REPORT OF *IN-CAMERA* PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

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

At Sydney on Monday 27 September 2010

The Committee met at 9.30 a.m.

PRESENT

The Hon. I. W. West (Chair)

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

VIVIAN VERNON BAYL, Executive Committee, Association of Doctors in Development Disability, Tumbatin Clinic, Sydney Children's Hospital,

ROBERT LEITNER, Chairperson, Association of Doctors in Development Disability, and

JULIAN TROLLOR, Association of Doctors in Development Disability, University of New South Wales, sworn and examined:

ALLAN DAVID STURGESS, Association of Doctors in Development Disability and Physician in Adult Disability Medicine, St George Hospital, and

HELEN MARY SOMERVILLE, Association of Doctors in Development Disability, Children's Hospital, Westmead and Westmead Hospital, affirmed and examined:

CHAIR: The Committee has considered your request to have your evidence heard in-camera and has agreed to it. However, the Committee or the Legislative Council may subsequently publish evidence if they decide that it is in the public interest to do so. Would you like to make some opening comments?

Dr BAYL: Thank you very much for allowing this time for us to speak with the Committee this morning. We look forward to taking questions from members. We are aware that there is no corporate memory in government, but we have a long corporate memory. Nine of us were involved in producing the original submission, and together we have 220 years of experience in developmental disability. Those of us here today have 120 years of experience in that field. Many of us worked in the disability field in the 1980s when the Department of Health was responsible for those services. Although there were gaps then, the department provided an excellent service that we all hoped would be rolled out across the State.

However, in 1989 responsibility was transferred to the Department of Youth and Community Services, which became the Department of Family and Community Services, which became the Department of Community Services, which became Department of Ageing, Disability and Home Care and then the Department of Ageing, Disability and Home Care in 2010. We have seen a lot of change. We have also seen a huge devolution of service through to increased brokerage of services, a huge increase in the number of managers employed and a very real increase in frontline services, particularly in case work and therapy.

We have no agenda other than our concern for the children, parents, carers and young people and adults with a disability whom we see. In 2005, the Department of Ageing, Disability and Home Care divested itself of health-related services, which at that stage involved doctors and diagnostic assessment teams. Case management and therapy services stayed with the department, which is now the Department of Ageing, Disability and Home Care. We have concerns about four main areas that relate particularly to unmet need and the first two items in the terms of reference. We are available to take your questions on those areas of mental health—in particular, the intake process, therapy services and interagency collaboration—because each of us has expertise in different areas that we would like to address.

Dr LEITNER: I sent the Committee a summary. Was it received and has it been distributed?

CHAIR: Yes.

The Hon. GREG DONNELLY: Thank you for appearing before the Committee today; we very much appreciate it. We also appreciate the body of expertise and insight you will be able to provide this morning. You mentioned corporate memory. Can you explain how you think a, shall we say, poor, lacking or ineffective corporate memory has a deleterious effect in terms of the State or the Government being able to provide continuity in services and support to people with disabilities?

Dr SOMERVILLE: I will make some comments and handover to the others. As Vivian alluded to, we have overseen a system that actually built up through the 1980s with an enormous amount of goodwill. It was clinician-driven, so I think the clinicians were the people who were able to assess the need and how the services should be configured, with a lot of consultations with the families. I mean, these families are in there for the long haul. People do not get better from a disability, which is one of the things that I think, the way services are configured now, it is as though they do. It was a very flat structure. I think it was clinician-driven. The intake was done by the clinicians. The decision on who got seen, when and where was done by the clinicians and the actual assessments were done by the clinicians and the therapy services provided by the people who had done the assessment. I think that got totally changed partly, I guess, by bringing in lots and lots of layers, and that has almost become impossible to even look at.

One of the things that I have written is, "How can we advocate, compliment or complain when we do not even know what the rules are?" We do not know what the intake rules are. We do not know how the decisions are made about getting a service. We do know that the teams that do the diagnosis and assessment, which is still sort of health-based, the issue whether it is Health, DADC or DOCS or whatever, is not our brief. Our brief is about whom can best provide the services. If we do not know what the rules are—there is no written information and it appears to us that that is deliberate—and if we do not have information how can a family or a person find out and ask questions? They do not even have a tracking system for when the referrals come in. We can ring up to find out, and we cannot be told where somebody is on the list, what is happening with the process. There are a lot of things that have changed. I would argue that a lot of that is because the focus has been on management. It has become a focus of lending out services rather than providing services. I guess we would like to know how we can look back at getting it back to what is the work that needs to be done.

