REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO SERVICES PROVIDED OR FUNDED BY AGEING, DISABILITY AND HOME CARE

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At Sydney on Monday 27 September 2010

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The Committee met at 10.20 a.m.

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PRESENT

The Hon. I. W. West (Chair)

The Hon. G. J. Donnelly
The Hon. M. A. Ficarra
Dr J. Kaye
The Hon. T. J. Khan
The Hon. H. M. Westwood

CHAIR: I welcome you to the fourth public hearing of the Standing Committee on Social Issues inquiry into services provided or funded by Ageing, Disability and Home Care. Today we will be hearing from Ageing, Disability and Home Care, the Aged Care Rights Service, the Department of Health, the Aboriginal Disability Network, the Official Community Visitors Scheme and the Deaf Society. The Committee has previously resolved to authorise the media to broadcast sound and video excerpts of its public proceedings. In accordance with the Legislative Council guidelines for the broadcast of proceedings only members of the Committee and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of any filming or photographs. Witnesses, members and their staff are advised that any message should be delivered through the attendants or the Committee clerks. I advise also that under the standing orders of the Legislative Council any documents presented to the Committee that have not yet been tabled in Parliament may not, except with the permission of the Committee, be disclosed or published by any member of such Committee or by any other person.

JAMES CAMERON MOORE, Chief Executive, Department of Ageing, Disability and Home Care, and

LAUREN MURRAY, Deputy Director General, on former oath:

CHAIR: Would you like to make any opening comments?

Mr MOORE: Only to say we are pleased to be back to answer further questions.

The Hon. GREG DONNELLY: I will selectively go through some questions with you. The first deals with home modification and maintenance. At the last hearing we heard evidence from the New South Wales Home Modification and Maintenance Services State Council, who stated:

> By law, we are meant to have a builder's licence to undertake the type of work we do when the value of the work exceeds $1,000. Unfortunately, of the 106-odd home modification services out there, there are approximately 40-odd services that continue to remain unlicensed. Basically they do not have the technical expertise to undertake the work that they are funded to do. This has been brought up with ADHC over many years and they continue to fund these projects.

Is it correct that Ageing, Disability and Home Care [ADHC] knowingly funds unlicensed builders and, if so, how does ADHC ensure the quality of work completed by such builders?

Ms MURRAY: I thank you for the question. I want to tell you a little bit about the issues of quality in the home modifications area just to start with and then I will go to the specific question of unlicensed builders. Under the Home and Community Care Agreement there are a series of guidelines for all services, including the home modifications area. Under that, they are required to comply with all legislation, State legislation and guidelines. That includes the Home Building Act.

Under that, work is required to be carried out by licensed builders. My understanding is that there are 98 providers not 100 and something or other, and they all provide their annual return of compliance and 96 of the 98 who have provided that have all indicated that they comply 100 per cent with the requirements, including legislative requirements. It is also true that a number of those providers do not necessarily have licensed builders employed with them, which may be what the home modifications person you were talking about before was raising.

The Hon. GREG DONNELLY: The State councillor?

Ms MURRAY: The State council of course, but almost all of those providers subcontract their work and it is a requirement that they use licensed builders to do that. In addition, we fund at level 2 and level 3 the degree of work and the size and scale of the work; we fund at both regional and State levels quality assurance technical officers who are required to check on the quality and provide advice and assistance around quality assurance in respect to the works. In addition to that, all local governments require certifications of works—qualified people, the same as for any of modifications work.

I understand what they are saying, in the sense that each individual's home modification service provider does not necessarily have a licensed builder employed with them but there are a number of mechanisms in place to ensure that is covered off. In addition to that, we are undergoing an evaluation of the home

modification program at the moment, which is expected to be finished in early 2011 with Elton Consulting and we are going to make sure that this issue of quality assurance is addressed in that process.

The Hon. GREG DONNELLY: When you explained in answer to my question that there was a process that, in some cases, involves subcontracting out of work to persons who were qualified builders, is it always the case that they are always qualified builders or builders with a ticket who actually do the work?

Ms MURRAY: It is always the case that it is required that the people undergoing the work are licensed builders.

The Hon. GREG DONNELLY: Is there a procedure in place which checks to ensure that that is the case?

Ms MURRAY: The service providers themselves are required to indicate that they are complying with relevant legislation and guidelines, which does indicate that there is a requirement that builders are to be licensed. I get that the State council is raising concerns around this issue and we will be looking at it as part of the evaluation.

The Hon. GREG DONNELLY: The Home Modification and Maintenance Services State Council stated that they spend time and money fixing work completed by other service providers. Given the long waiting lists and reported lack of funding in this sector, what steps are being taken to improve the standard of building work undertaken through this program?

Ms MURRAY: Part of their responsibility is undergoing that quality assurance role and providing assistance to providers, given the technical nature of some of the particular works they are doing and, as I said before, that evaluation will be looking at further enhancements to quality assurance.

The Hon. GREG DONNELLY: I will turn now to early intervention. The Committee has heard evidence that early intervention services are intended to prevent clients from needing longer term support. However, it has been stated that some people wait up to two years to receive early intervention services. Do you agree that there could be an adverse impact on an already stretched disability service system from people who have missed out on early intervention services requiring longer term support?

Mr MOORE: The short answer to that is yes. We need to put that in the context that we endeavour to use our resources in the most targeted way possible. We are endeavouring to prioritise people who we think can use the resources we have to the best effect. We endeavour to put alternative strategies in place for other people, which may not be near enough, so while I am saying yes, we are aware of the consequences that our objective is within the funding envelope that we have to maximise the amount of benefit that we can get out of the resources. The early intervention prevention strategies that we have are not just simply about dealing with very young children because the disability space is one of those where intervention strategies to prevent escalating needs can occur across the whole of a person's life span, so we endeavour to target the resources as best as possible. As I said at the last hearing here: Can we do a lot more? Yes, but we need more resources to be able to do a lot more. You have to take the balance between what extra resources would enable you to do that and what you can manage to get out of the resource envelope you have available to you.

The disability area has another characteristic that makes this a very difficult balancing act, which is where you have not been able to do enough early, then people's needs will escalate and then you will respond, in a lot of these case, where needs have escalated quite severely and those are very high-cost responses which then create a very unacceptable feedback route where the resources are now being diverted to do a lot for one person when they could have done a little bit for a lot of people and prevented the need maybe five to 10 years down the track.

It does actually help you better manage your resources but you have to have enough resources to do those interventions while still responding to the crisis. If you look through the material that has been presented to these hearings both in submissions and the transcripts, there remains a continuing strong demand for accommodation, which by definition is a high-cost service. We have to deal with that at the same time as trying to deal with the early intervention. We know we do not do enough, but I think we do the best we can and I hope that is largely seen to be the case.

The Hon. GREG DONNELLY: What is ADHC doing to reduce waiting periods in the early intervention program and ensure that all people who require this service have access to it in a timely manner? Just give us a snapshot.

Mr MOORE: There are two simple things: Under the Stronger Together program there is a significant additional resource that is available for early intervention/prevention types of programs rather than supported accommodation, so we have had a significant injection of funds through the Government that we have been using to get a greater quantity of early intervention/prevention resources in place. Secondly, as I was alluding to earlier, we are trying various strategies to stretch those dollars further. For example, we try sometimes with families to have group sessions. We try to get information sessions working, which are a lower cost, so you might not be able to do all the things that would be sensible and would help them but you can do some things. We are trying to stretch the dollars further, but the key one, which Stronger Together was a significant contributor to, was the increase in the capacity to deliver services by increasing funding. Dollars are what you need to be able to do this.

The Hon. HELEN WESTWOOD: The Government provided the department with a significant increase in funding in 2006—$1.3 billion for Stronger Together. How do you report on the use of that funding under Stronger Together? I am particularly interested to know how we can be sure that that funding was used for the programs for which it was intended.

Mr MOORE: The Stronger Together announcement included a commitment to a once a year report. That is embedded in our annual report and provides details of our achievements against the targets. Stronger Together came with what was seen as a very positive thing by a wide range of people in the sector, which is that if you turn to the last two pages of the booklet you will see mapped out by item and by year how much was going to be spent on respite for children and respite for adults, for example, and how many places that would involve. We provide a report each year that shows our achievements against that and we are pleased to be able to show that we have been able, as you redesign programs and think about how you are achieving things, to get more places for the dollars than was originally set out. That is the fundamental guarantee we are able to provide to people. They can see through an annual report process that we have done what we said we were going to do with the dollars that are available to us.

The Hon. HELEN WESTWOOD: We are going into the second five years of Stronger Together, but now that you are part of the larger Department of Human Services are you confident as CEO that the funding allocated for Stronger Together will remain, and can we be sure and confident that it will provide services for people with disabilities in New South Wales?

Mr MOORE: It is very hard for me to give such a guarantee personally. In the situation going forward with respect to the Department of Human Services—

The Hon. TREVOR KHAN: As a term, "going forward" does not fill me full of confidence.

The Hon. GREG DONNELLY: The Hon. Trevor Khan prefers "going forward together"!

Mr MOORE: Looking at the next five years of Stronger Together and how the funding would be included in the Department of Human Services, it would be a matter of government direction as to how those resources were applied across that five-year period. It would be the responsibility of someone such as me as the head of the Ageing, Disability and Home Care agency to do all that it takes to ensure that funding pressures across Human Services or the whole of Government do not undermine the availability of resources. Circumstances change and government priorities change. I cannot speak on behalf of the Government as to just what it will or will not do with any commitment that has been made.

There is a very serious concern that has been continually expressed by the disability sector in particular that the previous Minister and the current Minister have been very strong on trying to say this will not happen, but there is history in the disability sector that when previously partially embedded with a broader Family and Community Services portfolio, higher priority and higher profile issues, particularly in the child protection area, were seen, sometimes rightly sometimes wrongly, to have been the reason resources were not being made available to the disability sector. That is a very entrenched and firm view. Barely a week goes by where I would not be asked questions like those you have just asked me. The answer that someone like me and someone in the sector can give is that you have to remain ever vigilant. The annual reporting process is about as good as it can get from a bureaucrat like me.

The Hon. HELEN WESTWOOD: Is there some way we could ensure it is not diverted? Is there something that this Committee could examine further or recommend?

Mr MOORE: There would be nothing to stop a Committee such as this asking questions on an annual basis along the lines of, "Prove it to us; show us what has happened in terms of the resources you have had and how they have been applied." I am a bit unfamiliar as to what I could recommend in this space but for us the transparency process has been a virtue of Stronger Together to date and would be an important part of continuing with it. The Stronger Together process is a commitment to a broad base of carers and people with a disability—asking hundreds of thousands of people to do their bit and the Government will do its bit. By virtue of Stronger Together we are saying, "This is the bit we can do and we won't let you down. We will deliver." Since you are asking families and people with disability to commit the whole of their lives to a level of support, transparency is a very important part of it. Scrutiny of what we do is an important part of transparency.

Dr JOHN KAYE: I want to ask about the issue of out-of-office-hours home care appointments being cancelled or delayed. We heard evidence that there was no way of contacting a client when an appointment was cancelled because of illness or traffic delays, except at the Randwick-Botany branch where there appeared to be a system in place. Are you aware of this service gap and the consequences on people who are in home care and who are not notified that their carer is not going to turn up?

Mr MOORE: I am aware of instances of that. I have read through the transcript in relation to the people talking about the Randwick-Botany branch, about how it was managing its business. If I can step back for a moment. I think what is very evident from the material you have received is what a great opportunity comes from a process like this for people such as me to have another avenue to hear from people we are trying to help, and to see where matters of concern are being raised. People are sometimes uncomfortable in raising those concerns directly with their care providers or those who control their care providers. For me, I am attempting to go through the totality of what has come to this Committee and find out the nature of the issues, so they can be addressed.

I thought there was something interesting that they were describing about the Botany example. But I put alongside that that the Home Care Service of New South Wales does make a virtue of being the HACC provider who steps into the space where no-one else will go. That often includes late-night, out-of-hours servicing. I also think that, as an organisation that has 4,500 staff and is a $200 million a year operation, not everything will go perfectly. But the Home Care Service does an independently conducted biennial consumer customer satisfaction survey. The results for the last one are just in, and it attracts a 95 per cent satisfaction rate. So, yes, I know there are some things that have not gone well, but there has now been a long history of Home Care being in the mid to upper levels in terms of client satisfaction. That is done by an independent. It is not like a care worker asking, "Do you like what I do?"; it is an independent person coming in to check that, with a guarantee of anonymity.

Dr JOHN KAYE: Did that survey seek to analyse the issue of broken appointments?

Mr MOORE: It would not analyse an issue like that, but it would give us the vehicle to understand where there were dissatisfactions and the nature of the dissatisfactions.

Dr JOHN KAYE: And that survey did not throw up the issue of appointments being broken?

Mr MOORE: It would not have been asking questions that go to that. It would be looking at, "Are you dissatisfied, and if so why?"

Dr JOHN KAYE: You have indicated that you are aware of this gap in service. Are you intending to do anything about it?

Mr MOORE: We have already tried. Various actions have been put in place from time to time to try to get a better responsiveness to clients where services need to be cancelled because we cannot find a replacement for a worker. At the same time, we are going the other way in trying to also get a pool of relief workers, so that it is much easier, should one worker not be available, to reschedule appointments so that their work can be done. In the past there have been some very inefficient practices around how you reschedule. We are just now rolling out a new approach to that, which also means that there should then be fewer cancelled appointments.

Dr JOHN KAYE: On a similar issue, one of the matters that was raised with this inquiry was a lack of flexibility in Home Care services. For example, we were told that people were being told they had to go to bed before sundown and they had to get up after sunrise. We were also told of people being chastised by ADAHC staff when they requested a change in service provision. For example, if they said they wanted to have their daily shower moved from the evening to the morning, they were basically told off. Are you aware of this lack of flexibility?

Mr MOORE: I am aware of complaints about flexibility. I do not think the service is as inflexible across the board as those examples make out. At the same time, I would say that the behaviour as described by that person in terms of the chastisement is utterly unacceptable. It is not what we would tolerate as behaviour, and it is, from what I can see, not the standard behaviour of Home Care workers.

Dr JOHN KAYE: Do you have mechanisms in place to stop that kind of chastising happening?

Mr MOORE: You cannot be in everybody's house alongside every staff member. As I said, there are 4,500 staff members. But we have various value statements, codes of conduct, and branch management supervision arrangements, where we would be dealing with appropriate ways of dealing with clients. Again, I am not saying that about the specific examples there, and I am not trying to in any way denigrate the person who is making the comments there. It is never acceptable for a staff member to behave like that. At the same time, it is a matter of one human being dealing with another human being, and situations can get difficult from both sides at times and there are very trying circumstances that our staff have to work through. While I am not trying to excuse behaviour like that, I can explain it sometimes.

Dr JOHN KAYE: What about the situation of somebody who did want their routine altered to suit their personal choice? For example, the case that came up in evidence on 26 August was somebody requesting a daily shower being moved from the morning to the evening because it suited them better. Is that the sort of thing you see as important to accommodate?

Mr MOORE: Yes, absolutely. It is not always easy to accommodate it quickly, but it is important. We are not in the business of delivering showers; we are in the business of helping people get on with their lives—and it is their life, not ours. My message to my staff has always been: "It is about the client; it is not about the service. You do a great service, but having done a great service it does not follow that you have helped the client." As a good example, they get a great shower, but if it is not at a time that works for them and the life they want to live, then it is a great shower but it is not as good a contribution to that person's life as it could be.

Dr JOHN KAYE: There are in place policy guidelines or instructions to carers to focus on what the client wants, regarding the choices for the client?

Mr MOORE: I would not be confident to say that there is a policy as simple as that, but the processes and arrangements that the people who roster staff and schedule staff to meet the requirements of clients—those staff are driven by process. You have to be able to manage your workforce, but they are also driven by trying to get the best outcome for clients. And, overall, they do a very good job, as you can tell from the client satisfaction surveys. But there are always places where you can improve. I am pleased that this process has taken place, because often you see things in a different way.

CHAIR: As a Committee we are extremely mindful of the fantastic job that the Home Care Service of New South Wales does, and has done over many years. We are talking here about a continuous improvement, and no doubt the department is too. I look at the history of Home Care going back to the days prior to 1983, when I think most of it was voluntary. We have come a hell of a long way from the 1970s and 1980s to 2010. So, we are far from critical of the Home Care Service of New South Wales. I felt obliged to make that comment.

Dr JOHN KAYE: I echo those comments. I was asking about specific cases. But I agree with what the Chair said. I have had personal experience of Home Care workers who do a remarkable job of trying to match the needs of clients, and who really try to understand what those needs are and work to them. I was asking about policies of the department.

Mr MOORE: The specific examples are a great way to understand that you can always do better. That is something that the Home Care Service has done in its own quiet way; it is not because of people like myself. It is just that the Home Care Service has not set itself a place where its own staff seek to do better. Never perfect is always the problem, but they are, I am pleased to see, really in a very small corner of it.

CHAIR: I sense that the industry feels that it is on the verge of some big improvements.

The Hon. HELEN WESTWOOD: If I could continue along the theme that Dr John Kaye and the Chair have been asking about. I would acknowledge that Home Care is an organisation that is very different today from the organisation it was, say, 20 or 25 years ago. I was initially a HACC worker, and the organisation certainly has changed since then. Some of the evidence we have received would suggest that in some areas—and I am thinking of areas that are perhaps more geographically isolated—it can be more difficult to obtain suitably qualified staff, often simply due to the distances people would have to travel.

I think the reference to which Dr John Kaye alluded was that some of those older style managers were not as flexible in their approach, which is different from what we find today in the professional home care service. Have you, as a department, identified areas in home care where there are still some difficulties? What do you do in an area where you might have to make a 100-kilometre round trip? Are there things at which this Committee should be looking that would help to improve those sorts of services or to get over some of those issues for home care?

Mr MOORE: With all respect to the Committee, I think these are things where there is no high-level policy direction. There are issues about resources. More resources mean that you can do more. However, there is also a question about the realities. You can have all the resources in the world but, if you cannot employ the right staff at your premises because they are not available, you cannot change anything.

CHAIR: Or they are not trained properly.

Mr MOORE: We have challenges within our own operation. The remoteness service delivery is a particular challenge across the board. The home care service is one of our strategies for trying to address the issue of remote service delivery within the HACC sector. The home care service, because of its scale, has some inherent efficiencies that enable us to leverage higher costs for service delivery in remote areas.

CHAIR: How many branches does it have around the State?

Mr MOORE: There are 42 branches and about 108 formal outlets throughout the State. One example in the home care service in which I am particularly interested is in a place called Nyngan.

Dr JOHN KAYE: A place called Nyngan!

Mr MOORE: In my Sydney-centric language.

The Hon. HELEN WESTWOOD: It is on the way to Broken Hill.

Mr MOORE: Apparently there is something west of Oxford Street.

The Hon. HELEN WESTWOOD: It would be west of Anzac Bridge around here.

Mr MOORE: That is a standard comment that I make to anybody. It would not be novel and these days it is boring to most people. When the non-government sector was unable to continue to operate in Nyngan, home care services stepped in. It provides a whole of HACC. It does social support, transport and community transport. All those things are organised by the Nyngan branch. That is an example of where the home care service can go and where others cannot go. Because of its size we have the resources to back it, as long as the home care service is structured like that. Again, it is not a panacea that will fix everything but it gives us a much better resource base from which to fix things like that. I do not know whether you are coming to questions about the age split within HACC.

For us that is one of the big strong points in arguing with the Commonwealth about rational behaviour. If you start playing around too much with home care you will lose access to a resource that is a good way to fix services in a lot of places that you could not do easily elsewhere. Anyone can do anything but we can export management expertise from one location to another because of the way in which the home care service works. You cannot always get the right people in place all the time, but if you have someone who is not that good you can come up with an appropriate staff member elsewhere to provide supervision and support. If you have little

non-government organisations that is not possible as they do not have the wherewithal to do that in trying and difficult circumstances all the time.

The Hon. HELEN WESTWOOD: Is your budget flexible enough for you to be able to shift around those resources? It is not that rigid.

Mr MOORE: The Commonwealth is very pedantic in its accounting in relation to home services, but we just ignore it. It is the only place we can do it because of its size and capabilities.

CHAIR: Would you elucidate further on that issue? I understand that there are some real barriers between State and Federal funding. I thought you were alluding to a major issue when you were referring earlier to the breakup of aged care. It is not something that we can brush over; it is fairly fundamental to our deliberations.

Mr MOORE: Yes.

CHAIR: Am I missing something?

Mr MOORE: No. I am saying that there is a split, on an age basis, of responsibility for long-term care. The State Government does those aged under 65 and the Federal Government does those aged over 65. That has the potential of being significantly disruptive, in particular, in the HACC sector. I have just been giving you some indication of why the home care service is a strong entity and it is useful in the delivery of the totality of the HACC mix. It is not a panacea to do all of HACC but it does one-third of HACC services and it gives us a useful resource. By and large, the Department of Health has a big chunk of the remaining two-thirds. But certainly half the resources are in the NGO space and, predominantly, they are grassroots organisations.

Think of the Meals on Wheels organisation, which is largely a volunteer-based entity. It has a small amount of resources that come out of HACC funding. If you were to try to start breaking that up and putting it into a section for those aged under 65 and those aged over 65, you could easily disrupt that strong grassroots organisation. That is not government funding at work; it is volunteers at work—volunteers doing a good job for frail old people and people with disabilities in the community.

The Hon. MARIE FICARRA: I refer to large residential centres. When you appeared before this Committee on a previous occasion you said that you continued to operate 13 large residential centres in New South Wales. The Ombudsman's report identified that 31 residential centres were in operation in New South Wales. Why have those large residential centres not been closed? Why has the Department of Ageing, Disability and Home Care changed its position from closing those centres in 2010 to redeveloping large residential centres? There seems to be a change in direction. Why has that occurred? When will all those centres be completed? What sort of time frame are we looking at?

Mr MOORE: The original policy setting of the current Government was announced in 1998, that is, the reference to all those facilities closing by 2010. For various reasons—long before my time in the organisation—that proved unfeasible. By mid-2005 there was an extensive process of revisiting the policy settings around accommodation—not just around large residences but more generally—which brought to the discussion a concept that it was not just about bricks and mortar, and that you do not address an issue by changing the bricks and mortar. That works both in relation to large spaces—large numbers of people being accommodated together—and to small spaces. There is nothing inherent in the way in which a group home could operate—a group home with five or six people with a disability—that would prevent it from being institutionalised and having poor institutionalised outcomes. There are theories around that people talk about. I note in the transcript that some people have made mention of the fact that small guarantees better outcomes.

If people think they will get a better outcome because it is small, I think they have it wrong. We have seen enough examples of where small has not produced better outcomes. You have to have a policy setting that is about the people and about getting good outcomes for people, and then the bricks and mortar will follow. In 2005 a version of that policy setting was established by the Government. In 2006, when Stronger Together was announced, it included a change from saying that large residences would all close by 2010 to saying that they would close over time. The Government announced the closure of three large residential centres at the time that Stronger Together came down.

Those closures exemplified the redevelopment phrase that came in. That redevelopment phrase is saying that not in all instances will a large residence be closed and replaced by small community-based housing, which is what the word "devolution" was meant to imply. Redevelopment embeds the concept that you have to have horses for courses. We have to deal with the fact that we have a largish number of people who are ageing for whom aged care style accommodation is appropriate, and for whom it is proving particularly difficult to get access to residential aged care centres.

We are creating a place called Hamlyn Terrace, which is replacing the Peat Island facility—it is called a redevelopment; it is not actually a redevelopment on site—a 100-bed aged care style facility. Will it be populated exclusively by people with disability? Not necessarily, but originally a significant number of people who are in Peat Island will be moving to that facility.

We have replaced a much smaller residential centre called Grosvenor with a redevelopment on site. That is for people with high-medical needs and you need to have—and this is not accepted by everybody and currently legal challenges are being put to this—and I have said this in evidence to previous estimates hearings, at heart what we are trying to do with the replacement to the Grosvenor centre is to provide a facility that has high-quality medical and quasi-medical care; you need a certain body of nursing staff and you cannot run that out of group homes. People say you can if you spend enough money, well you can spend all the money alike and you're not get enough qualified nurses to run it out of an environment where you have completely separated one facility from another. They need supervision and they need networking among themselves to work effectively. We know that we need to provide high-quality nursing care to be able to provide the basis for a quality of life outcome for individuals.

We know that there are certain inherent limitations in terms of community engagement that can easily descend on larger places. We need to do something about that, and we do. But the policy is not one that says—and the word "redevelopment" tries to capture this—it will be only one type of thing that will replace large residences and that will be across the board small suburban housing. We recognise that a large part of the devolution, the capacity that would come from closing large residences, would probably take that form but not all of it.

The Hon. MARIE FICARRA: What do you envisage as the maximum number of clients you can have living in these redeveloped residential centres?

The Hon. TREVOR KHAN: People.

