

THE JOINT PARLIAMENTARY STANDING COMMITTEE ON COMMUNITY DEVELOPMENT MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON THURSDAY 4 NOVEMBER 2004.

Rev. CHRIS JONES, CHIEF EXECUTIVE OFFICER AND **Ms MANDY CLARK**, GENERAL MANAGER, ANGLICARE WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Thorp) - Welcome to you both. If it is okay with you, it might be a good idea if you give us the main body of the points you would like to make and then perhaps we could ask you questions at the end.

Mr JONES - That is fine. We appreciate the opportunity to come and speak to you. Part of it for us is when we heard about the establishment of the inquiry, the reference you had, it seemed to us that there was some opportunity for particular people who have been really struggling to get by to have the issue brought up. We have been pleased to hear some of those stories that have been told to you. From where we sit, our connection with particular groups of people is limited to a particular area, so in some sense it is that area that we can speak about today, which is why Mandy is here. She manages that acquired injury and home-care service for us. I can perhaps talk about the more broader things but, as you would appreciate, Mandy is here for the detail. So tricky questions are for Mandy and easy ones for me. We will see how that runs anyway.

Laughter.

Ms CLARK - Well, not knowing what people were familiar with, we have prepared a bit of a snapshot about what we do and the sorts of people that we work with. I will just read some information, if that is okay, and people can feel free to interrupt.

Anglicare's acquired injury and home-care support services were invited to talk with you today regarding our experiences of supporting young people with acquired disabilities. Prior to sharing our experiences, observation and feedback gleaned from our clients, families and other agencies, we thought it would be appropriate to give the committee a brief overview of the services we deliver and thus establish the context in which our experiences are based.

We commenced operation in December 2002, with the role of supporting injured Tasmanians to maximum their independence and achieve their desired quality of life. The majority of people we support have high complex needs and have sustained brain injuries, either traumatic or non-traumatic or spinal injuries which have resulted in permanent disabilities. We also provide support and assistance to people who have suffered multiple injuries and require short to medium-term support and/or nursing services while they are recuperating. They are outside the context of this committee.

Our service offers transitional, long-term and respite residential support located in the northern and southern regions. The residential support services encompass a

six-bedroom home and seven transitional living units located in Kings Meadows and a six-bedroom home and eight independent living units located in Glenorchy. Both complexes are owned by the Motor Accidents Insurance Board and both homes provide 24-hour support to the residents. Although not yet operational, Anglicare has also recently purchased a five-bedroom home in the southern region.

In addition to residential support, the service also delivers a statewide home-care support service which provides support to people returning to live in their own private homes, post accident. Support offered can include, but is not limited to, assistance with personal care, basic daily living activities, assistance with therapy regimes, housekeeping, transport, social and leisure activities and nursing services. Currently home-care services are delivered in Devonport, Burnie, Ulverstone, Sheffield, Meander, Launceston and surrounding suburbs, George Town, Bridport, the east coast, Hobart and surrounding suburbs, New Norfolk and Bruny Island.

Mr FINCH - Mandy, what sort of service was that?

Ms CLARK - That is home-care support, so supporting people to live in their own private residence.

Mr FINCH - Those were the areas that you are able to go?

Ms CLARK - That is where we're currently providing support. That is where the people are and that is where they live.

Mr FINCH - If others were elsewhere, you'd be able to spread out?

Ms CLARK - That's right.

Mr JONES - The arrangement that we have with the MAIB is to provide services across the State and to the islands, so it is to wherever the clients are, and then really it is a matter of our having to recruit appropriate staff in those local areas to be able to deliver services. It works on that sort of model - on the basis of people returning home from where the accident occurred, and that is where we will be supporting them.

Mr MORRIS - And you are only in this case talking about the compensable -

Ms CLARK - No. I was just about to clarify that for you. About 58 per cent of people with support are under the age of 40, and the age cohort of the client group is 17 to 92 years. That has been lower, but currently it is between the ages of 17 and 92. The service supports compensable and non-compensable clients, and I have made an assumption that people on this committee understand and are aware of the differences between compensable and non-compensable.

Mr MORRIS - Yes.

Ms CLARK - Referrals and support funding is received from a range of providers, including the Motor Accidents Insurance Board, other insurers - for example, workplace accidents - Disability Support Services, Home and Community Care, brokerage through

other home and community care providers and fee-for-service, and by that I mean people who may have been compensated and are actually funding their own support - private clients.

Supporting people with acquired disabilities is a complex process and it is not possible for us to share a comprehensive overview of our experiences over the past two years. Therefore the following information only attempts to provide a snapshot of what we consider to be some of our key learnings, insights and feedback received which are relevant to the terms of this committee.

So in terms of the first term of reference - adequacy and suitability of existing accommodation - the MAIB-owned facilities in the northern and southern regions in our view are adequate and suitable. They are good facilities in the sense that they are purpose-built and they are able to provide support to differing levels of need. In each of those complexes there is a main house with transitional units attached. In the south they are attached in the same street but not on the same grounds. In the north they are one large complex on the same grounds. The main houses tend to provide support to people with catastrophic brain injuries requiring 24-hour support, and the transitional units provide support to people with lower level needs and/or people with spinal injuries, and these are predominantly people with quadriplegia.

The transitional independent living units attached to each of the facilities also provide support to people through various stages of their rehabilitation. For example, a person can move from 24-hour support to a transitional unit where less direct support may be provided, yet overall the person still remains in a supportive environment that is supervised and has guidance with it. Without this option, some clients would be at risk of being inappropriately placed in nursing homes, as it may not be possible for them to return home post-discharge from hospital, or a person may spend long periods of time in hospital due to the lack of accommodation options which, in our experience in working with and supporting non-compensable clients, has been the case.

Accommodation options such as this also offer families alternative options and ease the pressures on the family if they are not able to support the injured person to return home. In addition, supportive accommodation options of this kind also minimise the need for crisis interventions. I think, regardless of the status of compensable or non-compensable, that sort of facility does offer those sorts of options.

Anglicare is not aware of any other facilities of this kind in Australia, and accommodation support options of this kind are not available to non-compensable clients in Tasmania to our knowledge. There are far fewer support and accommodation options available to non-compensable clients, and this identified gap is what prompted us to recently purchase a property in the southern region.

Mr WILKINSON - A number of people are saying in relation to the houses, especially with the non-compensable people and with respite, that there is just not enough room for those people to go into adequate houses for that respite. The young people who have had an injury - let's say they have fallen over in the street, been in a fight and fallen over and hit their heads - are just unable to afford to do that. Are you saying that what you have been seeing is adequate to fulfil their needs?

Ms CLARK - I think that the MAIB-owned properties are fulfilling a particular need.

Mr JONES - So it is really the non-compensables.

Mr WILKINSON - That is right.

Mr JONES - The compensables response - the MAIB stuff - is good.

Mr WILKINSON - Yes, that is what I have been hearing.

Mr JONES - Our suggestion of course is that that sort of response needs to be replicated for the non-compensables. The example for us is the house that we purchased out in Rosetta. It is not in a land-slip area - just. When we purchased that it had been on the market for two years. It is a six-bedroom house, it has a lift -

Mr WILKINSON - A lift?

Mr JONES - Yes, it has a lift because the guy who built it is in a wheelchair. He has had it on the market for two years. We came along and on the basis of what we have been trying to identify, we purchased the house. We did so because we know of the need there, but now I have no support dollars. I am going to take possession in two weeks' time and I am going to have a great house but -

CHAIR - And Anglicare is paying for that completely?

Mr JONES - Yes. We have purchased the house but what I can't get is any support dollars to put anybody into the house. Can you see what I mean? This is the example. The people you have heard from, they are right, there are no support options there and I suppose it takes organisations to say, 'What can be possible?' but in the end we have gone as far as we can and stretched it to buying -

CHAIR - Wouldn't that house be providing housing for people whom the State felt obliged to provide housing for? Do you get where I am coming from?

Mr JONES - Yes, indeed I do.

CHAIR - So if you hadn't done that and provided that facility then Housing would have had to do so in some shape or form.

Mr MORRIS - Or left them on the waiting list.

Mr JONES - Yes, or be on the waiting list. Some of the residents, as you would know, are being cared for at home by perhaps elderly parents or other carers and it's not quite working. I think there are possible solutions and, in our experience with what MAIB have been able to fund, it is possible to come to solutions. I don't think that is the question for me, given what Mandy has outlined about how it could work. It is the will and the funding to actually be able to do something about it. I think we are at that point now of putting some, I think, realistic proposals forward and of course now we are saying to Disability Services and the minister, 'Hang on, we can find a house; we have a house,

you have the client need and we are now getting to the point of saying "What is going to be in the budget?" '

CHAIR - Some kind of partnership.

Mr JONES - That is what we are saying is needed and there are other groups in the community that you will have heard from who are interested in similar sorts of things. When we found the house we thought, 'We can't let it go' and I tried to get Housing to buy it but of course that's another story.

Mr MORRIS - No, that's not another story, that's the same story and part of the same issue.

CHAIR - But Housing can't act as spontaneously as -

Mr JONES - To be fair, when I say another story, there were certain dilemmas for them in purchasing it that I don't have. I have to convince a board; I don't have to go through contract review and all that sort of stuff -

Mr WILKINSON - The best committees are committees of one, Chris!

Mr JONES - Well, of course, it is a team -

Mr MORRIS - He's working on it.

Laughter.

Mr JONES - But the reality is that for us, and it was just too good to lose.

One of the things that may have been said to Disability Services and Housing, if the house works then at least it is available now. We've purchased it and if there can be some arrangements about that down the track then we are open to that because we would prefer not to be owning property like that, but it was too good to miss.

Mr FINCH - Are you suggesting that that house is going to be for non-compensable clients only?

Mr JONES - The reality for us is I am about to have a mortgage on the house and we will need to come up with some way of funding it. It will be on the basis of people who are in need who can actually pay for the care. As soon as we have possession we have the State Manager of Disability Services coming out to have a look at it. I think -

CHAIR - Something will be worked out.

Mr JONES - something will be worked out, let alone whatever overflow there might be for MAIB and others as well. The other list of people that we are currently working with when they know that there's a house available that meets the standard then I think we should be able to fill it. Do you think Mandy?

Ms CLARK - I think the need is there.

Mr MORRIS - Can I just ask in terms, if I understand correctly, you don't actually have a defined client group to the exclusion of all others, so what you are seeking is a compatible set of people who don't necessarily have to be injured clients? Are there particular rules? They are obviously people with some sort of housing stress to start with in that they are currently in not ideal circumstances and they have an injury or a disability?

Mr JONES - We exist for Tasmanians who are disadvantaged and in poverty. I am hoping that is getting a smaller number, but there are other options for other people. So for people who are in housing stress and families and things, there are some other options for them. There are no rules around this house because it is ours; we haven't been funded anywhere. But it is related to the group of clients that Mandy has been talking about, and that is where the compatibility has to work. You have to make sure that you get the right people - the mix has to be right.

Mr MORRIS - You're not specifying that it's just for those with ABI or something? It could be someone who has perhaps a physical disability. If they're compatible with the other people, as long as they are in that broad client group you're working with.

Ms CLARK - If they're compatible. History demonstrates to us and feedback from clients that you need to move forward cautiously when looking at mixing client groups. I think, to be fair, someone with quadriplegia has very different needs than someone with a brain injury, and that may not necessarily be appropriate that they live together or reside together. They have two very different lives and their readjustment and life recovery processes are very different.

Mr MORRIS - But its compatibility you're looking for?

Mr JONES - For instance, our support for people with intellectual disabilities is a different stream to the stream Mandy is responsible for. There is a different manager and other people responsible for that. What we know works best is some form of difference - a different approach, a proper separation.

Mr WILKINSON - With the property you have purchased, are you going to staff that or would you be hoping that either the Commonwealth or the State - which is another question - will be staffing that and you'll just being the landlord of that property?

Mr JONES - We have gone as far as we can outlaying the capital and servicing the debt on the capital; the support dollars will need to come from somewhere else.

CHAIR - But they will come with the client.

Mr JONES - They will be associated with the particular care of the clients' needs. We are not going to staff it until we can get this funding for individual care package - how it might come, depending on who it is comes for. As I said, there is a range of different funding providers, if you like, a range of people who fund care for clients now, so it is a matter of trying to pull that together. I don't want to reduce it to the house we happened to have purchased, because it is bigger than that. But that is a bit of an example of the sort of thing that needs to take place.

Mr WILKINSON - The other thing we have been hearing is the fact that there is a real problem because of the Commonwealth and the State. Who is to put money into it? Is it the States' duty, is it the Commonwealth's duty, is it a joint duty? There seems to be a bit of a bottleneck there. Do you find that same bottleneck? Should the system itself as to who does the funding be sorted out? If so, how?

Mr JONES - Some of those negotiations around the Commonwealth, State and Territory disability agreement are clearly problematic for us. We happen to be funded under the State component of that; we don't receive any of the Commonwealth funding, but the overall agreement is Commonwealth-State funded. Clearly, there is some work that needs to happen about that. To me, some of that needs to be sorted through. If you have a shared home for people intellectual disabilities funded under the Commonwealth scheme, you get less than you do if it is funded under the State scheme. That makes no sense to me. If you are trying to support four or five residents, both sets of residents have intellectual disability, both sets of residents need a certain level of staffing, why is it that if you happen to be funded by the Commonwealth you don't get the same amount of money? Clearly, that has to be sorted it and there have to be better ways of doing it. The easiest way is for the moneys to be increased from the Commonwealth end, so that it is up at least to the State level of funding. That is under that particular component of the overall issue around those who are funded. To this point in time for us it has been those with intellectual disabilities.

Mr WILKINSON - Do you find it difficult to work through the differences between Commonwealth and State, who gives what?

Mr JONES - Mostly that is already sorted before we get to play - before we get involved. Most of that sourcing for funding these days is connected to the State because the Commonwealth funding has some history about it and it's connected to the earlier deinstitutionalisation processes.

Mr FINCH - On the question of the size of the funding you need, can I get some indication of your staffing requirements in these operations at Kings Meadows and down here?

Ms CLARK - I think that that is not an easy thing to answer in the sense that if you look broadly across people with acquired disabilities, obviously the degree of injury needs to be matched with the degree of support. What you need, from our perspective and our experience, when you are working with people with catastrophic injuries, is to provide the best opportunity possible for them in their recovery. You obviously need environments that can stimulate them, to be structured in the way you are approaching your work with them and be able to provide therapy assistance to a range of allied therapies, so it can vary depending on where that person might be.

Mr FINCH - Or the mix of people that you have there as clients.

Ms CLARK - Yes. For example, people have probably already talked with the committee about people with perhaps brain injuries who have challenging behaviour. In residential services, particularly if you have a large number of your client group who do require full assistance in terms of the injuries they have sustained, require people to provide them with support for pretty much all activities of daily living, the vulnerability of that client group perhaps around people with challenging behaviours is risky so it is about trying to

get that match. Fortunately, our experiences in the residential facilities to date are we are predominantly working with people with quite high support needs and we haven't faced those experiences. You have the added option too of independent living units in those situations but I think in the non-compensable world it is important that that is considered because supported group home-style options that I am aware that some providers are quite critical of in the MAIB area don't necessarily work for that group.

CHAIR - Thank you. Does anyone else have any further questions?

Mr WILKINSON - I have asked it a lot, but we have recommendations at the end of this, as you know, and if you were making a recommendation or recommendations, what would they be?

Mr JONES - For us the holistic approach is what I suppose is important. It isn't just a matter of a house or a support thing, it is actually attending to some of those other things that Mandy has mentioned. It is about the social support, access to other health-care professionals. You do have to look big and not be scared by what that might mean about the number, I think, and if you are saying, 'If we were going to respond to this particular group, young people with this need, this is what it's going to have to look like' and I think there is something about the system that MAIB have put in place. The costs around that I know are large but it does seem to me that it gives a holistic response because we are talking about people who we currently care for and if they come in as a child and perhaps are 17 now, as you heard, they could be 92 and they are still being cared for. To me, it has to look big; it has to look at whole of life. I know that it is not perhaps pithy enough in one sense, Jim, but, to me, it has to have that comprehensive nature about it. It has to look at the whole of life and for sustaining people for the whole of life because that is what is happening - people are living to 92 with acquired injuries. So for the young people doing that now it is going to be long term so we have to make sure that we have the resources in place.