The Hon. GREG DONNELLY: For the benefit of the committee, in terms of the change in focus to which you referred which came about because of a change in philosophy in the way in which it would be managed, what reasons were given at the time for the change from the more focussed client-driven person-driven through to bureaucratic? Did it just evolve or were there drivers behind it which had hoped to achieve a particular outcome from the structural change?

Dr SOMERVILLE: I will quickly answer and let the others speak. One driver was when they divided up the department so in the early 1990s there was DOCS and then they decided to set up the Ageing and Disability Directorate, and they became the ones who made decisions. They said, "We will decide on policy. We will decide on what should happen, and you folk in DOCS will do it". That created a huge wedge and there was a whole lot of issues which I do not understand because I am not part of the public service in that sense but there were different levels that people were at. There was very much this disconnect. It cost a huge, huge amount of money that did not go into services. It was decided after a few years that that was not a very good idea at all, let us go back to being one department.

At the moment it appears to us that they are the sort of management and they will get other people to do the service provision, yet, they have a huge amount of funding. I think that the funding, if you look at it, is going into layer upon layer, upon layer of management. It is a little hard for us to know. Like each therapist working in the system are grades one, two, three and fours all supervising each other which is okay but normally in the health system it would be one person. Then there is also a line of management that is administrative. Every report that you get has to be cross-signed by two different people. The use of the resources and services is very confusing to us and has created an administrative nightmare.

Dr BAYL: I will make a further comment on the intake issue. As Helen said, a big change has been clinician-based intake, where incoming information was examined and the need determined from incoming information which many of the adults or children have had very extensive assessment done previously and that was noted and recorded and action taken, based on that. Now every person, no matter what they want to access, whether it is case management, behaviour management, respite, therapy services, all have to go through a needs assessment. We just feel it is a huge waste of resources.

The Hon. TREVOR KHAN: I apologise, would you please repeat that?

Dr BAYL: No matter what service is being requested by the parent, the carer or another professional with parents' permission, whether it is respite, behaviour management, other accommodation issues, therapy services, all those things require, first of all, for a needs assessment to be done. So that the intake, a clerical person takes a call, they record the call in some way—we have problems even making sure that when a call has been made they actually match it up with a detailed eight-page report we send for our multidisciplinary assessment. They then wait three months to have a needs assessment. For the needs assessment someone goes out to the home, spends an hour in someone's living room, as parents tell us, and then they wait another 12 months before they get a service. This is for a three-year-old who desperately needs a service.

I took the liberty of looking at some of the previous hearing transcripts. In the very first day of your hearing you had people from ADHC attend. They stated the numbers of people and how long they were waiting for services. They said the majority of people have had a service within the past three to six months. What I am saying is that that service is often just a needs assessment and they are still waiting 12 months to actually get a real service. A needs assessment is not a service.

The Hon. GREG DONNELLY: On page eight of your submission you identify "artificial separation of disability and health sectors resulting in a fragmentation of delivery, care and disputes over who contributes what" which relates to the same theme of questions that we have been looking at. Would you elaborate on where the fragmentation occurs, as you believe it does, and the impact of the fragmented service on clients?

Professor TROLLOR: I think you are right. It really echoes what has been said so far. If you look at models of service delivery where human services are integrated with health you certainly see better outcomes. Surveys of clinicians in, for example, the United Kingdom versus Australia, show that clinicians working in the field believe that there are better outcomes and they feel much happier about the level of service they have been giving. We have a really robust model of an integrated nature in the United Kingdom. I was very fortunate to see that firsthand over an extended period last year, spending time in a number of different health services in the United Kingdom. It is so integrated to the point where everything comes to a central computer system. If you turn up in Accident and Emergency [A&E] someone can log onto a system, see what your contacts were with different aspects of human services and health. Every telephone conversation is logged so you can tell right where someone is up to with their health service.

If you come in to our A&E service here, you might have a community mental health file, you might have a hospital mental health file, you might have an A&E file, a hospital medical record and then you have disability sector which is entirely inaccessible. So the information cannot be integrated in any meaningful way. I think it really is an artificial separation. If you are looking at the whole of care for somebody, social services need to talk to health, the speech therapist needs to talk to the physician, the accommodations manager needs to be able to talk to the general practitioner. So you needs all of these parts of the puzzle essentially in one room, or at least with one frame of reference and the ability to refer to the same set of documents. We simply do not have that. It is an artificial separation which certainly in our view diminishes the quality of care, in particular mental health, but I think the whole of health.