Mr MOORE: We do not have any envisaging of what might be an upper limit. We look at things from what is a smart solution. As you said, there are 13 major residential centres at the moment that are still operating—a few by us and a few by the non-government sector. I know that number is not quite right, but there is a smallish number and the way we are approaching that is case by case. To not speak about clients or people at all, if you have an asset—let us take the example that we have of the moment of Riverside; an asset sitting out on the Bloomfield Hospital site. We cannot continue to invest in it, it is old, it is run down and it is not doing the best it possibly could for the people that are in it. We are going to rebuild it. The logical thing to do there is that we know that we need capacity for short- and long-stay people who have got dual diagnosis, serious challenging behaviour and forensic-type issues. We are able to therefore get new assets much more integrated with the Bloomfield Hospital mental health facilities; this gives us a chance to get great outcomes for individuals. So we need to change Riverside. Do not worry about what the theory of numbers is, but what can we do smart with the capacity we have got there and the assets that need to be reconfigured? The rule you are applying across that is one that says: "Does this get you what looks like the best outcome for people now and into the future?" That drives that decision.

That was part of the problem I think with the original devolution setting bit. When I joined the agency and with the debates that were going on it was too big a problem to solve. It made no sense to say 2,000 beds need to be built in the community. Why? Because we have 2,000 beds in large residential centres so that is what we will do. You have got to chunk it down and deal with smart decisions about individual facilities with a view to: What do you want to see across the totality of New South Wales' capacity? You know you are going to need some forensic units, some aged care facilities, lots of community housing. And our challenge is to try and get away from even the community-housing model because I think there are a significant number of clients that we have already in the facilities that we operate and, more importantly, some of the people who are going to need some form of supported accommodation, that are not about 24-hour, 7-day per week life supervision. The labels we are using are things like "drop-in support". But there are people who need to be in some proximity to paid

workers who can visit them from to time, and if they need to they can have a lot more help put in at a particular time for a week or a month or whatever, but not have the concept that there is a 24-hour, 7-day per week all year long staff arrangement around you.

So we know we have to get a big shift in the mix of accommodation but you are also heavily invested. People move into accommodation and unless their skills are capable of being developed or they are capable of doing in drop-in support, once they are there they are there for life and your commitment is to them for life. The good news for people with disability is that their longevity is rapidly catching up to the ageing population averages. That is a fantastic piece of news but it does require recognition of the longevity of the investment or the commitment to the individual. To go back to your earlier intervention discussion, it would be lovely to be able to divert more of our resources to early intervention prevention but if that was to be at the expense of pushing people out of existing services then that is really not going to be an effective strategy.

Because of longevity you do not have people naturally moving on rapidly so you have a turnover in your stock that enables you to reconfigure. You have very low turnover in our group home network because, fortunately, people are living well and the services we deliver are ones that are helping them live long and well. The downside of that is purely one for bean counters, which is that you do not have the resources being freed up easily. That is the nature of very long discussions with Treasury officials about just what is the appropriate financing policy for disability. That makes it a very difficult issue to resolve because you have got to carry a very large investment in the existing group even though you know you could do things differently and better.

The Hon. MARIE FICARRA: The Committee has received a number of submissions that talked about incompatible placement matching of clients or people in group homes. For example, the vacancy management system has resulted in many clients who were in stable placements being forced to move due to incompatibility, people being placed a long way from their communities, and a reported reduction in the safety of some of the clients. What is the purpose of the vacancy management system and how will you ensure that appropriate placement matches are made?

Mr MOORE: I think it is a little bit like the discussion we were having earlier about the home care service. We do our best to ensure appropriate placement and we do not always get it right. We have competing pressures in the sense that we have people who absolutely have to be placed and we do not have new resources available to place them. While it is a small number, we do have vacancies within our operation. People do die or move to other locations, so you have got vacancies that you have to fill. Our objective is to get the best compatibility that we can, and we do not always get it right. But there are growing pressures from a variety of families to have much greater say over who you live with, and we like to have alternative models that enable us to accommodate that but, at the same time, we do have an investment in a very large number of group home beds and we need to be able to make sure that those vacancies are used. Because people, as you will have no doubt seen from many of the submissions and what people are saying to you, there is a continuing great demand for supported accommodation and it would not be good, not looking at the individual's perspective but overall, for us to not be filling our vacancies.

The Hon. MARIE FICARRA: If you have to look at compatibility in placement, and given the constraints that you have got, is it really feasible that you are going to do an in-depth placement compatibility analysis?

Mr MOORE: We do.

The Hon. MARIE FICARRA: In answering that, how do you deal with a really serious issue when a person says, "I'm sorry, you've put me here. I just refuse to stay here", for whatever reasons, such as, " I feel I am incompatible"? What happens then, in terms of assessment and complaint handling?

Ms MURRAY: There is clear policy, but it is also a very individualised process in the sense that there is an assessment made of that individual person and in this sense of the sustainability of that grouping. The clinicians, the psychologist, the behaviour staff, the case managers and their families all provide input into that information about what will be the impact of that particular group people living together. In that sense there is a judgement made about whether, with support, that grouping is sustainable over the long term. That does not mean when you have people with significant disabilities, such as cognitive impairment and perhaps challenging behaviours, that sometimes that does not take a fair bit of work to provide that sort of support.

The assessments are made in conjunction, as I said, with people who know that person and know the other people about whether or not it is a fit. I am speaking from my previous role as a regional director when I say that there have been situations when family members have been very unhappy about the particular place that had been offered. For example, they would have been offered a particular address in a particular house and they would have refused to take that. It is possible for people to say, "No, I do not want this particular address in this particular accommodation." Then they will await a more suitable option on the register. It is common practice for regions to spend some time working with families and the person with a disability about trying to make sure that that accommodation placement is as good a fit as possible.

The Hon. MARIE FICARRA: My next question relates to quality. The Disability Discrimination Legal Centre referred to the Law Reform Commission's review of the Disability Services Act. The commission's report drew attention to the structural conflicts of influence in the quality assurance of specialist disability services. Other submissions have identified the benefits in establishing an independent body that is responsible for monitoring service providers rather than Ageing, Disability and Home Care [ADAHC] performing the role. Do you believe that that could be a possibility? How do you feel about an independent body monitoring the quality of service providers, rather than its being handled by your department?

Mr MOORE: I do not have any problem with independents; I have problems with some specific proposals about the nature of the independent bodies that might get involved. I think that the debate has moved a long way from the 1998 Law Reform Commission's review. We are now at 12 or 13 years on from that. I think you will find that the industry development plan that we have worked up for disability includes concepts around accreditation, third party accreditation being a key part of being able to get a sense of the nature of the quality of an organisation. We are building quality systems that will be available for non-government organisations [NGOs] to utilise.

I would really be reluctant to see the department being the arbiter of quality and would much rather have us be in the process of setting what are quality expectations, working with the sector and families and representatives of people with a disability to form a view about just what should be the extent to which we pursue quality improvement. It is a major area. It is not just a little thing. It is certainly one of the major things. Where I think the single biggest shift will come is in the growing chorus that is often expressed—I notice in the transcripts and submissions that you received—around the term "individual funding".

During consultations in the lead-up to Stronger Together 2 the Minister for Disability Services was at pains to be quite committed to what he was calling person centred, which does not matter whether you have an individualised funding package or not: your choice should be fundamental to the services you get and in what ways. That approach will place much more weight on quality in a classic consumer sense. We will then need to turn around and have a way for people with a disability getting confidence in that. It will not come from the department being a provider of that confidence. It will come from third parties.

But the strong preference from my perspective, or my advice to government, would be much more down the accreditation space rather than trying to introduce another bureaucratic entity whose job will be to pursue quality and provide another whole raft of hoops that people have to jump through to prove that they have got a quality service delivery arrangement. I think you will find a large body of the non-government organisations will be committed to the delivery of quality, particularly when there is competition for the funding. They will want to be offering quality services to families.

We will want to spend our time helping families to understand what choices are available for them and find ways to get them their choices, rather than pursuing the non-government organisations around the quality. Our objective is to let them have the tools that will help them to focus on quality, put the framework that allows that to be measured but not in a non- onerous way, and pursue the strengthening of the client's capability to choose and to get the information that they need to know about, such as what particular services operate.

The Hon. MARIE FICARRA: This is an accreditation pathway that you see in the future. Are you modelling it on anywhere that it has worked, and that you think is doing a good job of service provision?

Mr MOORE: We have not seen a good system that is in place, to be frank. The way in which the disability sector of New South Wales is responding to this is that we will make it work our way for ourselves. We have processes in train that come out of the National Disability Agreement around quality frameworks and national standards that give us a vehicle to be able to drive national arrangements, but New South Wales is

trying to take a leadership role in this space. My State colleagues sometimes do not agree with our leadership contention, but that is the way we are intending to pursue this.

We are just looking at our disability sector, not in terms of people, but in terms of organisations. We have built a very strong relationship to drive reform within that sector. It is not adversarial; it is always very cooperative. That is an environment that will help us to build a good system. When you look around, I do not know that people are entirely happy with how the aged care framework works and, as I see it, there are a lot of similarities between what the Law Reform Commission is proposing and what is in place in the aged care system.

I think you could probably find a much better way of managing the quality debate and driving it that has a lighter-handed presence from government in it and in which the government's resources are directed much more to helping clients to choose, so that the efforts and resources are put over on the client's base rather than on the government's side of things. That is the classic disability agenda. It is about empowering people with a disability to go and live their lives.

We spend our time debating whether we can have a quality monitoring authorities that can pursue non-government organisations. It is important, but if you have limited resources, where would you rather put them? That is why I end up very quickly light handed on a quality side of things, making it a big virtue that is scintillating for organisations to pursue. Government resources, precious resources that cannot go to front-line service delivery, go to client empowerment.

The Hon. MARIE FICARRA: Has your point of view been received well at a Federal level, if you see New South Wales as driving it?

Mr MOORE: There is a very cooperative arrangement with the key State of Victoria, Queensland and us. We get on very well. The Commonwealth participates at a bureaucratic level very cooperatively in that space. There is quite an appetite among disability officials to try to get some progress. The National Disability Agreement in many ways was a surprise for everybody that it got onto the Council of Australian Governments [COAG] agenda and got as far as it did. It is quite a unique agreement in some ways. It goes beyond what anyone expected. It is the only agreement at the national level that has income support as one element of the agreement. Nowhere else do you see the Commonwealth being prepared to put such a huge policy leader has income support into the general national agreements for discussion, but they have done so on disability. That is a good indicator that there is cooperation there.

The Hon. TREVOR KHAN: When someone with a mental or intellectual disability fronts up at accident and emergency in a distressed state, what access does the registrar at accident and emergency [A and E] have to the records of the assessments that have been done on person?

Mr MOORE: I would imagine none, as a matter of practice.

The Hon. TREVOR KHAN: We are talking as a matter of practice.

Mr MOORE: Because I am aware of a very significant number—it is not an uncommon area of concern about how people with a disability, particularly an intellectual disability, fare within the health system because the health system is not geared readily and easily for their special needs. That is the subject of ongoing work between us and Health as to how we might be able to rectify that. We have been providing some resources in Stronger Together to try to get within the medical processes a better sensitivity to disability issues, but it is difficult.

The Hon. TREVOR KHAN: Recognising that it is difficult, it is not a new problem. In fact, as long as people with an intellectual disability have been interacting with the health system they have had these sorts of problems. What is the nature of the interaction that your department is having with the Health department to ensure a more seamless access to information?

Ms MURRAY: There are a number of senior officer groups addressing a whole range of issues that impact on people with a disability. There is an MOU around mental health and also under criminal justice guidelines—

The Hon. TREVOR KHAN: Is the MOU on mental health in place?

Ms MURRAY: Yes, as I understand it. There are a number of practice guidelines around Health and us working together, particularly around people who have a forensic or criminal justice background. There are guidelines for our staff in relation to what to do when they have a difficult situation in terms of both Health and the criminal justice area.

The Hon. TREVOR KHAN: We are talking about a person with an intellectual disability fronting up at accident/emergency and the access to information. That is where I started. You are talking about guidelines with respect to the criminal justice system. I am talking about a person with complex needs fronting up at emergency. What information is available?

Ms MURRAY: In terms of what we are doing with NSW Health, NSW Health has just put together a framework for looking at improving medical health outcomes for people with intellectual disability. There has been a significant injection of funds to look at a pilot around clinical nurse specialists in terms of looking at triage and building relationships across the health sector. They are the types of services being piloted. In a sense, we do not know a great deal about what are the particular types of things that would assist people with intellectual disability to get better health outcomes. This is a way of trying to assess that.

Mr MOORE: The short answer to your question is that I cannot tell you specifically what happens. I am happy to get some information and give it to you. I am aware, as is Lauren in describing the various frameworks, the memoranda of understanding and pilots, what we are pursuing. But what actually happens in terms of someone fronting up in circumstances that you are describing, I cannot tell you off the top of my head. But I am happy to get the information for you from both Health and ourselves.

CHAIR: Can you tender the ADHAC mental health memorandum of understanding?

Mr MOORE: Yes.

The Hon. TREVOR KHAN: Are you certain it is in place?

Mr MOORE: If it is not, it is very, very recent. It would have been three months ago we had a final meeting where it was agreed that the document would be worked on no longer. The points of dispute were over and this was going to be the document that would be put in place. It has to be signed off by various people. I am not sure whether every single last person who has to sign off has done so. I will tender you the document and its exact status. If it is not in place, it will be in place. I do not want you to be misled into thinking that it has been in place for a long time.

The Hon. TREVOR KHAN: We knew that.

The Hon. HELEN WESTWOOD: If I could interrupt and continuing the theme, we have heard that health services were segregated from disability services in 2005.

Mr MOORE: Health and disability went their own separate ways, I think, at the beginning of the 1980s.

The Hon. HELEN WESTWOOD: What about clinical services to people with an intellectual disability?

Mr MOORE: Somewhere around 2005 there was a small diagnostic and assessment resource that we transferred to Health. From memory, it was about $1.5 million to $2 million worth of activities. That would represent a very small grouping. A number of 20-something staff comes to mind. I am trying to convey a sense that it is a very small thing. That was about trying to get Health responsible for what Health should be responsible for rather than having us trying to pick up bits and pieces of the issue.

The Hon. HELEN WESTWOOD: At the time was any mechanism put in place to monitor and perhaps review the implications or impacts?

Mr MOORE: I could go and look for you. Again, it is something I am aware of but not something I remember that much detail about, I am sorry.

The Hon. HELEN WESTWOOD: What is of concern is that you end up with a duplication of ADHAC now doing an intake assessment and then often that information not being shared with clinicians. Has that issue been raised with ADHAC that you are aware of?

Mr MOORE: I have heard versions of concerns like that on a couple of occasions. That is not to say it has not been raised with others. It is not something that filters up very regularly. I have two comments to make about it which I think we have to do something about, or at least one of them. Our assessment processes are much more about a person and their life rather than health-related issues. That is an important subset of what we are interested in. But the focus of what we are trying to do is on a person's whole of life and getting them a good life. That goes necessarily way beyond what may be in terms of health-related issues. In that context there are many more people with a disability, including an intellectual disability, than people that we see. We do not make sure that we have seen every single person with a disability before they go anywhere else in the system. Somewhere you will see statistics where we probably see in any one year at most 60,000 people with a severe or profound disability out of a population of over 200,000—these are under-65s. That just gives you a sense that at ADHAC special disability services or disability care needs are not the thing that you could filter through because we try not to get involved in people's lives unless we need to. That is the first issue.

The second issue is I do think that the number of times people with a disability and their families have to go through health systems to satisfy us that we have got the right health care plans in place is excessive. The number of times that GPs need to provide us a statement that a person with a disability has a disability in order to complete the right forms for going to various respite providers is absurd. That is something that we need to tackle. We have tried to streamline some things but it is quite clear that we have not gone near far enough. There must be ways in which we can have a much less repetitive requirement placed on people as to how they engage with the health system. If you have got certain disabilities at age five, you still have got them at age 10, 15, 20, 25. In the consultations we were doing a couple of months ago that was a very common theme—people describing to us their life in ways that you do not often get to hear. For many of them this was their life, this is what they did. You listen to it and you go, "You shouldn't have to do that. We should be able to make the world work in a better way."

The Hon. TREVOR KHAN: As it is my section, could I ask you to comment on this? One of the problems with calling people "clients" is that it allows those who work in your area to segment a person into a client for your purposes and not look at the person as a whole. That is what you do by labelling them as "clients". You depersonalise them to the extent where in any public service provision you provide a service by your department rather than look essentially at the person holistically. Do you want to comment on that?

Mr MOORE: You are dead right.

The Hon. TREVOR KHAN: I am glad you said that.

Mr MOORE: And that, for me, is one of the themes that is emerging out of the consultation processes around Stronger Together. Some of the theory about what we need to do better is this thing which is another version of sloganeering, that you have got to put services in their place; services are not an end in themselves. The description I was giving before about how it does not matter that you do a good shower—that is a given, that the shower is done in a way that fits in with the person's life—it is this issue which, in the disabilities space, is particularly challenging; it is not exclusively a disability issue but it is the one about it is not just specialist disability services, it is about the fact that a person with a disability should, indeed, be accessing expected access and be able to access a broad array of community services and health services that do not come through the specialist system.

The point that you are making is that various people at various times try and shift the language away from "clients" to "people", but bureaucratic processes are very heavy and drag it back to that. For us, I think you can make progress anyway in the sense of what we call a person-centred approach—just saying, your bid is about how you fit in to help a person get a good life. They may still use the language around "clients" but more and more you can see people starting to get in our space, the sense that it is not about whether they have done a good service, it is whether their service fitted in well to get a good outcome for the client.

CHAIR: We seek your indulgence to go on for a few moments so we can limit the number of questions on notice, because our time to get our report together is running out. Are there any important questions we need to ask in the next five or six minutes?

The Hon. HELEN WESTWOOD: Can I just ask about unmet need? We talked about that last time you were here and we have received quite a bit of evidence since. One of the things we heard from a couple of witnesses is that they feel there is already a lot of data that they supply to the department in their returns quarterly and annually and that they felt that from that ADHC should have been able to develop some understanding of unmet need. The other evidence that we heard is that the Federal department actually does have a data collection model that they think would be very useful for ADHC's purposes of defining and quantifying unmet need. Do you have a response to that?

Mr MOORE: I could do a slightly different version of the previous answer about being right. I would not be saying it is dead right; I think there are some serious misconceptions behind those positions and I am aware of it, I have seen the transcripts. It simply is not the case. That is why we have the data hidden away anywhere either at the Federal level or at the State level that enables the answer to unmet need. That is why we have as one of the priorities under the National Disability Agreement a process to build a better understanding. At issue is a really vexed issue that people have not comfortably debated, and that is it is about the whole of the population, not just the group of people who are clients, not just the group of people getting services, and, by definition, you do not have administrative data of the people you are not helping. By definition you want to make sure that you try and help people you are not helping before they are in crisis. You do not have that data that you can see.

You have to be incredibly careful that you do not end up looking at the data you do have and thinking it tells you everything about the world. The data that the service provides is fantastic data for some purposes, but if you use that data to tell you all you need to know about the population of people who need services and are not getting it, you are looking at precisely the wrong spot. People do not like that answer, but the fact of the matter is that you have to look at the administrative data in the context of the whole of the population and that is why the single biggest recommendation that could come out of anywhere, including this committee, in my view, if you want to deal with unmet need, is one that this committee has not got any sway over and that is that the ABS and the resources made available to the Australian Bureau of Statistics enable it to do a much more frequent and more detailed assessment of the population.

If we had things like what is called the SSTAT, if we had that on a triennial rather than a six-annual basis it would radically change our ability to discuss how we are performing. I think I alluded to this last time, that we are busy preparing advice for Government about Stronger Together, the second five years, using the same dataset that we had for the first five years.

The Hon. TREVOR KHAN: Could I just break in there? Am I right—and you have read the transcript better than I have, I think—that some of the evidence that we have received is that the Federal Government receives data in response to funding that it has provided that you yourself do not collect? I think that is some of the information that we have got here.

Mr MOORE: That may be the case but that information still does not enable us to answer fundamentally the question about unmet need and our approach is to strive to get a good picture of that where you leverage off all these little pieces of data. That is why we employ actuaries to try and pull all that data together so that we can get a view. But at heart you have got to marry that view to the population picture otherwise you are looking at what you already know. Maybe you could ask more questions and learn more detail about what you already are dealing with, but by definition unmet need is about that bit you are not meeting. So your administrative systems cannot give you that data.

Some people are making the contention that we could leverage off the number of people who are applying and that is where the data we showed you at the previous meeting of the Australian Institute of Health and Welfare says there could be 10,000 people who need accommodation services in New South Wales. Our administrative waiting list, our priority registers of need, show less than 2,000. What you do about that? Do we deal with just the 2,000, the 1,700 who are on the current and future needs registers? If the number is closer to 10,000 it would be bad advice to the Government to say we will just stick with those people who put their hands up. That really would be a serious mistake.

The number of people who apply—there was one example being used with me quite aggressively recently about I think it was something like 700 people applied for 100 places—I forget about the precise numbers but it was some sort of order of magnitude like that. Does that not tell you that there is a lot of unmet need? Yes. Can't you use that to do something about it? Not really, because you would have to go through and put all the 700 through all the detailed assessment and then you are only looking at the people who applied, not

the people who gave up applying. You could do something good about it but you still would not necessarily be doing the right thing; you would be looking wherever a light shines, not at the whole of the population, and if you really are trying to solve disability so you do not have a crisis creeping up on you, you have got to look into the dark places, not where the light is shining.

CHAIR: Is there any information you can give to us arising out of the Stronger Together consultation process?

Mr MOORE: There is a consultation document which we are about to release publicly that I would be very happy, subject to the Minister's concurrence, to provide to you.

CHAIR: We would appreciate that.

Mr MOORE: Some of the people at the final roundtable consultations used to validate the draft that we prepared were saying that they were a bit surprised at how honest it was and how much we had genuinely captured disparate views and not tried to sort of position them to tell our favourite version of the story.

CHAIR: We get the distinct impression that the industry as a whole, from government instrumentalities down, has got the best of intentions and these deliberations that are taking place through the consultation process for the second tier of Stronger Together and other consultations seem to be taken in an environment of everyone wanting to do the right thing. It is a very good start. It is a question of whether or not we can work out what the right thing is.

The Hon. TREVOR KHAN: What consultations have occurred with NSW Health and the area health services?

Mr MOORE: Nil with the area health services, but there have been discussions at the top level in NSW Health.

The Hon. TREVOR KHAN: Have there been discussions with anyone apart from the top levels of NSW Health?

Mr MOORE: I will check that and provide the Committee with a list of the people who contributed one way or another to the consultation process. I will endeavour to flag anyone from the NSW Health environment.

The Hon. TREVOR KHAN: I am looking at this "person" as opposed to "client" issue again.

Mr MOORE: The health, disability and disability education interface are critical areas. NSW Health is often the first to know about a person with a disability.

The Hon. TREVOR KHAN: Or schools.

Mr MOORE: Schools often establish the severity of a disability. However, more importantly, they are a fantastic environment in which to build the confidence of a person with a disability and their family, to ensure that that person has a good life not an ordinary life and where aspirations can be set higher rather than lower. Over the past three or four years with the transition to work program—that is, where we pick up after school finishes—we believe we have been able to help into employment as many as 1,500 people who would otherwise not have been employed. That is a fantastic thing to do as opposed to a person spending their life using specialist disability services.

CHAIR: Can you provide the Committee with information on the Coroner's recommendations resulting from investigations into the death of Kate Bugmy? I think he made five or six recommendations. Have those recommendations been actioned? Can you provide that information on notice?

Mr MOORE: I can provide that information.

CHAIR: I seek your indulgence in providing that as soon as possible because of the time pressures the Committee is facing.

Mr MOORE: I can supply that by the end of this week.

CHAIR: Thank you very much.

Mr MOORE: I would like to reiterate something I said earlier. It is very rare to have an open public inquiry like this in the disability arena. It is evident that a wide variety of people have found the wherewithal and willingness to put forward views. Not all of them are easy to hear, but we need to hear them. We will study the transcripts and submissions with a view to actioning everything, although people might not like what we do. The Randwick example is noted. We will provide an answer about what we are doing with regard to that more generally and the lessons that we can learn. Forums like this do not happen very often and I will ensure that the department does not leave it only to the Committee to respond. We will mine the material for our own continuous improvement. We as an agency are very grateful to have been able to go through this experience.

CHAIR: The Committee appreciates your assistance.

(The witnesses withdrew)

(Short adjournment)

JILLIAN PATRICIA McDONNELL, Advocate, Education Officer, the Aged-care Rights Service Inc., of level 4, 418A Elizabeth Street, Surry Hills, NSW 2030 and

THOMAS WILLIAM COWEN, Acting Chief Executive Officer, the Aged-care Rights Service Inc., level 4, 418A Elizabeth Street, Surry Hills, affirmed and examined, and

MARGARET ANNE SMALL, Acting Principal Solicitor, the Aged-care Rights Service Inc., Older Persons Legal Service, level 4, 418A Elizabeth Street, Surry Hills, NSW 2010, sworn and examined:

CHAIR: In what capacity do you appear before the committee?

