

DR KAREN HOOPER:

Welcome back from the break. We now have our third presentation for today. And joining us from Cairns via Zoom is Marlene Levasseur from Rights in Action. So thanks very much for joining us, Marlene.

MARLENE LEVASSEUR:

Thank you. Thank you for letting me be here today.

DR KAREN HOOPER:

Would you like to just, for the purpose of the public record, Marlene, just identify yourself and your organisation.

MARLENE LEVASSEUR:

My name is Marlene Levasseur. I'm a Disability Advocate at Rights in Action in Cairns.

DR KAREN HOOPER:

Thank you, Marlene, I'll hand over to you to make your presentation.

MARLENE LEVASSEUR:

Alright. Firstly, I would just like to acknowledge the Elders past, present and future. And I would like to just do a bit of an introduction first. Firstly, Rights in Action are grateful to QPC to be given the opportunity to be present today. As on the ground disability advocates with strong links to our local community in Northern Queensland, we feel that we have a lot of information to offer to QPC in terms of our practical, hands on, real experience of dealing with people living with disability in our region, the barriers faced by them and the rewards by accessing the NDIS.

Because our advocacy services are unable to meet the demand in our region, we target the most vulnerable by undertaking a risk assessment known as a spectrum of vulnerability. For example, the person has no natural allies is isolated and at risk. We have been witness to many serious cases of neglect and exploitation of people with disability in our region. This has led us to making numerous submissions to the Disability Royal Commission and then making the complaints to the NDIS Quality and Safeguards Commission. We also have a good relationship with the Cairns local police, who have referred some of these serious cases of neglect and exploitation to our office.

I'm just going to keep going on. It's been a long introduction, and I know that we've only got 30 minutes. I'm going to skip the next slide and just go into what's going to be covered to date. I've got six points. All of these points are gleaned out of the submission that I made to the QPC, I've made two submissions to date. The first topic is mothers with intellectual disability and their children with the same disability and interactions with government services. The second topic as a general comment on NDIS data collection, primary versus secondary disability. The third is comments on the QPC topic of improving participant outcome and reviewable decisions and appeals at 5.0 and 5.5 of their draft report.

Next one is going to be comments on the QPC information requests, Ways in which the contribution of general practitioners' outcomes can be increased." That's at page 119 of your draft report. I have

comments on the QPC topic of "Interactions with Government Services", and "Using government institutions to support access" at 14 and 14.4 of the draft report. Then, item six will be comments on the division of disability services between governments, QPC box 14.3 information requests on specific adverse impacts of cost shifting outside the Applied Principles and Tables of Supports. And then, I'll be summing up briefly.

And I'm happy to answer questions as we go along today as well. Feel free to interrupt me if you want to.

DR KAREN HOOPER:

Thank you.

MARLENE LEVASSEUR:

The first topic is mothers with intellectual disability and children with the same disability and interactions with government services. In particular, Rights in Action are concerned about the state's cost burden of mothers with intellectual disability and their children with the same disability being over-represented in the state's child protection system. There are situations where children removed from their mothers have access to the NDIS, but not their mothers.

Our concern is also linked to the negative outcomes of mothers and children being part of that system, such as trauma, isolation and ongoing mental health issues. These mothers and children are not having their rights and needs met as they are entitled to under international convention Human Rights Act and the Anti-Discrimination Act at Queensland. This is, in part, due to failures of interactions with government services and the many issues to be addressed for these mothers and children, not just gaining access to the NDIS.

As advocates acting for these mothers and children, we are witnessing numerous breaches of key protections on a regular basis which can be due to intergovernmental demarcation lines, a lack of understanding of a person's human and disability rights overlaid with discriminatory behaviour. There's some perception that mothers with intellectual disability are unable to parent. Excuse me just going to have a drink.

