

THE PARLIAMENTARY STANDING COMMITTEE ON COMMUNITY DEVELOPMENT MET IN MELBOURNE ON TUESDAY 10 AUGUST 2004.

INQUIRY INTO YOUNG PEOPLE WITH ACQUIRED DISABILITIES

Ms BRENDA BOLAND, Ms VITTORIA MANCINI, AND Ms MARGARET SUMMERS WERE CALLED AND EXAMINED.

CHAIR (Ms Thorp) - Thank you very much for making yourselves available. As you would be aware, the terms of reference for the committee are looking at the accommodation needs and other needs of people with disabilities who in Tasmania currently need to reside most frequently in aged-care facilities. We have heard on the grape vine that good things are happening in Victoria, and also Western Australia, so we are taking the opportunity to talk to people in the know and visit facilities where possible. How would you like to handle this this morning?

Ms BOLAND - We had a look at your terms of reference and what we thought would be most useful is if I do a bit of an overview and Vittoria and Margaret, who manage the detail and are managing the project we have on young people in nursing homes, could go through some of the initiatives we have going and some of the issues and support services that we are using.

In terms of an overview, Victoria has been struggling, I think it would be fair to say, with this issue of young people in nursing homes and how we work out a way of providing support for them. What we have really determined is a three-pronged approach, that there are young people in the community who acquire disabilities that perhaps end up in nursing homes via a route that doesn't really involve Disability Support, so they may come straight from rehabilitation or acute hospitals and end up there before the rest of the service system really knows about it. There are those people who are entering that we want to target and see if we can do things better there. There are young people in nursing homes for whom that level of nursing care is absolutely required and we cannot imagine them living in any other sort of setting, apart from that intense medical model, but for whom living with a whole lot of older people isn't a good outcome. So what we can do with the facilities that are there to make them more friendly for younger people. Then there are people who are in nursing homes who we think perhaps could live in a different type of setting altogether; the intense medical need is short term, it is not long term and with some rehab and some working through perhaps they could move into less intensive options, again, as a joint Commonwealth-State responsibility with the Commonwealth picking up the medical requirements. So that has been our strategy.

We have a number of things in place, that Vittoria and Margaret can talk to, like the Slow to Recover Program, which I am sure will be on your list to visit.

CHAIR - That's for people who need really long-term rehab?

Ms BOLAND - Yes. We have found that program useful. We have done some analysis around the young people in nursing homes and we have certainly been able to move some out. It is a priority for this Government to get some joint solutions with the Commonwealth, and that is really what we have been working at from the bureaucracy at the moment. It is probably useful now if I hand over to Vittoria to go through some of the initiatives we have going.

CHAIR - Before you go on, did you do an audit?

Ms BOLAND - Yes. We did an analysis of who is there; we did not interview the individuals. We got someone to go through and look at who was there and how they got there. We have some copies of that report for you, if you would like to have a look. Again, it raises Commonwealth-State planning issues, the funding, the different systems.

Mr FINCH - What numbers are we dealing with?

Ms BOLAND - It is about 1 400, is it?

Ms MANCINI - No, it depends on how you define it. In terms of the numbers of people who are currently in residential aged care under the age of 65 - we are using Department of Health and Ageing statistics - we have 1 536 in Victoria in high and low-care places, but we only have 229 who are under the age of 50.

Ms BOLAND - There is a large group between 50 and 65.

Mr MORRIS - I think it is true to say that we don't know how many we have.

Ms BOLAND - In residential aged care?

Mr MORRIS - Yes.

Ms BOLAND - I think those stats come from a database.

CHAIR - Does that take more analysis to find out the whys and wherefores and how long?

Ms BOLAND - Yes, absolutely.

We have also done a bit of an analysis of our ACAS data - aged-care assessment services data - to identify how many people under the age of 65 are received - a recommendation for residential aged care. We haven't been able to track these individuals to who moves in because that data isn't available. We have been able to identify how many of those people are out in the community, if you like, or who have been assessed. We know that the majority of them are in the community so therefore we have some understanding of how many people we would probably need to support who may be at risk of going in.

Mr MORRIS - What is that number?

Ms BOLAND - We had over 500 last year.

Mr MORRIS - So double the number that are already there?

Ms BOLAND - Yes.

Ms MANCINI - Actually no. We have 1 500.

Mr MORRIS - Sorry, I meant the under-50s.

Ms MANCINI - I will begin by saying that in Victoria at this point we are taking a fairly broad view of the client group, so we are talking about under-65. I know in other jurisdictions, other States, people talk about the under-50s, but there is some discussion at the moment about determining criteria for prioritising within that client group. As Brenda was saying, we are looking at a focus on some of the younger people who are in residential aged care, younger people who potentially could be cared for in the community so can transition out, people who are at risk of entry - and that is where we are looking at that ACAS group. We have also been looking at the client group who were sitting in acute, sub-acute and interim care who have an ACAS assessment but there are issues about the transition to either aged care or community-based care for them.

To date, our service initiatives have focused on four different areas. There are initiatives that have looked at improving that care and quality of life for younger people who are in nursing homes. We have looked at the transitioning from higher to low-care options and improving our cross-sector interface and client pathways to care. Once you read that report about the young people in nursing homes with ABI, that report identified significant issues in terms of referral pathways for individuals, so we have been working on improving protocols. We also have in place a number of initiatives and funding through our various programs that enable people within the client group to remain in the community. When I am talking about the 'client group', I just want to reiterate that from our point of view this covers younger people with disabilities, so that includes people with acquired brain injury, neurological conditions, physical disability as well as people with intellectual disabilities, premature ageing - so I am not quite sure how that matches your definition because you were talking about acquired. There is the DSA definition disability act.

I will talk a bit about those initiatives and give you a bit more detail about some of those. Margaret, do you want to talk about the establishment of specialist nursing homes?

Ms SUMMERS - Yes. I am Margaret Summers from the aged-care branch and responsible for the public sector residential aged-care places. I am not sure if you are aware, Victoria is a very large player in residential care -

CHAIR - As a government? As a State?

Ms SUMMERS - Yes.

CHAIR - Which is not the case in Tasmania.

Ms SUMMERS - No, that is not the case in most other jurisdictions. I think 16 per cent.

Mr WHITELEY - How did we get to that point?

Ms SUMMERS - It's historical, mainly through the co-location of aged-care facilities with small rural hospitals. Most of the rural provision is State provision and it is mostly co-location with small rural hospitals. That is the nature of this State. That has also given us the opportunity, I suppose, to look at a more strategic use of the public sector places that are Commonwealth funded, particularly in urban metropolitan Melbourne and the large regional centres. Certainly where other players in the market can look after the generic needs of ageing people, what we have been investigating is whether we can have a more targeted approach that assists with the demand management and the interface between acute and sub-acute disability and aged care.

Mr WHITELEY - Because that involvement is so high, is it government policy to roll yourself out of that over a period of time?

Ms BOLAND - It was a policy of a previous government and this Government very clearly not to.

Mr WHITELEY - Did you mention that percentage, other than the provision of -

Ms SUMMERS - It is 16 per cent of the total market sector.

Mr WHITELEY - Provided by the State?

Ms BOLAND - Yes, but 95 per cent is in rural. It is very small in metropolitan Melbourne.

CHAIR - Tim, at Nubeena Multipurpose Services has a few aged beds, a few acute beds, it is the local medical centre, the local physio visits and that kind of thing. Amongst that mixed, with aged-care beds, you might find one man in his fifties in a wheelchair for whom there is nowhere else to go.

Ms BOLAND - That interface between somebody staying in acute or sub-acute whose needs aren't the medical model but needs continuing care and accommodation then the use of public sector residential aged-care places is an option there, the idea being that there then should be an interface with Disability Services to provide for an age-appropriate environment in that case, and that hasn't always occurred. Two examples where there is that relationship at the interface with acute, sub-acute and disability is the Garden View Nursing Home, which has 21 places for younger people with ABI and other neurological disorders. The other place is the Cyril Jewel House. Both of these are provided through Melbourne Hospital. It provides 15 of 45 places to people with multiple sclerosis and Aged Care provides top-ups to supplementary funding because they are at the adjusted subsidy rate. Aged Care provides top-up to the places and Disability Services also contribute additional funding to support the disability needs. Certainly the Commonwealth funding covers the accommodation and care component but, in terms of providing that additional support, the Victorian programs all do that.

CHAIR - There seems to be an ongoing tension, doesn't there, between someone who is younger and in an aged-care facility and who pays for it and who is responsible?

Ms SUMMERS - That is certainly a position that all the jurisdictions fund themselves in in that way.

Mr MORRIS - What is the arrangement with the Commonwealth? Is there a formal arrangement in place for that?

Ms BOLAND - The Commonwealth legislation certainly allows the ACAS to assess people for eligibility. Where there is no other option available for accommodation, care and support, then residential aged care is an option. The legislation does not preclude that assessment of eligibility happening, so that is the entry part of it. It is about the planning and the allocation of places that the legislation says, 'These aged-care places under the aged care act are for services that are primarily delivering care for frail-aged'.

Mr MORRIS - I gather there is no bottom age limit as such, is there?

Ms BOLAND - No, it is on support needs.

CHAIR - Would there be an argument then on behalf of the Commonwealth to say, 'That person really doesn't need to go into a facility like this, so we don't have to give any financial support'? - so it all comes back to State support?

Ms SUMMERS - I don't think it is as clear-cut as that. That is something you would probably have to put to the Commonwealth, around how they determine that funding. Once a person has been deemed eligible and has been accepted by a residential aged-care funded organisation and has their residential classification for high and low care, then funding will follow that, so that is fine. The issue around the age is a planning national benchmark where places are allocated and provided on the basis of 108 places per -

Mr MORRIS - Yes - a population basis.

Ms SUMMERS - and so that is where you get 70 cut-off, in the planning and allocation of places.

Mr WHITELEY - But not in the delivery.

Ms SUMMERS - That is right, the delivery, the entry and the eligibility is a different approach.

Mr MORRIS - So to some extent it is up to the ACATs to decide who goes into those places.

Ms SUMMERS - They have guidelines which quite clearly state their parameters for defining eligibility. It is more about looking at the balance between what is appropriate and what is the need. So it is seen as a last resort for a very young person to be identified as eligible for entry into what might not always be an appropriate placement but is the only thing available.

CHAIR - So would there be, do you imagine, an unserved group in the community who are avoiding making that decision of going to that level of care?

Ms BOLAND - That is an interesting question.

Disability and a lot of the acute health policies are about putting as much service into the home as possible to keep people out. So there is probably some on the cusp who are getting a high level of both disability support, perhaps HACC and some other things, but where they have a deteriorating condition like MS or whatever there would be some who clearly are cognitively fine who just don't want to go into that level of care. So it's a difficult issue, there is no doubt about that.

CHAIR - So you've done an audit -

Ms BOLAND - Yes.

CHAIR - and identified people who are in aged care but who shouldn't be, the people who could go there if there aren't alternative routes and tried to free the state-funded places as much as possible so you've got the say about who goes where?

Ms SUMMERS - That's a progressive issue around the strategic use because, as you can see, with Garden View and Cyril Jewel that is 21 to 37 or so in that particular one. Then you will find across Victoria we know of individuals who are located in public sector residential aged care. Some of it being at a location to be close to their families and knowing that they can get that support as well.

Mr MORRIS - Yes, that is certainly an issue for us. I guess that is part of being culturally appropriate; the closeness or most socially appropriate is the closest to family.

CHAIR - I suppose too economies of scale would have to come into it, wouldn't they? And that is going to be more of an issue for Tasmania than it is for you in that, okay, there might be some advantages of having like with like, if you like, in terms of facilities.

Mr WHITELEY - But when you get down to some of our rural areas -

CHAIR - Obviously you may have one person in a whole community who is in this position.

Mr MORRIS - That is certainly the case with May Shaw at Swansea. They only have one young person in the facility.

CHAIR - So then we come down to socially appropriate and age-appropriate room even, food even.

Ms BOLAND - Yes, food and not singing the war songs around the piano, they tell us.

CHAIR - Can you see improvements since you have been doing all this?

Ms MANCINI - We have a long way to go. The cost of support for these people is very high, so it's cautious as we go. We're just trying to look at opportunities and free up things like some of the public sector redevelopments that are occurring to see if we can use that as an opportunity. We have made some inroads.

Ms BOLAND - We've taken an approach that has looked at creating the specialist service, if you like, within the centre but we have also taken an approach that looks at individualised packages of support to provide additional social support or service to individuals who are fairly isolated. There might be the one or two in a particular service.

CHAIR - Have you found that some of the health professionals need to be educated to be aware, in a particular nursing home, for example, of the very things we were just discussing?

Ms BOLAND - Yes we have.

We do not have a programmed response to that but certainly when we have spoken to regions who, for example, are looking at putting in a package to assist an individual who might be in a nursing home, they do work with individuals in those services, communicate with them, look at the way they can facilitate changing practice by giving information or even sometimes secondary consultation.

CHAIR - Given that we are further back down the track than you are here, what would be the best advice you could give us in terms of recommending how Tasmania should tackle this?

Ms BOLAND - Given that your numbers will be a lot smaller, and what you were saying about the small rural thing, there would be real opportunities to use disability supports to improve the quality of life for people who are in isolated places because you are not dealing with high numbers. So in terms of getting them out during the day or employment opportunities, seeing families and so on, would be something I would really focus on.

If you have higher numbers in the cities I guess it is about other options. Do people really need that high level of medical support? What are your disability support and your community support providers? How linked in are they about planning for some of those people to have different options?

CHAIR - So a proper analysis, then -

Ms BOLAND - Yes.

CHAIR - to make sure to make sure that those who are there really need to be there?

Ms BOLAND - Exactly.

And if they do, then what can you encourage those aged-care facilities to do to have areas that are more age appropriate, where people with children can come. That should be available to older people as well. It is particularly distressing in some of the very quick conditions where women in their forties suddenly deteriorate. It is very distressing for the families I should imagine, so if there is more capacity to try and put the disability and illness aside and have a life - that is at the forefront and the disability second. Nursing homes tend to operate the other way around.

The other thing to remember is that most people who go to a nursing home only live for two years and these people can live for 40.

Mr Morris - That's right. They're the long-termers.

Ms BOLAND - Yes. So is there capacity in any of your disability accommodation to do things a little bit differently for some of that population. That is what I would look at.

CHAIR - Like a separate cottage on the same grounds?

Ms BOLAND - Yes. What are their medical needs? We want to keep on to the Commonwealth about funding for the medical needs.

The other thing that is really important is the community care review. I do not know if you are aware that the Federal Government has put out a paper called *The Way Forward*, which is about the HACC and high-level packages, and younger people with disabilities who are recipients of those packages. So they are really looking at their policies around that and how people are going to get access to that.

I know that our colleagues in other States have been waiting on this report for a long time and we thought they would wait until after the election but it has come out just last week. It is more of a statement of intent rather than strong decisions but it is really worth getting for your people.

Mr MORRIS - Charles is on to it already.

Ms BOLAND - It didn't go as far as we dreaded, which was that younger people with disability wouldn't get any high-care packages; that is what we were worried about.

Mr Morris - Okay, so it hasn't gone that far?

Ms BOLAND - It hasn't gone that far. It talked about tighter assessments -

Mr MORRIS - As they would.

Ms BOLAND - Yes, probably have to jump through more hoops but it hasn't ruled it out, has it?

Ms MANCINI - No.

Ms BOLAND - That is a paper and a strategy that you really need to link in with this and the pieces of work that we're doing with young people in nursing homes - we're linking those too. They are separate because one is community based, but they're strongly linked because if people can't get high-cost packages or cobble together their package of support needs then they head into hospitals and nursing homes, and that's not good for anyone.

CHAIR - So your advice is to proceed cautiously, to have a good idea of exactly who we're dealing with?

Ms BOLAND - And where they are.

CHAIR - And where they are.

Ms MANCINI - And recognising the differences between the different needs within the client group. People with acquired injury, for example ABI, if you put in some sort of assistance in the early days can reach a point where they can stabilise and are more likely to be able to move into the community.

Then you have a different client group who are going to have a deteriorating condition and have a different path. It is also a question about targeting.

CHAIR - I suppose as far as possible involving the person themselves.

Ms MANCINI - Absolutely, an individualised approach.

Ms BOLAND - Keeping them connected is really, really important to their wellbeing and for their opportunities outside. Because although they may when they enter be very ill and need a high level of support, if you can keep the connection with the family and their outside life going then there are often opportunities to move, when everyone is through the shock or whatever, into other less intrusive areas.

Ms MANCINI - The key part of this is to recognise that for a lot of younger people the idea of the nursing home has been the end. What we are trying to create is that in fact it might be part of a path that might lead back to the community or there might be stays in high care during a person's life. They might have stays in high care but they can go back. So we create a pathway.

Mr MORRIS - It's not just a one-way trip.

Ms SUMMERS - That's right, which is quite different from the aged care.

CHAIR - I think all over Australia there are facilities that are appropriate for aged frail people that they will need at the end of their life or some will need at the end of their lifespan, and for the want of something else younger people with disabilities have been placed in these institutions because we have not had any other facilities available. Expense is an issue I suppose too?

Ms MANCINI - Facilities and models of care, because I suppose the thing is that over time new programs have been created that have provided higher levels of support in a range of supports in the community that weren't once available. So we have opportunities that we can build on. We can create some sort of new program with those more flexible supports that weren't in existence before.

Mr WHITELEY - You talk about models of care across the world - do you have people in your department tracking trends of successful models?

Ms MANCINI - No, my understanding is that we have tried to do lots of reviews and what have you, but there is not really much out there.

Mr WHITELEY - That is what I was interested to know whether you've been tracking anywhere in particular?

Ms MANCINI - No, but certainly the ABI STR program is in fact a world leader. That is a slow-to-recover program that provides slow stream rehab support and facilitates reintegration back into the community for younger people who have had the experience of catastrophic head injury.

That program tries to identify people who are usually in the acute system and then provides a range of supports to enable a person to receive support, rehabilitation and clinical care that is over and above maybe what they would get in a nursing home and to provide that over a long period of time - a number of years - with the view that they should reach a level of functioning that is improved and may enable them to go back home into the community.

I think we have two reviews going at the moment. One is reviewing the program and how it operates and the other one is reviewing the clinical outcomes. I am not sure where we are up to with both of those. They are not complete yet. Certainly it is a good program. At the moment there are 130 people using that program.

Ms BOLAND - It has quite good outcomes of people not staying in hospitals and rehab.

Mr MORRIS - So it recognises that many with ABI will get better if the efforts are put in and won't get better if they're not.

Ms BOLAND - That's right.

Ms SUMMERS - And that there is always going to be a level of maintenance that follows on -

Mr MORRIS - Sure.

CHAIR - A level of which?