Ms McDONNELL: As education officer, advocate for the Aged-care Rights Service.

Mr COWEN: As acting chief executive officer, as of 2½ hours ago so you might go easy on me, perhaps, of the Aged-care Rights Service Inc.

Mrs SMALL: As acting principal solicitor of the Aged-care Rights Service Inc. I have had a little bit of practise prior to this but I have only just come back into this position in the last 2 hours as well.

CHAIR: Do you want to make an opening statement?

Mr COWEN: The Aged-Care Rights Service Inc. [TARS] was established in 1986, funded by the Commonwealth to assist people in aged care facilities, nursing homes and hostels, high and low care residents. It is an incorporated association and a community organisation and community legal centre. There are basically three divisions to the Aged-care Rights Service. The first is TARS which I have just described. The second is the Older Persons Legal Service [OPLS] which has been operating for 2½ years and funded by Legal Aid New South Wales. It provides advice and legal assistance to older people over the age of 60 across the whole of New South Wales, as does TARS, people who are disadvantaged and perhaps suffering financial exploitation and/or elder abuse. The third is the retirement villages division which provides advice to residents, not operators, of retirement villages in respect of their rights and duties per the contracts that they have entered into and per the Retirement Villages Act.

Those three divisions also provide education services to the community and to other service providers on the rights and obligations of all stakeholders in the provision of facilities for aged people. It is a statewide organisation. We provide education, advice and legal assistance and support across the State. TARS provides non-legal advocacy and education. The OPLS provides legal advocacy and education, as does the retirement village service. I will now pass to Mrs Small who can provide more detail about the operation and functions of the organisation.

Mrs SMALL: He really did not leave me much to say. We provide free telephone advice service five days a week from 9.30 a.m. to 4.30 p.m. The phones generally run hot and calls that we cannot take directly go onto an intake list. I do not know if I am assuming that everybody knows what a community legal centre is but it provides free legal advice and assistance to really disadvantaged people in the community. We cover metropolitan, rural and remote. We are a statewide service and we are often requested to visit rural and remote areas to provide legal education and while we are there we will provide face-to-face appointments if requested.

I really do not think there is much more to add to that except we had a review of the service. There were only two of us in OPLS, and we had helped to set it up. A review of the service was carried out last year and it was recommended that a third solicitor be employed, and that solicitor has just come on board. That is all I have to say, thank you. I will pass to Jill now.

Ms McDONNELL: I am Jillian McDonnell. I have been an education officer and advocate at TARS for the past 2½ years. As an advocate, my role is to advocate for residents of aged care homes and clients of care packages, Commonwealth-funded services. Our form of advocacy follows the National Aged Care Advocacy Program guidelines of the Commonwealth Government. As Margaret has said, the other part of my role is education, providing information education sessions to residents in aged care homes, staff, community groups and professionals involved in all aspects of aged care. There have been a number of home and community care organisations where we have come along and presented information sessions to their staff as well. We work

closely with the solicitors of OPLS because sometimes a client will call us and it turns out they have a legal issue that they need to discuss, and we are able to refer them directly to the solicitors. The other way round, sometimes people call the solicitors and they have something to discuss about aged care, so they do the cross-referral with us.

The decision was for our submission to address just one term of reference in your terms of reference because of our awareness of people's rights and our experiences with aged care advocacy. So, the complaints, grievances and advocacy term of reference seemed to be the one that fitted our service. We often have people looking for Ageing, Disability and Home Care who phone us up, so we have two refer them to the Commonwealth centre. If people who are receiving Ageing, Disability and Home Care services phone us we are not able to assist them because it is not part of our funding, so we refer them back to the coordinator or the manager of the service directly. Our submission acknowledges the policies and procedures of the department, particularly with regard to complaints handling but we are aware there are a number of funded advocacy services for people with disabilities—and it was a point in our submission—but there is not a funded advocacy service for frail aged clients of Ageing, Disability and Home Care services. I think that was probably the main thing we wanted to bring out in our submission. Thank you for inviting us to come, because we were not expecting to be here. We are happy to be here.

The Hon. MARIE FICARRA: Thank you all for coming. It is widely recognised that we have an ageing tsunami—and I say that in the nicest possible way as one of the baby boomers who will be part of that tsunami. Can you comment on whether you believe the New South Wales Government has made adequate provisions to ensure older citizens are able to access appropriate and affordable services? Do you believe we are on track?

Ms McDONNELL: We might have to put that on notice because of our funding and the direction of our organisation and who we are and what we do. Essentially we are not able to assist frail aged clients of Ageing, Disability and Home Care. But we are aware there is a lot of demand in that part of the community and, as you said, that number of people is growing all the time and there are a few strains on needs of people out there.

The Hon. MARIE FICARRA: Please take that on notice.

Ms McDONNELL: If we can do that and as an organisation make a response.

The Hon. MARIE FICARRA: We have had quite a few submissions that have given us feedback on the Ageing, Disability and Home Care's complaint handling process. From your experience, dealing with the people that you do, do you have anything to say about the adequacy of Ageing, Disability and Home Care's complaint handling service or ability?

Ms McDONNELL: I have done a lot of reading and I know there is good policy and procedure in place with regard to Ageing, Disability and Care and what they put in place for service organisations in terms of complaints and handling processes within the organisation for clients, but from our point of view, as TARS, we are not able to assist people and we really basically have to send people either to the service organisation or to the Ombudsman which, often for people is a daunting thing to have to do, because we cannot assist them ourselves.

The Hon. MARIE FICARRA: Is there any time that you intervene and take up their case and go directly to the organisation or whoever they are complaining about to try to resolve it?

Ms McDONNELL: There have been occasions. A particular gentleman rang us a few weeks ago very distressed. I spoke to him initially and he said the service provider who was providing his service, that day was the last day of that service. He explained to me that as far as he was aware there would not be another service coming to assist him. In a situation like this I cannot say to this gentleman you have to go back to the coordinator, because that service finished that day, so I took it on myself to phone the organisation and follow it all up on behalf of this gentleman. Each time I phoned I had to speak to different people or organisations. Each time I did I had to explain TARS, explain my role, but in a sense I am not doing this in any official capacity, only to assist this gentleman. As it turned out, there was a service coming on Monday. It was organised and just through the history of this gentleman's care needs it was quite a problematic situation. But I eventually got to the stage to find out there was a service coming in, so from our perspective we made sure this gentleman was not left un-cared for.

The Hon. MARIE FICARRA: We noted in your submission that, from your advocacy experience, often frail aged people are unlikely to pursue asking for assistance if they have initially been knocked back or they are unhappy with Ageing, Disability and Home Care's initial handling, and they do not know they can go to the Ombudsman or they do not have the capabilities. What do you think, in our recommendations do you think this is something that needs more attention, more on education about individual's rights?

Ms McDONNELL: Yes, I think so, and I think we alluded to that in the submission. Older people need to know there is someone they can talk to. From our experience with residents in aged care homes and people receiving community aged care packages, it is common that people are hesitant, they are unsure, they do not know who to talk to. Often they just need someone to listen to what the situation is, and we do that with our clients and we will do that with Ageing, Disability and Home Care clients if they phone us. The only difference is we are not able to assist those clients, but in talking it through with people, the role of an aged care advocate is to help them work out what they should do about this, what would you like to do, who do we need to talk to, would you like us to talk to management for you, would you like us to write a letter? So, it is helping people to get a resolution to whatever their problem is.

The Hon. MARIE FICARRA: My last question is about people's unhappiness with the service they are getting. In your submission they are often very fearful that whatever service they are getting, whether it is adequate not, will stop or they will go down to the bottom of the list, so they do not speak out. In rural and remote areas this is because of the small township and limited services. Is it a growing problem, or what sort of proportion is involved?

Ms McDONNELL: I think it is a growing problem because it refers back to what you originally said with regard to this tsunami of people. We are getting more and more older people needing services and of course a lot of people are looking into the future and thinking that they want to stay at home for as long as possible so they are looking at getting services at home. But for all those reasons, who can I go to if I have a complaint? Who can I talk to? As you said, often they are hesitant to talk to the coordinator or the manager of the service. They need an independent person who they can talk to and who can help them work out what to do about this. We have that generation—I do not think the baby boomers will be quite like this because we are all quite good at complaining—

Dr JOHN KAYE: Oh yes.

The Hon. MARIE FICARRA: And demanding.

Ms McDONNELL: And demanding. That older generation do not complain. It is not part of their way of life. They accept things, even if they are not happy.

The Hon. MARIE FICARRA: Do you think there is a way around that? How would you improve the current system to empower these elderly people more?

Ms McDONNELL: It is informing them of their rights, letting them know what their rights are. As part of our role we use the charter of residents' rights and responsibilities, which is part of the Aged Care Act, and the charter of clients' rights and responsibilities for people receiving aged care packages. We try to reinforce with people in our education information sessions all the time that you do have rights and you do have a right to complain. It says on the charter you have a right to complain without fear of redress and retribution. So it is actually in the charter written for them. So that is what we do; we reinforce that with people all the time. We would like you to call us and we are happy to talk with you about what your problem is so that we can help you to work out what to do.

CHAIR: These rights and the ability to access redress, are you finding that you can meet the need of the rights versus the ability to access redress?

Mr COWEN: Probably if I can jump in here with my limited experience of the TARS service, but I have further experience. I came down to Sydney to take up the position as the principal solicitor with TARS from the Seniors Legal and Support Service in Cairns. I was the foundation solicitor there under a pilot project that went for one year three years in a row. Eventually, I am glad to say, just before I came down it was approved for ongoing funding. So I am not unfamiliar with the problem that older people have in relation to complaining. We worked closely with the HACC organisation providers in the Cairns district. There are a lot of

barriers for older people in making that initial complaint and taking up their grievance with the service provider, and even with their own families.

If there is an independent organisation that has a skill and an expertise in advocating on behalf of older people in that situation and who also conduct education services not only to the community that is being serviced but also to the service providers themselves, then that can overcome a lot of the barriers. It will not demolish them completely but it helps older people feel more secure in being able to put their grievance in good hands to be able to carry it forward for them. So having an independent organisation is probably one good step towards assisting older people in that area.

CHAIR: I was perhaps asking an impossible question. My question went to the issue of whether, after you overcome those barriers, the community in general has the capacity to meet the need after the complaint is made?

Ms McDONNELL: If I use an example, if a resident in an aged care home was to ring us up and made a complaint about the food in the aged care home, then—I hope I will be able to answer this for you. We would talk with that person about, okay, what can we do about this? We would talk to the person about what is in place at the aged care home so that you can make your complaint about the food. Each aged care home has a complaints process. They have residents meetings where they can raise issues, and that might be something that I would suggest to an older person. If they did not want to do that, we would look at other ways of making the complaint and supporting the person so that they did not feel that there would be retribution. If we can talk to staff as well, assist them to talk to staff, particularly management, with the—it is sort of inherent in the process that there would not be retribution or redress in any way because the person has approached us as an organisation. But that is not to say that people do not feel that with the service they are provided with, particularly people who are getting services at home. There is that sense there, and sometimes the organisation does not ease that negative feeling that people might have.

CHAIR: What is the percentage of complaints that you receive that you find are possibly a little unfair or unjustified? Ten per cent? Five per cent? Every complaint you ever get is justified?

Ms McDONNELL: From the person's perspective it is, yes. I guess you see that there is a continuum and something like a complaint about food or laundry, not getting the right washing back from the laundry or something like that, can be an important thing to an older person, right the way through to complaints that we have to say to people, "Look, we are not able to assist you with that. We would like you to talk to the complaints investigation scheme in the department." So you have that range.

Dr JOHN KAYE: I turn to an issue that you raised in your submission in respect of a number of groups in society who often fall through the cracks when it comes to provision. I think you list nine special groups amongst older Australians in particular. I would like you to go through each of the following groups and tell us what you think the Government could do to better assist each of these groups: lesbian, gay, bisexual, transgender and intersex [LGBTI] older people; persons with mental health illnesses; older homeless people; rural and remote older people; and isolated and single older people? I am happy to read the list or we can do them one at a time. Why not start with the LGBTI older people?

Ms McDONNELL: From the organisation's perspective, how would you like us to answer that question from our perspective as an organisation?

Dr JOHN KAYE: I guess the question comes to defining perspective. You see where it does not work. You see where people are not having their needs met because they are coming to you with complaints.

Ms McDONNELL: Yes.

Dr JOHN KAYE: Therefore, I presume you would form the view of how systemically those issues could be addressed. Rather than addressing them one at a time, you could address them by making substantial changes to the way we provide aged care. I wonder wondering if you have any suggestions to make in any of those areas. Let me go back one step. Is it fair to say that there are groups where the current arrangements simply do not provide for their needs?

Ms McDONNELL: The simple answer to that is "Yes".

Dr JOHN KAYE: Which of those groups do you think is the source of the greatest number of concerns being raised with you?

Mr COWEN: That is a little bit difficult to answer in the sense that the Aged-care Rights Service [TARS] is established to assist people who are residents of aged care facilities, so we are not actually funded for and therefore do not do education in other areas, such as delivery into the home or assisting homeless people and so on, so we do not get many calls from that type of service provider or on lack of service provision. We do get some, as Jillian has mentioned, and they are the ones that are alerting us to the fact that there is a problem, but we do not have our finger on the pulse of the statistics for that because we are not out there in that area alerting people to the fact that we exist and that we can help them, because we cannot help them. We can help them from a legal perspective in the Older Persons Legal Service, and again we are doing community education programs to alert people that we exist for that service, but this is a slightly different group that we are talking about, so the short answer is that we are not familiar enough with the statistics in that area to be able to give you a good answer on that. But I would say that commonsense would tell you that homeless people, for instance, are going to be missing out on the services that could be provided to them if they had a home, such as Meals on Wheels and the usual Home and Community Care [HACC] services, going into homes and helping them clean, taking them shopping and that sort of thing. If they have not got a home, it is very hard to provide that service to them. I am not quite sure how you would resolve that problem. Obviously you have to provide them with accommodation first to be able to provide the additional services that go with it.

Could I come back to a point that was being raised earlier? I think the member Mr Khan asked the previous witnesses here about approaching the person holistically. In the service that I was in before I came down to the Aged-care Rights Service we actually had a solicitor and a social worker working together on a client case, and that process would actually operate in the way that the client would come in for the interview and would be interviewed by both the solicitor and the social worker together. I might say—I do not know if we have any lawyers in the room—

The Hon. TREVOR KHAN: We do.

Mr COWEN: But lawyers do tend to approach problems with tunnel vision. I know this is hard to believe, but it does seem to happen. Because of your training and experience as a lawyer, you are looking at the problem from a legal perspective and focusing in on what the legal situation is. My experience working with a social worker broke up that tunnel considerably for me and allowed me to approach the people who came in in a more holistic way, and that was actually designed to do that, so somewhere in the Queensland public service there was a genius who thought up this idea. I do not know where they got it from, and I do not like to say that Queensland is any better than New South Wales, having been born and bred in New South Wales, but that particular approach enabled that service to provide all sorts of additional support to the client other than just trying to resolve the legal problem that they may or may not have had, so it became then the whole person rather than just the client.

Dr JOHN KAYE: We had a discussion earlier with Mr Moore from Ageing, Disability and Home Care. One of the issues that I think Mr Khan put to him was the nature of the word "client" and what it involved, and the segmentation of the individual into somebody to whom you deliver services rather than a whole human being. I have heard people use the expression "partner" as an alternative to "client". Certainly we are a long way down the track from when we used to refer to those people as patients, so we are heading in the right direction. Do you have a sense of whether we need to spend time worrying about this word "client", whether it is the best available or is the English language deficient that it does not have a better word? Is the word "partner" better? From your experience, do you have anything to add to that debate?

Mr COWEN: I guess "client", as a word, describes the relationship that exists between that person and the service organisation that is providing some service to them. There may be other words that are suitable, but really what it does is constrain the mindset of how we can assist this particular person and help them resolve their problems and, as has been mentioned several times, give them a better life. Anything that makes people think about that is probably a step forward. Even if you do revert back to using "client", you are aware that there is a lot more to this person than just being a client. That is probably important.

Mrs SMALL: Have you any idea of what a better word would be?

Dr JOHN KAYE: No, I was asking you. We get to ask the questions.

Ms McDONNELL: I actually like the use of the word "partner", particularly for us in the advocacy role, because that is what we do in a sense—we partner with that person and lead them through the process of how to resolve the issue that they have, and really encourage them to take it on board. That, in a sense, is a partnership, so it is not a top-down sort of relationship, but whether it would work in other situations, I am not sure.

The Hon. HELEN WESTWOOD: I am wondering about your ability to provide services to people who receive Home and Community Care funded services that might be delivered through a State agency. Is there any limit on you doing that? Home Care, for example, as well as other Ageing, Disability and Home Care services, receives some Federal Home and Community Care funding.

Mr COWEN: Basically we are not funded to provide additional services. There is a very small amount of money that is provided to us, which is about $68,000, to do some education work, but that does not go very far. We are not further funded to actually advocate on behalf of people in positions who may have some grievance or complaint about the service that they are providing or are being provided. There is that need to have that independence, and the Aged-care Rights Service is obviously in a position where it could provide that service if it happened to be funded to do it, but we are simply not funded to do it.

The Hon. HELEN WESTWOOD: So you are not permitted to do it in terms of your funding agreement with the Commonwealth?

Mr COWEN: We just do not have the resources to do that at this time, no.

The Hon. HELEN WESTWOOD: As a community legal centre, do you network with other community legal centres throughout Sydney?

Mrs SMALL: Yes, we do. Quite often we will present joint education sessions. I have one coming up next week with Kingsford Legal Centre and it is also an interpreter job where we are going to be speaking to Spanish-speaking people. We link up whenever we can. I recently did another one with Women's Legal Services for the Older Women's Network, so they provide their area of expertise and we provide ours, and look at issues that maybe they are not considering, because a lot of them tend to refer their older people on to us if they need to.

The Hon. HELEN WESTWOOD: Are you aware of other community legal centres providing other advice or advocacy to older people, perhaps because they do not have the same limitations on their funding and who they can provide services to?

Mrs SMALL: I know that the Elizabeth Evatt Community Legal Centre at the Blue Mountains has one older person solicitor who is there only one day a week. She is specifically there. I do not know of any others and I do not have any idea of what degree of aged people they are advising, but anecdotally I have spoken to solicitors. We have quarterly meetings—all the community legal centres get together—and I have spoken to three or four of them and have put forward the prospect of going and speaking to them and setting them up, and they are very interested, so that is about all that I can add.

Mr COWEN: I might just add that at the moment other community legal centres across the State actually refer older people to our service to give them assistance where we can. Of course the OPLS, which is a separate organisation to the Aged Care Rights Service [TARS] itself, although it works under the TARS umbrella, is set up to provide a wide range of legal assistance to older people suffering abuse or financial exploitation. It does not usually mean that would we would go in and advocate on their behalf in relation to services being delivered by a Home and Community Service [HACC] provider, although it is possible if they were being abused we would be able to do that but, in the normal scheme of things and having looked at the policy of grievance procedures that has been provided by the ADHC, we would not come into it.

The Hon. HELEN WESTWOOD: The OPLS service is open to any older person who is the victim of abuse or financial exploitation or only those people who are resident?

Mr COWEN: No, to anybody over the age of 60, and that is a little bit flexible too. Some particular cultural and linguistic diversity [CALD] community groups or Aboriginal and Torres Strait Islander groups, for instance, we are very flexible about them because they may be experiencing the sorts of problems that older people have when they are still in their early 50s, so we are flexible on that. The initial advice is free and

provided to anybody, but if we took it up as a case, then we would need to determine that this person is actually disadvantaged. We are not set up to provide assistance and philosophically we do not provide assistance to older people who are wealthy, for instance.

The Hon. TREVOR KHAN: Firstly, how much funding do you receive? I suppose that is a rude question; it is like asking people's age.

Mr COWEN: We have here annual reports and multiple copies of them. We are happy to table them and provide all members with a copy if the Chairman is happy to have us to do that.

The Hon. TREVOR KHAN: Will that answer my question?

Mr COWEN: That will have the information in it. As I say, being in this position for only 2½ to 3 hours now, I have not got myself across all the detail.

The Hon. TREVOR KHAN: That is fine. I will move on to the next question. In terms of a model of providing advocacy—and this may run contrary to your own organisation—do you see providing advocacy services for ADHC clients to be on the basis of providing advocacy services for people above 60 and then somebody else provides the below 60 service or is a better model of providing advocacy services to have an advocacy service that provides for all ADHC clients?

Mr COWEN: It is a very good question because there are quite a lot of clients receiving those services, for one reason or another, who are actually quite young.

The Hon. TREVOR KHAN: Indeed, two or three is perhaps the start of the intake process into the service?

Mr COWEN: And I can see that it would be very useful to have a service established that could provide for the full range of age groups that are receiving that particular service because you do develop an expertise in it. As I mentioned earlier, other community legal centres across New South Wales actually refer older people to us because they know we have the expertise. We are in the process now of developing a training program to go out to other community legal centres to actually increase their capacity to deliver the sorts of services that we are delivering to older people in their communities, so it is a rural and regional approach that we try to adopt too.

Yes, simply defining somebody as being over 60 and in need of the service and there is this organisation that can do it properly is not the best way forward and in fact we would be better off having this service being provided by the same organisation across the full range of people. I suppose in developing expertise for something though, if you have an expertise in assisting a 16, 17, or 18 -year-old, that may not be translated because those people are probably more likely to be suffering from some disability and receiving that service than an old or frail person, who is not actually disabled at all, and that is where we would come into it, where we are providing that service. I believe there is something like 38 organisations already that can advocate on behalf of a range of disabled people at the moment, but there is not any organisation that is set up to advocate—I am not commenting on whether they do it well—

The Hon. TREVOR KHAN: I accept that.

Mr COWEN: But there is none set up to assist older people who are receiving the HACC services.

The Hon. HELEN WESTWOOD: Is it possible to get a picture on the legal needs of older people in New South Wales, given that you can only provide to a certain group and it seems that community legal centres are referring back to you. Are you confident, from your experience, that we have an understanding of the main issues facing older people in New South Wales?

Mr COWEN: No, I do not think so, but I do not think that is restricted to New South Wales. I think that is across the country as a whole. My experience comes from Queensland and the latest figure that I have been able to find is that there were 35,000 sufferers of abuse in Queensland over the age of 65 is 2004. My experience of working in the sector in Queensland—and the way they did it was to establish five of these seniors legal support units around the State—is that the demand for the service is overwhelming. I do not imagine it

would be any different in New South Wales, and there is a similar organisation established in Victoria and they found the same thing.

Although there was a reference to a tsunami of aged people, I would like to think of it as a tsunami of wisdom because although the population and the demographics are getting older, it is also getting wiser. Unfortunately, the children still want to get their inheritance before mum and dad actually shuffle it off and they get up to all sorts of nefarious things to do it. Abuse itself, of course, takes many forms. It can be physical abuse, straight out assault, but it can be psychological and isolation—a range of those sorts of things that older people are suffering from and are victims of. I do not think that the community at large really understands that. It is a little bit like child abuse awareness was 25 years ago and it has taken a long time to get the mind shift in the community about child abuse and it will take a similar time to get the mind shift about elder abuse.

The Hon. HELEN WESTWOOD: Would it be appropriate for community legal centres, and I say this because they are widespread, to have the capacity—and I assume they do not because they refer people back to you—to have services provided to older people in New South Wales with lawyers who specialise in the older community?

Mr COWEN: I think that would be a very good step forward. The current OPAL service operates mainly on telephone advice and with older people, that is a bit of a problem in itself. If you could actually sit and talk face-to-face with the older person who has the specific problem, that is a giant leap forward. Often older people will come into service, have an interview with the solicitor and, in my experience, a social worker and they are apprised of the legal situation, the social situation and what their options are. They leave happy just knowing that and they decide not to take any action against their son and daughter for all sorts of reasons, knowing they do have these options available to them and that, in itself, can relieve a great burden for them.

Mrs SMALL: That can take time and resources, especially with the advice line, which is constant. It can take a couple of hours to help somebody that way and it is time consuming.

Mr COWEN: It is a resource intensive system when it is set up to do it that way.

The Hon. GREG DONNELLY: Thank you for coming along today. Your evidence has been most helpful. My first question is a general one and if you need to take it on notice, feel free to say so. In order that I can at least capture a snapshot of the organisations associated with advocacy for and on behalf of elderly people in Australia—I have not had a chance to fully read your report—what other organisations are involved in similar work to your organisation, which provides legal advice and related matters? There is a whole swathe of issues that affect elderly people and which we will be confronting, and we have touched on quite a few this morning.