Rights in Action are of the view that we can have reduced the State's cost burden on the Child Protection System, Mental Health services and others by advocating for these mothers and children by building capacity and addressing all their needs and issues such as housing, health, education, finances, Centrelink payments, child support, other legal matters, QCAT applications for the appointment of guardian and public trustee, NDIS matters including access, pre-planning, planning, engagement of services, review of services, reviewable decisions and appeals. An example of the complexity of issues to be addressed via advocacy for these mothers is set out in our submission at Appendix A of our Rights in Action case study MD, which is at page 14 of our submission.

We are also of the view that these issues cannot be addressed by simplification of the NDIS and streamlining of intergovernmental services because the issues faced by these mother and children are complex and many. That is, there's a need for strong skilled advocacy to enable all the stakeholders to be pulled together to achieve the best outcomes and act in the best interests of the

mother and the child. Mothers with intellectual disability are not able to navigate those multiple services successfully without advocacy.

They have no power, they find it difficult to articulate their needs or bargain for them, and many are unable to read or write or use information technology. That's my first topic over. Does anyone have any questions on that issue that I've just read, or that topic I've just read?

DR KAREN HOOPER:

Marlene, we might hold questions until the end, just so you have time to get through your slides.

MARLENE LEVASSEUR:

Alright. Thank you.

DR KAREN HOOPER:

Thank you.

MARLENE LEVASSEUR:

Alright. Moving on to the second topic now, which is the Right in Action general comment on NDIA data collection, primary versus secondary disability. There's an inherent flaw in NDIA primary data disability collection due to only one primary disability being able to be recorded against a participant's record. This is a systemic issue leading to NDIS access being denied, plans issuing inadequate funding, which then leads to requests for internal review or external review to the AAT.

This data collection flaw impacts upon how QPC interprets primary disability data provided by the NDIA because it is simply inaccurate impacts on participants and takes up valuable resources in terms of advocacy, Legal Aid, the NDIA and the AAT. I'm just going to move on to my next topic now, which is improving participant outcomes and reviewable decisions appeals at 5.0 and 5.5 of QPC's draft report. Rights in Action to date have had a 100% success rate on NDIS internal reviews and AAT appeals.

The clients who we have represented on NDIS reviewable decisions and AAT appeals are unable to self-advocate or represent themselves on NDIA internal and external review in the AAT because of the nature of their disability. Once again, I'll refer QPC to the case studies Appendix B, page 19 of our submission.

Legal Aid currently only receives Federal funding for one NDIA lawyer for all of Northern New South Wales and Queensland. The bar to access legal aid is extremely high, and they lack capacity to take matters on. Rights in Action have skilled legal advocates who undertake this work and act as representatives to fill this gap and to ensure that people with serious disability who are unable to advocate for themselves have access to justice. Our Federal funding for this work has been reduced to 75% and we are unable to keep up with the demand for our service in our region.

State funding for this type of as advocacy work would fill the gap and ensure access to justice the vulnerable people. With our advocacy, vulnerable people with disability in our region have much better outcomes and reviewable decisions and appeals, which means they do not fall back onto the State mental health, child Protection, disability services and the criminal justice system because they gain access and have their reasonable and necessary support needs met under their NDIS plan.

It is also highly likely that when the NDIA implements independent assessments in our region, there will be a spike in reviewable decisions and appeals. We recommend to QPC that state funding also be applied to our advocacy work in our community on reviewable decisions and appeals to fill the gap, ensure that people have access to justice, their NDIS support needs are met and to reduce the State's cost burden of people not gaining access to the NDIA or not having their reasonable and necessary support needs met.

Moving on to the next topic now, topic four. QPC Information Requested at page 119 of their draft report. Ways in which the contribution of general practitioners to the NDIS participant outcomes could be increased. Our advocacy of the most vulnerable people in our community has effectively increased the contribution of general practitioners to NDIS participant outcomes by the way we practice.

Bulk billing doctors do not have the time or motivation to increase participant outcomes, all our clients have bulk billing doctors. Many of our clients are unable to articulate their needs, bounce from bulk billing doctor to doctor, which means that the general practitioner has limited understanding or knowledge of the person's history or current circumstance in terms of NDIS matters. Once again, I refer to KD's story, appendix C at page 22 of our submission.