Ms HAY - And the system and support services to be a lot more flexible?

Mr JONES - As Mandy said, there are some criticisms about certain models around people with acquired brain injuries and one of the things that we know about that is that you do have to have the capacity to respond to the individual needs with individual services, so that needs a bit of flexibility from health-care professionals as much as others.

Ms CLARK - In terms of people with other injuries - and a good example is spinal injuries, quadriplegia, particularly with young people - I think some of the issues that you face as a service provider sometimes can be somewhat out of your control. A good example of lack of flexibility is industrial awards and the rigidity sometimes where awards don't allow you the flexibility to tailor and deliver a service in accordance with exactly the way a person would want it because you have some other restrictions around you.

CHAIR - What kind of thing.

Ms CLARK - If you are a young person with quadriplegia and you decide, 'I want to go here tonight', just like any one of us makes our decisions, remembering that essentially a support worker is the arms and legs of someone with quadriplegia, you might need somebody to come with you or you might have rostered hours. We have industrial

obligations to meet for permanent staff around their hours. If shifts are cut, or they might want to go off and do something - a holiday, for example - awards do not cover those sorts of things. They don't cover somebody who might only be rostered to work two hours but they really need to be there for three for a particular reason.

Mr JONES - And it takes a fair while to work through some of those things. We are on a fairly steep learning curve over two years. We met with HACSU earlier in the week to try to come up with some way of meeting our obligation for staff because if you can't meet those you can't recruit, and you need to do that. I think we will get some flexibility around it. Can you see what I mean? This is just an example around industrial stuff. They are saying yes, the staff are saying yes; no-one will go anywhere near AWA so what sort of industrial agreement can we put in place. If we just do this about staff and industrial issues, then the next thing is about access to physiotherapists and so on. Some of that flexibility that is needed for the whole of life takes a fair bit of working through, but that is what is going to make a difference for the young people that you're talking about.

Mr MORRIS - Can I just come back to the compensable and non-compensable issue. From what we are hearing, is it your experience as well that the rest of the system will learn a lot from what the MAIB is doing and how they're approaching things in general. In terms of how we might in future deal properly with the non-compensable situation, can we learn lots of lessons from what the MAIB is doing?

Mr JONES - One of the things is that MAIB - and it is not a paid advertisement just because they happen to be sitting over there -

Laughter.

Mr JONES - there are some very distinct advantages from the MAIB system about the whole of life because of what the legislation provides for. They have a responsibility for the whole of life. Because there is a statutory responsibility for a government business enterprise to do something for whole of life, it actually means the system does work for them because they have that responsibility. I think that is a big difference; the focus of their attention is to make sure this happens. They contract to us and tell us 'Your responsibility is to make this happen'.

Mr MORRIS - So it's a clear responsibility?

Mr JONES - It is.

Ms CLARK - The security for people for support for the rest of their lives.

Mr JONES - The idea is that that sort of act is going to be dramatically changed in Tasmania, but it is not going to happen. There is the security for it but it also means that there is a responsibility to be exercised: future planning about what it is going to be, where they are going to live, what we are going to do about people entering into relationships - all that can happen. The contract for these guys is very thick, whereas if you compare that to some of the stuff we do with the State Government it is different. There is a different dimension to what we deal with here. I think it is appropriate

because it comes back to what I am saying about whole of life, long-term, all those sorts of things. It has to have a different relationship about it.

Mr MORRIS - As much as we don't wish anyone an accident, it just seems at the moment, if you're going to have an accident, clearly you want to have an accident that gives you cover preferably by MAIB, or WorkCover perhaps, where there is a clearly defined path and you will be cared for. But if you happen to be half a second or half a metre away from that cover, you are just out of luck. Well, you're not out of luck altogether; it's just that your level of care and service will be much reduced and a lot less predictable.

Ms CLARK - And the pressures on your family will be far more significant. Families tend to pick up a large part of that.

Mr MORRIS - So in an ideal world, if we could expand that guarantee or legislative protection that comes under the MAIB and the WorkCover area, if that could be extended to everyone, would that be the best situation we could currently hope for?

Mr JONES - We would need to have a look at that. If we just look at the care provisions, that is indeed the case. As you know, we put in our State budget submission; what does that do to the overall level of State debt and other bits and pieces.

Mr MORRIS - Sure.

Mr JONES - We have a view on that other broader question, as you can imagine, but certainly in terms of the care response then clearly this sort of system works very well for us in Tasmania.

Mr MORRIS - That is what we are focussed on here.

CHAIR - Thank you very much for your contribution. You have given us a lovely intro to the gentlemen from MAIB. Thanks for your time.

THE WITNESSES WITHDREW

Mr LAWRENCE WALSH AND Mr PETER ROCHE, MAIB, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you very much, gentlemen. If you could give us an overview of your perspective and your point of view in terms of the hearings, then perhaps we will quiz you later.

Mr ROCHE - Thanks for the invitation to MAIB to appear before the committee. Given the time constraints, I will just provide a broad overview. I note that Mandy has already covered some of these areas so I might just skip some of that detail. Lawrence is an occupational therapist employed by MAIB, and he will be able to provide some information on the services actually provided.

The history of MAIB's venture into this area began in 1991 when the legislation was amended so that people requiring two hours or more of care per day for an indefinite period were entitled to daily care statutory benefits. That daily care means treatment, therapy, nursing services, all sorts of assistance, services to rehabilitation et cetera, and there are no statutory limits on the total amount payable as daily care. This means that people with severe brain injuries or quadriplegia are entitled to medical services and attendant care services for the rest of their life, irrespective of who caused the accident. This is quite a departure in the Tasmanian scheme from many other States in Australia where their compulsory third-party is based around fault. So in terms of the care provided, persons who are catastrophically injured on our roads are treated equally in relation to this long-term care, irrespective of who may have been responsible for the accident.

On average there are about eight to ten daily care claims per annum, and we currently have around 71 people who qualify for this particular benefit. Those people comprise 42 males and 29 females. Without running through all the distinctive age groups, it is interesting to note that in the two bands between ages 11 to 30, that group comprises about 50 per cent of the total number of people on daily care. This probably reflects the driving habits of some younger people, and from an MAIB perspective it means that we have a long road of provision for this care, particularly for teenagers who are catastrophically injured. I think you would appreciate that this has to be carefully managed to make sure that the funds are put aside. Costs are incurred on a year-by-year basis, in some cases for up to 50 years, so prudential management is certainly required. Of that group of people, 51 have acquired brain injury; spinal cord injury, 17; 2 are in what we call the orthopaedic group, and they are normally elderly persons who have suffered maybe as a pedestrian - been knocked over by a car - and they have suffered an orthopedic injury. People like us would make quite a speedy recovery but, by virtue of their age, they require this ongoing care. We have one child with a burn injury.

Just getting back to the negligence basis, 43 of the group were caused by the negligence of another motorist and 28 were injured on this no-fault basis so that is something that is quite significant in our scheme that those 28 people in some other schemes would not qualify for benefits of any description.

When a person is identified as requiring or potentially requiring daily care, the management of the claim moves to our specialist staff, of which Lawrence is one, to

provide the professional advice and we make early contact with the family and the doctors and the appropriate interventions apply. A typical catastrophically injured person's transition would be, say, from the intensive care unit of a public hospital in the first instance and those with severe spinal injuries are normally transferred immediately to Melbourne. They move on then to a high dependency unit to a neurological ward and then to a rehab ward, perhaps in another hospital facility, and finally on discharge to either home or to MAIB facilities and that is clearly a choice for the injured party and/or their families.

I overheard in the previous group the Anglicare people who gave you an overview of the accommodation that is in place both in Hobart and Launceston so I probably don't need to go over that with you again. It is known by the committee that the accommodation is currently managed by Anglicare and available for both short and long-term stays as well as respite.

Mr WILKINSON - Before we get off the point if I could just ask a brief question, please. You were talking about intensive care, high dependency, rehab and then either home or to a MAIB facility, how many people do you find go home first but then the parents or the partners or whoever it might be realise that they just can't care for them as they should care for them and then they go to an MAIB unit? In other words, I just wonder how many people are really aware of what it takes to provide the care that is required.

Mr ROCHE - I'm not aware, just off the top of my head, of more than a couple of people where this has actually happened. I think it often crystallises during that period of hospitalisation, that family members realise the significance of the injury. I am not aware of more than a couple of people who have moved from the home situation into an MAIB facility.

Mr WILKINSON - So that is mainly sorted out, I suppose, in the rehab ward.

Mr ROCHE - Yes. Lawrence could probably tell you more.

Mr WALSH - I think it is a possibility that that may happen and it may happen in the future as a consequence of our supporting a lot of people in their home, so it is a possibility that that situation could arise. I am not aware that it has arisen recently but it is certainly a possibility, but I think our care would allow for that flexibility in providing either respite or some term of accommodation if the need arose.

Mr ROCHE - Can I just add to that as well. Even though 1991 does seem quite a long way away, you will remember that these numbers start off quite small and in the total journey that MAIB have got we are still very much -

CHAIR - You are acquiring clients?

Mr ROCHE - Very much and we change the way we manage things as well. This scheme will continue to grow until 2020 or even 2025 where the number of claimants continues to grow and the scenario, Jim, that you have raised will probably happen more in the future as the parents grow older and the whole issue of carers coming into the house becomes too much for them or one parent passes away. So whilst we have had a few

people that I am aware of only up until now, I suspect in the years ahead those numbers will grow.

Mr WALSH - Certainly respite is provided too. We have a couple of families where the person with the disability will spend a period of time in their homes.

CHAIR - If a client is covered by MAIB, do they receive funding from any other source as well? Would they still, for example, receive a disability pension?

Mr ROCHE - Yes. If we can just look at a couple of different scenarios. A person, say, in employment would be entitled to a disability allowance for, say, five years under the MAIB scheme. Obviously, during that period, there would be no possibility of a Centrelink allowance. If their injury was caused as a result of someone else's negligence, there would be a damages claim made and settled somewhere around that period, in which case there would be a preclusion clause in the Centrelink legislation which wouldn't allow them to claim a disability allowance for a period of time, depending on the extent of the settlement. But certainly there would be other people who weren't in employment and would be able to move onto some Centrelink allowance pretty much straight away.

Mr WILKINSON - With special damages, people require special needs, therefore they get a higher figure than would otherwise be the case - if they can prove negligence. Do they pay you that money? In other words, if I were injured - hopefully, I am not - if I were driving a car and somebody failed to give way to the right and, as a result, I needed special care for the rest of my life, I would get a pay-out for that. That money comes to me, the individual, to then be paid out to my carer. Do you get paid that money from the individual's estate?

Mr ROCHE - For this particular group of people, what we describe in-house as the 'future care people', the benefits are paid as a statutory no-fault benefit and are not included in the damages settlement.

CHAIR - So they are quite separate from damages?

Mr ROCHE - Yes. They can still be paid a damages settlement for pain and suffering, they can still be paid a settlement for their future economic loss - which is the loss of earning capacity for the rest of their life. The medical, the rehab and the attendant care is not settled under the damages claim and is paid as a statutory no-fault benefit for the rest of their life.

Mr MORRIS - In terms of the benefits that MAIB pays, there is no component other than for their care as such? Accommodation can be included in that presumably, but what about a food component, for example? If a person is injured, you are covering medical and rehabilitation expenses, potentially accommodation expenses - certainly in terms of the properties you own that Anglicare contracts you for. What happens for their other needs - clothing, food, entertainment, whatever?

Mr ROCHE - If I could just answer that by going back one step when we talked about the accommodation, where people now have the choice to come to an MAIB facility or return home. The construction of the MAIB facility pre-dated me by a little while - the

accommodation was built in the early to mid-1990s. That was constructed because of the lack of suitable accommodation in the community. As I understand it, there were instances pre-1991 where young people were sent off to nursing homes because there was no other suitable accommodation.

To move back to your particular question, we are responsible for the attendant care, the medical and rehabilitation care et cetera, but the person is still responsible for their own clothing and personal needs. Certainly for those people who are in their own private homes, Anglicare are wheeled in and in conjunction with the professionals they provide those amounts of hours that are required for that particular person on a daily basis. Quite obviously, the people involved are still required to clothe themselves and attend to their personal requirements et cetera.

Mr MORRIS - So, given that they cannot earn an income and unless they have an independent income, they presumably would qualify for a disability support of some sort.

Mr ROCHE - Absolutely, yes.

Mr MORRIS - A Commonwealth benefit.

Mr ROCHE - Correct, yes.

Mr MORRIS - Thanks. Just another quick question. Would we be welcome to perhaps pay a visit to one of your facilities?

Mr ROCHE - Absolutely. Some members of the Parliament have already visited, and you would be most welcome, and we could probably arrange that. I will put something in place for Charles. Obviously, what we do in cases like this, we regard these facilities as a home for the people, as a sort of MAIB place or Anglicare place. It belongs to the people. So if I have an approach from someone to view the facility or indeed I volunteer, what I would do is contact Chris or Mandy and ask them for a time that would be suitable for a visit, because obviously there are busy times in the houses, so we arrange visits to coincide with times that do not inconvenience residents.

Mr JONES - Afternoon tea with a cream cake usually works, Tim.

Mr MORRIS - Beautiful. I'll get baking.

Mr WILKINSON - I was going to say, maybe lunch, Chris.

Mr FINCH - Just while you collect your thoughts, Peter, I could probably ask you just maybe a quick question about where you have a set-up in Launceston and one in Hobart. Is there any pressure or any future projection of a facility closer to people on the north-west coast?

Mr ROCHE - We are monitoring our accommodation needs all the time, and we are currently in a phase where we are maximising what we have at Glenorchy and Kings Meadows. In the last year or two we have made some small renovations to maximise the number of beds we can get without making these places too big. A six-bedroom residence is recommended as about the optimum which gives you the economies of scale without making

it into an institution. At this time I am not aware of any significant needs on the north-west coast, but in the years ahead it is not beyond the realms of possibility, if the numbers warranted it, that the board would consider construction of a facility up there somewhere.

Mr FINCH - So you don't feel any pressure at this stage or there is no ginger group there agitating for you to maybe take action in this way?

Mr ROCHE - No, I am not aware just off the top of my head of any sort of significant numbers of people. We have had some people through our Launceston facility who come from the north-west coast. One of the very interesting things about the whole management of these facilities is the philosophy that once they come through the hospital stream and if they, for example, come to our facility, what we would dearly like to see is continuous improvement whereby the person, after a period of time - and that might be a year, it might be three months, six months or it might be two years - makes a recovery to such an extent that they can go and live semi-independently in a unit on site where they can have greater independence, but still have the care readily available. In other instances people have made recoveries to such an extent that they have been able to move back into the community. So we have had people from the north-west coast as well as other areas of the State who have been through that transition, and that is particularly gratifying for all the people who worked with these people. I am not saying they have made recoveries to the extent that they are totally back to normal. Some still have quite debilitating injuries, but their recovery has been in some instances quite spectacular, and they have been able to go back into the community. But we are monitoring the accommodation needs all the while, and currently we are maximising what we have to make sure it is put to best use. Something else that the MAIB does is that under our legislation, we have what is known as the Injury Prevention and Management Foundation. One of the objectives is to lend support to organisations dedicated to the care of accident victims. The legislation provides for us to put aside an amount of premium to fund approved projects. We are currently funding, and have done so for a number of years, a number of groups who were involved. For example, this year almost \$300 000 will be paid to groups such as the Brain Injury Association of Tasmania, Headway North West, Headway Support Services who are located in Hobart, the Paraplegic and Quadriplegic Association of Tasmania, the Road Trauma Support Team and the Tasmanian Acquired Brain Injury Service which is located in Launceston. I think I could safely say that a whole lot of their attention is probably to people who are not the subject of MAIB claims, so we are getting some benefit out there to the community to some people who otherwise might not be able to find the services that are available.

Mr WILKINSON - Are they getting \$60 000 each or was it \$300 000 divided on a needs basis?

