LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND DISABILITY

(Reference: inquiry into appropriate housing for people living with mental illness)

Members:

MS K MacDONALD (The Chair)
MS M PORTER (The Deputy Chair)
MRS J BURKE

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 30 AUGUST 2006

Secretary to the committee:
Mr D Abbott (Ph: 6205 0129)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents relevant to this inquiry that have been authorised for publication by the committee may be obtained from the committee office of the Legislative Assembly (Ph: 6205 0127).

WITNESSES

The committee met at 2.29 pm.

GALLAGHER, MS KATY, Minister for Health, Minister for Disability and Community Services and Minister for Women

THOMPSON, MR IAN, Executive Director, Policy Division, ACT Health

BROWN, DR PEGGY, Director, Mental Health ACT

URBANC, MS AMANDA, Director, Rehabilitation and Older Persons Mental Health Services

DRUITT, MR STEPHEN, Acting Manager, Mental Health Policy Unit

THE CHAIR: You have all heard the card being read before. I formally thank you for making yourselves available today. Minister, congratulations on the new job. For the record, I ask each of you to state your name and the capacity in which you appear.

Ms Gallagher: My name is Katy Gallagher. I am Minister for Health, Minister for Disability and Community Services and Minister for Women

Mr Thompson: My name is Ian Thompson. I am executive director of the policy division, ACT Health.

Dr Brown: Dr Peggy Brown. I am director of Mental Health ACT.

Ms Urbanc: Amanda Urbanc, director of rehabilitation and older persons mental health services.

Mr Druitt: Stephen Druitt, acting manager of the mental health policy unit.

THE CHAIR: We were just talking privately about privacy issues and how they relate to people exiting the PSU and ward 2N and possibly have an impact on there being a seamless transition from the PSU/2N back into the community. I think that we should revisit that conversation now so that we can have that information on the record for the sake of the inquiry. I will give a bit of a speech on what we were talking about. It may be better to get Mr Thompson to address it.

Mr Thompson: The Health Records (Privacy and Access) Act provides for the capacity for information to be shared between the treating team and, in the circumstances of discharge from an inpatient unit, information can be passed on about people who are receiving care to other care providers. The issue which has been talked about and which Dr Brown can definitely expand on much more than I can is the question of exactly what the treating team is and what information can be passed on to people like a housing case manager who would not in normal circumstances be considered part of a treating team for health services.

THE CHAIR: Dr Brown, do you want to add to that? You made a comment about the optimal plan being for a joined up approach.

Dr Brown: Yes. When someone is being discharged, the ideal is that you have a joined up approach whereby all persons who are going to be participating in their support and follow-up care are participating in the development of a plan and they have relevant

information to support whatever role they are taking in the community. In a circumstance where someone is leaving an inpatient facility and has a community agency providing support around their housing needs, if the consumer himself or herself does not give consent there are some limitations there on what sort of information can be provided without consent, and that could potentially undermine a successful transition to community-based living.

THE CHAIR: Mrs Burke talked about a constituent getting in contact with her and being in conflict with her daughter, who is in public housing and has a mental illness. The mother, if I am summarising it correctly, was concerned about other people freeloading off her daughter. I think you made a good point there. Do you want to repeat that?

Dr Brown: I guess the issue arises of differences of perception, particularly between parents and children, and sometimes that actually leads the children to deny consent to involve parents or other people because it has been a source of conflict in the past and they want to try to avoid that in the future. But then, of course, parents who continue to play a caring role no matter what feel like they are being shut out, that they have not got adequate information. If that consumer is deemed to be capable of making an informed judgment and says to us that they do not wish their information to be discussed with a specified person, there is not a lot we can do about it. What we seek to do in those circumstances is to work with the consumer and, I guess, come to understand the source of conflict and the reason behind their not wanting information shared with someone who would seem to be part of their support network. Often over time in working with someone you can facilitate some change, but sometimes you cannot.