Rights in Action have found it more effective to gather all the relevant evidence, then make the NDIS Access Request Form, draft up the NDIS Supporting Evidence Form and then attend on the treating doctor with the client for sign off. It is at this point where we were able to articulate to the treating doctor on behalf of the vulnerable client the outcomes to be achieved for them via the NDIS funding, IE, physio therapy, psychotherapy supports, et cetera. In effect, we are training doctors on the NDIS is lexicon, deepening their understanding of a patient's situation holistically. For example, health, living situation, disability issues and other issues to be addressed. This also alleviates the work burden on bulk billing doctors for which they do not receive payment.

Rights in Action firmly believe that if we are State funded for NDIS access participation, preplanning, planning and engagement of services for the most vulnerable people in our community with intellectual and/or psychosocial disability who are unable to articulate their needs, much better outcomes will be achieved. This will lead to greater contribution by general practitioners as their understanding of NDIS matters via advocacy will be increased, plus they will have a greater understanding of the person they are treating, which will reduce risk and requests for review and appeal.

Once again, I refer to KD's story, Appendix C at page 22 of our submission. Once again, there are many issues to be addressed for these people not just NDIS access. A holistic approach needs to be taken to achieve outcomes which are lifelong, build capacity and are in the best interest of the person. I'm going to move on to topic five now. Interactions with Government services at 14.0 and Using Government institutions to support access at 14.4 of the draft report.

Rights in Action has set out at Appendix A Case Studies at pages 14-18 of our submission, which reflect how complex matters can be and the multiple issues to be addressed when advocating for mothers and their children with intellectual and/or psychosocial disability, particularly if Child

Protection are involved. It is not just a matter of gaining NDIS access, it's addressing all the issues for these vulnerable people.

That is housing, attending on Child Protection Case Planning meetings with the mother, arranging Legal Aid funding on Child Protection matters and assisting with the giving of instructions to lawyers, health, education, finances, Centrelink payments, other legal matters, QCAT applications for the appointment of the Office of the Public Guardian and public trustee, Child Support, NDIS Access, preplanning and planning, NDIS internal reviews and external reviews, and following up on NDIS service provision and other issues. These mothers are unable to self-advocate, articulate their needs, navigate or traverse the various government institutions, complete paperwork or bargain for the needs to achieve good outcomes for themselves and their children without advocacy.

It is the diverse knowledge and skill set of the advocates together with an understanding of the various legislative frameworks and government policies that facilitate the interactions with government services for these vulnerable women and their children, plus we know the person. This type of advocacy practice model achieves good outcomes so that those children are not under long term child protection orders of the state and their mothers learn how to self-advocate via the advocate, and also learn how to parent and be a good mother.

We are of the view that via our advocacy practice model these vulnerable mothers and their children achieve much better outcome. And it alleviates the cost burden of State Funding of Child Protection Services and the Office of the Public Guardian. It reduces emotional stress of mothers. Reduces the trauma of children in long term care. Reduces the nature of foster care. Reduces the need for children under long term protection orders transitioning to guardianship when they turn 18. It also ensures NDIS access for the mothers and their children.

And means mothers and their children can live together as a family with love in their lives. All the mothers that have acted for on Child Protection matters have successfully had their children reunited with them. They've gone on to live a very good life and they're a lot more happier.

Once again, these mothers and the children are over-represented in the child protection system. Even if the various government institutions support access, this will not address or support all the issues faced by these mothers and children in order to lead better lives. Alright, so I'm just going to move on to my next topic now. Topic six, Division of Disability Services between government. the QPC box 14.3 Information request, Specific adverse impacts of cost shifting outside the Applied Principles and Tables of Supports.

Rights in Action noticed over the last 12 months, there's a pushback from the NDIA on allied health professionals like psychologists under a participant's plan with psychosocial disability. For example, referring the participant back to the treating doctor for mental health treatment plan. The issues are that the participants might already have a treating psychologist who do not provide therapy under a mental health treatment plan. Psychologists working with people under a mental health treatment plan are not prepared to draft up NDIS reports because there is no cost benefit and they are time poor. Under this scenario, the participant is disadvantaged by this inappropriate attempt at cost shifting from Federal to State.