Mr ROCHE - It ranges between \$58 500 for the Brain Injury Association of Tasmania to \$40 000 for the Paraplegic and Quadriplegic Association - it is about \$50 000 each. We have a system where we work with these groups in allocating these funds each year and to put some transparency into it. It is always difficult because they always need money. We cannot ignore that. We come to them and say, 'We have a bucket of money to distribute, so let's sit down around a table', which we do every year. We have been doing this for the last couple of years and generally it works out pretty well. We get the cooperation of the groups and they understand our dilemma and I understand their dilemma.

Mr WILKINSON - They wouldn't want to be uncooperative, would they.

Mr ROCHE - No, but it is good to be able to sit down and work these things out.

There is another project that is currently under way that comes out of the foundation. They are currently funding a three-year project being conducted by the Neurotrauma Research Group at the University of Tasmania. The main objectives of the project include the establishment of a neurotrauma register for Tasmania, tracking brain injury from the time of injury, undertaking quality assurance on health care currently provided, and the investigation of new treatments which may improve the outcome for brain injury and neurotrauma. The total cost of that project is in the order of \$600 000. Obviously MAIB would like to see some benefits or its own clientele, both for now and in the future, but obviously this is an across-the-board project that will hopefully assist everybody in this State who is unfortunate enough to suffer brain injury. The medical specialist that we deal with who is involved in that group is Dr Mark Slatyer.

CHAIR - Thank you.

Mr WALSH - I will talk about more of the practicality of the services provided to our clients. Underpinning the way we approach our clients and the services we expect to be provided to our clients by service providers, are the objectives, principles and standards set out in the Disability Services Act 1992. I will just touch on those very briefly but they will make sense as we go through this.

Basically, services are designed to enable persons with disabilities to achieve their maximum potential as members of the community, to ensure that quality of life is achieved by persons with disability as a result of the services provided for them. We administer funding in respect of clients with disabilities that is responsive to the needs of those clients. For all service provision provided to MAIB clients with permanent disability, we request that the services are designed to achieve positive outcomes for the client; that conditions of everyday life of one our clients with a disability are the same as or as close as possible to the conditions of everyday life for other members of the community; also, that services are provided as part of a local and coordinated service system, involving many different service specialties; that services are tailored to meet the individual needs of each client; that services promote recognition of competence and skills rather than deficit and disability; that programs and services are to be designed and administered as to ensure that no single organisation providing services exercises control over all or most aspects of that client's life. So there is obviously a lot more about the disability services act, but they are the main things I wanted to mention.

The practicalities for us are that clients in MAIB accommodation support facilities receive care that is assessed independently and at regular intervals by professionals able to assess care requirements for people with disabilities. Consideration is given to all aspects of the client's life and family situation. Clients agree to the level of care and a plan is developed with all relevant parties to deliver that support. Clients in accommodation and generally as well in their own home receive ongoing medical review, treatment and a range of therapy services to ensure their health is monitored and maintained in the short and long term and that clients continue to regain skills for integration into the community. Medical and therapy services are checked often and MAIB receives medical reports and therapists provide client reports that are goal

orientated and outcome focused. Late last year we tendered for specialist case management services, for the case managers to provide case management services to our severely injured clients at various stages in their lives.

Case management is a specialist service. It is provided for clients who experience difficulty in identifying, navigating and negotiating needed services for themselves and may be required at specific times in the life of a person with an injury or a disability. The role of the case manager is in identification of client needs across a whole-life spectrum, formulating a case management plan with the involvement and agreement of the client and others, supporting the client with their reintegration into the community, planning and linking the person or care giver to access services and monitoring the appropriateness and progress of those services.

Anglicare, our main care provider, provides to us monthly progress reports and ensures that services and care are delivered on a day-to-day basis. Anglicare also ensures that care staff are adequately trained and supervised in the carrying out of their duties with clients. MAIB has regular meetings and forums with service providers and professional body groups to ensure that the latest and best theory and practices apply to service provision for our clients with disabilities. We also audit service providers to ensure that they provide appropriate and necessary treatment and rehabilitation in a timely and efficient manner. We expect that rehabilitation service providers conduct client satisfaction surveys to gauge the success of their involvement and service delivery, and that includes case managers and vocational rehabilitation providers et cetera. For our future-care clients, there are three MAIB staff who work in examining the service levels and the service provision to ensure that what is provided is of high quality and necessary for that person's rehabilitation. We also assist in funding equipment to assist a person's independence and access into the community. That may mean a bed or a wheelchair, it may mean lifting equipment - there is a whole range of equipment to assist the independence and safety - and we also assist in modifying clients' houses and workplaces to make them safe and as independent as possible. We are involved in providing an accessible environment at their home.

MAIB has purchased wheelchair-accessible vans. We have one in Hobart and one in Launceston, to be used at the accommodation facilities to transport clients to medical, rehabilitation and community appointments. Finally, we fund transport costs to and from medical and rehabilitation appointments, and to assist that person access the necessary services and rehabilitation.

CHAIR - Thank you. Questions?

Mr FINCH - Can I just check on the numbers with you, Lawrence. Peter mentioned before the figures of 42 male and 29 female, I believe, but surely your client base would be larger than that. Were they only the people who are in special accommodation? How many people are you dealing with in the MAIB operations?

Mr WALSH - Total clients?

Mr FINCH - Total client base. People in homes, in facilities, I suppose in hospitals as well.

Mr ROCHE - Okay. MAIB receives around 3 500 claims per year and of those 3 500 claims, about eight to ten we identify as people who we refer to as future care claimants, or potentially future care claimants. So since 1991-92 these numbers have grown.

CHAIR - They add on?

Mr ROCHE - They add on, but it does not add up to like 10 times 12 is 120 or something like that because there are people who are very much potentially in the system and their recovery is such that they do not require this ongoing two hours of care per day, and some of those persons have had their claims settled by a common law settlement and there is an amount included in the settlement for some low levels of care on an ongoing basis. But this 71 people will continue to rise, as I suggested, up until about 2025, I think, as new people come into the system. They are the ones that we are talking about with this intensive care requirement on an ongoing basis.

CHAIR - That's your threshold, isn't it, that two hours?

Mr ROCHE - That is correct, yes.

CHAIR - Once that is reached, that is the definition of that future care.

Mr ROCHE - Yes. And these are ones that are predominantly acquired brain injury and spinal cord injury and they are pretty much all quadriplegics. So we have a whole host of other claimants that require all sorts of medical attention and rehabilitation and goodness knows what.

CHAIR - But there's an end point in sight?

Mr ROCHE - Yes.

Mr MORRIS - Even if it is not in sight, they are still continuing to improve as such?

Mr ROCHE - Yes.

Mr WALSH - They may recover totally from their injuries. That is possible.

Mr MORRIS - Right. So this group clearly will not totally recover. Well, it does not stop them doing so but it is highly unlikely.

Mr ROCHE - But they are the ones with very special needs on an ongoing basis.

Mr FINCH - Can you just give me some idea too, when you are assessing new clients, when these eight to ten claims come to you, how actively do you look to encourage those clients to be perhaps cared for at home? Is that paramount in your thinking or is it down the scale of your thinking? Do you try to achieve that result so that perhaps the home is looked to as the area where they will be rehabilitated?

Mr WALSH - I think mostly yes. If people can return home, I would consider that, I guess, as a therapist, as being the best option, for someone to return to back to what their life was prior to the accident. But really it is case by case and an individual's own

circumstances that are assessed in that situation. Some clients may not have their own home. They might be renting. There are all sorts of variations there and it really comes down to a case-by-case basis. An example is that some people have to wait till their homes are modified, there is a period of time when they do not need to be in hospital anymore but they are still waiting for their house to be modified or they have to sell their house and purchase another one. But I think ultimately it is really what is in the best interest of that client and the best possible support that is available to them.

Mr FINCH - Regarding that assessment process, could you just give me some idea, Lawrence, of the process that takes place? I suppose the chemistry is what I am trying to understand. Do we have a lot of frustration out there by families and by people wanting perhaps for the time span to be truncated? Is it a process that goes through fairly smoothly, or is it difficult, it is always difficult or sometimes not difficult? What's the process?

Mr WALSH - It think it is all of those things. It depends on how severe the injury is. It depends on how good or otherwise the person's support network is prior to the accident. There are a lot of people involved in that process. It is a range of therapists, doctors, different family members but there are so many variables that exist with that process of determining what amount of support is required in the best environment for that person to live in.

Mr FINCH - Is there a frustration out there? I am wondering about -

CHAIR - Why don't you just say 'Yes' so we can stop asking Peter.

Mr FINCH - I don't know the answer. I am asking questions that I don't know the answer to. Is there frustration, concern or are people agitating to have that process streamlined more?

Mr WALSH - Traumatic injury and traumatic very catastrophic injury creates an enormous amount of stress and pressure on families. I think their main concern is whether their family member will survive after a car accident. So the answer to that question is: there is so much emotion and so much trauma associated with an accident that the outcome is a very complex process. Some people manage it very well, surprisingly well, and with other families their whole structure breaks down, so you get that complete spectrum, in my experience.

CHAIR - Thank you. Any other questions? I am just mindful of the time; our next witnesses are here and we are already 10 minutes late.

Mr MORRIS - I will be as quick as I can. Peter, don't go into it too far, but what if the MAIB were to be given the responsibility for a public liability across the board similar to the no-fault scheme that we have, how much extra business would that be - and this is excluding professional liability at the moment? I am just trying to get a scope of how much of this traumatic injury in the State that you currently deal with and we know that vehicle accidents in particular are a very significant proportion of the traumatic injury in the State? If public liability, for example, was transferred to you as well - that is another issue we have that I am particularly interested in - would it make much difference to the size of your business?

Mr ROCHE - There is a national study being conducted at the moment by PricewaterhouseCoopers, who are looking at long-term care on a national basis and, from memory, the numbers for Tasmania - the additional numbers through that public liability area that you speak of - aren't significant. I cannot remember exactly how many -

CHAIR - It wouldn't be double though.

Mr ROCHE - Heavens, no; it is just a very small number.

Mr MORRIS - And professional liability presumably similar?

Mr ROCHE - I can't give you the exact numbers because I am not sure the exact numbers are actually known by anybody so a lot of this work is done on best estimates. All I can say is that my recollection of the numbers was that there were not a whole lot more. Certainly, the motor accidents form the bulk of those who are catastrophically injured.

Mr MORRIS - And the other thing just in that line, do you have a communication with New Zealand and the Accident Compensation Commission over there because I note the way you work is, from my understanding of how they work, quite similar except for the fact that they are a lot less involved in lump sum payments and so forth over there?

Mr ROCHE - The CTP schemes in Australia meet a couple of times a year and more recently the CEO of the ACC in New Zealand has joined that group so we are hearing more and more about their approach to accident compensation than in the past. Obviously their scheme is totally different to anything that exists in Australia because it covers the workers compensation aspect, the motor vehicle aspect and in fact the 'everything' aspect.

Mr WILKINSON - Is it good?

Mr ROCHE - Jim, there has been quite a history with it. My understanding is that, when it was first introduced, the benefit regime or more correctly the income stream did not match the cost of the scheme and my understanding is that the scheme got into severe financial difficulties and they had to make a significant change in their approach, and I think they are running off some of the past debt now. But the scheme as in place at the moment is very much financially viable on an ongoing basis, so from that point of view they've sort of got it right now. You would really need to sit down very closely and do a comprehensive study as to what we have here in Tasmania and what is available in New Zealand because in some aspects of the New Zealand scheme you would say they are providing better benefits, say, than Tasmania, but in other areas because they do not have any access to common law, for example, I am sure some people in Tasmania would not be happy with the type of benefits that are available in New Zealand. So it is very difficult to line up some of these schemes because the benefits structure is so different.

Mr MORRIS - Okay. I think that is a good answer, and I am really interested in exploring it more because I think there is some real potential with what we do, and with what New Zealand does, to look at a way forward for trying to bring the currently non-compensable people into a system which seems, from what we are hearing, to work really well as far as the MAIB is concerned, but it is only a very defined area.

CHAIR - Thank you very much, gentlemen. That was most informative. Thank you for your time.

THE WITNESSES WITHDREW.

Mr ADAM DORAN, SOUTHERN PARENTS GROUP, AND **Mr TIMOTHY McCULLOCH** WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Thorp) - You would both be aware of what we are trying to achieve here, as a committee, aware that there was concern in the community that some of our younger people were being inappropriately or less than optimally placed in aged-care facilities, so we wanted just to explore the issue generally and to make some concrete recommendations to Parliament about how that situation could be rectified. You wanted to give us a bit of an overview about where you are coming from.

Mr DORAN - Yes. I became aware of the whole situation in March and I put a submission in, which you have, about not so much acquired disability but my son was born with a disability, and that's permissible, and Tim McCulloch has a similar situation. He has two boys who are autistic. My son has an intellectual disability, microcephaly. He was born with a small brain. We are both getting to the stage now, or our families are, where we are finding respite and long-term accommodation of any sort is becoming increasingly hard to get. I guess everyone here is a parent. Is there anyone here who is not a parent? Okay. As you get older, this worry about what is going to happen to your sons and daughters is an increasing worry.

CHAIR - When you cannot do everything.

Mr DORAN - Yes, this is right. I am hoping Di Fuglsang from the Association for Children with Disabilities is going to join us. I guess my concern and obviously Tim's concern is that my son is not going to be properly supported.

CHAIR - How old is your son?

Mr DORAN - He is 19. We have been pretty lucky really with the support we have got from the State Government. James went through the normal education rehabilitation facilities that the State offers with adult annex and the Hazelwood Special School. He was integrated for a couple of years at Rose Bay High School. He has been to the Hobart College in their life skills unit for a couple of years and he is now with the Parkside Foundation doing two years of the SIPs program - the Supported Individual Program - that Disability Services provide. At the end of next year, though, James will be back in our care. I talked with Disability Services yesterday and I said, 'What's the situation? How's the funding situation?' Nothing.

This is mine and everybody else's worry; it is Tim's worry and Di Fuglsang's. Her daughter grew up with my son at Hazelwood and we have been colleagues for a long time in this particular cause. We all face this worry of what is going to happen as parents. You have all got children - it is a terrible strain on us. It is not just our children, it is the members of our family. I have two other sons - I think they have probably got the impression now that they are going to have to look after James when they get older and I don't want them to have that impression because it is ruining their lives too. There is an expectation there that they may have to do something and I want to be able to assure them that the State -

CHAIR - That is not the case.

Mr DORAN - It is not the case.

CHAIR - What would you see as a reasonable expectation? I have a just turned 20-year-old son. I do not know when he will ever leave home, but most parents assume that at some stage down the track our children are going to leave home and go and live independently of us.

Mr DORAN - By legislation, after 18, they are on their own anyway. I could turn my child out in the street tomorrow and say, 'Sorry, mate' and I think a number of people have considered doing that because the need in Tasmania is so bad at the moment. We are pretty good because we are fairly vocal and we are able to stand up for ourselves. Di has campaigned for years - you have probably heard of Di.

CHAIR - Oh yes, we have.

Mr DORAN - We are able to stand up for ourselves, but it is those people out there who can't do anything -

CHAIR - What should be happening?

Mr McCULLOCH - There is a myriad of things that need to be done. It is where you are coming from, what the disability of your child or adult son is. My main concern is that there have never been any clear pathways for parents to look at, to go down. My eldest is 27 now. Both my sons have autism. David, the eldest, suffers from Asbergers. Intellectually he is very bright but he sits way over there and he is more interested in running around playing with butterflies. He needs a separate focused set of events happening for him. My other son, who is now 19, is what is known as passively autistic and Sam is not terribly bad in the spectrum disorder so this is why they are such a grey area. Autism is a very special needs area because the boys are not intellectually disabled, they are quite intellectual but Sam who runs on the cusp of not being badly autistic gets very depressed - he is on quite big doses of SRIs at the moment. Since he left a structured environment of school, while he has not been on the verge of suicide, he has been very close. He has two full-time psychologists working with him at the moment. One we got through the SIPs program. We have just applied for a second year of funding and after that it runs out, as Adam just alluded to a minute ago, and then you are on your own with that.

