LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON EDUCATION AND COMMUNITY INCLUSION

(Reference: Inquiry into Loneliness and Social Isolation in the ACT)

Members:

MR M PETTERSSON (Chair)
MISS L NUTTALL (Deputy Chair)
MS N LAWDER

TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 7 MAY 2024

Secretary to the committee:
Ms K Langham (Ph: 620 75498)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents, including requests for clarification of the transcript of evidence, relevant to this inquiry that have been authorised for publication by the committee may be obtained from the Legislative Assembly website.

WITNESSES

Privilege statement

The Assembly has authorised the recording, broadcasting and re-broadcasting of these proceedings.

All witnesses making submissions or giving evidence to committees of the Legislative Assembly for the ACT are protected by parliamentary privilege.

"Parliamentary privilege" means the special rights and immunities which belong to the Assembly, its committees and its members. These rights and immunities enable committees to operate effectively, and enable those involved in committee processes to do so without obstruction, or fear of prosecution.

Witnesses must tell the truth: giving false or misleading evidence will be treated as a serious matter, and may be considered a contempt of the Assembly.

While the committee prefers to hear all evidence in public, it may take evidence in-camera if requested. Confidential evidence will be recorded and kept securely. It is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly; but any decision to publish or present in-camera evidence will not be taken without consulting with the person who gave the evidence.

Amended 20 May 2013

The committee met at 12.31 pm.

SCHIRMER, PROFESSOR JACKI, Health Research Institute, University of Canberra
LIM, ASSOCIATE PROFESSOR MICHELLE, Principal Research Fellow, Ending Loneliness Together

THE ACTING CHAIR (Miss Nuttall): Good afternoon, and welcome to the public hearing of the education and community inclusion committee for its inquiry into loneliness and social isolation in the ACT. The committee will hear today from a wide range of witnesses who made submissions to the inquiry.

The committee wishes to acknowledge the traditional custodians of the land we are meeting on, the Ngunnawal people. The committee wishes to acknowledge and respect their continuing culture and the contribution they make to the life of the city and this region. We would also like to acknowledge and welcome other Aboriginal and Torres Strait Islander people who may be attending today's event.

The proceedings today are being recorded and transcribed by Hansard, and will be published. The proceedings are also being broadcast and webstreamed live. When taking a question on notice, it would be useful if witnesses used these words: "I will take that question on notice." This will help the committee and witnesses to confirm questions taken on notice from the transcript.

The committee does recognise that this is a sensitive topic, and the secretariat has information on support organisations available for witnesses and people attending or watching who are impacted by issues raised during the hearing.

We welcome witnesses from the Health Research Institute of the University of Canberra and Ending Loneliness Together. Do you have any comment to make on the capacity in which you appear.

Prof Lim: I am an associate professor in the Sydney School of Public Health and the CEO of Ending Loneliness Together.

THE ACTING CHAIR: I remind you of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. For witnesses appearing remotely, this was sent to you by the secretariat. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered a contempt of the Assembly. Could you please confirm that you understand the implications of the statement and that you agree to comply with it?

Prof Schirmer: I confirm that and agree to comply.

Prof Lim: I also confirm that and agree to comply.

THE ACTING CHAIR: Thank you. With that in mind we will get into the hearing proper. Would either of you like to make a brief opening statement today?

Prof Schirmer: Thank you for the opportunity to give evidence. Loneliness and social isolation, as you know, are increasingly recognised as significant threats to public health and important areas to focus on, to prevent mental and physical ill-health. We feel the impacts of loneliness across a lifespan, across diverse cohorts, and at personal and social levels.

At the University of Canberra Health Research Institute, our aim is to deliver leading research to support a healthier future for Canberra. Our team examines a range of factors that influence health and wellbeing, and amongst those we conduct some specific projects that shed light on both loneliness and social isolation in the ACT; namely, we have our Living Well in the ACT Region survey, and our social fragmentation index.

The Living Well in the ACT Region survey uses an internationally recognised measure of loneliness to examine how frequently we have people who are experiencing significant or profound levels of loneliness in the ACT. We have measured data on loneliness across the ACT five times in the Living Well in the ACT Region survey since 2019, and that is including during the COVID lockdowns and out of COVID lockdowns. These data are reported on the ACT government's Wellbeing Framework data dashboard, so you can explore them there, but some of the data I will talk to goes beyond what is in the dashboard.

The key thing that has come out is that, while we have seen fluctuations in levels of the loneliness people experience over time, there are some groups for whom it does not really change; that is, if you are living with a disability that severely restricts your day-to-day functioning, you have an extremely high risk of having high levels of loneliness—34.6 per cent in one of our recent surveys. If you have recently arrived in the ACT; more than a quarter of recent arrivals who have come in the last three years have pretty high levels of loneliness. It takes a while to settle into the ACT, and we have a really high population that comes in as new to the ACT. So that is a particular area of challenge for the ACT. We also have single parents, carers, people with moderately restrictive disabilities, people who are living alone, renters and those living in units and apartments and identifying as LGBT, as well as the ones who are often recognised, which are the youth aged 18 to 29.

Contrary to a lot of public data or assumptions out there, people aged 65 and older are some of the least likely to experience frequent loneliness. It does not mean that older people do not experience loneliness—some do—but it is at lower rates than for other age groups.

We separately have our Australian neighbourhood social fragmentation index, and that highlights that we have several suburbs with high social fragmentation. It measures isolation or risk of isolation. That includes Belconnen, Braddon, Turner, Phillip, Greenway, Kingston, Barton, Bruce, Lawson, Lyneham, Dickson, Gungahlin and Duntroon. If you know Canberra, you would know that a lot of those are characterised by a lot of recently arrived residents, a lot of younger people living there, a lot of units and apartments. They are all risk factors. We know they are risk factors from the international literature as well.

While we have growing evidence of the distribution of social isolation and loneliness in the ACT, we still have limited high-quality evidence about the types of interventions that work best. More and more interventions are being trialled worldwide but a key challenge that has been found in multiple reviews is that we lack some of the evidence we need about which interventions are most effective. And a lot of the interventions that have been trialled have been trialled amongst elderly people, not amongst some of the ones who are actually at higher risk than elderly people of experiencing profound loneliness and social isolation.

The last thing I will talk to is that the Health Research Institute is currently starting a new intervention project called the Connect Up project. That will be developing and piloting interventions to reduce isolation and loneliness amongst people aged 18 to 30 living in Bruce and Belconnen. They are some of the high-risk areas. They are also areas where we know a lot of youth experiencing loneliness are located in the ACT. We look forward to co-designing interventions as part of that project and pilot testing them over the coming year.

THE ACTING CHAIR: Thank you so much.

Prof Lim: I will speak to a lot of data on the national and international level. I also sit on the World Health Organisation technical advisory group which has launched the Commission on Social Connection this year. This is a three-year, high-level commission that will hopefully make recommendations back to our governments at the end of the three years.

We know from the State of the Nation report late last year that loneliness is a highly prevalent issue. Almost one in three Australians report feeling lonely. About one in six Australians report feeling severe levels of loneliness at any given time. In terms of gender, there really is not any difference between men and women—and that is very similar to the international data that we see; but, similar to a lot of the international data, we know that young people in particular are highly vulnerable.

Whilst that did not record older people as highly vulnerable to loneliness, that could be an artefact of who we are targeting to do these sorts of large studies. Often the most vulnerable older people, the ones who are isolated and the ones who are lonely, rarely take part in surveys. There are also other issues around intergenerational attitudes that mean older people might under-report loneliness because they are meant to get on with it, and they want to present as stoic. I am yet to be convinced that it is an issue that is not highly prevalent in the most vulnerable of our older Australians, and I think a lot more needs to be done in this area.

What we do know from data from the State of the Nation report is that if you are lonely you are about twice more likely to also report chronic disease, almost five times more likely to have depression, four times more likely to have social anxiety, and almost five times more likely to report poor wellbeing. People who are lonely are less engaged in physical activity. They are more likely to have social media addiction and are less productive at work. So there are not just the health outcomes but the workplace productivity impacts—things like high levels of absenteeism, high levels of presenteeism. All those things are associated with loneliness.

In this year’s State of the Nation report, which will be released in August this year during Loneliness Awareness Week, they will also be showing trends—persistence of loneliness and isolation. We are no longer in the phase where we just want to capture prevalence; we also want to capture ongoing, more enduring, persistent levels of loneliness, and look at how that is linked to worse outcomes.

Unfortunately, we do not really know about the high prevalence of loneliness. Australians hold a lot of misconceptions of what it is and what it is not. They think that people who are lonely are less worthy and that it is a sign of weakness. And because of those misconceptions almost half of Australians that we surveyed said that they would actively conceal their loneliness. More than one in two do not talk about their loneliness to anyone, and almost half are embarrassed to talk about their loneliness. This means we are not really getting the help that people need early. They know that this is an issue, but they do not know how to get help, where to go and in what context. I think Australia has a lot of work to do in terms of providing our community with recommendations not just about our most vulnerable groups but also the public health messaging—what we are telling our community and how we talk about loneliness in a healthy way.

THE ACTING CHAIR: Thank you so much to both of you for that. With that in mind, we will now proceed to questions. I am happy to kick off and then we will go one by one in terms of substantive questions.

My first question is to Professor Schirmer. Within your submission there was mention of a plan, a co-design intervention program using link workers, to address the social isolation. I think you have already briefly touched on this, but what communities, in particular within the Belconnen district, were consulted?

Prof Schirmer: Yes. At the moment the consultation process is starting, because that intervention will be a co-designed process with people aged 18 to 30 living in both of those suburbs. The reason Bruce and Belconnen have been targeted is that we know that our social fragmentation index data for the ACT shows that they are two of the several suburbs with high fragmentation. We also know that that is where we have high clusters of people recently arrived in the ACT, and that that is a risk factor showing up in our other data collection. Also the area is co-located with our university, which is very helpful for us.

We do not know what intervention we will be doing yet because we want to make sure that we are actually co-designing with people on the ground as a first stage of the project. There are many options for interventions, but this will be intervention at the individual and local community scale. It will not be touching as much on the public health messaging that Michelle talked about, which we absolutely agree is critically important to address some of the challenges around loneliness. We need those interventions at all those scales to really address this challenge.

THE ACTING CHAIR: What patterns do you expect to emerge when you are looking into social isolation? Do you have any theories about that yet?

Prof Schirmer: Just for clarification, do you mean patterns of which people are more and less isolated?

THE ACTING CHAIR: Yes, absolutely.

