevant. They may be able to get some help, for instance, with housework, yard work or something like that. They will take that in lieu of the other services they might need. As I say, you can't up the ante on discharge planning without addressing the questions around the provision of services within the community care sector.

Another issue I want to raise relates to dementia specific accommodation. We know that dementia is on the increase in the ACT. We know that we have an ageing population. We know that the numbers of older people are going to double in the next 10 or 15 years, and we know that the rate of dementia increase is going to be in similar proportion to the ageing of the population.

There have been a number of demands around for dementia specific accommodation, but COTA is of the view that we need to clearly understand what sort of accommodation is required for people with dementia. There are residential care places that provide for people with dementia, often with dementia that's easily managed. One of the major problems is where the dementia isn't easily managed and you have people who have a behavioural problem. There have been some very high-profile media cases in the not too distant past about people not being able to access those particular services in Canberra.

Our view is that we don't know how many people suffer from that level of dementia where they have uncontrollable behavioural problems, and we don't know whether we ought to be spending money on high-level dementia accommodation or whether we should be looking to provide more generally for people with other levels of dementia. What we're saying in our submission is that we need to know that. We need to have a look at what the needs are in those particular areas, so we're asking the government to spend some money on doing some research into where the money would best be spent.

It's my view that in the longer term we are going to need a high-level dementia care facility within the ACT where people with difficult behaviours and so on can be managed, but whether that needs to be done next year or not I don't know. We're suggesting that the government needs to have a close look at that.

The final issue I want to talk about you would argue is not necessarily a health related issue, in that the ACT's role is in relation to the allocation of land rather than a health service. The federal government is responsible for the allocation of aged care places within the ACT. One of the problems is that they allocate the places, then the provider has to provide the beds, and often that can take a considerable period of time while the facility is built.

I'll give you a specific example. There have been 69 or 70 places allocated to Calvary Hospital, but Calvary have to build a new facility. They're looking at the land on the site of the old Bruce Hostel, and they're currently negotiating with the government for that block of land. But the places have been allocated. The land hasn't yet been made available. Once the land has been made available, you have to go through the whole process of design, siting, building, commissioning and all those sorts of things, so it could be two or three years before those beds are in place. Whilst the Commonwealth can say they have allocated the beds, they're actually not available to people within the community, and that causes a great problem, because we know that there are a large number of people waiting for places in the ACT.

The ACT can play a role in that. I must admit that in the past a lot of work has been done on how we can coordinate this a little better. I think what we need to do is continue to work in that area but also look at pre-approval for land so that if a provider can get a pre-approval from the ACT government for the allocation of land on the provision that they get the places we can reduce the time to get the beds in place by a considerable margin. I do know, from my discussions with the Commonwealth that they are prepared to look at issues around the pre-approval of places and say, "If in the next round we allocate 60 beds to you, how quickly can you put them on the ground?" If they get that guaranteed pre-approval, they can come to the ACT government and say, "We need the allocation of land." Then you can short-circuit it by at least 12 months.

THE CHAIR: What's your view of the need? We've just been told that 23 per cent of people over 65 are in Belconnen. You don't agree with that?

Mr Purcell: No.

THE CHAIR: So would you like to say what you think it is?

Mr Purcell: I'd say it's probably around 7 or 8 per cent.

THE CHAIR: So there's a differing view about that. That needs to be clarified.

Mr Purcell: The proportion of the ACT population over 65 is currently around 37,000, and I don't expect Belconnen to be at a higher rate than the community generally. It might be a little higher than elsewhere, but I wouldn't be more than 8 or 9 per cent at the very most. In some suburbs it may well be. Certainly in the older parts of Belconnen

around Aranda, Macquarie and Page it's very high, but generally within Belconnen it's nowhere near 23 per cent. The ACT overall is not going to achieve a rate of 23 per cent for another 40 years at least.

THE CHAIR: I think we are going to have to wrap up, unfortunately. Thank you very much for your submission.

Mr Purcell: Thank you very much.

JUSTINE CAINES was called

THE CHAIR: Just for your information, this hearing is being broadcast. You can say if you're not comfortable with that, and I can have that changed.

Ms Caines: No, that's fine.

THE CHAIR: I remind you that these hearings are legal proceedings of the Assembly protected by parliamentary privilege, which gives you certain protections but also responsibilities which we ask you to have regard for. Thanks for your submission. Would you like to address the committee?

Ms Caines: The Maternity Coalition has been lobbying the former government and the new government for a number of months now in relation to extending midwife-led care in the ACT. Midwife-led or one-on-one midwife care throughout the entire period of pregnancy, birth and the postnatal period is available to around 5 per cent of women in the ACT.

Over the last 15 to 20 years it has been demonstrated through at least six federal and state inquiries to be the most appropriate and the most cost-effective care, yet governments have been very slow to act.