THE CHAIR: I suppose there is that as well. As you said, the parents' perception of the way their children should lead their lives is not necessarily the way that the children want to lead their lives and, if they have reached out, they are allowed to get on with doing that no matter how much they may not be living to the ideal. Minister, do you want to make a statement about anything?

Ms Gallagher: Only briefly. I think the inquiry by the committee is timely for us as Mental Health ACT is doing a lot of work on setting strategic directions through the mental health services plan and through other documents as well, including the legislative review of the Mental Health (Treatment and Care) Act which is under way. I think it is timely. We will be interested in the findings of the committee and how we can respond to those through those frameworks, but also in our government response. I note that the committee has undertaken extensive community consultation with a range of groups. That work will assist us in addressing some of the areas of concern.

I have met with a number of organisations since taking on the portfolio. I have taken the time to visit the PSU and 2N as well since taking on the job. I will continue to get out and about as much as I can to see what is happening round the place. Also, it is a great opportunity to hear directly from people who are providing the service and receiving services about where they think things are going and what could be improved. I get a sense that Mental Health ACT is improving its services dramatically. That is the feedback I am getting.

It is an area where there has been a lot of criticism in the past, which has had a lot to do

with the nature of the work that Mental Health ACT engages in, but there is significant optimism, particularly across the community sector, about the reforms that are under way and some of the work that is being done. I think we need to seize on that optimism. A lot of that happened under the leadership of Dr Brown and her team. I think that it is an area where governments will have to continue to respond to the escalating need in the community. I would not say that there is a crisis or anything like that, but there certainly is evidence to say that the needs of the community in relation to demands for increased mental health services are there.

This budget has set aside $8 million to meet some of that increase in demand with a range of initiatives. One that you will be interested in is essentially a step up, step down facility for young people. It is going to be targeted at young people in the early stages of their illness, either the first episode or very early on, to see whether that kind of response supports them better than going into a more acute type of accommodation than perhaps they need at that time. The mental health budget now is just over seven per cent of the health budget, so it has had significant increases since 2001, when it was around $25 million. It is now about $52 million. So we have seen big increases, but we could probably sit here and have a long discussion about whether they have been meeting demand. I think that in future budgets we will again need to see increases in the resources provided to this area.

We are also doing some work around a new PSU. A lot of work has already been done. There was disagreement going into the last budget round on, essentially, the size of that, what size it should be. That work will be finalised this year as well. I am getting strong representations about what you could call a step up, step down facility in the community as a bridge between people's current accommodation and the PSU or 2N at the other end, something in the middle. I do not know that you will get too much disagreement on some models for that or the need for that. I guess the challenge for government in a small jurisdiction is how to provide all of those accommodation types when there are no economies of scale, essentially. So we need to build a PSU big enough for it to deal with the population we see, which would be still a relatively small facility.

There is disagreement over whether it should be a 50-bed or 30-bed facility. From the government's point of view, 50 beds probably would be better for us in terms of providing some extra accommodation and the cost per bed. That probably would better meet the needs of our community, but the community view is that that is too large for the type of facility it would like to see. It would like to see a smaller one, about 30 beds, and then more services out in the community. The challenge for me, essentially, is how I can deliver what is wanted across the groups, in line with what government needs to provide at that acute end. How do I provide something we can build that will last for the next 20 years?

Let's face it, no future government would not want to be having to build another facility because this facility was not built big enough for the population in 30 years. In terms of the provision of accommodation in the next year or so, the decisions government has to take, I see that as our biggest challenge. How do we meet the competing interests but provide capacity within the system to grow as Canberra grows and the needs of our population grow? Perhaps I can just leave it there.

MRS BURKE: You were talking about the demand, whether it be escalating or

whatever. People are being diagnosed in a way they never were before. I know that this inquiry is about housing, but early intervention in mental health cases is relevant. I know that there are some programs on that. I think the government has done some on that. Is that going to be more of a focus? Talking about facilities, we may need only 30 beds if we can get them at the early intervention end.