Prof Schirmer: Broadly speaking, at the moment we have geographic data on a fragmentation index that indicates proxies for isolation. We also know that your subjective experience of loneliness often, but not always, tracks isolation. So I would say you would see some similar patterns for those we have seen by measuring subjective experiences of loneliness, but it is quite possible that with isolation we will have—and we know other studies have found this—groups of people who are objectively isolated but do not experience loneliness. So there is that diversity of experience, where some people do not have both simultaneously.

MS LAWDER: I will start with Professor Schirmer, too, if that is okay. You talked about some risk factors, including a higher risk for those people living in apartments. I can see on your map the distribution in the ACT. How does that compare to other parts of Australia and overseas? Is densification a risk to our mental health? We are looking at densification for a whole lot of environmental and other reasons, but will there be less desirable flow-on effects?

Prof Schirmer: I would not say densification, in and of itself, is a risk to mental health. But I would say that it depends on how densification is done. There are examples internationally of people with very cohesive communities living in units and apartments. I think the reason we have highlighted units and apartments here is that in Canberra we have a reasonable number of renters. We have reasonable clusters where you have people who have recently arrived living in units and apartments, and that can be a risk factor. We may also have a cultural factor, where there is not a culture of getting to know people in those.

We have quite differential experiences as well, in that it is a higher risk. It does not mean that everyone living in a unit or apartment is experiencing loneliness. That is not the case at all. And we have, undoubtedly, examples of people who would say they have an incredibly friendly, socially active unit in an apartment block where there may have been a local leader in that block who has led social activities and encouraged engagement, which can make it an incredibly friendly place and an incredibly socially connected place.

To make a long answer short, densification, in and of itself, is not the issue, but it is about those policies around it. It is even down to some studies identifying that the design of the group spaces—the spaces for social interaction—within densification or within unit and apartment block developments makes a very big difference, as well as the social places outside them in the publicly managed areas, like local parks, walking paths—all those things.

MS LAWDER: Are you saying partly it is about connectivity from the apartment to the neighbouring facilities to make sure that there is appropriate greenspace and not just buildings that are one foot, one metre or half a metre—whatever the technical metric term is—apart: so close together but you do not have open space for people to gather in?

Prof Schirmer: I would not get that precise with the data that we have, but I would say the evidence is pretty strong that it is about that connectivity from your apartment to a place where it is easy to interact with other people.

THE ACTING CHAIR: Specifically on the link workers, I know that you have mentioned that, as part of the co-design process, you would be working this out, but are there particular roles you expect link workers to play in addressing the social isolation?

Prof Schirmer: I will have to take that question on notice and ask the people who are leading the work.

THE ACTING CHAIR: That is completely fine. Thank you.

MS LAWDER: Associate Professor Lim, when you talked about the link between loneliness and chronic disease, anxiety, depression et cetera, is it chicken and egg? Which comes first? Is it causal or a correlation? What is the relationship?

Prof Lim: That is a very good question. There is some data that says they link to both, so that is the relationship, and it is reciprocal. It depends. For example, with loneliness and mental ill-health, we know that loneliness is acting as an epicentre to poorer mental health existing in our community—people with mental health disorders. It does precede, but we also know that if you have high levels of social anxiety, it is almost more likely to lead to more loneliness. So social anxiety—in particular fear of evaluation from others and a fear of embarrassment—actually does stop people having interactions, and therefore being more lonely.

There are pathways which a lot of researchers are looking at—for example, what factors lead to or might interact with the pathway between loneliness and poor health: things like health regulation behaviours—physical inactivity, diet, maybe medication adherence. Those sorts of things are being examined a lot in international data.

THE ACTING CHAIR: My question is also to Associate Professor Lim. Within the section, "What do Australians think about loneliness," you said that many people have negative misconceptions about loneliness and that makes early intervention more difficult. What would you say are some of the key mechanisms for early intervention so far, understanding that the data is still in process?

Prof Lim: Is that in terms of changing or improving our awareness?

THE ACTING CHAIR: Yes, improving awareness and identifying it early on, and whether that is through programs or peer support.

Prof Lim: Yes. Let me go one step before. I can go to the low intensity and then cover more of the high intensity. First of all, the problem that we have in Australia and in many parts of the world—not just Australia—is that "loneliness" is still seen as a bit of a stigmatised word. It is probably how we talked about depression 20 years ago, when I was training as a psychologist. People did not really understand what depression was.

This is where we are at with the word "loneliness". People do not really understand it. They get it confused with social isolation, but we do know that they are different constructs. One is a much more subjective feeling of isolation, and the other one is something that we can count, as it is objective. Because of that misconception, people think that the solution to loneliness could just be putting people together, when in fact it is a lot more complex than that, because we do not know if someone is lonely unless we ask. We do not know if they have an impact of loneliness unless we measure it.

We need very good awareness-building campaigns to make “loneliness” a word akin to feeling hungry or thirsty. The way I feel about loneliness is really your signal to asking me if I would like to connect. It is very similar to, “Would you like to eat?” or “Would you like a drink?” We need to start like that, and that way people will get more comfortable with seeking the help they need early. Also, helping people to manage their loneliness for themselves and others becomes a lot easier, and it has a flow-on effect—so, getting the help early, connecting early as opposed to retreating, connecting in more high-intensity solutions, perhaps, within our community or within our relationships or individual-type therapies. Those sorts of things become more acceptable when we ensure that loneliness is something that we can openly talk about.

MS LAWDER: I am wondering—it is open to either of you to answer—if you are aware of research that explains how people might address loneliness and social isolation. What kinds of ways have they undertaken to improve their feelings of loneliness? Is it joining a book club or going to squash? What does help, do you know, or are you focused more on the research of loneliness and social isolation?

Prof Schirmer: I might let Michelle answer first and then I will add to it, because Michelle probably does a lot more work on this. I do some work in the intervention space but probably a lot less than Michelle.

Prof Lim: The question really depends on your age group. There are strong preferences related to age, and accessibility on top of that. With a young person, for example, going to a book club may be much more terrifying than interacting in a much more closed manner. I would say that how people select their solutions sometimes also depends on whether they are aware that they are lonely, because loneliness does come with a stigma. Also, people do not think about their own loneliness because, again, it is not acceptable. There is this internalised shame that goes along with it.

What I will say in general is that loneliness is a bigger problem. It is highly prevalent and very difficult to resolve. What we actually need is an all-systems approach. Loneliness and interacting with people and having these meaningful connections is weaved into everything we do. For some people going to a book club might not be enough because they might have additional challenges in the way they eat, perhaps, which might drive them to really not engage, for example, in social activities. So they might go into those things, but they might not be meaningfully engaging in those things.

We also note—just on the side—that not all social connectedness is healthy. Some connections that we have are not healthy. It is about us almost improving our “social hygiene”—that is what I call it—because we need to know what is good for us and what is not, and how to access the kinds of help we need. Again, this goes back to that awareness. The person themselves or us as a community need to talk about our experiences of social relationship and what we need, because what I might need might be very different to what you need. That makes it, again, a problem that is highly prevalent and commonly experienced but very difficult to resolve because there is no one-size-fits-all solution.

Prof Schirmer: I would probably add to that—again, with that emphasis that the intervention that is effective depends on the specific circumstance, and the extent of loneliness and/or isolation—that one of the groups I would like to highlight is people who are living with a disability where society presents significant restrictions to functioning. Amongst that group both isolation and loneliness are incredibly high, and that is where there is a lot of scope to put in place functional interventions that actually remove some of those barriers we know exist.

During COVID and the first lockdown, we happened to be measuring our loneliness. Loneliness rates did increase during the lockdown; then, as soon as we came out of lockdown, they headed back down again. If you are a person living with a disability that presents that level of isolation, you are living like that all the time, and there are a lot of very functional, practical policies and strategies that can enable people with disabilities to have the same opportunities for social connection and social interaction as other cohorts, and that I think can act really well.

Sometimes we need to focus on that more than the generalised book club and social club. I am a little cautious about saying that because they also can be good in the right circumstances, but who are the groups who are experiencing those functional barriers to even having the opportunity for the social interaction that a lot of the rest of us take for granted? There are really important things to be done there. I agree completely with the whole-of-systems approach.

The other group I would like to highlight is the recently arrived, because I think that is one where a few surveys—to some extent including ours—have found that there are higher rates of subjective loneliness in the ACT, particularly amongst those people in their first three to five years living here. We have a decently large population cohort of them. The ACT has traditionally been a place where a lot of new people come in as young adults.

We are only just starting to have our little second generation and third generation Canberrans these days. Having interventions that help people to have opportunity to make social connection in that first year, where you have had a break in social connection because you have come from elsewhere and you have to create new social connections, is another obvious opportunity. Hopefully, that is something that the intervention project we are doing will particularly give some insight into.

Prof Lim: The kinds of interventions that are effective for people sometimes depend on whether they experience transient or episodic bouts of loneliness and social isolation, or often what are persistent ones—ones that endure over a period of time. The interventions that might be more effective for the group that has more enduring, chronic attacks of loneliness and social isolation might be ones that need to be more intense—more involved. A book club is one very light, low-intensity solution; perhaps they need a lot more than just a book club.

Prof Schirmer: Yes, I very strongly agree with that. That is where the medical intervention comes in—counselling and therapy—to address some of the negative ideas, self-talk, that will happen, and that will mean you will not even get to the book club, because you are convinced there is no way that that can happen. That intervention can be incredibly important for those who are probably at the highest risk of some of the most negative health outcomes because of that persistent loneliness.

MS LAWDER: I am certainly not trying to malign book clubs in any way.

Prof Schirmer: I actually love book clubs.

MS LAWDER: I have a clarifying question. How do you measure loneliness? Is it a certain number of meaningful interactions in a week? What exactly are we talking about, in your survey?

Prof Schirmer: In our survey, measures of the number of interactions are more of a measure of isolation. Measure of loneliness is about your subjective experience: do you feel lonely? You can ask people, "How often have you felt lonely recently?" and that is one valid measure. We use one that asks about three separate aspects of it, and I put them in here, because I thought I might be asked this question.

MS LAWDER: I am glad to oblige!

Prof Schirmer: We asked about three items: how often do you feel that you like companionship? How often do you feel left out? How often do you feel isolated from others? People can tick "never", "hardly ever", "occasionally", "sometimes", "often" or "all the time". We are not asking them to say how many days a week. That is not something you can do subjectively. Also, it is not the most important thing for subjective loneliness. I know that my husband would feel really lonely a lot less easily than me. I need a lot more social interaction than him, to not feel lonely.

To measure isolation, we look more at things like how frequently you are interacting with other people. Do you have a partner that you live with? You can then also move to things like measuring the quality of some of those relationships, because it is quite possible to be both subjectively lonely and isolated when surrounded by a lot of people. Not everyone has the benefit of healthy, functioning relationships, housing and homes that keep them safe from loneliness and isolation. That is how we do it. The fragmentation index uses data from the census. It taps into isolation by looking at: how long have you lived there? Are you living with a partner, de facto or married? What sort of family are you living in? Also, there are the population turnover rates. They are some of our measures there.