Ms SUMMERS - A level maintenance.

Mr MORRIS - But it will be a much lower level of maintenance because the more successful then the lower level of maintenance.

Ms MANCINI - This program is interesting because it provides funding to the individual according to needs. So it is not about a block funding to a service.

Mr MORRIS - Right.

Ms MANCINI - It follows the person where they are at and it also can move up and down as their needs to change.

Mr MORRIS - Who does the assessment of those needs?

Ms MANCINI - They have case managers who get allocated to an individual, but they would ask for special assistance and other assessments as required. Then they have a brokerage fund so they can purchase what is required. It has been quite successful and we will see what the review says.

CHAIR - What do you think the challenges are now from here onwards, not that this is any particular point in time?

Ms BOLAND - I think the Commonwealth/State issues they are the real challenge because, with the ageing population and the pressure on ageing and the Commonwealth giving that priority, the need to continue to provide financial support to this group is important. State governments don't want to pick the whole lot up; there needs to be a joint response. They have an innovation pool where we have done some joint funding, but the majority of it has come from the State, but still it is a good precedent for some of that. I think that is a challenge. And I think the other challenge is really just the whole way that policy is going around trying to maintain people at home in their community. That continues to be a real challenge because it is about transport, it is about family, it is all sorts of things. I do not know whether it is an issue in your State, but the Workcover issues of people going in to care for people in their own homes, the home as a workplace; there is a whole lot of -

Mr MORRIS - We haven't got to that one yet, but we will, no doubt.

Ms BOLAND - Yes. There is a whole lot of issues around that, and of course that is a challenge in relation to this group too.

Mr FINCH - Because people would want to take them on and care for them in the home without realising the implications and the complications of the process -

Ms BOLAND - That's right, yes.

Mr FINCH - and then maybe deterioration that occurs.

CHAIR - Do you find there is a big difference between what goes on with people who are compensable and non-compensable?

Ms MANCINI - Yes, probably.

Ms BOLAND - Yes.

CHAIR - Anecdotally, what would the difference be?

Ms BOLAND - The Transport Accident Commission - it depends on which point of compensation -

Ms MANCINI - It may be a TAC incident, yes.

Ms BOLAND - So if it is TAC, they do provide individualised packages of support. Anecdotally people have said that there is just greater access to more money, which

means you can purchase what you require, but even then they are limited by what is available out there as well.

CHAIR - So you would have all the spending money, but if you don't have the products to purchase -

Ms BOLAND - Yes, exactly.

Ms MANCINI - We are doing some joint work with them around some of their residential models that they build. We can buy places in there for people.

CHAIR - Okay. So they build a facility specifically for people they are looking after, but you may well have some citizens that the State needs to support who could well move in there as well.

Ms MANCINI - We have done some of that, yes.

Ms BOLAND - A useful model in rural or isolated communities particularly when you have small numbers of people in the different systems, and if you bring them together you can actually make a service bible.

Ms MANCINI - Yes, so we do not have to deal with the capital issues, just a package of support, so that has worked well.

CHAIR - Yes, that is great.

Ms BOLAND - We work a lot with them. Our disability support is moving towards individual planning and support, so we are moving away from funding programs into an allocation of a package to people that goes through this whole process of what it is, but about targeting, using money wisely to really assist them, and they are doing the same, although they are going a step further at TAC and wanting to give the funding to the person to manage themselves. We are not at that point yet.

Mr MORRIS - We do have both. We have a bit of that as well. Basically I think we are heading in the same direction, yes.

Ms BOLAND - Yes. So we have worked closely. They are changing their legislation.

CHAIR - With mixed success, I might add.

Ms BOLAND - Oh yes, they're tricky issues.

CHAIR - Particularly when you have other people determining how the money is spent within the family and not necessarily knowing what they -

Ms BOLAND - Yes, not necessarily the person. They are the real issues, aren't they.

Mr WHITELEY - They really need a plasma screen.

CHAIR - Oh yes, or an in-ground pool, stuff like that. So some clients I suppose would come into the system through Workplace Standards or whatever the State equivalent is?

Mr MORRIS - Workcover or whatever it is.

Ms MANCINI - Some people come through the court system, once they have had their compensation. When their compensation ends they also come back into our system.

Mr MORRIS - Right. Okay.

Ms BOLAND - Mostly it is car accidents and TAC, but the other group that grew a couple of years ago through Slow to Recover was the drug overdoses. There were a lot of people getting acquired brain injury, and there was also a group that picked up those hideous viruses over in Vietnam and places; young people just travelling around got encephalitis or whatever it was. There is a group of those as well.

CHAIR - That hasn't had a lot of publicity, has it.

Ms BOLAND - That is awful, yes. Terrible for the family.

CHAIR - Is this something that people can be inoculated against, or just bad luck?

Ms BOLAND - I think so. I think they are more aware of it now, but there was a couple of high profile ones we had where the parents are really agitating for a different response.

Mr MORRIS - Yes, sort of like a viral thing of the brain, is it?

Mr WHITELEY - Yes.

Mr MORRIS - We certainly don't know of any cases. That is something we will have to mark down to watch out for.

CHAIR - Absolutely.

Ms BOLAND - So those people don't get compensation, nor do the drug ones, so there was that group. I think the drug ones levelled off. They seem to have got a better handle on that, but there was a spate of drug overdoses a few years ago with terrible consequences for people.

Mr FINCH - I am just curious about that audit that you did, because we do not have anything like that.

CHAIR - Most of it is there readily available.

Ms BOLAND - I suggest you read the report, and then if you have any queries about how we did it we are happy to answer them.

CHAIR - That would be great.

Ms MANCINI - You can e-mail me any questions - she says very confidently.

Mr MORRIS - Great.

Ms BOLAND - Are you undertaking particular inquiries at the moment in Tasmania?

CHAIR - We have the Standing Committee on Community Development that issues like this come to. Tim Morris actually raised this. It is a particular passion of his, so it was referred to the committee and we agreed to take it on.

Mr MORRIS - So basically we will come up with some recommendations for the Government, and then they in time will respond to us.

CHAIR - And hopefully act on it.

Mr MORRIS - Yes.

CHAIR - One of the advantages is that we are a committee of both Houses and every political party is represented, so as far as possible we make our reports consensual so there is no argument when the ideas come up in Parliament, and it makes life a lot easier, doesn't it?

Mr MORRIS - That is the whole idea.

CHAIR - Thank you very much for your evidence.

THE WITNESSES WITHDREW.

Mr MARK ZENTGRAF AND Ms PAULA DIMAKOS WERE CALLED AND EXAMINED.

CHAIR - We are a committee of both house of Parliament from Tasmania and we look at basically community development issues through references that come through a variety of places. This particular one came through one of our members, Tim Morris, with particular interest with what was happening with younger people who, for a variety of reasons, were living in aged-care facilities and how appropriate that was and what we could do to try to improve the practice. And you people obviously have a lot of experience in the area. So if you could perhaps talk about what you do in a summary form.

Mr ZENTGRAF - We are from Melbourne Health which is one of our networks around Melbourne. We are a conglomerate of different facilities or campuses. Ours predominantly is Royal Melbourne Hospital, Melbourne Extended Care, North-West Dialysis Service, North-Western Mental Health, Victoria Infectious Diseases Reference Laboratory and we also have component of residential aged care which I manage and Paula if a facilitator of one of the facilities.

Mr FINCH - Melbourne Health, is that a State body or is it a private body?

Mr WHITELEY - No it's a State body. So this is all State Government.

Mr FINCH - Do you cover Victoria?

Mr ZENTGRAF - We cover north-west Melbourne as an area, as a service. That's our local community but our major hospital, Royal Melbourne Hospital, a tertiary hospital which gets referrals from across the State. So it is just opening a new major trauma service which will be equivalent to the old trauma service and so we -

Mr WHITELEY - So is Melbourne Health replicated in other areas?

Mr ZENTGRAF - Yes. There is Melbourne Health, there's Southern Health, there's Eastern Health, there's Bayside Health. So what they've done is really grouped campuses together, put them under the one board and management as well.

Mr WHITELEY - So they a part of the part of the Health department?

Mr ZENTGRAF - Yes.

Mr WHITELEY - They are not a separate business enterprise of the Government?

Mr ZENTGRAF - No.

Mr MORRIS - How separate are you or how high up are you in operating independently as such in terms of your administration?

Mr ZENTGRAF - I fit into a division of the organisation so we were a divisional structure. The whole organisation is divided into about six or seven divisions and we form part of the Ambulatory and Continuing Care Division which has only just been created in the last month, I suppose. I report through to the director of that division. So we fit in nicely and in that division we have the emergency department of the Royal Melbourne Hospital. We have all of the aged-care wards which sit in Melbourne Extended Care, which is another campus. Also we have ambulatory care, with patients at both Royal Melbourne Hospital campus and also the Melbourne Extended Care campus and residential campus. So we fit in right across the full spectrum.

We have four residential-care facilities that I manage. At the moment they total probably around 165 beds, although we do have more bed licences. We have a low-care facility at Melbourne Extended Care which is a 60 to 65-bed facility at the moment. We have just gone through a downsizing exercise in the past year because there was not as much call for low-level care at the moment. I'm not sure whether you are experiencing much the same

Mr MORRIS - Yes, exactly the same.

Mr ZENTGRAF - But it was 120-bed facility and was reduced down to 96 and we have now made it 60 to 65 beds. We also have three high-care facilities, one of which fits on the Melbourne Extended Care campus. That is Garden View House, which is Paula's facility. It's a 24-bed facility, but we only have 21 Commonwealth bed licences for it. It is for complex care and young, acute, non-compensable ABIs, which we have in there. We have another 30-bed facility called Boyne Russell House, which is high care as well and which sits out in Brunswick. We are currently increasing the complexity of that facility at the moment, which is not that much different to not for profit and private and this stage. But we are increasing its complexity to better fit into the needs of our organisation.

We have another 45-bed, high-care facility called Cyril Jewel House which has 15 MS-specific beds, which is also for the younger type client. When I say young, under the age of 60 or 65; those who require 24-hour care but who are able to access the community in some shape or form. So we have a specific 15 beds for that group attached to another 30-bed facility. So they have a separate wing.

CHAIR - How does that physically look different. Does it look physically different?

Mr ZENTGRAF - The design of that facility is fairly much the same. It is just that the rooms are slightly larger because of the needs of wheelchairs and those things. And there are more single rooms than double rooms. So in that wing, out of 15 beds there are two double rooms and the rest are single. So there are 11 singles. The 30-bed nursing home is separated into two wings of 15. So there are three wings, each with 15. But in the general nursing home there is five double and five single on each side. So the layouts are slightly different.

Mr WHITELEY - So even though there's separate wings, what communal facilities are there? They are all acting separately?

Mr ZENTGRAF - No. The 30-bed nursing home has its own dining room for the 30 residents there. And the MS residents are also able to able to utilise those facilities if they want. What we have found is that the MS residents themselves prefer to be a bit more separate, mainly because they are a younger group and have some different needs. So they do have their own dining area and lounge area as well. We have an activities or a leisure and lifestyle person who manages activities for the full 45. But we find they end up having separate programs which are more tailored to the different groups.

Mr WHITELEY - So there's not a lot of integration?

Mr ZENTGRAF - There's integration if they want to integrate but the reality is that is not forced, far from it.

CHAIR - The people who are there, is there a model that would better service them if you were able to provide it, if money was no object?

Mr ZENTGRAF - I don't think one model suits all. I think you have to look at all of the different models that are out there the suit the individuals. We are cohorting a particular group of clients who will be living away from possibly their own geographical area and their support networks.

CHAIR - So their needs are such that you couldn't support them in their local community?

Mr ZENTGRAF - You could as long as you had the right amount of dollars to support the care that is required. What you might be doing is replicating the same system over and over again, which might end up being more expensive than the cohort. For either model you make a decision which way you want to go and how much money you have and the type of quality of care you want to deliver. I'm not saying that our model is the best model by far; we are just saying that our model is -

CHAIR - My ears pricked up when you said, 'not necessarily in their geographical area', which must have implications socially.

Mr ZENTGRAF - Yes it can have, but I suppose the reason why a lot of people end up in our facility is because it is a specialised level of care for a specialised group of residents.

Mr FINCH - Can I just ask you a little bit about those people with MS. You said you have an allocation of 15 beds for them. What utilisation do you have of the 15 beds.

Mr ZENTGRAF - One hundred per cent utilisation.

Mr FINCH - So is there need for more?

Mr ZENTGRAF - I think, yes, there would be need for more. If they don't come into our facility and they required 24-hour care, they will end up in a generic nursing home, which in itself may be suitable as well. And part of our discharge criteria for people who end up in our facility is that at a point in time where their needs are no longer different from the generic nursing home resident then it is time for them to move on to a generic nursing home. So they do not have lifetime tenure. So they come in on a contract,

signed, fully aware that once their needs become more of a general nursing-home-type resident, that is a point in time that we look at exit. But I have to say -

CHAIR - That would be a hard decision sometimes, wouldn't it?

Mr ZENTGRAF - It is not being pushed at this point in time. In actual fact I had a discussion with Barry Furness from MS Victoria yesterday, who looks after the operation of MS beds, and they are looking at reviewing the exit policies for people within their respite and also their longer care facilities. Because we have a very close relationship with them, we are looking at the same exit policies. So we look at the type of supports that are required to ensure that this is a very smooth transition. Of course it becomes very difficult because cognitively there are a lot of changes in the individuals over the periods of time that they end up staying with you. And so their understanding of a contract may differ, come the time to leave. So, yes it is a difficult situation.

Mr MORRIS - With the people who are coming in there, are they coming mostly from the community or from nursing homes?

Mr ZENTGRAF - I think the majority have come either from the community itself or from one of MS's other facilities.

CHAIR - So you've provided quite a high level of care, then?

Mr ZENTGRAF - A very high level of care. Our staffing ratios for the MS wing is the same for those 15 beds as it is for the 30 beds, because they do have a higher need.

Ms RITCHIE - Do you do family satisfaction surveys, given you have a specialised service and some people I would imagine would travel quite a distance probably to see some of their relatives who may be accessing that service? Sometimes in Tasmania we get a bit regionalised and people feel it is too far to go an hour or two hours driving. Everyone wants this localised service but obviously when you have economies of scale and things like that you just can't, as you were saying earlier, repeat things all over the place. So do you get feedback through surveys or are there any other mechanisms you have for evaluating family satisfaction, that they are more than happy to, if they are accessing specialist services, to undertake that travel?

Mr ZENTGRAF - Anecdotally, the experience is that families are very happy because their loved one is being cared for and supported in an environment which is often 24-hour care. Often they have gone through that turmoil of having to look after them at home and not having anywhere to place them. But from the survey view point, we do move on audits which look at all of the standards across aged care, and that would include satisfaction of both residents and family. In general the satisfaction by residents has been reasonably good. But whether transport is specifically targeted, no, I'm not sure.

Ms DIMAKOS - It doesn't specifically target transport. But we do have people who travel from Benalla.

Ms RITCHIE - I was just interested because Tasmania is such a dispersed population. Are people happy to travel because the service is so good or it is so specifically designed for what their loved one needs, so it doesn't become an issue because this is what we need.

Ms DIMAKOS - That's what we find happens at Garden View House.

Mr WHITELEY - Would it be fair to say - I suppose you only know this out of your gut feeling but I suppose if a couple - parents - have been caring for somebody in a 24-hour situation, and the impediments that places on their own personal lifestyle, to have to travel a couple of hours two or three times a week in the overall equation of lifestyle is not such a big deal if they are getting good, high-level professional care. Would that be fair?

Mr ZENTGRAF - I think it is an interesting point and I think this probably pertains more to Paula's area which has the non-compensible ABIs. We have people from the age of 17 to 18 to the age of 65 in relation to that. As Paula just mentioned, we do have one person who is from Benalla.

Ms DIMAKOS - Well, the thing that happens is the parents share the travel. They actually do live in Melbourne for a week so they are stationed here and then one of them goes back home because they do have another son back in Benalla so it makes it a bit difficult.

Mr WHITELEY - But that would be an unusual situation for you at Benalla.

Mr ZENTGRAF - Well, no. The idea of this unit, for the particular cohort of residents that we have in there, is to give the individuals a two-year tenure within the nursing home. Some of them are actually able to get increased allied health supports during that time and we slow-stream rehab them. The goal is to actually get them back into the community or back home within a two-year period of time. In relation to that I think families are generally fairly accepting of having to travel, knowing full well that eventually, if all goes well, their loved one will end up going back home with supports in place or will end up back in the community with supports.

CHAIR - So what is this area you are in, Paula?

Ms DIMAKOS - Garden View House.

CHAIR - What happens there?

Ms DIMAKOS - It is a 21-bed residential-care facility and predominantly we cater for people with acquired brain injuries and neurological disorders from the ages of 18 to 65. There is a limited tenure of two years and the criteria also state that we do look after three tracheostomies, which is quite unusual for a residential care facility to be able to provide that type of care.

CHAIR - So that normally would be done in the hospital

Ms DIMAKOS - Yes.

Mr MORRIS - So it is highly focussed on rehab.

Ms DIMAKOS - Slow-stream rehab.

Mr MORRIS - Right. Slow-stream rehab. Can you extend the two years - if good progress is being made -

Ms DIMAKOS - Yes, we have in the past. Yes, we can.

Mr MORRIS - Right. So it is there another six months.

Ms DIMAKOS - That is right because the aim would be to get them back into the community, so that wouldn't be a problem to extend it.

Mr ZENTGRAF - And by that time they will have declared themselves predominantly one way or the other.

Mr MORRIS - Yes.

Mr ZENTGRAF - So if they require a bit more then you have the ability to extend it, but if it looks like they are not going to benefit anymore and really they are going to be more of a long-term nursing home care then we would be looking for that sort of placement.

CHAIR - Which I imagine would come down more to someone's mental attitude than simply their medical condition, would it not?

Mr ZENTGRAF - Probably a bit of both, yes.

Mr MORRIS - So the transition then is from Garden View to -

Ms DIMAKOS - What happens is we do have discharge planning. We have two years so goals are obviously identified earlier on in the piece. The first six months or year helps us determine whether we aim to have that person back home or whether we have to start wait-listing with nursing homes. If we do aim to have them back home we need to identify the sort of packages they need to take with them. If they are under the State care program then that goes with them but if they are not then we need to start applying for a first-home package or whatever is appropriate.

Ms RITCHIE - So is that very intense two-year period where you are trying to ascertain which way the person is going to go, I guess.

Ms DIMAKOS - It is intense, yes.

Mr ZENTGRAF - Their daily calendar is always pretty full.

Mr WHITELEY - So your percentage coming out at the two-year point is pretty high?

Ms DIMAKOS - We have had a lot of movement this year. I have been there for almost three years and we have had about five people go back to their family home.