Ms Gallagher: The COAG agreements between governments have focused on early intervention, prevention, education and understanding, and the commonwealth is looking at a range of initiatives, including the provision of support to young people in schools who are exhibiting signs of needing some extra support. A component of this year's budget initiative will go to that. A significant part of the $8 million—$3 million of the $8 million—will go to initiatives around that. Perhaps Mr Thompson can talk a bit more about the thinking on some of that. All governments agreed at COAG to focus on this area. The challenge for the ACT, and it is a challenge in every area of government, is how to shift it around when the needs are there in the acute area. Within your resources, how do you provide everything you need to provide there and, at the same time, try to build in the building blocks to shift it round and remove some of the pressure from the acute end because you have done this work at the beginning? There is no disagreement about that, but the challenge for us is how to do that within our relatively small budget. Do you want to talk about early intervention, Mr Thompson?

Mr Thompson: Yes, if the committee is interested. I will hand over to Mr Druitt, who is the author of the ACT mental health promotion, prevention and early intervention initiative, if he wants to add more detail. As the minister said, we are talking about $3 million over four years. We are in the process of commissioning the various elements of that work. We have already provided funding to Mental Illness Education ACT to expand their program. We are in the process of going out to tender possibly on workplace mental health promotion activity, building on some other work that is already under way elsewhere in Australia. Is there anything that you want to add, Mr Druitt?

Mr Druitt: A fair bit of the money that is going into mental health promotion and prevention at the moment is more at the clinical end. For instance, about one-third of it is going into expanding perinatal health services. I think that that increased capacity will provide perinatal services with the opportunity to intervene earlier and reduce the impact of mental illness such as postnatal depression earlier. For me, the flagship model of the PPEI program is the workplace stuff, which is really going into workplaces and aiming to give workplaces a whole framework for mentally healthy workplaces. It is not just looking at helping people who are falling over in the workplace with things like depression which are a huge cost at the moment, but having a framework that ensures that the workplace supports better mental health and wellbeing for everybody. That is a real prevention program. Another thing the money is going into is better physical health for people with serious mental illness. We know that those two things interact and so, in that sense, that is quite a preventive program. There are a number of initiatives acting together to start the implementation of that plan.

MRS BURKE: Does any of the work that you are doing on that discuss the housing or accommodation of people? Is there anything in what we are doing here that is going to feed directly into anything that you are doing? Having a roof over your head is a basic human right of life, is it not? I am interested to know whether there is anything that you are specifically doing there.

Mr Druitt: Part of the framework for the mental health services plan is looking at all the things that contribute to mental health problems, and accommodation is one of those. It is one of the things that will be looked at under the metal health services plan. The same thing with prevention as well. It really looks at the determinants of people's mental health. It looks at things like participation in the work force, accommodation and social connectiveness.

Dr Brown: I would like to add to that in terms of the initiatives in this year's budget. One that Mr Druitt has not mentioned to date is an enhancement of the COPME program, the children of parents with mental illness program. That is very much about having the capacity to work across whole of government and link agencies to support parents with a mental illness and their children. So it is not just focused on the children, but also the parents themselves. Links with housing are very much a part of that. Another initiative is actually providing rehabilitation officers to specifically support people in the post-discharge phase. There will be two new staff employed to undertake that work. Again, linkages with housing are very much a key part of that initiative.

Ms Gallagher: For the committee's information—I do not know whether you have received one already—I have here a list of the organisation that ACT Health funds.

THE CHAIR: It would be very useful to have that.

Ms Gallagher: You can see the range and number of services.

THE CHAIR: I think we have had something before, but I could be imagining that. I have a couple of questions. Quite a bit of this goes beyond the focus of the current inquiry we are doing because we are touching on a number of areas of concern. An ongoing issue is the agreement with New South Wales on funding for patients who theoretically come across the border into the ACT, but there is movement backwards and forwards between New South Wales and the ACT.

Ms Gallagher: Is it both ways? I thought it was just a one way stream. No, they do go home.