MS LAWDER: Are there barriers to improving your feelings of isolation? Returning to book clubs and squash, for example, my mind was going to whether socio-economic status, and therefore potentially costs of living, might have an impact. I was thinking potentially about a free activity versus something that costs you money to attend. Do you have much data on that?

Prof Schirmer: The short answer is yes; we see social connection and social activity decline when people are under financial stress. Financial stress, absolutely, is a risk factor for loneliness. I do not know whether Michelle has data as well—probably a lot.

Prof Lim: We have not launched a survey yet. In terms of the effect of financial stress and strain on loneliness, people are cutting down on activities of social interaction because it costs too much to interact with people. Even with things like having people over to the house for a meal, when you are financially stressed, you are less likely to do that. Also, you are more likely to then experience loneliness.

Going back to the previous question, the loneliness outcomes framework that Ending Loneliness Together has put forward is very similar to the one that was mentioned. We do the four-item UCLA loneliness scale, and the reason we are proposing that is that this is what we call measurement in variants. Regardless of whether you are 18 or 85, you will respond to those questions in the same way.

With the framework that has been proposed by the federal government, we have also submitted a question on a one-item loneliness scale—the Office for National Statistics, on frequency of loneliness. It was about how often you feel lonely. Those things have already been proposed by the federal government.

THE ACTING CHAIR: I am asking this of both of you. Other submissions—Meridian is one that jumped out—mentioned that loneliness in Canberra can be articulated well with the iceberg analogy. I think you both touched on the idea that people who do reach out for help are only a small portion of the people experiencing loneliness. You mentioned stigma, but how do we offer support not just for the people that reach out but for the people that do not? What are the principles of universal design that can aid that?

Prof Lim: This is not something that is the flavour of the month; this is something that we need to address right now. We need to think about how we can create our environment, our community, our schools and our workplaces to facilitate and promote social connections, to reduce loneliness and social isolation, and think about ways in which we can build our environment to support us in not just initiating meaningful social connection but maintaining meaningful social connection.

In addition to things like awareness campaigns, we should think about what policies the government can put in place. Can we, for example, teach young people how to navigate social challenges as they age? Can we better prepare older people to retire socially, not just financially? Can we look at having workplaces that promote people to be together and to form meaningful connections outside the work context?

We can do an awful lot, including things like building places that are safe for people to come together. We can ask questions about where we should start. We have to start somewhere. This is not just a health problem, a social problem, a business problem or an economic problem; it is a problem for all of us. We have to think about this as a multisectoral issue.

THE ACTING CHAIR: Sometimes the connection that feels most genuine comes from grassroots groups—community organisations. What role do you see for government in improving social connectedness? Is it enough for government to do their own programs or should they be seriously investing in community groups and spaces, in order to have genuine connection?

Prof Lim: I agree. First of all, we do not have enough funding for community organisations to do the work they need to do. In addition, we do not have enough training or guidance for these groups to do the best work that they can potentially do. We need funding to ensure that they receive the best training and guidelines, so that they are aware of what tools to use and how to work with very vulnerable groups, including people who might have mental ill-health or people who might have existing issues.

We need to better support these community grassroots organisations to do the best job that they can. We need funding for peak bodies, and we need funding to go to these organisations themselves, so that there can be sustainable approaches. Many of them might do very small-scale work with very small segments of the population; then they are no longer sustainable and they have to close down. That is such a huge loss to the community. We need to know how to better support these grassroots organisations.

Prof Schirmer: I absolutely agree with all of that. A lot of grassroots organisations are under pressure. We talk a lot about social prescribing as one of the potential interventions for loneliness, but one of the challenges with social prescribing is how to make sure that GPs, or whoever is doing the prescribing, have an understanding of, "This loneliness is different to this loneliness." What is right for this person might be different to what is right for that person.

We know that social prescribing, when well targeted, can do well. We need to do that. With the prescription that is given, whether it is a free voucher to go fishing, free transport to get out and do an activity or free membership to a sports group—exactly what was just said—we need to make sure that the people in that organisation who are meant to be supporting people who may have profound levels of loneliness and some comorbidities are actually able to support them. One of the most challenging things is that we do not want to prescribe an activity and then have someone try it and feel just as lonely, if not more so. That is a real risk if we do not design well.

Prof Lim: In addition to that, there needs to be training to link workers. We found—and we delivered that for the Victorian government—that there was such a varied background in the people who are doing this work. Not all of them are coming from the same place.

Prof Schirmer: Yes.

Prof Lim: Basically, we help them, with the latest evidence from our international work overseas, with how things are defined, how it works and how to assess. Everyone came from a completely different place. Again, there needs to be education of our frontline practitioners—people who really make a difference. We all need to come from the same place—how to do it, how to tailor it, how to assess, how to monitor and how to direct.

Prof Schirmer: It sounds like a great investment would be to invest in those sorts of courses for a wide range of people from across sectors and organisations to be able to participate in. That has certainly come up as a real need.

MS LAWDER: In your research, have you considered, or had any evidence about, the role, positive or negative, of social media in people feeling isolated or lonely?

Prof Lim: The last State of the Nation report, late last year—it is also based on international data—showed that this is very much an issue that is affecting our younger cohorts. We do not see these trends in the older adult space, because older adults use social media very differently.

I will speak about younger people. We found that it was not about frequency of use; it was about how people use it. When we develop dependency or addictions from problematic social media use, that is when there is a difference. You actually rely on using these tools more than you should do. When you do not use it, you feel worse. Those sorts of things are what we call problematic use. That is when it is quite highly associated with loneliness.

We are modelling that data now for the next State of the Nation report, coming out in August, because we have longitudinal data that examines this over a period of time. We suggest that the problem is much more specific to younger cohorts—around 18 to 34 years old.

Prof Schirmer: Certainly, in our work, we do measure, as part of our survey, some additional data on types of social connection that people have, including social connection that happens via social media. There are plenty of examples of positive social connection via social media that can engender a sense of community and connection. The classic example is the Facebook community noticeboards. Depending on how well they are moderated and run, they can be fantastic or they can be terrible. I am lucky enough to live in a region with a fantastic one. I know that it has helped new residents to connect with each other, build support, and all of those things.

It is not a question of whether social media is good or bad; it is about how we design fantastic ways for people to interact that are positive, via social media.

THE ACTING CHAIR: Have you been able to gather any evidence, especially during the pandemic, when actual physical interaction was at a minimum, that there were certain spaces where, particularly for younger cohorts, the ability to communicate online would promote better connectedness?

Prof Schirmer: We do have data for during the lockdown and after it. We know that loneliness increased for all cohorts. What we saw was not a change in the level of loneliness, based on that, but that the link between your level of loneliness and your subjective wellbeing was not as strong as if you were able to keep in contact with people via means other than seeing them face to face.

In other words, the loneliness had a less bad impact on your wellbeing if you were feeling lonely but you were still managing to at least get online and you figured out Zoom or Teams—remember that we all had not done that at that stage; I still probably have not!—and you were able to still talk to grandma or the grandkids. That did offset it; to some degree, it weakened that really strong association between your level of loneliness and your wellbeing.

MS LAWDER: Professor Lim, you mentioned in your opening comments Loneliness Awareness Week, which I had not heard of before. What occurs during Loneliness Awareness Week?

Prof Lim: Late last year, Ending Loneliness Together launched an inaugural Loneliness Awareness Week. It was a week for addressing loneliness and talking about loneliness.

It was about really improving loneliness awareness. We launched a piece of research last year, the State of the Nation report. That was launched by Andrew Leigh in Parliament House last year. This week is trying to destigmatise loneliness and show that loneliness has no face. It has different faces. It looks at different segments of our population.

This year we are focusing on the CALD communities and, hopefully, on children as well, if we are able to. We are focused on getting Australians to use the right language to get the help that they need. We also have a directory on the website where people can enter their postcode and look at what kind of things are happening within their open spaces. We help to direct people to some groups that could actually help them and who are on the ground. This year, that will be the first week in August.

MS LAWDER: Okay; I will keep an eye out for it.

THE ACTING CHAIR: Absolutely. Other submissions made recommendations about the benefits of community sport, which you have also both touched on. You mentioned people who are less likely to engage in physical activity. How do we bridge this gap, regarding those who do not engage in sport but could greatly benefit from it?

Prof Lim: Is the question about promoting sport participation?

THE ACTING CHAIR: Yes, absolutely; and whether that is an access question or just about promotion.

Prof Lim: This is also an activity that does not have any stigma associated with it. It is a nice activity in which people can come together. This kind of activity has more of a public health lens. The data that has been looked at by the University of Sydney has shown that loneliness should be looked at in a positive way. Again, only certain cohorts of the population might have access to sport participation or can have sport participation. This is one of the many strategies that we can promote as an activity that can bring people together to form a meaningful connection.

Prof Schirmer: Sports groups, absolutely, are one of the supports that can help people to address isolation. It is important that we do not focus on sports groups at the expense of other activities that can also incidentally promote physical activity—things like local landcare and parkcare groups, where you get interaction, you go out into nature, you are connecting and walking. We need to make sure that we are considering that broader range of interventions that can promote physical activity, without necessarily requiring someone to play a sport.

THE ACTING CHAIR: On behalf of the committee, I thank our witnesses for their attendance today. If you have taken any questions on notice, please provide your answers to the committee secretary within five business days of receiving the uncorrected proof *Hansard*. Thank you both for your time.

KELLY, MS LISA, Chief Executive Officer, Carers ACT
JOHNSON, MISS JESSICA, Policy Officer, Carers ACT

THE ACTING CHAIR: We now welcome witnesses from Carers ACT to the public hearing of the education and community inclusion committee inquiry into loneliness and social isolation in the ACT. I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered a contempt of the Assembly. Could you please confirm that you understand the implications of the statement and that you agree to comply with it?

Ms Kelly: I agree.

Miss Johnson: I agree.

THE ACTING CHAIR: Would you like to make a brief opening statement?

Ms Kelly: Yes. Thank you for inviting us to present today. A carer's wellbeing is directly related to their experience of loneliness, and in Canberra our carers are lonely. Carers face compounding barriers to social connection—some that are universally shared and others that are unique to carers and to the ACT. Both can be addressed when the fundamental barriers of recognition and choice are acknowledged.

It is not unusual for a carer to feel consumed by their carer responsibilities and to feel as though they have no other role in society. This is especially true for carers who are unable to work because of the care they provide. When 87 per cent of carers tell us that they do not feel that other Canberrans understand or value their role, a role that has consumed so much of their identity, it is not surprising that they feel lonely.