Our recommendation is that funding for psychosocial therapy be fully funded under a participant's NDIS plan. Alright. Let's move on to the next topic. Moving on to a summary now. I'm just going to wind up, it shouldn't take me very long. Without independent advocacy of the most vulnerable people in our community with intellectual and/or psychosocial disability, they will not lead better lives and are placed at serious risk, even death. The KD and MD case studies in our submission are examples as is the South Australian case of Ann Marie Smith, where a woman with disability died in her chair due to her neglect and there was no independent check on service provision.

It is not just NDIS access, all issues impacting on their lives needs to be addressed to enable them to build capacity and not be placed at risk. It's important to have independent advocates here, to ensure that service providers are kept in check and people with disability are not neglected. Rights in action have made numerous submissions to the Disability Royal Commission and complaints to the NDIS Quality and Safeguards Commission around serious neglect by service providers of people with disability in our community.

Simplification of the NDIS and streamlining of intergovernmental processes will not address these people's needs because they lack capacity and require informed supported decision making to address their many complex issues, that is, they require one person who understand the life story and current situation rather than many to guide them through the issues to achieve successful outcome.

Mothers with intellectual disabilities are particularly vulnerable, they are unable to navigate multiple government services without advocacy, they have no power, find it difficult to articulate their needs or bargain for them, and many are illiterate and unable to use information technology. It is via advocacy that these mothers are empowered and learn to self-advocate, and also have all the support that you need wrapped around themselves and children to lead a good life. And that's it for me today. Is there any questions?

DR KAREN HOOPER:

Thank you, Marlene. That was a very comprehensive presentation. Obviously, you touched a number of critical issues. Maybe I could just start with a very high level question, then we might get into some more detail. Obviously, you have a very important role as an advocate in the NDIS. Just wondering what the key challenges are for advocates in navigating this scheme, and assisting and supporting their clients. You've raised a couple of issues there, that sort of impact on client outcomes.

I'm just wondering, from a very high level perspective where you find the greatest issues are in the work that you do.

MARLENE LEVASSEUR:

Well, in terms of advocating on NDIS matters, it's particularly difficult when we're advocating for people with intellectual and psychosocial disability. We request the NDIA to be on the record, like one of my clients can hardly communicate. And they ring directly for planning meeting with the client, the client doesn't know what's going on. I've got another client who's totally blind, he can't read any correspondence, they still send correspondence out to his address.

There's an imbalance of power there, when it comes to those types of people. So we've been really good from an advocacy perspective. And we are noted as representative advocates on the record. And if we can include that we be contacted, we're the point of contact for those people, that would be very useful in terms of being able to advocate for them and have their disability needs met.

DR KAREN HOOPER:

And Marlene, you mentioned referring complaints to the Quality and Safeguards Commission. Be really interested in your views and perspectives on how well those complaints are handled and whether those channels are working effectively.

MARLENE LEVASSEUR:

Well, it's my belief that there's only five people at that Commission's office, and they've got a huge workload. There is a bit of pushback there, in terms of advocates trying to, pushing it back on advocates and other representatives to try and deal with the issue and deal with the person that, deal with a person directly what the complaint is about, normally we do go through that process, because that's the proper complaints process. I'm starting to feel that I'll probably have better success going to that the Fair Trading to make a larger claim against the service provider rather than the Commission, the Quality and Safeguards Commission.

It seems that their framework is just more around about policy, what service providers should be doing. I think it's not their fault, it's just under their Act, they're a bit powerless to actually push things to a greater level. But we have got one particular service provider in our region that keeps coming up again and again. We've made numerous complaints about them. But we're quite sure the outcome is at that moment, because my colleagues have been dealing with that particular issue. Yes, that's all I can answer on that question.