THE CHAIR: Yes, sometimes they go back across the border to New South Wales. Good luck with the negotiations with New South Wales. My opinion is that they will never end.

Ms Gallagher: I think it is for arbitration now.

THE CHAIR: Good luck with that. From a slightly different perspective, does the fact that we do have people coming here from New South Wales present a challenge in terms of planning, because you would not necessarily know who could be coming across the border? They would not necessarily have to be coming in from New South Wales. Sometimes they might fly in from Victoria, although I do not know why.

Dr Brown: Sorry, do you mean in terms of clinical planning or service planning generally?

THE CHAIR: Yes and yes.

Dr Brown: To start with service planning, yes, it is a challenge. We do, however, have an idea of roughly the percentage of people that live outside the ACT's geographical boundaries that access our services and it does not seem to change a huge amount from year to year, so that gives us some basis for planning. At the clinical level, yes, it can present some challenges. There are some obvious challenges. If, for example, a person has been subject to involuntary detention and treatment in the ACT, come the point of discharge you may wish to continue with that overarching legislative framework, but that could present some challenges because there are only certain ways it can apply if someone is going back to New South Wales. Generally speaking, it is not a major challenge to organise ongoing mental health care, be it community-based staff or medical follow-up, but liaising with other agencies, such as housing, in New South Wales can present some challenges sometimes. On the whole, it is probably fair to say that in the past we have worked quite well with New South Wales regional housing agencies. In fact, they would probably tell you that we have worked too well.

THE CHAIR: What do they mean by that?

Dr Brown: They have been known to say that we send too many people back across the border. In fact, they say that we send across the border some who never came from across the border. I do not believe that to be the case. It can present some challenges at times in terms of communication. We do not have the same links with New South Wales housing, for example, as we have with ACT Housing. In terms of those infrastructure arrangements that support ongoing community-based care, it is just a bit more challenging. It is not impossible, but it is more challenging.

MRS BURKE: I would say it is an opportunity, Dr Brown. We often use the word "challenge". If we do not have a challenge it does not then become an opportunity for us to find a solution. But not to make too light of it, it can be very frustrating, I am sure. It is not an easy job.

THE CHAIR: I think that is a good point, though. I was reading through some notes which the secretary made up for me and I jotted down a little comment: are we as a society tending to look at the mental illness problem rather than look at the person and say, "Here is a person—oh yes, they also have a mental illness"? I think it is important that we as a committee keep that in mind when we are deliberating on the report.

We have heard some very sad stories from a number of witnesses—people who have relatives with a mental illness. It is not an easy thing to live with. There is not necessarily a crisis going on there. I do not want it to be blown out of proportion. I would like to see it as continuing to treat people with mental illness as people. Yes, they have a challenge in the fact that there is a mental illness but there are others of us who do not have mental illness issues and we have other challenges to face. We will not go there. It was just a thought.

MRS BURKE: I was just thinking about trying to get a bit of focus—not that we have gone too far away from it—on what we are about. I am not sure whether you have in front of you, chair, the terms of reference of our committee.

THE CHAIR: Yes, I do.

MRS BURKE: Maybe it would be helpful for the committee, with your indulgence, chair, to get perhaps some thoughts or feedback on where you see mental health dove-tailing into some of those references there.

Ms Gallagher: Mental Health ACT works very closely with Housing ACT. In fact, recently I think there has been a MOU renegotiated or updated. I think there are a number of measures in place, including working with Housing ACT on priority allocation. I think an area of focus will also be on sustaining tenancies and how you manage that. I guess housing as a business can sustain sometimes quite difficult tenancies but that are vital for the people who are living there.

We can go into more detail if you want; I am happy for officers to do that. I do not have all the detail but that is certainly the first and second terms of reference. I think our list of services, which we have just tabled, will give you a bit of an idea about opportunities for non-government stakeholders in the provision of various models of housing that are out there already. That list was prepared for me when I came into the job because I needed to get a picture of where everyone was coming from and what they did.

