

TRANSCRIPT OF PROCEEDINGS

FAMILY AND COMMUNITY

DEVELOPMENT COMMITTEE

MR J. PERERA MLA, Chair
MR J. SCHEFFER MLA, Member
MRS J. POWELL MLA, Member
MS M. WOOLDRIDGE MLA, Member
MR B. FINN MLA, Member

INQUIRY INTO SUPPORTED ACCOMMODATION FOR VICTORIANS WITH A DISABILITY OR MENTAL ILLNESS

WITNESSES:

**MS MARILYN GALE, MENTAL HEALTH CO-ORDINATOR,
BALLARAT COMMUNITY HEALTH CENTRE**

**MS ROBYN REEVES, EXECUTIVE OFFICER,
BALLARAT COMMUNITY HEALTH CENTRE**

BALLARAT

9.42 AM, THURSDAY, 20 NOVEMBER 2008

THE CHAIR: Good morning, everybody. Thank you and most welcome to the public hearing. I'm Jude Perera. I am the chair of the Family and Community Development Committee which conducts this inquiry into supported residential accommodation for people with disabilities and mental illness. Onto my left is deputy chair Jeanette Powell, member for Shepparton, and my extreme left is Mary Wooldridge, member of the committee and also member representing Doncaster, and to my right is Bernie Finn, member for Western Victoria region and also a member of the committee. And there is Johan Scheffer, he's on the way. Very, very shortly, he'll be here. He's the member for the Eastern region of Victoria.

Now, the committee is looking into issues such as the standard, range and adequacy of care and accommodation currently available, the appropriateness of the current service providers, how unmet need is managed in Victoria, accessibility and appropriateness of accommodation for rural communities, ethnically diverse communities, indigenous Victorians, and the impact of the current service provision on families and carers. The committee is an all-party investigatory committee of the Victorian Parliament and is due to report to the Parliament by 30 June next year. After this, the government has up to six months to reply to the committee's report and recommendations.

All evidence taken at these hearings is protected by parliamentary privilege as provided by the Constitution Act 1975, and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments a witness makes outside the hearing may not be afforded such privilege. We are recording the evidence and will provide a proofed version of the transcript to each witness at the earliest opportunity.

Now, I would like to call upon the first witness to give evidence. That would be Marilyn Gale from Mental Health, coordinator. Have a seat. Please introduce yourself for the Hansard and also give a brief description about your organisation you represent today, and then continue with your verbal submission and later on followed by questions. Thank you.

MS GALE: I'm Marilyn Gale. I'm the mental health coordinator for Ballarat Community Health Centre. We support people with serious mental illness through a psychiatric disability rehabilitation support service called APROTCH, and that covers the central highlands which is an area that covers part of the - - -

MS REEVES: Grampians region.

MS GALE: - - - Grampians region, yes. Mirboo, Ballarat, Hepburnshire, and Goulburn Plains.

MS REEVES: And I'm Robyn Reeves, I'm the Chief Executive Officer of Ballarat Community Health Centre, looking to contribute as well.

MS GALE: So in one year, we're funded to provide a service for up to 120 people. We do that with an EFT of 6.8. Currently there are 96 consumers supported by APROTCH, 34 of whom are currently residing in supported accommodation,

including eight people living in community residential units, four people in SCU and two in rooming houses run by NGOs. We have an EFT of 1.2 for home-based outreach. The focus of my discussion will be on SRSs and I've just listed a number of issues for those with serious mental illness who live in supported accommodation, the first one being financial constraints. With accommodation costs taking on average 90 per cent of a person's entire income, many are left with no alternatives for leisure, recreational, or vocational options.

They are still obliged to pay for all personal items such as toiletries and clothing. The capacity for people to pay for extras such as birthday or Christmas presents for family, for instance, is severely compromised. People with mental illness are addicted to tobacco at a much higher rate than the general population. While this impacts on their quality of life, they appear to have a reduced capacity to control this addiction. However, this places an even greater financial burden on those who smoke. People with co-morbid diagnosis such as mental illness, alcohol and other drug abuse and acquired brain injury have particular problems with securing and then maintaining accommodation.