DR KAREN HOOPER:

And you mentioned independent assessments, and you made a comment that you would expect to see a spike in appeals as a result of the introduction of independent assessments. What leads to that view?

MARLENE LEVASSEUR:

Well, it's based on the experience I've had with dealing on NDIS internal reviews and external reviews to date. I don't think an hour or three-hour appointment with the independent assessor understands that person, who's going to be better to assess all the information and background about that particular person? That's one of my concerns. I also note in the AAT, where I've been representing clients that the AAT takes the view, if a matter is in dispute, that their preference is to look at evidence on the record, rather than a one off NDIS assessment.

Because these people may have had the same treating doctor for many years, and they've had the same therapist for many, many years. So they view that that material is far more important than a one off assessment by the NDIA to try and prove a case against the participant that's getting funding. I just don't think the independent assessments are going to fully realise all the client's disability. I've got another client who had a tri-disability of bipolar, MS and also ankylosing spondylitis. And they just didn't, they had to have an internal review, he's denied access in the beginning. They didn't read all the material that was on the file.

And then the plan issued didn't have inadequate funding under the plan as well. So I had to do another request for internal review until the plan came out. That's my fear. I mean, they're not reading material (INAUDIBLE)

I understand that it's an insurance scheme. And they've got to be financially viable to have a lifelong effect. But my fear is that people's, their reasonable and necessary supports aren't going to be met. That's what's going to lead to internal reviews, requests for internal reviews spike.

DR KAREN HOOPER:

Thank you. And you raised data issues around reporting and recording of a person's disability. So, in your view, if those data issues were resolved, would that automatically lead to better plan outcomes for the clients that you support?

MARLENE LEVASSEUR:

Yes, I'd say so. Be able to record like a dual or tri-primary disability in one box rather than that being noted in the secondary disability. Because their secondary disability that's recorded, they don't seem to get as much attention. I don't know what the processes are internally with the NDIA, when they're looking at people's disabilities. But they tend to, I think currently, currently got a list of disability, there's list one, list two, lists three.

So they just go through list one and pull out the first primary disability there. And then the other two get relegated to, or the other one gets relegated to the second disability. And then the focus at the planning meeting is on the primary disability even though you've got evidence to say that all these disabilities are impacting on this person.

DR KAREN HOOPER:

And what's your general view of the effectiveness of the planning process, aside from the data issues? Do you find, genuinely, that they're leading to positive outcomes for participants?

MARLENE LEVASSEUR:

Yes, I do. But I know for the advocate, there's normally a lot of work involved in that. Because we gather all the evidence. And the way that we do achieve good outcomes is we do all the preplanning. We actually provide that to the NDIA and also the LAC part of the planning meeting and ask them to consider it before we go ahead with the planning meeting. And that makes the process a lot more fluid, and usually achieve good outcomes for the person as well.

DR KAREN HOOPER:

So one of the recommendations in the draft report is that planners and LACs have a greater coaching role in those planning conversations, particularly around assisting participants to set goals. Do you see value in that approach?

MARLENE LEVASSEUR:

Well, I'm concerned, because the NDIS is an insurance scheme. There's conflict of interest there. And also with the LAC, the LAC is funded by Federal government as well, or by the NDIA.

My view at the moment is, it's a very adversarial system. I think that's part of the economic climate as well. And I just don't think that's a good idea, especially for people with intellectual disabilities

and psychosocial disability, you really need someone there, to advocate and stand up for them. Their needs aren't going to be met. I just think it's a conflict of interest for NDIA to be coaching people on what they view as their support needs, reasonable necessary support needs.

DR KAREN HOOPER:

And an experience that you've had in the planning process, Marlene, do you find that the plans map well to participant goals?

MARLENE LEVASSEUR:

Not always. Sometimes they lead to internal reviews. Sometimes... I think one thing that keeps coming up time and time again, is that a lot of my clients will never work. They can't work, they don't have capacity to work. They're on a disability support pension. And when the first, even though you've got all the evidence that's stating that, that they'll never participate, there'll never be an economic participation with those people, it seems to, there always seems to be some sort of goal, even if it's a third goal, that they'll find employment in the future, or be assisted to find that. It's just an unrealistic expectation. Although they're good if those people could be identified, we would cut that issue out.