Mrs SMALL: They are mainly specialist centres, such as the Welfare Rights Centre, because Centrelink issues arise with a lot of elder abuse cases and they are the specialist service for Centrelink. The Older Persons Tenants Service is another one. We refer people to the specialist centres as well rather than deal with them ourselves most of the time because they are the experts in that area.

The Hon. GREG DONNELLY: Is there any organisation that straddles and knits together all these organisations that do this important advocacy work for elderly people?

Mrs SMALL: I would say it is OPLS in New South Wales.

The Hon. GREG DONNELLY: Could you describe to the Committee what OPLS is and the organisation as you understand it?

Mrs SMALL: OPLS is the Older Persons Legal Service. Until last week it consisted of two solicitors and the principal solicitor over-arched The Aged-care Rights Service [TARS] retirement villages. There is the telephone advice line, which you have heard about. We are one of the few centres that run a telephone advice line every day of the week.

The Hon. GREG DONNELLY: When you say "few centres", do you mean in Australia?

Mrs SMALL: Community legal centres that I am aware of. You can get a Community Legal Centre booklet that sets out the times you can access community legal centres online in New South Wales and the hours they are available. The telephone advice line takes up a lot of our time because quite often there are follow-ups

and we need to check Acts or do some research, or something like that, and get back to people. We are quite often in high demand for community legal education and in rural areas as well. Workers as well as individuals are really keen to come along and put questions. Doing submissions in relation to policy takes time. Apart from this hearing there is a Commonwealth inquiry at the moment into advance care directives that we are preparing a policy for. Casework comes into it somewhere along the line and you really do not have the time to deal with many cases because there is just too much of everything else going on.

The Hon. GREG DONNELLY: To coin an old phrase, you seem to be operating on the smell of an oily rag in terms of the amount of work and potential work available vis-a-vis your essential resource base. Is that a fair statement?

Mrs SMALL: I think it is reasonably fair. Of course, we have been going for only two and a half years. I was one of the people who were instrumental in helping to set it up. Melissa Chapman was the other solicitor. Within a matter of a couple of months we were inundated with calls. It has been constant. There is a roster for half a day each day of the week and there are not the resources to put into it. Just about every Community Legal Centre would tell you that the resources are not allocated sufficiently for the work they need to do.

The Hon. GREG DONNELLY: Are there similar structures operating in other States and Territories around Australia?

Mrs SMALL: I am impressed with Queensland. Tom has informed me about that. They have a much smaller aged population and yet they have five centres. My understanding is that Queensland was the first to set up an older persons' legal service, and that was a long time ago—maybe eight to ten years ago. There is certainly one in Victoria.

Mr COWEN: There is a national organisation that has a specialist group for older persons' legal services and we have meetings a bit less frequently than monthly. I will be going to the National Association of Community Legal Centres annual conference in Melbourne on 27 October and we will have a meeting before that conference begins of all the service providers for the older person. Each jurisdiction has set up its own quite distinct approach to it. New South Wales has one service that provides for the whole State via telephone. Queensland has five services set up to do the regional work. Victoria has one service but does outreach to other community legal centres in Victoria. Western Australia basically has the one service as well. I am not absolutely sure how Western Australia manages it. I think South Australia's set-up is similar to New South Wales. I do not know the detail of how the Tasmanian one operates but hopefully after the end of October I will have a pretty good idea about the way the other States have set up their systems.

We have these meetings to get together and the national association has been putting together a submission to the Commonwealth to try to get some guaranteed Commonwealth funding to support the provision of legal services to older persons. My experience tells me that you do not want just the legal service. Older people's problems seem to extend well beyond just the legal area. They may come in with a specific legal problem and they may have the capacity to overcome all those barriers that stand in the way of seeking assistance because it is a specific legal problem, but once they get in there they reveal that in fact their problems go much deeper and much broader than that.

The Hon. GREG DONNELLY: Thank you for the very important work you do for the elderly in the community.

Ms McDONNELL: Can I add to Tom's answer? Our advocacy service is part of the National Aged Care Advocacy Program, which is funded by the Commonwealth Government, which means that every State and Territory has an organisation the same as TARS to provide advocacy service for Commonwealth-funded aged care. Four States—South Australia, Queensland, Western Australia and Tasmania—have organisations that are funded to provide advocacy services for Home and Community Care clients and clients with disabilities. We are one of the few out of that group of organisations that are not.

The Hon. HELEN WESTWOOD: Where is that funding from?

Ms McDONNELL: Some is Commonwealth funding and some is State funding. I can get you the details.

The Hon. GREG DONNELLY: That would be appreciated.

CHAIR: Thank you very much for being with us today. It is greatly appreciated.

(The witnesses withdrew)

RICHARD JOHN MATTHEWS, Deputy Director General, Strategic Development, New South Wales Department of Health, and

CATHRINE MAY LYNCH, Director, Primary Health and Community Partnerships, New South Wales Department of Health, affirmed and examined:

CHAIR: Would you like to make some opening comments before we proceed to questions?

Dr MATTHEWS: No; I am happy to take questions.

The Hon. TREVOR KHAN: I refer to your submission, particularly the last page, which deals with the mental health memorandum of understanding. Firstly, can you tell us where the memorandum of understanding is up to precisely, because there seems to be a degree of variation in the evidence as to where it is up to?

Dr MATTHEWS: I think I can say that it is finalised. It went across my desk this morning quite early, and I signed it in my anointed position. It has now gone to the stage where the directors general will look at it, and I am sure will agree with it, and there will be a formal arrangement whereby they sign.

The Hon. TREVOR KHAN: Is it possible to get a copy of it?

Dr MATTHEWS: As soon as it is approved by the directors general. I did say rather glibly that I am sure they will accept it. They may, in fact, wish to make some changes of their own. As soon as it is signed, I am sure there will be a photo, et cetera, because it is an important document. I will make certain you get a copy.

The Hon. TREVOR KHAN: That is yes, with a caveat?

Dr MATTHEWS: Yes. Even if it is changed by then, you will get a copy of it. It is a definite yes.

The Hon. TREVOR KHAN: What you rightly point out is that people with an intellectual disability have a higher propensity for mental illness. I think that is essentially what you say, is that right?

Dr MATTHEWS: Yes.

The Hon. TREVOR KHAN: But there would be a lot of people with an intellectual disability who do not suffer from a mental illness. That would be right also, would it not?

Dr MATTHEWS: Absolutely.

The Hon. TREVOR KHAN: And yet, many of those people with an intellectual disability will end up fronting up in the health service?

Dr MATTHEWS: Yes.

The Hon. TREVOR KHAN: And, in many cases, their needs will have been dealt with by ADHC, to a greater or lesser extent?

Dr MATTHEWS: Yes.

The Hon. TREVOR KHAN: And information would be available within ADHC that may be very useful to clinicians who are dealing with the person who is fronting up, say, at accident and emergency, would that be right?

Dr MATTHEWS: That would be correct.

The Hon. TREVOR KHAN: If all that is correct, why are you only dealing with people with a mental illness and not people with an intellectual disability?

Dr MATTHEWS: Well, we are not. But that memorandum of understanding deals with those very specific issues. We are also developing a framework for providing health services to people with intellectual disability generally. I should point out that, like every other member of the community, people with intellectual disability have access to Medicare, and as such their first port of call for primary care in a proper world ought to be a good general practitioner and referral to various things. We provide specialist services, and of course we provide hospital services, and we provide the bulk of the emergency services. As a principle I am sure we would all agree with, people with disability should access the health system in its entirety—in the same way as the rest of us—but should receive appropriate levels of support and specialised services when they are needed. So, we are dealing with the groups separately but complimentarily.

The Hon. TREVOR KHAN: If you are dealing with them separately but in a complimentary fashion, and if there is a framework that you are working towards something more, what are you working towards with people who have an intellectual disability but do not fall within the subset of also having a mental illness?

Dr MATTHEWS: Cathrine is the principal architect of the framework, so I might ask her to talk to it.

Ms LYNCH: The piece of work around mental illness and intellectual disability is one specific component, and maybe a small subset of a larger component of work that we do with ADHC. It can be a particularly difficult area. When you have someone with an intellectual disability, sometimes their behaviours may present, if they have a mental illness, in an unusual way to other people with a mental illness, or it may be a product of their intellectual disability. So, there needed to be a shared understanding between ADHC and Health about what Health could provide. There are some specialist psychiatrists who do provide particular assessments in intellectual disability, so that deals with that bit in particular.

However, there is another framework and service agreement we have been working towards with ADHC, which is really more about the health care needs of people with an intellectual disability. That is a tiered approach. As Dr Matthews mentioned, at the primary level, the universal level, it is what everyone would expect to receive through general practice or community health services. At its highest level, people with intellectual disability also have some quite complicated physical health problems—particularly, for instance, gastrointestinal-type problems. So there is also a need for specialist health services. That means that those clinicians have a specialist skill set, not just in gastroenterology but in how it might present in that population of people where there is a more complex picture. The framework has five levels. That is called tier five, so it is a quite specialised area.

There are already some services that provide at that level. We have some additional funding to trial a particular model. We are not sure if a clinical nurse consultant model works best, or one with a small team. There is some evidence that small teams worked best. In fact, there are some small teams already. The one at St George Hospital, for instance, would be a flagship one. At the highest level, what we are also establishing is a clinical network of experts—those kinds of physicians, from general practice right through, that have a special interest in working with people with intellectual disability. That framework, although it does bring in the mental illness, is actually more about the physical side.

We are working on a lot of things with Ageing, Disability and Home Care, but another one is the hospitalisation of people with an intellectual disability as well.

We ensure that when those people come to hospital their communication needs, or the way in which they are looked after, are accounted for in hospital. In addition, we are working with ADHC to have carers present—whether it be a carer from ADHC or a member of a person's own family—to support him or her in the hospital environment and to work with and communicate with staff about supporting that person at the same level—or probably a little less to tell you the truth because hospital staff are there all the time. But if people need some support in the home to do everyday activities they might need that support also in hospital. For instance, some people need help with feeding themselves and that kind of thing.

Dr MATTHEWS: The framework will work at a number of levels. The first level is awareness so that people are aware of the problems and aware of the places to which they can go to get specialist help. That does not apply only to families; it is also where general practice can access specialist help. We have to build an additional workforce, which is a challenge in this area as it is in many areas, and we have to introduce new services. We recognise that and we are starting to do that. We also have to have a pathway and a means of providing specialist support for people when they are admitted to hospital. We are putting it in place. Is it complete? No, it is not.

The Hon. TREVOR KHAN: I was not seeking to be critical; I was trying to work out where it is up to and where you are seeking to go. I am sorry to cut across you, but it was not intended that way.

The Hon. MARIE FICARRA: The New South Wales Ombudsman states in his submission that families have reported extensive waiting times to access equipment as part of the Program of Appliances for Disabled People [PADP] and that often the waiting period is up to two years. I know you have commented on this issue before. As a result it has had an adverse effect on people's education, health and independence. What is being done to address the issues that have been identified by the Ombudsman and to improve people's access to these essential aids?

Dr MATTHEWS: As you know, I have given fairly extensive evidence at estimates committees and in other places about PADP reforms which fall into two areas. The first is the establishment of Enable, the single processing centre, and over time replacing the various processing centres around the State to act on what essentially are the prescriptions written by clinicians for various forms of disability support. That has been a difficult but a successful process. At the estimates committee hearings I was asked a question that I had to take on notice about the information technology [IT] system at Enable. I have made inquiries and you will be getting that information in writing. Those problems have been overcome, it is now being introduced and we will be supporting that activity very shortly.

Every year there is considerable enhancement to that program. The paediatric component almost invariably has its waiting list completed each year. The adult one I think is at about $25 million. However, it is an area where need and technology are dramatically expanding the potentialities to support people with disability at an exponential rate. I have given examples before in this place of Stephen Hawking and Christopher Reeve. There are enormous technical improvements in those sorts of things to support disability. It is a program that will need to increase in scope over time—and it has. Catherine might wish to talk about the way in which the new centre will take over from the old.

Ms LYNCH: All the centres in area health services will be transitioned by the end of the year, which will enable us to scrutinise any waiting lists. Some strategies have been put in place in order to get people out of hospital in a timely manner. One is the Specialised Equipment Essential for Discharge, or SEED program—the essential equipment for people with spinal cord injuries program—which works to get people out of hospital and back into the community as quickly as possible. Clients that are in ADHC facilities get their equipment through ADHC. Those with disabilities who are not in those residential facilities use the Enable program, which has a number of component parts. One is the PADP program, or the Program of Appliances for Disabled People, and there is also the home oxygen equipment for people program and the ventilator dependent program. There is one other.

Dr MATTHEWS: The artificial limbs program.

Ms LYNCH: It is now called the Prosthetic (Artificial) Limbs program.

Dr MATTHEWS: The waiting list is coming down. We have much better data on those waiting lists. It has not been a priority but we need to divide it into two sections, one of which is waiting for something very special to be made. When some of these modern aids are prescribed these days they are unique to individuals and there is a manufacturing period. We have that wait but we need to ensure that it is as fast as possible. There is also a resource-based wait.

The Hon. MARIE FICARRA: Has the PricewaterhouseCoopers recommendation on waiting periods been adopted by EnableNSW? You can take that question on notice.

Dr MATTHEWS: We might have to as it is a specific recommendation.

Ms LYNCH: It is probably a little detailed.

The Hon. MARIE FICARRA: I refer again to PricewaterhouseCoopers review and to the recommendation about establishing standards and key performance indicators, and to providing timely information about the status of a client's application, the processing time and the waiting times. If you do not know the answer to this question you might need to take it on notice. Have the standards and the key performance indicators been established, and can you provide the Committee with a copy of those standards and

with performance data regarding the time it takes to process applications and the waiting times experienced in such an assessment?

Dr MATTHEWS: We are happy to take that question on notice and to provide that information to the Committee. I know it will be assisted by the new IT system, which will enable the running of these reports on a regular basis. However, we will provide that information to the Committee.

CHAIR: When taking that question on notice will you be mindful of the time frame within which we have to put together our report? Can you give us an indication of how quickly you can provide that information to us?

Dr MATTHEWS: Not absolutely, but we will talk to Bronwyn Scott who runs the service and get back to the Committee secretariat tomorrow with the time that it will take.

The Hon. GREG DONNELLY: Do you anticipate any problems occurring when administration for the HACC program is split between the State and Commonwealth governments in 2012?

Dr MATTHEWS: I think that will create some challenges for us all. If you are a 45-year-old with cystic fibrosis, care in the home is little different from what it is if you are an 80-year-old with advanced respiratory disease from another cause. The choosing of that age of 65 is an historic choice. I am told that it was first introduced as the pension age in Prussia in the nineteenth century, at a time when only 3 per cent of the population reached the age of 65.

Nevertheless it is a construct that we have embedded into various things in our community but because of longevity some of those things are now under pressure. There is talk of the pension age increasing from 65 to 67; the French are struggling to get it from 60 up. So it is an artificial construct, and particularly in small regional and rural communities there is likely to be only one service, if indeed there is a service at all, and to have the policy and funding after your 65th birthday with one level of government and before your 65th birthday with another creates some challenges. There is, of course, also a significant body of mostly nursing staff within NSW Health—and I can only speak for Health—funded through the HACC program of about $75 million. Those nurses across New South Wales go into the homes of people of varying ages and provide services as part of that program.

The Commonwealth taking funding and policy responsibility for over 65, bearing in mind that about 80 per cent of the services are for over 65, means that after a period of time, five years, it could make that service contestable. If the Commonwealth tendered those services and they were won by a private, a charitable or some other agency, then NSW Health would be left with $75 million worth of staff with no funding source. You can imagine that is a risk to the State. So it is problematic but, nevertheless, it has been agreed between governments and we will have to work to make it a success.

The Hon. GREG DONNELLY: Will you please tell us how NSW Health works with other agencies to implement the Government's whole-of-government strategy: Towards 2030: Planning for our changing population strategy?

Dr MATTHEWS: NSW Health has responsibility obviously for the delivery clinical services—that is our main responsibility. That delivery of clinical services, generally known as geriatrics, operates in hospitals at the acute and the subacute level and in the community. It intersects with the Commonwealth responsibilities through the Aged Care Assessment Program [ACAP], and across the State there are 38 ACAP teams that have two functions: the first is to assess people for Commonwealth-funded programs such as facility-based aged care or community-based aged care; and the second is around assessing for clinical services. Those teams are approximately 50 per cent funded by the Commonwealth Government and 50 per cent funded by the State Government. Again, a Commonwealth decision to potentially separate them creates some issues for us.

The State is the service at the moment that has the expertise to provide those services, and they are very much complementary services. When a patient is in hospital with an illness, which is increased frailty, and an assessment is being made as to whether that person can return home with some assistance or is going to need facility-based aged care, that assessment is very much tied up with the provision of clinical care. We would argue strongly that whatever the funding sources for those services are they should remain together. There is an extremely successful, jointly funded program, known as Transitional Aged Care, where—and we like to take credit for the intellectual property in New South Wales—elderly folk who have been assessed as needing

facility-based care, after assessment in hospital, get a 12-week intensive package of multidisciplinary care in their home. Interestingly, something like 60 per cent of people who were originally assessed as needing facility-based care have been able to remain at home for at least a period. Demonstrating that success has meant that the Commonwealth has fully funded the second round; as well as being of significant benefit to citizens who wish to stay at home there is also a significant financial benefit to the Commonwealth Government because the facility-based program is its most expensive. It is an example of where with this interface of responsibility it is possible with goodwill to put in place programs that bring about improvements. I think that is happening but, as you would all well know, I have long been a proponent for a single point of accountability for all these things—I think that would solve a lot of our problems.

The Hon. HELEN WESTWOOD: To continue along that theme—and you may have covered some of this in your answer; I apologise if you have and I have missed it—the model in which you have got assessment teams funded by the Commonwealth, then enabling appropriate referral and coordination of service provision to that cohort, is there a reason why the same model or same approach could not have applied to people with an intellectual disability?

Dr MATTHEWS: There is a slightly different skill set. Assessing the needs associated with ageing and increasing frailty has some complementary skills with the assessment of that around disability, but there are some very separate skills and it is not, of course, just about intellectual disability—these days it is much broader—but the principle, which I think goes to the heart of your question, is the same. You put the patient or the individual at the centre and you say: "What needs does this person have to have their disability supported so they can function normally and participate in the community and the workforce?" That is the key question, and then having provided that assessment you say: "How do we put in place those things?" The principle is exactly the same.

The Hon. HELEN WESTWOOD: Is there resistance to that across the various bureaucracies or agencies that provide services?

Dr MATTHEWS: I do not think there is a resistance. I think it is a matter of putting in place the frameworks that Catherine's branch is putting in place. The fact is that the responsibility of the agencies is considerably different in relation to what they are doing and meeting their targets in the State Plan. Everybody is very busy and dealing with various kinds of need. I think the answer is actually putting in place structures that get people together and to work together with a common mission, and that is what we are working on.

The Hon. HELEN WESTWOOD: Some of the evidence we received from other witnesses has been around the interpretation of confidentiality when it comes to sharing information from whichever bureaucracy, usually ADAHC, carries out the assessment and other providers of services, such as Health. Has there been an issue that you are aware of? Is that something that is addressed in a memorandum of understanding?

Dr MATTHEWS: Yes. It has been an issue, and it always is an issue. There are a couple of things I would say. Firstly, confidentiality and the exchange of this information is not an issue, if you have consented. If you are trying to assist a person and you go about getting that consent and they do not want to give it, quite frankly I think you have to examine your own approaches as a practitioner. A lot of our folk can be a bit precious about it. Again it is a matter of putting instructions out about it.

What we have managed to achieve in another area around Keep Them Safe for kids who are at risk is a really outstanding example of how agencies can get together and put in place an information system that enables, in that case, approximately seven or eight agencies to appropriately share information. It can be an issue, but in this particular case where you really do have a patient or person for whom you are trying to put together some structures to assist them, as I say if you cannot get consent from the patient, the parent or guardian, then there is something wrong with you as a practitioner, in my view.

Dr JOHN KAYE: I will put a question to you that I put to another witness earlier. One of the issues here is the relationship between somebody with a disability and the service providers who address those disabilities. One of the issues is the language we use about that. We used to call them "patients", and now we call them "clients", which seems to be a step in the right direction. But where do we go to from there to take it away from that sort of model and more into the partnership model? Do you see value in changing the language?

Dr MATTHEWS: It seems to me generally we change language a lot and over time the new language has a tendency to become pejorative. It is my background, I suppose: you have noticed that I have used the word

"patient" quite a bit today. I am hopelessly stuck in a medical model. What can I say? I think the relationship you have with the human being you are dealing with is a skill, and in this case it is particularly difficult if you are dealing with intellectual disability. You have a relationship with a person, with parents and guardians, and as a practitioner your job is actually to convey the factual information, the options, the risks and the opportunities in a way that the people you are dealing with can understand, and then have them make choices. That is the way it should be.

I think it used to be called common sense but then it got called natural thinking and then it got called something else. These are the sorts of skills that we need to teach our workforce. You might argue, and I might not disagree, that many doctors are not particularly good at communicating with their patients. In the area of intellectual disability and disability generally, where there are lots of increased barriers to communication, it is a workforce skill that we need to inculcate into the workforce. That is about leadership, I think.

Ms LYNCH: The comment I would add is that I think it is partly the role and the relationship that you play as well. I think a doctor or a medical practitioner has a certain relationship. In that relationship, everyone is a patient. I am an occupational therapist. The way that I am trained to work in a range of things is actually more of a partnership model. Dr Matthews is smiling because we have often had conversations about the way that we do our business, but as an occupational therapist you work in partnership with the person. You look at their goals and their outcomes. It really is the model of practice that you work within. I would probably say that it varies across Health and across ADAHC, depending on the intervention and what you are doing as well.

Dr MATTHEWS: I would be prepared to be a radical and say that for reasons of tradition, multidisciplinary teams have been led by doctors and it may be that needs to change a bit. They are a highly skilled group of people who bring some very particular skills to the team, but in this area there might be other better and more natural leaders of the team. But some reforms take a while longer than others.

The Hon. GREG DONNELLY: I think that is "go forward together". Dr Mathews, there are two phrases that you have not used, about which I am very pleased: one is "going forward together" and the other one is "the disability space". I have not heard you refer to operating in "the disability space", for which I am grateful.

The Hon. MARIE FICARRA: I think we have been here for too long.

CHAIR: Is there anything you would like to add?

Dr MATTHEWS: I think I have probably gone too far already.

The Hon. MARIE FICARRA: The Committee has received evidence that families who have young children with significant communication and feeding difficulties are often reluctant to be transferred to ADAHC services once their child has been diagnosed with an intellectual disability. It is thought that parents are frustrated by ADAHC's service quantity, quality, timeliness and transparency, according to submissions we have received. Could you suggest reasons why parents are more comfortable using New South Wales Health services as opposed to those provided by ADAHC? That is what we are hearing, which is sort of like a compliment, but I would like you to expand on it.

Dr MATTHEWS: But it is quite a tricky question. I think in particular a lot of children have very complex birth defects and medical problems leading to disability. They tend to be looked after, assessed and provided with health services in tertiary children's hospitals which, when you look at them, are large, well resourced, shiny places of great expertise, great compassion and great concentration of services and where people in our community really get very well looked after, I think. If you go to Westmead, to Randwick or to John Hunter, where the tertiary children's hospitals are, the vast majority of parents, even in very difficult times, have very good experiences.

There is no ADAHC equivalent to that. It is very often at a time when people are going home that that places enormous pressure on parents, the other siblings and everybody. It may be that some of that criticism is related to that transitional issue. I guess it is a very important area, and I think it is something that our New South Wales kids endeavour needs to take on as part of its work, and we need to probably get the same complementary relationship with ADAHC in this specialist area that we have with other cohorts.

The Hon. MARIE FICARRA: How would you help ADHAC provide services in a better fashion?

Dr MATTHEWS: We can provide some expertise and we can provide training. In fairness to ADHAC, I would have to ask a question, and I do not know the answer to the question. Are our handover procedures adequate—because there is a point where there is a significant handover from the intense medical functionality to ADHAC—and are we available to give additional support thereafter when needed? We would need to go through a process to do that. I think NSW Kids is the ideal venue. I am meeting with the new chief paediatrician on Friday. I will add it to his list.

The Hon. MARIE FICARRA: Very timely. Thank you, Dr Matthews. Going on feedback, submissions we have received highlight the importance of government departments and agencies working collaboratively. In your submission you discuss the success of the New South Wales Hunter Access Point. Can you give us examples of other successful initiatives that have been conducted by your department and ADHAC?

Dr MATTHEWS: Hunter is really the trial for getting the single access.

The Hon. MARIE FICARRA: Or any that have been unsuccessful? We always learn from those, as the feedback forms the direction of policy planning from their success or otherwise.

Dr MATTHEWS: There is the Acquired Brain Injury [ABI] Interagency Steering Committee. This is about support for people with acquired brain injury who are often young people, very slow to recover. We are working very closely with ADHAC to improve that particular pathway.