Mr MORRIS - Percentages discharged from which direction?

CHAIR - That would be so variable because if you look at 25 people you could skew it statistically so easily.

Mr MORRIS - How long have you been going?

Ms DIMAKOS - This criterion only commenced at Garden View from the year 2000 so prior to that it was under a different criterion.

Mr MORRIS - Right.

Mr FINCH - So is your centre replicated throughout the other areas; you are with Melbourne Health, are you?

Ms DIMAKOS - That is correct, yes.

Mr FINCH - Okay. So your work is replicated throughout those other divisions?

Mr ZENTGRAF - No, Garden View is very unique and so is Cyril Jewel. They are both very unique models in Victoria and probably Australia.

CHAIR - Just to fill you in a little bit, we have got individuals living in nursing homes dotted around Tasmania and our concern is should they or should they not be there. What we are also looking at is almost a transition house for someone who has acquired a brain injury or has some other condition that needs all the help you can give them and at the end of that time, then, you are making the final decision - back home, aged-care facility, whatever - so this is not a static situation at all.

Mr ZENTGRAF - No, except those who arrived prior to 2000 remain there. They have lifetime tenure.

Mr MORRIS - Right. So how many have you in that situation.

Ms DIMAKOS - At the moment eight, I think.

Mr MORRIS - Right. So in fact the five who have returned home is quite a high percentage of your throughput as such? Yes, so they are, in some ways, the real successes, are they not?

Ms DIMAKOS - That is right.

Mr MORRIS - And if you have only got half the facility available anyway for those who are not permanent, you have only had 20 to 25 or so of the non-permanents in since 2000 who you have been dealing with?

Ms DIMAKOS - I have not actually got the statistics. The question is do we have 25 -

Mr MORRIS - Of the available beds for those whom you are intensively working with, how many have come to live within the facility over the last four years?

Mr ZENTGRAF - With the limited tenure?

Mr MORRIS - With the limited tenure.

Ms DIMAKOS - Over the last three years?

Mr MORRIS - Three years.

Ms DIMAKOS - I would say half, I guess.

Mr MORRIS - Yes. But how many individuals would that be?

Ms DIMAKOS - I would have to get that figure.

Mr MORRIS - They have got a maximum tenure of two years but some do not even stay that long?

Ms DIMAKOS - Some do not, actually. We have got some that will be going home a little bit earlier than that.

Mr ZENTGRAF - Some have died.

Ms DIMAKOS - And some have passed away, that is right.

Ms RITCHIE - What about the waiting list? Given you have got the 25, and you have still got nine, how long on average - I know it is probably a difficult question - would other people who are waiting to access this very specialised service be waiting to get in?

Ms DIMAKOS - That is a tricky question. I will let Mark answer that one.

Mr ZENTGRAF - We would look to take from our own area first into our facility -

Mr WHITELEY - And the waiting list for your own area would be?

Mr ZENTGRAF - It will vary. You may not have anyone initially, or you may have five people waiting and then we would look from outside our own area, which would obviously have a bigger pool.

Ms RITCHIE - So you would have a disadvantage then if you are wanting to access the service and you live in an area outside your specific -

Mr ZENTGRAF - Not necessarily. It is like any other nursing home. It can be just a matter of luck at that particular point in time.

Ms RITCHIE - But if two clients applied at exactly the same time, the advantage would be given to the person who lives locally in the area that you cover. Is that what you are saying?

Mr ZENTGRAF - What I am saying is, yes. Can I just say it is not a policy. It is just a guideline that we would preferably take someone who is in our own area because it

makes a lot more sense to have someone who is geographically located, just for their own family and themselves.

Ms RITCHIE - But having said that, there is no-one else that does what you do, though?

Mr ZENTGRAF - No, that is right. Not to the extent that we do it. Not with the numbers. There may be nursing homes or other facilities which may have one or two of this type of resident but not to the point where there would be anywhere between eight and 10 at any one time.

CHAIR - If you had an open cheque book and you were sent down to Tasmania to get the best situation for young people with disabilities who are currently being sent to nursing homes for want of a better facility, from scratch how would you start it up? What are the important foundation stones to put in place, do you think?

Ms DIMAKOS - It depends what the funding system is going to be. If it is a residential funding system -

Mr WHITELEY - Let us say you have a blank piece of paper, you can write it.

Mr ZENTGRAF - Basically I would be wanting to know what the individuals and the families want and not set up necessarily one type of facility. Once again, I think you need to have many options. Once again we are just showing you one model but there is probably hundreds of models out there that you could work. Some people are actually going to benefit maybe from living on their own or with any supports. Others may well benefit from living in a group environment, but a small group environment, with supports. Others may benefit from having cohorted expertise and living there for a period of time with supports.

CHAIR - As in this situation.

Mr ZENTGRAF - And you may want to have all these different models to transition from one to the next; that is how I would probably view it. You would probably want to have people assessed by experts in a particular area to see whether they are going to make gains or not. Then from there you might want to channel out to more specific or more appropriate types of accommodation for them further on down the track. Certainly I think inappropriateness in aged care is probably a point that you are all trying to make. Having one young person in an aged-care nursing home I would agree with is not necessarily the most stimulating environment for a young person but if you cohort them and then channel them to different facilities or different community circumstances which may benefit them and their families, it is probably the way to go. It will cost a lot.

Mr MORRIS - It already costs a lot.

Mr WHITELEY - Are you saying that in an ideal world, another multiplication of the Garden View concept across Victoria would be of enormous benefit? We are not here to question Victoria's situation but you are obviously saying there is need there and if the magic wand could come out that would be great.

Mr ZENTGRAF - If you look at Slow to Recover and what they are trying to achieve, and they have done a fantastic job I think in supporting non-compensable ABIs, I would not know the exact numbers but there are probably 50 to 60 people still waiting on the list to have supports in place.

CHAIR - And inevitably there would be deterioration while you are waiting, I would imagine, if someone who needs rehab -

Mr ZENTGRAF - Depending on where you are. I think if you are in a nursing home, yes, because you are not funded for that, particularly if you are in a private nursing home. Whether it be public or private, I think there will end up being a level of deterioration unless there are extra funds there to give additional allied health support during that time. It may not even just be allied health support; it might be personal care attendants because the work is very heavy.

Mr WHITELEY - Can I just ask a question about the exit process. Hypothetically, two years comes, and you said you can go this way or that in the sense of being assessed as being suitable for generic care, into a nursing home, or back into community care. When you say community care, do you mean going back into their own home with a support structure? Is there anything in between? What are the options in the middle here?

Ms DIMAKOS - There are CRUs, community residential units, that we have moved one person into so that is -

Mr WHITELEY - So they live by themselves or in a group?

Ms DIMAKOS - It is a community house but it is 24-hour care by personal carers and they share that house with six people, so the people with disabilities can access that.

Mr WHITELEY - It is sort of like a big home with 10 bedrooms and each have got their own room and the carers have their own rooms.

Ms DIMAKOS - That is right. They have some communal rooms of course but they do have their own bedroom. That is correct.

Mr WHITELEY - But they eat together.

Ms DIMAKOS - They can if they choose to.

Mr WHITELEY - What did you call that?

Ms DIMAKOS - Community residential unit. The waiting lists are huge for that.

Mr WHITELEY - What would be the ratio of care to client there?

Ms DIMAKOS - I think they work it out in regard to the needs of each client in that unit, so I really -

Mr MORRIS - So they are individual packages and they combine to purchase three carers or whatever?

Ms DIMAKOS - I think so, yes.

Mr WHITELEY - Okay, so that's one option. Are there others?

Ms DIMAKOS - Depending on the functional gains that they have made and what that person can do. We had one person that we discharged to a Salvation Army unit that has a support worker, but this person was able to make some high functional gains, so they can walk and talk and be able to do certain things for themselves. So from high level they actually left the unit requiring low-level care, so it really depends on what sort of gains they make, yes.

Ms RITCHIE - So is that where the majority of clients are actually ending up, waiting for some sort of community care? So you have at one end a number going into nursing homes, young people going into nursing homes, and at the other end some actually progressing well enough to go back home and live relatively normally with mum and dad or other relatives. But are the majority of the clients - because I just noted that you said there were huge waiting lists for community group homes, what we call group homes, or whatever you want to call them - actually in that category?

Ms DIMAKOS - Currently no, because currently we have the majority that can go back home. They have the supports at home, like family members who want to take them back home and be a primary carer with a support package, or the Slow to Recover goes home with them, yes.

Mr WHITELEY - It is a very individual thing, isn't it, as you said. I suppose in an ideal world every model of care for every individual is probably potentially different, if you were precise enough, which is a policy nightmare.

Mr ZENTGRAF - Exactly. If you had all the money in the world -

Mr WHITELEY - Let's be honest, it's a policy nightmare.

Mr ZENTGRAF - Exactly.

CHAIR - It sounds to me though that what you are saying is: understand the client very well; make sure the level of assessment of their needs for the short term and long term is done by experts, so that you really do see, particularly with slow to recover people, that those gains may be small and incremental but they will be there with the proper treatment; and then never see people as static, but that what might be an appropriate accommodation model now may not be the same in five years or even ten years, and keep flexible and talk to all the different sectors about money. Is that the message I am getting?

Mr ZENTGRAF - I think there needs to be a combined response across all levels of government around addressing the issue, so it is not a Commonwealth and it is not a State and it is not a local government issue, it is an issue for all of them. That is difficult in these days where everyone is struggling for the buck, everyone is looking for other ways of trying to get things paid for, and I think basically there needs to be a removal of

those tiers of the three levels of government and the dollars spent in a very smart way. I am not sure how you do it. I am not even sure that it is possible.

CHAIR - It certainly sounds like something to aim for.

Mr ZENTGRAF - I think in an ideal world that is how you would attack the problem.

Mr MORRIS - We have our assessment work essentially done by our Aged Care Assessment Teams. Now they have the name 'Aged Care' Assessment Teams. Do you think there is room for establishment of a sub-specialty within that general area whereby we have perhaps a young person assessment team as opposed to an aged-care assessment team? Would that give us any better value, because at the moment our situation is that a young person can assess the ACAT team. They can be assessed and can qualify for a nursing home. Is it appropriate that we actually have people who are better trained at working with younger people who are not dealing with frail-aged issues, or are dealing with far more complex issues being analysed? I don't know whether they are getting the proper analysis because of that. The people who are doing it are aged assessment specialists rather than specialists in dealing with younger people. I don't know whether you have the same situation here, whether your initial assessments are done by ACATs or -

Ms DIMAKOS - They are.

Mr MORRIS - And do you think that is working fine, or do you think there is need for improvement there?

Ms DIMAKOS - What happens is they are actually quite cautious in approving an aged-care client record for someone who is under the age of 65, so they would always be careful before they sign off, depending on where they are going to be transferred to, if it is a generic nursing home, so they don't take it very lightly in regard to approving an aged care client record for someone who is 20 or 40 or something like that. So whether or not they need more training or there needs to be something different -

Ms RITCHIE - Is that where you were coming at it from, Tim, in terms of their understanding the mental and, I suppose, physiological aspects that go with young people as opposed to older people, and are you aware of whether or not their training involves those things?

Mr MORRIS - Yes.

Mr ZENTGRAF - I am not sure if I can answer that.

Ms RITCHIE - Yes, it is probably something to take up at home.

Mr ZENTGRAF - I would have thought that they would be measuring things in accordance with the RCS and the guidelines that are set out, and I don't think it will distinguish between young and old. It is really just around care need and care type.

Mr MORRIS - Right.

Mr WHITELEY - But I think your comment about them being more cautious -

Ms DIMAKOS - They are cautious.

Mr WHITELEY - I mean, let's talk honestly. I think they would need to be, because they have to justify taking an aged-care bed from a person over 65, so they would need to be far more cautious and need to be able to justify that allocation, wouldn't they?

Mr ZENTGRAF - I am just wondering if it also sits around whether they should be looked at as requiring disability services as opposed to aged care, and so we are going through that cost-shifting again on a few points.

Mr WHITELEY - Yes.

CHAIR - If I were in that area, I would be wanting to make sure my client got as many dollars as they possibly could, and if that involved qualifying for an aged-care placement I would be pushing it, if I were a worker, because there would be more money there.

Mr MORRIS - There might be more money, but there might be less appropriate care.

Mr ZENTGRAF - There might be more money, but it is not going to meet the level of care that is required. You will run at a loss. We run at a significant loss.

Mr WHITELEY - When you take young people?

Mr ZENTGRAF - Yes.

Mr WHITELEY - That is an interesting comment. Why is that? If they have met the criteria that is other than age, basically equivalent to somebody in need of high-level aged care, why do you make the comment that it costs a lot more? What is different?

Ms DIMAKOS - It is not mainly the RCS. It is mainly the ratios that we have are higher, and all the clinical -

Mr WHITELEY - Okay, for younger people?

Ms DIMAKOS - Yes. Well, it is for the -

Mr ZENTGRAF - No. We do not have 1:7, 1:8, 1:15 ratios in our areas for our nursing homes, because our residents are far more complex than just your generic not-for-profit private nursing home. We also do not have any personal care attendants working in any of our facilities, mainly because of the industrial nature of our being attached to a public facility, so therefore we are only allowed to have Division 1 and Division 2 nurses. Therefore we cannot cut our costs back. We work under a different management structure as well, because under the EBA as well we are required to have facility managers in each facility, which are grade 6 and grade 7, and then we have after-hours coordinators on our off sites as well, whereas if we were in the private sector we might be able to get away with one director of nursing and managers. So we have other costs that are associated. The nurses who work in the public sector get paid more than the nurses who work in the private sector, and also there is a disconnect between the

Commonwealth and the State EBA. The Commonwealth don't become involved, so there is no increase in Commonwealth funding to increases in EBA.

Mr WHITELEY - Good point. I hadn't thought of that.

Mr ZENTGRAF - Neither the two meet, so the State ends up supporting the facilities, because the Commonwealth funding is not able to meet the needs, but it is not only around the complexity that we have. I think you have seen the reports anyway going out from the Hope review and that sort of stuff. A lot more facilities, even not-for-profits and privates, are finding it a lot tougher now than they were.

Mr WHITELEY - Can I ask a question about the composition in the State of the provision of care, public versus private? I am just a little confused. Obviously with the private situation, we heard about TAC and so on. What is the composition? How does it all work for State versus private? What is out there in the private sector? How is that funded?

Mr ZENTGRAF - I'm not sure that I really understand the question.

CHAIR - Are we talking about compensable people who -

Mr WHITELEY - Well, are there private operators out there dealing with -

CHAIR - Rich people.

Mr WHITELEY - Yes, I suppose that is fair enough. I mean, what's out there?

Mr ZENTGRAF - There is the TAC, which is a prime example.

Mr WHITELEY - Where there is compensation?

Mr ZENTGRAF - That is correct.

Mr WHITELEY - But what about others that -

CHAIR - Say if you were Kerry Packer.

Mr ZENTGRAF - Well, there are other private providers out there where you could go in for rehabilitation.

Mr WHITELEY - Are there private operators where you broker? You mentioned the Salvation Army, but that would be an individual support package that was then paid to them. So there are plenty of private operators?

Ms DIMAKOS - That is right, and we need to access them, to bring them into family meetings and that is how we make a decision on what we utilise and what is appropriate for that individual.

Ms RITCHIE - What do you think are the pros and cons as in why wouldn't the Government then look at what you are saying? You indicated that it is much more expensive for the

State to run certain facilities than it may be for private operators, so what advantages is the Government getting by running its own State facilities? Why wouldn't we just hypothetically say, 'Okay, let's get all the private operators' -

CHAIR - I thought you were a good socialist.

Laughter.

Ms RITCHIE - No, no, I am just asking a question.

Mr WHITELEY - It's an obvious question.

Ms RITCHIE - I am sure there are many advantages, that is why I am asking for them. I am just asking what you think.

Mr ZENTGRAF - I think it is a good question as well, and it is only an opinion that I give you, but I think that if you left it to the privates to do what we were doing, these particular individuals would still be in the hospital.

Mr WHITELEY - Right. Qualify your statement.

Mr ZENTGRAF - Okay, so what would happen is they would still be in acute or subacute, because there would not be the funds for the private or not-for-profits to be able to take this client group and manage them, because they would run at a loss.

Ms RITCHIE - So it is a money-making issue, basically, turning the profit?

Mr ZENTGRAF - No, it is not turning a profit at all. It is actually just trying to have something to break even. It is being realistic about the type of level of care. One has to step away from dollars and quality. Sometimes you have to make the decision that if you want to offer a quality service it is going to cost more, and so I do not think it is around profit. I just think it is underfunded, and the reason why the not-for-profits and privates are not - well, I should not even put in the not-for-profits, because the not-for-profits will take this client group if they can, but the privates are a business themselves and they at least want to break even or make a return on investment, whereas this client group, with the care needs that they have and the amount of funding that they get, will not be able to make that.

Ms RITCHIE - I was just going to ask if I could get perhaps a further distinction, if we leave the State out of it, between the not-for-profits and the private, is there a gap there? Are we seeing the lowest quality of care being offered by the privates? Maybe they are not going as far as the not-for-profits perhaps because they have that desire to make a profit, even if it is a small margin that they want to make?

Mr ZENTGRAF - No, I don't think you can make that distinction. I think they offer quality care as well, and if you look through the web site, I am sure you will find they are all doing very well in relation to the standards.

CHAIR - But it is unlikely that someone whose needs are very extensive would there?

Mr ZENTGRAF - I would say it would be unlikely that they would go there.

Mr WHITELEY - I am a little bit confused, because if we go to a model where the funding is transportable, in the sense that your need is assessed at x level and therefore requires y money -

CHAIR - You are not getting y ?

Mr ZENTGRAF - We do not believe we are getting y .

Mr WHITELEY - Yes, this could become very complicated. At the end of the day you have a bucket of money made up of however it gets into the bucket, I am going back to Alison's question: if that same bucket of money was disbursed out, same level, out to private, non-government and State, your intimation earlier was that these non-government and probably private organisations can provide, because of some limitations that are placed on you that are not on them, that cheaper. They are not paying as greater wages.

Mr ZENTGRAF - Yes, they will have a different staffing structure which -

Mr WHITELEY - That is right. It has an impact on dollars.

Mr ZENTGRAF - That is right. I understand what you are saying but then -

Mr WHITELEY - We could argue all day that it is not enough. These guys are saying it is not enough. I am sure they are out there saying the same thing but if you have got -

CHAIR - But he is actually running at a loss.

Mr WHITELEY - Well, no you are not.

CHAIR - Yes, he is. He has said, "We are running at a loss."

Mr WHITELEY - You cannot be running at a loss. In theory he may but in practice he is not because he does not have an overdraft, so it is taxpayers' money that has to be funded. At the end of the day he is half right, or you are half right, because there is no such as a loss in government. That money has to be found.