DR KAREN HOOPER:

And do you have any views on the role of support coordinators in helping your clients find the services that they have identified in their plans?

MARLENE LEVASSEUR:

We have a market that's undersupplied here in Cairns. There's a great disparity around different service provider organisations in terms that some have a very narrow view of the role, some have a very broad view of the role. I think it still definitely needs to be clearly defined. I find some support coordinators are fantastic, they'll go over and above what they're expected. And you've got others that will just clearly set the line and will not deviate. And as an advocate, that's very difficult for me as well, because I can't keep advocating for the client on certain matters, like finances, that's a tricky area as well, because it's a conflict of interest for the service provider to be dealing with the clients finance.

That's where we normally get a guardian or trustee appointed. Yeah, it's either they're also interpreted broadly or very narrowly. The lack of experience as well. Lack of experience of support coordinators up in our region. Particularly indigenous support coordinators.

DR KAREN HOOPER:

OK. And just heading back to your presentation for a moment, you talked about the difficulty that mothers with intellectual disability have in accessing the scheme. So, in your presentation, you mentioned the importance of advocacy. Is there anything else that needs to be done to support mothers with an intellectual disability outside of advocacy services?

MARLENE LEVASSEUR:

Well, I think I was thinking about that. And the problem is with these mothers with intellectual disability, they need guiding through the whole process, because there's so many issues to be addressed, they really need strong advocacy, and then learn from that advocacy. I mean, they've

got, I mean, they've got, they've got so many different issues. They might be going off to DV services, then they might go off to the Women's Center. The Women's Center might only run with them for three months, and then they'll take on the next client.

There's just no consistency. The only way that you can really deal with it is that they have to have a consistent person in their life, to build the support and then let them go. I was thinking in terms of how would we get referrals, how we will be engaging with them, the Women's Center, the DV services, for referrals for those women to our office as well. It's difficult with child safety, making the referral, because mothers don't want to admit that they've got a disability a lot of the time, they're frightened. But if they are shown to have a disability they'll be used against them, they'll say that they've got poor parenting skills. But they really need someone that's sort of on their side to speak up for them.

DR KAREN HOOPER:

And Marlene, what's been the experience of advocacy during COVID? Were there any particular challenges that you faced during that period?

MARLENE LEVASSEUR:

We still, we viewed ourselves as a essential service. So we were still seeing clients. One particular client, which is KD in the submission, he was totally blind. And he's in an over 55 retirement village. There was a COVID lockdown out there, and he didn't have a safety plan, there was nowhere for him to go. At the time, he was only getting two hours of support per week. So I had to draft up a safety plan. A safety plan for him and there was nowhere else for him to go outside of the village. It's not the job of safety services either, to do that.

And I had to - the other difficult thing was the onsite managers. This particular client was unable to navigate to the communal dining room. But they had to shut down the communal dining room due to COVID and deliver meals to the room. But they couldn't deliver to Ken, because they would have had to go inside his room. Which meant they could only just leave the meals outside his door, and he doesn't tend to open his door very much. So just bang, bang, here's your food on the ground outside. And that was pretty horrible.

DR KAREN HOOPER:

So some practical challenges there.

MARLENE LEVASSEUR:

Yeah, yeah, yeah. So we've got out at the end, it's a really good story, actually. (INAUDIBLE) One of my pet stories.

DR KAREN HOOPER:

And did you move online at all, in delivery of your services in terms of conducting meetings online?

MARLENE LEVASSEUR:

Oh, only with other stakeholders like the Queensland Alliance of Mental Health.

DR KAREN HOOPER:

But not with ...