In relation to the fourth term of reference, I have spoken briefly about it. As I said, I will be working with Dr Brown and officers from health about finalising something to take forward to the budget in relation to a new psychiatric unit. I have not finalised in my head what that might look like at this stage.

MRS BURKE: That will be dependent upon what you feel may be able to be done with the non-government organisations or—

Ms Gallagher: No, this is separate from that. I think everyone knows that the current psychiatric unit at the Canberra Hospital is not an adequate facility. It is relatively old; I think it was built in the same year as Quamby was built—in 1991, the year of bad architecture and bad building in Canberra. Both buildings are terrible. You would hope that they would have had a longer life expectancy than they have had.

There has been significant work done. I went on a tour of the PSU with Dr Brown, who showed me some of the refurbishment. Quite major redevelopment in one area has been done to try to make it more acceptable but I think there is agreement that it is not. The government has made it clear on a number of occasions that there needs to be a new one. The challenge for me is to secure the funding for that through the capital works program.

Also, importantly, as I touched on, there is agreement if we all agree on a 30-bed facility. If we want anything bigger, that is where there starts to be disagreement. I know from a government point of view, we have different issues that we need to look at and that the community groups who are lobbying for a smaller facility need to look at. Part of that challenge is how we build a building not just for 2006 but that will be able to provide the support that is needed in 2026 or 2036.

There just needs to be a bit more discussion—primarily with me, as the person who is going to take it through the budget—about the finalisation of that model and if there is opportunity for linking into that new facility some sort of transitional step-down, step-up

facility. I have not taken advice on that but I will do so before the budget.

That covers the government's thinking around some of those accommodation models. The other area, of course will be the forensic side, with the new prison coming on line. It will be on line, I am advised, in early 2008. There is also an issue there which we have not addressed suitably at the moment.

THE CHAIR: There are a couple of things I wanted to say. They occurred to me while you were talking, minister. First, you were talking about the MOU with Housing ACT and you made the comment about difficult clients for Mental Health ACT. I cannot go into too much detail because it was a confidential hearing that this came up in, but one of the people who appeared before us was in a Housing ACT property and she manages her illness fairly well. However, her illness is impacted upon, I believe from the evidence that she gave us on that day, by the housing situation that she is in. It is not ideal and she has been trying to move to more appropriate housing for some time now. She is not an unreasonable person.

Obviously, the people that you have in common with Housing ACT may often have more challenging behaviour than the people who are only Housing ACT clients. But I do not think it needs to be said that that is necessarily the case, because it is not always necessarily the case; it is sometimes others who are causing problems instead.

The other point I wanted to talk about was forensic mental health. We have talked about this with Dr Brown before. I think we are all volunteering to go to Trieste to look at the trial that they have in place. During one of our hearings Sebastian Rosenberg was talking about the model that they use in Italy, specifically in Trieste. He has only looked at it from afar; he has not been there himself. He was saying that, apparently, with the forensic mental health there was a staggering number—over 100 to 150 and it went down to fewer than a dozen people, less than a handful of people, within a forensic mental facility.

It might have been Dr Brown who commented that there have been various reports on the Trieste model. It was just a thought that I wanted to put on the record. I am not saying that we should not build the mental health facility, because I think we do need it. If we can find other ways of dealing with people who are in these facilities, we would all love to be faced with that situation.

MRS BURKE: The trick is to not get them there in the first place. This is always back to early intervention and the impact it may have on your facility, minister, whether it be a 30 or 50-bed facility. The projections of pumping your money at this end—

Ms Gallagher: If the committee wanted to recommend that we go over and have a look at that model, the government would be forced to respond to that.

THE CHAIR: Only if we all get to go!

Ms Gallagher: You would probably find a very quick government response to that. Seriously, on the forensic side, it is not something that I have been briefed on fully, only because I have not requested it yet. As we are progressing, some of these things are the impact of the prison and the impact of having a number of potentially new users of our

services and how we meet that need and the best model for meeting that need.