Ms LYNCH: It might seem like a small example but I think it has been quite an important piece of work—the Home Enteral Nutrition, or HEN, piece of work that we have done with them. This is where people need to be fed intravenously. A lot of residents in ADHAC houses have the HEN as feed. We have worked with ADHAC to identify what some of the problems were. Often these clients were presenting to the emergency department with either the fitting coming out or with infection. We have worked closely with them to identify the source of the problem. One of the things was training and the other appropriate equipment. We have worked quite closely to analyse the problem, look at the data and look at the role of Health. ADHAC staff can do that work but they need appropriately trained clinicians to help them with the training. That has a benefit not just for the clients but it also for our emergency departments. We are being pre-emptive. We have put in an earlier recognition of the problem by providing training. We did that with ADHAC and Health and also our Agency for Clinical Innovation, which is a network of clinicians with an interest area. We have a network of those clinicians and dieticians as well who are interested in particular in that area. That has worked really well, again, looking at the problem, looking at the client and then looking at what we can do together to solve it. Rather than saying, "This is your bit, this is my bit", we work closely together with the patient or the client as the focus.

The Hon. HELEN WESTWOOD: I want to ask about the issue about young people in residential aged care. You may not be able to answer this or you may want to take it on notice. I am interested in Health's experience over time of people moving out of larger residential care facilities into smaller group homes. Does Health have an opinion on the health outcomes for those people?

Dr MATTHEWS: This has been a difficult and controversial area for a couple of reasons. One is that there have been some models of care that could be improved. The other one, of course, is again the issue between the Commonwealth and the State about who is responsible. There is a cohort of young people who need facility-based care. More and more people are getting home but there is always going to be a cohort who, for reason of the severity of their disability or because they really do have absolutely no family supports, that facility-based care is necessary. There is a principle that, as far as is possible, people should be placed with their own age cohort. Certainly the idea of a young person with severe disability being put in an aged care unit is extremely, I think, unfair is probably about the best word I can use.

CHAIR: But becoming more common?

Dr MATTHEWS: There is a shift. At a previous COAG meeting the Commonwealth made some money available to transition people out. The cohort that is still there is an ageing one, increasingly approaching the age for aged care. Responsibility will transfer to the State as part of the reforms now and with it the existing Commonwealth funding because that transfer is in the first instance cost neutral. Designing appropriate facilities—which can be located with aged care; I do not think there is any problem with having an aged care wing and a young persons' wing as long as the care in the aged cohort is fine—is now very firmly a

responsibility of the States and one the State will have to take over. Those significant reforms will really start to gather some steam between now and 2014.

The Hon. HELEN WESTWOOD: We heard earlier evidence from ADHAC that they are looking at establishing a 100-bed facility for people with high level medical needs. Has Health been involved at all in any of the consultations about the plan and structure of that facility?

Dr MATTHEWS: Yes. For instance, at the Macquarie Hospital at Ryde, their rather old facility has had some very long-term residents. We made available some vacant land on site. They are in the process of constructing, I think, five five-bedroom villas and that will be a much more modern style of accommodation. The residents will move out of that centre. Likewise, moving out of Peat Island, I think they probably gave you that evidence.

The Hon. HELEN WESTWOOD: Yes.

Dr MATTHEWS: These transitions are regular agenda items at our senior officer group meetings. We give advice about how health services can be best accessed. Some of our older facilities in both Health and ADHAC are isolated. That was considered to be a god thing at one time. So relocation closer to two things: one, the other specialised services that people need; and, two, closer to the universities. One of the things that drive quality in a service, whether it is a health service or a disability service, is teaching. So we need to train specialist staff—medical, nursing and, in particular, allied health—and having students who ask you questions and research is one of the key drivers of quality. I think we need to rethink that old policy of isolation and be thinking, to borrow a term from mental health, about mainstreaming.

CHAIR: Before we close are there any comments you would like to make to us?

Dr MATTHEWS: Only to say this is a really important area and we thank the committee for undertaking this work.

CHAIR: You have not got any recommendations you can give us?

Dr MATTHEWS: Awareness. I will go out on a limb: this is a community issue; it is not just a government issue. In the end the government is here to serve the people with the money that people give the government. So it is a community issue and the community needs awareness because whether it is disability or mental illness or illness of other kinds, it is going to get us all in the end, so the community needs to take this on board and decide that it wishes to invest in it and the community will drive governments to do so.

CHAIR: Well said. Thank you very much for being with us.

(The witnesses withdrew)

(Luncheon adjournment)

DAMIAN GRIFFIS, Executive Officer, Aboriginal Disability Network, affirmed and examined:

CHAIR: Thank you for being with us this afternoon. Would you like to make some opening comments before we go to questions?

Mr GRIFFIS: By any measure, Aboriginal and Torres Strait Islander people with disabilities are amongst the most disadvantaged Australians. They often face multiple barriers to their meaningful participation within their own communities and the wider community. The vast majority of Aboriginal and Torres Strait Islander people with disabilities are at the periphery of all aspects of the disability services sector. In accessing individual advocacy services this is particularly acute despite the fact that in many ways Aboriginal and Torres Strait Islander people with disabilities are the group within the Australian community who are most in need of individual advocacy support.

The prevalence of disability amongst Aboriginal and Torres Strait Islanders is significantly higher than that of the general population. Until recently the prevalence of disabilities in Aboriginal and Torres Strait Islander communities has only been anecdotally reported. However, a recent report by the Commonwealth Steering Committee for the Review of Government Service Provision made the following conclusions: The proportion of the indigenous population 15 years and over reporting a disability or long-term health condition was 37 per cent. The proportions were similar in remote and non-remote areas. This measure of disability does not specifically include people with a psychological disability. The high prevalence of disability is approximately twice that of the non-indigenous population and occurs in Aboriginal and Torres Strait Islander communities for a range of social reasons including poor health care, poor nutrition, exposure to violence and psychological trauma arising from removal from family and community, and substance abuse as well as the breakdown of traditional community structures in some areas.

Aboriginal people with a disability are significantly overrepresented on a population group basis among homeless people, in the criminal and juvenile justice systems and in the care and protection system, both as parents and children. Historically, much of the focus on Aboriginal people with disabilities has been from a health perspective. Whilst this is essential, particularly regarding primary health interventions, it has come at the cost of failing to recognise the social aspects of general disability. This has meant that the barriers that produce discrimination against Aboriginal people with a disability remain firmly entrenched and the general wellbeing of Aboriginal people with a disability has not improved in any meaningful way.

Furthermore, the impact of colonisation and the resultant dispossession of land and displacement from places of cultural significance have had an impact on the lives of many Aboriginal people with a disability, which is difficult to measure. All of these factors contribute to the fact that disability rights from an Aboriginal and Torres Strait Islander perspective is an emerging social movement. In many ways this social movement is starting from a baseline position.

The Hon. GREG DONNELLY: We have got some proforma questions to ask you. In your opening statement, and to draw you out a little bit in terms of some of the issues there, you identified that there is approximately twice the prevalence of disability in Aboriginal and Torres Strait Islander communities when compared with non-indigenous, and also 37 per cent of the Aboriginal population live with a disability. Could you identify some of the main barriers that exist regarding Aboriginal people receiving appropriate disability services which are perhaps not being adequately addressed?

Mr GRIFFIS: You start with the word "disability". In traditional language there was not a comparable word to "disability". That suggests one of two things really. There is some evidence to suggest that some Aboriginal people with a disability may have been viewed as having special powers, if you like—they had a place of status within their community. That is particularly people who are, say, blind or deaf. It tends to suggest that it is an accepted part of the human experience in that there was not a label for it. But that is perhaps a slightly romantic view. In other communities it might have been a case of, depending on the nature of the disability, it depends on whether a person was well supported. If people were living in permanent dwellings they could probably be guaranteed some level of support, but if people were moving around it might have been harder.

So we have a problem with the word to begin with. I do not use the word in community, for instance—very rarely. It tends to be an impairment-based discussion: Does Aunty or Uncle have trouble getting around?

Or does cousin have trouble understanding or is cousin down the road a bit slower than everyone else? Sometimes that language is a bit of a problem for the rest of the disability rights sector because that might be viewed as being slightly offensive. That is the way to communicate it. Very few Aboriginal people identify as having a disability. The 37 per cent figure is not terribly reliable; some would argue it is much higher. The way that statistic came into being is still debated. It is based on hospital admissions and things like that, so it is not terribly reliable. People do not put up their hand and say, "I am a person with a disability." That is a problem in itself.

The Hon. GREG DONNELLY: What are your thoughts about the strategies that might break down those barriers in terms of the capacity of service providers to reach out with assistance?

Mr GRIFFIS: Sometimes these things are a bridge too far. We must start with a conversation around what is a disability according to the Disability Services Act and educate people about their rights and entitlements as a person with a disability. I meet plenty of Aboriginal people who should be on the Disability Support Pension who have never heard of it because they are not engaging and self identifying. The idea of creating a service system without people feeling safe and confident or even understanding what is meant by "disability" will not work.

The investment needs to be at the front end. That is, we need to establish local networks of Aboriginal people with disabilities so that they can share their stories in community and tell people how they have managed to negotiate an often complex system. It is not inconceivable that Aboriginal mums with a child with a disability might deal with five or six government departments in the first five or 10 years of the life of their child. Most people would find that overwhelming. We already know and it is well established that Aboriginal people have a natural distrust of the government sector. That is not working either. We should provide community with the opportunity to have the conversation itself.

It is not always about providing services. I can think of a community that simply needed a wheelchair accessible bus; it did not need a Home and Community Care program or a disability services system to be put in place. There are already people in that community who are what by any other standard would be regarded as professional carers. They just need more resources to do it. A community development model would be more appropriate. We think that is the way forward and that is what we have been advocating around the country; I do that on a national level.

The Hon. GREG DONNELLY: In your opinion is there any good benchmark or example that the Committee could examine, or certainly better than New South Wales is offering?

Mr GRIFFIS: What is happening in Western Australia is positive. I have had a fair bit of exposure to the Kimberley region. The Western Australian Disability Services Commission is doing a good job, although it would be the first to admit that it could do better. Its local area coordinator model has great potential in that it involves a person located in community who effectively acts as an advocate. They do not really have restrictions on their role. They become conduits and linkages for people to access services. I have seen some good things happening in Western Australia. The commission is a standalone body. I have met with the director general several times and he talks about how he can access Treasury more easily. Where there are good things happening, it tends to be on a regional level, not across State or Territory jurisdictions. I have certainly seen positive things happening in Western Australia.

The Hon. GREG DONNELLY: Is that initiative relatively new or has it been happening for a while?

Mr GRIFFIS: I understand that the local area coordinator role has been around for a long time. That methodology has been replicated in other countries because it is working so well.

The Hon. HELEN WESTWOOD: Is the experience of Aboriginal people with a disability living in the city or in larger urban areas different from that of those living in more remote or regional areas?

Mr GRIFFIS: From what I have observed, people in the Sydney area are more likely to have choice and options and they are more likely to be able to work the system in their favour, but that is not universal. This is not a new issue, but we are concerned that once we get beyond Newcastle, Wollongong and the Blue Mountains, where half the Aboriginal position does not live, there is extraordinary unmet need. There are not the services available to be able to meet demand. Aboriginal people with disabilities in regional areas are more or less hidden, not in an abuse and neglect sense, but there is such a lack of services and confidence in the

sector. Parents and carers are reluctant to seek help because they are concerned that they will be judged to be bad parents. There is more choice in the Sydney metropolitan area. By definition, that should mean that more Aboriginal people access services in the city. There is also a much more robust community transport sector and Aboriginal controlled sector. The Aboriginal community-controlled health sector is very strong in the inner west at least.

The Hon. HELEN WESTWOOD: I refer to cultural appropriateness of service delivery. Is there a difference between the coast and remote areas or even with regard to types of services?

Mr GRIFFIS: Some regional communities are still very fractured. In my travels around the country I still find that western New South Wales is as confronting as anywhere else. Those black-white relations go back a while and the tensions are there on both sides. Sometimes that translates into people having difficulty accessing the local disability services provider. Logic suggests that where 80 per cent of the population is Aboriginal many more Aboriginals would be accessing disability services.

One of the most common calls we get to our office is from disability providers wanting to do a better job and to engage more culturally appropriately. We do not have the resources. I do not want to make this about me, but I am the only staff member of our organisation. We think there is a real opportunity to do some training, and I mean more than about bush tucker and BBQ stuff. I am talking about meaningful engagement about disability and the different way it is talked about in Aboriginal communities. People might go into a community with a brochure saying they are a disability service provider. Many Aboriginal communities will not understand what that means and will be nervous about what might happen if they engage with the provider. Even the notion of service is—for want of a better word—foreign in many ways. Many people do not understand the idea of going outside community to get support.

The Hon. HELEN WESTWOOD: Do Aboriginal communities' experiences of government and negative feelings about strategies like the intervention and so on transfer to providers of disability services?

Mr GRIFFIS: Yes.

The Hon. HELEN WESTWOOD: Regardless of whether they are a non-government organisation?

Mr GRIFFIS: I think non-government organisations have a better chance. We only received funding from the State Government about three months ago after about nine years, but we got funding finally. We had a lot of success in our own experience when we had funding from the private sector. People in the community felt a lot more comfortable talking openly to us when they knew we were not government funded. I guess we have established ourselves well enough with credibility to be able to accept government funding now anyway. I think non-government organisations are better placed, and the evidence suggests that in some parts of the State an organisation like People with Disability Australia, about 15 to 20 per cent of their clients are actually Aboriginal people with a disability which is an extraordinary achievement.

They have done that, and it has taken 10 years, and probably a lot of swallowing of pride to be honest and copping it a bit in forums from time to time. But they have now established themselves well enough to be able to go into say western New South Wales without us being there. They have done that by taking their time to build relationships and trust and that can take a long time. But it is almost just about being polite in a way too, I think. Sometimes its called cultural, and I do not know that it always is in a way. I think it is just about being polite sometimes. The advantage we have here is that it is about disability mostly, so it is not really about Aboriginality, it is about disability. So it is an advantage that we have that we are trying to get outcomes for persons with disability, not for their cultural needs necessarily, sometimes we are though, having said that.

The Hon. MARIE FICARRA: Disabilities is not really recognised as an entity the way we see it, how does the indigenous community see it themselves? Is the level of awareness of the need to do something evolving or is it just accepted and accommodated?

Mr GRIFFIS: That is a great question. There are different stories where you go and that is one of the challenges. As we know Aboriginal Australia is so diverse. So in more traditional communities sometimes disability is viewed as bad karma. It is not unlike the way it is viewed in other cultures where married wrong way, that is why your child has disability, if someone is visited upon you and perhaps cursed you in a way. So that is still a very real feeling in some parts of Australia. We have seen less evidence of that in New South Wales but there is still a perception. On the other side of the coin though there are plenty of examples I can think

of where a person with a very obvious disability is very well supported in the sense they are not labelled, and they are not viewed as being any particularly different in any way. But where it runs into trouble is they might not necessarily have the resources to be able to fully participate in their community.

It is not even about giving them a label necessarily, it is just about giving them the resources—it might be a wheelchair, say, to be able to go to the local community hall and participate in the elder's group meeting or something. And that is all that needs to happen. It does not need a huge investment around service provision. It is complex and it almost requires some really detailed analysis because I have had conversations equally with elders that will say things like "We don't have Down's syndrome in our communities". Well we have several members that have Down's syndrome. But that is not unlike where disability was 50 to 100 years ago. It was 100 years ago that people with epilepsy were possessed by the devil. In some ways it is almost a catch-up I think on some level. That is why I think the investment needs to be at the front end. I would argue very passionately for that. There needs to be a conversation first instead of things coming in over the top. I just do not think that is probably good use of money in any case. But it just gives an opportunity for people to understand what the rest of Australia means when we talk about disability.

The Hon. MARIE FICARRA: What do you mean by "needs to be a conversation"? What sort of recommendation from this Committee would help you with that "conversation"?

Mr GRIFFIS: Our organisation is made up of members who are Aboriginal people with disability, their families and carers. So it is a very unique organisation in an Aboriginal context in that it is almost a consumer organisation in some ways. What we advocate for is the establishment of local networks in different parts of the State where conversations can begin to be had, but also more than that, conversations are nice and everything but they actually have an individual advocacy function. One of the things that happens when I run a forum and I have a consultation and then straight after the forum several people come up to me and have a yarn and say, "Look I need you to go and see cousin now, or Uncle Rod down the road because an issue that needs help straight away". So it is establishing local networks that in time can perform their own advocacy functions. It is not unlike, say, a local area coordinator role that happens over in Western Australia but actually more community controlled, if you like, community oriented. So it is very much about community development I would argue at this stage and getting outcomes through individual advocacy.

The Hon. MARIE FICARRA: In relation to knowing the numbers and the need that is out there because census data is limited and, as you say, it is often flawed because of misinterpretation by individuals, do we need to get a handle on what the situation is and put in some resources?

Mr GRIFFIS: I think that would be the other area, yes, definitely. Research is a real weakness. Absolutely, other people have probably talked about the problems around the census data and disability in general but we all well and truly know that many Aboriginal people do not fill in census forms, so there is a real problem them. But we also need to do it in a way that is not a sort of tick the box sort of approach, it is more about, I would argue, the qualitative sort of approach that starts to filter through the stories and the experiences of people and then that can be replicated around the State. I think it is an absolutely critical area that needs major priority. I would be slightly nervous about how it is done, that is all, and that would require a bit of thinking but I have no doubt it is a critical area.

The Hon. MARIE FICARRA: The submission from ADHC states that the Aboriginal service development and delivery directive is, "working on initiatives to bring about systematic structural reforms to improve disability services for Aboriginal people". How effective do you believe ADHC has been in introducing that systemic structural reform for Aboriginal people? Has it ticked any boxes?

Mr GRIFFIS: I think it has got a lot better in the past couple of years. I think the advent of an Aboriginal virtual region is a very positive step. The best way I can answer that question is share our experiences as an organisation. We began in 2002 and for the next six years, I think it was, we did not receive any funding from the State Government but were often referred to in government information as being an individual advocacy provider, for instance, but we had no resources to do that. We still do not really know why that happened but we are grateful now that we have got some funding in the past couple of months, and it has taken a substantive amount of time to get that.

My members and I worry that there will be a lot of investment around service provision and those people that know how to work the system will be able to access it but those people that are hidden away that we can come across, and it is much easier for us to meet these people because we do not have the label being a

government person coming in with a pen in his top pocket sort of thing. We tend to be able to be invited into people's homes and we can see unmet need very directly. They are the people that I am really concerned about or the young Aboriginal kids with disability who are not part of the education system and, therefore, do not become part of the disability service system if you like.

We meet plenty of young Aboriginal kids that do not go to school or have not been to school or have been suspended at primary school age, for example, and then just disappear out of the system and, for all intents and purposes, effectively do not exist in the disability service system context. That is the area about which we are most concerned and they are often the people who are most in need. There have been positive developments in the past couple of years. We have a very good relationship with the Aboriginal virtual region senior people and that has been really positive. In the sort of middle years between 2010 and now there was a disbanding of the Aboriginal Policy Unit which was problematic. But we seem to be back on track now which is great. We certainly get consulted a lot more than we have in the past so that is positive.

CHAIR: Were you involved in the recently delivered Ombudsman's report and the findings of that?

Mr GRIFFIS: Yes, we were consulted. I have not had the opportunity to read it. I got a copy on Wednesday or so. We were involved in the consultations, yes.

CHAIR: I was hoping you had read it. The findings made by Mr Barber go virtually through five or six different areas. One was the level of awareness of Ageing, Disability and Home Care's funded and operated disability services, which you have touched upon. Another was the type of consultation mechanisms in place between Ageing, Disability and Home Care and the relevant service providers, and I think you have given us the flavour on that. The extent of planning to meet the needs of Aboriginal people, you might want to give us some thoughts on that, and the experience of front-line workers, both Ageing, Disability and Home Care and service providers staff and their views about what works in consulting with and delivering services, and some examples of good practice?

Mr GRIFFIS: I will answer the last bit first, examples of good practice. I have seen a couple of examples across the State. There is an organisation in Condobolin that is doing a great job. It has a day support program and a supportive employment program operating that is Aboriginal owned and operated. That is the only one I can report on operating as a non-government organisation. I am not aware of anyone else. What tends to happen is that aged Aboriginal services interact with Disability also. So there really is no stand-alone, Aboriginal-operated disability service provider across the State. Having said that, I would argue it is probably some way off, to be honest. There is not a lot of professional background in disability in the Aboriginal community. There are plenty of Aboriginal health workers, comparatively, but not a lot of people who have an understanding of the social justice issue around disability. Certainly some of our members do who become strong local advocates, but that is a real weakness and perhaps that is another area—it is not our area—that needs to be invested in as creating a career path.

I have seen some extraordinary things at a local level, Aboriginal people who have a disability themselves who have managed to mobilise their local community and get outcomes for themselves and for other people in their communities, but again they do that voluntarily, and that is a credit to them. On the planning side of things, as we probably know, Aboriginal people are certainly well consulted. They are some of the most consulted people in the State. There are plenty of reports and plenty of consultation happens. It is another thing when the outcomes are met. The planning side of things, again, needs to involve a concerted outreach approach. I see a lot of great brochures that have nice Aboriginal motifs on them are sitting in the waiting rooms of health services or whatever, and that has been a bit of a trend, in some ways.

But it requires sitting down and having a yarn with people. Again, I go back to being polite, in some ways. I know that is resource intensive and costly, but we live in a big country and that is cricket, I suppose. There is nothing more I can say about that, it is just the way it is. Getting out and sitting down and having a yarn with people over time is a challenge. That does happen a lot. Organisations go out and have a conversation with people. It is just whether they go back and whether they are prepared to hear that they will cop it a little bit and have to swallow their pride. Something we do a lot of is partner with existing disability rights organisations and go out into the community and introduce them to communities. So, the planning side of stuff needs to involve outreach basically.

CHAIR: I think there are some follow-up questions from other members of the Committee but I think it was Jim Moore who indicated before us, I think on the first occasion, the issue of listening is an art and the art is hearing an understanding.

Mr GRIFFIS: Yes.

CHAIR: There is a lot of listening but maybe not a lot of hearing and understanding. Are you aware of the coroner's investigation into the death of a young Aboriginal woman? If you are aware of those recommendations, have you any thoughts on that?

Mr GRIFFIS: I would not want to comment on it too much but to me it is like an experience that is not uncommon in the sense that some parents or carers or family members needed more information and needed some support that better explained to them how they can better meet the support needs of their daughter—I think it was from memory. The system failed there somewhere and I think sometimes there is a perception out there, particularly in regional parts of the State that Aboriginal people just come to us when they need this type of thing. We have to flick that over completely and find a way to go to people instead of the expectation that people will come to the service world. When people do engage with the service world, it is invariably at crisis point and sadly it is sometimes too late and their experience is not a positive one. Often, in relation to disability, it will be around quite a major medical intervention.

I can think of examples—old fellas with complications around diabetes—and they do not engage the health system until absolute crisis point and they end up having to have an amputation and they get wheeled out to the front of the hospital and that is the end of it. There is a tick in the sense that there is a health intervention but they go back home and they cannot move around in the community, they cannot access anything anymore. Someone should have come across that issue somewhere down the line well before and had a conversation with that family and sought support much earlier, but it is not an unfamiliar story, sadly.

The Hon. TREVOR KHAN: You may not be able to assist, but what interests me is the interaction between Ageing, Disability and Home Care and health services and how effective that interaction is. I suppose if we translate that into the circumstances of indigenous communities, are you able to indicate the level of interaction you have seen or you understand to be occurring between Ageing, Disability and Home Care and the Aboriginal health services?

Mr GRIFFIS: The only way to answer that is in relation to the Program for Aids and Appliances for People with Disabilities, which is run by the health department, effectively.

The Hon. TREVOR KHAN: That is right. As I understand it is run by the health department.

Mr GRIFFIS: Yes, that is my understanding, and it does not operate terribly well in the sense that we meet Aboriginal people who have needs for, say, a wheelchair and they can wait two, three or four years. That is not just the experience Aboriginal people have. Anyone in regional parts of the State seem to have that experience. That is my experience of the interaction and the problems there. I would be reluctant to comment too much because we have been pretty focused on our relationship with Ageing, Disability and Home Care. That is an example where it does not seem to be working out terribly well, the Program for Aids and Appliances for People with Disabilities.

The Hon. TREVOR KHAN: Do you see Aboriginal health services having a role in the provision of what we can describe as Ageing, Disability and Home Care-related services rather than setting up a whole new stream? I am not being derogatory but there seems to be a capacity to create organisations almost for the sake of creating organisations, so nothing gets to a size where it is capable of functioning effectively.