CHAIR - That is not what you say on the floor.

Mr WHITELEY - I think you understand what I am saying though, do you not, by the look on your face. I am sure you are doing a brilliant job. I am not suggesting for one minute that you are not but you have privates over here and your non-governments and your Salvos and Anglicans and whatever over here. You said earlier that because of restraints on you that are not on them that it does not cost them as much to deliver a service. I am not going to get into an argument of whether they do it better, but is that right?

Mr ZENTGRAF - They have less overheads.

Ms RITCHIE - But they are not delivering the same services, though.

Mr ZENTGRAF - So you cannot compare apples with apples.

Mr WHITELEY - No. You cannot with anything can you but -

Ms RITCHIE - But from what I am gathering the higher level stuff is coming your way, whereas these other operators -

Mr WHITELEY - Because they are able to.

Ms RITCHIE - Yes. But it is because of the cost issue as well.

Mr WHITELEY - Because they are able to because - do not take this the wrong way - they have an open cheque book. There is no such thing as a loss.

Mr ZENTGRAF - We do not actually have an open cheque book, but you are right. We get underwritten.

Mr WHITELEY - That is a good word. We are not saying you are not poor managers.

Mr ZENTGRAF - No, but the reality is we still need to manage towards a particular budget. We recognise that for our four facilities last year we budgeted for a \$2.8 million loss. That is four facilities, 160 beds.

Mr WHITELEY - I am not having a crack. I am just trying to make a point based on your ratios, based on EBAs versus all that. The point is well made, Alison.

CHAIR - It still does not work, but never mind.

Ms RITCHIE - I am actually failing to see what your point is.

Mr WHITELEY - You were half going that direction anyway. You were going to that end anyway. That is what you were asking.

Ms RITCHIE - I just wanted to get an indication of why, perhaps, if this money was -

Mr WHITELEY - It is a Labor thing but it is okay.

Ms RITCHIE - If this money is so short it is obviously not working -

Mr WHITELEY - It needs more money, does it not.

Ms RITCHIE - Yes.

Mr WHITELEY - It does not matter who gets it.

CHAIR - Thank you very much for your time. I appreciate it.

THE WITNESSES WITHDREW.

Mr TOM WORSNOP, MANAGER, BRAIN SERVICES INJURIES UNIT, MELBOURNE CITY MISSION, WAS CALLED AND EXAMINED.

CHAIR - Thank you for coming.

Mr WORSNOP - Are the terms of reference about nursing homes or are they broader?

Mr MORRIS - It is broader. It includes residential support for people with disabilities.

CHAIR - Some of us have read a paper about Melbourne City Mission. It had some case studies attached. I cannot remember the names.

Mr WORSNOP - I think the reality is for over 20 years or so there has been lots of stuff written about this issue. It is actually about achieving some outcomes. That has been the big problem.

CHAIR - Yes. So if you would just like to take some time to give us an overview of what you are involved in, trends, models, what you think is working.

Mr WORSNOP - I have not prepared a spiel or anything particular so I can just give you a bit of a background in terms of what we do and how we intersect with this issue. I manage the Brain Injuries Services Unit for Melbourne City Mission, so the particular focus is people with brain injury. We have a range of services, including a statewide case management service which particularly focuses in on that group of people who have been in the acute system or in the rehab system but their level of need is too high normally to cope with in terms of the disability system so there is a specialist case management service working with people 18 to 65 primarily who have a high level of need, and a significant amount of that need is about trying to find appropriate accommodation for them.

We have been doing that since 1993 with this particular focus. One of the big issues that has come up in our work has been this issue of too many young people being in nursing homes and aged-care settings rather than in disability-focussed or age-appropriate settings. So one of the things we did was initiate, together with a range of other people - you have probably met some of them already - this Young People in Nursing Homes consortium to try and actually figure out what the issues were and then try and progress some sort of an alternative approach to these young people's needs. So my main focus has been the brain injury group but we have a fair bit of experience now through our case management services of the range of issues that come up for these young people.

I think that most of the issues are fairly well known. The aged-care system is not an appropriate setting for a whole range of reasons but primarily it does not have a rehabilitation or a disability focus at all. It also is funded at too low a level to really provide people with the needs that they require, and because of the age inappropriateness of the settings then all the focus of the services are not towards this group. They are towards a different group.

Mr MORRIS - They are a minority within it.

Mr WORSNOP - I think one of the things that has been quite clear to us, working with young people in nursing homes, is that nursing homes have two distinct functions. One of them is the palliative end-stage care for the other group of people who are in them. They are not necessarily just young people but that whole approach which is about supporting people who have nursing-home level support needs. There is not an alternative in the State system that actually provides that. I think there are people over 65 who are also in that category too but primarily we are concerned with the 6 000 or so across Australia who are under 65. The case management service has been able to, at an individual level, find alternative accommodation for individuals whom we might be working with but the scale of numbers is against us -

Mr WHITELEY - This 6 000, Tom, is that ABI?

Mr WORSNOP - No, that is all young people under 65. You can start to categorise that group I know but the reality is that it is the same issue for people who are 64 as for people who are 24, really. The aged-care system is not catering for their needs properly. One of the things we have got in Victoria in the ABI sector is this Slow to Recover program.

Mr MORRIS - We talked about that earlier this morning.

Mr WORSNOP - So that is one of the few State-funded disability support systems that actually is able to go into aged-care settings. One of the major problems is this blockage between the Commonwealth system of aged care and getting young people with disabilities in that system access to the State-funded disability support systems. There are only a few of those programs that actually in Victoria will allow State-funded systems in them.

CHAIR - Yes, I was trying to get to that with the last people we spoke to because Slow to Recover people are allowed in there. Is the aged care sector saying, 'We do not accept people for whom there is a good rehabilitation outcome'? Is that what they are saying?

Mr WORSNOP - No, with the Slow to Recover program that can be delivered in an aged-care setting.

CHAIR - But usually not, is your implication. It is only that particular program.

Mr WORSNOP - That is one of the few programs that are State funded that actually allow people to get access to the State system while they are in an aged-care setting.

Mr MORRIS - Yes, while they have got Federal funding for their accommodation.

Mr WHITELEY - They are federally funded for their bed. They can also access the Slow to Recover money.

Mr WORSNOP - Yes, that is right.

CHAIR - So does that create tension on occasion whereby there is some kind of pressure, if you like, on the individual or that individual's family to make sure that they get assessed suitable for aged care because of that need to get accommodation, though it may not be the appropriate place? Do you see where I am coming from?

Mr MORRIS - So that they are not fully relying on the State for payment.

Mr WORSNOP - That is, I suppose, one of the big questions. One of the outcomes of the Chris Fyffe document was that the mechanism for getting into the aged-care system through ACATs assessments and all that sort of stuff in no way intersected at all with the assessment work that is done to get into the disability system. Therefore you have been streamed into one or the other and once you are in the aged-care system you are lost to the disability system apart from services like ours that are funded to go into the aged-care system and find people. The other mechanism is that there are some individuals out there, particularly GPs or people who work within the aged-care system, who actually come across young people who are referred because of their reputation. Young people are in aged care and through that process they then get referred into case management services like us, for example. It has really been a problem because people, once they are in the aged-care system, get lost to the mechanisms that are available.

CHAIR - No-one is in there advocating for them or saying perhaps you should not be here.

Mr WORSNOP - That is right.

Ms RITCHIE - Is it because disability and ACAT do not seem to be able to interconnect at all because of our cumbersome government structures, that one lot will not talk to this lot?

Mr WORSNOP - There is the political dimension to it, which is that the Commonwealth Government is saying, no, young people with disabilities are a State responsibility, but the State is saying we would take it up if we had the resources so the Commonwealth has to give us more resources. There is that political dimension and we have been around and around that merry-go-round for years. The other point though is there actually needs to be some political leadership to change that. The State systems have been saying we would like to do something about this. We have been saying the Commonwealth needs to take some leadership to create a policy capacity because it is the same problem in every State of Australia. It is not as though it is any particular State government that is the problem. There has to be some leadership to actually solve this across the whole of the system. There has not been any real response from the Commonwealth in terms of taking leadership to say, okay, this is a broader question than just one State versus one Commonwealth department.

CHAIR - You could argue then that the idea of an ACAT or ACAS assessment should not even be applying to someone who is 20?

Mr WORSNOP - The response we get back from the ACAS people themselves are that they do not have appropriate assessment tools for people who are young.

Mr MORRIS - That is what I was trying to get at before.

CHAIR - So in a way it should almost be a completely separate situation whereby a young person is assessed by seeing an individual with expertise in their area or some understanding of age and cultural-appropriate settings.

Mr WORSNOP - Yes. What we are finding to is that some ACAS teams are saying we are going to refuse to assess people anymore because we do not have the appropriate tools. If we keep on assessing them all that will happen is that we will re-create the problems for the young people going into the aged-care system. Other ACASs are saying there is not an alternative so if we do not assess them they will be stuck in somewhere much worse than an aged-care bed.

CHAIR - Perhaps a hospital, even.

Mr WORSNOP - Yes. And there is a reason to keep people in hospital because they are very expensive beds and then that requires a solution. I think there is a real dilemma for ACAS teams in terms of whether they do or do not assess young people.

CHAIR - We already have the expression 'bed blockers' used to described older people for whom an aged-care position is appropriate, let alone people who are 18 or 20.

Mr MORRIS - Yes, who are still in the acute sector. I presume we have quite a number.

CHAIR - I do not know.

Mr MORRIS - We do not know. We really do not know but we do know that our hospital system is grinding to a halt at least in part because they cannot discharge appropriately.

Mr WORSNOP - Going back to the Slow to Recover Program, that was set up specifically to try to achieve outcomes for a group of people who were in the acute system. To be able to enter into the aged-care system even they required some rehabilitation supports that would be flexible enough to meet their slow recovery needs. That was set up but that is also grinding to a halt at the moment because of funding issues there. We have seen the numbers slowly increasing in this target group over the years. There was a glitch last year. When Chris Fyffe put the report together it looked like there might have been a plateauing of the increasing numbers of young people in nursing homes, but the figures this year have increased again.

Mr WHITELEY - It sounds like something might not have been quite right there last year. If it was unusually down and then suddenly it has gone back again, it sounds like there was a bit of a -

Mr WORSNOP - It wasn't going down, it was sort of plateauing a bit. I think there was just some unusual configuration.

CHAIR - That's right and people are surviving car accidents and traumatic operations that used to kill people - that is the other reality, too, isn't it?

Mr WORSNOP - Absolutely.

Mr MORRIS - Which is because our medical system has become faster and better, I suppose.

Mr WORSNOP - People are surviving with much more serious injuries and for longer periods of time they have to be looked after, that is for sure.

The other issue that goes on with the ABI sector of course is the compensable versus non-compensable system. I am not sure how it works in Tasmania, whether it is the same as here.

Mr MORRIS - Virtually the same as here, from what we understand. We have the Motor Accidents Insurance Board and Workcover, which are the two organisations, apart from perhaps any private insurance arrangements. We haven't really touched on that side of things yet. We are aware of it. It tends to be the non-compensable that we have really been dealing with. We don't know a lot about the compensable ones yet, do we, except that funding isn't such a problem.

Mr WORSNOP - That's part of it, too.

CHAIR - But even if you have the funding, that doesn't necessarily mean you can find the services you want.

Mr WORSNOP - I think in Victoria anyway the TAC system and the WorkCover system, because of the way they operate, they say that there are no young people in the compensable system in nursing homes. I don't think that is completely true, but they have achieved purpose-built accommodation because of the funding they have access to. There is still a lot of that work going on year by year.

Mr WHITELEY - Is that a single facility or are there a number of them across the State?

Mr WORSNOP - There is a whole range of different things.

Mr WHITELEY - The TAC has funded?

Mr WORSNOP - Yes. Because the legislation requires the TAC to fund around the individual, it is a much more complicated process of trying to get conglomerate outcomes for a group of people, but that has been achieved.

Ms RITCHIE - They have even entered into some sort of partnership arrangements with the State, haven't they, taking on some other clients, I think we heard earlier?

Mr WORSNOP - Yes.

Ms RITCHIE - Do any of the NGOs tap into that?

Mr WORSNOP - It is a starting point at the moment. There is one service that they are celebrating at Beaumaris.

Ms RITCHIE - We are going there tomorrow.

Mr WORSNOP - That took a lot of work but there are both compensable and non-compensable people going into that service. It took the TAC kicking and screaming to bring the Department of Human Services to the table to get the public people in there as well. It is just that the discrepancy between the funding levels is enormous. However, the needs that people with compensation have and the needs of people without compensation are very similar, so trying to bring those mechanisms together to fund things is the way forward, I think.

CHAIR - So a group like the TAC could do the capital work and then the State-funded clients could rent out or sublet or whatever.

Mr MORRIS - It would be interesting to see whether New Zealand has this problem, given that they have their Accident and Compensation Commission.

Mr WORSNOP - They have a universal system.

Mr MORRIS - Yes. It would be interesting to see whether they have this problem, which seems to be a major problem in Australia, and whether the New Zealand system has resolved it.

Mr WORSNOP - We had a representative from the New Zealand Government come out to the Young People in Nursing Homes Conference last year and she talked about their universal health system. None of us have been there to inspect it particularly, but they are claiming that they have much better residential-type outcomes for young people than we have.

Mr WHITELEY - Is this universal cover on all accidents?

Mr MORRIS - Yes, it is a no-fault scheme.

CHAIR - So it doesn't matter whether you are covered by MAIB or WorkCover?

Mr MORRIS - Yes, there is no such thing as a non-compensable claim. It is actually a different system altogether, so everyone gets compensation somehow. It is not bulk compensation, it is rehabilitation and accommodation.

CHAIR - It is not a pile of money handed to you?

Mr MORRIS - No.

Mr WORSNOP - I just want to follow up on the point you were making. One of the things that we have really figured is that in the process of the young people in nursing homes campaign, you need to look at a whole range of different solutions for different people. It is not a one-size-fits-all solution at all. The case management work we do is working with people with very complex arrays of needs and that can include behavioural needs as well as physical rehabilitation, social rehabilitation, family support and a whole range of things that go on. It is very difficult to say there is one nice little model that you can fit everybody into.

CHAIR - Which is always going to be a difficulty for a small area like Tasmania, with a dispersed population, because purpose-built facilities are difficult to arrange.

Mr WORSNOP - We have seen some facilities built on the basis that they think there is some projected need and then the facilities stay empty because they haven't really matched the individual needs of the client group or their local community need. You cannot put somebody in Kilmore if their community is based in the Mornington Peninsula; it just doesn't work. Similarly, you might have people with MS, ABI or Huntington's who may have a similar need now but within six months they diverge. It is very difficult to find a one-size-fits-all solution to this.

CHAIR - So flexibility and lots of options and a sense that needs will change over time would be essential?

Mr WORSNOP - Yes.

CHAIR - Just because you find a spot for someone on this particular day, 12 months later that setting may be inappropriate? Is that what you are saying?

Mr WORSNOP - Yes. One of the things that I am very interested in trying to create in Victoria - and I have been struggling to find a way of doing this - certainly with the ABI group there is that catastrophic injury, then there is a period of stabilisation in an acute setting and then there is often this period of slow-stream rehabilitation which involves both therapeutic input from physios, occupational therapists et cetera, but then there is this other aspect of it which is really around social rehabilitation and people trying to find a place for themselves in their new world. That period of time can vary from six months to 10 years. What I am very interested in trying to find a way of doing is creating an alternative to nursing homes for that period of time - because that is where a lot of them go - to finding a rehabilitation focus. It is difficult to find a one-size-fits-all for that as well, but I think it is a real gap in our system that we don't have a place where there is nursing home level of care which is focussed on young people's rehabilitation, which actually has an ethos in it which is about moving people back to the community and socially reintegrating them.

Mr MORRIS - So it is actually driven by the rehabilitation opportunities that exist for people, but it comes with nursing-home level of care?

Mr WORSNOP - Yes. People who are referred into our system are often people who have virtually no response at all. They have had their catastrophic injury, they are in the acute system and they are medically stable but they are not responding. People at that stage can tend to be written off by saying, 'Oh, they're in a vegetative state', but I have seen people within six months' time being up and walking and I have seen other people who are 10 years down the track who are still basically just getting blinks together for yeses and noes. It is a very unpredictable science, I think.

CHAIR - But that also seems to indicate that you don't give up on anyone either.

Mr WHITELEY - You don't just chuck them in a nursing home. So you're saying they come out of acute with no real signs and into a nursing home, but we may never have known with good, solid, focused rehabilitation what was possible?

Mr WORSNOP - Yes.

Mr WHITELEY - That's sad, isn't it.

Mr WORSNOP - Today I was going to bring a mother along with me, who is part of the nursing home consortium, whose son has been in a nursing home bed for, I think, about seven years now.

CHAIR - Is that the case study attached to the document I got from Charles - a mother wrote it?

Mr WORSNOP - It probably was.

CHAIR - He had complex needs but really long-term ones.

Mr WORSNOP - Yes. He has basically got locked-in syndrome; he is able to blink yes and no. He is one of those classic people who was the centre of a social network of people, a very active character and a lawyer, so he was making a fairly significant contribution. Then he had a catastrophic injury. The problem is that lots of people have written him off as being non-functional, but in fact it is quite clear that he has been all along but it is trying to find the mechanisms for him to communicate what his needs are. His mother has been doing a hell of a lot, she is an extraordinary person. He is in that group of people who could be easily written off. He was the centre of quite a social circle of people and those people looked to him. They still circle around him but the problem is, as he is in an aged-care nursing home, he is slowly trying to maintain that circle of people and it has been quite complex.

CHAIR - Whereas if you are in a more appropriate setting, where the music could be different, he could have a glass of wine and a biscuit and cheese - that kind of stuff - rather than a cup of tea and a pikelet.

I read the case study with a great deal of interest because that seemed to me to sum it up.

Mr WORSNOP - Mary, the mother, is in the process with that group of friends of trying to pin down what it is that he needs for his long-term future. While she did some work for us around looking at the nursing home environment and how to improve it, ultimately he needs an alternative accommodation setting where it really will enhance his capacities.

Mr WHITELEY - There must be many more like him.

Mr WORSNOP - Yes. I guess they are the group that often get missed out because they are just too hard. People who are in rehabilitation have a complex temporary need for rehab but get somewhere and are able to communicate their needs, even if they are limited in their capacities. They tend to get somewhere in the system if we can help them out on an individual basis but this other group are really the group that misses out altogether.

CHAIR - That probably comes down to how the staff deal with the client feel: where's my reward, where's the feedback, where's the result from all this effort?