I am hoping that we will get Sam a job and he will do anything because he wants to be normal. My first marriage broke up and I am now married again and we have twins the same age as Sam and he sees them as being normal. He can't hack it because he's not normal and he wants to be normal whereas with David, the 27-year-old, he is quite happy just running around the yard chasing butterflies. But he wants to do things and he has just finished his third year of TAFE doing IT. He has had some support in TAFE, they have been very good, but now we have to get him a managed job and it is virtually impossible. The disability coordinators all have very high case loads and it is a real struggle to get access to a coordinator. There is not much funding available; you fight for the funding as parents. It is almost dog eat dog. In some ways it is like having a penalty for having a child who is disabled. All you want for your disabled child, as well as your

other children, is to get them on to live as best a life as they can and be as independent as possible.

I will just digress for a moment. There is no counselling for parents who have disabled children. It is a nightmare. From my first marriage the middle child is a daughter; she is 22 and living in Darwin. She does not talk to me anymore because I broke up with her mother, but it is all part of the same emotion and you can't divorce the emotional side from the practicality. I want what's best for the kids. My ex-wife needs counselling because she is never going to die because she has to look after two boys. She can't even handle the fact that they have become adults; she still sees them as children. She has a 27-year-old child living at her place and that is quite an emotional thing for me, that there is no avenue to get counselling. There is no pathway to start with as to where to go and the nature and range of the disabled people, whether they be adults or children, is so varied you can't have a black-line continuum through.

CHAIR - So there's no way known you could say, 'I want my son's name put down for group home supported accommodation'?

Mr DORAN - You can, but the waiting list is so long. Disabled people just don't pass on. Twenty years ago there was a life expectancy but that has grown through medical advancements and medical science, and that is part of the problem. People are living longer, costs are going up -

Mr McCULLOCH - Often guys with autism will live a normal life; they're just born with autism spectrum disorder - and that's the problem. What happens when I die? We can't fully provide for every issue; we have other children to consider and you have to give them equal time. You tend not to, which really pisses off the children within the normal spectrum. That is one of the reasons my daughter went a bit wayward for a while. She is happen enough now; she still has a few issues but they've never been dealt with because there is no way to get hold of formal counselling to invite people together to sort out the emotional problems.

CHAIR - It's seven years, you're saying, for a waiting list for a group home?

Mr McCULLOCH - Something like that.

Mr DORAN - I think that would be fairly conservative. It's probably longer than that.

CHAIR - So one magic wand solution could possibly be a huge injection of money into providing this supported accommodation.

Mr McCULLOCH - That's coordinated through Disability. I am lucky, I struggled and struggled and both of my guys have a disability service coordinator, but they don't get much from them because they are not intellectually disabled and therefore they can generally manage their day-to-day activities whilst they are living in a home situation. But when they go and live on their own we will need a massive dose of help to get them started on their own.

CHAIR - And the same with your son?

Mr DORAN - Yes. It is hugely expensive to do this.

CHAIR - I suppose the initial expense would be the purchase of the property?

Mr DORAN - Yes. I am part of a successful group that has got money from the State Government in the last two years - the new St Giles group home. We petitioned David Llewellyn and banged on the door until we got some money out of him, but it is only transitional. It is only one week out of two. James is going to need to go into full-time care simply because we're getting older. There is an expectation from people anywhere in the world that society will take care of disabled people. Years ago you'd stay at home and look after your elderly mother or your infirm. I am sure everybody here has some sort of story about a relative or knows somebody who has devoted their life to looking after someone. Why do they have to wreck their lives when really it is up to society to say, 'We have a sector of the community that is disabled, we should plan effectively to look after that sector of the community for their lifetime', and put money aside?

CHAIR - If your life circumstances changed overnight and you were no longer capable of caring for your son, for example, he'd have to go into a nursing home?

Mr McCULLOCH - My guys would be more out in the street because they're not intellectually disabled but aren't capable of looking after themselves, especially the 27 year old.

CHAIR - And you couldn't put them in a nursing home because it's not appropriate.

Mr McCULLOCH - They'd end up at Bethlehem House or somewhere like that. It is not just group homes. My older son probably would not want to live in a group home because there are no like-minded autistic group homes. There is no such thing, really, and David knows he would not want to go and live with a group of people who are probably not similar to him. But we cannot develop it because there is just nowhere for David to go at 27, nowhere at all. And it is not just group homes. Perhaps we need to think about some sort of hostel-type accommodation where they go for while, where the guys are just looked after by a central person rather than a full solid group home activity. I am sure there must be a range -

CHAIR - We have seen models in Melbourne, for example.

Mr DORAN - They are moving a little bit towards the institutionalised thing with maybe nine people in a block setting but in separate flats, which I believe is a great idea. It is economically feasible and is cost-effective.

CHAIR - And theoretically that accommodation could be purchased by Housing Tasmania.

Mr DORAN - Well, there seems to be this thing between Housing Tasmania and Disability Services. They buck-pass it backwards and forwards, you know, and yet out at Glenorchy you have all of these units that were in the paper the other day that no one is living in, for goodness' sake, and we have this crisis of respite. Ordinary people such as Tim and myself see this in the paper and we say, 'What the hell's the Government doing?'

CHAIR - And yet if we could have the relevant bureaucrats in here they would say 'this is the reason' and then proceed to justify it.

Mr DORAN - Yes, I am sure they can justify it, but to the men on the street, such as ourselves, we think 'let's do something'.

CHAIR - Housing wouldn't feel there was an obligation, because in both instances the boys are being housed.

Mr DORAN - That is right. I am sort of in between. I'm looking to the future. What's going to happen in five years' time.

Mr McCULLOCH - Short of packing their bags and dropping them off out at Lutana to the respite house and saying, 'Look, there you are fellers, they're yours, good luck', which has been threatened to happen and, 'Mr Llewellyn, here's half a dozen adults' - and we are not talking about young children any more, we have moved on from that - what can we do? Everyone looks at you blankly and says, 'So what?' But unless you actually go and drop them off nothing happens.

Mr MORRIS - Right, so you have to force the situation in that regard.

Mr McCULLOCH - Yes, and I do not believe that should be an emotional problem that a parent needs to go through. There is enough with the problems of dealing with the day-to-day activities.

Mr DORAN - It's bad enough with normal children!

CHAIR - Yes, exactly.

Mr DORAN - It has become more of a worry for me. When James was born I said, 'Well, we can look after James, that's all right'. You know, 20 years ago it was cool, but as soon as they start to leave school and you start to see ahead a few years, you start to think -

CHAIR - I come from a special education background, and that nexus between school and going out into the community is huge, and if people fall through the cracks at that point sometimes you never see them again. I am quite confident that previous students of mine are quietly living quite miserable lives.

Mr McCULLOCH - More than likely they are, yes. It gets to a stage where a parent can only cope with so much. When they were all young, as Adam says, it is okay, but when they get to 18 or 19, the normal range of children in your home, having turned into mini-adults, are all away with their own experiences of learning to live as independent young adults. You couple that with the house pressure of a couple of autistic kids and that makes it extra hard for those young adults to mature because mum and dad are seen to be favouring the one with the disability. That is a real problem of a nexus point going from 16 to 20. After you get over 20, the mini-adults who are in the normal range have gone on to do their own thing, hopefully, and we are left with the disabled adults for whom there is nowhere to go, nothing to do much. You are dog-eat-dog trying to win some finance packages.

CHAIR - And yet if those supports were available you could comfortably take time to see your son or whatever move in and become independent from you.

Mr DORAN - Yes, I could die happy.

CHAIR - I know exactly what you are saying.

Mr MORRIS - Could I just explore that little bit further, Adam, with James. You said that you have funding till the end of next year for him for educational purposes.

Mr DORAN - Right, life skills, yes.

Mr MORRIS - And the reason that that is going to cease, is it because he has become an adult?

Mr DORAN - I suppose so. I have never actually asked the reason why the funding is not going to be there, but I guess it is. It is two years and that's -

CHAIR - Maybe that is considered to be the entitlement or something.

Mr McCULLOCH - They won't give you any more than two years' funding through SIPs packages and stuff like that. I have applied for a second SIPs package for Sam, the youngest, for the psychology program that he is on and it looks like we may get it, but after that two years that is the end of it, no more.

CHAIR - We have the same issue with Year 13 at college too.

Mr McCULLOCH - The department, to be fair to them, is only given a certain bucketful of money and they have to prioritise the young adults or children whom they see as priorities and they just cannot keep giving one person money because there is not the money there to give.

Mr MORRIS - I am interested less in the money at this time. We know what the solution to money is -

Mr McCULLOCH - It comes down to money though.

Mr MORRIS - Yes, I know it does.

Mr McCULLOCH - Throwing the money at it doesn't always fix the problem either, let me say that. The money needs to be coordinated and properly managed, otherwise it just becomes a waste of money and I don't want to see that happen either.

Mr MORRIS - Which is why I am interested in pursuing the issue where James is likely to be at. When he gets to the end of this funding package, do you believe that it would be worthwhile his accessing more education in terms of gaining more skills to allow him to become less dependent on you? Is he likely to become less dependent on you or whoever else his carers are?

Mr DORAN - It is hard to say because he has an intellectual disability. His understanding is there and we are not sure how much he does understand but he is very manipulative and so obviously he does understand.

Mr McCULLOCH - He has some normal values, does he?

Laughter.

Mr DORAN - He is independent - he can make a cup of tea and things like that - but he still needs 24 hours care because he can't communicate back to you. He does talk but you wonder where he is coming from. Life skills training is always good for James, will always be good for him because he still can't cross the road. He can't shower himself. I still have to shower him. So, yes, as a means of giving something for James to achieve, something to look forward to, it would be. I think it is always going to be an option. He has to do something with his life. I don't want him just sitting at home because he is just going to sit there.

Mr McCULLOCH - It's sad.

Mr DORAN - It is. It is sad for us and, as I said before, there is an expectation of people in the twenty-first century that the Government will pick up this. I am being selfish here really because I should be saying, 'No, we can look after James' and people do that.

Mr MORRIS - But you can't do it indefinitely.

Mr McCULLOCH - Well, you get old.

Mr DORAN - That's right. I am planning now because the State is going to have to pick him up eventually. So what is going to happen? Are we going to bite the bullet now and plan for the future, which is what I want to see. I want to see a life management bureau set up -

Mr McCULLOCH - a pathway.

Mr DORAN - so that when a child is born with a disability they are immediately planned for for their life. I mean, an expectation of 50 years and in 20 years' time we are going to require this much, we are going to require a group home and there is a focus.

Mr FINCH - Like we do with MAIB. They have that person for the entirety of their life. They are committed to that system.

Mr DORAN - Sorry, we are digressing away from your question, but it is all part of the big picture.

Can I just mention the Gray family who live two doors up from me in Lindisfarne. Jarod Gray is a 17-year-old and for years he grew up with my other two sons and two years ago he was involved in an accident in Harrington Street. He went through the windscreen of a car which was driven by a guy whom he had met that day. It was their first time in a car and they killed the person they hit. Jarod he has been in a coma since and his parents have taken him out of care virtually now. He sleeps at a respite centre at Glenorchy.

They have built a huge unit on the back of their house through the combined help of people in the building trade, because his father is a carpet layer and he knows all these people, and these people have virtually donated their time and everything. They have built this huge unit in which they are going to put him up but MAIB apparently are still arguing about it - they haven't paid a cent.

CHAIR - You're kidding!

Mr WILKINSON - And he was a passenger?

Mr DORAN - He was a passenger.

Mr WILKINSON - And was the other bloke who was driving -

Mr DORAN - Tim Watson -

Mr WILKINSON - And because he was drunk they are saying that James should have known that he was drunk.

Mr DORAN - They have offered a 'payout'. They haven't actually defined what payout means for a life. Jarod Gray was always a bit upfront; he was a cocky young teenager full of swagger. He used to come over to my place but he was really good with our kids. He was an accident waiting to happen - really, I am surprised he had not killed himself beforehand because he liked to get out in the fast cars, like a lot of young people in Tasmania do. It has been absolutely terrible for his parents because his mother has virtually devoted herself to him.

CHAIR - Where is he during the day?

Mr DORAN - He is at home. They come and take him back every night to -

CHAIR - And how long ago did this happen?

Mr DORAN - About two years ago. He is still in a coma. He is responding to physio; he can lift his leg.

CHAIR - But who is paying for the physio?

Mr WILKINSON - They're paying for that - MAIB.

Mr McCULLOCH - But the fact is he can't get a resolution to the problem. It is a sad indictment on our society - I know of the case because one of my kids used to knock around with one of them, too - that you can't get a resolution to the problem. Surely it must be an emotional bad time for the parents.

CHAIR - It's a parent's worst nightmare.

Mr WILKINSON - If you could rub a crystal ball and say what you wanted, being reasonable as to what would be an attainable aim, what would you have?

Mr DORAN - I would like see - and not for myself because I think we've done fairly well out of the system so far; I am glad we've got James into this group home at St Giles - some sort of planning unit or something separate. I have never been able to tie Disability Services down to how they plan. Let the Government take this by the skin of its teeth. It is never going to be solved and there is always going to be a problem there.

Mr McCULLOCH - Jim, to answer your question, when my youngest went through school we didn't know he was autistic because there was no mechanism for diagnosis back then. He was a naughty boy who sat at the back of the class. It was because he lived in a dream world and it wasn't until later in life that we learned about it. My first marriage ended and I got married again and my wife now works for Parkside Training and the Parkside Foundation which looks after disabilities and training of people. It was only then that I found out that disability coordinators were available. For 20 years I didn't know. We went to all the doctors and had eye-tracking tests done on David and manual tests and we didn't what was wrong with him.

Mr MORRIS - They just didn't bother telling you that these things were available?

Mr McCULLOCH - That's right. To be fair, the medical fraternity didn't know a lot about autism. It has become quite a good buzz word in the last five years and there is a lot of expertise around now, but then there wasn't anything. However, we move on. As everyone knows, I work for the ABC and I have been on a reasonably good salary, but that changes next March for me because I'm retiring and I drop down to probably nearly a third of what I was one. That makes more pressure again. Generally there are two income stream family situations these days and lots of people with adults or children who are disabled have to leave the workplace and go to a lower salary. We are all two income stream earners now; that is what society expects us to be.

Mr WILKINSON - So therefore you're saying with the planning that what you need is identifying the problem -

Mr McCULLOCH - Yes.

Mr WILKINSON - and, as a result of identifying the problem, then having a pathway from that. We believe that you can never say what is actually going to happen, but we believe that what is probably is going with your son or your daughter is this, and then at least you'd know what the future was going to bring.

Mr DORAN - That would keep all the parents in Tasmania who have disabled kids a lot happier. They'd know that something was happening, that the State was going provide something. That would take the strain off us and our sons and daughters. It is the worry and the stress of the parents.

Mr McCULLOCH - That's where I would see a counselling service come in where parents can go and talk about their problems, see some professions who were able to talk through the problem - the problems you are likely to expect for your particular child. In my case there are two adults with two different problems. I see the pathway, Jim, as a very full process. It is not 'there it is' and we all head along down the path and we all throw money at it to make it work. No, we might get to here, as long as it is adequately resourced and has professional people in it to deliver knowledge to parents. The

Government shouldn't take up every single aspect of this. If you empower the parents and/or partners to go on and help move forward that is where I see it as a multifaceted pathway.

Mr FINCH - Rather than stumbling blocks.

Mr McCULLOCH - Yes. It's always been, 'Oh look, there's something new. I didn't know about that. I found this on the Internet'.

Mr DORAN - It's not just us, we are reasonably intelligent; it is those people out there who don't have an ability to speak up for themselves. They're shy, they feel they can't communicate properly or they are in remote areas and can't access transport. They might be disabled themselves; there are a number of people like that in the community. They are the ones who really need the help. Tim and I can articulate fairly well and we can come to committees like this and say our piece, but it is those people out there who really worry me. I know people who haven't got any care, 'Don't worry about me. I'll be right. I'll look after myself, I'll look after my daughter'. And they drop dead.

CHAIR - This is going back to what I was saying before - that through the education years, up to 18 or 19, it is okay. But if you don't have someone who knows, and it is done for you almost, the families you are talking about who are not good at accessing services, have problems at that point when the child leaves school. Unless that person is proactive and links themselves into the disability services that are available, they just sit at home and rot.

Mr McCULLOCH - A lot of that could come from the schools, too, these days. Some of the schools don't have very good packages to look after children with disabilities. They will all take them on board because they need to, because it is part of the touchy-feely way that we are, but some of the schools have very poor disability support packages.