I think there is agreement that there will have to be some type of forensic mental health facility. How we get it going and when it gets going are still to be determined. Certainly, going towards the next budget round, which will start in the next couple of months, we need to go forward with a fairly good idea around our needs and our requests in the provision of appropriate accommodation and the range, the various types and the numbers that we are going to need.

THE CHAIR: Certainly, like the general prison population, I am sure that it is suitable for people who are in the forensic facility as well to have their wider support network, whatever that might be, close to them as well.

Ms Gallagher: Yes.

THE CHAIR: Then we go into the discussion about the general prison population and how many of them should be clients of Mental Health ACT as well. But that is a whole other issue. Have I missed anything?

MRS BURKE: No. I do not know how much longer we are going to continue on with this and whether we need to meet again. I need to go away and think about today. We do need to get disability talking to housing talking to mental health and all the cross-border issues. They may be minor things but it is really the age thing that concerns me, and there is some of the privacy stuff. We have pretty much covered the good ground today.

Ms Gallagher: We are more than happy to provide any further information that the committee wants, on request.

MRS BURKE: Yes, post today.

Ms Gallagher: As you are finalising your report there may be some things that come up that we will be able to assist you with.

MRS BURKE: Thanks, minister. In terms of your time lines for what you are doing, how far down the path are you with that, or is it in its infancy or—

Ms Gallagher: Which, the services plan or—

MRS BURKE: The mental health plan, yes.

Ms Gallagher: Consultations around that have just started. There is a lot of excitement around this—more excitement than you normally find in a strategic plan document; it has me quite intrigued—particularly from the community stakeholders. It will certainly be a fairly comprehensive consultation strategy which will go for the rest of this year.

MRS BURKE: It will be good in terms of time lines that we get ours finished and we can feed into yours—

Ms Gallagher: It would be fantastic for this report to be finished in time for it to feed into that, yes.

MRS BURKE: As I said—I cannot say it too many more times—housing is the single biggest issue. Of course, we are talking about the forensic facility too and post forensic incarceration. So there are all those issues as well. But that is probably a debate for another day. But in terms of policy we need to keep them in mind too.

THE CHAIR: I am sorry, I was having a conversation with the committee secretary. Did you mention a date when you would like us to have the report in by?

Ms Gallagher: No. I just said that consultation around the mental health services plan has only really just started. I was just commenting that there is a lot of interest in this document and that I would imagine that that would go for the rest of this year. Consultations are proceeding on that framework. It is not that I am pressuring the committee to finish its work by any means, but if that work were finished in time to feed into that it would be good—and also for the next budget round, which, as I said, is going to start towards the end of this year, particularly if there is a trip to Italy in there! I think I am the only member who has not been overseas yet. I am the least junketed person here—the no-junket person.

MRS BURKE: Do you mean we go on junkets?

THE CHAIR: As the secretary says, perhaps you could go to Nigeria.

MRS BURKE: You could do an exchange with Ms MacDonald, minister.

Ms Gallagher: Thank you but no. I have not had my shots.

THE CHAIR: I do not think it is unrealistic. Mr Abbott has just come in as secretary. I do not know how long he will be on the job, but somebody will help draft the report. The secretary speaks for the chair, gets some ideas and then goes away and does all the real work.

Ms Gallagher: I also said that, if there were things that arose out of today or the secretary is not up to date on all the evidence and information, if there was further evidence we could provide, we would be more than happy to provide that in any way the committee sought.

THE CHAIR: We appreciate that. My personal desire is to see that we have a report to the Assembly by the end of the year. I would certainly like to see it being fed into the plan. It would be beneficial to all, I believe. We were talking about this before but, given that you have given us this long list of organisations that you fund, it seems to support the comment made by one witness that there are too many agencies in this town and too many historical and personal agendas.

Ms Gallagher: Was that me that said that?

THE CHAIR: No.