These people often have behaviours that alienate them from their peers and create difficulties for SRS management that lead to homelessness or unstable or limited choice for accommodation. There is little flexibility in SRS accommodation. Once placed in this environment, it's very difficult to change. Mental illness is episodic in nature and may require variations in the level of support required, therefore it is possible that this level of care may be temporary. However, it is difficult for people to have the ability to save enough money to transfer to private rental or other alternatives once placed in an SRS. Ballarat has a poor ratio of GP per head of population and only a small number provide bulk billing.

Where transport is difficult, this can impact on a person's mental and physical health. Our region have at least two SRS that were formerly motels. These properties are on the outskirts of Ballarat where public transport is some distance from the residents and proves prohibitive for most to use. Public transport in-region is poor, particularly at night and weekends. Even if people could access transport, their financial position would still make it prohibitive. Overcrowding in some SRSs means that some people share rooms, often with someone they don't necessarily like. There is a lack of privacy and therefore dignity in these environments. Having worked in mental hospitals in the '70s and '80s, I am reminded of the institutionalisation that was prevalent in that era.

Inconsistency. New regulations in 2001 require that SRS no longer have shared rooms, but receive insufficient funding to make single rooms viable, whilst allowing SRSs registered prior to 2001 to house up to three people in a room. Lack of appropriate respite accommodation in the region. Often respite has to be provided in an aged care facilities or motels that are not consistent with need. Boarding houses are unregulated, do not have community visitors, but operated in some cases as SRSs – for example, they oversee medication. There is no requirement to provide transport for outings or recreation, and no funding for those who do provide this valuable service in SRSs, and local council requirements vary and can be onerous.

Things like valuation vary – varies considerably against what the council say an SRS might be worth compared to an independent valuation. And I guess my last point is that I see an increase in home-based outreach would lessen the need for supported residential accommodation. With our service only having 1.2 EFT, we actually support 14 people within this region. It's not enough.

MS REEVES: And if I could add a few points to what Marilyn has already covered, with the SRSs in this region – and I refer to the Grampians region as well, because there is hardly any outside Ballarat, one at Ararat – there is very little option for the residents of the SRS if something goes wrong and the provider needs to make a change, so there was an instance recently that it was – well, a few years ago now, where a whole SRS and all the residents were moved from Ballarat to Ararat without really any choices, and there was nowhere else for those people to go. So they were, you know, moved an hour down the road to a new town where they had no support services, no access to their existing GP.

And that is the sort of thing where the SRS residents are really at the mercy of lack of choices. There are CRUs, and Marilyn and I are particularly focused on SRSs because our current clients tend to be living in SRSs, but there are some community residential units fully funded by DHS for people with intellectual disabilities in the region. Often, they are set up to provide services for people who are likely to be away during the day. There has been some changes in that over the years, but certainly, as people with intellectual disabilities age and perhaps become more frail, they need the capacity to be able to remain at home and be supported with staffed accommodation units.

We do also have a significant number of younger people living in Ballarat area who are living in aged care high level care facilities or nursing homes because of lack of other choices for them, and that is inappropriate accommodation. In terms of the SRS providers, it's incredibly difficult for them to actually do anything else beyond what they currently do with a pension-only SRS. The numbers are not that large usually in the units that you can supplement what the basic services – also, and this isn't related, but separate point – often the only social activities that people living in our SRSs are able to undertake is supported day programs that might be funded by home and community care program or in other ways through DHS.

There is usually, with that funding, an expectation that the client will make a contribution, and that contribution is added to the running of the day program. But usually, people in SRSs have very limited income, so that means that not only is their accommodation restricted in what it can offer, but the day program also is somewhat limited. Which means, overall, quality of life is impacted. There was one other thing I was going to tell you, but I've forgotten. I'll jump back in. That's probably all that we wanted to say at the moment.

MRS POWELL: You were saying that most people are in SRSs in Ballarat. How many clients would be in an SRS?