CHAIR - What I have found, too, is the transition at the end. You go to a lot of trouble about getting a transition program together but there is no follow-up.

Mr McCULLOCH - My younger son has been left matric for a year now and still hasn't got a job. He has been going to his Job Match place but there is nothing around. Sam will stack shelves or do anything; he just wants to get a job. He is on a disability service pension and he hates it because he just wants to get a job. Because of his form of autism he lacks a lot of self-confidence. He is on doses of SRIs at the moment. Sam is very single minded, he can't take lots of input overload, but he can build computers and do lots of things. But he cannot get a job because Job Match say they can't find him anything, not even stacking a shelf. He is 19 and physically able.

Mr MORRIS - But there's not even a computer repair place that will take him, even as a volunteer to get started?

Mr McCULLOCH - No.

Mr DORAN - It's just not economically feasible. Some friends of ours have a girl who is slightly simple and she was employed at Coles. They wanted her to take on check-out duties but she wasn't quite up to that, she was just stacking shelves. She loved it; she

would come into town on the bus and go down there and then go home. They virtually just put her off. They got a new manager who found it wasn't working or something - personality differences or whatever the case might have been - so she is back at home now. Her father is a senior person in Treasury.

Mr MORRIS - So that's an area where there could be a lot of support. I presume that the Government itself doesn't employ many people with disabilities?

Mr McCULLOCH - No.

Mr DORAN - They try to. I work at the Royal and we've had work experience people or people with slight disabilities working there - but it is a fairly technical field.

Mr MORRIS - I guess it's because of the nature of the work the Government undertakes.

Mr McCULLOCH - Yes, it is not always practical. I work for the ABC and we have only one disabled person. She is a blind presenter in Burnie and she manages herself quite well, but for people we are talking about it wouldn't be a very practical entity.

Mr DORAN - It's having some support throughout the day. Care is expensive - it is \$28 an hour for a carer. Considering some of the people they have to look after, I don't see that as a bad thing really.

Mr MORRIS - No-one's arguing they shouldn't be properly paid. Can I come back to a question regarding the St Giles facility? Is that seen as respite? He is there half time, so every second week he goes there and stays for the week, or is it just during the day?

Mr DORAN - No, he comes into town to Parkside and then he goes home and sleeps overnight. They only have people there from three o'clock in the afternoon to nine o'clock in the morning. If he is sick, he has to come home. He had to come home yesterday because he threw up at Parkside. Goodness' knows why, because once he got home he had the stereo on and was dancing around the living room floor. But they didn't have anybody at the group home to look after him at two o'clock in the afternoon, so he had to come back to me. He has also got some behavioural problems which mean that he can be aggressive sometimes. The carers immediately ring up and say, 'Sorry, we can't have him'. They're entitled to do that because of the liability.

Mr MORRIS - That's understood. So if you don't happen to be home, what happens then?

Mr DORAN - Well, they'd have to look after him. If he was really sick, they'd take him to the Royal. That's the usual situation.

Mr McCULLOCH - Or you have to leave your job for the day and go home and look after him.

Mr FINCH - I am curious about the paper - were you reading that?

Mr DORAN - I thought we might get onto the funding. You get this sort of thing - the man on the street reads this 'Pokies Secret Deals' and the amount of money that Mr Farrell is making, or his family company, and the secret deals that have been done. It says that in

contrast the Victoria Government has appointed a senior bureaucrat to do a \$4 million study and yet the State Government here hasn't done anything. They have this cosy little deal - and okay we get a certain amount of revenue.

CHAIR - I wouldn't believe everything you read in that either. There's a bit more to it.

Mr DORAN - There probably is, I know, but that's the impression that Tim and I get and everybody else gets the same impression. Why are we putting money into pokies, race horses, car racing - you name it?

Mr McCULLOCH - I don't know what the budget for Disability Services is now from the State Government, but I know it hasn't gone up at all in the many years. I was talking to the guy who runs Parkside Foundation the other day and apparently it has been fairly steady, yet the number of people who are born disabled and go on to mature and become adults with disabilities has increased - for whatever reason, we don't know - but there is no commensurate proportioning of budget to cover it. So we are getting further and further behind in that area, without extra money being delivered to manage extra problems.

CHAIR - We have the minister appearing before us this afternoon, so we will have some questions for him.

Mr DORAN - I would like to submit this to the committee. It is just my personal notes.

CHAIR - Thank you for your time, gentlemen.

THE WITNESSES WITHDREW.

Mr KEN HARDACRE AND Ms JANE BLAKE, ADVOCACY TASMANIA, AND Ms LISA WARNER, PUBLIC GUARDIAN, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Thorpe) - Thank you very much for making yourselves available to us. As you would be aware the work of the committee at the moment is looking at young people with disabilities who may not have the most appropriate accommodation options available to them and therefore may end up living in nursing homes which may or may not be the appropriate choice at the time so we are trying to get a good general picture of what the situation is in Tasmania for people who find themselves in those positions, the kind of dramas they need to confront and the opinion of the people who work in the area as to what the situation should be rather than what is. I do not know how you would like to do this - would you like to each of you give an overview of where you are coming from and then give us an opportunity for questions?

Mr HARDACRE - Sure. Advocacy Tasmania submitted a written submission back in April and you might have some questions related to that. It contains some real life and current scenarios of situations that we deal with. In putting the submission together I guess we drew on a range of situations where we are working with young people with acquired disabilities. We have had a number of cases in recent times of accident victims who have been in hospital for very long periods of time, where they have had very few options and have basically become stuck for up to three years in one instance before something could be found that was more appropriate.

We work with young people in nursing homes who find themselves in there and also a lot of situations in the last couple of years of trying to support people particularly with degenerative conditions such as MS and motor neurone disease, so that they do not end up in a nursing home, where their community supports are failing them or are inadequate. For want of a little bit more they could remain at home but they are in danger of ending up in a nursing home as some of those people do - in their 30s and 40s usually.

There are also situations of people who are struggling at home to cope. Their families are struggling to cope and support them and sometimes their levels of support might not be huge but even just modest amounts of support and the right sort of mix of things would help because, as you would know from this inquiry, there are a range of things that people usually need to remain living in the community. Every little bit of support and assistance is often a hard won battle and it wears people out. In the end that can be why the person ends up in a nursing home because the carers have just run out of energy and run out of fight.

I guess the other group are those people who are being supported in the community, not in nursing homes. They may be in say ABI's specific support services or general services that are catering primarily for people with intellectual disabilities and they find themselves in those sorts of systems even though they may not be right for them and there are problems that go with that. Some of these problems are to do with the under-funding at the specific ABI-type services, some to do with the inappropriateness of intellectual disabilities specific type services that these people have now found themselves. I guess we are drawing upon all those different backgrounds and are happy to talk about our experience in each of those areas.

Just to summarise briefly where we are coming from with the report: we felt that a very significant event about four years ago was when Disability Services changed its eligibility criteria so that where it had previously focused on intellectual disability - it is called Disability Services but it should have been called intellectual disability services - the eligibility criteria under sector reform were changed to reflect what the act had always expected, and that was that Disability Services would provide for people with a range of disabilities.

What that meant was that suddenly people with acquired disabilities were now part of the client group where they had not been previously. That was a very positive and worthwhile step because it was important to divert this group of people away from nursing homes because it meant that Disability Services now had a responsibility to do something.

From our perspective the problem has been that it has taken them by surprise. They were not geared up to know how to respond to that change and the level of need that they have been faced with is far greater than they ever anticipated. For example, the sort of people I talked about, who were often the accident victims in hospitals, have very high support needs. If they do not have a compensation package to go with them the dollars it costs to support them are very high and they have not been ready for that.

There are very few specialist services out there, such as the ones run by MAIB and Eskleigh and they are, for the most part, underfunded so they could not take on these groups of people in any significant way. The periods that people are being hospitalised for are so long that often you end up with a situation where families are then pressured to take the person home or an inappropriate option is found to plug them into. Where people are wanting and able to stay at home the support that they need is often best provided in an individualised fashion so they are sent off to stand in the queue for an individual support package which, as you probably know, has about 250 people on the waiting list at the moment with only a very small trickle of people getting anything. I think the committee meets once a quarter, so it is a sort of mission impossible to stand in that queue. Then if you are lucky enough to get an individual support package the maximum is about 30-hours a week. If you have a degenerative condition, such as MS, things are going to get worse, not better. Once you hit the 30 hour ceiling then the next option is a nursing home. There is nothing in between and we have worked with many people where our role has been just to try to squeeze a bit more out of the system to keep them at home that little bit longer which ultimately is a lot less expensive than a nursing home, but then of course we get into the issues of Commonwealth-State type funding arrangements with those sorts of things.

They are just some of the problems that have emerged particularly in the last four years since Willow Court closed and since sector reform changed the eligibility criteria. I might stop at that point seeing I am hogging things a bit.

CHAIR - Okay. If you are happy to move on.

Ms BLAKE - I think I would like to add to that. I work with Ken at Advocacy Tasmania; Ken is the manager and I am the southern disability advocate. Initially I was based at Willow Court but now have the 62 region and people with acquired injuries is a growing

number on my case load for all the reasons Ken has spoken about. As part of the change four years ago, initially they actually appointed in each region a specific service coordinator - or case manager as they used to be called - for people with acquired brain injury but those positions have now just blended with the rest of Disability Services. We were actually quite pleased that that happened and we thought, 'Okay, someone who can be skilled up, trained and stay with the clients', People with acquired injuries do not have a static disability. They may well go from a period where it is touch and go whether they live and they are in hospital with intensive supports and then they go through the slow recovery stage.

They also have a past life. Several of my clients have families, have been married, have children. Often that has broken down so not only is there the grief and loss and anger around what has happened to them through the accident but it is the whole loss of who they were and rebuilding and then as things start clicking into place there is that recovery and improvement. When Ken and I were talking about today, one of the things I was saying as we revisited the paper I wrote in April, which was based on my cases, was that some of those clients have improved and are already moving beyond where they are at the moment and needing the next model. So what is needed is a very active planning process with these clients -

CHAIR - This keeps coming through, doesn't it?

Ms BLAKE - which needs to be ongoing. It is not a plan for, say, the next two years. It probably needs to be revisited every three months because of the recovery rate and it may well be that now they have moved into the stage where they have intensive counselling. They are in the stage where they start getting ready for a work option or whatever and that is really missing.

Mr MORRIS - So that is individual planning, is it not?

Ms BLAKE - Absolutely. Some people would call it personal planning or whatever, but it is an individualised plan and you need a key person to be driving that.

Mr HARDACRE - There was an expectation prior to sector reform, when service coordination was called 'case management' that that was what case managers did. They would support the person through a claiming process to look at their life and look at the range of things they wanted to have in their life, not just services, but other things - a more holistic way of looking at a person's life. They were there beside them through those different processes of things that need to happen.

When the eligibility criteria changed four years ago, case management became 'service coordination' and now it is premised on the notion that it is issues-based. So if someone has a problem, a service coordinator will help you to solve that problem; then they will disappear back into the undergrowth. It is not there beside people for the long term. It does not help them plan in any holistic way and in many cases it is next to useless. We think that is one of the things that must radically change, not just for this group of people but overall for people with disabilities. It is not a system that works well for them.

We understood why it changed. It changed because the amount of work was such that they had to manage the workload differently, but we do not think it has worked terribly

well. It certainly has not worked well for this group of people who need something much more active.

Mr WILKINSON - So what do you do? Obviously you have them but how do you have them; how do you coordinate it? Do you have the one body with a person in charge giving out certain patients, if I can call them that, to different case workers. How do you do it?

Ms WARNER - I completely support everything that Ken and Jane have said about some of the problems and issues. Planning is really important because what we have now is a situation where it takes a crisis to actually get a service coordinator to go and do something. This is often both traumatic for the client and incredibly expensive to fix, whereas if you had active planning, a planner or someone who supports that person to actually go through those steps -

Mr WILKINSON - But how do you do it, Lisa, because we heard it previously as well that they did not really know what their future was because there were no people there they could go to, to get this plan. They did not know what was expected when the child was 19 or 20 and they did not have the support that they were having in their earlier life.

Ms BLAKE - There is a current system, Jim, which either could be rejigged or tailored. You could either bring back the ABI specialist service coordinators or you could attach case managers to some of the specialist ABI services such as Headway or Cay-Lea. I know that there is a staff person at Headway, for instance, for some of the compensated clients - and that is another whole issue which needs a comment on - who does some coordination.

It needs recognition but it needs funding of positions. You need several people and it would be a very active role, not just doing that plus a day service, or that plus other clients.

Mr WILKINSON - Do you have the person - we will just call it the CM, the chief manager - on top? That person has then got to look into what Headway has got, what HOPES have got, what BIAT has got, all those different areas because there seems to be a number of different organisations looking after their own special need. So do you have this -

Ms BLAKE - That would be the State Manager of Disability Services, as it stands at the moment.

Mr WILKINSON - Sure. But it seems to be a bit disjointed at the moment. That is what I am feeling anyway. I might be totally wrong but that is what I am feeling.

Ms BLAKE - I think what Ken alluded to is spot on; I just do not think they realise, once they broadened the eligibility guidelines, who was going to walk in the door. It was something that needed to happen because of the discrimination legislation but they were not prepared for it.

Mr MORRIS - That was four years ago.

Ms BLAKE - That is right and they have not caught up, so now we have got a real backlog. Lisa and I are in weekly meetings around clients such as those we are describing because we are in crisis the whole time.

Mr WILKINSON - How can you ease that? That is what I am trying to find.

Ms BLAKE - We are hoping this committee will direct Treasury to -

Laughter

Mr WILKINSON - You live with it, though, you know what the problem is. We come in to it and listen to the evidence and think we may know but without living with it -

Ms BLAKE - We need some case managers.

Mr HARDACRE - We have a service system that is largely oriented towards intellectual disability, so supportive accommodation services largely see themselves still as working this group of people. The same with respite services and services. You have little bits and pieces tacked on nowadays for ABI groups such as Headway. You have to broaden the way the whole sector operates, both government and non-government, that see themselves as working for people with disabilities and get away from this fairly narrow way of doing things.

They might need some specialists in some areas to train them because they do have different needs. People with ABI have particular need and needs a certain understanding from their workers. However, it still looked at in that intellectual disability fashion and so people are plugged into gaps in intellectual disability services. One can argue a lot of them do not always work that well for people with intellectual disability. We have also found that this is a more demanding group because they have had past lives, they have different expectations, their family have expectations and they come up against some of these services. Do not get me wrong, we have some fabulous services but we also have some that are very ordinary. So some of these families and these individuals come up against services which they find to be very unresponsive and doing little other than feeding and housing their sons, daughters, brothers, sisters.

Ms WARNER - And heaven help you if you have more than one disability, if you have an intellectual disability and a mental illness and an alcohol or drug issue or something else. Getting services to actually communicate with each other is nigh on impossible. There are times when you have actually had to herd everyone into a room and shut the doors and say we are not leaving until someone accepts responsibility.

Ms BLAKE - And again a case manager or a service coordinator could coordinate - not deliver the services but really coordinate a lot of the planning for the client and bring the services in to meet the needs.

CHAIR - What did you want to say earlier about the difference about compensible and non-compensible clients?

Ms BLAKE - There is a huge difference; mind you, money is not always the answer. I have clients who have been compensated and do have money and still have these coordination

issues, so it is not the total answer but it certainly makes life a lot easier if they can purchase services and pay for staff. They are able to buy into services if they want to go to Headway or if they need staff or if they need to catch taxis or whatever. Clients who do not have compensation, the ones that have come to me, have mainly been inappropriately slotted in either to Willow Court or to Disability Services' group homes where there are people who are non-verbal and/or have intellectual disability; they're just inappropriate. It is a 'be grateful for what we can give you' attitude. It is very much the welfare attitude: we have nothing here and there is a bed here -

Ms WARNER - I have a client with Huntington's Disease who ended up in Tyenna in a locked ward because there was just nothing available. He was too young for a nursing home and it was just a real struggle to get him out of there.

Mr WILKINSON - And where was he from?

Ms WARNER - He is from Hobart.

Mr WILKINSON - And you took him up to Tyenna?

Ms WARNER - Yes. Because there was nothing else.

Mr WILKINSON - What was up at Tyenna?