Mr WORSNOP - When they are in an aged-care setting of course the staff who are trained to do aged-care support are not trained to deal with this type of complexity of disability at all. We all find it challenging to speak to somebody who is not able to communicate back to us apart from blinking. So you really require an environment where there is expertise available that can assist to enhance that communication.

CHAIR - You could imagine situations in a nursing home where what would be completely appropriate treatment of a much older person would be shocking - the language you hear - and if the person is completely aware of what is going on but just can't communicate it would be horrible.

Mr WORSNOP - Because we are a statewide service, we work with people in metro Melbourne but we also work across the State in the remote areas. The capacity for the aged-care system to work appropriately is different in the country than it is in the metro areas. My observation of that is that in the metro areas people tend to be divided up in terms of their tasks: we will do the rehab, you will do the nursing et cetera. In the country areas everybody fills in around the edges. There is one particular young man I know of in East Gippsland who is in a nursing home in the local town. It is one of those nursing homes that is attached to the hospital, so it is a community thing. For them to build a purpose-built facility to address his needs - he is probably the only one in that region - it becomes quite difficult. The actual approach of the nursing home and the fact that there is much more stability in the staffing in rural areas than there is in Melbourne often -

Mr MORRIS - So the relationships between him and the staff are much closer and much longer term.

Mr WORSNOP - Yes, and that comes back to that issue that you need to see the person in their setting to figure out what is the solution. In his case, he is not verbal either and his grandparents are his major supporters. In general the system seems to be working for him in a nursing home because the community works around that nursing home much more than it would in Melbourne.

CHAIR - We have the population of Geelong in the whole State and a decentralised, dispersed population, so this multipurpose service or centre model seems to be on the increase. You have so many acute beds, so many aged-care beds and occasionally a younger person with a disability in a central place that is the community hub. People are in and out all the time.

Mr WORSNOP - You can stream your volunteer supports around age groups and things like that probably more in a smaller community. You tend to have bigger mechanisms for voluntary recruitment and it becomes a bit more alienating in a big city.

CHAIR - This fellow may well like to go into the city, into a group home situation, for a month of the year or a week or a weekend and have a different social life.

Mr WORSNOP - That's another issue which we are seeing a bit at the moment because there is a bit of a crisis with the Slow to Recover program funding. For people with a catastrophic level of injuries the option at the moment is an aged-care system or going back to a family if they are lucky enough to have families, but some of these families are

now coping with incredibly high level of support needs for young people without the benefit of the Slow to Recover program because there is no money for it at the moment.

Those families are doing it tough, but the only respite option they really have is a nursing home bed because that is the only system where they can be guaranteed that the nursing care needs of their young charge are being addressed.

CHAIR - Which would make them loath to use it I would suspect.

Mr WARSNOP - And often the nursing homes that we do use for respite will accept somebody for one time but then they say, 'Oh no, they are too difficult for us or their behaviour is inappropriate and they are disturbing the rest of our residents so we won't have them back'.

CHAIR - Couldn't give them a sleeping pill at 8 o'clock and knock them out for 12 hours.

Mr WARSNOP - So the case managers are pulling their hair out trying to find the next possible respite option for them.

Mr MORRIS - So they can't access disability respite, as a rule?

Mr WARSNOP - There isn't anything out there, really.

Mr MORRIS - Right, okay.

Mr WARSNOP - There are rare places you can get.

Mr WHITELEY - So respite is another whole issue.

Mr WARSNOP - Yes.

Mr MORRIS - We've got the same issue. The respite facilities are full of people who are permanent.

Mr WARSNOP - Yes. People move them in there because they can't cope and there's nowhere to move them so they're stuck.

CHAIR - It sounds like flexibility is a big issue?

Mr WARSNOP - Yes.

CHAIR - A range of options, so there's nothing that is going to be one size fits all.

There will be occasions when being associated with any aged-care facility in a rural setting may be appropriate because there would still be things you could do within that setting to make it culturally more appropriate et cetera.

Mr WARSNOP - And it would be important to see in the aged-care setting that you can get access to the State disability system mechanisms which -

Mr MORRIS - Are rare.

Mr WARSNOP - Yes, but I assume it is the same in Tasmania. The disability standards that we work on for disability services in Victoria are very different to the standards that are put in place for aged care. So it is getting the ethos of disability provision, which is advancing in its own way over time; getting access to that sort of approach rather than the aged-care approach is really important.

CHAIR - We should also be looking at things like a very high intensity rehab facility, like we were talking about before. Someone is out for a couple of years to get the very best and most intensive rehab, regardless of their condition. You could almost do that on an economy of scale, couldn't you?

Mr WARSNOP - I think so.

The bit about that that I have noticed - and it is fairly anecdotal - but with the sorts of people whom we see with high level injuries, when they are in this slow recovery phase there seems to be a point where their major recovery process has been achieved. It varies in length but they do want to move on from that setting because the setting is associated with the pain and the agony of doing that. So I think that concept of a transitional rehabilitation focus is really important because they do need that level of support, but there is a point where they want to move on, too.

CHAIR - It's almost a graduation.

Ms RITCHIE - I was interested when you raised the example of the regional person receiving care. Even if they are in a multipurpose centre they are getting care but it is probably a good level of care and they are seeing the same people every day. During the rehabilitation process - and it might just be anecdotal or evidence or your gut feeling - are there more benefits that flow to the client as a result of being cared for by the same people regularly rather than being in an institution or a facility where you see all sorts of different people every day because it is such a large facility so you do not get the same people looking after you every day? Do you think that localisation with the same person or two or three people in your weekly routine is better than a whole gamut of people at a bigger facility?

Mr WORSNOP - Absolutely, and it is particularly relevant to the ABI area because one of the issues with cognitive disability is that often people's ability to translate one setting or one experience to another one is limited and that is because of the damage they have. So consistency of approach and consistency of seeing people if your memory is not good are all mechanisms that help enhance somebody's rehabilitation.

The aged-care system at the moment is in a bit of a crisis and the turnover of staff in the aged care system is appalling -

Ms RITCHIE - That's right, that's why I asked the question because I am aware of the large turnover, certainly in other areas as well.

Mr WARSNOP - Yes.

Mr WHITELEY - So when we have Tasmania, with the dispersed population, on one hand we have this compelling case for community and being in a localised scene, with family down the road and all that. It is a compelling case long-term, probably.

In the process of rehabilitation which could be, as you said, six months or two years, there comes a point where they are ready to make a transition, to graduate. In that time period, if you were an hour or hour and a half away from where mum and dad or brothers and sisters live, does one outweigh the other? Do the benefits associated with this concentrated consistent rehabilitation process in that short period up to two years outweigh being located near home?

Ms RITCHIE - Having it locally or not having it locally but travelling. We asked this question earlier.

Mr WHITELEY - Is that consistency of rehabilitation important?

Mr WARSNOP - It's a million dollar question. My experience of this, and all of the therapy people would say, is that consistency is one of the goals you have to achieve, especially in the early rehab phase.

Mr WHITELEY - If we could link that, as you said Tim, to some accommodation options for family -

Mr MORRIS - So that they can come down and be near.

Mr WHITELEY - Although an hour and a half is not far, but if they were three hours away they could stay for a couple of days; maybe there are some answers there.

Mr WARSNOP - Certainly if it is set-up as a transitional type of approach then you are also not stopping people's hope that they will return to their local community.

Mr MORRIS - So there will be a clear phase beyond that.

Ms RITCHIE - A fluid period. We are not saying that this would be the person's long-term; it's a two-year model, which is what we heard about earlier.

Mr WHITELEY - Up to two years.

Mr WARSNOP - The two-year model is a bit of a challenging one too. There was always this idea that you had a two-year plateauing effect, but it is not quite as simple as that. I think the long-term studies that are being done at Bethesda Hospital here are indicating that rehab takes a much longer period of time. It is very difficult to say just two years, however there does seem to be a rehabilitation phase, which varies in length. There is a point where people stop wanting to be in the rehab phase and wanting to get on with their lives.

Mr WHITELEY - You are saying it doesn't just stop at two years, it's not a magical number, but would it be fair to say though that after say, two years, you might need to come back to focused rehab two or three days out of seven rather than every day. Is there evidence

to suggest that you can go back to your community, to mum and dad back home for four days and you come back to a focused rehab for three days? Does it have to be everyday?

Mr WARSNOP - Our experience is that it varies quite a lot from person to person. One of the things that we see is that episodic type improvements occur. With the Slow to Recover program there is this concept of two years of rehab and then you go onto a maintenance program, but we have been working with people on that program for seven or eight years at times. What is more classically the case is that there is this earlier period where it really takes intensive rehab. Then there are more episodic improvements that then require intensive therapy interventions to try and maximise what those improvements are.

CHAIR - If all of a sudden you got some fine motor movement and someone went, 'Great, there is movement there now so we need to really practise and make sure that is strengthened'.

Mr WORSNOP - Yes and if you can intervene at those times efficiently and effectively then you can maximise the capacity for that person to gain from that.

Mr WHITELEY - I suppose that is the key, to have the space available and the window open, isn't it?

Mr WARSNOP - Yes.

Mr WHITELEY - Not to say, 'You will have to wait three months before we can handle that'. It is a matter of saying, 'The opportunity is there now, capitalise on it'.

Ms RITCHIE - But they are not necessarily things you would need to go back to do.

Mr MORRIS - There might be short-term residential opportunities.

Mr WHITELEY - That was what I was leading to.

Mr WARSNOP - It may be that a transitional centre might have a few beds that were available for this sort of use too.

Mr FINCH - With all these changes that are occurring, and every case is different as you say, when the situation does occur when you have the acquired brain injury, is there a case manager or is there an case management system that plots the course of the development of the issue, whether it's being solved or when the two-year point kicks in? Does the system manage that person and the way they develop with it or is it just flicked over from here to there? People change jobs and then there is no real concentration on how this person is getting through the system.

Mr WORSNOP - I think the ideal is that you have a consistent case management person working with the person over the period of time that they need you.

Mr FINCH - What's happening on the ground here?

Mr WARSNOP - There is a turnover of case managers in the system. Case management is quite a challenging thing to do and I would say that the average length of time a case manager works in our service would be three years or something like that. If you can keep the same person working with the same teams, the therapists and others, over a longer term I think you have better outcomes for people.

Because we know that there is going to be a turnover of staff we try to make the relationship with our service rather than with the individual case manager, to try to at least allow them to feel that there is a consistency about the approach that we are taking even if the individual staff changes.

Again, it depends upon circumstances. Some people want to change the case manager because they want to leave some stuff behind too and a change of staff might be nice for them.

Mr MORRIS - It might be a good thing to do.

Mr WARSNOP - Yes. The case management services are funded at various different levels. If you want to keep people on you have to reward them a bit. You cannot give them base rate case management pay and expect them to manage very complex therapy teams, put in submissions constantly about where improvements have been, project what is the next six months of treatment that is required, and cost all that. You are talking about a fairly senior type of approach to that sort of system.

CHAIR - They are probably being paid under a community services model rather than a medical award or something?

Mr WORSNOP - Yes.

Mr FINCH - How many clients would a case manager have on average? Two, three, half a dozen?

Mr WARSNOP - The complex case management services that we run are the people who do the Slow to Recover type of work, as well as people who aren't in that, and they have a case load of about 18 at any one time. We aim to have a turnover of about half a dozen a year at that level so that is the sort of level that we are talking about.

The departmental case managers who working with people primarily with intellectual disability in Victoria have case loads of about 14 rather than higher loads. We had a caseload of 20 for our case managers for a while but it was really hard work; it was probably a bit beyond what they could do.

Mr MORRIS - Eighteen would be hard work.

Mr WARSNOP - Eighteen is hard work but it is more realistic, particularly when you've got a group of people some of whom are relatively new and you are doing a whole lot of work in terms of setting things up. Others are on a much more longer term approach. So you have to have that mix as well.

CHAIR - Does anyone have any further questions at this stage?

Mr WHITELEY - Your involvement is at the level of case management. You don't yourself provide any of the options that you're referring to? You don't provide facilities?

Mr WARSNOP - No, we do have other disability facilities but not with this group. It's partly because the case managers also have to negotiate with residential providers as well and it is better to have them located outside the system.

At one stage we had a particular residential service for people with ABI. It was a nightmare because you needed the Chinese walls to try and separate your lobbying for better outcomes in the residential service if you're a case manager. I think it is much better to try and have that service separate.

Mr MORRIS - Yes, that's right. You have a clear advocacy role for the individuals?

Mr WARSNOP - Yes.

Mr WHITELEY - What was the number you said may be in Victoria were categorised ABI?

Mr WARSNOP - It is hard to get the numbers but the number of young people in nursing homes under 65 in Victoria is about 1 035 or 1 300 - I can't remember the exact number - and we think about 40 per cent to 45 per cent of those people have ABI. So we are talking round about 500 people in Victoria with ABI in nursing homes.

Mr MORRIS - And that includes the compensatable?

Mr WORSNOP - They are saying that there aren't any compensatable people in that group, so it would include the occasional ones.

Mr MORRIS - Right, okay, because they seem to magically disappear.

Mr WARSNOP - There is some hard work done at creating accommodation options for the compensatable group, but they are far more expensive than what the public system can afford.

Mr MORRIS - Oh, yes, I recognise that but if somehow we can learn more from what is going on within the compensatable sector seeing, firstly, whether the outcomes are much better than the rest have been able to deliver and how we can get the most out of learning what they are doing.

Mr WORSNOP - There is one document that I have from the United States. Tim Feeney has been working with a service in the States which has really been looking at outcomes for head trauma rehabilitation. This group has been putting together some documentation around the costings of doing community-based rehabilitation versus facility-based rehabilitation. And I have brought a copy along for you. Tim and Mark are the two gurus concerning people with ABI, the complex and challenging behaviours of people who have classically been shoved into facility-based places to try to keep them off the streets. There are some really interesting stats in terms of some of the financial outcomes that they've been able to achieve by doing the work in the community. This is from 2001 and I will leave a copy of that. If you want any further information Tim

Feeney and Mark have more recent costings. I know the bottom line in this is always looking at financial issues.

CHAIR - We can come up with the best recommendations in the world but if they're not affordable they will get ignored, unfortunately.

Mr WORSNOP - Tim Feeney has just been in Adelaide. He had come to us from New Zealand and we flew a couple of our people over to Adelaide to do a workshop. He is going to back to New Zealand next year. We are hoping that we might be able to attract him to come to Australia for a bit to do some real work on the ground with people. So it is useful for you to know of somebody like him who has a lot of really good information about this group of people.

CHAIR - I thank you very much. Further questions members?

Mr MORRIS - No, I think we will come back to you with more questions if we have them. I am happy.

Mr WORSNOP - You have my contact number.

Mr MORRIS - Yes, we do.

CHAIR - We do. Thanks very much Tom we appreciate it. We'll send you a copy of the report.

THE WITNESS WITHDREW.

Ms MORKHAM WAS CALLED AND EXAMINED.

DEPUTY CHAIR (Mr Finch) - Thank you very much for your time today, Bronwyn. Would you care to make your presentation?

Ms MORKHAM - First of all, I wanted to thank everybody here today for the invitation to come and speak with you and to congratulate you on being the very first parliament in the country to undertake an inquiry like this. This is a very major thing and I think set the stage for the Senate inquiry federally, which has now closed. I really want to say that I think this has been marvellous leadership on your part and truly groundbreaking because it has never, ever been an issue before. The Senate inquiry, even though the term of reference is there, is not a stand-alone inquiry, so congratulations.

Ms RITCHIE - In our aged-care inquiry some of that came out but it did previously as well.

Ms MORKHAM - As a stand-alone issue. I think the issue itself is now such a major item on the landscape and you are the first to do this, so it really is quite groundbreaking.

Today I wanted to talk about the national level, to try to give an overview to this. I have brought along a copy of the submission that we put into the national inquiry which contains quite a bit of the sort of information that I thought you might be interested in seeing. I thought I would talk generally about a couple of issues and then leave it up to you to ask some questions of me. That will allow you to direct it to where you want to go.

The latest figures we have is that there are 6 261 young people under 65 in aged-care nursing homes around the country. I have a figure in here broken down by State - and I will get it in a minute. One of the biggest problems we have is getting hold of data at all because each State collects differently and DHA, for obvious reasons, isn't keen to hand it out. I think the Victorian Government is trying to negotiate with them to get the data broken down by region, but they collect by age range and State. That is all they will give out.

DEPUTY CHAIR - I am a bit surprised you got that figure, 6 261.

Ms MORKHAM - That is as of March this year, so it is probably higher now. They have gone back into their shells a little bit. I rang them the other day to get an update - I think they are worried about the election being announced and so everything is starting to close down. As of March this year that figure is current. There are 1 500, roughly, under 50 nationally.

Ms RITCHIE - In Victoria we had another figure earlier - 229 under 50.

Ms MORKHAM - I had a disk with this all on it and then at the last minute the computer died, so I am sorry about that. I was going to give you a proper Power Point.

Victoria at the moment has 1 536 people under 65; Tasmania has 161. Victoria has 229 under the age of 50; Tasmania has 23 under the age of 50. New South Wales is the

biggest State in terms of figures; they have 2 222 under 65. Across the board it goes New South Wales, Victoria, Queensland, South Australia, Western Australia, Tasmania, the Northern Territory and the ACT.

Mr WHITELEY - Do you have the population figures?

Ms MORKHAM - Absolutely. When I can resurrect the computer I will send you a copy of the presentation I was going to give you - a disk of it, if you like.

With these figures, in this last round Victoria was the worst - 66 young people had gone in over a two-month period in Victoria alone, partly, I think, because of the policy the current Government has here of closing down the supported residential units, so there is less physical capacity to take people up. That is one of the reasons and it might change a bit. It was a bit sad because Victoria has tried to do some things and yet it had the highest national intake in that two-month period. So with that set of figures we now have a young person entering a nursing home every day somewhere in the country. For quite a while we have been saying that these figures are going to start to spike, that they have managed to have an fairly even, gentle increase but now it is starting to really spike.

Mr WHITELEY - Why is that?

Ms MORKHAM - A number of things. I think medical technology is saving lives now where even five years ago people would not have been saved. I think we are really now starting to see the impact of ageing carers - people who have had their kids at home and cannot do it anymore. We have a situation in Victoria where older parents are taking their adult children to respite and just not picking them up again.

Mr MORRIS - It's the same in Tasmania.

Ms MORKHAM - That is a hidden thing. We really aren't able to track that very easily at present but I think it is the thin end of the wedge.

DEPUTY CHAIR - You said one person every day - projecting into the future - enters an aged-care facility.

Mr WHITELEY - Who are under 65.

Ms MORKHAM - Yes. In that two-month period, where we had that massive increase, on those figures there is a young person going in every day - in fact, it is more; it is two young people every three days - somewhere in the country. If that rate of increase continues, we will be looking at something like 10 000 in by 2007.