MS GALE: I think they vary in size from very small to, say, a house-type situation, to I think around 60 would be the maximum.

MRS POWELL: And what's your view of each of those? Which one do you think provides the better service?

MS GALE: I think that's – you can't sort of judge that on size so much. We do have – I can only say about one SRS which I know to be excellent and provide excellent accommodation, high levels of staffing, nutritious food, good quality care, and that would be Hillview in Ballarat. There are some much poorer ones that – yes, I'm not a community visitor so I don't see the whole extent, but what worries me is that boarding houses are not applicable to the same regulations and they can get around those regulations by being a boarding house, when really, they are an SRS. I think the regulations need to be broader to encompass all levels of accommodation; where people with a disability are living, they should all come under the same regulation.

MS REEVES: And I think it's worth commenting in response, in addition to that, that the SRS regulations tend very much to focus on physical requirements of the property rather than necessarily standards of care that might be appropriate in the facility.

THE CHAIR: So in the boarding houses, they don't get the real support?

MS GALE: No. No.

THE CHAIR: So they're not registered as SRSs?

MS GALE: They're not, no. They're boarding houses, so they don't come under that, the same regulations as a supported accommodation.

THE CHAIR: But they get funding, everything, they operate like SRS?

MS GALE: I don't know what their funding is.

MS WOOLDRIDGE: It's a private – commercial - - -

MS REEVES: Private for profit.

MS GALE: Yes.

MS WOOLDRIDGE: - - - rental agreement.

MR FINN: Just a couple of numbers, if I could. You mentioned that some renovations were needed to provide better accommodation for a number of people, could get them out of situations where they might be sharing with somebody that they didn't particularly like. What sort of expenditure would we be looking at, do you think, to provide you with your ideal?

MS GALE: We don't actually run any SRSs.

MR FINN: No, no, but how much do you think is needed by government to bring this up to scratch?

MS GALE: That's a tough one.

MS REEVES: The facilities that we're talking about are generally privately owned.

MR FINN: Okay, right.

MS REEVES: So they're not necessarily receiving government funding.

MR FINN: So we - - -

MS REEVES: But they're under government regulation.

MR FINN: Right. So we're talking about government, I suppose, ordering them to bring their accommodation up to standard, or - - -

MS GALE: Well, you've got two levels. You've got – since 2001, you're saying, you know, you can't build anything with shared accommodation, it has to be single rooms and you have to have so much space. But pre-2001, you still had SRSs that don't have to meet those standards, so there is a real anomaly there. You – somehow, you have to provide adequate funding to have the older ones fixed and for the new ones to be viable.

MR FINN: Yes. I was also very concerned to hear you talk about young people in the setting of an aged home or something similar to that. How many young people do you think in Ballarat would be in that situation?

MS REEVES: I haven't checked numbers, but I think there's at least 10 younger people in nursing homes in Ballarat. And some of them have been there for some significant time, possibly after a car accident, an acquired brain injury, things like that, where they do require a high level of personal care and attention. It can't be managed in something like an SRS or a lower level facility.

MR FINN: And when you say "young people", what ages are we talking about between?

MS REEVES: I'd be talking about people under 50, and in this region, I know of a child who was about 12 placed in a nursing home at one stage, because his parents simply couldn't manage the level of disability.

MR SCHEFFER: You "know of" – that was an occasion not in the past? The 12 year old that you're talking about?

MS REEVES: That was probably four or five years ago, but that person is still alive.

MS WOOLDRIDGE: Can I ask, one of the – in terms of the terms of reference and the relationship of SRSs to, sort of, the funded supported accommodation, do you see with the people, your client group or others that you know of, that they're inappropriately in SRSs because of a lack of availability in CCUs, CRUs, or other mechanisms? I mean, one of the things we're trying to establish is: is there a relationship between the people who are in SRSs and what they're providing, whether

they're getting the care they need, and a failure in the higher level of supported accommodation that is funded by the government?