Ms WARNER - A bed.

Ms BLAKE - This is the mental health at Tyenna.

Ms WARNER - Yes.

Ms BLAKE - It is usually just the bed.

Ms WARNER - It is a place for someone, especially if they are going through a period when they are not responding to medication or there has been some change. Jane and I have a client who is pretty stable and periodically he goes through real episodes of very challenging behaviour, so to find a place to keep him alive for the next 24 hours is often really challenging. A challenging experience because, the Royal will not take people unless they have an identifiable mental illness. You do need some sort of crisis care as well.

Ms BLAKE - We need some respite beds for people with acquired brain injury, that have the staff who can cope with the highs and lows of their disability.

Mr WILKINSON - Because it is more than respite, is it not? It is like an emergency.

Ms BLAKE - That is right. Some crisis accommodation.

Mr WILKINSON - Yes, but crisis accommodation to cope with those people that have these mood swings, maybe aggressive mood swings.

Ms BLAKE - That is right. In the case that Lisa is talking about, that gentleman has accommodation and 95 per cent of the time it is actually meeting his needs really well for accommodation, but there is 5 per cent of the time when he actually needs a different model for a few days. He needs some pretty skilled staff to work with him right there and then.

Ms HAY - Is there a cycle to that? Would you have a warning, so if something is going to change within his normal behaviour -

Ms BLAKE - Yes, there is escalation.

Ms HAY - The question I had from before was that compensable people and those who do not have that cover and therefore cannot get the services that may be available. Is the healing or the dealing with the disability or the situation so much harder, does that play on their cognitive state as well, and does that also affect the family more if they just do not have that money for services?

Ms BLAKE - We did not use the clients' correct names in our paper - Hobart is very small - but one of the examples that I would like to talk to you about, which illustrates exactly what you are asking me, Kathryn, is a good one in that there are four people and all have acquired disabilities. All have quite different abilities and disabilities. Two are in wheelchairs and two are mobile with assistance. About eight to ten years ago a financial package for each one was sort of cobbled together, trying to work out initially whether they would stay at home. Eventually they combined these four packages and these people, and a non-government organisation took them on with the money that they brought with them. It was sort of like, 'Well, this is what they've got. Can you make do?'. Now what has happened is what I alluded to before. They have changed and their needs have changed. One has really improved with skills and has moved from a wheelchair to a walking frame, but her needs have changed because of that change and what she requires. Another one has deteriorated because of age and a whole lot of other variables. Now what happened with that non-government organisation is they had not been reviewed for the last eight to ten years for the amount of money. It just continued, it was the same sort of block grant that kept coming. I only became aware of this when they actually said to the clients, 'We are going to have to charge you. You are going to have to pay us money towards paying the staff'. In other words they are asking clients to pay some costs towards the support hours, which is not the usual thing. You usually get a grant. They are all on pensions and they couldn't afford it. So that is my story in there, my particular client who had come to me was then told to cut down on her cigarettes. Well, that's a whole personal thing. That is another issue. She could no longer afford gifts for her grandchildren and could not afford to go swimming, which is part of her rehabilitation and the reason she got out of a wheelchair. She probably couldn't afford to go to Headway for three days because they have to pay for activities and attending.

So it became a huge issue. It turned out that it wasn't just this client. It turned out that it was affecting the clients in this house, and the NGO management and myself then approached Disability Services to look at this. Now this happened in January in this year and we are still in this battle. These clients have now been reassessed and, surprise, surprise, they have found their needs have changed. If that were an ongoing part of planning that would have been picked up. Yes, they agreed that the non-government organisation needs more money, and the non-government organisation has agreed that

with more money they will put on more staff because of changing support needs, and will reduce the rent, which means that my client can afford birthday gifts. However, despite being told by disability management that the money will be flowing, I have not been able to go back to my clients since January and tell them that anything is changing or happening, and yet we are told it is going to happen.

The other part of that story is that I rang Disability Services to ask who is the service coordinator. I'll get them involved with this big picture. All four of them had the same service coordinator, who said 'No, I haven't met them. No, I don't need to meet them. It's just a name only, and if they want to meet a service coordinator or need help we'll actually have to start the whole get-a-service-coordinator process again and they will appoint an active one', which they did. Someone has been appointed. I don't not know who. They have not been out to see the clients. This is 11 months later, the story of people who do not have money and the sort of fight you have to go in.

Ms HAY - Say with the birthday presents, do they sometimes choose their loved ones rather than their own care? Would they cut down on the services?

Ms BLAKE - To be quite honest, what are they going to do? None of them could live independently. They really do not have a lot of options other than to pay the increased rent. They have nowhere else to go. My client actually wanted to move and you get, 'There is nowhere for her to move'. So they are locked into a position that is not comfortable, that is not a coordinated planning process. The NGO board has been saying they are going to pull out of supporting this house because they are not getting enough funding. The clients and their families are feeling incredibly under pressure - and this is a fairly reasonable typical story. It sounds pretty dramatic, but this is the plight of people who are non-compensated. It is real beg-for-services stuff.

Mr HARDACRE - Some of it also relates to the history of the sector, where the money that fuels most of the supported accommodation services really came in during the 1980s and 1990s, so services that were set up after that missed the boat and they are having to scrape by on what they can get. These services for people with acquired disabilities are in that category, by and large.

Ms BLAKE - Another case that is alluded to is where we have had a client sitting in hospital and then have been taken on. When they move into the NGO sector, Disability Services seemed alarmed at how much they cost. There is a very unrealistic picture about the costs around people with high-support needs and acquired injuries. It can be alarmingly high because they need support with everything. Not all of them; you might not need it with personal care but you might need it with behavioural challenges. So it is usually one-on-one staffing around the clock, and that is expensive.

Mr MORRIS - We heard earlier from MAIB that they have a service charter built into their legislation about what they have to provide. Does Disability Services essentially not have any service charter? It just has a bucket of money that it deals with as best it can, or does it have a service charter? If it had the same one as MAIB, how far short of meeting that obligation would it be?

Mr HARDACRE - I am not quite sure how to answer that. Do they have a service charter? I guess they have an act.

Ms BLAKE - They've got acts and standards.

Mr HARDACRE - That's right, and I guess it was the act and the standards that said very clearly that people of all disability types were entitled to use the services of a government-funded body.

Mr MORRIS - If they were available.

Mr HARDACRE - If they were available, yes. If it's not there, it is not there. Part of our message is that the sector that needs to be developed for this group of people has not been developed. We started to include them more four years ago but we didn't develop the infrastructure and the specific services that they need nor the skills within the existing sector to take them in, so we are still trying to plug them in wherever we can without changing what we have.

One of the more positive things that has happened - and I think it is one of the things that might lead to some positive change if we can develop it more - is the individual packages that are out there now. There are something like 360-odd people on individual packages around the State. Certainly we have found, in working with people in that situation, that they are very popular; people do like them. If the package is attached to them, they have some power to go service providers and say, 'This is what I want to do. These are the sorts of services I want'. Where we have seen the most innovative things happening in the sector, a lot of it has been driven by the availability of those packages. Some of the more innovative services have seen the opportunity there and thought, 'Okay, if we can provide this group of people with what they want, we will grow and become stronger services'.

Ms BLAKE - But there needs to be a recognition that those packages might be quite large for people with acquired brain injury; they are not going to be a small package.

Mr HARDACRE - That's right. They have dried up; we have seen very few of them in the last couple of years because we now see the waiting list - it has developed. I guess it does open the opportunity of things being a bit more driven by the needs of people rather than what the market can currently supply. We would certainly like to see that developed more. We wrote a paper on this - had a paper commissioned about three or four years ago on individualised funding and its potential in Tasmania for developing disability services. It has not really gone anywhere but if the committee is interested we would be happy to give you a copy of that.

CHAIR - I think we would appreciate that.

Ms BLAKE - The flip side of it, though, Ken, which Lisa and I have experienced, is then if a large package is given to support a particular client then there is a bit of argy-bargy because they think they will be able to bring the cost down once they settle somewhere. It is unrealistic to think that they are going to get over their acquired injury or that their needs are going to lessen. It is unlikely and that puts pressure on the service provider. We have done a lot of work to find a good quality service to meet the client's needs only to find that that NGO is having pressure put on them to reduce their costs.

Ms WARNER - Following on from there, it seems that we only have one model for accommodation. It is that four-bedroom group home that sits out there. There does not seem to be a lot of flexibility in thinking about it, outside the individual support packages which mean that people can actually live in different environments. If they really dislike someone they do not have to live with them for the next 30 years. We must look at how else you can structure it, to have some transparency about how people are funded and what kinds of programs we should be having. All kinds of people would come up with different models but we have not really tried anything else.

If you look at Sue Hodges and HOPES and some of the models that they have come up with, they are really interesting. Why can't we try it? Tasmania is a small enough place where we ought to be able to say 'Let us give it a go and let us get together with the Commonwealth, pool our money and see what we can develop from it'.

Ms BLAKE - I think the transparency is an interesting thing. I have had several clients who have moved from hospital into a position within a departmental group home set up primarily for people with intellectual disability. There is no transparency with the cost for the department group homes. You would not have a clue what they cost. When they move, because of neglect basically, we push that they be moved from there to an NGO and then the department says, 'Look how much they are costing'. Compared to what? We do not know, so I agree, the transparency certainly needs to be there. It may well be that it is more expensive but we would not know.

Ms WARNER - But then there are also costs with some clients where you the police are constantly involved in someone's life. They are constantly bringing them back. There was one police station where they said that it cost in excess of a few hundred thousand dollars for this particular client when you added up the police cost and the cost of disability services. It is sometimes different departments saying, 'We will have this and you take that'. When you actually add them up, if you were able to combine that money and actually put something together that met the needs of the client, the cost to all of us in our society would be much less.

Ms HAY - And a better outcome.

Ms WARNER - Much better outcomes.

Ms BLAKE - Absolutely. One of the things when we talked about the changes for people with acquired injuries and their recovery period is the importance of rehab. That certainly is something that could also be coordinated but it is really difficult to get rehabilitation services. Certainly if they are plugged into the intellectual disability group home model, they are unaware of and unfamiliar with rehab. You never see a physio or an OT in the group homes but this is really essential for people who are in recovery. Physio, OT and counselling are hard to get. If they are in hospital you have the system that is happening for them in hospital but it stops when they leave hospital and then you join the list for community OTs or community physios. It is certainly harder since rehab closed down; it is a whole other issue. It is a linkage issue but it is also the availability of these people.

Mr HARDACRE - I think a similar scenario applies to those people who end up in nursing homes. They are sort of lost to the community once they are there, and then they no longer have access to all sorts of things -

CHAIR - But problem solved.

Mr HARDACRE - That is right.

Ms BLAKE - Equipment.

Mr HARDACRE - Equipment is a good example with the nursing homes.

Ms BLAKE - Huge issue, equipment.

CHAIR - Most nursing homes would not have the equipment that would be required to look after somebody who required high-level physiotherapy and things like that.

Mr HARDACRE - That is right.

Ms BLAKE - They might have two wheelchairs: they might have an electric wheelchair and a manual. They might have a tilt table. They will have hoists, they will have slings, you know. There is often a lot of equipment and it is back to the community equipment scheme to battle or it is off to the Lions Club to get dollars. It's pathetic. It is really difficult.

Mr WILKINSON - I know a couple of people who came from interstate to Tasmania because of Douglas Parker. They had a disabled child, intellectually fine but physically disabled. There was an uproar when Douglas Parker closed with a lot of them. Should something like that open again? I know it is only in one place, but you have your physiotherapy, occupational therapy, all those services in the one place.

Ms BLAKE - It certainly was a one-stop shop where they could get all those services, yes.

Mr WILKINSON - Should something like that open again, or are there better options?

Ms BLAKE - I don't know whether it is just numbers within the service, whether if they increased the number of physios and OTs that were available, or again if there was a recognition around the growing needs of this group so there were more that were just working with this group. I am not sure, Jim, if we need them all based somewhere, but we certainly need more, and there needs to be a recognition from the people who are supporting the clients that this is an ongoing need too. Yes, it is sadly lacking, and again getting back to that whole coordination and planning, that needs to be part of looking at what are the current health issues, what are they needing.

Mr WILKINSON - When you talk of hoists and you talk of special wheelchairs, hoists to get them in and out of swimming pools, things like that, for the numbers you have probably within Tasmania you can only afford, from my thinking anyway, the one place, because if you endeavoured to afford them, like we do in our hospital system, on the west coast, the north-west coast, the north, the east coast -

CHAIR - The community built it at Nubeena, a swimming pool with a hydraulic chair in it - all done by the community.

Mr WILKINSON - Terrific. That's terrific if they can, but we cannot spread our butter too thinly with it, can we, because if we do, we don't give them the treatment that they need.

Ms BLAKE - You're talking about hoists in specific areas such as a swimming pool, but -

Mr WILKINSON - Just hoists used for an example, but with other services that can be provided, do we try to spread our butter too thinly?

Ms BLAKE - I would question where's the butter before we even spread it?

Laughter.

Ms BLAKE - I think we still have to acknowledge this is a group that has needs. I don't think we've even got to spreading it around, to be quite honest.

Mr HARDACRE - Because if you've gone from hospital into a group home for people with intellectual disability and there is no longer a consideration that you need rehabilitation, then there is no need.

Ms BLAKE - All better. Left hospital.

Mr HARDACRE - So it is not even acknowledged. And the same with nursing homes.

CHAIR - Particularly slow-to-recover people, I would imagine.

Ms BLAKE - Absolutely, and the whole grief and loss around families. I have several clients who were married with children. There's a total breakdown of relationships, which is reasonably typical, and just dealing with the grief and loss around that, but also accessing children. It is very complex.

Mr HARDACRE - Jane was telling me a story earlier today updating one of the stories in our submission, which was about a fellow with a severe acquired disability who eventually was slotted into an intellectual disability group home, got very poor care, very little stimulation. Basically his life shut down. He was neglected. There is a health complaints inquiry into his situation. He is now living elsewhere being supported by a non-government organisation who are battling to keep the funding to support him, but he has changed quite dramatically in the months that he has been there.

Ms BLAKE - He was absolutely fixed. It was like he was frozen; his whole body, his whole face was fixed and did not turn. He is non-verbal. Since he has moved and there are more things going on, he is head-turning and tracking and watching and now smiling, and when I was there visiting another client the other day he was eavesdropping, having a really good look and smiling and really following the conversation. This was the change in three months, and he had just sat neglected by another service for eighteen months.

Mr MORRIS - Lisa, I have your submission here. I would like to come back to the core of where we started with this inquiry, which is the young people who currently are in nursing homes. We have a number of people who are in nursing homes. Do you have a fairly good idea of the names of the individual young people who are in our nursing homes and which nursing homes they are in?

Ms WARNER - No, I don't.

Mr MORRIS - Do you believe that the Government might have such a list or how we might go about finding out? I know of one personally; I have been and met one young person in one particular nursing home and I have friends and acquaintances who know of some others. What is our best course of action to try to find out?

Ms BLAKE - We have an aged-care advocate.

Mr HARDACRE - I thought Disability Services had a joint project with Commonwealth Health and Ageing to look at this as an issue and really identify who was in the homes. At the same time, the State wanted to talk about older people with disabilities in State-funded residential services. I thought there was a process of looking at that. The strategic planning unit at Disability Services was having a look at this.

Mr MORRIS - We have spoken to them. They weren't really that clear, in my memory.

CHAIR - The minister is here this afternoon, perhaps you could ask him.

Mr MORRIS - I am warming up to that. I am just trying to get an idea of what you know about what is going on out there. The other thing, from your role, Lisa, you have mentioned that young people are not eligible for special equipment and can't access rehabilitation. What is the disqualifier? What is it about them that disqualifies them from accessing that?

Ms BLAKE - When they are in nursing homes.

Mr MORRIS - So if they've been assessed by ACAT and placed in a nursing home, they are disqualified from that?

Ms BLAKE - They are no longer eligible for the community equipment scheme.

Mr HARDACRE - They are a Commonwealth responsibility and the Commonwealth in nursing homes will provide somebody to push you around in a wheelchair but won't supply you with the wheelchair

Mr MORRIS - So this comes back to your role as guardian, if you are a guardian for a number of these or you are allocating or dealing with those issues. Do you warn friends of people with serious disabilities that if they are going to go into a nursing home they are not going to access anything that is going to help them get out of there? It is effectively a one-way street, isn't it, at the moment?