Carers are notoriously time poor. They do not have the luxury of time for leisure or social relationships. For many, the choice to provide care is not a choice at all. Canberra's carers are the least likely in the country to access respite services. They tell us that this is because of the lack of suitable options. How can we expect carers to engage in community or form social networks when they are required to care continuously, when they cannot have a break?

Let us personalise the experience into an understanding of the life of Mary, who cares for her son who lives with profound disabilities. As a sole carer, Mary's days are a whirlwind of hospital visits, travelling to see specialists, mountains of paperwork and non-stop advocacy. Consumed by her carer responsibilities, she has no ability to work and no time for leisure. She attempts to join a playgroup for her son, but they meet at a local playground which does not suit her son's needs because it is not fenced and it is inaccessible. Being on the sole carer payment, the mother is on the poverty line, so even simple social outings are over-budget. When she manages to attend community events, she faces judgemental stares, and her son's disability-related behaviours and outbursts draw attention.

After over a decade of non-stop caring and increasing isolation, a doctor suggested

Carers ACT. The mother was excited that there were subsidised social activities and that she was eligible for respite care, and could finally have a night off from caring. But her son has complex needs and behaviours, and the mother found that there was no service provider in the ACT willing to offer respite care for him. She continues to care for her son non-stop for the rest of her days—lonely, isolated and exhausted, because she has no other choice.

Solutions do not need to be revolutionary; they need to be practical—more fenced playgrounds, accessible public spaces and events, creative public awareness campaigns and accessible respite options. While these changes are simple, they could be life changing for a carer.

To tackle loneliness and isolation among carers, we must be practical. We must provide carers with choices, with recognition and with adequate consideration. Solutions that we propose in our submission are not revolutionary, but the implications they have for the lives of carers might be.

THE ACTING CHAIR: We will now proceed to questions. Recommendation 2 of your submission emphasises the importance of self-identification of carers. One of the examples that you gave is promotion at events, and carer express lanes. Could you please go into a little more detail on what this would look like?

Ms Kelly: We have been talking a lot about how we encourage carers to identify, to recognise the benefits of identifying, to recognise what that means for them in terms of overcoming barriers to access. We have been talking about what it would look like if, at Skyfire or the Canberra show, as a carer, I could have a fast lane. Particularly for carers of people with neurodiversity or sensory disorders, standing in line can be particularly challenging and difficult. It would mean the difference between whether or not I could come to the event. If I could watch other carers doing that, and if I recognise myself in them, I would be more encouraged and more likely to self-recognise and self-identify as being a carer and access the services and supports that might be available.

In all of the activities and events that the government puts on and are sponsored by the government, carers should be at the forefront. How do we see them recognised? It is not just about disability being recognised in car parks, but having closeness to access, facilities that are available in the space, and sensory spaces next to first aid spaces. Those sorts of initiatives would help people to self-identify into the space of being a carer and take away some of the stigma.

MS LAWDER: I will ask a question similar to what I asked the previous witnesses, about barriers to participation. I refer, for example, to cost of activities. You have mentioned in your submission that many carers cannot undertake other work outside the home because of their carer responsibilities. Are you talking here about people who receive a carer payment or people who do not, or both?

Ms Kelly: Both. Carers who receive a carer payment are visibly struggling financially, and we know that, because their payment is not enough to cover costs of living. We also know that carers who are employed will be struggling as well, because of increased medical costs, increased equipment and increased strain on finances. With running machines in your house 24/7, there is an electricity cost. Those sorts of costs that come through in caring families, which are not often subsidised, and in places are not often recognised or seen, can have a significant impact on family budgets and family income. In particular, I refer to the income you have that is not attributed to anything—your flexible income.

MS LAWDER: Discretionary?

Ms Kelly: Discretionary; thank you. Your discretionary income is probably what is impacted the most. I refer to the ability to go to a movie or go out for dinner. Those things are seriously compromised in all caring families; we just see it more so where the income is also lower.

MS LAWDER: You also mentioned that the lack of adequate and appropriate respite can contribute to some carers not being able to participate more. But is that enough? If you could have respite once a month or once every six months, is going out once a month enough to feel included?

Ms Kelly: I think it is a start. I do not think it is everything. One of the things that constantly breaks my heart is when we do an activity like a cocktail party or a social event, and a number of carers will come up to me at that event and tell me that that is their one and only social event in their year. The survey of disability, aging and carers tells us that most carers only get to one social activity in a year, particularly without the person they care for. That often hits me, because I think: imagine having to be able to choose only one social event in your year; which one would you choose? How do you do that?

Respite is one way, but it is not enough. If I have respite and no financial support then I have a break from my caring role, but I have no income to go and do anything with that break. We often see respite as being this separation of the two people in the relationship, and that is often not what a lot of carers want. They actually want to stay with the person. They are in a relationship with this person, to a large degree, so they want to be in that relationship, but they want to have a break from cooking, cleaning and doing some of the more everyday care tasks. It is about how we help to support respite in multiple ways. We need to see respite and social inclusion as something built into the daily, weekly, fortnightly and monthly lives of carers, in the same way as it is for the rest of us.

Miss Johnson: I would like to add that we are working a little bit on trying to change the idea of respite being just, as Lisa said, something where the two parties come apart. We are trying to phrase respite as something that is an outcome: a break from the caring role rather than a break from caring.

MS LAWDER: Interesting. Is there resistance to going to respite by either carers or individuals being cared for?

Ms Kelly: We know that depends on the person, to a large degree. For example, we know that, if people who are aged and frail have a bad experience of respite—if their first experience is bad—trying to get them back to respite can be increasingly difficult. We know more and more that we need to do better at making sure those experiences are positive, encouraging and supportive. We also know that, for example, respite in aged care that involves a six-week stay in a nursing home is often not congenial to a carer or the participant and often does not fit with what it is that is needed in those people's lives at that time.

We know that carers who have the highest care load are the ones who are often least able to access traditional respite, because the options in Canberra are just not there. The people they care for often have care needs or behaviours that exceed what is available for them in Canberra. Respite can be something that provides great relief to some families and some carers and it can be something that is just not accessible to others, so it is not a solution in its own right.

We need to rethink what we mean by respite. For me, respite might be about going to a playground and allowing my son to play on the equipment in the playground while I have a coffee, and not worrying about them running away, not worrying about them crossing a road, not worrying about them getting out of my sight, and just having 10 or 15 minutes to have a coffee in some peace. That could be respite for me. Being able to go with my friends to do that could be respite for me. Allowing my parents, who are ageing, to take my child to a park and feel safe in doing that could be respite for me. But when we do not think about social spaces and we do not think about recreational spaces from the lens of a carer and only think about disability being a physically impaired disability, we are actually excluding a whole range of natural respite and natural social inclusion activities for carers.

THE ACTING CHAIR: What sorts of planning can we do in social spaces to make sure that carers are included? Is it things like adequate seating and sensory spaces? Are there particular examples you could give?

Ms Kelly: Yes. We have talked about having carer-inclusive checklists for both events and spaces. We have talked a lot about this before. Instead of thinking about whether it is accessible for people with disability, people who are aged and people with mental illness, if you actually make things accessible for carers you make it accessible across the board. What does that mean? Where is the parking situated? How quick and easy is it for me to get out of the event? If the person I am caring for cannot cope anymore, can I get out easily? What does that look like? What does the road or pathway look like? What does it look like if I do not have a disability car parking sticker? It might not be that I need it all the time, but I do need it at events. Is there a safe space for when my sensory challenged child has a breakdown and needs a break from what is happening? Is there a safe space to which I can take him at the event that can help me calm him and recalibrate so that we can continue at the event? Is there a possibility that I can have some financial support?

Getting to something like Skyfire, for example, is great, but the cost of taking food, buying food and doing all of that stuff becomes quite exorbitant. Can we think about how transport routes work for families with disability? Can we think about how to get transport to an event and back from the event? What does that look like? Do we need to have some buses that are quieter and are specifically designed to have sensory capability and capacity in them? Getting home from some of those events in very loud and crowded buses can be problematic.

We think about some of the recreation facilities. For example, I was at Stromlo recently, at the pool there. The car park is such a long way from the front door. That is fine if I am pushing someone in a wheelchair, but, if I am not pushing someone in a wheelchair but have somebody with a physical ailment of some sort, that becomes a barrier to being able to access facilities and being able to provide facilities.

On the other hand, I also think we need to do more about stigma. I know that parents will not often take children or adults with disability who have behaviour that can be confronting for other people. They just will not go. The stigma, the look, the sound and the conversation that happen are barriers. How do we help people understand what those behaviours are, where they are coming from and what to do in a situation when you see that happen? Do you offer help? How do you do that? How do we come together and realise that caring is actually a community responsibility?

THE ACTING CHAIR: Would you see benefit in expanding the ACT Companion Card program and offering carers their own individual card with the aim of further increasing social inclusion of carers?

Ms Kelly: We would counter the Companion Card with a carer card.

THE ACTING CHAIR: Wonderful.

Ms Kelly: We are not massive fans of the Companion Card. We would prefer to have a carer card—a card administered through Access Canberra, a card that is recognised across Canberra.

MS LAWDER: How would that be different to the Companion Card?

Ms Kelly: A Companion Card gives you access if you are with the person. It provides you with supplementary or free access to things, but you have to be with the person and they have to meet particular criteria of disability to get the Companion Card to start with.

MS LAWDER: A carer card would give the carer the opportunity to—

Ms Kelly: Yes. It gives recognition. It gives awareness. It actually holds an identity for the carer separate to the person they care for. So often the carer's identity is secondary and behind the person they care for. Often it is about: "Tell me what you do for somebody else and we will celebrate or recognise that," rather than saying, "Let's see what you do and who you are, and celebrate and recognise you." It becomes a bit of a club: "I have a carer card. You are a carer. Look at this. Isn't it great?" We can connect with each other and have identity with each other in that space. It might be that I can have a carer card because I care for somebody with a chronic health condition that does not meet the criteria for a Companion Card and is not necessarily associated with a traditional form of disability, but I have actually recognised that I play a significant role in assisting a person with the task of daily living.

It is a great way for government to show that we recognise, support and validate the role carers play in our community. It also has added benefits for things like additional bins when we move to full implementation of the food and organic waste trial. We know through the pilot of that that those additional bins were essential for some carers. It would mean that they could access a carer access line or fast lane and that they could get parking closer to events because we recognise that card. It would also mean we could link it to emergency care plans and things so that, when carers are unable to care or are incapacitated to talk, somebody will know they are a carer and will be able to provide additional supports in that space.