In the ACT the closest thing we have to midwife-led care is the community midwifery program through the Canberra birth centre at the Canberra Hospital. That program is cut into two teams: a northside team and a southside team. The northside team is the only team that can offer women one-on-one care. The southside team offers a team approach. A woman throughout her pregnancy will hopefully—no guarantee—meet all of those midwives. When she presents in labour to the birth centre, once again hopefully she will see a midwife she knows. This is less than standard.

All the research points to the fact that when a woman has a relationship with one carer, as you could probably imagine, the outcomes are far better—things like less reliance on analgesia and drug use during labour, quicker births, better births, higher rates of breast feeding, lower incidence of postnatal depression. In Canberra we have a 33 per cent incidence of at least one day in a specialist—ie QE II—postnatal facility. That is the same cost as a hospital day stay, so that's \$500 per day stay. That's at least one day, and that's pretty full-on specialist care.

We aren't providing care to women that is producing good outcomes. As I've said the midwifery program at the birth centre is the best, but it has not been adequately resourced. Since 1997 there has been a push for it to be extended. The problem is that there is a national midwife shortage, particularly of women who have experience in working one on one. A lot of midwives who work in the system are used to team and general obstetric nursing-type practices, whereas you walk into a shift, you do your eight hours, you know no-one, you do your shift and you go home.

What we've presented to government is a program to utilise independent midwives. It doesn't have to be just our local midwives. It can be Australia-wide. Unfortunately, independent midwives to date have been unable to secure professional indemnity

insurance, so the vast majority of them, very responsibly, are pulling out and not providing independent midwife care.

Up to 100 women in the ACT have utilised independent midwife services per year. It's not a huge number. That's largely because it's cost prohibitive. It's not Medicare refundable, and most health funds offer only a small rebate to women.

So what we've said is use the skills of independent midwives, who are highly skilled in working one on one, because that's the only way they work—some of them have worked for up to 20 years on a caseload basis—and supplement the skills of the Canberra midwifery program. It's not an “and/or”; it's a “both”. If we get the program for the 120 births as we've outlined, we will be meeting the current unmet demand of eight to 14 women being turned away per month from the Canberra midwifery program and the women who choose to birth independently with midwives who will no longer be able to do that.

This will allow the excellent skills of independent midwives to be utilised and will allow the Canberra midwifery program to be better skilled. David Elwood, who is the head obstetrician and gynaecologist, and Rosemary O'Donnell at the Canberra Hospital have said that the Canberra midwifery program does not have the experience. They openly admit that. They certainly do not have the experience to undertake home birth. They are supportive of home birth, as is the current government. The health minister has said that it is the right of women to choose where they birth?

The fact is that they won't be able to provide that service, and we have a very real fear that women will birth unassisted at home. That is a public safety issue. It's unacceptable. What we want to do is achieve good in both areas—utilise the skill but certainly do it in a public program and allow the Canberra midwifery program to get that skill as well.

We have suggested to the government that at least half a position—a full position is a midwife taking 40 births a year—say, 20 births, be designated to the CMP, so there is an interchange between both programs and midwives who don't have caseload experience work with independent midwives and get one-on-one experience, which is available in very few areas of Australia, and skill up the CMP as well.

We're fearful that they won't do that. We think they'll only extend the CMP. I've asked Professor Elwood how they intend to do that with a national midwife shortage. He is unsure how they are going to do that. Although, as I said, we are supportive of CMP, we fear that high transfer rates will continue. The Canberra midwifery program—and we've verified this with them—has a 70 per cent transfer rate for first-time mothers and a 49 per cent transfer rate overall.

There is a duplication of services. You present to the birth centre and, for whatever reason, you need to go upstairs for drug relief, a whole range of things. So then there's a duplication of services. You take your midwife from the CMP, who could be with other women, upstairs to another midwife in the labour ward. So it's not working, because they haven't received the resources and they aren't experienced enough. We want midwives in the system to have that experience, and we think this is the best and cheapest way to do it in the short term.

Independent midwives, for very good reason, will not work back in the system as employees. Like specialist medical staff, they have chosen to work independently. That is the only way we will secure their services—in a visiting medical officer-type capacity. Obviously, their indemnity would have to be covered, because they are only a small group of professionals. They have not been able to secure independent indemnity insurance.

There's a precedent in WA. There is a program called the community midwifery program—they're not overly original—in Western Australia. That has been running for six years extremely successfully. They run it exactly how we are proposing. We have briefed health bureaucrats, the Chief Minister and advisers on that program. They have a very low rate of transfer. They largely birth women at home, so they are providing radical, for want of a better word, care very successfully. Their breastfeeding rates are brilliant. They've got an 89 per cent breastfeeding rate post 12 months, which is fantastic. They've been running very successfully.

With the lack of professional indemnity insurance, the Western Australian government were successfully persuaded that the model of care was not unsafe but in fact very safe. Birth itself is not unsafe; it's the model of care that surrounds birth. Specialist obstetric care, when it's not necessary, is in fact an unsafe model, because resultant interventions are the things that create problems. They've provided indemnity cover for them. The Northern Territory government have also provided indemnity cover for independent midwives.