Ms WARNER - Usually, because there is nothing, as Ken said before, once you exceed your number of hours and there is no way that you can live on your own and be supported by your carers or your family, then it is a nursing home.

Ms BLAKE - I don't think we would be recommending a nursing home, though. That is one of the reasons people will stay a long time in hospital because the families cannot take them home. We are saying, 'They can't be discharged until we find something for them'.

Mr HARDACRE - We are supporting a lady - she is about 50 at the moment - who has MS and her MS deteriorated to the point where she was totally dependent on her carer, and she had a live-in carer. Without that live-in carer she would have been in a nursing home years ago, but the carer was on the verge of burning out. Just to get high-care respite for her, she had to go to Launceston. We couldn't get anywhere in Hobart that would take her because getting access to Commonwealth-funded, high-care respite nowadays has become an increasingly difficult challenge. They see it as a nuisance. You have different people cycling through the system, through your nursing home, you don't know them, it makes it harder to care for them. They often have high-support needs - too much trouble.

Ms BLAKE - They're often put in locked dementia wards.

Mr HARDACRE - These are younger people anyway who shouldn't be going to a nursing home.

Mr MORRIS - No, but it would suffice for respite.

Mr HARDACRE - They need high care. That lady had to go to Launceston and that worked for a while; that brought a bit of time for her carer, but since then she has gone back home because it has broken down - the carer has had enough - and I think she is now in the Royal waiting for a permanent aged-care bed because there is nowhere else for her to go.

Ms BLAKE - To a certain extent the hospital has been the alternative accommodation for the last few years. Quite a few of these clients with acquired injuries stay for years.

Ms WARNER - The other client group that hasn't been mentioned today, which I think I am seeing more of, are people who end up in prison. They may have an acquired brain injury or a mental illness and often there is a young group. There is a younger group of men. So we have seen huge increases in the number of those kinds of groups. There is just no accommodation. They are often a group of people who have had a homeless existence or drug-induced psychosis and there is just nowhere for them to go so they end up in prison at the cost to the community of hundreds and hundreds of dollars a day and completely inappropriately housed.

People with borderline intellectual disabilities as well end up in prison. We have been talking a lot about people with intellectual disabilities or acquired brain injuries but that is another place, besides the hospital, where people end up.

Ms BLAKE - I have two in prison at the moment that I am supporting and they are there because there was no alternative accommodation. While they are in Risdon or while they are in the hospital -

CHAIR - They must have committed a crime, surely.

Ms BLAKE - They did.

Mr HARDACRE - But they would have been out by now if there was somewhere for them to go.

CHAIR - I see.

Ms BLAKE - They would have been out or there would have been a different outcome if there was supported accommodation.

Mr MORRIS - Surely they are not allowed to keep them in prison any longer than their sentence?

Ms BLAKE - But if you have an IQ of 51 and you cannot plead and there is nowhere for you to go, that is where you sit until Disability Services deem they have a bed, and they say they do not.

Ms WARNER - I had a client once and the magistrate from court called me up one afternoon and said, 'This woman has been here 20 times in the last two months. She is homeless and we do not know what to do. They keep sending her to the hospital and no-one admits her because they say she does not have a mental illness. Please can you just do something and find some place for her to live?' She said, 'Until you do, I will send her back to prison and just organise some psychiatrists and get somebody other than the psychiatrist at the Royal who keeps saying she does not have a mental illness' -

Mr WILKINSON - She kept coming to see me. Truly.

Ms WARNER - The magistrate or the client?

Mr WILKINSON - The client.

Ms WARNER - It is very difficult.

Ms BLAKE - I think one of the things, Lin, is that it is all part of the health budget. It is all under Minister Llewellyn. However, it does not come out of Disability Services' budget. I think we need to acknowledge it is still costing the State - the Government - money whether they are sitting in Risdon or sitting in hospital and I think we would all agree that it would probably be the same amount of money if they had decent supported accommodation in the community.

CHAIR - It is breaking down those silos.

Ms BLAKE - That is right.

Ms WARNER - This woman was arrested for failure to move along so her crime was sitting in the mall or sitting wherever she was and nobody wanted this person outside of their shop so the police would say, 'Move along,' and she would say, 'No,' and they would arrest her. She ended up spending a significant amount of time in prison for that, so we are not looking at people who should be kept isolated from the rest of society because they are a danger to us or other people.

Mr MORRIS - It is just that they failed to move from outside someone's shop.

Ms WARNER - And there is nowhere for them to move to.

Mr WILKINSON - But that is the case too is it not with a criminal like Rory Jack Thompson. He said, 'I should not be in prison because I have been declared insane. There should be a special place for me which is not a prison because I am not a convict. I have not committed a crime but there is no other place for me.' That was his continual argument until he committed suicide.

Mr FINCH - I just wanted to explore something you said a while ago about the four-unit accommodation. You made it sound like it was passe or that they are locked into that sort of syndrome of four units. We have seen accommodation in Melbourne where there are about eight different units in a complex. What are you suggesting? Are you saying there should be more flexibility with the arrangements?

Ms WARNER - Absolutely. I think that different models work for different people and for one person, two hours a week support in their home might be enough to allow them to move in their own home and the community but for other people -

Ms HAY - Or even different models along the pathway.

Ms WARNER - A different mix of things because it is horses for courses and everyone's disability is quite different. If we had different models it would be wonderful because then you could actually have some choice about what was the most suitable type of accommodation. I know that HOPES have been advocating for a cluster arrangement with a common house where people could actually have some social interaction and a kitchen and have meals and things like that.

Ms BLAKE - And you could maximise your staffing too because there are certainly times when you might need a couple of people for lifts or, around certain times, for personal care, and at other times they are fine on their own. If you have some sort of complex then you can swing your staff around. However, Lisa and I both have clients who live in complexes and sometimes the dynamics of complexes can be challenging, so you do need to have your own space, I guess.

Mr HARDACRE - The whole system needs to be managed a little bit more creatively, because often, in that four-bedroom configuration, once people are in they stay there, and if it is a 24-hour supported house then that person will get 24-hour support for the rest of their life whether they need it or not. So we also have people living in these sorts of set-ups who could cope with much less support. It is not a good use of resources for those particular people. In a previous life I worked as a manager of the supported accommodation services for people with intellectual disabilities, and we had people who

went from 24-hour group home supported accommodation, over a period of years with intensive support and education development, to very minimal support, but it took a lot of effort and it takes that intensity of planning and working with people that Jane was talking about, which is missing a lot of the time in what we see.

Ms BLAKE - I think what we have operating at the moment is a very expensive way to go. Lisa and I are continually at crisis meetings and it costs a lot of money to immediately get another service to come in to plug things up. It is not cheap what they are doing at the moment on the whole so, while we need more money in this sector, I think we need to look at what is currently being done and whether the money is being well utilised as well.

Mr MORRIS - Could I ask how do you think that might be done? How do you think a review of Disability Services might occur in a meaningful sort of way? We are hearing absolutely damning evidence of the way Disability Services are managing it. Perhaps they have not fully accepted their -

CHAIR - In his opinion.

Mr MORRIS - In my opinion, yes. Perhaps they have not fully accepted their so-called new role of the last four years and do not comprehend the breadth of it or the depth of it, but they seem to have a lot of services out there which seem to be quite fixed. In some cases they do it really well, but then once they have someone sorted out they just stay in that box. There seems to be very little ability to change things. It is always a battle to get changes to meet the new needs, whether it is for fewer services or for more services. It seems to be equally as difficult. What can we do? Do we have a royal commission into Disability Services? I mean, that is probably overdoing it -

Mr FINCH - It's got a nice ring to it.

Mr MORRIS - but it has got a nice ring to it. How could we about it? We seem to need a fairly significant bomb under the service as such, an ability to loosen it up, reorganise it and bed it down again. After that it may still be short of resources and we can go down that path then, but in the meantime it seems like there is a lot that could be done. Have you any comments on how we might approach some sort of inquiry? I am not going to suggest to this committee what Disability Services could and/or should be doing.

Mr HARDACRE - I don't quite know specifically how to do that. I guess from our point of view what we see is where all these different interfaces do not work, so it is about the way we respond to and support people with disabilities in our community. Disability Services themselves have a key and pivotal role, but there are Housing Services, there are Mental Health Services, there is Transport, there are all those different things which do not work.

CHAIR - It is a whole education of the Government.

Mr HARDACRE - And we try to fix it sometimes with a person called a case manager, who tries to get all the balls juggling at once to make it work, and some of them, if you get a good one, can make it work for some people. If you get a bad one, then the balls always get dropped and nothing much happens for the person. But there has to be a better way,

a better system of doing this for people in the first place. I don't quite know exactly how you do it, but it is something to do with the pooling of the funding, giving people more control of the resources so that they can purchase or get access to the services they need. We refer constantly to people in this sector as consumers, but it is an artificial term. It is rubbish. People are not consumers, because consumers have power to make choices. The groups of people that we are talking about are given limited options and told to take it or leave it. So we do have to shift the power towards the consumers and the families a lot more than we have at the moment, and I guess I would come back to pushing our little barrow a bit about individualised funding and looking at that. We felt when we looked at this a few years ago, this came about because we had looked at the problems that we as an advocacy service were seeing across all the areas where we work, what it had in common and the problems we were seeing. In a given year, we have about 1 000 cases where we work with individuals, either people with disabilities or older people across the State. Some of the common threads were around a lack of choice, lack of control, lack of responsiveness from services and poor quality. It seemed to us that that power shift was a critical thing that needed to happen to start to address a lot of these things; they are interconnected. We are under no delusions that it's easy.

Mr MORRIS - Perhaps Disability Services should only be trying to go as far as providing case management?

Mr HARDACRE - Quite possibly.

Mr MORRIS - And then, apart from that, it is the customer buying the services. When they buy them off Disability Services or another -

Ms WARNER - Perhaps the customer could be funded to purchase services wherever they wanted, including case management services.

Mr MORRIS - Sure.

Ms WARNER - There might be an independent advocate. Maybe they'd come to you and say, 'We want you to run this because we think you're a good advocate and you can drive the services'. I don't know.

Mr HARDACRE - Most of us are involved in sector reform in some way and we felt that one of the things that came out of that was that the department had too many roles - service provider, funder, monitor and evaluator of services - and that there are conflicts of interest within those multiple roles. We would rather see the department provide the funding and do the policing.

Ms BLAKE - Out of service provisions.

Mr HARDACRE - What are the standards? Are you meeting your standards? If you're not doing a good job, these are the sanctions. As long as it remains a large provider, I think we will always struggle with those things.

Ms BLAKE - Well, if they are a service provider, they should be setting the standard, and they're not. They are probably the worst service in the sector.

Ms WARNER - If there was a standard they could say, 'We insist on a review once a year. We want a report. We want to know how much funding, what your needs are, how they have changed. We want evaluations coming in all the time'. They could set some pretty high standards.

Ms BLAKE - Yet they don't. They are probably bottom of the barrel as far as standards are concerned.

Mr MORRIS - Do they know that?

Ms BLAKE - Well, we certainly give them enough headaches.

Laughter.

Ms BLAKE - I am forever at Disability Services, Tim.

Mr MORRIS - Does the minister know that, do you think?

Ms BLAKE - I think so. We certainly encourage our disgruntled clients and families to write to the minister. Ken has been on the ministerial advisory committee and we work a lot at that systemic level.

Mr FINCH - Just completely changing tack, we have a couple of members who are from the north-west coast -

CHAIR - We wondered what services were available for them.

Mr FINCH - You are probably southern based -

Mr HARDACRE - No, we have an office in Burnie and one in Launceston as well.

Mr FINCH - Are you clients spread around the State? Are people better catered for in Hobart where the bureaucracy is or is it Hobart and Launceston and the north-west is missing out? Can you give me a bit of a picture?

Mr HARDACRE - A general comment, Kerry, is that we find that because the north-west is probably less endowed with overall services, people - and this is Disability Services staff as well - are more creative in the north-west and work more collaboratively together. Our advocate, Chrissie Jamieson, who works in Burnie, has worked for us for three years and worked for Speak Out for six years prior to that. She is a local girl and knows everyone and has a good relationship with Disability Services up there. The regional manager is a very switched-on lady. We have mostly good experiences and good relationships in the north-west. In the north we have the exact opposite. We find them to be unresponsive, disinterested and difficult to deal with. In the south we find it probably somewhere in between the two, a bit of a mixture. Obviously it is bigger, there are more personalities. For example, with the service coordinators, there are some absolute gems and there are some you wouldn't feed, so when it comes to getting responsiveness for your clients, it is a lucky dip. Some will work very hard and bend over backwards and act as case managers rather than short-term service coordinators to get a result for people; others will do the absolute minimum.

Ms BLAKE - There are, just by size of population, Kerry, more options south so clients will have more choice. If you are looking for a day service and you are in Wynyard, you are not going to have a lot of choice but if you are in Hobart and suburbs you are going to have a choice of three or four maybe.

Ms WARNER - But it does not make them better choices. Again, it all comes back to the people you have working there.

Ms BLAKE - We certainly have north and north-west representatives, as Ken alluded to. The Office of the Public Guardian has representation in the north and north-west.

Mr FINCH - I am a bit concerned about the picture you paint though, Ken, of people working in the service in the north of the State. Is that highlighted? Does that amplify your concerns there? Does the minister or the service know about that?

Mr HARDACRE - There is a lobby group that has developed just recently in the north of the State of parents who live with disabilities as a response to this, as a response to the lack of responsiveness. They had a protest I think earlier this year out the front of Disability Services in the north and they are planning one out the front here in a couple of weeks' time, primarily because they feel the lack of respite services, lack of supported accommodation services in the north of the State are particularly bad. They call themselves the DRIAM group - Disability Regional Information Action Meeting.

Mr MORRIS - We have had contact with them. In fact I think we had a couple of their members when we were taking evidence in Launceston.

Ms BLAKE - Would you like them to put you on their e-mailing list, Kerry?

Mr FINCH - That would be good.

Ms BLAKE - Then you can be kept abreast of the current northern issues.

Mr HARDACRE - So there is a great degree of frustration in the north of the State.

Ms BLAKE - I think one of the things is there are regional differences that are quite subjective. I know Mary Bent and Mike Plaister, the State Disability Manager, would like statewide consistency but that is not the reality of what we find on the ground. Would you agree?

Ms WARNER - Yes.

CHAIR - We might leave it at that. Thank you very much. Thank you for your time and your contribution. That was wonderful.

THE WITNESSES WITHDREW.

THE HON DAVID LLEWELLYN, MINISTER FOR HEALTH AND HUMAN SERVICES; AND Ms ANNIE CURTIS, SENIOR PROJECT OFFICER, STRATEGIC PLANNING, DISABILITY SERVICES WERE CALLED AND WERE EXAMINED.
Mr JOHN NEHRMANN, MANAGER, STRATEGIC AND BUSINESS SUPPORT, DISABILITY SERVICES WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

Mr LLEWELLYN - Thank you very much for your invitation and the work that you have done on this particular matter. I think we have been given, over the time and from previous evidence, the numbers of young people with disabilities who are in a nursing home situation and I think that has not changed all that much. I think there still are some 23 people on a statewide basis who are in this category and who are under 50 years of age. Between 51 to 65 the number of people in that situation that figure increases to 105.

You have requested that I attend the meeting today to clarify a number of issues, and I am happy to do that. Through the process of Disability Services framework, the service is actually focusing on forward planning in consultation with stakeholders. I am trying to deal with the first dot point that you have there. The strategic plan has recognised that there are a number of people with disabilities who do not currently receive the most appropriate service and that the services have changed substantially over the past 20 years or so, therefore we have to offer a variety of service options that we obviously were not involved in in previous years to enable Disability Services to achieve those outcomes. We also have to, as part of the planning process, enhance our current management approach to people in this category.