The Hon. HELEN WESTWOOD: The assessment that is done initially, is any of that information being passed on to other agencies that may provide services to your clients? For example, does Health have the capacity to access that needs assessment? Does it have status within Health?

Dr BAYL: We never get to see what Ageing, Disability and Home Care decides or what the needs assessment involves. Speaking personally, the team I work with sees approximately 400 children a year for assessment, and I think other people here can also comment on that. We have a team which is a doctor, a psychologist and a social worker but we also use therapy services in the hospital for part of our assessments. We provide a very detailed assessment. We provide a very detailed joint report and we make numerous recommendations, and if we are recommending therapy services or casework management, we would give the details of Ageing, Disability and Home Care, and we have designed our own intake form that we attach to an email to send to them because they did not have an intake form that had the information on it which we could say these are the services we are looking for from you.

We also give parents information and put amongst our recommendations a range of non-government organisations, because non-government organisations are the ones that provide the service. We can get therapy services through many of the non-government organisations and we can pick it up within six to eight weeks time. But getting through Ageing, Disability and Home Care, we have had families come back a year after we first saw them where we have said we want to review the progress and they have come back and said they have not done anything yet. We had a needs assessment three weeks after we saw you and nothing has happened since.

The Hon. HELEN WESTWOOD: Have you had the opportunity to feed that back to the various bureaucracies, both Ageing, Disability and Home Care and Health?

Dr BAYL: Absolutely. We have regular three-monthly meetings with Ageing, Disability and Home Care and we have tried to challenge them on how they prioritise. They said they sit together and they talk about it and they look at the computer screens. We said yes, but how do you decide? Why is it this particular child is not getting the service, why are most of these people not getting a service? They said they are on a waiting list. They have had a service, they have had a needs assessment.

Dr SOMERVILLE: There is a lot of confusion about the term confidentiality and sharing records. I am lucky, because I have great collaboration with Ageing, Disability and Home Care and my nurse at the adult hospital and at the Children's Hospital is funded by Ageing, Disability and Home Care—and that funding is very precarious at the moment—and also dieticians, because we see a lot of children with very severe disabilities, cerebral palsy, who require other forms of feeding and have a lot of health problems. We have an excellent relationship with them. Git has taken us a long time to build that up. The fact that you have two departments sharing patients means that you share information. I do not know where it has come from but over the years we have tried to make them understand what confidentiality means and that the sharing of information is what is best for patient-client care, and there is a very difficult understanding of that.

It is very concerning, as I alluded to before, the lack of documentation of very serious meetings they have about people, where recommendations have been made, for instance, that a person needs a public guardian and we make a recommendation because of a health issue and we cannot get any record of what is happening, and they often use this confusion about confidentiality, or whatever. But where the sharing works, it works beautifully. In rural areas, and I must say, we do some outreach clinics on the South Coast, it is fantastic because you all have to get on because you all live in the same town so sharing between Health and Ageing, Disability and Home Care is often much better in smaller communities.

Professor TROLLOR: This is very much at the local level, people talking to people, it is not at an organisational level. So you have these pockets where it works very well by nature of the personalities involved but for the vast majority it does not work. You are probably aware of the memorandum of understanding between Mental Health and Ageing, Disability and Home Care, which has been worked on now and it is signed by both director generals. I guess that is a philosophical agreement to work together in a certain way and framework, which in itself is a positive thing and will hopefully lead to the establishment of some local meetings between Ageing, Disability and Home Care and Mental Health representatives. But, unless you have a fundamental change in the system whereby there is designated funding that is handed down and administered by people who are not bound by the Ageing, Disability and Home Care-Health—the us and them—boundary, it will not get very far. That is my view.

The Hon. TREVOR KHAN: I might just admit I am not aware of the memorandum of understanding, in case that is relevant.

CHAIR: I think it is publicly available and we can access it and get a copy, is that true?

Professor TROLLOR: It has been signed. I do not think it has been rolled out at this point.

The Hon. TREVOR KHAN: So, it is not publicly available?

CHAIR: It is a question of whether or not we can access it.

Professor TROLLOR: That is the question. You could seek to do that. I understand it has now been signed by both director generals.

The Hon. HELEN WESTWOOD: Have you been involved in the consultations of Stronger Together? That is the department's approach to disability services. Do you know about Stronger Together?

Professor TROLLOR: Yes.