We believe it is far better to utilise a public program than just indemnify midwives for their private work. If it doesn't happen, we will have 100 women fronting up to the public health system. You would have to impart our intervention rates and our postnatal bed stays on to that model. Whereas these women were free to the public system, they will be slotted into the system. We have a 20 per cent caesarean rate, which is consistent with the national average, but very importantly we have the highest postnatal days stay, at four days. The average in New South Wales is about 1.8 days. So four days at \$500 is \$2,000 alone on hospital stay. A normal vaginal delivery is \$1,800. There's \$3,800. For \$3,500 we can provide the entire care from six weeks pregnant, when very few women know they're really pregnant—and that's pretty early days—to six weeks post, one on one, with 24-hour assistance during the birth guaranteed. That's a huge cost saving. Obviously, it won't be recognised with 120 births. We're happy to admit that, but as the economies of scale grow it will be recognised. David Elwood confirms our figures.

I'm here to say that we need to promote this model. As I said, an extension of CMP will not do it, unfortunately. The other big issue is that we have one very committed and progressive obstetrician in this town, but we cannot link a program to an altruistic personality. That does not work. It has happened in New South Wales, and this obstetrician has recently left and the program is going to fold.

We've had examples of this at TCH with the birth centre. When Professor Elwood goes away on holidays, obstetricians of other persuasions come and change protocols. That is not appropriate for women. Women should be determining their own care with the carer of their choice, and it should be based on evidence. It clearly is not.

Women are undergoing procedures that have very little, if any, scientific basis. In fact, the dangers of them haven't even been proven, and that can be backed up. What we're asking for is a program that stands on its own merits. The midwives who would work in this program would be accredited with the Australian College of Midwives, which is a rigorous five-year process. They would be accountable to clinical review procedures, as would any visiting medical officer. We don't expect any favourable treatment, but we expect that women be able to have a carer of their choice.

The World Health Organisation suggests that 85 per cent of women should be birthing normally. The converse is true in this country. We have about 10 per cent birthing normally. Midwife care is deemed to be the most appropriate. We think that more than 5 per cent of women on the north side of Canberra should have that choice.

In the last week we have had support from the Calvary Hospital. This program can go across Canberra. Currently you can only birth at Woden, at the birth centre under the CMP. Under this program a midwife will provide the vast majority of visits in the woman's home, at her convenience. For first-time mothers and mothers who have a few children, it's most convenient. The program will allow women to birth in one of three places of their choice: at home, in the labour ward at the Canberra Hospital—not at the birth centre, because there's clearly not enough space and we don't want to compete with them—or at Calvary Hospital.

Currently that service isn't available. For many years, Calvary Hospital has wanted a birth centre. Birth centres cost a lot. We don't need bricks-and-mortar support for this. It's not the pretty curtains and the floral doona that create results; it's the model of care. That has been proven. If women have the midwife of their choice and develop a relationship over that period of time, the results will speak for themselves. We've met with Calvary Hospital. The CEO and the medical director are both very supportive in principle of our program, as are three consultant obstetricians. It is unheard of that we have the support of three obstetricians. That's unbelievable.

We can attract privately insured women to this model, and they can pay for it. We're not asking for a whole lot of money. It's \$500,000 for 120 births over a year, but it has the real capacity to recoup those costs. With the high level of private health insurance in Canberra, there is a real chance to recoup that money. I know that the CMP have been asked by many women with private health insurance whether they could have their services and then the obstetrician of their choice should they need that care. Of course they can't provide that service currently. It would take nothing to do that, and we've explored that.

This program will allow everyone to win. It will allow women to make that choice. It will cap the unmet need, and it will help the CMP get the skills they need.

THE CHAIR: That's very clearly explained. Thank you very much.

MELANIE GREENHALGH was called.

THE CHAIR: Thank you for giving your time to address this committee. You're probably aware that we have not yet got any documentation from government on their priority, so we're regarding this as a consultation exercise, without knowing the direction of the government. We've got a sense of it from their public statements, but we don't have the document that we thought we'd have formally outlining their position.

This is a public hearing. As you know, it's being broadcast. You should also understand that these hearings are legal proceedings of the Assembly protected by parliamentary privilege, which brings with it protections for you but also responsibilities that we ask you to have regard for. If you'd like to address the committee, state your name and capacity in which you appear, please.

Mrs Greenhalgh: My name is Melanie Greenhalgh, and I'm the Coordinator of the Junction Youth Health Service, which is auspiced by Anglicare Canberra and Goulburn Youth and Family Services.

I haven't really gone to the effort of putting together an opening statement. I understand that you've got quite limited time, and hopefully you have read the documents. One was a budget submission, and the other two were project proposals. I took a little bit more of a proactive stance this year and decided to put up some possible projects that could address the needs we've identified in the budget submission.