MARLENE LEVASSEUR:

No, definitely. None of my clients would be able to do that. They don't have information technology, they can't use it. That's a particular area that I'm concerned about too, in terms of crisis. There's all this information technology out there, for people with intellectual disability or blind and deaf, they miss out of this. I think one way of properly identifying those people, if they have a disability support pension record. If they were given high priority in the list in terms of crisis.

DR KAREN HOOPER:

So, a chapter in our draft report looks at the interaction of services as you've identified in the presentation. There are some issues around the fact that some of the clients that you deal with require multiple services across multiple agencies. How well is that coordination and information sharing happening at the moment?

MARLENE LEVASSEUR:

Well, there's demarcation lines. I know - I'm giving you a scenario. One particular mother that I acted for, which is MD in the submission is that she had her two children removed under a 12-month order. So basically, that meant Child Safety were the guardians of her children. And then I got the guardian appointed, and he was the guardian for making mum's decisions, but he couldn't make any decisions about the children, because the children were under child safety. That sort of demarcation line.

So, the guardian wasn't attending on any child case planning meetings, which is vital. Because you have to pull everything together and get, the support coordinator should be there at the meetings as well. Because child safety want to know what supports are in place for mum in terms of NDIS, and then you've got to coordinate children at that particular case planning. A different support coordinator for the kids and then a different support coordinator for mum, that you get that all together. There's legal issues as well, that the guardian probably should have been aware of. Information sharing is not particularly good.

The other issue as well, is that Child Safety get specialist reports, which is skewed towards removing the children in their favour, removing the children from their mothers around their lack of capacity to parent. And then under an NDIS plan, where I've been involved getting NDIS access and participation from others. The purpose of getting those reports is to maximise funding. So you've got two different purposes of the reports, and child safety is always keen to get those reports as well. But it's very difficult. I never give the reports, I just always give what the recommendations are on the schedule of supports to prove that the mother is going to be getting to enable the kids to be reunited. So, there's that difficulty of information sharing there as well.

DR KAREN HOOPER:

And Marlene, how well do plans take into account the responsibilities of mothers with intellectual disability? Do they provide extra support for those parenting responsibilities?

MARLENE LEVASSEUR:

Yes, they do. Except if there's a special criteria that mum does have an intellectual disability, and she's got to develop her parenting skills. They do provide that support, but you have to have, that particular case I was just telling you about was really difficult, because over two years, the children -

sorry, over 12 months, the children were reunited with her. They started off with one day a week, and then three days a week, and then five days a week, and then, finally, seven.

And every time we had to get a fresh OT report, based on the children being in her care, either one day a week, three days a week just to show up the support. And the other issue that we have in our region too, is a lot of service providers are prepared to, especially with babies, they're not - they don't want to pick them up and nurse them, because if they feel that if anything happens, they're at risk then, as well. That's a challenge that needs to be overcome too.

There are some people that do it, and some that don't. And you got to have boosters in the car, and things like that as well, in the support car.

DR KAREN HOOPER:

Are there any other areas of service deficits facing your clients in that particular cohort?

MARLENE LEVASSEUR:

There needs to be more in home support. I mean, even with child safety involved, we've got all these theoretical parenting programs, like that mum with the three kids. I mean, she's busy being a mother without having to sort of pick up all the kids, drop them off at school, and then go to this theoretical parenting course that she's not going to get. It's the in home supports, they're really important, so that they can build capacity around their parenting skills.

And they basically don't have the time. If they're involved in child safety, there's so many expectations placed upon them. They might have child safety coming out to see them once a week. They might have people from the new pin program coming out to see them also. And the expectation that they go to this parenting program, plus they're trying to look after the children, take them to school. Some of the expectations are unrealistic, I think. And place extra pressure on the family which is not needed.

DR KAREN HOOPER:

Well, Marlene, thank you very much for your submission and for joining us today from Cairns. And certainly, we'll be sort of following up and reflecting on those issues when it comes time to finalise our report. So thanks again.

MARLENE LEVASSEUR:

I look forward to seeing it. Well, thank you so much for your time today. OK, I'll stop sharing now and leave you, bye bye.

DR KAREN HOOPER:

Bye bye.