Mr MORRIS - Is it looking like that is going to have - unless there is a radical change - a serious impact on the capacity of the aged-care facilities?

Ms MORKHAM - I think it will. At the moment this cohort makes up 5 per cent of the aged-care population.

Mr MORRIS - Okay. And that projection goes to 10 per cent?

Ms MORKHAM - Yes, it would be about 10 per cent. In itself, I think it is significant stand-alone, but when you add in the fact that because these young people have such high-care needs and they are time-intensive and cost-intensive and the fact that the aged-care homes have to take from their total group of residents to support them, it means that the other aged residents aren't getting their cut of the pie. The impact is quite significant, I think, on those fronts as well.

One of the things that we are particularly concerned about is the lack of training that happens, and through no fault of the nursing homes or the staff. These people are not trained to deal with the more-intensive needs of young people. They are certainly not about rehabilitation and their staffing levels are very much less. There needs to be a higher staffing level. I am sure you are well aware of all this, but it is something that we are quite concerned about and one of the reasons that the Senate inquiry federally is important because it is looking at the quality of care generally. I guess, as part of that, one of the things we have seen is that where people have been able to work with a nursing home around the needs of a particular young person, if things change all that expertise that has been built up goes. The expertise is usually developed over quite a period of time; it takes a lot of effort to get it there and it can disappear very quickly. We have a number of nursing homes in Melbourne that are closing. One in particular had four young people and a very well-trained staff who had been trained up. They are all going, they will just be dispersed to the winds and that valuable expertise will be lost. That is one issue. Particularly in inner Melbourne, we have a number of aged-care facilities that are closing and there is a major crisis happening as we speak about where these people are going because of the land values.

Ms RITCHIE - Why are they closing?

Ms MORKHAM - Land values. The inner city has become so expensive and a lot of these properties are quite old.

Ms RITCHIE - And they are private operators?

Ms MORKHAM - Non-profit. Some of the churches have them. The ones I am thinking of in particular are all church-owned and they are on properties that are worth millions. The other thing is the impact of the aged-care accreditation standards. They cannot afford to upgrade them. In this case, this one is moving - and this is where Mary's son is - from North Fitzroy in inner Melbourne and relocating right out on the fringes into the suburbs. Chris' friends are all around him in there and we often say Mary should be known as a social secretary because she has managed to sustain Chris' friendship group really cohesively, which is so unusual. That is the other big impact on young people in a nursing home: they lose their friends. The friends find it very difficult. Aged-care homes are not easy places to go to sometimes.

Mr MORRIS - It's not so bad if your granny is there, you expect it.

Ms MORKHAM - You can leave and it is not such a personal impact. But for most young people, especially if they are in their teens or 20s, the friends drop away very quickly. Chris is a very rare chap; he has friends who come in and take him down to the pub or take him off to a concert. They try to involve him. I was at a function recently where one of his best friends was speaking and he was saying that that is getting harder. They

have sustained this now for the seven years since Chris had his injury but these friends have now married, they have young families and their time is now being taken up with other things. Even though they have a commitment to Chris, it is getting harder to involve that.

Mr WHITELEY - There is probably more guilt involved in this parting than there would be in a normal situation.

Ms MORKHAM - Indeed.

Ms RITCHIE - That happens with friends all the time, doesn't it.

Ms MORKHAM - Indeed it does. They are really abandoning him, I think, and he is very needy. I don't know if you saw Andrew Denton's *Enough Rope* when he had Sam Neill on.

Ms RITCHIE - Yes, I saw that.

Ms MORKHAM - Sam Neill was talking about a very close friend of his who has a car accident, sustained massive injuries, including a brain injury, lived in a nursing home and died a couple of years ago. He had kept up that friendship, wrote and went to him. Again, it is very rare thing for that to happen, but it reinforces the social isolation that these young people experience. They cannot get out of the nursing home because there is no funding.

In another case, we had a meeting recently with a young chap with MS who lives in a country nursing home. He needs a wheelchair but does not have one because the nursing home can't provide it. It does not have the equipment, nor does it have the funds to get one for him. He is either in bed or he can sit in a water chair, if that is vacant, but it means that somebody else can't get into the water chair. He hasn't been out of the nursing home in the five years since he has been there and is now suffering intensive depression, plus his health has deteriorated because he needs some fairly intensive management that the nursing home can't provide.

This raises another issue that I think is really important and that is the effect on nursing home staff. Because these young people are there for long periods of time, they built up quite close relationships with them and that impacts on them very badly because they feel very guilty. They know what they want to do, they know what they would like to be doing and they can see these young people deteriorating and they can't do anything about it, so it starts to impact on the staff from that point of view as well.

In overall terms, when we are looking at staffing levels or quality of care, those issues need to be brought to the fore. I think it is hard to get staff into aged care anyway at the moment, but it is especially hard when you have to spread yourself so thinly with this younger cohort.

They are some of the issues that I think young people face. I have been trying to get a program going whereby we get some Internet connectivity happening for young people as a way of breaking down the social isolation and helping them to be their own best advocates, too. We found that most of the momentum we have been able to generate has

come from people meeting these young people and hearing their stories and really seeing what the impact has been on them. We had an anonymous donation of some money and I am pursuing one of the telco's to try to give us the connection. We hope that that will help break down that social isolation, but that is just one part of it obviously. Would you like me to talk about the sorts of things that young people need in the nursing home or are you okay with that?

Mr WHITELEY - No, that would be helpful.

Ms RITCHIE - I do not think we have heard too much about it actually.

Mr MORRIS - Yes. The other thing I would like to come to is your thoughts on the State/Commonwealth relationships, given your national perspective.

Ms MORKHAM - Certainly. Young people, by and large, clearly need rehabilitation so there is the physical body and most nursing homes operate on that medical model where it is the body that is looked to, and understandably, but as well as that physical body, and with most of the young people who are in there, there is a need for quite intensive rehab that continues over a number of years. I will just digress a little bit and talk about brain injury.

With acquired brain injuries, in Victoria we have the Slow to Recover program, which I am sure Tom would have mentioned. That has a two-year time period and then people are put onto a management program with fewer hours but we know very little about brains and the way that they recover from injury and in some cases we have seen that you might have intensive rehab for five years before that starts to happen. We have had a young guy whose parents were told he would be in a vegetative state for life. It took five years of persistent rehab before they could see any change, yet now he is learning to run, so he has gone from someone who could not move to being able to run.

We have another young woman who was assaulted when she was 16 - an unprovoked assault. She is 18. Her parents had to really fight for her to get on to Slow to Recover and I guess that is the other thing to say that because of the crisis in the system in aged care, because of the pressures on hospitals, they need to move them on when they can do no more, but generally these young people leap from disability. They just go straight from aged care - a bit like Monopoly - but they do not get the \$200 and they do not pass 'Go'. They just go straight in so there is no pathway from the hospital to Disability and even sadly, where there is some sort of a pathway, Disability will often - and I am generalising here but I do know of specific instances - say, 'We would rather you take them to aged care because we just do not have any facility to care for them anyway', so they are doubly disenfranchised.

So there is the physical rehabilitation, there are equipment needs which are not covered at all and because disability funding cannot go into the nursing home as it currently is, major disability funds are needed. We have got a young guy in Kilmore who was wearing a leg brace when I saw him but the community had got together and donated for him and he does not have a wheelchair either. There is speech therapy. There is just the general stimulation. The social interaction. It is life itself in a way, isn't it, that they do not get and for people with brain injuries and disabilities generally that stimulation is

critical to keeping well, mentally and physically, and to getting better because without that the depression rates are massive and they are very severe depression rates.

Because people cannot get out of bed they lose muscle mass. They get worse. So in fact by not putting some money forward we are actually creating a bigger drain on the system further down the line, which reminds me of the other piece of information and that is the 'bed blocker' argument which you are all aware of, I guess. I think nationally we have roughly 2 500 frail-aged living in acute care hospital beds at a cost of \$372 million a year. Every year that is just wasted in that sense from a health budget but obviously that upstream blockage, if we could deal with this issue - I think it straddles so many portfolio areas - we would see a lot of benefit in other areas as well.

With the CSTDA my view is that it has failed completely. I do not think it has done what it was initially meant to do. It has become a really confrontative engagement for all concerned where people have to try to fight for more money, a bit like the Premiers' conferences where people go to Canberra to try to drag as much out of it as they can. It has become very politicised and it really has not delivered the sort of disability funding that is needed. I think in real terms it has gone backwards. That is one thing. I think it has either got to be seriously rethought or disbanded altogether and something else put in its place.

I personally have doubts about the whole issue of a system based on age. I really think that is a major mistake. We need to be looking at need and I think the Commonwealth's argument that young people are the State's responsibility because they are disabled and disability is a State responsibility is going to seem less and less solid as the ageing population comes in and with the rise in disability rates that happens with age, I think the Commonwealth will end up dealing with a lot more of this than it has ever anticipated. One of the arguments we try to use is that they are going to be dealing with these young people and people with disability more and more and more, would it not be better to start to have a dialogue with the States and a shared responsibility around the issue.

We have a little bit of movement on that, not a lot. I think Julie Bishop, the new Minister for Aged Care is certainly much more willing to listen and to consider the issue itself and is a little bit more lateral thinking I think so there has been some movement there and the innovative pool, which the Department of Health and Ageing put up, and is the only response at the moment federally, is something that we have tried to encourage the States to take up. The biggest problem is that it has got a two-year limit and the States understandably are very wary of committing to something in which they are going to be left holding the baby.

Personally I do not think that will happen. I think Health and Ageing is now much more aware of the complexities with young people and they have indicated to us that they are willing to revisit the guidelines and make them a little bit more flexible, extend the time and so forth but they are very, I suppose disappointed is the word. They are disappointed that none of the States have got on board with it so we are trying to say to the States that this is one way that we can get Commonwealth involvement and I really believe that we have to have Commonwealth involvement. The States cannot solve this on their own.

The Commonwealth has got to be involved for a number of reasons. One is that they are going to be dealing with these young people whether they do anything or not. They are

going to get them because the States simply have not got the capacity. The second reason - and this is contentious too, I should say; there are people who would disagree with what I am about to say - but we believe that nursing homes have to remain as an option for young people. If what we are about is providing a range of alternatives, of choices, options on the spectrum sort of thing, because there is no one size that fits all then remaining in a nursing home has to be there for a young person. It has got to be an option.

Mr WHITELEY - That has got to be an option, one of many.

Ms MORKHAM - Yes, one of many and the option should be there because well, in country areas where the critical mass is very low or the services are limited, the nursing home might well be the place where they can stay with their family and friends, in proximity to them, but if they are going to stay then there needs to be disability funding going in with them to sustain them so again there is the sense that the Commonwealth has got to be involved, that they cannot just say, 'Here they are, take them back, it is all over'. They have to be involved. Because of the funding they need to be involved because nursing homes should remain an option with the add-on disability funding.

With regard to the CSTDA, I think DHA is the third-biggest funder of disability in the country and yet it is not a signatory to the CSTDA. I think if we are going to have a CSTDA they have got to be in there talking and managing it too.

Mr WHITELEY - Is the senate committee going to be looking at all this?

Ms MORKHAM - I hope so. Yes, we have put that into our submission to them. Tim, there was something else you asked me.

Mr MORRIS - Really I was just looking at what you think the options might be or must be for the Commonwealth and States to get together simply because there is such pressure to push costs across to one or the other that it is causing incredible efficiency problems. So much effort on both sides seems to be pushing people from one to the other. It is not only in this area but if that energy and resources was combined to put into the effort then we would at least have some of the funding that we need.

Ms MORKHAM - Yes. I think the Commonwealth is becoming a bit more aware of that too, in little increments. In terms of what the options are, one of the arguments I have been using is that the Commonwealth needs to maintain the bed money at least, \$38 000 on average I think for a bed, give or take, so if they could maintain that and the States put in the disability funding on top of that which is probably a little bit more than half. It depends on what State, what the costs are and so forth but generally speaking anywhere between \$70 000 to \$75 000 would be needed to support one young person in a community-based arrangement.

Mr WHITELEY - It is about half and half.

Ms MORKHAM - Yes, it is about half and half. The States may have to come up with a little bit more than half. The Commonwealth would like them to come up with a lot more but they will not. Victoria has just signed off on the only innovative pool project to get through and I cannot tell you, that took so much effort. Well worth it but I think -

Mr WHITELEY - What is the project?

Ms MORKHAM - It is a project to bring three young women out of nursing homes. They all have MS and they are moving into a shared house in suburban Melbourne.

Mr WHITELEY - With care?

Ms MORKHAM - Yes, with 24-hour care. In this particular mix the Victorian Government is putting up 80 per cent and the Commonwealth is putting in 20 per cent.

Mr WHITELEY - Out of the pool?

Ms MORKHAM - Yes. And the Victorian Government has said that they will not do that, that that is far too uneven a share. They will be looking for it to change significantly or they will not come to the table. I think the thing is it is the first one to get up, it has opened the door a little bit and now we can negotiate, and the Commonwealth is willing to negotiate. I think it is starting to understand that it has to do something. Just saying no, they are just coming in. The States are not doing anything because they do not have to and the Commonwealth is picking it up so if they want to see anything happen they have got to be a partner in some shape or form. That is one option.

That has a two-year life but we have already been given to understand that that will continue on. Even if you looked at it politically, I think a government that closed the door would be very silly to do that. I do not think it is going to be let go.

Mr MORRIS - But it gets past the election and allows sufficient time for negotiations to occur before the two-year period expires.

Ms MORKHAM - Yes. So there is that one. We have Pellatt Street which opened today and that was largely a consumer-driven initiative. We have philanthropic funding to buy the property, we had some money from the Victorian Government to buy the property and the Victorian Government is putting in all the money for the attendants' support care. These people have got a very different model though. There are 13 individual units on the site, each with its own - like a little flat - private courtyard at the back and some lovely shared space in the centre. They are pooling attendant care hours. They have all got packages of attendant care and they retain three hours of their package for individual use. Because it is the first one, the proportions is probably a little out of whack and it has been determined I think to make sure that their care is there. I think two of the units are for respite too but eventually there will be 13 people on site.

So that is a really interesting model and in some ways is probably the way of the future, and the way I see the Commonwealth being in that is that if these people are coming out of nursing homes they will be providing some of that bed money to follow them through and sustain them there.

Mr MORRIS - To stick with them, right.

Ms MORKHAM - It has not happened necessarily in this case, it has not gone down that road, but for the future I think that is the way to go. We are getting a number of

aged-care providers contacting us because the smaller hostels that they have had running are no longer profitable so they are getting rid of those, putting people into bigger sites and some of these smaller hostels - and St Martins Court was a former aged-care hostel - really lend themselves to redevelopment for young people.

It is more the funding model that needs to be addressed. I think I was telling Charles there is an annexe that the MS Society built at Keilor, Cyril Jewel House, and this has got Commonwealth and State money in it but it has been remarkably off the radar. I do not think anybody else wanted to acknowledge it is there in case a precedent was set but it has been there for a number of years.

It has got its own set of problems. I think in any of these options there is never a perfectly great one. There is always some negatives and positives but there is a lot that can be done. Cyril Jewel certainly has 15 beds. It is annexed to the aged-care nursing home so it draws on the services of the nursing home as a cost saving. The State Government here puts in top-up disability funds. The residents there have got their own bus. Some are going to uni. They all go out. They have it as a home that they leave from and come back to so that works well for them.

Ms MORKHAM - It has a higher staff/resident ratio. People are trained in MS and what people need with that.

Mr WHITELEY - Do we know how much Commonwealth funding has gone into that 15?

Ms MORKHAM - I can get the figures for you. I think MS put in the money to build the annexe, and I think the Commonwealth maintains the bed money, so they are aged-care beds.

Mr MORRIS - So they are aged-care beds.

Mr WHITELEY - That's right. I am interested to know how much of the \$38 000 has been transferred across.

Ms MORKHAM - I think it is the full \$38 000.

Mr WHITELEY - And just on that, that figure right back when you first started, you said 6 261, but was it \$379 million or something?

Ms MORKHAM - \$372 million in -

Mr WHITELEY - In aged care in \$38 000 lots?

Ms MORKHAM - No, \$372 million is the total cost of the health budgets around the country that is going into acute care because the aged can't get out.

Ms RITCHIE - That is for aged people in hospitals.

Mr WHITELEY - Yes. The 6 261, though, was young people in nursing homes.

Ms MORKHAM - Yes, under 65.

Mr WHITELEY - Okay. They're obviously getting paid -

Ms MORKHAM - They would have the \$38 000 -

Mr WHITELEY - That's what I say. I just want to do my own sums there.

Ms MORKHAM - Good. I should have the calculator with me.

Mr WHITELEY - That is an important point.

Ms MORKHAM - Well, it is.

Mr WHITELEY - That is how many people are in nursing homes. Either you or someone before you talked about a heap of young people not in nursing homes but who should be in care, but their parents just cannot, for whatever reason, bring themselves to put them into nursing homes. Do we have any data at all about what the vastness of that need is?

Ms MORKHAM - The short answer is no. In a way I think people are trying not to know sometimes, but it is hard to count it too. I can say that in Victoria there are 3 000 families on the service needs register.

Mr WHITELEY - But that is not with their family in aged care?

Ms MORKHAM - No.

Mr WHITELEY - So it is 3 000 over and above your 1 536.

Ms MORKHAM - Yes. And they are not all going to need high level support, but they are pretty urgent because to be on the service needs register at all you have to be pretty needy.

Mr WHITELEY - I was just thinking very practically. In theory -

Ms RITCHIE - You are thinking about how many carers there are across the nation though, aren't you? Is that the question you're asking?

Mr WHITELEY - I've just got a few things running in my head. I just want to know how big this issue is. It is all very well to identify the 6 261, that's tragic enough. I just know in my electorate, talking to some people there are people who just, come hell or high water, will not put their young family members with needs into a nursing home. They just will not.

Mr MORRIS - But there will come a time when they won't be able to look after them.

Mr WHITELEY - That is right. Look at that guy we took evidence from up in Launceston. That was so tragic.

Ms MORKHAM - And it is a horrible thing, because to be a parent who is getting older and who has no idea what is going to happen to their child I think must be just awful. There

is one family in particular in the Gippsland regional area here where their daughter was injured at 22, I think, in trying to stop a bolting horse. She was on a horse and she tried to stop this other horse and it crashed into hers and she suffered a brain injury and so on. Her parents are now in their early 80s. Her father has just had his second hip replacement. They are very worried. They are hanging on for Helen, and there is nowhere for her to go. They will not let her go to a nursing home. She is not suitable for a nursing home. She has recovered. The interesting thing about them is that they have not had one iota, not one penny, of government support. They are farmers so they don't have a lot of money, but they put in a swimming pool for her rehabilitation. They care for her themselves still.

Mr WHITELEY - The reality is that one day they are not going to be there.