I also want to make it clear that the budget submission is in no way a wish list for youth health. It identifies three areas of need and highlights those. I understand that the committees have limited time to look at issues in detail.

We express a hope that the ACT government will take a cross-portfolio approach to youth health, considering that we work holistically with young people, looking at the social determinants of health. We often work across a number of areas that are touched on by many departments of government. It's not always the responsibility of the department of health to fund these areas. We'd be looking at a cross-portfolio approach.

THE CHAIR: A cross-portfolio approach is consistent with a lot of the submissions we've already received. Over the years we've heard that. I wouldn't mind hearing you talk a little bit more about health promotion and prevention that you're focusing on with projects.

MR SMYTH: Who are your clients? What sort of age group are they?

Mrs Greenhalgh: We're targeting 12 to 25. Predominantly that's young people who are homeless or at risk of homelessness. In the ACT "at risk" is a very broadly used term. We certainly see young people from a range of socioeconomic groups with a variety of needs. Generally it is across the board.

MR SMYTH: In the last year did I read that you have seen several hundred?

Mrs Greenhalgh: Yes, quite a few. We're only open from 1 o'clock to 5 o'clock each afternoon during the week. Statistically, my feeling is that if we were to have the GP and nursing services and the extra counselling services, we could be open from 10 till six weekdays and still be full. A lot of young people find it very difficult to access us in the afternoons, particularly those engaged in education. They're forced to wag school to get along and have some of their needs addressed, which is often a good thing.

MR SMYTH: I think we would refer the second and third proposals here to our inquiry into school age health, because I think both of them have information that we'd find pretty useful. I'm not sure if you're aware, but this committee will hold an inquiry into the health of school age Canberrans.

Mrs Greenhalgh: Yes, I had heard rumblings. They're very brief accounts of our experience. We have tried to keep it quite short so it's readable. We'd certainly be interested in being involved in that inquiry.

THE CHAIR: Last year you got money for a doctor to extend the hours, but is it correct that you couldn't find a doctor who would do that?

Mrs Greenhalgh: Yes, we received 10 hours extra GP funding to pay GPs at a very base rate, I have to admit, which is one of the reasons that we have difficulty in recruiting. We haven't been successful in finding a GP for those hours. I've just recently started meeting with Family Planning ACT to look at a joint recruitment strategy and pooling our money, linking it to other areas to try to attract GPs to our service. That's in the pipeline at the moment.

THE CHAIR: How would that work?

Mrs Greenhalgh: Essentially it would be looking at what pools they had available.

THE CHAIR: You are already using a doctor?

Mrs Greenhalgh: Yes. We are looking at coming up with some sort of package means that they spend some time at Family Planning and some time at the Junction. The Junction is a unique model in that what we get from other service providers such as ACT Community Care and Canberra Sexual Health Clinic all comes as in-kind as part of our relationship and working together. We only fund a small amount of GP hours, but we've certainly had quite a lot of difficulties in recruiting.

MR SMYTH: When the Youth Coalition spoke to us, they said we should ask you why the STD rate among young people is going up. You might have some more practical knowledge of the why.

Mrs Greenhalgh: This links to our health promotion needs. The 1980s was fantastic for the HIV message. Australia has become very complacent about HIV, because we haven't had the massive outbreaks that were predicted, unlike Third World countries. We are a First World country. Our service has been trying to put forward to young people that HIV is a very small risk compared to other sexually transmitted infections, which often have long-term infertility implications.

Young people are not practising safe sex. Our service does not have the capacity to promote that message in the schools we work with. We have quite a lot of young people referred from schools, which is fantastic. But we can't reciprocate that relationship and provide outreach to them to promote safe messages. Increasingly, young people are taking risks.

MR SMYTH: The generations that were indoctrinated by the grim reaper ads have got that message, but the subsequent generations have had no message given to them?

Mrs Greenhalgh: Yes, and nationally the focus has not been strong. We've certainly been approaching it in a very piecemeal way. That is having ramifications for the Junction. Particularly high in young women is chlamydia. The reinfection rates for that are quite alarming, because we cannot draw the young men in to receive the medication that's required. It is just a medicated response. It is very quick. It can be eradicated quite easily. We service the young women and we provide them with the safe message. They then go back to relationships where there is still infection and bounce back to us.

A lot of the work of a health promotions officer would be looking at young men's health. The team has talked about rego checks, trying to engage young men to use the service to make sure that their health is in a positive state.

THE CHAIR: One of your projects is for a counselling position. Lifeline, who spoke to us earlier, want to set up a face-to-face crisis counselling service. They also talked about Youthline and the need to resource that better. Do you think both are needed? A lot of young people claim they would use Lifeline face-to-face service. Government is presented with various requests for free and accessible counselling for people of all ages but especially young people. Would you argue that it's better for you to have that service specifically for young people, or should it be a generic one such as the one that Lifeline would provide?