Ms Gallagher: Not speaking only about mental health but speaking generally as someone who works across the community sector in my other portfolios, and as minister

for community services, there are too many organisations that receive very small amounts of funding and find it very difficult to deliver anything substantial for those amounts of money and that do not necessarily have the seed funding. They are using some of these small amounts of money to keep their organisations going. That reduces outputs to the community. I am not speaking about mental health in particular here. It is historic. Things grow on top of each other.

It is also meeting the different needs of the community, which is quite legitimate. There are a range of different philosophies on what people want from particular services. In the disability area, there are families that want day care for their adult children with a disability. There are those that want a much more inclusive community-based one. The last thing they would want to see is their family member in a day care-type situation. There are a range of reasons why this has come about.

When you look at it across the board, it could compromise the level of service that is provided. There are such relatively small amounts of money given to a number of organisations. It is a legitimate concern, particularly for government when we are looking at efficiencies, outputs and all that sort of language. I am not sure how you solve it.

I know there is a program under one of my portfolios that has around $2 million. Mrs Burke and I have spoken about it a number of times. It is around $2 million and it goes to about 35 organisations. What we ask of them, what we give them and what we want to see out of that $2 million currently delivered in that way—how do you stop that, change that or reform that?—is a bigger challenge. To reform it will mean smaller organisations, particularly, will lose grants. That is always a very difficult thing to manage.

THE CHAIR: Nobody wants to lose their funding.

Ms Gallagher: All will have legitimate, strong arguments about why they should be sustained. That is the challenge now that we are at a point where we see that across the board, not necessarily only in mental health.

MRS BURKE: Minister Hargreaves and I talked about this with Kasey Chambers at the YWCA. There were similar things at Holder. You have a centralised administrative body. Everybody else can keep their anonymity. With the money that is now being creamed off to dissipate the effort and results that you are talking about, you would have a centrally located administration, like independent serviced offices in the business world. It strikes me, when I look through these, that they cannot go on. I am sure you have done the same. All are valid. Is that something you are considering, a similar model to Mr Hargreaves's?

Ms Gallagher: That has been put by some organisations—dare I say it—a shared services centre where the governance and administration of an organisation can be pulled. That frees up those organisations, which have only one or two members, to do some more of the work. That is certainly an aim that has been put to me, as is the more radical approach of consolidating all the services under regional community services. It depends on where you sit on the argument. It is an impossible one to resolve, but there has to be some reform. If people want the dollar spent in the best way that it can be

spent, there has to be some reform in this area.

THE CHAIR: We might have exhausted our questions at this point. Thank you very much for coming.

MRS BURKE: Before you go, Ms Urbanc, was there anything you wanted to say on older persons? Is that your area of expertise?

Ms Urbanc: It is one of my areas, yes—that and rehabilitation.

MRS BURKE: Was there anything you wanted to say for the record?

Ms Urbanc: Obviously, the building works for the in-patient psychogeriatric unit are well under way at the Calvary campus. That will provide 20 beds for mental health elderly people with a psychiatric disorder but also with psychological symptoms associated with dementia.

THE CHAIR: There was much concern about the loss of the rose garden.

Ms Urbanc: The concern is not as grave as it was. There is going to be much more of a courtyard for the 2N area than was first thought.

THE CHAIR: It was not expressed by me.

Ms Urbanc: No. It was very much a concern expressed by staff and a consumer group of 2N ward, but they have accrued some more space as a result of building works on the site. It is not going to impinge. They have lost the tennis court, obviously. I am not sure how extensively the court was used anyway.

I guess one of the issues that the in-patient unit will give rise to—and it is not that this is not a current issue—is the exit points for people requiring placement. We have flagged that with the CEO of Calvary in terms of the complex that is being built across the road. That is going to be a challenge for the ACT, whether they are mental health associated issues or serious general health issues. We are working very collaboratively with Calvary and the aged care rehab stream. We are looking to set a model of very high quality care for the consumers.

THE CHAIR: Thank you very much for your attendance.

The committee adjourned at 3.20 pm.