Miss Johnson: This is something we have spoken to our carers about in a couple of focus groups—the idea of having something from the government that recognises them. We hear quite often from carers that they were not allowed to be a carer, essentially, because they were not eligible for carer payments, so it was like: "I am not a carer." Obviously, that has a lot of ramifications because it means they are less likely to access supports, whether that is through Carers ACT or elsewhere. The idea of having a card that recognises them as a carer, even if they are not meeting minimum Carers Australia criteria, is about having something that says, "I am a carer. I do something above and beyond what is expected."

MS LAWDER: Does this give them discounts or access to things?

Ms Kelly: It is interesting. A lot of carers will say that the financial discount is not the driver for them. It is actually about the doctor saying, "Prove to me you are a carer," and they can. It is about when the health professional says, "I can't talk to you unless you're the carer," and they can prove that they are. It is about when Hoyts has a carer ticket price without a Companion Card, and they can prove that they are a carer when asked for it. It is about that recognition. It is about being able to say, "I have a card that says I am a carer." It may sound like a very small thing, but it has huge meaning for carers in terms of recognition of their identity and recognition that they play a role in the community that we have seen, and we want to recognise and celebrate that.

We at Carers ACT would say, "Actually, we could use this as a mechanism to get discounts for carers in places"—there are some chemists, for example, that provide carers with discounts—and this would help verify that. It would also help us to bring other people and businesses on board to do some of those things—an easy way to identify who is and who is not entitled to that discount.

Miss Johnson: It acts as an extra kind of promotion. You could say, "Hey, Salvos, I know Vinnies has a carer discount," and they might say, "What is a carer?" and you would have this magic little promotion card in your pocket.

THE ACTING CHAIR: Do you think that a scheme with a carer card could be an access requirement for concessions? I am envisaging something like transport, where there are concession prices and stuff like that. Do you think that would be a useful part of it?

Ms Kelly: Yes. We would probably see the carer card taking over from the Companion Card. One of the ways we want to ensure that carers are socially included and are able to access things would be through free transport or discounted transport. The carer card would act as validation for that. If you think about it, if you do not have the person you are caring for with you, how do you prove that you are a carer? Carers look exactly like all of us do. They do not often have a tattoo on them or an indication in any way. The barriers that we sometimes come up against include how to prove somebody is or is not a carer, and this could be a way to make sure that we are proving that the right people are being recognised, are given those benefits and are being supported.

MS LAWDER: You mentioned in your submission the long-term social and economic cost—for example, to do with superannuation and whether you are a paid or unpaid carer. What do you think the government, federally or locally, should do about that?

Ms Kelly: We would really love to see superannuation as a start for people who receive a carer payment. The research we have done shows that, over a lifetime, a carer will have about $175,000 less in their superannuation than their peer equivalents, which means that they provide service and support to the community as a carer when they are caring, and then they pay for that for the rest of their life. They pay for it in their retirement and pay for it in their aged care. We are calling on the federal government to see that the superannuation guarantee, when people are receiving a carer payment, is one form of recognition and thanks, but it is also a way of actually saving money in the longer term. The calculations that we have done show that people will not need an aged-care pension because they will have enough in their superannuation funds to provide them with the supports that they need, and that the compound interest process of superannuation means there is actually less cost for the government over the long term. Pushing for superannuation federally is certainly something we are working on with the national carer network at the moment.

We also need to think about whether the carer allowance and the carer payment are actually adequate for the level of care and the work limitations that caring can provide for some people, predominantly women. We need to think about whether that level of government support is adequate and provides the thanks that we should be providing to carers for stepping out of the workforce and taking on that role. We would call on the ACT government to support our call federally for the need for superannuation payments for carers. We were grateful to see it for parents under the parental leave scheme, but we believe carers have a greater need and a greater longer term need for that support than most other groups do.

THE ACTING CHAIR: In your opinion, do carers that care for people with a mental illness face different challenges and psychosocial hazards that impact their ability to socialise?

Ms Kelly: Yes, in short. I can answer in one word: yes. Caring for someone with a mental illness is a different form of caring. There is a lot of emotional stress; a lot of what we call mind calorie stress. If they are caring for somebody with a mental illness, they spend a lot of time thinking about that person and a lot of time worrying about that person, and a lot of their energy is taken up with being concerned about what is happening for that person. There are little things like never being able to leave their mobile phone and never being able to turn it off, feeling like they constantly need to be available. I should not admit this out loud, but sometimes your phone rings and you look at it and say, “I don’t want to answer that,” and you put the phone down and think, “I’ll get back to that at some other time.” When someone is caring for somebody, they cannot do that. Every time the phone rings, they have to answer it. Every time the person they care for calls, they need to stop everything and make sure they are okay. Respite from that is totally different.

Respite from somebody who is aged or respite from somebody with a disability can be relatively easy to plan and do. Respite from somebody when they are occupying all of your mind space is a totally different thing because, even when you are separated from each other, they are still going to be in your head and they are still going to be in your worries and concerns.

What we know is that mental health carers, more than any other group of carers, are very focused around fixing the mental health system: "If I can get better supports and better assistance for the person that I am caring for, that in itself reduces the impact of caring for me." But we do not hear that in other systems as much. We hear about needing to fix aged care and needing to fix the NDIS and all of that, but carers in those sorts of situations are able to articulate the barriers and what would help them with their health and wellbeing.

Carers for people with mental illness are much more entwined and it is harder to distinguish what can help the carer as opposed to what we need to do to help the person with the mental illness. The stigma associated with that is also a problem. Particularly over the last 12 months, 18 months or two years in the ACT, we have seen terrible reporting of mental illness and terrible ways in which people have spoken about people with enduring mental illness. We have had instances of people displaying violence, and the way that is then portrayed in the media, in government and on political floors has significant impact on carers. We need to be more considerate about the fact we are talking about someone's son or someone's daughter and that the mental illness is not who they are. They are someone's son and they are someone's daughter, and we need to start with that. The stigma is certainly significantly higher for carers of people with mental illness.

THE ACTING CHAIR: Thank you so much. On behalf of the committee, I thank witnesses for their attendance today. If you have taken any questions on notice, please provide your answers to the committee secretary within five business days of receiving the uncorrected proof *Hansard*. Thank you so much for your time. We really appreciate that.

Hearing suspended from 1.50 to 2.11 pm.

REED, MX KAT, Chief Executive Officer, Women with Disabilities ACT
NEWMAN, MX PIPPA, Policy Officer, Women with Disabilities ACT
LAWLER, MR NICOLAS, Chief Executive Officer, Advocacy for Inclusion, incorporating People with Disability ACT
WALLACE, MR CRAIG, Head of Policy, Advocacy for Inclusion

THE ACTING CHAIR: Welcome back to the public hearing of the education and community inclusion committee for its inquiry into loneliness and social isolation in the ACT. The proceedings today are being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed live. The committee recognises that this is a sensitive topic, and the secretariat has information on support organisations available for witnesses and for people attending or watching who are impacted by the issues raised in this hearing.

We now welcome witnesses from Women with Disabilities ACT and Advocacy for Inclusion. I remind you of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. For witnesses appearing remotely, this was sent to you by the secretariat. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered a contempt of the Assembly. Could you please confirm that you understand the implications of the statement and that you agree to comply with it?

Mx Reed: Yes.

Mr Wallace: Yes.

Mx Newman: Understand and agree.

Mr Lawler: Yes.

THE ACTING CHAIR: Fantastic. Would you like to make a brief opening statement?

Mr Lawler: Yes; I would like to make an opening statement.

THE ACTING CHAIR: Thank you. And Women with Disabilities ACT?

Mx Newman: Yes, we also have an opening statement.

THE ACTING CHAIR: Wonderful. We might start with you, Mr Lawler.

Mr Lawler: Thanks. Advocacy for Inclusion welcomes the opportunity to appear before the committee and to speak to us. I will make a brief statement and then Mr Wallace will take questions from there.

The Health Research Institute at the University of Canberra made the case well this morning about the prevalence of isolation amongst people with disability, so we will not recap this evidence. The Australian Institute of Health and Welfare data says people with disability are twice as likely to experience social isolation as those without. The ACT Wellbeing Framework tells us that 26 per cent of people with disability were often feeling lonely; whereas the general figure is 8.8 per cent. Some groups are extremely isolated. A 2015 submission by the Summer Foundation to the Senate inquiry stated that 21 per cent of younger people in nursing homes never go outside, 34 per cent never participate in activities and 53 per cent receive a visit from a friend less than once a year.

The prevalence of loneliness amongst people with disability has increased over the last 20 years. We see a range of causes. Poverty and access to spaces, places and transport are all factors. Many people are in poverty; so additional costs regarding transport can place a premium on activities and outings. In the last few years, COVID-19 has exacerbated loneliness and social isolation of people with disability. Some people with disability need to shield to protect their health and remain in lockdown. Some services and groups closed during COVID and did not reopen. Others are still closing. The closure of the Y gym at Chifley and the possible closure of the hydrotherapy services by Arthritis ACT is a concern because these are also social spaces. Some block funding services which were to provide special opportunities closed when the NDIS came in.

Isolation has consequences. There is consistent evidence linking social isolation and loneliness to worse physical and mental health outcomes. People with disability are among the people most needing a friend to call on in an emergency yet the least likely to have one. In bushfires, we came across people who had no-one to help them clear away leaves or flammable material. We see people in hospitals with no visitors. We hear about people who have falls and are not found for days. Isolation also makes people more vulnerable to violence, with no-one even around to sound the alarm or help someone leave.

Our submission highlights certain things we think need to be done. These include but are not limited to improving access to transport, spaces and places, starting with a focus on social planning and improvements to tackle these, putting more effort and attention into non-elite grassroots sports and recreational activities for people with disability, ensuring that youth foundational supports address gaps in community sports lost during the NDIS transition, providing COVID safe spaces, community development and in-reach to COVID safe places, addressing the lack of information and referral capacity for inaccessible services, including sports, tourism, recreation and the arts, improving OT and activity support for people spending extended time in health settings at the University of Canberra Rehabilitation Hospital and other settings; stressing the need for a disability participation agenda outside employment, and making social connection with disability a focus in government activities and data collection.

Finally, organisations like AFI would like to be doing more to connect and create supportive spaces for people with disability. We note that WWDACT has done this successfully in the past. It is not something we are funded to do and, like WWDACT, we advocate for funding to DPOs to do work in peer support, social connection and activity.

THE ACTING CHAIR: Thank you very much. Mx Reed?

Mx Reed: Women with Disabilities ACT is run by and advocates on behalf of women, non-binary and gender-diverse people with disabilities in the ACT. Women with disabilities have unique experiences due to the intersection of gender and disability and face compounding barriers to participation in all aspects of life. Both gender and disability discrimination work to exclude women with disabilities from the ACT community and, when they cannot access the supports they need, they experience incredibly high rates of social isolation and loneliness.