Mrs Greenhalgh: There are obviously arguments for and against. Regardless of who gets what, we need more resources in the counselling area. The risk that we run is that young people who are not in a point of crisis, who are not having suicidal ideations and who are not putting themselves and others at extreme risk are not able to access any services at all. CAMHS and the adult mental health service are stretched to capacity. I believe that the model of service delivery is being compromised because of the need that is gushing in there at the present time.

We believe we're on a winning model because we've had the counselling position with us for a year, but that's not to say that Lifeline or Youthline couldn't possibly offer that too. A large part of why we're really interested in having the second counselling position is to offer young people choice. At the moment we've only got the one free service that doesn't have any sort of family involvement. A lot of the young people we're working with are homeless or at risk of homelessness, and they've had trauma and abuse in their lives. But they are not at a point of crisis. They're looking at making moves to go forward. Our service is not a crisis service; it's very much about young people making change and getting their lives on track.

THE CHAIR: So there's a difference?

Mrs Greenhalgh: Yes, there is.

THE CHAIR: What's the situation with your accommodation?

Mrs Greenhalgh: We're still there. We're hanging on. Since the change of government, we haven't heard anything from the department of health since change of government about their thoughts or plans on the building and what will be happening. We're hoping that the department of health is working on securing us some space in the section 56 development with the other youth service providers that have already got space purchased through DECS.

THE CHAIR: But you just don't know?

Mrs Greenhalgh: We have no idea. When I began in the position, I was taking each day as it came and wasn't getting new resources printed or promoting our building, because we were a little bit each way. With the recent silence on the issue, we can't hold off on a lot of that stuff. We're going to have to go ahead and spend.

THE CHAIR: We'll make inquiries of government.

Mrs Greenhalgh: It would be helpful.

MR SMYTH: Just for some of the people listening here today, you're located where?

Mrs Greenhalgh: In the QE2 building.

MR SMYTH: And you've been there for how long?

Mrs Greenhalgh: Since May 1998.

MR SMYTH: And is it a good site?

Mrs Greenhalgh: No. It serves a purpose now. It was built to be a nursing mothers hospital. That's very obvious. It's got some clinical rooms which I don't believe are up to appropriate hygiene standards. There are a lot of minor surgical procedures and things we could do but choose not to, because I don't believe they're of a high safety standard. Things fall in and lots of things block and overflow.

THE CHAIR: Do you have any idea how long you can stay there?

Mrs Greenhalgh: Well—

THE CHAIR: You don't know that either?

Mrs Greenhalgh: No.

THE CHAIR: Okay. We'll make some inquiries on your behalf. I think we're going to have to conclude. Thanks for your submission.

CHERYL DAW was called.

THE CHAIR: Thank you for coming to address the committee, and for your submission. This hearing is being broadcast, and is obviously public. If you are not comfortable with that, at any point, you can let me know.

I would also remind you that these are legal proceedings of the Assembly, protected by parliamentary privilege. That gives you certain protections but also responsibilities which we ask you to have regard for. Before we start, could you please state your name and the capacity in which you appear?

Ms Daw: My name is Cheryl Daw. I am the Manager at FaBRiC, which is family-based respite care.

THE CHAIR: Would you like to address the committee now?

Ms Daw: Yes, thanks very much. I will speak to the submission I sent to you. It is really just an awareness of the situation, in terms of the service we provide. FaBRiC provides respite care to families who have a child with a moderate to severe disability, whether that be intellectual, physical or sensory. The respite care we provide is home-based or recreational—and occasionally we provide host care. The service is provided by support workers. The maximum amount of care a family can be given is 40 hours over a four-week period.

Over the past 18 months or so, FaBRiC has experienced difficulties in being able to provide the level of respite needed for families in the ACT community. We have had a waiting list. Up until recently, we have had over 100 families waiting for care. We were successful in winning some money about a month ago, from a tender that was put out to the public. To an extent, that has alleviated the need, with regard to our waiting list.

We have just been sent information from the department that there is an interim payment related to the SACS and home care awards, under which we are employed. That will also help to alleviate our waiting list. Prior to this, we had to stop providing Sunday care. We also closed the waiting list because we just could not cope with the demand. This has made life a lot easier.

With the award payments, we are still unsure as to what sort of funding we will be given next financial year. If nothing is forthcoming for our budgetary planning for next year, that causes concern. With the interim payment, we can provide care. However, we do not know to what extent we can help those families, or for how long. If we have to take away care, that causes further concern.

One of the important things is that we do not have the capacity to research how much need is out there I think that is something the government needs to look at—not just for FaBRiC, but for all community service organisations in the disability sector. We need to know the commitment the government is going to put forward in relation to the awards. That will allow us to meet the appropriate pay scales for support workers and so on. There is already a shortage of support workers—particularly those with training,

qualifications and experience. That seems to be across the whole sector. So whilst we now have some money to help us, we are having trouble getting support workers. It is a bit crazy.