The Hon. HELEN WESTWOOD: We have had quite a bit of feedback from various witnesses that it has improved services. It has been a significant increase in funding as well as a different approach to providing disability services. We have heard evidence from non-government organisations and various advocacy groups. They are up to stage two at the moment and doing consultations. Have you had an opportunity to have any input into that review?

Professor TROLLOR: No. It is really owned and run by Ageing, Disability and Home Care. It is not something we are invited to comment on or provide any guidance for upcoming submissions.

The Hon. HELEN WESTWOOD: Is that because you are seen as Health?

Professor TROLLOR: Yes, it is not our business really.

Dr BAYL: I think our understanding of Stronger Together—from an outsider's view, that we are not party to decisions or what happens within Ageing, Disability and Home Care—we have all worked very close to the department prior to 2005 when our services were transferred, but certainly the impression is they probably are doing a better job from the point of view of accommodation issues and respite issues, but we are very much aware of huge gaps in services, particularly in mental health, and having a network where there is adequate health services for adult transitioning from paediatric care to adult care. We are trying very hard to set up systems in Health but Health sees those as disability issues and Ageing, Disability and Home Care should be dealing with it. There is a difficulty with fragmentation in that area too.

The Hon. HELEN WESTWOOD: That means you see people with an intellectual disability or developmental disability through their life cycle?

Professor TROLLOR: Correct.

The Hon. HELEN WESTWOOD: One of the things I have heard from others in the field is that people with intellectual disabilities and developmental disabilities living longer has changed the management of their health. Is that correct?

Dr STURGESS: I think that is true. Hospitals these days are highly specialised. If you come with chest pains, a cardiologist will work on you. Intellectual disability does not fit too well into that model so far. So the poor clients often do not find a home in a hospital, so they come to emergency very upset for behavioural reasons. One thing we are trying to do in southern Sydney is develop a system where we pick children up in year 11 and year 12 at school from school clinics. They get to know an adult physician who is often there and then, if they have to come to hospital, there will be people who know their problems. We would very much like Ageing, Disability and Home Care and Health to cooperate on that so there is a similar system in all hospitals. It is not particularly expensive, I do not think, but someone has to have responsibility for the care of these people when they are adults. Nearly all the children become adults and they will live for many years.

Professor TROLLOR: You are quite right, there is an issue of ageing of this population. For example, someone in the 1950s with Down syndrome would be expected to survive until aged 12 and now it is till about age 60, which is quite a profound change. Their health needs are also changing. We are a doing a large study in the South East Sydney Illawarra Area Health Service, but essentially, as Allan says, unless you have a system that is rolled out statewide and we have dedicated clinicians who are willing to work in this area, then there will be a gap.

Dr SOMERVILLE: There are two things that are very serious things for complex people, say, with cerebral palsy and very complex health needs. The number of people turning 20 has gone up by 50 per cent in the last 15 years, so managing all those complex health problems has now become a priority and very much well rolled out in the paediatric system but we are all struggling. We are doing big transition clinics at Westmead. It is happening but it is getting adult clinicians in and it is getting funding. There is some initiative from Health at the moment which we hope will occur where the ACI, which is the clinical excellence, which used to be the greater metropolitan task force group, has a transitional group and is now looking at having an intellectual disability group so again it can be clinician driven to look at what is required to build up these services and replicate some of the ones that are happening in Alan's area, which I think are providing excellent services but it is a small area.

Dr LEITNER: But the model is there. I think if we reflect that families need help in a lot of areas, be it social, be it education—and we cannot forget education—and then welfare and health, and they often have to go to a confusing array of professionals. He says something, she says something, the teacher says something. If you just get together in a room like this—not as nice as this; we would love to have a room like this—and actually talk about the issues, even if we have a range of very complex problems, like I know you are facing at present trying to come to solutions, if we come together, put it on the table, it is surprising that at the end of the day once you have used all that expertise and the expertise of the carers and the families you often come up with some practical solutions, goodwill and strategies to move forward.

CHAIR: Father time is causing us some stress and we need to hear from you the very important evidence you are giving us. Are you able to stay with us for another 15 minutes?

Professor TROLLOR: Of course.

CHAIR: We need you to think seriously about the issue of publication because it is important that we publish as much as possible evidence that comes before the Committee, so you need to think seriously about that particular issue and whether or not your evidence needs to be in camera. We might just ask our witnesses who are coming at 10.00 a.m. if we can put them back by 15 minutes.