Mr GRIFFIS: Yes, I would have to say that is a fair call. I would be telling fibs to the community if I said there was going to be Aboriginal disability servicing created. I do not think that is going to happen. I do not know there are the economies of scale to justify it. Therefore, you need to look towards the Aboriginal community controlled health sector but historically it has not done a good job in this area. So far I have been quite critical of the Government but I have to be equally critical of the Aboriginal services sector, sadly,. There are a lot of reasons why. The Aboriginal community controlled health sector has some extraordinary challenges. It provides a universal role across all sorts of different issues so it is under enormous pressure, but Health is not Disability, as we know. The medical model of Disability has had a profoundly negative impact on lives of

Aboriginal people and I would argue we are still dominant. So, the whole Closing the Gap conversation, I would argue, and our members would argue, is heavily medical-model focused.

Another example I can give is Aboriginal kids with hearing impairment. It is a huge problem, very high rates of it. So Aboriginal kids will get a medical intervention for their hearing impairment, a very simple procedure and that fixes things up generally. But some of these kids for two or three years have not been hearing properly so they have a learning disability, so there is now a second disability which has become a primary disability or vice versa. Where is the support for that? There is a tick for a medical intervention but nothing around the social model side of things.

I worry that the health service sector would take that approach, because that is the way they operate anyway, but it is the only way they could do it because they are so overstretched in any case. Plus in the end they are about health. As we know, disability is about education, employment, transport—it is all sorts of things. So absolutely Aboriginal people with disability need greater access to the community control Aboriginal health sector. There are some Aboriginal community control buildings that are not accessible around New South Wales. That suggests that it is kind of sitting somewhere else, which kind of odd to a disability advocate and someone who has been involved in the area for a while now. It does not make a lot of sense. I think there is a way to go there. I would be more inclined to get the disability service sector to do a better job because they already have the expertise around disability. We are talking about disability mostly, but they need to be able to do their work in a way that is much more culturally appropriate, accessible and all those sorts of things. I think the Aboriginal health community control health sector plays one part in the role; they do not play the whole role.

The Hon. TREVOR KHAN: I am not trying to verbal you but if I was to take you argument to a logical extension you would get rid of, for instance, Aboriginal legal services, because they are actually providing legal services.

Mr GRIFFIS: I am not going to go there. I do not live in those circles; I do not know how that operates.

The Hon. TREVOR KHAN: If it is not the health services, is there another existing body within—

Mr GRIFFIS: Aboriginal home care is the other community provider. Aboriginal home care is basically the disability service provider for Aboriginal people across New South Wales. But Aboriginal home care's operations are basically about keeping the house tidy and in-home support, which are critical. But they face challenges, too, because they can often have clients who have quite complex and high-support needs, and the staff do not have the expertise necessarily in how to deal with that. I think we are talking about getting the disability service sector currently to do a better job. That would be my starting point. But then again, we are not always talking about service provision; sometimes we are just talking about more resources for a community.

The example I used before of a wheelchair accessible bus, that was all that was required in that community. There was not a need for a service provider to come in over the top, if you like, because there are people in the community who are professional carers by any other definition, and have someone to drive the bus and that is the end of it. That is all that was needed so that they could drive the 120 kilometres down the road to do the groceries a couple of times a week and get to doctors' appointments. So it requires that consultative thing to sort of work out, sit down with people and ask what they need. I would be surprised if communities say things like, "I'd love a disability service provider coming here." You know what I mean? I think a lot of the time they would be saying, "Just give us the resources and we'll be able to address this issue, no problem."

CHAIR: It seems to be consistent with what we have been hearing for a number of years.

Dr JOHN KAYE: I want to ask you a question that relates to a couple of things you have said already, and it is about the inherent mistrust that exists, historically justifiably, between Aboriginal people and organisations like DOCS and by extension all government organisations in general. How is this playing out with Aboriginal communities? Is it reducing opportunities for people with disabilities?

Mr GRIFFIS: Yes, I would say it certainly is. People just do not engage. They do the best they can themselves to support a family member with disabilities. I was only having a chat with some people this morning about, for example—I meet plenty of Aboriginal people who should be on the disability support pension and are not because they do not want to go into the Centrelink office and share their story in a space that is not very private. It is as simple as that sometimes, and therefore they do not participate, do not engage. It is a

real problem. We think the advantage our organisation has is that we can act as a conduit, and we do that quite a bit. In a couple of weeks time I am going out to Walgett and Moree, as we do from time to time, and going up there with a non-indigenous disability service provider, Ideas New South Wales, who are our leading information provider. The idea is that we take him out and say to people, "These are good people for you to know. They provide a service you might want to use." The advantage is that it is an non-government organisation so it does not have quite the same connotations. If we introduce it into communities where we are well established it tends to be viewed reasonably favourably. No, people just do not engage, basically.

Dr JOHN KAYE: A lot of this is historical.

Mr GRIFFIS: Yes.

Dr JOHN KAYE: Are there ways we can overcome that? Are there things this Committee could recommend that would begin to overcome those historical barriers?

Mr GRIFFIS: I think it is about resourcing organisations that are of and for. I really do. I think it is about giving the opportunity back to community to be able to plot their own way forward. I am not romanticising it because that does come with plenty of challenges. Like any community anywhere, there are politics at play and things like that, but the advantage that an organisation like ours has is that it is made up of Aboriginal people with disability, their families and carers. It is not made up of particularly dominant families in one community. It is made up of people with disabilities themselves. We think by having local networks established around the State people can then start coming up with their own solutions and actually say to the DADHC region, "This is all we need in this region. Before you start bringing in a home care service, this is what we need to be able to address this issue in our community." I think that is a clear way forward.

Dr JOHN KAYE: What about the situation with the medical model for disabilities? Would it be fair to say that that specifically disadvantages Aboriginal people with disabilities?

Mr GRIFFIS: Yes, I would say that, definitely. Most of the language out there around Aboriginal issues is always health related, as it should be—do not get me wrong; it absolutely should be. All the indicators are there for a good reason. But it comes at the expense of looking at the whole of life of a person. I think sometimes in this evidence-based world where you want to get outcomes for people, and rightly so, you want to know that 2,000 Aboriginal kids have had their hearing impairment treated. That is tangible. You can measure that, but it is much harder to measure how many of those kids have a learning disability and how many of them have had support for their learning disability. I think the medical model is still very dominant. The way to address that is to continue to support the movement—it is not always a popular term. The social movement of Aboriginal people with disability needs to be supported to address the medical model, which is too dominant.

Dr JOHN KAYE: Access to early intervention in many situations has positive life-altering outcomes, particularly, for example, for autism, where early intervention, as you know, can lead to much better outcomes at schooling and better engagement throughout life. It is probably fair to say that Aboriginal people have less access to, when you correct for location and socioeconomic background, Aboriginal people would, first, still have less access and, secondly, would access less those early intervention services. Can you give us some guides as to how we can correct that situation?

Mr GRIFFIS: I sometimes wonder if it is worth acknowledging that it is really hard to do. I think it is okay to say that. In some parts of the State areas are very remote so getting early intervention and services out there are hard. But at the same time I would say that is just the State we live in. It is a big areas, that is just the way it is. I can think of a fellow I met a few weeks ago, a young boy who is 3½ years old who is not speaking yet. I am not a doctor or a health professional, but he is not speaking yet so he requires an intervention but because of his location it is hard for that service to get out there or it must happen, say, twice a year, and you kind of better make sure you are in town on that day or you miss the opportunity.

Early intervention is critical. I think education of mothers when they are carrying children is another area that needs significant investment. There are some good things happening in the Northern Territory around that sort of stuff where mums are told about the risks of smoking and drinking while carrying a child, and I think that sort of education—early intervention before the baby is born—is critical too. There needs to be a lot of investment in that area. It is not an area of our work obviously, but there are plenty of things going on around the country that do that well.

Dr JOHN KAYE: If there were someone here from the Department of Health or the Department of Aboriginal Affairs they would say instantly to you, "We do invest very heavily in infant and maternal health." Are you saying that those investments are not adequately targeted?

Mr GRIFFIS: All I can say is that I still encounter very young Aboriginal kids with obvious disability that have not had any intervention. We still come across it. I do not know why it is not working, but obviously there is a failure there somewhere. It is still something we encounter all too often. It is complicated—it depends where you are. I mean sometimes the local health service is not held in high regard or sometimes it is those people who know how to work the system get access to the system. Some Aboriginal families and carers, because they have had a lot of experience over a number of years, which is good for them, might know how to work the system in their favour. If this is the first time that disability has come up in your family, there is the health department to begin with, then Ageing, Disability and Home Care, and probably when the child turns five there will be the education department, and there is Centrelink to talk to. I do not know that it is unique to Aboriginal parents and carers either necessarily, but it is a cumbersome system, and if you have a bad experience once or twice, that is enough—"I will just try and address this by myself".

The Hon. HELEN WESTWOOD: In your submission you mention the high number of Aboriginal people with disability who are in the criminal justice system, and we had some earlier evidence along similar lines. Do you know what type of disability is most common amongst those who are part of the criminal justice system?

Mr GRIFFIS: Yes, this is an area that concerns our organisation greatly because in many ways it is still anecdotal really. It is very hard to get the numbers, and even in the rest of the prison population I do not know that the data is that reliable, but there has always been a story around intellectual disability, mental illness, in the Aboriginal prison population—acquired brain injury also—so they are going to be prevalent. The way it translates is particularly if you are in a regional part of the State and you are an Aboriginal person—but also non-Aboriginal people for that matter. If you are an Aboriginal person that has an episode and you are running down the main street of Dubbo with your clothes off or whatever—you are not well—you are put in the back of a police paddy wagon and you then become part of the prison system. Usually there is no mental health intervention there at all and you become more or less imprisoned for mental illness, I would argue, so that is an area that is of great concern.

The Hon. TREVOR KHAN: I have heard that comment made by many local court magistrates.

Mr GRIFFIS: Yes, it is frustrating for them, I am sure, and I think it is very difficult for the police too. They are caught in a really difficult place too. That is the way it translates practically. There has always been a high prevalence of intellectual disability in the prison population, and it is no different for Aboriginal people, and the acquired brain injury side of things is perhaps a bit of an unknown. There are also, of course, Aboriginal people who acquire disability when they are in jail, for whatever reason, so that is an area of major concern, an area that we have not really had the opportunity to delve into, but we know it is an issue and we hear about it all the time. I think it requires some research in a way that is done sensitively and I think that would expose a high degree of unmet need in that area.

CHAIR: Do you have any recommendations for us before we close?

Mr GRIFFIS: No, I think it is just a huge area. It is an emerging social movement that we are trying to build here. There is any number of priority areas. Criminal justice is just one. Accessing disability services is a problem across the board. I guess we would argue really strongly that all the development in service provision in the world will not work unless people feel they trust the service system and feel confident in it. We have seen that for a long time now in all sorts of different areas where there is a lot of money and investment, we would argue, into the service side of things. In some ways it is about taking a deep breath, and when you see unmet need you want to go and fix it straight away—there is no doubt about that—but sometimes I think it is about investing at the front end and giving communities an opportunity to understand what on earth we are talking about here. Having said that, there is an opportunity for the rest of the disability service sector to understand the positive ways in which disability is viewed in many Aboriginal communities—flip it over the other way.

CHAIR: Thank you very much for your assistance today; it is greatly appreciated.

(The witness withdrew)

ROSALYN GRACE ARMSTRONG, Official Community Visitor, affirmed and examined:

CHAIR: In what capacity are you appearing before the Committee?

Ms ARMSTRONG: I am an official community visitor and a member of the official community visitors consultation committee in conjunction with the NSW Ombudsman's office. I am appearing as a representative of the official community visitor group, not the Ombudsman's office.

CHAIR: What is your professional address?

Ms ARMSTRONG: My address is a home address. Official community visitors report using an on-line system from their homes.

CHAIR: Would you like to make some opening comments?

Ms ARMSTRONG: I will, if you do not mind. As a member of the northern team of community visitors, I visit an area north of the Hawkesbury up to the border, although at the moment my visitable services are mostly contained in the Hunter and Central Coast areas. I visit people with disabilities, including those people living in large residential centres, such as Stockton, and group homes. I visit children in out-of-home care, I visit children in out-of-home care and young people with disabilities, and I visit licensed boarding houses.

On behalf of official community visitors of New South Wales I have provided you with a written submission that examines issues of concern that official community visitors have identified during their visits to visitable services relevant to the terms of reference of the inquiry. It also details information about the scheme, legislation under which official community visitors are appointed and some information about what are visitable services. At this point I would like to provide a brief address about who are official community visitors and how they go about their work.

We are statutory appointees of two Ministers, the Minister for Ageing, Disability and Home Care and the Minister for the Department of Community Services under CS-CRAMA. We all have backgrounds that enable us to directly relate to children, young people and people with disabilities, but these backgrounds are as diverse as the services which we visit and we are not only independent of the service but we are also independent of each other. We are, however, organised into geographical teams and do write reports and identify issues in a relatively consistent way that allows the NSW Ombudsman's Office to collect pertinent data on issues that are identified, resolved and unresolved, and I refer you to detail, including recent annual reports tabled in Parliament.

As do the backgrounds of visitors vary so also do the services we visit. Not only do group homes operate differently to boarding houses and large residential centres under the auspices of their varying legislation policies, but more importantly they also differ across organisations and within organisations. As a visitor, we have a role to establish relationships by listening to what people, their family and advocates have to say about the service. As a general comment, as well as reporting the not so good, we also identify and report examples of good practice. Identifying issues is therefore about using everything we have learnt in both our personal and professional lives to create a picture of what a service should look like.

It is about asking questions, listening, observing, reading and often making sure visits are done at different times to see different aspects of the service—all to identify what the issue is that we may have to report on. This is not always easy to do when questions that you ask often cannot be answered by the person themselves or their support person, not just because their communication skills, in comparison to the community visitors, are not as well developed but because they have often never been given the information. This applies not only to families, to people with disabilities living in visitable services but often the staff that operate those services as well.

Fortunately CS-CRAMA facilitates a process of enabling visitors to view any relevant service documentation. It is often this process that provides us with the basis for formally advising an organisation of a matter that needs some resolution. To resolve issues we use knowledge about the industry, including policy and legislation. We talk with people involved, encouraging them to problem solve; we research and identify similar

situations and bring any outcome to the attention of management. We write, we talk, we make phone calls, we follow up, we network, we negotiate. There are, however, some constraints. We cannot give directions.

So how is it, you may ask, that we achieve the outcomes for residents? These outcomes are achieved in many and varied ways, including empowering residents and families and also putting in front of management of service organisations examples of better practice that they may like to consider. In some cases issues are resolved by making a complaint to the NSW Ombudsman's Office or by way of a direct approach to the Minister's office, as CS-CRAMA allows us to do so. But again, for some real-life situations, if you are interested in reading how these outcomes are achieved and what are achieved, I refer you to the many case studies in this recently tabled annual report.

The resolution of systemic issues may, however, require a different approach and to this end, as a group community visitors have two main mechanisms to achieve this. The first is via our ministerial working party where each team is represented by an elected visitor to bring forward systemic issues to the attention of both Ministers' offices and, alternatively, through the consultation group, which I represent today. We often inform the Ombudsman's Office of systemic issues and they are able to carry out appropriate investigations and make recommendations to agencies and Parliament based on our feedback. There are, however, other opportunities that arise when we can give a voice to people receiving residential services about issues that have a negative impact on their lives, this inquiry being one of them. I am eager to answer any questions that you may have regarding our submission.

The Hon. TREVOR KHAN: How many official visitors are there in New South Wales?

Ms ARMSTRONG: I think it is around 39 at the moment. Visitors are appointed initially for a three-year period. The appointment can be reviewed for a further three-year period but only two periods. They come and go. There is recruitment going on at the moment, but there is somewhere around about 39 at this point in time.

The Hon. TREVOR KHAN: What is your geographic area?

Ms ARMSTRONG: The northern team, and it extends from north of the Hawkesbury to the New South Wales-Queensland border. Under normal circumstances we would have five or six visitors.

The Hon. TREVOR KHAN: That answers my next question; you have five or six covering essentially the north of the State, is that right?

Ms ARMSTRONG: That is correct.

The Hon. TREVOR KHAN: And you mainly deal with the Hunter and the Central Coast?

Ms ARMSTRONG: The Central Coast, the Hunter and about-to-be-appointed visitors will continue the work of visitors who recently left in Armidale, North Coast, far North Coast, Tamworth and Moree.

The Hon. TREVOR KHAN: Are they appointed in a geographic area? I am from Tamworth so I am interested in that area.

Ms ARMSTRONG: In some sense; the Ombudsman's Office, who coordinates the recruitment process, may be looking at recruiting so yes, there would be an opportunity to appoint somebody particularly in an area where there was no community visitor. Obviously there are resource benefits to do that.

The Hon. TREVOR KHAN: One would think so; probably a benefit to the people in receipt of the services as well?

Ms ARMSTRONG: Look, community knowledge is a huge thing but, as you are aware, people with disabilities have been forced to move from their communities into large residential centres and boarding houses in metropolitan areas for years so whilst a sense of community may assist, I think the ability to relate to a person with a disability would be more important.

The Hon. TREVOR KHAN: I now move on to licensed boarding houses. How many licensed boarding houses are there?

Ms ARMSTRONG: There are about 50 or 60 at the moment. There are approximately 800 residents accommodated in licensed boarding houses across New South Wales. They vary in size. For example, I visit a boarding house on the Central Coast with 59, a boarding house on the Central Coast with over 100 residents, a boarding house in Newcastle with four and one with 11, so they vary in size.

The Hon. TREVOR KHAN: You will have to explain it to me—I will admit my ignorance—because I have not come across the term: How do the operators of licensed boarding houses make their money?

Ms ARMSTRONG: They charge between 85 and 87 per cent of all pensionable income and there are some additional charges that some operators may impose. For example, I am aware of one operator who imposes an additional 3 per cent charge to provide what can generally be described as case management services—taking a person to a doctor, talking to their GP.

The Hon. TREVOR KHAN: How are they differentiated, apart from the funding, from what could be described as the run-of-the-mill boarding house?

Ms ARMSTRONG: The run-of-the-mill boarding house requires no licence, unless of course there is more than one person with a disability living in that boarding house. The identification of people with disabilities living in boarding houses is a matter of concern for community visitors. Because boarding houses are licensed under the Youth and Community Services Act they are monitored by licensing officers employed by ADHC, and community visitors visit licensed boarding houses. Community visitors do not visit other boarding houses or rooming houses that are not licensed.

The Hon. TREVOR KHAN: Let us deal with the other boarding houses and rooming houses. How would the operator of that sort of establishment know whether they had more than one person with a disability? What test do they apply?

Ms ARMSTRONG: There is a test under the Act, however when you spend 10 or 12 hours a day with a person for a period of weeks, months or years there is likely to be some indicator that that person has a disability of some kind. That disability may be related to a motor vehicle accident; it may be an obvious physical disability or it may be an acquired brain injury from drugs or chronic mental illness.

The Hon. TREVOR KHAN: Or alcohol.

Ms ARMSTRONG: Or alcohol.

The Hon. TREVOR KHAN: Taking into account my limited experience of boarding houses, I would have thought it would be almost the rule that you are going to have more than one person with an acquired brain injury in a heck of a lot of boarding houses in New South Wales.

Ms ARMSTRONG: I could not agree with you more.

The Hon. TREVOR KHAN: What is the implication of having more than one person with a disability in a boarding house that is unlicensed?

Ms ARMSTRONG: The implication is that it is an illegal operation or, to use a term that ADHC may use, a PIO—a potentially illegal operation.

The Hon. TREVOR KHAN: Who checks on these illegal operators/operations?

Ms ARMSTRONG: Some years ago there was a system of visiting following either anecdotal information or complaints. I am not sure what happens now. It is certainly a community visitor's view that there is no regular monitoring of boarding houses, but ADHC may say differently.

The Hon. TREVOR KHAN: So in essence it is an Act you have when you are not having an Act. Is that the bottom line?

Ms ARMSTRONG: I cannot comment on the process by which ADHC continues to identify and manage illegally operating boarding houses. All I know from my working in the community is that people with disabilities are often driven to take accommodation in these facilities because—

The Hon. TREVOR KHAN: There is no other accommodation.

Ms ARMSTRONG: —they find it difficult to get anything else. Through our work we are aware that there are agencies and community-based services that continue to refer people with a disability to unlicensed boarding houses because the alternative is the street.

The Hon. TREVOR KHAN: Looking at it from another perspective, the reality is that given the limited low-cost accommodation in the community we have an Act that limits the number of people who can be in a boarding house without providing an alternative place for people to live. In essence you are creating a system that cannot work in that circumstance, are you not?

Ms ARMSTRONG: Yes. Certainly a system that is very ill. There is an argument, and it certainly would be a social justice argument, that a person is better off in a boarding house than having no roof over their head. However, given that the people who run and own these places are making a profit—otherwise why would they be in business—I think there is also an onus on the Government of the day to ensure that those people with a disability who live in an unlicensed boarding house receive a service equivalent to those who live in a licensed boarding house. However, I might add, and I am sure the statement is made in our submission, that the people living in licensed boarding houses do not receive a service equivalent to that received by people who live in funded group homes.

The Hon. TREVOR KHAN: With regard to your observation about the owners receiving profit, in another inquiry by this Committee it was identified that the amount of boarding house accommodation, particularly in the Sydney city area, had dropped off remarkably and essentially had not been replaced with other like accommodation, such as public housing. There was a drop-off in single room or small accommodation without a suitable alternative being available to people.

Ms ARMSTRONG: I am certainly aware that the number of licensed boarding houses has decreased over the last few years. Anecdotal evidence would suggest that the number of unlicensed boarding houses has increased. Another agency might be able to provide you with better data than I can. I can only refer to anecdotal data.

The Hon. HELEN WESTWOOD: To continue with that theme, is there a reporting mechanism for unlicensed boarding houses?

Ms ARMSTRONG: Not that I am aware of. The only thing I am aware of as a member of the community and as an official community visitor is that if I was asked by somebody, "What can I do about my accommodation?", and I identified that their accommodation was an unlicensed boarding house, I would give them the phone number of the local ADHC office.

The Hon. HELEN WESTWOOD: You talked about the service level at licensed boarding houses. What sorts of services are provided and do other ADHC-funded organisations provide services to licensed boarding houses?

Ms ARMSTRONG: The types of services provided to licensed boarding houses depend on three things: firstly, the proprietor; secondly, other community-based services; and, thirdly, some ADHC services. The proprietor may or may not provide a range of case management services or assistance with going to the doctor et cetera. ADHC will provide personal care to those people identified as being unable to fully meet their own personal care needs. ADHC also funds an active linking program, which provides community access outings to people in boarding houses. They are provided at a fairly low level. For example, at the boarding house where I was this morning I was talking to a gentleman and he was terribly disappointed that he was not going out today. He had been told his day out is Friday.

The Hon. HELEN WESTWOOD: In your submission you talk about the areas in which you have communicated to ADHC that organisations are not meeting the needs of clients, and you feel that the department has not responded to that appropriately or has not addressed it.

Ms ARMSTRONG: I think the concern expressed through the entire document is that there are visitable services out there that are not meeting the requirements under the Act. If I could refer to a quotation from the annual report which has been tabled in Parliament, in 2008-09 there were 4,569 issues identified. The community visitors have a process by which they identify an issue under a classification scheme. All those classification schemes are linked to standards. If you identify an issue, it is because there is an aspect of a standard not being met, whether that standard is, in the case of children's services, an Office of Children's Guardian standard, whether it is, in the case of a boarding house, a Youth and Community Services Regulation, or whether it is, in the case of group home or a large residential centre, a Disability Services Act standard.

What we are saying here is that in that year there were over 4,000 instances of standards not being met. Why are standards not met? One of the views of community visitors is that people can get away with it, to put it in succinct language. We do not believe that services are monitored adequately in order to ensure that every service to a person with a disability meets the standards under which that accommodation service is auspiced.

The Hon. HELEN WESTWOOD: Have you had any communication back from the department at all about that?

Ms ARMSTRONG: As individual community visitors?

The Hon. HELEN WESTWOOD: Or even as an organisation. Does the department come back to you to get more information, to consult you about how it could be addressed to rectify it?

Ms ARMSTRONG: I think it is easier to answer it as individuals because, as I say, each community visitor is an independent. The role of a community visitor is to report those incidences where standards are not met. So, yes, we would write; we would report. And yes, the service will write back and report. And yes, the community visitor will follow up. We are running probably at a rate of about 55 per cent of issues resolved.

It may be something that is relatively simple, although significant to the person. The other day I was in a group home for young people and a young man whose communication skills are very limited was being fed liquid food via a juice Popper bottle. He was making some quite significant noises which to me were discomfort and pain. I do not like noises, and I do not think anybody else would view them differently. In talking to the staff, they acknowledged that feeding was a painful process for him. But there had been some issues surrounding consent by his mother to some alternatives.

One of the first things that a community visitor does in this instance, when we are very aware that people with profound disabilities should have regular swallowing and nutritional assessments, is to check the documentation. I found on this occasion that this young man had not had a swallowing and nutritional assessment since 2007. The assessment in 2007 said that this was a positive way to feed this young man and he enjoyed his foods. But over that period of time, it is very clear that that has changed.