Around one in six people with disabilities in Australia reports being socially isolated. Whilst this data is not disaggregated by gender, we know that women experience isolation at an even higher rate. Loneliness and social isolation arise wherever the human rights of women with disabilities are breached, from inadequate health care to isolation from like-minded people, unsafe public spaces, lack of formal supports or inaccessible transport. In addition, women with disabilities experience violence at higher rates, including restrictive practices, forced isolation, coercive control or institutionalisation—all of which lead to further social isolation. It is important that the committee considers the unique experiences of women and girls with disabilities in policies and initiatives that foster social inclusion as a priority cohort.

We are a member-based organisation and draw from our members' stories in our submission to this inquiry and our comments today. We are the only organisation in the ACT that represents the intersection of gender and disability and have provided much-needed community supports to our membership in the past, including parenting support groups and community "crafternoons". However, as Nic Lawler highlighted in their opening statement, our funding and funding for organisations such as Advocacy for Inclusion from the ACT government is inadequate. To allow us to support community groups and our reliance on short-term grants mean we cannot provide long-term programs for our membership to strengthen their relationships and grow in numbers.

In our joint submission with Advocacy for Inclusion to this year's ACT budget, we called for additional funding for our organisations, both to continue our advocacy for the human rights for women with disabilities and to provide regular and safe spaces to grow our community and combat loneliness through sharing similar experiences.

THE ACTING CHAIR: Thank you so much. We will now proceed to questions. My first question is to Women with Disabilities—actually, it is to both groups. Transport was identified as a key barrier to social inclusion. Would including free and accessible transport to ACT government recreational activities help address this key barrier for women with a disability and people with a disability?

Mx Newman: It would definitely make a difference for members of our community—noting that transport just to ACT government events does not solve the problem of being able to leave one's house to access other community events, to visit friends and to grow relationships outside those events. Something that came up for our membership is that not all ACT government transport services are necessarily accessible. Excluding the Renault buses, other buses might have ramps that do not accommodate electric wheelchairs that are over the weight limit. Also, the frequency of public transport services often means that this is inaccessible for women with disabilities to get around to the events and to the places that they need to go. I am sure Advocacy for Inclusion will also have things to say.

Mr Wallace: Thank you. In short, yes, it would. We advocate for a whole-of-community business case for making public transport free across the board. But, of course, that is only if you can actually use them as a transit option. For many people with disabilities, buses are simply not something they can wrangle with. What is required is more attention to point-to-point transport, including community transport and the ACT's taxis. With the wheelchair-accessible taxis, in particular, we think they need to be looked at again. There are issues of people not feeling safe when they go on them; it is a very difficult transport mobility and an expensive one. There are also issues around shared paths and navigation when you leave the bus or get out of a taxi to get into the venue. So it would certainly make a difference, but it is not a quick solve for the whole thing.

Mx Reed: I would quickly add that, in writing our submission, we wrote about a member who experienced waiting up to two hours for transport after an event—so the transport home from the event—and it was only a 10-minute ride. They were waiting for two hours. I think there are broader issues involved. Yes, inaccessibility is one of them, and I am very much in agreement with AFI that, across the board, that would definitely improve some things, but there are some bigger issues at play.

The other thing I want to draw attention to is the lack of safe transport for women with disabilities, in particular. We draw attention in our submission to providing incentives to have more women drivers on public transport. We know that our members have said that being able to access transport where the driver is a woman has made them feel safer.

Mx Newman: This is also the case for wheelchair-accessible taxis where it is often quite a vulnerable position. Women appreciate feeling safe and having the option to choose their driver and have that sense of safety when they are accessing transport.

MS LAWDER: We have had some debate in the Assembly about the government's failure to deliver, I think, 33 new disability-friendly buses. The Renaults are still in operation. They were meant to be phased out by December last year, I think. Have you had any engagement with the government advocating for them to deliver those disability-friendly buses more quickly?

Mr Wallace: Yes, we have, quite consistently. We launched a policy platform last week calling for all the Renault buses to be off the road and replaced with accessible ones well within the next term of government—so 2026. But, really, they should have gone already. This is a problem, but it does not solve the whole problem for people with disabilities in the transport mix. We think that moving around the city is actually becoming more difficult for people with disabilities due to a number of factors. The use of micro-mobility devices and the ubiquity of rideshare is a problem for us. Micro-mobility devices mean that people feel like they cannot travel on shared paths. Rideshare is also not offering an accessible option for people with disabilities. So the transport mix is actually changing and it is not adapting for people with disabilities.

We would echo the comment that it is time to have the whole bus fleet reliable. But, even if you have a section of it that is inaccessible, people cannot travel with confidence because they do not know if the next bus that comes is going to be one of the older ones. That is the core problem—the confidence in going out and knowing that you are going to be able to go out and get home safely.

MS LAWDER: It is my understanding—and it may be a bit dated now—that often the ex-government buses move on to become community group buses, and that is perpetuating the problem. Is that still the case?

Mr Wallace: Yes. We think there need to be upgrades to some of the community bus fleet. By and large, they are better, but we also actually need things other than buses. I use the example of being in a wheelchair travelling on a bus, even if it is a community bus. Most taxis are buses, but all of the wheelchair taxis in the ACT are modified transit vans—so they are kind of mini-buses running around. Some people, including me, do not feel comfortable travelling on them at all because you get shaken up too much. So we need some other options.

MS LAWDER: You mentioned point-to-point transport. What do you mean by that? Can you explain that a little more?

Mr Wallace: It goes from your door to the door of the place that you are trying to get to.

MS LAWDER: Is that a taxi?

Mr Wallace: A taxi, an Uber and community transport. For many people, community transport is really important because it is the only low-income version of that where it is done by volunteers and you are not paying a lot.

MS LAWDER: You also mentioned, as part of that, shared paths. Do you mean lack of maintenance or do you mean people leaving scooters around, or is it a bit of everything? What is your issue about shared paths?

Mr Wallace: They are becoming busier and are populated by the micro-mobility devices and the e-cycles as well. We have reports of people nearly being bowled over as they are going on their little walks around their suburb. The maintenance of bike paths and street paths has degraded, we think due to the wet weather that we have had over several years. We are observing a lot more cracks and problems with them. There are areas outside aged-care residential where people have no way of getting out and accessing the local shop because the bit of pathway right outside the village is broken and it takes a long time to repair. So it is a mix of things undermining confidence of people in wheelchairs, on walkers or who are frail to get on to a street path or take any kind of significant journey without risking a fall or a trip hazard.

MS LAWDER: Is that fear of being out on shared paths worse at night, or is there no real difference?

Mr Wallace: WWDACT would probably have some comments on this. With poor lighting, as the days get shorter here in Canberra, allied to temperature as well, it becomes more difficult and challenging for people to navigate around. A fall for a person with a disability or an ageing person is a serious event that will likely put them in hospital or can result in mortality. People are kind of self-selecting and choosing not to travel on pathways that they feel are dangerous, a bit busy and perhaps a bit scary as well.

Mx Newman: We hear from our members that a lot of them do not feel comfortable going out at night, and it is because of the ongoing issues we have talked about around safety. But a lot of it is also about lighting. I think women with disabilities feel especially vulnerable at night. There is not as much confidence that, if something goes wrong while they are outside at night, someone else will see them and be able to step in and help. There is an increased fear of experiencing micro-aggressions and discrimination.

THE ACTING CHAIR: A lot of submissions have talked about priority groups. I note that we have so far tended to talk about them in isolation. But you made a very good point that women with a disability have a good sense of the intersection. How important do you believe an intersectional lens is when it comes to discussing loneliness?

Mx Reed: It is incredibly important. We highlighted in our submission that even taking the cohort of disabled people and adding an additional lens and an understanding of gender depression and vastly increased rates of gender violence means that women with disabilities need different policy responses to address all of the things that are limiting them from being able to participate fully in the community and, especially on the violence issue, to be able to access the help and additional help to leave a violent situation. We have raised in our submissions that something like crisis accommodation is not necessarily physically accessible and there are additional barriers to accessing any kind of crisis support as a person with a disability in the ACT. That is just one of the issues that is compounded when you take an intersectional lens when looking at the experience of loneliness. But we recognise that our community has other intersectional identities. Indigenous women with a disability or queer people with a disability also have specific experiences and barriers to participating in the community.

Mx Newman: I would like to add that women with disabilities tend to have multiple disabilities and a lot more chronic conditions—and autoimmune conditions as well. We saw during COVID that there was an increase in domestic violence cases, and it is important to note that many people with disabilities are still isolating at home for COVID. So, for women with disabilities who are in situations where they are experiencing violence, it is only increasing, and the access to supports is decreasing, unfortunately.

THE ACTING CHAIR: Thank you very much for that. Anything to add, Mr Wallace or Mr Lawler?

Mr Wallace: I will just add that there were all sorts of learnings from intersectional segments of the disability community that are making attempts to do community development, and peer support are doing some of that well. The LGBTIQA+ community is doing disability teas, there is a Roundabout program, and there was an online event back when COVID came, which I think has been ongoing. There are lessons, we think, in some of that work for other segments of the disability community that are also feeling quite isolated. We need proactive in-reach work, and often in particular settings. I am happy to talk about that in a bit more length, perhaps later.

THE ACTING CHAIR: Thank you very much.

MS LAWDER: One of you—sorry, I cannot recall whether it was Mr Lawler or

Mr Wallace—mentioned the closure of the Y gym at Chifley and the potential closure of some hydrotherapy facilities organised by Arthritis ACT. Those are technically not ACT government facilities. Is it funding-related? Can you expand a little for us on why that is important for social inclusion or reducing isolation and loneliness for people with disabilities?

Mr Wallace: Yes. While the Y gym at Chifley was not government funded, there was an approach to government for funding. We think, by the way, that there were issues around the way that services closed, but there is also the coming closure of the hydrotherapy pools operated by Arthritis ACT. We note that there is sometimes a happy combination of social spaces with programs providing rehabilitation and support, but it is difficult enough getting out, when you are in the disability community. If you can get out and go somewhere, you are often mixing social opportunity with an opportunity that brings you some wellness and relief from pain, and it is disappointing that these things are falling away. We have seen a number of these kinds of services—which basically worked well in a block-funded system but do not work well now—that have fallen away since the introduction of the NDIS.

The Rainbow café was another example. It used to be a drop-in café that supported people with psychosocial disability just to meet up and network, but it could not cope with the NDIS transition. We are troubled by a number of services that look like that, that are run by non-government organisations but often off the back of their extensive government contracts and donations to the community and other work, that seem to be closing down at the moment, and that is leading to a reduction in, I guess, people's available social capital to meet and mix with other people.