The Hon. MARIE FICARRA: We are respectful about your dedication to the field in which you work and the evidence that you have previously given and the fact that you have so much expertise. It is a vexed issue. I am looking at your two-page summary of key issues, which are fantastic and very comprehensive. On the interagency collaboration that you were just answering the Hon. Helen Westwood with, could you elaborate a little more there in terms of your summary point? Is there anything else? I am looking at it and I am seeing good collaboration such as the transition model and hospitalisation of ADHC patients detailed in the submission. This interagency collaboration seems to be very focal from beginning to end. How does that impact on the delivery of service, the early intervention programs? Is there anything that you can beef out in that interagency collaboration that we should be looking at in our recommendations?

Dr LEITNER: There are a number of good models of that actually happening. In this document, right at the end, our last point, there are three models described.

CHAIR: Can you just describe this document?

Dr LEITNER: In the submission, my apologies. If you go to point G on page 23 there is a list of interagency collaboration, and we give the examples of the school physical disability therapy teams and there are a number across the State run by Health. There is the hospitalisation of patients project at St George Hospital which Alan has been very responsible for. It would save the hospital and the system and the Government a significant amount of money which can go back into prevention and actually work in the community. We have very much ad hoc education, non-government organisations very much on side there, and there is the transition model which has already been spoken about where there is a very strong relationship between a number of government departments. Education is very much on side, and we must remember education has essentially got all of the clients with disability coming through there and it has the data on those clients.

The parents are very fond of the teachers generally because they entrust their child who needs their care for many years. Then there are the paediatricians who have been looking after the client families. Then you have the adult physicians who are coming in, and the adult psychiatrists who are coming in and being introduced to the families. Then you have ADOC coming to those services. You have the behavioural support team coming there and you have a room like this and you have the agency of clinical innovation, which Helen referred to. So you have a very strong coordinated group, a very powerful group and strong links into the families who are worried; for instance, what is going to happen? I do not have the schools there any more. What will happen? My husband has had a heart attack. I still have to care for this person. They will be home with me all the time. Then they come and see someone who is gentle like Alan and they are very reassured that there is a plan to go forward, et cetera. It is very much that team scenario.

Professor TROLLOR: Again, Robert, this is because someone like you and others in the clinic have negotiated this network. It would not otherwise exist.

Dr BAYL: It is specific to one particular area, which is the central sector of south eastern Sydney. It does not happen in the northern sector of south eastern Sydney area health where I work. It does not happen in other areas across the metropolitan area or the State. This particular system has been set up by good collaboration because of individuals who are motivated to make that work on both sides. We have tried hard to do a similar system but have not been able to find the individuals who are prepared to give it a go in our particular area. So it is a great system that Robert is explaining but it has not been planned as a statewide network. Something like that could be planned as a statewide network.

Another option is to look at purchasing services from other agencies, which is what ADHC already does, such as purchasing services from the Spastic Centre for the intensive family support. They purchase services for a range of different things. They do purchase some services from Health for their physical school therapy teams, but they only happen in certain areas. One option would be to look at all therapy services being provided either by Health, non-government organisations or both and ADHC getting out of that completely and just purchasing the services that are in fact doing a good job and have a good network already established. Maybe in mental health there are other ways of purchasing services through Health. So I think it is important to look at a creative way of trying to improve the situation. Robert's system has worked very well there. If it was brought out across the State it probably would work very well, but it involves the goodwill of the actual people involved.

Professor TROLLOR: The New South Wales Health service framework for health care for people with intellectual disability was worked on extensively by Robert. Robert was on the group and others were part of that group, and that document, I think, has been submitted to Treasury for costing. But it highlights a tiered service for people with intellectual disability which I think is a comprehensive array of services which hopefully would meet needs if it were in fact funded.

Dr SOMERVILLE: One of the issues in the health system is that in fact—as you would be aware, in the adult system everything has become very sub-specialised. The orthopaedic surgeons, if you look at their list now, they have the ankle orthopaedic surgeon, the shoulder one, this and that. So, as you can imagine, it is really going to be a slow process and involve a lot of training to have physicians who are going to coordinate care, like Alan does, and in our area we have some people training in rehabilitation medicine who are very keen but there is still no funding through Health so I think it has to be a collaborative thing.

Having said that, having a presence in outpatients, which we do—I do a joint epilepsy clinic with one of the neurologists at Westmead and the disability component of it is looked at by us and by our Ageing, Disability and Home Care funded clinical nurse specialist who can go out into the community as well, and it operates on a shoestring—means that at Westmead, in outpatients, we have so much better acceptance and care for people with really very high levels of both physical health problems and mental health problems. Once you have a presence—we have no funding, but once you start to have a presence—you find that the general hospital staff from all areas start to look at what the needs are of these people and start to rise to the challenge, but it needs to be integrated.