The Hon. TREVOR KHAN: Are you talking about a loss of the swallowing reflex?

Ms ARMSTRONG: I am not a speech therapist, so I cannot make that comment. What I am talking about is that he had not had a swallowing assessment since 2007. In 2007 a speech therapist was saying he enjoyed being fed this way. He clearly did not enjoy being fed this way any longer. That, clearly, is an example of bad practice. But that is a relatively easy one to fix: You pick up the phone and you ring that regional manager and say, "I'm sending in a report; this is what it says." Very quickly, they will get a swallowing assessment.

They are the easy issues to have resolved. The much more difficult ones are like the young man who has been in a blocked respite bed for 2½ years and never had any individual planning. It is said, "He is in a respite centre; we don't do individual planning." This young man is a permanent resident of a respite centre until such time as we find him other accommodation, and therefore he should be delivered the same sort of service. There should be planning for this service.

When we say we identify where standards are not being met, in some cases they can be met. Is it an oversight, is it a lack of supervision, is it laziness, is it a whole range of things? But there are other cases where you have resident-on-resident abuse. That can be managed by having behaviour management systems in place that do meet best practice. But over five and six years, when the abuse continues, even though it is being managed in accordance with best practice, it remains an unresolved issue, and it remains an example of where

the service does not meet the needs of that young man. And, in terms of his right not to be abused, it does not meet the standards.

The Hon. GREG DONNELLY: Thank you for coming along today. With regard to the issue of boarding houses being considered accommodation for people with disability, is your argument that there are no circumstances where they may be appropriate, or that we need to be very clear in our minds about the circumstances for which boarding houses may be appropriate for people with disability?

Ms ARMSTRONG: The argument is more about equity. A person with a disability living in a group home has a right to receive X services. A person with a disability living in a boarding house does not have that same right, because the operators of that boarding house are not required to deliver services in accordance with the Disability Services Act. That is it in a nutshell; it is about equity.

I will give you a classic example of where people with disabilities are so marginalised. Recently I had to intervene for a young man who had been living in the same boarding house for 12 years. Just recently, because of the changes of residents in that boarding house, he does not get on so well any longer with his housemates. He has been asked to leave. People in licensed boarding houses have no tenancy rights. They do not have the basic tenancy rights that are afforded every other person.

The Hon. TREVOR KHAN: In any boarding house, licensed or unlicensed, the Residential Tenancy Act does not apply. So it is not a licensing issue.

Ms ARMSTRONG: When we talk about the different levels of service, we have people who have identified disabilities who receive a disability pension. They get X service here and X service over there.

The Hon. GREG DONNELLY: Taking that argument a little further and drawing on your experience, is there an increasing incidence of people with disabilities living in caravan parks and in mobile home parks?

Ms ARMSTRONG: I am sorry, but I cannot comment on that. It would be only an anecdotal observation.

The Hon. GREG DONNELLY: Could I be bold enough to ask you to make that anecdotal observation? Let me tell you why I have asked you that question. A growing number of places such as caravan parks and places are now permanently fixed; in other words, whole parks in which the elderly in particular are now residing are set aside for them. In relation to relatively cheap accommodation vis-a-vis rental accommodation, we are observing that people with disabilities are gravitating towards that type of accommodation.

Ms ARMSTRONG: In the current economic climate, in particular, in some regional towns such as Newcastle, people with disabilities are finding it more difficult to find accommodation than a person without a disability, just as a woman with five children is having difficulty in finding accommodation at the moment.

The Hon. GREG DONNELLY: For my information, as I do not know the area as well as some other members of the Committee, take a typical day for persons with disabilities living in a boarding house. Do they leave the boarding house in the morning to participate in some activities and return in the evening? Is that a typical timetable?

Ms ARMSTRONG: That is a good example of the inequity of service. Persons in a group home would usually have a day program for four days a week and then they would have a day at home. A person with a disability living in a licensed boarding house can leave that boarding house and go for a walk, but there is no onus on the proprietor to assist that person in organising a day program. As I mentioned before, ADHC funds a community access program for people living in licensed boarding houses but, as I said this morning, the young man to whom I referred was very disappointed because he could not go out on the bus. He was told, "No, your day is Friday." That is one day a week and that is only a morning outing.

The answer is that there would be very few. There are some people who live in licensed boarding houses—I could count them on my hands—that hold down jobs. They choose to live in a licensed boarding house as opposed to an unlicensed boarding house because, as they will tell you, the food is better and the service is better. They have acknowledged that, if a boarding house is to be their home, they are better off in a licensed boarding house than they are in an unlicensed one.

The Hon. GREG DONNELLY: For those people who are living in a boarding house—let us use as an example a licensed boarding house—with what would they occupy their time during the course of a day? Are there any activities that they would do?

Ms ARMSTRONG: No.

The Hon. GREG DONNELLY: They watch television.

Ms ARMSTRONG: They watch television, hang around and have a cigarette. Half the people living at the place that I visited today probably do not have access to their own money. In the morning they would get an allocation of cigarettes from the proprietor. One young man to whom I was talking has just gone onto the proprietor's program because the proprietor thinks he should give up smoking. He gets eight cigarettes a day. The proprietor buys the cigarettes and charges the residents for them.

The Hon. GREG DONNELLY: At a premium, I speculate?

Ms ARMSTRONG: The proprietor tells me that he buys them wholesale and he sells them at the same price.

The Hon. GREG DONNELLY: I refer, next, to the number of unlicensed boarding houses. How would you describe the increase in the number of unlicensed boarding houses over the past three, four or five years? Has there been a significant increase, a small increase, or a moderate increase? Can you give us a figure on that?

Ms ARMSTRONG: No, I am sorry, but I cannot. I can tell you only about the people that I know and that I have met who have lived in a licensed boarding house. As that licensed boarding house is now closed they are moving into a house run by the same people that used to run the licensed boarding house. However, that is not a licensed boarding house. I cannot tell you whether or not there has been an increase.

The Hon. GREG DONNELLY: My final question relates to the issue of boarding houses, both licensed and unlicensed. Do they exist around the State, or are they concentrated in the big cities? Is it something that occurs in, say, a smaller regional town or city?

Ms ARMSTRONG: Newcastle is an example, if you take Newcastle as a regional centre.

The Hon. TREVOR KHAN: I would not.

Ms ARMSTRONG: As opposed to Tamworth, Moree, et cetera. There is a boarding house in Orange, one in Albury, and there are boarding houses in Bundanoon. There used to be one in Dungog and one in Tamworth, but I do not know whether it is still there.

The Hon. TREVOR KHAN: The Rex; it is still there.

Ms ARMSTRONG: But it is not licensed.

The Hon. TREVOR KHAN: No, I did not think it would be.

CHAIR: Is it still operating?

The Hon. TREVOR KHAN: It is still operating. It certainly has a lot of people in it.

CHAIR: You said in your submission—as have a number of other submissions—that there was some benefit in having an independent body taking on the role of monitoring service providers. Could you elaborate on that? Are you aware of any existing independent organisation that may be appropriate?

Ms ARMSTRONG: I am happy to make a statement on behalf of all my peers and official community visitors. There is a pretty unified view that there should be a body that monitors services to people with disabilities—a body that is independent of the funder of those services. Is there anybody? No. They used to have the New South Wales ageing and disability department [ADD]. We have the Community Visitors Scheme

which is not set up primarily for that purpose. In a sense it engages in that as it assists residents to get a better service, but it is not set up as a monitoring service.

The Hon. TREVOR KHAN: Do you believe that the Act should be amended to require the licensing of boarding houses when they have one or more handicapped persons, as specified in the Act, rather than two or more, or do you believe that boarding houses should be restricted from having any handicapped persons living there, to use the term that is used in the Act?

Ms ARMSTRONG: I need to confine my comments to the current legislation, which does not provide equitable services to people with a disability. The legislation itself needs to be amended to ensure that all people with a disability have access to the same level of services, whether they are in a licensed or an unlicensed boarding house, or a group home, for which they all pay. Everybody pays a percentage of his or her pension, plus costs. However, for that same amount of money everybody does not get an equal service.

The Hon. TREVOR KHAN: How do you envisage people getting that equality of service? Who would pay for it?

Ms ARMSTRONG: I would say that, in the interests of social justice, funding should be available to provide that service to everybody with a disability.

The Hon. TREVOR KHAN: That means government funding?

Ms ARMSTRONG: Government funding.

The Hon. MARIE FICARRA: What takes you into these situations where you observe issues? Is it family and friends, the actual person with the disability contacting you, is it a regular roster or is it a combination?

Ms ARMSTRONG: It is a combination of all those things. We have allocated visits. So we will allocate a service two, three, four, six times a year, every month, depending on the number of people who live there and the vulnerability of them.

The Hon. MARIE FICARRA: Do they know you are coming?

Ms ARMSTRONG: No. So I will visit a service and the usual good manners apply—you are entering somebody else's home. In a group home, for example, where people have a reasonable level of communication skills, I will knock on the door and say, "Hi, may I come in? This is who I am." I have been visiting for nearly three years now so people are starting to get to know me, so it is, "Come in Roz and sit down." You do the usual chat, "How have you been?" et cetera. But, like any other good salesperson because it is in a role about ensuring that you get information, I would ask questions. If it is just after winter I might say, "How has everybody been? Has everybody been well or has somebody had the dreaded lurgy?" I might get a reply such as, "No, I have been really well but so-and-so did not go to work the other day because she fell down the stairs and broke her leg." That is a lead and you need to follow that up. Why did that person break their leg? What were they doing upstairs? Do they have other issues? That is a situation where you are actually given some information by the person themselves. But, yes, you may respond. You may go and look at a service and visit somebody there because somebody has told you something.

In a large residential centre such as Stockton it is a little bit more difficult because people have profound disabilities and they are not able to communicate in the same way. But you would apply those good manners with that chitchat in the same way but it will be with the nursing unit manager or with the officer in charge. So you would ask the same sorts of questions, "Has everybody been getting day programs?" You may walk in somewhere in the middle of winter, when it is freezing cold, and if you are touching something being used in the place and everybody has frozen fingers you would start asking questions such as, "What has happened to the air conditioner?" You may find out it has been like that for a month. So it is that process also. It is also about your observation. You may see somebody that you have talked to or sat with before who is normally an engaging person even though their verbal communication is limited, they usually engage with eye contact, put their hands out or something, and they are sitting in a corner like this. You would ask and if you get the answer, "I don't know" then the first thing you would do is go to the documentation and have a look at the health records. But you may get an answer that says not well, family member has not visited, or you may get what is a very real explanation as to why the person is like that.

The Hon. MARIE FICARRA: You are obviously well experienced in what you are doing and you have been in that role for three years. You are the ideal person for the job. Is there a turnover? Are you representative of others?

Ms ARMSTRONG: I am very representative of others who have worked in the sector. But as a result of a major car accident when I broke my neck I have a physical disability and also an acquired brain injury, so sometimes I just go off the beam a bit and my brain just stops operating.

The Hon. MARIE FICARRA: Not today and compared to some of us you are doing very well.

Ms ARMSTRONG: All of the visitors have different combinations of experience with disability. Yes, we are all very experienced and have that ability to observe and pick up things.

The Hon. MARIE FICARRA: Fearless reporting—you are obviously doing a lot of reporting. But if you have got to make an adverse report that will concern ADHC or DOCS, for instance, do you feel free in doing that?

Ms ARMSTRONG: Absolutely. I think one of the most important things about the program is the independence. I can sit here categorically and say on behalf of all community visitors that we engage in fearless reporting. It may be that a service organisation believes that we do have a conflict of interest. It may be perhaps we have a family member receiving the service from them or perhaps we have worked for them sometime in the past. The office of the New South Wales Ombudsman is responsible for coordinating the program, so they would contact the person there and say, "We believe there is a conflict of interest". As a community visitor, when you first started you put your hand up if you felt there was any conflict of interest that may impact on reporting.

The Hon. MARIE FICARRA: You were talking before about an average of 74,000-plus issues that were identified say last year, on a yearly basis, and that you achieved roughly through the scheme about 55 per cent resolution. Will you give us a little bit more information about the quality of services and do the findings from your visits feed into quality or compliance monitoring processes undertaken by ADHC?

Ms ARMSTRONG: First of all, I said 4,500 issues were reported. No, unfortunately, we are limited under the legislation in terms of involving third parties. So it is not a process by which we would make a report to ADHC about a service it funds, and as at this current time ADHC does not have access to that information. The Wood Royal Commission recommended that the Children's Guardian have access to the reports of community visitors, and we are in the process at the moment of entering a memorandum of understanding in order for that to be facilitated. Certainly I think there are opportunities whereby a visitor who has intimate knowledge of a service may provide some good advice on how that service meets standards and whether or not they are providing a service that improves the quality of life. But, by the same token, the line of caution would be: "Do you want to be the person that says service X should not get X amount of government funding?" It is a very fine line and the legislation certainly under which we were appointed would certainly have to be looked at in order for that to happen.

The Hon. MARIE FICARRA: Do you believe that there needs to be some sort of improved quality monitoring service?

Ms ARMSTRONG: Yes, I do, most definitely.

The Hon. MARIE FICARRA: Anecdotally community service workers have said to me that they believe unlicensed boarding houses are increasing in number. You mentioned the number of licensed boarding houses going down and unlicensed boarding houses going up, but we do not have statistics on that do we?

Ms ARMSTRONG: No.

The Hon. MARIE FICARRA: We should really do an audit on what is happening out there and better regulation. I know it is not your responsibility but what is the role of the local councils and the Department of Planning in allowing unlicensed boarding houses to continue?

Ms ARMSTRONG: In terms of my knowledge they are the only agencies that would have any information as to the numbers and whereabouts of unlicensed boarding houses, rooming rooms, and only because of their own planning requirements.

The Hon. MARIE FICARRA: Do you believe that there is a case for ADAHC working closely in collaboration with the Department of Planning and the Department of Local Government to improve the lives of disabled people living in boarding houses as a whole, but unlicensed boarding houses in particular?

Ms ARMSTRONG: I certainly believe that there is an opportunity for ADAHC to play a major role in ensuring that people with disabilities get better services. How they do it, of course, is one of the difficulties.

The Hon. MARIE FICARRA: Your submission states that people with disability often move from one accommodation service to another. This movement between services is "mostly focused on the needs of the service provider rather than the person with a disability" and also that "the policies and procedures that guide this process are either nonexistent, vague and/or poorly implemented". Do you wish to elaborate on that?

Ms ARMSTRONG: Those comments are made particularly in relation to the movement of people through funded services. Our experience is that the vacancy management processes currently employed by ADAHC do not focus on the individual's need. I understand at the moment that they no longer undertake compatibility assessments, but the compatibility assessment process has been replaced by a sustainability assessment which, I believe, is more about funding; in other words, it is the sustainability of the group home in terms of available funding as opposed to the best interests of the residents.

The Hon. MARIE FICARRA: That is something that is pretty disappointing. We are told by ADAHC that they are meant to be moving towards person-centred care, yet it is sustainability versus compatibility. If they are moving to sustainability, that goes against what they are saying about person-centred care. Am I reading it correctly?

Ms ARMSTRONG: As a group of people, Official Community Visitors have yet to see any really good examples of person-centred planning in the sector. Certainly it is not apparent in ADAHC.

The Hon. MARIE FICARRA: Are you familiar with ADAHC's vacancy management scheme?

Ms ARMSTRONG: I am familiar with it.

The Hon. MARIE FICARRA: What do you believe influences their assessment of accommodation placements? Do you believe that provide stability, or is it distressing to some?

Ms ARMSTRONG: I think the factors that impact on good vacancy management of people with a disability are internal factors. If there is a vacancy in a group home, whether it is an ADAHC group home or whether it is a funded service group home, that vacancy is filled through the regional vacancy management process. I have seen occasions when vacancies in group homes remain unfilled for months on end, even though it is not my role to make a comment on community-based services—I only visit visitable accommodation services—but in the knowledge that there are people in the community awaiting placements. I have seen vacancies exist for quite some time while there is a process of internal ADAHC bed rearrangement. I think the phrase is "an accommodation challenges project".

The Hon. MARIE FICARRA: An accommodation challenges project?

Ms ARMSTRONG: My understanding of the phrase "accommodation challenges project" is when the region initiates, because of the number of vacancies, a review of placements.

The Hon. MARIE FICARRA: But on the whole, what has been your feedback with the way that they handle the placements?

Ms ARMSTRONG: I think vacancies are filled sometimes very quickly because of what may be political implications. Vacancies are sometimes filled by a person who has no apparent commonalities with other residents. For example, you may get a person who is in a wheelchair and move in with a group of people who have good mobility skills and indeed where one resident may engage in some aggressive behaviour. That makes a person in a wheelchair become a target. I have seen that happen. I have seen situations in which people

with acquired brain injury who, while they have significant physical disabilities and communication impairments, are being placed in a group home with people who have profound intellectual disabilities. Where is the compatibility in that?

The Hon. MARIE FICARRA: Obviously it is not person centred in its approach. Thank you.

The Hon. HELEN WESTWOOD: I just want to clarify a couple of things that I understood from your answers. Are you able to provide services to people with a disability who are receiving respite and accommodation services, or is it only people who are in out-of-home-care permanently?

Ms ARMSTRONG: No. Funded or ADAHC-run respite services are a visitable service.

The Hon. HELEN WESTWOOD: Do you visit across all the ADAHC services, or is it only accommodation? For example, we have heard from people like Home Care and other support services that are community based. Do you visit those, or do you have the opportunity to comment upon those?

Ms ARMSTRONG: No, but a visitable service is defined under the Community Services (Complaints, Reviews and Monitoring) Act 1993, [CS-CRAMA]. In respect of commenting on other services, I can only comment anecdotally about information that families have given me, or about what I see in my own community.

The Hon. HELEN WESTWOOD: Thank you very much.

CHAIR: Thank you very much for appearing today.

(The witness withdrew)

(Short adjournment)

COLIN ALLEN, Director of Services, Deaf Society of New South Wales, and

STEPHEN NICHOLSON, Manager, Consumer and Community Services, Deaf Society of New South Wales, affirmed and examined (through interpreters):

CHAIR: Welcome to Mr Allen and Mr Nicholson from the Deaf Society of New South Wales. In which capacity are you appearing today?

Mr ALLEN: Director of Services, Deaf Society of New South Wales.

Mr NICHOLSON: Manager, Consumer and Community Services, Deaf Society of New South Wales.

CHAIR: Would you like to make opening comments before we go to questions?

Mr ALLEN: Certainly. Good afternoon, Mr Chair and members of the Committee. We are very pleased and privileged to have the opportunity to take part in your deliberations and to give the views of the deaf people who live in New South Wales. When I say deaf people I include, of course, deaf people from cradle to grave all over the state of New South Wales to whom we provide services. We are probably the primary and longest-established agency in New South Wales providing services to deaf people. We have a vision of deaf people having true equity in our society. What this means is respecting human rights of deaf people and respecting our language, our culture and our right to participate fully in society.

I think it is absolutely terrific that one of the earlier witnesses that I saw from the Aboriginal Disability Network I can see strong parallels with our presence here today. There are a lot of similar issues. Of course, very different communities with different needs but both communities have very strong histories, strong culture, strong language and a strong sense of community. It is in that spirit that we provide all the different services that we do to deaf people. Those services include sign language interpreting services and consumer and community services. We have the Deaf Education Network within our organisation and we have other advocacy services. Three of those services are either wholly or part funded by the New South Wales Government, two in particular. We have one stream of services where employment is funded federally and the interpreting service is often a fee for service but we have detailed in our submission where that differs.

We have ambitions to set up a full translation service. By that, what we would like to do is provide the information that is available in society in Auslan to deaf people. I should, by means of clarification, explain that Auslan is an abbreviation for Australian Sign Language and it is very much on a par with all spoken languages. It is a full language, rich and capable of expression. The Office of Industrial Relations was the first of the New South Wales government agencies in New South Wales to provide their government information to be translated into Auslan by our newly established translation service. This is a burgeoning service and we hope it will grow more, particularly in light of the UN Convention on the Rights of People with a Disability. There is a particular clause, clause 9, that deals with access.

Today we are very much focusing on the community and consumer service part of our suite of services because there is a long history of receiving funding from ADHC [Ageing, Disability and Home Care] within that service stream of our organisation. So we will primarily be addressing that department. Our original submission does not detail how much of a loss-making venture this department is for us. The funding that we get is particularly to cover the services that we provide, especially in regional areas of New South Wales where there is a large amount of unmet need. We never even manage to break even. We have six offices across the State of New South Wales. Four of those six offices are basically funded from our reserves from our own fundraising activities. For the last five years we have basically lost $2 million from our own coffers to cover the gap in provision service. Without that, deaf people would become lost within our community.

I know you have received our original submission. We have basically focused on four recommendations: the ADHC increased funding for deaf people specifically for deaf-specific services in regional Australia; that the criteria for the attendant care program be expanded to cover deaf people with extra disabilities, such as blindness; current services do not address the Auslan and language needs of the group; and also we recommend the ADHC make it a priority to provide Auslan translations of complaints procedures because they are all text-based and we would appreciate consideration being given for that information,

particularly in relation to complaints procedures or the disability standards in services to be made available in Auslan so that deaf people can fully understand their rights.

The criteria for the attendant care program being expanded—it is very important for deaf people, particularly deaf and blind, to be covered by this program and unfortunately that is an oversight. We have our resource folder that can be tabled for your further deliberation and consideration. That concludes our opening remarks.

CHAIR: What are you going to table?

Mr ALLEN: An addendum to our submission.

Document tabled.

Mr ALLEN: Mr Chair, there is a special present there for you in the folder. It is a map of the fingerspelling alphabet, so there is no excuse for you not learning how to fingerspell now.

The Hon. HELEN WESTWOOD: Mr Allen or Mr Nicholson, the interpreter services that are provided by the Deaf Society—which is an area in which I have got some familiarity and some experience, so I will start there—do you believe that it comes anywhere near meeting the needs of deaf residents in New South Wales, or do you think that there is a lot of unmet need in Auslan interpreter services?

Mr ALLEN: No, the services do not meet need. There are a lot of services that are provided by Government and other agencies that the Deaf Society has basically taken responsibility for covering, from weddings, funerals, big occasions in people's lives and access to any legal services. There are some things that are covered by the Government but certainly not anywhere near 100 per cent of the services that deaf people require access to via sign language interpreters. So there are many situations where there is clear unmet need.

The Hon. HELEN WESTWOOD: Is some of that unmet need because there are not enough interpreters out there with Auslan skills at the level that the deaf community in New South Wales requires or is it a combination of that and lack of funding? Could you give the committee some ideas about what could be done to help meet that need?

Mr ALLEN: We consider that we have a reasonable number of sign language interpreters in New South Wales, particularly in Sydney. Of course, as soon as you move to the country areas then you have got a huge disadvantage—a large decrease in the number of available interpreters. We have to often refuse to provide interpreting services where no funding is available. Unfortunately in the Deaf Society that is a situation that occurs a great deal. I will just check with Mr Nicholson if he wants to add anything.

Mr NICHOLSON: I just wanted to reinforce the fact that there is a real discrepancy within regional areas. A lot of clients would like to make appointments; they are able to make the appointment but the interpreter is not also available at the same time. There is also a travel cost incorporated within a lot of those appointments that may not make it viable to have an interpreter travel out to a particular appointment.

The Hon. HELEN WESTWOOD: Have you put to Government in the past that you need additional funding to meet that need and what has been the response from Government?

Mr ALLEN: My understanding at the moment, and I cannot provide any detailed answer to that, the Australian Federation of Deaf Societies—an umbrella organisation under which we come—are looking into right now a survey of the unmet need of funded sign language interpreting services across Australia. That is a Federal Government initiative to look basically at access to all the different levels of court attendances that go on in Australia. But in terms of the high skill level needed within, for example, the education system in terms of sign language interpreters, I understand this is germane to the committee's work and HACC-funded or ADHC services, but there is a terrible lack and dearth of suitably qualified trained and experienced interpreters working within the education system, and that then leads to significant other problems.

The Hon. HELEN WESTWOOD: We might come back to that. You are right, our inquiry is focusing on ADHC, but I hear what you are saying. Maybe that is something we can come back to.

The Hon. HELEN WESTWOOD: Your recommendation about attendant carers having appropriate Auslan skills, I am wondering if that also extends to other service providers. The deaf community is obviously ageing like the hearing community in New South Wales, and I would assume there are increasing levels of need. So, for example, services like home care or respite care, are you finding that there are workers in those areas that have Auslan skills or are they pretty much non-existent?

Mr NICHOLSON: In terms of attendant care, that particular program, they have very strict criteria and that is fine but they do not incorporate things such as particular groups like people who are deaf and blind, who we mentioned earlier, and they would like to continue to live independently. However, they do need that support and they need to put in an application for the attendant care program. So we are able to provide them with that application and we are able to provide staff or at least provide them with a pointer to staff who have those Auslan skills. But that is only in the areas we are aware of. So, particularly in regional areas, that may not be the case.