Currently the level of unmet need within the disability sector is tackled by utilising waiting lists for services. This incorporates waiting lists for the individual support program and the accommodation and day services on a statewide basis in both metropolitan and regional areas. In July 2002, the Australian Institute of Health and Welfare published a national report into unmet need for disability services and effectiveness of funding and remaining shortfalls. We monitor the things based on those sorts of benchmark arrangements that are established at a national level. The national disability administrators regularly collate national unmet need information and have endorsed a priority research project into the national assessment and resources allocation, which incorporates demand management. We will be anxious to see the outcome of that, if there is something in that that needs to happen. My preference is that we deal with these things on a uniform basis, on a national basis, and that you pick up issues across the nation.

It is generally acknowledged that there are a number of people currently supported in the community who are not known to Disability Services, so while we have talked about these numbers, there may well be a group of people who do not show up, for whatever reason, on this list. They are supported by families or through informal arrangements with carers and they are not going to be recognised from a predictive point of view unless they choose to come forward and access support through Disability Services.

We have recognised, as a department, the need for flexible accommodation options for people with disabilities. In this year's Budget we have increased the budget by \$3.8 million in the disability sector, with a focus on development of accommodation

options. I know that that is not going to meet our need for the future and I have been trying to work through a whole series of things as Health minister, not only in the disability sector, but also with mental health and in the hospital sector. Through analysing things thoroughly and then deciding where our priorities are and where we need to put the money, instead of just applying an approach of throwing money at the situation and hoping that it will fix it, we want to try to identify where best we can utilise the resources to achieve an outcome. I have done that now consistently with the hospital sector, with the Richardson Report and expert committee that analysed a whole lot of things. We have recently made a \$75 million statement on trying to achieve some outcomes there. Next week we will be in a position to make a statement about - perhaps those are not the right words -

CHAIR - Like next week?

Mr LLEWELLYN - No, next week is fine but sort of, is not fine.

Mr WILKINSON - We will edit *Hansard* for you.

Mr LLEWELLYN - We need to be positive about these things. We are going to make a positive statement about mental health next week which I hope will resolve some issues there and we have been looking at the question also from the disability sector. We have acknowledged that there is an unmet need there and certainly the majority of our approach with regard to the disability sector will have to be in next year's budget but there will be a need for some additional support further on before that as well so I am looking to make some statement about that in the future also.

That is of direct relevance to your situation here, I guess. So we have made a significant attempt to address these issues that you are focusing on. The focus that we have been taking are in areas of support for people with dual disabilities, challenging behaviours, spinal injuries, acquired brain injury and those sorts of things. We are obviously committed to individualised funding as is evident in certain increased demands and allocations of packages and support to individuals through the ISP and day services that we have been providing.

It can be a very costly exercise, as you have probably all found when you have investigated this particular matter. The individual support program currently allocates hours of support to individuals and they can then choose their preferred service provider so that provides some flexibility but it has got limits in relation to the number of hours within the program that we have to allocate and the unmet need that is still there in the system, and that is going to require additional resources.

As I say, currently, again in the event that a person's support needs are beyond the available resources, we have got a special program that has been put in place. You have probably been over this with the other departmental officers - I think Annie came before but John has not - but we have got a board of exceptional needs that look at these situations when they come up and they look holistically at the needs of the individual, negotiate an appropriate package of support and then that package is attached to that particular person. As I say, that can be, in some cases, very, very significant - up to \$0.5 million, particularly if that person requires more than 24-hour support, one-on-one involving six people virtually on a rotational basis. Some people in certain

circumstances that are very difficult to manage may even require two-on-one support from time to time.

The Board of Exceptional Needs is also an avenue for focusing on improved coordination between the various services within the Department of Health and Human Services. We have got a draft disability services strategic plan which will encompass - obviously we are still operating on that to some extent - 2004 through to 2009 and we hope to have that finalised by I think about February next year, John?

Mr NEHRMANN - Yes.

Mr LLEWELLYN - That will involve some further discussion with the community sector and others. They have been involved in the process to date and that is one of the other reasons we probably need to focus our attention on next year's budget for additional resources. We really do need to know exactly where we are going, in the same way as I mentioned with the Richardson Report before with hospitals. We have done the review and report on mental health services and now we are in a position to focus the money in the right place there and we need to do the same thing - finalise it with the community anyway, the priorities and so on. That will be finalised in that strategic plan and then we can actually position the resources in that area. But there are some things that need to be done that we know about in any event. There is a big issue about turnover of staff in Disability Services, I think like probably in other areas too, and that does not make things any easier.

Mr WILKINSON - Is that an Australia-wide situation where there is a turnover, or just a Tasmanian situation?

Mr LLEWELLYN - No, I think it is pretty uniform.

Mr NEHRMANN - In terms of health professionals, it is probably a national issue. I think it is a little bit compounded for Tasmanian, especially in our rural and remote areas. We find it very difficult to attract people and then to retain them. Part of it is also the relativities around salaries that are paid compared to other States. So there are a number of factors. The general issue, as far as I am aware, is national. If you look at nurses, basically the main problem we have is in terms of health professionals. You are looking at specialist nursing, OTs, speech therapists, nurses, psychologists. They are very hard to get hold of and, as I said, very hard to retain.

Mr FINCH - John, is it part of the landscape in those sorts of areas that you move around, to freshen up and to gain more experience?

Mr NEHRMANN - Yes, I think to some extent it is because if you come into the industry on say a professional level 1, you tend to stay and obviously you are looking in terms of your own career, so you are looking at moving into a P2 position and a P3 position. So in those early years, yes, there does seem to be a fair movement of people until they, I suppose, find the area they really do have an interest in and want to stay in.

Mr LLEWELLYN - We have reduced a little bit the pressure on the respite services, but certainly it is not enough, and that is an area we have to do more. I think there has been a small amount of money put into that particular area and some repositioning as well

there, which has eased the situation. But again, as I say, it is still an issue. The Commonwealth-State-Territory Disability Agreement was not all that satisfactory in its completion and it has certainly restricted our ability a bit there and has certainly taken some resources away. We are going to be required to meet more need with less money or assistance from the Commonwealth point of view, and that is an ongoing issue that we are just going to live with, I guess.

CHAIR - Would it be fair to say, Minister, that those issues listed in the letter we sent you, which are the ones that seemed to be generally raised by the people that we have spoken to, are ones that Disability Services and, through that, the Department of Health are aware of? Do those issues come as any surprise to you?

Mr NEHRMANN - They certainly do not come as a surprise to me, apart from the second one that talks about the unknown level of unmet need. I found that a little bit surprising because nationally the level of unmet need has been pretty much known since 1996 when the original Yateman Report came out, and we have certainly been running waiting lists since around that time. So in terms of knowing the level, we know that on a regional basis and we collate it on a statewide basis.

Ms HAY - So are some people not bothering to go on the waiting list because of the duration of time?

Mr LLEWELLYN - Yes, that was the point that I was making earlier on, that there are always going to be people there who are looked after by families or through other informal networks and so on, and we cannot be absolutely accurate with that, but we know what the curve is going to be pretty well.

Mr NEHRMANN - Yes. What we measure is people who come to us and basically get a formal assessment done in terms of their level of need, and then we may be able to meet part of that and we register the unmet need component. There may be other people out there. To what extent they are seeking services we just don't know. You could argue on one point that if they were desperately seeking services they would make contact with us. You can look at it in both ways or you could say that maybe they have just given up trying to get anything, but the reality is we do not really know what the numbers are.

Mr LLEWELLYN - I thought the dot point was focussing on those sorts of people rather than on those people who are registered with the system or are likely to register, so that is what we responded to. I think I have covered most of those dot points to some extent but they are issues that were raised with you.

CHAIR - One of the things that was raised with us was the contrast between the kind of services for someone who has a compensable injury and is therefore looked after by MAIB or WorkCover, whatever, as opposed to someone who has fallen over and hit the head on their footpath and there is no-one there to pick up the pieces. I wondered if you would like to comment on the contrast between those two client groups.

Mr NEHRMANN - I think there is a huge contrast. If you have, for instance, a serious accident in your car on the road, unless you have been breaking the law in some things, you are automatically covered and automatically compensable, but if you have it somewhere else you are not. There is a real inequity. I am not too sure how much we, in

terms of disability, or even our agency, can do about that. My understanding is that it is part of the MAIB Act that specifies those sorts of things.

Mr LLEWELLYN - I suppose you could if you wanted do the same thing for the same reason. Under the MAIB Act, those people that travel in cars pay a certain amount of money to the insurance company, MAIB, in order to accommodate the person who might find themselves in this situation. As a welfare state you could say to all the citizens, 'You are going to have to pay a \$30 levy for the future and that will cover you for any contingency in the future', so it is a similar situation. We could do that but that is not what happens.

Mr MORRIS - Have you discussed that?

Mr LLEWELLYN - No, I have not.

Mr MORRIS - Will you discuss that; in New Zealand does it.

Mr LLEWELLYN - Yes, it is an issue, but, no, I have not discussed that with anyone. It is not done anywhere else in the nation either as far as I know.

Mr MORRIS - No, not in this country. Can I ask a couple of questions? One is to do with ISPs. We heard I think that there are some 300-odd individual support packages out there at the moment?

Mr NEHRMANN - Yes, that is about right - about 315.

Mr MORRIS - Yes. Can I ask how many new packages have been created and put in place in each of the last two years.

Mr NEHRMANN - We can get those figures for you.

Mr MORRIS - If you could. I am quite happy to have those provided. Could you also provide us with the current different waiting lists that you have, the numbers that are on those and the amount of need in each of the lists that is being met each year.

CHAIR - How quickly you come off the waiting list once you have been on it?

Mr MORRIS - I do not know if that is quite the way I want it, but, yes, average stay or something like that, or the number of people who are coming off the front end of the list each year.

Mr NEHRMANN - Sorry, how many years back?

Mr MORRIS - Just two. The last couple of years. There is no point in going back too far.

CHAIR - There was one suggestion that was made to us today. We had the Public Guardian and Advocacy Tasmania in. One issue they raised, and I do not know that I had thought about it before and I do not know if the rest of the committee had, was that they saw a bit of a conflict, if you like, in the fact that Disability Services funded and reviewed and policed services but also was a service provider. They seem to think the whole thing

would work more easily if Disability Services were purely a funding and policing body and not a service provider. Do you think that argument has any validity?

Mr LLEWELLYN - A lot of the services are provided by not-for-profit organisations as well.

Mr MORRIS - This is talk about the rest of them.

Mr NEHRMANN - If you want my opinion, the way the service system works at the moment is that roughly 75 per cent of all those services are provided by the non-government sector and 25 per cent are provided by us. We see ourselves as pretty much a service of last resort, of you like. What worries me about outsourcing all of the services is that in the past we have run across situations where the non-government sector will invariably wash their hands of clients who are difficult to handle and give them back to the government sector. I would be really concerned if we did not provide at least some kind of a safety net in terms of respite services, service coordination and certainly some level of accommodation support. Time and time again organisations have said to us, 'We can support this client for this amount of money', yet six months down the track, unless we double the money, they are not interested in doing it any more. To me, it would put us in a more vulnerable position if we did not have the option of providing some level of service. I think you can have a debate about what the appropriate level should be - should it be 80-20, 90-10 or whatever - but the reality is that we outsource more services to the non-government sector than any other State. Most are still around the 50-50 or 60-40 mark. As I said, I would have concerns about everything going -

CHAIR - It makes sense when you put it that way.

Mr LLEWELLYN - All of these particular cases, I think without exception, are cases that find their way onto my desk because of the fact that they have become very difficult. Other organisations will write in and say, 'We can't handle this. We need more money'. We can name specific cases, but it is probably not appropriate.

Mr MORRIS - In relation specifically to young people in nursing homes, we have more or less agreed numbers - they're not strictly agreed - on how many young people there are in nursing homes. Is it possible for this committee to have a list of those people? We would like to talk to some of them; we have not yet spoken to any of them. We think it is important that some of those get a chance to have a say about their experiences and feelings, where that is possible, and also the carers who support them and how they are seeing things. Is it possible to have a list of those whom you know? Maybe we might come up with other people whom you don't have knowledge of. We are not going to publish that or anything.

Mr LLEWELLYN - I think we would need to ask whether they would agree to it.

Mr MORRIS - Well, maybe even just the number of people in each of the nursing homes that has young people in them.

Ms CURTIS - Because of the work the accommodation working party is doing under the bilateral agreement, we are looking at conducting a survey of the younger people in nursing homes. At the moment that is primarily being driven by the Commonwealth

because of their knowledge of the names and the different services and that sort of thing. We have asked if we can get names, but we can't get those names through aged-care facilities because of privacy and that sort of thing.

Mr LLEWELLYN - Yes, it's not that we're trying to avoid giving you the names.

Mr NEHERMANN - They are in Commonwealth facilities; even we have difficulty getting that kind of information sometimes from the Commonwealth.

Ms CURTIS - I am sure the working party would have no problem, once the survey has been done, to provide feedback to you.

Mr MORRIS - We would love to have some; they are getting hard to find without physically going around the nursing homes. I know of some personally.

The other thing that has been raised with us is that when people are assessed by ACAT and go into a nursing home, they then no longer qualify for rehabilitation services and equipment services, which I presume are State funded.

Mr LLEWELLYN - Not if it is in a nursing home - it is Commonwealth funded, then.

Mr MORRIS - Sorry, the equipment and rehabilitation services, which they would have had access to prior to them being located in a nursing home, but they no longer get access to those facilities.

Mr LLEWELLYN - Because they are supposed to be provided in the Commonwealth setting.

Mr MORRIS - I don't know that they are.

Mr LLEWELLYN - That is the silo problem.

Mr MORRIS - What I take that to mean is that once ACAT has assessed them and they have then been placed in a nursing home, they are then cut adrift by the State, even if prior to that they were getting access to services. Can that be looked at?

Mr LLEWELLYN - Well, it is exactly the same as an aged person. If an aged person is getting frail, medical services will come along and provide things and if you are in a hospital setting will provide rehabilitation and all those sorts of issues in the hospital setting. But if they are then assessed by ACAT for a nursing home place and they go into the nursing home, it is then the responsibility of the Commonwealth to provide those services. So it is no different.

Mr MORRIS - I hope they are made well aware of that situation before they get assessed or as part of that assessment process. Okay, thank you. My last question really is just going back a bit on rehabilitation. What was the reason for the closure of Douglas Parker?

Ms CURTIS - I wasn't in Tasmania then.

CHAIR - When was it?

Mr NEHRMANN - Early 90s, mid 90s.

Mr LLEWELLYN - I cannot give you a definitive answer to that. I could ask the department to provide you with a reason as to why that happened as part of the planning

Mr MORRIS - It is just that we have had some evidence presented to us that that was a facility that was much appreciated and much used, but they were not able to give a satisfactory explanation as to why the Government chose not to continue the funding for it.

CHAIR - There were others who were also saying it does not really matter if they are all put in a place like Douglas Parker, we just need more physios, ten or fifteen or whatever, regardless of where they are situated. We just need them.

Mr LLEWELLYN - I think that underpins the issue that you have here of young people with disabilities in nursing homes. The ideal situation is to have them in their own environment if we possibly can, and then they are provided with all of the support services, but they all ought to be provided with support services in nursing homes as well.

Mr NEHRMANN - That's right, yes.

CHAIR - So it shouldn't preclude you from having them because you make that move.

Mr LLEWELLYN - No. If we are going to break down this issue of who funds what, it creates all sorts of bothers. Richardson mentioned that in his report about hospitals. We have recently had Tony Abbott saying 'We will take over the hospitals', but will he provide a decent service? The Federal Government has not achieved an ideal outcome in regard to nursing homes, can I say, by being a bit political.

Mr MORRIS - We are well aware of that.

Mr LLEWELLYN - And they are much further away from where the action is. It seems to me it is always the case that the further you get away, the more impersonal you get about the issues and the more difficulties you have.

Mr MORRIS - Just on that Commonwealth/State issue, Minister, have you had a look at the some of the writing of John Menadue who did the reviews into the South Australian systems, where he has proposed a couple of models that might overcome this? Do you think they offer any possibilities for Tasmania?

Mr LLEWELLYN - They might, but I think they are still fairly bureaucratic because they involve independent authorities that are going to take over this role, which again are all divorced from - I think in one of the models it did still involve the State Government directly in it, but they acted like a grants commission in a sense. That might work, but it certainly gives food for thought, anyway.

CHAIR - Thank you very much, Minister. It is much appreciated.

THE WITNESSES WITHDREW