The other thing is that whilst we have had some money to help us, we still have families waiting. There was a commitment by the Labor Party in the election campaign for a million dollars. We are hoping that that will be put into the new budget process.

THE CHAIR: What sort of training do people normally get, to become support workers?

Ms Daw: Sometimes it is just experience. We encourage people to do the certificate III, disability studies, at the CIT, or other equivalent places. Often they do that in conjunction with a traineeship.

THE CHAIR: With you?

Ms Daw: Yes, we have done that. We try to do that, but it is very hard. If a person has any other qualifications, then they cannot reap the benefits of a traineeship from the funding source. They are required to have a first aid certificate. We just take each case as it comes. We provide orientation training and other training programs throughout the course of the year.

MS MacDONALD: Presumably, that orientation training program talks about the different types of disabilities they will encounter.

Ms Daw: Yes. We are talking with CIT at the moment. We want to try to come up with a training program that fills the gap between the orientation we do and the certificate III. Hopefully, we will be able to put something out, on that.

MS MacDONALD: How long does the certificate III normally take?

Ms Daw: It normally takes about 12 months. They study for either half a day or a full day at the CIT each week.

THE CHAIR: One day a week?

Ms Daw: Yes. It is half to one day a week.

THE CHAIR: For 12 months?

Ms Daw: Yes.

THE CHAIR: You have recently been able to increase the number of hours of service. However, you feel that we do not really understand what the unmet need is out there. You are feeling the pressure, I imagine, from people who want respite that you are unable to provide?

Ms Daw: It has been only in the last four weeks that we have heard about the tender. We have received some moneys for that. Then there is this interim payment which will be coming through from the government.

THE CHAIR: For SACS and home care?

Ms Daw: For SACS, yes. The pressure has eased. We have been able to take some families off the waiting list. The Sunday care service will start to flow again. We stopped doing that because of the high overtime rates that we had to pay support workers.

THE CHAIR: You think \$1 million should be added to the area. What is actually happening? In the situation of unmet need, are you focusing on the most urgent cases? Is that how you make your decisions?

Ms Daw: Yes. There is a tool we use to assess each family. Basically, that gives them a score, and the higher needs are scored higher. If there are people on the waiting list, we would take the higher needs first, rather than the person who has been longest on the list. Their score shows how many hours they will be allocated.

THE CHAIR: Thank you very much.

TONY CAMPBELL was called.

THE CHAIR: Thank you for coming to address the committee. I need to inform you that this is being broadcast and recorded. This is a legal proceeding of the Assembly, which gives you the protection of privilege. However, we ask you to use that carefully. Could you state your name and the capacity in which you appear?

Mr Campbell: My name is Tony Campbell. I am the manager of Supportlink Systems.

Supportlink Systems presents itself as a solution to the gap between GPs and social support services—particularly within the ACT. We began in 1996 as a community service. Supportlink Systems is a branch of Tuggeranong Community Service. In 1996, we realised that it was quite difficult for people to access social support services. We realised that, as far as the goal of trying to improve early intervention was concerned, there was not a great deal of early intervention happening through the programs we were running.

In identifying various models, we began to look at a model which realised that, when people had a personal or family issue, they often related that issue to a group who we call intermediaries—school teachers, GPs, police, employers, et cetera. In realising that people often presented their personal issues to the likes of GPs—that is the focus of our proposal today—we began to realise that there was a real gap between the referral from the GP and the social support services. We have worked with doctors for a number of years. We understand that something like 45 per cent of patients who go to see a doctor will present with a social issue of some description.

Tuggeranong Community Service covers youth, aged and the family—quite a broad spectrum of community services. In making the analysis, we realised that about ½ to 1 per cent of all referrals would have been from GPs. That told us that GPs were not well-practised at making referrals. You can understand that, because they do not have the time or resources—and sometimes they just do not have the culture—to do that. It is not that they do not care, but those systems are not in place. In the ACT, we have 2,800 separate social support providers. That ranges from the self-help groups, right up to the more sophisticated operations of, say, ACT Community Care.

In 1996, we undertook to bridge the gap between GPs and social support services. We have done that with the police, Centrelink, schools, et cetera. However, the majority of our work has been with the police and GPs. We realised that we had to develop an easy method, an industry tool. It had to be something whereby doctors could gather enough information on one sheet and, in under 60 seconds, be able to totally activate a referral for their patient. That was our criteria. It had to be sharp, short, and very accurate. We developed the system. In its infancy we began to see doctors use it fairly progressively, and sometimes even aggressively.

The general comment we got back was, “It is about time something like this was developed.” We saw our referral rates at Tuggeranong Community Service increase to the extent that about 20 per cent of all referrals were from GPs. Tuggeranong is a high volume area. We went from an almost negligible number to 20 per cent of our overall referral rate being from GPs. So we have been able to provide a solution.