Ms MORKHAM - Well, Ian is 83 and his wife is 82, but that is right, they can't.

Mr WHITELEY - And brothers, sisters, uncles, aunties, they might not be as committed or as able.

Ms MORKHAM - They won't be on both counts, exactly right.

Mr WHITELEY - And at that stage that young woman, Helen, might only be 38 or 42 or whatever, with 20 years left.

Ms MORKHAM - Exactly. I think if we took the 6 261, and then there is 1 500 here and another 3 000 on the SNR, even if you said half of the 3 000 - 1 500 - if you doubled it I don't think you'd be far outside, but that is just a guess because there is no way of knowing at this stage.

Mr WHITELEY - Yes? That's just in Victoria.

Ms MORKHAM - The other thing to say is that there is no evaluative tool for young people. The only evaluative tool is the ACAS assessment for aged people, so we have somebody now who is going out and part of her brief is to try and find these young people, wherever they are, and to ask them what their needs are - the social person is so important in this, the intellectual, emotional and social needs - to try to develop a tool that can be used for young people, but part of that will be to find them too.

Mr WHITELEY - How on earth, though, can we, you, or any parliamentary committee or the government, for that matter, even try to commence a process of policy development without the quantitative data. I cannot believe that this is not available in a form - not just for us in Tasmania.

Ms RITCHIE - You are talking about carers though, aren't you?

Mr WHITELEY - No, I am talking about how many people are out there with varying degrees, from nought to 100 per cent, of need. Where is this data?

Ms RITCHIE - A lot of people would get caring allowances as well. You would think that Centrelink and carers' associations and things like that would be able to give us data.

Mr WHITELEY - And then the State departments on top of it. Surely there is a way, though, that you should not have to go out there and dig it out. Do we not want to know about it?

Ms MORKHAM - No, it is not that. I think it is just that every State collects differently. The Commonwealth collects differently. I had a meeting with Julia Gillard recently, and I asked her was there any data, especially around the health budget, in this, and she said, no, it is just not being collected. I think it is one of the big things, the fact that we have a projected 50 per cent increase in demand for disability services in the next decade; I think AOHW put that out.

Mr WHITELEY - I can understand that. At the same time the demand will also increase into aged care nursing -

Ms MORKHAM - Precisely.

Mr WHITELEY - so you have an absolute explosion just waiting to happen.

Ms MORKHAM - Yes, it's huge, on all levels. The other thing I was going to mention was a young guy in New South Wales who dived into the Murray where there was unseasonably low water, and he suffered a brain injury and a spinal injury as well. He is a quadriplegic, but he still has his own business. He lives in a country town. He needs to come to the nursing home to be helped into and out of bed and to be helped with food and so on, personal care, but he leaves every day. He goes to his business and comes home at night, calls in and has dinner with his parents who live down the road on the way home. That is another way in which a nursing home could be useful. He doesn't want to leave the town. He has issues, though, with the nursing home - and these are within the last six months - around the food. The food he is getting is not what he can eat. It is mush. So he eats largely with his parents, but bowel care for him means he has to eat fruit, so they are not cutting up his food. They want to mush it up for him, but he needs to eat the food. Now again, without knowing the nursing home and the staff, there is an issue there. I am sure they are under pressure and they just cannot cope with his higher needs, so that is one example. They are leaving him increasingly longer in bed before they get him up. He is being told he has to get to bed at 5 p.m. because the staff go off at 6 p.m., all of that sort of thing, which just gives an indication of the sort of things that they have to confront.

DEPUTY CHAIR - I was going to ask about the Cyril Jewel House. Is that specifically for MS?

Ms MORKHAM - Yes, it is, because MS Victoria put the money into that. And people do not leave. There are lots of things around it that you might want to change, because it is a 15-bed wing and it is not as individual as it might, but it is hugely in demand because there is not much else, and when people go in they won't leave. Now they have issues around ageing in place. People who get to 65 do not want to go, and they don't want to move next door because they know what is over there, and that raises the whole issue again of nursing homes. I do not think they are what they were originally intended for. They have become catchment areas for people with dementia and Alzheimer's.

Mr WHITELEY - So maybe we need a whole new rethink about whether nursing homes should exist or whether or not there should be facilities of care which include the care of older people.

Mr MORRIS - They can specialise. Various ones can tend to specialise in various areas. We have ADARDS down in Tasmania, which is a specialist dementia unit for difficult dementia patients. There is some really innovative stuff going on, but they only handle one particular type of client, and obviously there is a lot of room for more specialisation, for managing different types of clients or different groups of clients who are compatible.

Ms MORKHAM - Yes, and again that needs a massive injection of funding into that, doesn't it, because at the moment if you can get a place you are lucky. You don't have a choice about who else is there and what else is going on. So it is a difficult issue, but I really think that this issue, aged care, is part of a larger issue about how we address the needs of the community and members of the community when they are there, particularly with disability, which has a very poor public profile, I think. It is just hardly there at all. That has to change too. I often have hope for the baby boomers - I am on the tip of the baby boomer group - but I think as they start to come through we are going to see that change anyway. They are a group that will demand these changes. I think change will come in terms of where they want to go. They are going to drive a lot of that change.

Mr WHITELEY - Their expectation levels are far different.

Ms MORKHAM - Exactly.

Mr WHITELEY - And they will be far more prepared to speak out.

Ms MORKHAM - They will be vocal about it too, because they are used to getting what they want, in a sense.

DEPUTY CHAIR - And the other frustrating thing for you too, Bronwyn, must be that their needs change as the issue develops or diminishes.

Ms MORKHAM - Precisely.

DEPUTY CHAIR - So that is where it is frustrating. You might think you have a handle on a case, but it changes all the time and needs different assistance and different strategies.

Ms MORKHAM - You certainly do, and it is a good point to make in terms of what are the options, because as well as having a range of options, anything from a three-bedroom shared house to somebody living like the guy in New South Wales who comes in and out of the nursing home daily, or an annexe, or Pellett Street, I think we also need options that have that flexibility built in to take account of changes in life circumstance or changes in life goals. A young woman at 18 won't want necessarily to do the same things at 28 or 35, and how do you facilitate that? This young woman of 18 that I was thinking of before is going home to live with her family. They come from a fairly close-knit community. They could not take Angela home were it not for the community literally giving them what they need. The community has donated materials and labour to build a little flat at the back of their house. She could not have gone home otherwise.

Mr MORRIS - But what a great solution, but it won't be for everybody.

Ms MORKHAM - It won't be there for everybody. And we had another young woman who had an asthma attack at 19 who has gone home after two years on Slow to Recover. Her parents desperately wanted her home. There was similar community involvement to adapt the house, but six months on the signs of strain are pretty evident, whether they are going to be able to sustain the care she needs, because she is still recovering, and her mother has had to cut back her work hours. The father still has his job, but things are starting to really impact on them. They are getting exhausted already. So even if the supports are there, whether they remain is another matter. What happens if the parents die, or when they get older? For all of those issues we need the flexibility built into the arrangements that are developed, I think.

Mr WHITELEY - I think there are a lot of those hidden pressures that also become a cost on government anyway. I mean, how many times would we see relationships break down with their children involved, and the cost where mum and dad can't cope, the marriage suffers, and then there are all these other issues that then surround it. It must be very costly to the community.

Ms MORKHAM - It is.

Mr WHITELEY - So it is a matter of putting the funds in at the front end of the tube, or at the end of the day you will have to insert it down the other end.

Ms MORKHAM - It is preventative, really, isn't it, yes.

Mr WHITELEY - Exactly.

Ms MORKHAM - We have a young guy in New South Wales who had a misdiagnosed meningitis attack and has an acquired brain injury because he vomited when he was unconscious and stopped breathing. He went straight to a nursing home while he was still coming out of a coma, and his parents have been at his side every day of the week, and I think we are now eight months post-injury. But they have gone in every day and they have developed their own program of stretching his limbs, because with an ABI you get very big muscle contractures that are quite painful, so they stretch him. They have been trying to stimulate him. But they have been abandoned. It is an outrageous situation. They have had to try and make the call on all these decisions without the knowledge or the expertise. They have tried to go back to the hospital. The hospital told them not to bother. He had a PEG feed that got infected, and they were just told to take it out and put another one in, no anaesthetic, nothing. So they are representative of a group who have to try and cope, and they struggle. The father has managed to keep his job going over this time, I think because he did a lot of it on the phone, but he is about to lose his job. Now there we go. He will be on unemployment benefits. They are trying to put what money they have into equipment. He needs a tilt table. They are doing all of this themselves with no support from anywhere. It is a wonderful nursing home -

DEPUTY CHAIR - Why aren't they getting any help?

Ms MORKHAM - He is in a nursing home and the nursing homes aren't funded to provide it. At the nursing home he is in they have been very lucky to have a director of nursing

who has been utterly supportive and has actually put her own job at risk by paying for physiotherapy to come in. I forget the number of hours he is entitled to a year, but she has actually brought someone in at the nursing home's cost, and I know it is a private thing. She has been told off now for that and told she mustn't do it again. But they are now trying. They have had a wheelchair donated I think but he is too big. He keeps falling out of the wheelchair. So again, he needs a tilt table. Because he's been unable to move and hasn't stood up for so long he has developed bony spurs on his hips. As a result of that immobility, he has massive pain now when he moves. He'll either have to have an operation to get rid of that or be left as he is. So if the preventative stuff had gone in we wouldn't have had the cost of the operation, the father would have the job intact and there are demands on the system everywhere you go. So solving this and putting in that preventive money would really have saved everybody I think.

DEPUTY CHAIR - Bronwyn, we certainly don't envy you your work as an advocate. There obviously must be so many stories out there similar to the ones that you've just told. I am just wondering if there are any final questions that might come from that. Are you going to provide some stuff for us electronically?

Ms MORKHAM - And I have brought a couple, as you can see, very badly stapled together copies of the Senate inquiry we put in. I will also send some disks of the presentation.

DEPUTY CHAIR - Bronwyn, I'll make sure that Lin gets a copy of the complimentary remarks you made when you first opened up here today, about us being the first Parliament to look at this circumstance.

Ms MORKHAM - You've shown foresight and innovation. It's all true, though, because this is the first one of its kind.

Mr MORRIS - We try.

Ms MORKHAM - Yes it's really great, congratulations again and thank you. I was also asked to offer Alan Blackwood's apologies. He wanted to come along today and he was going to talk a lot more about the Blackwood Street innovative pool project but I can get him to send that to you. He was heavily involved with Pellatt Street this morning and he's off tomorrow to Canberra. They have a thing happening up there so he had to head to the airport. So his apologies.

THE WITNESS WITHDREW.

Mr JOSEPH CONNELLON WAS CALLED AND EXAMINED.

CHAIR - Joseph, what we're about is we are a standing committee of the Tasmanian Parliament with representation from both Houses and across the political spectrum and we have investigated since our inception a series of issues including things like aged care and ambulance services. I have a particular interest that came from Mr Morris here about the issue of young people being possibly inappropriately housed in aged care facilities in Tasmania. We have taken a reasonable amount of evidence today and locally but with your experience and your relationship with the Pellatt Street Project, your information would be really valuable. If you would like to just go ahead and give us your information and then, if you don't mind, we will interrupt you with questions.

Mr CONNELLON - Please do. I've brought a kit of information which I will give out to you and it has a number of things in it. I am the CEO of Supported Housing but I came to this issue of young people in nursing homes with particular baggage in that six years ago I became CEO of Headway Victoria, an advocacy group in Victoria.

CHAIR - Yes, we have a branch in Tasmania.

Mr CONNELLON - We launched a campaign around young people in nursing homes who in fact -

Mr MORRIS - Which we have just had Bronwyn leave.

Mr CONNELLON - Yes, that was as a result of that campaign. I remember clearly on 1 April 2000 there was a march from the Mall to Parliament House, which happened nationally to raise awareness to the issue. I went from there. I then worked in government for the Department of Human Services and wrote the acquired brain strategic plan for them. That also included a portion on strategy around addressing the issue of young people in nursing homes because the majority are in fact people with acquired brain injury. Some two and a half years ago I became CEO of Supported Housing and today I have been at the opening of the Pellatt Street Project, which you rightly say is very important. I might talk about that in a bit more detail later on. I might just talk about supported housing which is a unique creation to Victoria, from what I can work out. I am not aware of other entities around the State.

Mr FINCH - Is that Singleton Housing?

Mr CONNELLON - It's where we came from. We started as Singleton Housing 13 years ago and seven years ago they created a foundation called Supported Housing. Singleton Housing was around mixed equity, it was around people with intellectual disability in group houses. Supported Housing is far broader, and essentially the tail now wags the dog. Supported Housing is the largest provider of community housing in Victoria for people with disabilities, and by that I mean people with intellectual and physical disabilities and also people with mental illness, so that we don't make that artificial divide between the two, and with the biggest provider of housing in the HIV-AIDS community. Our role is to provide housing in whatever form it's needed. We are focused on people with disabilities who require support. We provide no support

ourselves but we have 46 partner agencies ranging from mainly non-government but some government agencies. It seems to me that the deal is that we do the bricks and mortar and they do the support. As long as they can support the person they can put in whoever they like. We don't have a role in selecting the tenant. We sit in this funny intersection between housing and disability.

The other thing about us is that we are quite entrepreneurial. We are quite aggressive in that we will go out and develop projects. A Pellatt Street project, for example, involved the board committing \$1.25 million worth of funds when we had \$600 000 available, so they essentially bet the bank on it, and that was about the equity of the organisation. They weren't particularly foolish because they knew the market and they're experienced property developers and financiers so they know what is going on. Clearly these are people who want action. I have to say, in terms of that particular project, that pre-dated me by about a year or two, so I can't claim any credit. I was a big horrified when I arrived there to find out what they had done but they said, 'Here it is, you go away and fix it', which is what today has been about.

The role of SHL is this sort of broad property company. Somebody called it a real estate agent and the minister today said we might be insulted by that, but in fact we are not. We do whatever it takes, picking up on the ABI-dominant philosophy. We do whatever it takes to get the solution, and that could be going out finding a property. We were recently commissioned by an agency to find properties for people coming out of the detention centres in South Australia in Melbourne. We would just go and find a property of a particular brief. We might modify it to provide home mod service to the Transport Accident Commission. We own some properties but our major business is just managing. Most of the stuff we own is managed by others; we do the ownership development, whatever it takes.

CHAIR - Is it a not-for-profit organisation?

Mr CONNELLON - Yes, absolutely. We were the first entity to migrate from a incorporated association to a company limited by guarantee in Victoria. And we needed to do that to satisfy our financiers because we were borrowing commercially. In a given year we might do 20 feasibility projects which could be anything from something for Jewish Care for people with intellectual disability to something for those working for people with mental illness. It is a range and it could be a single unit by itself or it could be a whole range. It could be a group house. It doesn't really matter to us, we just do the bricks and mortar. We see ourselves as the back of house.

We managed 900 tenancies of people with disabilities who require support. They are in 500 properties. We have about 100 properties under management. We own about 70 of those and a small number of those we manage on behalf of other NGOs. We provide a range of tenure so that some our stock is transitional so people might stay a couple of months. Some of it is long-term but some of it is shared ownership which is where Singleton came from. That was originally shared ownership. They might have support that ranges from somebody dropping by once a month to 24-hour, live-in support. In fact we have one project where we have two staff members on one person 24 hours a day, which is extraordinarily demanding. From our point of view, our role is the same, to get the bricks and mortar to make that happen essentially, so that instead of that traditional role having the two services intertwined, they are clearly separated. This has its basis in

ideology, I suppose. This is about people with disabilities taking their role in the community as a tenant, but it's also about practicality. We focus just on doing housing. We let support be done by the support people. We understand it but that's their stuff. We are always walking around looking at properties, looking at opportunities and bringing that particular focus to it. We are quite narrow in that sense.

The partners we have range from the funders, the DHS and also the Transport Accident Commission people with funds in the Supreme Court. You do get some interesting things. The Government, for instance, is most of our business. Yesterday we had a call from somebody who had some money and wanted to do something for people with disabilities and they have a house and the deal is that we manage the house, they don't get any rent but they don't get any bills either. So we just manage to break even, we just take care of it and we are like a trusted agent, if you like.

I've explained to you about our management and the access to our properties, essentially through our support partners. The thing that is unique about it is our focus on disability and people with disabilities who require support and our focus on partnership. We only do it with others and we favour those people who do the hardest end of it. We have a capacity to deliver. We have done a number of projects and we have done some of the most complex projects and we have expertise in planning and development. One of the trends in disability accommodation is in over-engineering. Today, to deliver a group housing is costing the Victorian Government, is in the order of \$200 000 per head. If you go to New Zealand, and we recently did some work with IHC New Zealand, a joint presentation conference, they are coming in at about half of that. The project that I have come from delivering today has capital funding of \$600 000 from State Government, which is housing money, CSHA money, and we have 14 people accommodated - or 13, one staff in it - so you can do the maths on that. This is not Rolls Royce accommodation. What we provide is modest accommodation and so we fight very hard around that issue of engineering and over-engineering. We are pragmatic, if you like. That is where we come from. It is a capacity to do things and a wanting to do things and assembling the expertise. I have 15 staff and they are very experienced. The building person was the CEO of a building company before he came to us, so we don't come from a traditional social services. His main background was a business degree at college and then working in the city in investments. So it's about outcome focused. While we can play the policy game, we are not that interested. The thing that makes a difference is getting people into houses because that's what changes their lives and that's what we see.

We piloted a development for people with mental illness for the homelessness program in Victoria, which I have to say I was very dubious about, which is about simply taking people off the streets. As a landlord you're thinking that if this goes wrong my job is to deal with the neighbours, but the remarkable thing is that it hasn't gone wrong. What we see is demonstrably people getting better quality of life. It is remarkable; it is this centrality of accommodation and having it secure and affordable. I know that is the rhetoric and the cliché but it is absolutely true and it's just remarkable. We figure if we do this part of this well, develop projects and put them up, other people can do the support and if we do it really well our tenants never really know who we are, and we are just somebody in the background, which is fine by us.

Mr MORRIS - You've got a job to do.

Mr CONNELLON - Yes. So before I move on to Pellatt Street, do you have any questions about us?

Ms RITCHIE - Yes, you're only in Victoria at the moment. Are you looking to expanding to other States?

Mr CONNELLON - Yes, it's one of our challenges. I'm talking to the New South Wales Government about some of their de-institutionalisation and that's as much to inform me as to inform them. We sit in a particular place in the world that says we believe in disability community housing - that is, small developments in the community where people have tenancy rights who are of the community, which is a very narrow view of the world when you look at disability accommodation. They have some lovely institutions in New South Wales. If they want to rebuild them into better institutions we are not going to be part of it, but if they want to do the hard road and go down into community inclusion we will be there.