THE ACTING CHAIR: A strong theme today has been the need for more funding for community services across the board—the kinds of opportunities when we talk about Chifley and hydrotherapy facilities. Is that an opportunity to provide more sorts of secure funding in those particular cases? Apologies if you have already answered that.

Mr Wallace: I do not quite understand the question.

THE ACTING CHAIR: Would you say that there is a strong case, especially in examples like the closure of the hydrotherapy facilities, for more recurrent and reliable government funding for community services?

Mr Wallace: Yes. As we invent this new foundational support system, we would advocate that those are precisely the kinds of services that should be funded. It should not just be about carving out bits of the NDIS to the states; it should be about identifying the areas where there are gaps in services, but also segments of the community where there are gaps in services.

I would make the observation, if I may, that people in some settings like the University of Canberra rehab hospital, where they are staying for long periods of time, actually require some direct support to be activated. We have raised in our submission that we think there needs to be a remit for occupational therapists and activities officers to ensure that we do not have people who are in settings, often for 12 months at a time, with nothing to do and no social connection whatsoever.

THE ACTING CHAIR: Thank you very much. I believe I have another substantive question—you can tell me if I am wrong—for Advocacy for Inclusion. Within the recommendation about promoting inclusion for non-elite sports, there is a mention of grants in education and training. In an ideal world, how would you see this implemented to best suit the needs of people with disabilities in the ACT?

Mr Wallace: There are a number of ways that we can do it, but the reason for mentioning elite sport, and employment, by the way, is that at the moment governments, both state and federal, see their participation remit for people with disabilities in very narrow terms. It tends to be about activating people economically. So you have a raft of employment services that are funded just to do that, and also there is some interest, I think, in elite sports, so that gets funding and attention.

We would argue, for instance, that the employment services, instead of just choosing to activate people economically, ought to be trying to activate people to get a hobby, join a club or be a volunteer. There is evidence that if you get people active and involved, their health improves and their employment opportunities improve over time. It is really good social policy as well as being a human rights imperative. People have a right to live in contact with other people. We think that some of the levers and programs that are already running need to prioritise social inclusion. At the moment I think it is seen as a bit frivolous—like we are supporting people to go on holidays. Well, actually, no; we are supporting people to be connected to clubs, hobbies, events and arts activities in their local communities, and that needs to be seen as legitimate.

We also think there needs to be a reactivation of the old community development officers. There used to be community development officers that were charged with activating people with disabilities, particularly people in settings. They would go out and actually create particular programs. Now, a 21st century version of that would do it differently—they would not be segregated programs—but at the moment it is no-one’s job to ensure that there are participation opportunities for people with disabilities outside employment. That is part of the ballpark—to be focused on that. Also, we think there need to be activities from workers and people whose job it is to activate people.

THE ACTING CHAIR: Thank you very much. Anything to add?

Mx Reed: Yes. We really agree. On the emphasis on sport, a lot of our members have come back to us with a frustration that there is an emphasis on an obviously important sector of community activity but not one that is accessible to everyone, and not one that is of interest to everyone in our community, either. Additional grants opportunities and funding opportunities that are specific to sport are not always going to involve a section of the community where our members can engage meaningfully. There are things like inclusion coaches. If we are re-imagining how community organisations can be supported to include disability, that should expand beyond just sport.

THE ACTING CHAIR: We heard from previous submissions that, even within a physical activity context, rather than necessarily prioritising sport, we should make sure that there are other recreation opportunities for physical activity—I think they mentioned Landcare and things like that—that are not necessarily sports related. Do you have a view on which of those would work particularly well?

Mx Reed: Any of them. Our members participate in a wide range of social activities, where they can, but there are always accessibility concerns and issues. We even heard from one member recently that during a six-week waiting period to get a wheel on her wheelchair fixed, she is unable to participate in her normal volunteering and community activities, regardless of whether those are physical activities or not, because of that accessibility barrier. All the way down the pipeline, there are barriers to people participating in community events.

Mr Wallace: Including, if I may add, a lack of information about what they are. So, if you are a person with a disability and you are a fan of a television program, or you are into chess, or you want to go hot air ballooning, where is the information and referral service that can tell you about the welcoming and accessible sports, recreation and arts activities that are in the community? There actually is not one. There used to be, and it lost funding when the NDIS came in.

We think part of the picture is that there needs to be a way for people with disabilities to identify community groups, organisations and opportunities on the ground for them to get involved in. The ACT government used to hold regular—like annual—Connect and Participate expos, where they would invite clubs, societies and places that you could volunteer in to come and showcase their wares and talk to people with disabilities. We think that is a good initiative, but there also needs to be an online space.

We see people who are getting NDIS funding that would enable them to participate, not knowing where they can go because there is no resource to find them or support them to actually broker a link with a club that might be inclusive of them.

MS LAWDER: We talked about Arthritis ACT and you just mentioned the Connect and Participate expos. Back in the day, were these the tier 2 or tier 3 that lost their funding when the NDIS came in? Do you recall what the category was or what it might be called now—the referral and support information rather than actual services?

Mr Wallace: It was a discrete commonwealth program called the Specialist Disability Information Services program, that did not make the journey to the NDIS. It was actually defunded by the federal government.

MS LAWDER: Yes.

Mr Wallace: Prior to transition they tried to get the NDIA to take it up, but they did not want to. Now I think there is a recognition that something like this is quite desperately needed. There are lots of people trying to do little websites and information and referral services. The problem is that they have to be continually updated and they need to be accurate. A person with a disability cannot turn up to a dog walking society and find out that the ownership or the membership has changed, and they are no longer welcoming. That really burns the person's confidence in participating.

To do this well you would need to have an ongoing service, ideally managed by people with disabilities—because we know the kinds of questions to ask—that is available on the internet and via phone. There used to be something like that, but it is gone.

THE ACTING CHAIR: Before we finish, is there anything that either of you would like to add or to highlight?

Mx Reed: Mostly everything that we covered in our submission. A lot of it has been mentioned today.

Mr Wallace: Chair, I just highlight—it is not in our submission, which is why it is worth highlighting—the lack of visitable housing and the social isolation of people. For some people with disability, they cannot visit the home of a friend because there is no toilet that might be accessible or there is no stairless entry to the house. That is incredibly isolating, if you think about it. On top of everything else, it makes it almost impossible for people to form and hold close friendship networks.

I would also point to the importance of those kinds of friendship networks as a social safety net in times of emergency. As Nic said at the start, we see people that do not have anybody that they can call on if they are in a bit of trouble or if they suddenly need garbage cleared away outside their home in a bushfire emergency. People lack those friendship networks. It needs to be seen as a social asset. If there is one thing you could do that would really make a difference, it would be more visitable housing for that group of people so that they can actually go to dinner with a friend. I mean, how normal is that?

THE ACTING CHAIR: Thank you very much. I really appreciate that. On behalf of the committee, I thank you all for your attendance today. If you have taken any questions on notice, please provide your answers to the committee secretary within five business days of receiving the uncorrected proof *Hansard*. Thank you all so much for your time and for your contributions.

JAKAB van DOOREN, MS KATERINA, Member, ACT Youth Advisory Council
HARRISON, MS LILY, Co-Chair, ACT Youth Advisory Council
BARANCEWICZ, MX MADISON, Member, ACT Youth Advisory Council
WINFIELD, MR CONNOR, Member, ACT Youth Advisory Council

THE ACTING CHAIR: We welcome witnesses from the ACT Youth Advisory Council. Thank you so much for coming in. I remind you of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered a contempt of the Assembly. Please confirm that you understand the implications of the statement and that you agree to comply with it.

Ms Jakab van Dooren: Yes.

Ms Harrison: I have read and agree to the privilege statement.

Mx Barancewicz: I have read it and agree.

Mr Winfield: Yes.

THE ACTING CHAIR: Thank you for that. Would you like to make a brief opening statement?

Mx Barancewicz: Yes. Good afternoon. Thank you for the opportunity to appear before the committee this afternoon. We welcome the opportunity to provide a submission to this inquiry and to provide an important youth perspective to the conversation about social isolation and loneliness in the ACT.

As was highlighted in our submission and made clear in the recently published 2023 HILDA report, loneliness among young people has been steadily on the rise for many years. In fact, people aged 15 to 24 are now more likely than all older cohorts to be socially isolated and feel lonely.

As we are sure you are aware, given that this inquiry is taking place, loneliness and social isolation have significant, immediate and long-term impacts. This means that when addressing the issues of loneliness and social isolation in the ACT, young people must be considered as a key stakeholder.

Our submission highlights the topics of accessible recreational activities and providing for vulnerable cohorts as having key importance in the discussion of loneliness and social isolation in the ACT. Our submission makes five recommendations, based on these topics.

We believe supporting young people to regularly access structured and unstructured recreational activities will reduce loneliness and social isolation in the ACT by creating opportunities for socialisation, supporting young people's access to a social network with the broader community and promoting a stronger sense of belonging and better mental wellbeing.

Barriers, including those relating to cost, transport and the accessibility and adequacy of existing facilities, currently inhibit young people's ability to engage in recreational activities. We therefore believe that alleviating these barriers should be a priority in the ACT government's plan to address loneliness and social isolation.

In addition, when addressing loneliness and social isolation in the ACT, it is crucial that the ACT government consider and provide for vulnerable cohorts of young people, such as young people with a disability, young carers, LGBTQIA+ young people, young people with existing mental illness, Aboriginal and Torres Strait Islander young people, young people transitioning out of family homes and into independent living, and young people in out of home care or youth justice systems.

We welcome questions from the committee.

THE ACTING CHAIR: Thank you so much. We will now proceed to questions. We will go back and forth, and if we have any supplementary or follow-up questions we will ask those as we go. I have the first question.

In your submission, within recommendation 5, you mentioned improving the physical infrastructure of community centres and public recreational facilities. Does the Youth Advisory Council see the benefit of ensuring that public facilities within the ACT overall cater to young people or do you think that young people would benefit more from having their own facilities that have been co-designed with them—or both?

Ms Harrison: Thank you for the question. Straight off the bat, I would say both definitely have merit and would be appreciated by young people. Obviously, making sure that any recreational community space is appropriate to a young person's needs, accessible by that young person and available in their local location, is very important for improving overall social cohesion and young people's engagement in the social fabric of the ACT.

However, we do know that, as Madison has just touched on, for each of those specific cohorts and where identities intersect, it is very important to co-design specific spaces that can meet those needs. Best practice is to engage meaningfully from the very beginning with those young people, to ensure that co-design theme and that we are also providing a service that will deliver on addressing the barriers and providing outcomes needed by those young people.