CHAIR: Julian, you referred to a document that we have no knowledge of.

Professor TROLLOR: This is the New South Wales Health framework document that was worked up last year.

Dr LEITNER: I was on that committee. I understand that Catherine Lynch is going to be presenting to you later today from New South Wales Health. It is a document that took a number of years to develop. It was a collaborative document.

CHAIR: We have five minutes left. You say the document is coming to us?

Dr LEITNER: Yes, as I understand.

CHAIR: Are you also able to give us a copy?

Professor TROLLOR: Yes.

CHAIR: What is it called?

Dr LEITNER: The New South Wales Service Framework for the Healthcare of People with Intellectual Disabilities.

The Hon. MARIE FICARRA: Do you have any further clear messages, since you have all come together and reflected?

CHAIR: We will also send you some questions on notice, if that is okay?

Professor TROLLOR: Sure.

CHAIR: Which we would then determine whether or not we publish.

Professor TROLLOR: The thing that strikes me is that where comprehensive services have been negotiated by individuals there is a great potential to work together with Ageing, Disability and Home Care, and it works very well. We have a good example in South East Sydney Illawarra, but in order for that to happen at a much broader level across the State we really need designated funding and training for staff, and a model that breaks down the barrier between Ageing, Disability and Home Care, non-government organisations and Health.

The Hon. HELEN WESTWOOD: Is there support for what you are doing at the bureaucratic level across the agencies?

Dr LEITNER: Yes. I was asked to present at the New South Wales service framework and a lot of the work and a lot of the model is actually based on work that was done in our area, examples from Helen's areas, et cetera, where there was good collaboration. Part of it was very much led by New South Wales Health.

Dr SOMERVILLE: Disability is a whole-of-life care, but I think the health system also needs to respond to primary, secondary, people in the community—a lot of people require GP services, a lot of people require general physician services or psych services. Our feeling is very much that the group who needs to be funded through this framework document is the various levels, so that you have a system that can see people in the community and provide their healthcare needs, which is largely general practitioners, community health and allied health, but right through to intensive care and palliative care, which many of us are dealing with more and more, and really the system needs to be across all those levels, if there is any funding.

CHAIR: There seems to be furious agreement across the board; they just cannot agree on what has been agreed on.

Dr SOMERVILLE: You should have seen us at the meetings leading up to this.

The Hon. HELEN WESTWOOD: Are there other places around the world or even within Australia where you think that the model is right or doing much better than what we are doing?

Professor TROLLOR: No. In fact at a recent conference we hosted a symposium that looked at models of health care for people with intellectual disability, focusing on mental health but more broadly, and this was across Australia and New Zealand. There were no places in Australia or New Zealand that had a comprehensive service model, and the best that we can come up with in this country is snippets of excellence from Helen's service, Robert's service and Vivian's service and try to work out a model that will apply here, but certainly internationally in Canada, a very comprehensive model, and in the United Kingdom, and beginning to develop in the United States.

The Hon. TREVOR KHAN: Was there a paper presented at the symposium that might be useful to us?

Professor TROLLOR: I have been trying to get one of the speakers to write his paper, but he has not so far.

The Hon. TREVOR KHAN: There was no Power Point presentation?

Professor TROLLOR: We could, as a group, present the model, but the model has been articulated in the health service framework. So we are reinventing the wheel. We have come together and there has been a lot of input into that health service framework document either by direct representation or by proxy.

Dr SOMERVILLE: I do not think there is clarity in the document of the model, though, but perhaps exactly what you are talking about could be fleshed out a little.

Professor TROLLOR: Yes, true.

CHAIR: We have run out of time. Could I ask a question, which you do not necessarily have to answer: Is there any reason why we should not be publishing? I am having difficulty working out why we should not be publishing.

Dr SOMERVILLE: No, I do not have a problem. I was the main dissenter because of the reasons that I explained to somebody who called me, but I have spoken to all the other members. If we could have a look, I guess, but I do not feel that there would be any dissent.

CHAIR: As the chair of the Committee, I am having real difficulty in putting forward any sort of position that you should not publish.

Dr SOMERVILLE: That is fine.

CHAIR: I would need help in coming to grips with not publishing because your evidence is extremely important to this Committee's deliberations, so I thank you for that.

Dr SOMERVILLE: Yes. We are happy.

(The witnesses withdrew)

(Evidence in camera concluded)