Ms RITCHIE - Have you had any discussions with the Tasmanian Government, given that we've gone down the road of de-institutionalisation?

Mr CONNELLON - No, I have had some discussions with the Brain Injury Association because I was part of that national network with Sue Hodgson, who I am sure you know. Essentially the expertise we have is exportable. We would be happy to do projects but we only work in partnership with local expertise. We use local architects and local support partners. What we bring is a conceptual framework and it's almost insurance. Because we have been around 13 years we think we've made every possible mistake so we think we know what we are going to run up against. It is comforting to people to know that we are there as partners or that's how they should see us.

Ms RITCHIE - Just as an aside from what we're doing, did I hear you say that you also helped provide housing for people leaving the justice system - for example, prison? Did you say that or not?

Mr CONNELLON - No. I am smiling because some of our tenants have not left it, they've gone back to it. No, there's a correlation between people with disabilities and the justice system. There is a pilot in Victoria, the Transitional Housing and Management Project looking specifically at that, and I can't remember who is doing it. The Office of Housing would be able to help you.

Ms RITCHIE - Okay. I thought it would be something interesting perhaps to you because of the whole issue surrounding people leaving prison and not being able to secure accommodation. Then, therefore, they're easily likely to get back in because they don't have a house and I just wonder if that was -

Mr CONNELLON - It's no uncommon, particularly with people with brain injury and people with mental illness. Our criteria is that if you have a brain injury, mental illness or you have a disability, we work with you and we work with everything you have. So we do run across it.

Ms RITCHIE - Sure, thank you.

Mr FINCH - How do you get the briefs to do the projects that you take on? Where do they come from - from organisations, individuals, from government, new clients? Do you deal with them individually or groups of clients with the same issues?

Mr CONNELLON - There is always far more demand than funding. There are always projects out there. We have 18 queued up at the minute ready to go if I could get the money and they essentially come from our partner agency. There is a particular process going on in Victoria called the affordable housing strategy -

Mr MORRIS - Funny that.

Mr CONNELLON - registering a number of affordable housing associations -

Mr FINCH - Has a ring to it.

Mr MORRIS - It has a ring to it that we're familiar with.

Mr CONNELLON - In Victoria they're nominating four-plus associations. One of them will be disability and we are one of the contenders for the disability and probably the frontrunner, I would say. As part of that process we range around our partner agencies over a two-week period and asked if they had any projects. The deal was they had to put up 25 per cent of the capital and they have to be people with disabilities who required support. We received 15 projects and I think they totalled about \$30 million. We have a program called the Mixed Equity where we put up the first \$100 000 and the family put up the rest and that is \$50 000 coming from government and \$50 000 coming from us. In that circumstance we are working with a group in Ballarat and that has been quite instructive because we found that it is much more difficult to work with three family members as a group than individually. If we are going to do more of that we are going to need more resources to do it. Individuals are fine because you negotiate their requirements one on one but there is a set of dynamics that go on that just get very complicated, particularly when they interact with support.

The likelihood is that we will do more through agencies and essentially that is packaging up the agencies' proposals to spend money, and the reason the agencies want to do the projects is government is putting up some money under the AHA strategy.

We also do feasibility and development work. I am working with people in Geelong who we have no projects with or properties but they specialise in working with people with autism. This is an emerging area; we really do not understand it and what I am doing is being their bricks and mortar advice. I am trying to learn about what those people need and what we need. A year from now we might get a project and five years from now it might be a priority and we will build it. So it is long term. We tend to have a large number of projects in development from disparate sources chasing funding all the time.

Mr MORRIS - Can you just enlighten us a bit more on what you think it is that New Zealand has that enables them to deliver at half the cost of Australia?

Mr CONNELLON - I think it is around government provision in Victoria. About half of the supported housing is provided by government and it tends to drive government policy.

Government, instead of looking at a regulatory issue in terms of just funding and regulations, sees itself as a provider, and government and bureaucracies are notoriously and rightly risk-adverse. It builds in more and more protection.

The other thing that happened in Victoria, of course, was the Kew fires which 20 years on is still resonating. So that is part of it.

You only address it when you get government to take that broad view. I find it enormously frustrating that we spend twice as much money on the construction that we really need to at a time when we have 3 000 people waiting for places. There are pressures, if you are a bureaucrat in the State department, to look after those that you house and those that you don't.

Mr MORRIS - Right, okay.

Mr WHITELEY - Compared to New Zealand, where are the savings though?

Mr CONNELLON - Design in straight quality of materials, but also in the tendering processes. Our buildings are bigger and everything is built with a 30-year or 50-year lifespan - more than is normally required.

The way the New Zealand people do it - they are dominant in the markets - this is IHC; they have about 80 per cent. They go out to developers and have a look at - houses are quite big on new estates these days. They take a big house and essentially pick the design and knock out a few walls and it becomes a group house. They are adapting from something that a developer is doing a whole lot of the time.

When we do it here, to build a CAU today we go out and we commission an architect who goes through the specifications which have just been redefined into more risk-adverse strategies and tactics and then it is put out to tender and people see it's government so that whack a bit on for the trouble of dealing with government and, of course, they will get paid for it. It is just a series of processes. It is a combination of things. I was a bit staggered when they revealed the numbers because in every other aspect, construction in New Zealand is more expensive than Victoria.

Mr MORRIS - There you go, isn't that interesting.

Mr CONNELLON - Yes, it is interesting, particularly when I look what we deliver today in Pellatt Street for half the cost, but that is the nature of government.

Mr WHITELEY - But there is something to be said for, like you said, every dollar over spent in the bricks and mortar it's one dollar less they've got for others or within the individual support packages. At the end of the day it comes from all the one source, doesn't it?

CHAIR - I'm not really sure how much of a link there is between our affordable housing strategy and provision for people we are talking about today.

Mr MORRIS - Quite strong.

The move that's run by Housing Tasmania and the move over recent years has been very much towards Housing Tasmania providing housing for those with disabilities of various sorts rather than just low income.

CHAIR - Oh yes, I am aware of that but what about those Smart units? They're not building group houses.

Mr MORRIS - Oh, yes. My understanding is that they are not outside the affordable housing strategy.

Mr WHITELEY - I haven't seen any.

CHAIR - Me neither.

Mr MORRIS - Right, okay. I thought they were specifically included in the strategy.

CHAIR - We may need to get Housing Tasmania in to ask exactly what they are doing.

Mr MORRIS - Yes.

Mr CONNELLON - We are a creature of the Office of Housing in Victoria. It might seem strange. We get \$2 400 a year recurrent funding from disability services and \$1 million from housing. Our role is to navigate the housing world and capture as much housing and property and money for people with disabilities.

Mr MORRIS - I wonder whether there's the capacity and sufficient size in Tasmania for that type of model to work for us.

Mr CONNELLON - What sort of model?

Mr MORRIS - Of having someone like yourself who has -

Mr CONNELLON - You'd buy in the expertise. It's a plane trip. What you need is the big picture stuff. You've got the architects, builders and support providers on the ground, I would assume.

Mr MORRIS - Yes, absolutely. We do indeed.

Mr CONNELLON - There is no reason. We have a lot of experience and it's your opportunity to build on that.

The Pellatt Street project - there is a small plan in your kit.

Essentially this is a really interesting story in that this is the cutting edge of our national response to getting young people out of nursing homes. This is the state of the art and when you see the project you realise how it is quite a modest thing.

This was a retirement village built in 1981 by the Uniting Church and like a lot of units built with Aged and Disabled Persons Act funding, independent living units are running down. This one was structurally okay but they had not provided for maintenance and

they couldn't fund the contribution so the financial gearing was all wrong. It got to the stage where they owed \$800 000 and the local people couldn't keep it going and the central agency said sell. So they sold.

We bought it for \$1.25 million. We got \$600 000 from housing so it is a housing project and then we - and this is over a four-year period, I have to say - subdivided it and sold that part of it off. These are individual units, we did not end up doing the group house.

This was bought by Australian Home Care Services which is a subsidiary of the MS Society. They were also our partners in the site so they provide services right across the site and it ranges from people with - two of the units shown here are wheelchair-accessible and one over here. All of the people here have acquired brain injury or degenerate neurological conditions - MS and those sorts of things. You have high level care over here plus two respite beds.

There is 24-hour staff on site but in some cases the people on site just require some supervision. It is that problem you have with people with cognitive impairment who can get into very interesting scrapes unless you realise what is going on. There is essentially a decay of their circumstances, but this will pick it up. We have a staff unit sitting here that is supervising access to the site.

From our point of view, while it was very difficult what we provided was fairly simple units. These are typical independent-living units and not as flash as we would be building today, but as an alternative to a bed in a nursing home, these are fabulous.

CHAIR - Can you give a thumbnail sketch of the people who are living there?

Mr CONNELLON - Two of them are in wheelchairs, physically disabled from traumatic brain injury. There are guys in their 20s, a couple of women in their 30s and 40s with MS. There is another guy who has a brain injury who has no physical disability or no particular impairment but has quite significant cognitive impairment and gets into trouble. It is a real mixture.

Mr FINCH - A range of issues - not just MS or just Huntington's disease?

Mr CONNELLON - That's right.

In a housing sense this is very modest housing accommodation. It is quite adaptive.

Mr WHITELEY - But as you said, compared to a nursing home, it is a five-star suite.

CHAIR - The people who are living there, are they people in general who come from the area?

Mr CONNELLON - Some of them do. This is in a suburb of Melbourne called Beaumaris which is extraordinarily expensive. I have to say that one of the things that happened soon after we bought the site was that the neighbour across the road rang up and asked what we were doing with it. When we said we were putting up houses for people with disabilities, he said, 'Oh, no, you can't do that; far too expensive.'

Laughter.

Mr CONNELLON - I had great pleasure at the opening.

Mr MORRIS - Yes, I'll bet.

CHAIR - Is Beaumaris near Oakleigh?

Mr CONNELLON - Yes, on the other side. On the beach side.

CHAIR - Right.

Mr CONNELLON - I couldn't afford to live there.

They have a connection with the region. Some lived there but not all of them did. It is an interesting exercise putting a bunch of people with fairly high needs into a fairly affluent suburb. There were some initial problems but this is building on a property that was originally the church and the tennis courts so this bit of land has had service in the Presbyterian Church for 80 or 100 years and we've continued that. This is St Martin's Court. This is the name of the project. That was the name of the church.

Mr WHITELEY - It's got community ownership.

Mr CONNELLON - That's right.

CHAIR - You didn't get any planning objections from anyone?

Mr CONNELLON - Oh, yes, absolutely. and we employed very expensive and ugly planning lawyers to sort it out. That's what we do.

Mr FINCH - What sort of objections would you get?

Mr CONNELLON - They were dressed up as traffic, but essentially a nervousness about particularly people with brain injury living in the community; the community is not that comfortable with it. They confuse them with all sorts of other things.

There is an exemption in the Victorian planning code, which is not well understood, which was put in place for creating CTUs mental health units which essentially exempts any DHS-funded development from planning. So we roll that out. It does not exempt us from getting car parking; we still have to jump through that hurdle but once you've got it there you are arguing about something else and that is just incredibly neat.

Laughter.

CHAIR - We had a situation recently where the Government purchased the Welcome Inn at Kingston. It was an unused motel, basically, or an under-used motel. I can see where people like yourselves would come in because there does not seem to be a natural unit or part of housing that knows quite what to do next rather than just hand the whole thing over to -

Mr MORRIS - The Government's owned it for two years and it is still a motel. They haven't been able to manage the process of conversion.

CHAIR - There is probably not the expertise -

Mr MORRIS - No, there's not.

CHAIR - in the housing unit or whatever it is.

Mr MORRIS - It is the first time they have done this sort of stuff.

Ms RITCHIE - Yes, and quite rightly. As the point was made before, people in the department are focusing on the people they already have housed, that is what they're spending their time doing, looking after their existing client base whereas we need extra people who are out there to pick up things for us.

CHAIR - So theoretically then, an organisation like your own if it were present in Tasmania would be constantly on the lookout for opportunities like the Welcome Inn whereas it seems to have fallen into a bit of a hole, this particular one. They would be making it happen, getting the tenants in.

Ms RITCHIE - Just like private developers are doing for their own interests.

Mr MORRIS - Yes, that's right.

Mr CONNELLON - That's right. We are developers.

Mr WHITELEY - Can I ask a question about the care providers, the supervisors? What do you call them - carers? Do they live on site?

Mr CONNELLON - No. There is 24-hour, on-site presence. There is a staff unit but they are not caretakers.

Mr WHITELEY - Can they sleep there?

Mr CONNELLON - Yes, it has a sleep over.

Mr WHITELEY - So basically that is a roster? Eight-hour shifts?

Mr CONNELLON - I am not quite sure what they peak at. I think they might have a peak of three on site, but it moves up and down with the day.

The other thing about it is that it is not a residential care model, it is an outreach model so that it is much more flexible in the way it's approached. You don't get trapped into that whole debate about whether it is somebody's home or somebody's workplace. This is somebody's home.

Mr MORRIS - I was just going to ask on that point. What is the arrangement? Have people the option of purchasing or are they all rental or is there a flexibility there?

Mr CONNELLON - No. Outside of what we delivered, we got funding for seven units and we have nine on our side and that was under a straight capital grants program. We have this mixed equity program, the one I was talking about when you put up the first \$100 000. We used two of those places to fund the other two units because we have different eligibility for housing and disability services. There is an asset limit in the housing side and I have forgotten what it was but I think it is up to about \$50 000 or \$60 000. Once you have assets above that you are not eligible for public housing and this is public housing eligibility. We used a mixed equity component to get those other people in. They typically have assets of maybe \$100 000; they are not that rich. They are in that middle area where they have some money but not enough to afford to buy their own place.

CHAIR - Like the vast majority of people, probably.

Mr CONNELLON - Well, no, the majority of people with disabilities don't have anything. MS is a bit different -

CHAIR - I was thinking along the lines of people who acquire it rather than having a disability.

Mr CONNELLON - Even those who acquire it, they run down their money very quickly. When I was at Headway we looked at some of the settlements. There was a guy in South Australia who I think got \$10 million or \$12 million. That was going to expire before he would.

CHAIR - Is this because of the cost of his care?

Mr CONNELLON - It is just extraordinarily expensive.

Mr WHITELEY - Ownership resides with whom? The State?

Mr CONNELLON - No, no with us. SHL.

Mr WHITELEY - So the title is retained with them and the Government then leases it from you?

Mr CONNELLON - No, no they just give us a grant and we go away and do it.

Mr WHITELEY - So you maintain it?

Mr CONNELLON - Yes, and our funding model is such that we charge people an amount of 25 per cent of their income plus Commonwealth rent assistance. The net cost is the same as if they're in public housing. With that money we can run it and we can maintain it and also, more importantly, we can fund modest upgrades as they need to happen.

Ms RITCHIE - So housing doesn't do any of that?

Mr WHITELEY - You don't fund the care, though?

Mr CONNELLON - No.

CHAIR - Meanwhile your equity base is growing to the point where it would be easier to borrow to do other stuff.

Mr CONNELLON - We don't have any problems borrowing, we have problems paying it back.

Laughter.

Mr MORRIS - Can I just follow that previous line? Your tenants qualify for Federal rent assistance -

Mr CONNELLON - Yes.

Mr MORRIS - because of your unique private - in our case, Housing Tasmania tenants do not qualify for Federal government rent assistance.

Mr CONNELLON - There is a fairly contentious debate -

Mr WHITELEY - Because they are in a State asset.

Mr MORRIS - Yes.

Mr CONNELLON - No, no. We have tenants in properties owned by the State who qualify for Commonwealth rent assistance.

Mr MORRIS - Now that's worth knowing about.

CHAIR - How did that happen again?

Mr MORRIS - Just let's write this down carefully.

Mr CONNELLON - The Commonwealth rent assistance rules are complicated and fraught. There is not a lot of clear policy statement on them but it is clear that if you are a tenant of the State Housing Authority you are not eligible but if you are a tenant of another agency you are and that definition of that tenancy seems, in the Commonwealth mind, to relate to how it is managed, not who owns it. Because we had leased properties - the Office of Housing leases properties to us - our tenants quite comfortably get CRA and where it has been challenged it has not been a problem.

We are obviously nervous about it because they are at risk but I have noticed in the last year there has been a move, even in an area which is quite grey for us, the transitional housing where we in fact are not the owners and do not have a lease, we are simply an agent the way a real estate agent has it, those people are getting CRA as well. I get the sense there is a dialogue going on which I am not party to between the States and the Commonwealth about CRA and community housing.

CHAIR - There will be a lot more after the next Federal election.

Mr MORRIS - Yes. But I would say in the meantime it is a wonder there is not a major lease of all the Tasmanian housing properties to get it once removed.

Mr CONNELLON - The other policy statement for the Commonwealth is that they will not sanction large-scale transfers.

Mr MORRIS - Right.

Mr CONNELLON - We transfer but it is incremental and I do not know what broad scale is.

Mr MORRIS - So essentially if you are creating new spaces they can built into it and they can pick up the rental assistance.

Mr CONNELLON - Yes, but you can also transfer an amount as you go through. We have got 65 000 public housing units or something in Victoria.

Mr MORRIS - Right.

Mr CONNELLON - The other thing I think which is critically important in terms of housing policy directions at the minute is that you rightly said before that there has been increased focus on people with - in Victoria they are called special needs but people with high needs in housing so it was seen as an accommodation arm with lots of support programs in government, so a much more whole-of-government view. That has changed quite dramatically in Victoria over the last six months and it is to do with the realisation that the Commonwealth-State housing grant will not sustain growth in the portfolios, in fact may not sustain the portfolios.

I know that some States are in a lot of trouble. I know that South Australia is and will be disposing of between 10 or 20 per cent of its stock -

CHAIR - So is Tasmania. We have got about \$200 million a year I think from the Commonwealth for housing and we pay back all but about \$20 million of that in interest on old loans.

Mr MORRIS - Mind you, the terms and conditions of those loans are not too bad in terms of the net portfolio.

CHAIR - True but it would be nice to have it written off though, wouldn't it?

Mr MORRIS - I do not know that is quite where it is going actually but anyway it is some of the best loans the State has got.

Mr CONNELLON - However, in this circumstance there is a liability - I mean properties are an asset. They also are a liability, you have got to maintain them, and Victoria I think is the best place of all the States and we are going to struggle to maintain our public housing portfolio and one of the ways it will happen is there will be a refocus on the working poor away from those most in need. We are seeing it with the Affordable Housing Strategy which is clearly targeting that so I am deeply concerned, as an advocate for people with disabilities who in the past have had quite good access to public

housing and community housing but that is going to erode significantly over the next five to 10 years and I can see the compelling reasons why it would.

CHAIR - Thank you very much.

THE WITNESS WITHDREW.