Last year, the ACT government was good enough to give us a \$100,000 research and development grant, to develop this concept on line. That was because this has not only a local application, but the capacity to be used interstate as well. We are now going down the path of developing an on-line service, supported by a company called APIR Systems. That is an authentication and privacy-focused software company. We have set Supportlink Systems aside from Tuggeranong Community Service. It stands as its own not-for-profit company, and we are currently in the stage of developing our board of management.

We would like to present the fact that we have a good innovation here, a solution to a problem. Potentially, if we are able to present this to every GP in the ACT, we could have an outstanding model within Canberra.

THE CHAIR: Can you tell us how it works?

Mr Campbell: Sure. A patient with anxiety issues goes to see a doctor. During the consultation, it comes out that the person is having problems at home, say with the children. A child might have ADHD, or the person might have communication problems with their partner. We must remember that GPs say this is common. They say 45 per cent of patients who go to see a doctor will present with a social issue. The doctor asks, “Would you like some support?”

MR SMYTH: Along with the immediate health problem that causes them to go?

Mr Campbell: Yes, in addition to that. That is right. The GP will say, “Would you like some support?” The person says, “Yes.” On the sheet, the doctor fills in the name and address and ticks the boxes. In the pilot form, the sheet is faxed to us. It will be developed on-line soon. We receive that referral, and we manage the process. Out of 2,800 providers, we will find the right provider to engage for the patient on behalf of the GP.

THE CHAIR: You are sort of case managers?

Mr Campbell: In a sense, but we do not do thorough case management. We do not follow through with the patient.

THE CHAIR: You do not keep them on your records, it is just that initial contact?

Mr Campbell: Yes, but we do further assess the patient’s needs. When the referral comes in, we contact the patient. From there, we begin to explore the real issues. It may be that we bring in more than one service to meet the needs of the person.

We have also found, through this system, that we can bring in a host of national players. We are able to improve the accessibility of services by bringing in telephone support services that are located all over the country. There are men’s lines, incest lines—the whole range.

THE CHAIR: Do you just give them the numbers? Is that how it works?

Mr Campbell: No. Most models—in fact I think all models that I have come across—will just give a phone number. We engage the service provider and have them engage the patient. We monitor that to make sure there is an engagement, so no-one falls through the gap. Once the service provider has contacted the patient, we will report back to the GP on the outcomes. That is not their personal outcomes, but the fact that X service has engaged Mrs Smith, who they referred two days ago. We are taking the complexity away from the GPs. We are absorbing that ourselves, and it is working tremendously well.

THE CHAIR: You do not have an answering service that says, to push No 1 if you want this, and to push No 2 if you want that?

Mr Campbell: No, we do not. In fact, the department of family and community services provided \$22,000 to have this independently evaluated. In my additional material, I have presented the executive summary of that. In the executive summary, it shows that 30 per cent of referrals to the system were of an early intervention nature. In addition to that, 25 per cent of referrals were for males. We are taking the system to the people's networks through GPs, et cetera.

You tend to find a whole range of phone numbers, posters and pamphlets all around the place. Yet that does not necessarily mean that, when people are having a personal issue, they will just happen to find that poster or pamphlet, although some will. Having received a pamphlet, some will be bold or courageous enough to make a phone call, but the majority are not. They do, however, disclose issues to their doctor or school teacher, because they trust them. By developing this industry tool, we are able to include that trusted network in the referral process, so we are riding on the back of it.

THE CHAIR: The doctor says to the patient, “Are you comfortable with me giving this out?” Do they ring you, or do you ring them? Does the person have to ring you?

Mr Campbell: No, we ring them.

THE CHAIR: So the doctor asks if the phone number can be given?

Mr Campbell: Yes.

MR SMYTH: If you look at the bottom of the form, you will see that, for the doctor to take it further, the patient has to sign it.

MR SMYTH: Tony, you have also run this with the police and the business community, haven't you?

Mr Campbell: Yes. Through the chamber of commerce, the system now sits with 1,000 businesses across the ACT. Just from the police, we now process something in the order of 800 referrals per year. We now have about half of the police force using the system. That has begun to change the whole culture of policing.

MS MacDONALD: For the chamber of commerce and for businesses, how does it work?

Mr Campbell: We have a partnership agreement with the chamber of commerce. We provide a form that is developed for business. It will look a bit different from that, but it has issues that relate to business. They then make it part of their membership package. They give their members a very well presented package of these forms. They are in pad form. So when an employee says to their employer, “My family is falling apart”, the employer is able to say, “How about we get you some help?”

MS MacDONALD: So it is being treated like an employee assistance program?

Mr Campbell: That is right.

MS MACDONALD: Do you have any data or statistics on what the uptake is by business?

Mr Campbell: Yes, we do. I do not have it here, but we have had a lot of interest from business. Once again, it is value-added to the objectives of the chamber of commerce. Imagine someone presenting to their boss at work. If you have been a boss at work, you will appreciate the fact that many people will come with social issues, but often it will stop there. The boss says, “I’m sorry to hear that. If we can be of assistance, great.” But now, through the system, they are able, with the same process as GPs, to tick and flick.