Mr ALLEN: Could I just add that we are very appreciative of the funding and deaf people are appreciative of services that are provided to them, but communication is the key for deaf people, particularly for deaf people who have become actively involved in the service provision they receive. I think you heard similar arguments made by the Aboriginal Disability Network earlier on. I think there are very, very strong parallels in the experiences of Aboriginal people and the deaf community, particularly over deaf people feeling comfortable with identifying with the people who are providing them with care and also the people that they are ageing in a home with.

The Hon. HELEN WESTWOOD: Are there any specific needs of the ageing deaf community? Are their needs very different from the general ageing community in New South Wales that the Deaf Society has identified?

Mr NICHOLSON: I cannot think of anything in particular other than culture and communication for deaf people who use Auslan—Australian Sign Language. However, there is a lot of fairly similar need out there to the wider community. The wider community just gets their needs met more often than the deaf community does, unfortunately.

Mr ALLEN: Again, if I could add, basically it comes back to the language issue and cultural understanding. That is basically the fundamental.

The Hon. MARIE FICARRA: On the point of funding, page 6 of your submission says that the Deaf Society's services had a zero per cent increase in dollar figures from 2008-09 to 2009-10 and it would appear a zero per cent yearly increase until 2012. Can you tell us how much funding your organisation requires to operate at current and anticipated capacity?

Mr NICHOLSON: That is correct; it is inadequate. Over the past two financial years we have been running a deficit. We overspent probably by $500,000. I refer to the graph in the paper just tabled. It clearly indicates the amount of income and expenditure and the overall result, which is the deficit column in red.

The Hon. MARIE FICARRA: Are you happy with the level of funding?

Mr NICHOLSON: No.

The Hon. MARIE FICARRA: That question was tongue in cheek. What would you like to fulfil the needs of the increasing ageing deaf community?

Mr NICHOLSON: As we said in the submission, the deaf community is ageing. Many are moving away from the major metropolitan centres to regional centres. Unfortunately, when their health declines they need more support. That is more of an issue. Our regional offices do not provide the suite of services that we are able to provide at the Parramatta office. We will obviously need to do something about that. This is going to become more of an issue, so something needs to be done right now.

Mr ALLEN: If you want to nail it down, we would have liked to have had $2 million over the past five years. That figure is set to do nothing but grow as the ageing population grows and as they increasingly move to regional areas. At the moment we have adequate funding for elderly people at only one centre at Blacktown and, of course, that is metropolitan Sydney. It has some staff with sign language skills. Apart from that there is

nothing in New South Wales. After consulting with the community, we would prefer to set up cluster homes that create a suitable environment for deaf people to retire to in dignity. We are in no position to pay for that, especially given the deficit we have been running.

The Hon. MARIE FICARRA: Has the cluster home model been discussed with Ageing, Disability and Home Care [Ageing, Disability and Home Care] or anyone else?

Mr ALLEN: I will have to take a step back. The first point that we must get to is ADHC understanding deaf people's needs in the first place. It provides many of services, but the turnover of staff is enormous. Every time we talk to ADHC we have to go back to the drawing board and explain what people with disabilities are, what deaf people are, our language, our culture and so on. When we try to put arguments and to be involved in culturally and linguistically diverse [CALD] issues, we are told we are not allowed to because that targets only those who do not speak English. We say, "We don't speak English." In many ways we fall into a gap between the disability sector and the CALD sector. It is impossible to get understanding at the top level of government and in ADHC that will then trickle down to the service level because of the high staff turnover. We are on the outside of a locked and bolted door trying to find the key to get in. We are often told, "There is somebody out there with a certificate II in Auslan. That is good enough." We tell them that they simply do not understand. These are culturally and linguistically sensitive services that are expensive to deliver. We are capable of delivering them, but they are not being delivered.

The Hon. MARIE FICARRA: This is the opportunity to give us a reasonable wish list for the future.

Mr ALLEN: We can be more than reasonable.

The Hon. MARIE FICARRA: This Committee is not Santa Claus, but we would like to make appropriate recommendations to the Government for the future. This is your chance.

CHAIR: Do not be shy.

Mr ALLEN: We have a very extensive wish list if you want us to be frank. Kicking it off, deaf people themselves should be employed to work in the different service and provision areas. That is easily the most appropriate way to provide the right kinds of services. The same applies to CALD groups and women's centres. You would not appoint a man to run a women's centre. I am sure that everyone asks for increased funding. I will be very specific and say that we need more funding for regional centres; that is where we would like it targeted. Two out of the six offices are completely funded by our reserves, which is inappropriate and not very sustainable. The need is growing. As we have said, deaf people are moving to the north and south coasts in particular. There is a ticking time bomb. If we plan appropriately now, we will have economies of scale rather than be faced with fixing the problem at a later date.

Mr ALLEN: The attendant care program criteria need to incorporate people who are deaf and blind as eligible to receive that service.

CHAIR: The Committee has heard evidence regarding difficulties with the mix of attendant care and home care. One has State funding and one has a mix of Federal and State funding. If you are receiving one you have difficulty qualifying for the other. Do you have any comments about that?

Mr NICHOLSON: People who are deaf and blind have applied for both and have been unsuccessful because they do not meet the specific criteria for one or the other. They have ended up becoming reliant on our organisation again. That is an unfunded service, but we need to provide that quality of service. If that is not there, there is nothing.

CHAIR: What has been said to you about that dilemma? Have you simply been told that it exists and that you have to accept it? Have any attempts been made to solve the problem?

Mr NICHOLSON: I have raised the issue of people who have not met the criteria. The response has been that I should get in touch with Home and Community Care. When we have done that, Home and Community Care has said they do not meet its criteria and that we should go back to the other service. There is a catch 22.

Mr ALLEN: So the deaf-blind clients become a tennis ball in a match between the two services, neither of which say they are eligible and neither of which are willing to provide.

Mr NICHOLSON: We do actually have one person who is deaf and blind within the attendant care program and the reason they actually manage to do that is because they actually became a client with that service before the criteria changed and they feel they are getting quite good service and now also other people who are deaf-blind are seeing the service that person is getting and wondering whether their service is.

Mr ALLEN: We are talking about one client that we know of is receiving this kind of funding and the numbers of deaf people with a visual impairment, as the population ages, is, of course, growing, so this is another ticking time bomb of a funding demand that we are currently covering that we can see exploding in the future.

The Hon. MARIE FICARRA: Please continue with your wish list?

CHAIR: Or have you finished?

Mr ALLEN: Oh no, we are certainly not finished. If it is okay with you I would like to that on notice in a sense so that we can prioritise. I understand that you prefer answers to questions on notice to be delivered by the end of the week. Is that correct?

CHAIR: If that is at all possible, as we are running out of time in terms of having to present our report to the House.

Mr ALLEN: Okay, we will make sure we do that.

The Hon. GREG DONNELLY: Thank you for giving this important evidence today which we appreciate. On page eight of your submission raises concern about the adequacy of ADHC's complaint handling processes to address the grievances of deaf and deaf-blind clients. How do you recommend ADHC improve its complaints handling processes to better suit the needs of deaf and deaf-blind clients in New South Wales?

Mr ALLEN: Again I raised this issue originally but like Aboriginal people we would prefer deaf people who can use Auslan to provide services. We would also like information and material translated into Australian sign language so that it is accessible to deaf people. What ADHC really ought to be doing, in the same way that they provide all the foreign language translations for all their material, deaf people are at a loss to understand why this material is not available in Australian sign language. That is really the fundamental issue and it is the initial barrier that prevents deaf people from knowing their rights and from ever making a complaint.

Mr NICHOLSON: Yes, I support that.

The Hon. GREG DONNELLY: Has there been any explanation given to your organisation about why that material is not available in the way you have described?

Mr ALLEN: The common response that we get is financial.

Mr ANDREW CONSTANCE: The cost?

Mr ALLEN: Yes, the cost, and certainly it is not cheap. There is an incurred expense to translating material into Auslan but ADHC should be respecting the deaf community, their language and their rights in the same way as we do with all citizens. Indeed, we do more with the other languages in Australia. The national language policy right back in the 1990s recognised Australian sign language as a language in Australia and yet the attendant rights that you would expect going along with that, and the availability of information in Auslan has not flowed on.

The Hon. GREG DONNELLY: I refer to my question four. Would you clarify the statement on page seven of your submission that ADHC's services for deaf people are non-existent in all areas except Sydney and Lismore?

Mr NICHOLSON: Basically, we have funding allocated for Lismore and Sydney. However, there is nothing for Newcastle, Coffs Harbour, Tamworth or south coast—Wollongong basically. So we actually try to juggle our funding around so that we can actually provide that service and make sure that it is in existence. The thing is the demand then becomes bigger and bigger and we, as our organisation, is not able to sustain that. So particularly we have people who move, particularly to the Central Coast, the Hunter area and also Orange and South Coast. Those are fast-growing areas and when they actually move from the metropolitan area they expect the level of service to be the same as it was in Sydney. Then the problems do become more complex. You advocate the access and then they do not actually have interpreters who are able to do that. So then you have community workers who have a number of limitations on what they are able to do. We have quite a number of statistics that show an increase from year to year. It is really quite an astounding increase. I will just see if I can refer to page four of our original submission.

It says within Sydney, Lismore had more clients who were case managed. Other regional areas had more what we call drop-in which is basically people who come in off the street who may need support. They may need literacy support. They are not able to understand letters they have received. They may need help in perhaps booking an interpreter. We have seen that that is an area of real growth and it is growing exponentially. It is not just the fact that we have people coming in face to face, now we have people who are living in areas further away and they are accessing some services and information via the web cam. So people need to be available more of the time to be able to provide any service and assistance they may need.

The Hon. GREG DONNELLY: In your supplementary submission you outline an impressive range of service that you provide. What is the most important service that government should be focussing on or should Government try to weight its support across the range of services?

Mr ALLEN: I think given the context the community and services—we hear to talk about that and we particularly need ADHC support and the New South Wales Government's support in order that we can provide those services, including parent programs for parents that have deaf kids. We are providing all of this through our own funds at the moment. Hearing parents, when they have a deaf child, are often in shock or grief and it is really important at that very early intervention stage to get in. We provide services, like I say, from cradle to grave and those very first community and consumer services specifically can empower and advocate for those people to meet their needs. All these older people who are living out in the community, there is a huge demand, and like we say a growing demand. If we are going to target the funding anywhere and see any focus from government it would be on the consumer and community services initially, because that is the lifeblood of the community and the service, the fundamental of the service.

The Hon. HELEN WESTWOOD: We heard quite a number of other answers about early intervention programs for children with a disability. I understand that most children tend to end up as part of education or perhaps some speech pathologist, and so on, which is not necessarily an Ageing, Disability and Home Care service—some are, but not a lot. I would like to give you the opportunity to comment because we have heard from a number of other disability organisations, physical, sensory and intellectual disability, about the need for early intervention programs for children. I would like to give you the opportunity to comment about that from the Deaf Society's perspective.

Mr ALLEN: In today's world we always hear about his wonderful technology that is available for deaf people—Cochlear implantation, a very popular thing. The benefits it can confer on people are appreciated but it is certainly not a technology that answers all the needs for all the people, and when you look at a child you need to look at the whole child and all of that child's needs. Even if they get a Cochlear implant young, it does not matter in a sense if they do not get access to language, because it can be then a double disadvantage. Most of the research, the medical evidence, says it is important to implant the children as early as possible, at the absolute early stage, to give them a chance to develop their listening and speaking skills. The research bears that out, and that is fair enough, but then they realise very much later on a human level that if the implant does not work, what you then have is too little too late. Oh, maybe we should move over to a sign language program, but by this time the child is maybe eight, 10 or 12 and, in effect, languageless, because they do not get access to the alternative, plan B, early in life. So, they are getting back to fundamental human rights and language rights of people.

Basically, it depends on whether you want to have a medical focus or a human focus. The StateWide Infant Screening Hearing program that exists for the early diagnosis of deaf babies, whereby nearly all newborns are tested at one or two days, does indeed refer the parents and families to medical services only, professional medical services, to look for a cure—and that is their favourite word and favourite terminology—operating very

much under the medical model, forgetting that child's potential membership of community, language, and getting access to information. The basic problem we have is that the information the parents are receiving is not unbiased; it is biased extremely towards the medical provision of services.

Contrary to that, it often surprises hearing people to learn that if deaf people have a deaf baby they are very happy to have a deaf baby. We know of many situations where this has happened and professionals have recommended a Cochlear implant and the deaf parents have said, "No, we do not want to give our child an implant," and they are then put under an awful lot of pressure by service providers and are criticised, harassed and bullied almost by service providers to give their child a Cochlear implant. So, the language rights and the language issues of deaf people and their right to take in information with our eyes, the facility we do possess, is being denied to us wholesale. So that is our concern, that these so-called professional services are incredibly biased in terms of their recommendations and referrals for parents.

There are some wonderful instances of good practice but, on the whole, you would have to say the information provided to parents is woefully inadequate on the community side of things. There has been a history of huge government funding in the Cochlear implant area, particularly in Queensland, much to the consternation of the deaf community in Australia, and we would not like to see that replicated in New South Wales.

The Hon. HELEN WESTWOOD: Does the society know of any research or attitudinal studies that are following deaf children who have been implanted and whether that generation of deaf children is old enough now for us to have a picture of what the outcomes are? Are those children taking up jobs in the professions at the same level as their hearing peers or are they identifying as hearing adults rather than deaf adults? There may not be any answer to that. I am not sure whether that generation of kids is old enough now to have some results?

Mr NICHOLSON: As far as we are aware, a lot of people who use Cochlear implants are accessing our services but we do not have any information as to what areas of life they are active in and what their achievements are. However, I think that is definitely something for future exploration for us, to look into what has happened to those implantees.

Mr ALLEN: When you look at the deaf community, the hearing-impaired and people with hearing loss, obviously within those communities we have wide diversity. We get very different needs. But without meaning to make too much of an emotional impact, we have anecdotal evidence of deaf kids saying they want to divorce their parents for making the wrong decision, that they did not even know there were other deaf people in the world, that there was a deaf community, that this information was being deliberately kept from them by the medical professionals and then, by default, by their families.

The Hon. MARIE FICARRA: Do you believe your society should be involved in administering the Home and Community Care program for supporting deaf people in nursing homes and hostels?

Mr ALLEN: That would be excellent. That would be a terrific way of providing services. We are the experts. We are the specialist in providing services to deaf people. We know exactly how to do it in the right manner. I would like to see us establish a very healthy partnership between the Home and Community Care program and our services and I see no reason why we cannot work together to achieve very good outcomes for older deaf people because we will be providing services by people of their ilk.

The Hon. MARIE FICARRA: Obviously you would need resources to properly train a whole batch of required staff for this?

Mr ALLEN: Definitely.

The Hon. MARIE FICARRA: Make it part of your wish list.

Mr ALLEN: We will. Yes, ma'am.

CHAIR: You have already spoken about this to some extent but perhaps you could elucidate a bit further. The Committee has received evidence that deaf blind people do not receive any funding for services unless they are diagnosed with an intellectual disability. Can you clarify whether this is the case—which I think you may have already—and, secondly, what types of services do deaf blind people require to ensure they can function to the best of their ability?

Mr ALLEN: In terms of the intellectual disability information, I am not sure, but in working with people who are deaf blind, we have had people who contacted our service because they see themselves as primarily deaf and, additional to that, as someone who is blind. So, they feel they have a right to access services from the Deaf Society of New South Wales because we have sign language that they can put their hands over and feel it, or see it within the residual vision that they have, so we can provide information that they need for communication, but we do not necessarily have access to other resources. So, people are falling through the cracks because we have one part of the skill set but do not have access to the other. Would you like to add anything, Colin?

Mr NICHOLSON: No.

The Hon. GREG DONNELLY: Mr Allen, in response to one of my earlier questions you made reference to the Queensland experience and what was happening in Queensland. Can you elucidate and explain what the issue is in Queensland that is of concern to you?

Mr ALLEN: I am just seeking the name—I want to be specific because off the top off my head I cannot remember.

The Hon. GREG DONNELLY: You can take it on notice if you wish.

Mr ALLEN: Yes, I will. We will provide that information by the end of the week.

The Hon. HELEN WESTWOOD: Again, you may need to take this question on notice. I am wondering whether you are aware of deaf people who are in the criminal justice system. We have heard evidence from other organisations about the number of people with a disability who are disproportionately represented within our criminal justice system. I am wondering whether you have any experience that this is the same with deaf people.

Mr NICHOLSON: Yes, in answer to your question. As far as we are aware, perhaps in the last two years we have 22 deaf and hard of hearing people within the criminal justice system or in prison within New South Wales but we do not know the actual details. But I am aware that when police intervene there is a lot of lack of communication, and again particularly this goes back to regional areas. The police system, the justice system, is not overall and across the board aware of the fact that they need to provide interpreters for these sorts of things. So we have sometimes been involved in terms of lobbying to make sure that deaf people get that access as other people do. Also, more things do occur because of the overall socioeconomic status of deaf people.

The Hon. HELEN WESTWOOD: More specifically, have you had deaf people who are within the prison system who have needed your services at all?

Mr NICHOLSON: Yes. We have actually been involved a number of times. We have had people who have requested access to being able to send text messages on mobile phones, because that is the way in which they communicate. They are not able to use a regular telephone. However, they are prevented from that because of the fact that they are in the prison system so sometimes they are allocated a particular time and a particular place to be able to access SMS, to be able to access that communication. The other issue is people who are watching television without those open captions everyone else is able to watch, closed captions. So we have been involved in a few cases where people are able to use our services to advocate for them to be able to see these things.

The Hon. TREVOR KHAN: Again, dealing with hearing impaired or deaf prisoners, are you aware of special arrangements made by Corrective Services for their housing within the prison system, or are they dispersed throughout the prison population?

Mr NICHOLSON: I am aware that there is only one deaf person in Long Bay Jail. They are within the disability unit. That is where they are housed. Obviously it is a safer area for them. But in other areas, as far as I am aware, they are just dispersed throughout the prison system. Again, as I said, this is anecdotal. If there is any further information, I may not be aware of it, anything that has come up recently.

Mr ALLEN: I think we can just let our imaginations run riot in terms of how horrible it would be to be a deaf person in prison, to know nothing about what is going on on a daily basis, to have sign language as your mode for communication and yet nobody within your proximity that can use sign language. I think you can all use your imaginations and work out just what that experience would be like.

The Hon. TREVOR KHAN: That is why I was asking the question. It seems to be self-evident that a hostile environment becomes much more hostile in those circumstances.

Mr ALLEN: And again I will bring everything back to language. It always comes back to language. Imagine it would be equivalent to having your tongue cut out, in a sense, and being put in a place where you can no longer speak to the people around you.

The Hon. TREVOR KHAN: That would be awful for me.

The Hon. MARIE FICARRA: And so good for the rest of us.

The Hon. GREG DONNELLY: On page 7 of your primary submission you speak about the issue of deaf people being accommodated in nursing homes and hostels. Would you like to comment further about the matter of deaf people living in such accommodation?

Mr NICHOLSON: I am aware that HACC does promote the opportunity for people to stay within their own home longer by providing services within their home, which is great, but you have other services, such as meals on wheels, all those sorts of things, people making sure that their medication needs are provided for. However, you do have that person who is coming in and again there is that communication issue. There is that lack of communication. Obviously that makes it more difficult for a person living in their own home. In terms of ACAT, if you have a senior person who needs to be referred and perhaps placed into a hostel or a nursing home, the person within that assessment team will be providing an assessment but not necessarily with that real understanding of their cultural and linguistic needs. They may not have that understanding of why it is that person is behaving in that manner and it may in fact be due to a cultural difference. So they may be placed inappropriately. Sometimes they have been diagnosed as someone who has a mental health issue whereas that is not the case. It is basically due to their behaviour that has been misinterpreted. We have seen that in a number of places, unfortunately.

Mr ALLEN: I would just like to add, again I do not want to hit the emotional button and say "poor us" but the Deaf Society of New South Wales is the only organisation that tries to cover that service gap. There is another organisation that provides a little bit of support through their church organisation and that support is very much appreciated but it is a serious concern for us. I understand it will go on the wish list. The lack of people providing services with AusLan proficiency and deaf culture awareness is endemic.

The Hon. TREVOR KHAN: You raised an issue before of funding and said that you have funding for provision of services I think in Sydney and Lismore. Can you explain in a sense the historical circumstances of how you got funding for Lismore but not for Newcastle and Wollongong? I am not standing up for Newcastle and Wollongong, you would understand, but it just seems to be an odd historical quirk that you end up with such an odd mix of funding provision.

Mr NICHOLSON: I guess historically Lismore was established by the local area, their deaf association at the time, rather than by the Deaf Society of New South Wales, historically. So they applied for funding separately and provided a limited number of services but then they closed down. ADHC realised there was real value to that service and wanted it to be continued so they approached the Deaf Society of New South Wales and from there those services in Lismore have continued, which is why it is just those two areas that have been funded. Lismore and far north New South Wales do have quite a large deaf population, and they have been ageing obviously, and that has been happening for quite some time, but in the last few years we have other areas of growth that are starting to catch up where we have older deaf people and again an ageing population.

The Hon. TREVOR KHAN: If there were to be a service established at, say, Newcastle or the Central Coast—and I do not leave out Wollongong for a particular reason—what sort of service would you be looking at? If you were to establish a service on the Central Coast, what would you be looking at putting in place and at what sort of cost?

Mr NICHOLSON: I would say the priority there would be a full-time caseworker. We would also have a fixed address. We would also have somewhere where people know that they are able to attend because there are some complex needs within the community. As I said, we have older people and we have people who have additional disabilities. They require advocacy just with their everyday life, as people do in Sydney. People out of those metropolitan areas want the same services basically.

The Hon. TREVOR KHAN: I understand that. Would the Central Coast be the location that you would see as the next priority, or would it be Newcastle or Wollongong, or would it be somewhere else?

Mr NICHOLSON: It is not something we are talking about actually establishing. We are more talking about the services that we have provided being improved and expanded upon, so of the areas as I mentioned earlier we have Tamworth, Coffs Harbour and other areas where we do have some sort of services provided, but they need to be expanded to meet the needs, particularly like the Riverina area. As I said, these need to be provided and improved upon.

Mr ALLEN: Part of our strategic planning has indeed targeted those four areas that Stephen has mentioned and that is why we are very happy to have the opportunity today to basically say to you it would be four or five locations, but if you are asking for a real priority I would say that the South Coast is probably the most disadvantaged in terms of service provision at the moment.

Mr NICHOLSON: I would have to agree with that.

The Hon. TREVOR KHAN: In saying the South Coast, do you mean Wollongong or based in Nowra, or where?

Mr NICHOLSON: Currently we have a 12-hour-per-week service provided and that is South Coast through to Nowra. That is the area which it covers—all of that area.

The Hon. TREVOR KHAN: Twelve hours?

Mr NICHOLSON: Yes, 12 hours per week, and obviously we would prefer to have that expanded in hours to cover the whole area. Tamworth only gets 10 hours a week, and Coffs Harbour. What we provide there is what we call a drop-in service, as I referred to earlier. We do also have other areas such as Dubbo. We have started to notice that there is more of a need there too.

The Hon. HELEN WESTWOOD: Do you think that the survey done by Louisa Willoughby on the distribution of Auslan use in New South Wales would be useful in terms of understanding where the populations are that may have greatest need? I know it is on the website, but perhaps you could send that to the Committee and we could table it for our reference.

Mr ALLEN: Absolutely, we will do that. One important note to be aware of is that those statistics were derived I think from the census, and it was in fact the 1996 census, so there is a huge problem because the question that was asked in the census was, "What language do you use in the home?" That was the wording of the question and it required deaf people to put Auslan. We did not actually know whether these people were deaf or whether they were hearing people that used Auslan, so there was a disadvantage in the way the question was phrased—because you could have answered the question that way.

The Hon. HELEN WESTWOOD: Yes, I did.

Mr ALLEN: So it does not specifically identify how many deaf people we have and where the deaf populations are.

CHAIR: In the couple of minutes we have left before we have to adjourn for today, are there any recommendations you want to put to us? I know you have done your wish list. Is there anything further you want to add before we close?

Mr ALLEN: Before we close I would just like to bring us back to the point that you are very lucky to have the Deaf Society of New South Wales covering all these gaps in service provision, particularly over the last five years—$2 million worth of unfunded services that we have been covering from our reserves. This loss-making venture is simply unsustainable for the size of organisation we have, and it should not happen in the first

place, so the New South Wales Government should accept its responsibility for providing services and we look forward to working with the Government to achieving basically that goal and for improving deaf people's lot.

CHAIR: Thank you for being with us this afternoon. You obviously have support. We appreciate your expertise and giving us the opportunity to hear your words.

(The witnesses withdrew)

(The Committee adjourned at 5.46 p.m.)