THE ACTING CHAIR: What are some of the traits of centres that you would consider inclusive of young people—ones that promote connection? For example, is it things like the opening hours, the facilities, what training staff get, the access and the programs they offer?

Mr Winfield: It is definitely about having opening hours that are not just, say, nine to five, that are open before the usual school or work times and afterwards, into the evening. It is about having staff who are inclusive of young people in general but also of specific vulnerable groups, who are trauma informed and have first-aid and mental health first-aid training. Centres need to be clear about their support for young people in various cohorts so that young people are not surprised by staff not being accepting or by the centre not having the right facilities. It is about making spaces accessible for everyone and also making things accessible for young people.

Ms Harrison: This is something council have talked about extensively. Across the board, what we come back to is reducing barriers to entry wherever possible. Having as much information as possible available from the very start is something that young people really value. That includes showing what the space looks like, how to get there, who will be working there, what paperwork you might need to fill out, what the service offers and what young people need to do to access those offerings, and if they need to bring ID and what costs there are. As much information as can be made publicly available from the very start is something that is really valued. Particularly for young people with different needs, things like having photos of the service and what it looks like are really valued.

THE ACTING CHAIR: Do you reckon these centres would be better located within the main CBDs of Canberra, like Civic, Woden and Tuggeranong, near the interchanges, or do you think there is benefit to having them in smaller suburbs like Erindale, instead of Tuggeranong, or Kippax, instead of Belconnen?

Mr Winfield: I think that both are great, depending on the different things that various centres are offering. It would be good to have more stuff going on locally so that it is more accessible to young people transport-wise.

Ms Harrison: Council agrees that both are necessary, particularly if Canberra becomes more spread out. Making sure that young people can access something that is as close to home, school or work as possible is very important, as is backing that up with transport options, so that young people are not reliant necessarily on a parent or carer and their independence can be promoted wherever possible.

MS LAWDER: I want to ask specifically about mental health services. In your submission you have talked about this a bit on page 4. We know that loneliness and social isolation can lead to mental health issues and that, conversely, mental health issues can increase loneliness and social isolation. It would appear from your submission that, both in educational and in other community settings, you feel there need to be more robust, readily available mental health services. Is that specifically for young people or across the board?

Mx Barancewicz: Thank you for your question. That is a very interesting question. Council have discussed the need for mental health services. We have discussed having mental health services specifically in educational settings. Sorry; I am very nervous.

MS LAWDER: That is all right. Take your time. No drama.

Ms Jakab van Dooren: I can speak to this. When it comes to mental health services for young people, council has discussed often the barriers to accessing those services, such as costs. Getting to the services themselves can be quite difficult for young people, particularly in vulnerable cohorts. I think those are the areas that we would be interested in focusing on: what kinds of barriers are stopping people currently accessing mental health services?

Mx Barancewicz: Young people also have specific needs that need to be addressed when creating mental health services. For example, for young people under the age of 18, there are the complexities that come with needing to have a parent or carer also engaged with the service. That, of course, can make things more complex for a young person. This needs to be considered when creating mental health services—how we can best support young people with this, especially considering that not all young people may feel comfortable with having parents or carers associated with this. Having services that are tailored to young people's needs is important.

MS LAWDER: Have you had much feedback from other young people? I understand the issue with parental involvement or not, but is there a waiting list? How easy is it to get into a mental health service? Have you had much feedback from people about that?

Mx Barancewicz: Yes, we have had feedback about that. Currently, it is very inaccessible to get into a mental health service in the first place, due to long waiting lists, the costs associated with it and the barriers, like parental support. If your parent or carer does not support you accessing a mental health service then there are barriers in accessing a mental health service. It is also about waiting times and costs.

Ms Harrison: It is about meeting the young person where they are. One professional available at a school might not be able to see all of those people, so what sorts of other options are available in the community? We know that young people often need to try several practitioners before they find someone they are comfortable with. If you need to leave the person you are currently seeing then you enter another waiting list to see someone else and you sort of go back to the beginning.

We have heard from young people about the value of active waiting periods and other supports that can come in to meet those needs while they are waiting to access the support that they need. It is about triaging cases as well and having the preventive supports but then also meeting people when they are in crisis and being able to manage that well.

Mr Winfield: We have heard that there are difficulties with getting into specialist services particularly. For young people with complex mental health and physical health needs, it is more difficult to find practitioners who will treat them.

THE ACTING CHAIR: You mentioned the importance of reviewing our transport network and how accessible it is to young people. What sorts of changes do you reckon would make the most difference to staying connected to each other? Would it be more about the frequency of weekday and weekend services or about where the actual physical bus stops are? Is it about having more rapid buses or just more reliability of services? What do you think would make the most difference?

Ms Jakab van Dooren: Thank you for your question. In our report we mention all of the things you just listed as being very important for increasing accessibility. I think pinning down a key one is hard because lots of young people have different needs. I am just thinking. I think that when it comes to after-school, extra-curricular activities for younger kids, having frequent bus routes located near schools can be really useful.

Having accessible public transport on weekends for young people is also important. A lot of recreational activities occur on weekends for young people because they are busy during the week with school. Also, lots of young people work during the weekends because that is the only time they can work. Having accessible and frequent bus routes during those times means that those young people can access different employment opportunities, which ensures that they stay connected to employment. That can support their social connectedness in that way.

MS LAWDER: In your submission you have also talked about cost as a barrier, for example, to sporting activities. We have heard that from other witnesses today as well. I was on the cost-of-living inquiry and I know your council made a submission to that as well. I understand that your recommendation is for targeted funding opportunities to provide young people with better access to participate in sport and other recreational activities. A lot of those activities are run by community organisations, clubs—the Vikings club, and football and netball clubs. What do you envisage? Is it a grant from the government? What would you like to see to make sport more accessible for young people cost-wise?

Ms Jakab van Dooren: When we ran the Youth Assembly last year, when we were talking about the cost of sport in particular, one of the things we noticed was that in the ACT we do not have a sports grants program for young people, whereas in most other states that is available. That is one option that we have noticed in the past that young people have asked for.

Ms Harrison: We have not discussed specific advice around the mechanisms of how funding models would work. When we talk about access to sport—knowing that cost is one of the barriers, for uniforms, participation fees and everything—it is about tying it back to social health and wellbeing. It is a huge protective factor in keeping young people connected to their communities. Particularly for young girls, it is giving them those leadership skills, those collaboration skills and keeping them connected with other young women as they go into their early high school years.

Just recently, council heard from a young girl who is now turning 10 and so is no longer able to play in a mixed hockey team. She has to go and play with the boys because there is not a girls' team, and that is at a community level. What we are really looking at is bringing in robust supports to keep community-level sport really active. That is what helps people to step up through those tiers, if they would like to, to be able to keep playing until adulthood, if that is something they would like to do.

It is a social determinative health protective factor. We cannot speak specifically to the funding, but we know from our own experience and from conversations we have had on council that it is something that provides a lot of value to young people's lives.

MS LAWDER: You refer to "other recreational activities" in your submission. Are you interested in just that physical activity or do you also mean perhaps painting classes for those people who are not sporty? Is that what you mean by "other recreational activities"?

Ms Harrison: Perhaps another member could speak better to this, but we do know that people have different ability and access needs and levels of comfort. For some people it will not be about playing a sport; it might be about participating in a club or a drama class or something like that.

THE ACTING CHAIR: We have time for a couple more questions. When you talked about vulnerable people, and particularly young people with a disability, in your submission, you mentioned the difficulty in getting NDIS support or even an official diagnosis to participate in a lot of programs. We have heard in other inquiries and from the Education Directorate that things like universal design are important, where you just set up the system for everyone up-front. Do you think there are particular programs or mechanisms that we can put into our systems to make them a little more friendly to young people with a disability before diagnosis, or if they do not get diagnosed?

Ms Harrison: Sorry; would you mind rephrasing the question?

THE ACTING CHAIR: Yes; absolutely. Do you think there are particular supports we can put in place for young people who might have a disability but have not been diagnosed? Are there particular things we can do to design our centres, our transport network or our high schools that would make a difference to their participation and their inclusion? It is a bit of a curly one.

Mx Barancewicz: As you mentioned, it is anything that could make services more accessible. Firstly, with all services—and especially transport and building design—I think we have mentioned that they need to be made accessible to a wide variety of different people, including people living with disability. That is something that can be done: just make sure that, with services and transportation and that sort of thing, people with disability are considered when those are being designed and implemented.

Ms Harrison: I think Madison said it perfectly. We have not discussed pre-diagnosis, but where anything is made more accessible it supports those people.

THE ACTING CHAIR: With respect to LGBTQIA+ young people, are there particular programs, places or attitudes that the council has or that people you have talked to have found particularly welcoming? It would be awesome to have references for best practice.

Ms Jakab van Dooren: That is a very good question. From my experience, as an LGBTQIA+ young person, I have found that spaces feel more accessible to me when they are—how do I phrase this? I have found that the recreational opportunities I have most enjoyed have been in places like my schools, building a sense of pride and community. I think that having fun events for queer young people is excellent and also creating spaces in the ACT that are inclusive, like community centres. When I see a Pride flag at a community centre, I feel very welcome.

I am currently at university. My residential hall has a queer officer to make sure the space is inclusive. It is about making sure there is representation for young people, and for queer young people, in these spaces so that we can keep up to date and make sure these areas are inclusive. When a space feels inclusive to me, I am more likely to go to it and socialise with people, knowing that I am going to find people like me in that space or find allies who are not going to judge who I am.

Mr Winfield: I would also add that council has heard it is not only about community spaces. It is also about having gender-neutral bathrooms and change rooms, and having procedures in place that make gender-diverse young people in particular feel safe to exist openly in that space and feel like they are not being sidelined or shoved in a corner.

Ms Harrison: I think Connor touched on it earlier, when we were talking about the health system, but it is about ensuring that there are specialist providers who are available—people with that specialist knowledge, a trauma-informed care background and understanding of the specific needs. That can be across the board. Like you said, it is about having the queer officer at your residential hall. It is also about ensuring that there are specialists and people trained in the specific frameworks and best practices that make those places accessible and safe.

THE ACTING CHAIR: On behalf of the committee, I thank you for your attendance today. If you have taken any questions on notice, which I do not believe you have, please provide your answers to the committee secretary within five business days of receiving the uncorrected proof *Hansard*. On behalf of the committee, I would like to thank our witnesses, who have assisted the committee through their experience and knowledge. We also thank broadcasting and Hansard for their support. If a member wishes to ask questions on notice, please upload them to the parliamentary portal as soon as practicable, and no later than five business days after the hearing. This public hearing is now adjourned.

The committee adjourned at 3.21 pm.