THE CHAIR: So you engage the service provider yourselves, on behalf of that person?

Mr Campbell: Yes.

THE CHAIR: Does that mean you have to have the full story of that person’s issues?

Mr Campbell: We certainly have to have an outline of what the issues are, and we do that by phone. When the referral comes in, we authenticate it by ringing the person. We will say, “Do you still want to go ahead with this process?” Occasionally, someone will say, “No, I do not want to. I did yesterday, but I do not now.” That is all related to the window of opportunity. That is one of the reasons this system works so well—it is because you are dealing with people’s windows of opportunity. It opens up when they disclose it. You bring in a proactive service where they do not have to dial a phone number.

THE CHAIR: They can, if they want to?

Mr Campbell: Yes. They can, if they want to.

THE CHAIR: So they do not have to use you as a middle person and tell all their personal stuff to you?

Mr Campbell: Absolutely.

THE CHAIR: They have a choice.

Mr Campbell: We find that most do appreciate the fact that someone else is doing the managing for them, someone else is going to have a provider contact them.

THE CHAIR: Do you find, very often, that the service you ring will say, “That sounds like someone we should help, but we cannot, because we do not have enough resources”?

Mr Campbell: Yes, that can sometimes be the case. We will then look around for other providers that could offer a more responsive service. That may be—we have trialled this—to bring in those national telephone support services, that are literally sitting there waiting to deliver service. We are able to enhance the services that are available to people—on the ground.

MS MacDONALD: I note that this is a new concept in Australia. Has any work been done on it overseas?

Mr Campbell: No, not that we know of. Our patent is pending on this. We got it patented because we received advice that a for-profit company would most likely take this concept and turn it into dollars. We thought that if it had that potential, we would rather see funds go back into the community.

MR SMYTH: To finish up, you would like to see the government give you \$160,000 so you can develop it fully?

Mr Campbell: Absolutely. We think this is a solution to the fragmentation that exists out there, where you have many providers of services, all working reasonably autonomously. We are not saying they do not have their own networks. However, when you look for the linkages between the police and GPs, et cetera, back to those providers, they are just not there, unless you happen to have a doctor, know the local community service or know a couple of services. That is about the extent of the linkages. In here, we are able to cover it 100 per cent.

MR SMYTH: When the local police officer is referred to what they think might be a crime scene or breach of the peace, they find it is a social problem?

Mr Campbell: Exactly.

MR SMYTH: Often, they are not fully equipped, or do not know where to go.

Mr Campbell: Yes. Perhaps I could give an example. We are designing a system to fit with people who are unrehearsed in making assessments of people’s needs. That is one of the difficulties that exist with the referral process—people simply do not know how to do it. If we can remove that and provide the system, that will be well and good.

We trialled this at Centrelink. We did not take it to the social work department, we left it with the customer service people. Those are the people who, on a day-to-day basis, process the applications people make. We had 20 minutes with the Centrelink staff. They went away with the forms and, within a few weeks, the referrals started rolling in. In the pilot stage, it was only in Tuggeranong.

One referral came to my attention. There was a young mother who needed some assistance with parenting. In the top right-hand corner, there was an underlined note which read, “Urgent”. One of the workers brought it to me and said, “What do you want to do?” I said, “Okay, you’d better get into your car and go and see this person straightaway.”

The worker rolled up to that young mother’s house, only to find that she was preparing for her suicide, right there and then. To our knowledge, that lady had no previous history of mental health issues. She was a young mother who had simply had enough.

THE CHAIR: Are you counsellors?

Mr Campbell: In our programs, we also provide family support. This system is about systems, it is not about being the direct provider.

THE CHAIR: You are listening to someone’s story. I am wondering if that would be like the other sort of referral—like Parentline, for example.

Mr Campbell: Yes.

THE CHAIR: Do you know that one?

Mr Campbell: Yes.

THE CHAIR: I am wondering whether you need counselling skills to be able to identify what the needs are—someone who knows the right questions to ask, to determine how urgent it is.

Mr Campbell: Yes. I would have to agree with that. In the pilot form, we were thumbing our way through all of that. We have now come to the conclusion that we do need a qualified counsellor to manage the referral process. Our next employment will be on those grounds.

In the bigger picture, we are activating community infrastructure that, historically, has engaged people in their issues. We are riding on the back of that interaction and bringing them into the social safety network. The police are finding enormous efficiencies out of this. GPs find enormous efficiencies because they do not have to run around—they can do it briskly and easily.

There is a win-win situation. The person wins, because they are getting connected to someone who can assist them, and the GP is getting a service which is not costing them anything. The provider does not have to spend their resources in trying to make linkages to the likes of GPs because it is done for them, through the system. Once again, we present this as a very positive innovation and a solution to the systemic issues which surround holistic health.

THE CHAIR: Thank you very much.

The committee adjourned at 1.20 pm.