MS GALE: Well, for a start, public housing here is incredibly under the pump, if you like. Our waiting list for public housing are very high, so that makes it difficult for people to receive support in what would be their own homes. And the level of support that's available to keep people within their own private accommodation is very low. So those two things combined mean, I guess, that some people who could live otherwise in private accommodation can't do so.

MS WOOLDRIDGE: And then what about the relationship back to the CRUs and the CCUs in terms of that level of care versus, you know, a couple of hours a day in a, you know, in a home setting? So you've talked about public housing, you've talked about SRSs, I'm looking further back up the chain. Have we got, you know, secure extended care beds? Are there the CCU beds? Are there the CRU beds?

MS GALE: We have no park here. We do have SCU, but no park beds, which, you know, could be a real benefit to keeping people out of hospital or needing that high level of care.

MS REEVES: The CRU – I mean, yes, the CRU generally have been targeted to people with intellectual disability, and we're talking about a group of clients with mental illness, so they would have very limited access there. I think it's probably worth comparing the cost of running something like a CRU to government compared to the cost of an SRS. You know, they're not comparable, and maybe there is nothing wrong with having SRSs that are private for profit, but there is very little profit to be had in a pension-only SRS. The SRSs that are able to charge high fees can obviously provide a high level of service, so maybe the appropriate response is some level of support to the SRS to enable them to, you know, provide a range of services that might be available in a CRU.

MS WOOLDRIDGE: Your organisation, when I read some of the aims of it, is to minimise stress, promote health and wellbeing, and develop independent living skills. If somebody comes to you and they are stressed out because they can't find appropriate accommodation, what do you do to help those people find the accommodation, and how many of those have had to leave Ballarat because there is nothing here in Ballarat?

MS GALE: Well, we do the run-around of all the agencies who do housing; Centacare Ballarat provide housing for people with mental illness, and that is supported, so we'll try and refer on to them, but – and there are SAAP-funded agencies as well within the area. There are places like Lisa Lodge, the Salvation Army provide housing. So we'll ring all those places, but it's not unheard of for people to be staying in motels or caravan parks.

MS REEVES: And some of those agencies that Marilyn referred to are really crisis accommodation, emergency accommodation. So what they can provide is short to medium term if they aren't already full, and usually they are anyway.

MR SCHEFFER: Did you want to follow up?

MRS POWELL: The other part of the question was, are you aware of how many had to leave Ballarat to go to somewhere else?

MS GALE: No. Probably couldn't put a figure on that. Because we don't do housing ourselves, yes, probably the housing people who do provide that accommodation would have a better idea of what their waiting lists are.

MRS POWELL: But what you're saying is there is a lack of – that the sort of accommodation that you would probably put or refer people to, there's a lack of that in Ballarat.

MS GALE: Absolutely. In talking to the worker from Carers Choice, a Commonwealth carer respite, she pointed out that respite was particularly difficult, that they often needed to use motels or accommodation that wasn't appropriate to the needs of that person. So respite – and I believe DHS spoke of providing some – a couple of beds in an SRS some four or five years ago, but to date that hasn't happened.

MR SCHEFFER: Yes, I would like – firstly, my apologies for arriving late and as a result of that I didn't hear all of your presentation, so I'm sorry for that. But you did say a little way back about variety and standards, and you mentioned Hillview as being an excellent service. Could you just talk to us about what accounts for that variation and why it is that Hillview is better than some of the others?

MS GALE: The physical environment is quiet new. It's maintained. They have high level of staff. The staff and proprietors are well-trained and they have a background in mental health. The supervision, just the nutrition, their meals, all of that is excellent.

MS WOOLDRIDGE: Is it a pension level 1?

MS GALE: Yes.

MR SCHEFFER: So how do they get that to work?

MS GALE: You'd need to ask them that, because they are having difficulties. Yes. They also provide transport. They do – they have a bus and they take clients out for day trips or to do their shopping and that type of thing. So they go beyond what is, you know, actually what they're required to do. And that is what makes them an excellent facility.

MR SCHEFFER: All right, so comparing like with like, that they operate on residents that are there that only have their pensions to contribute, that is equal, but yet they're able to produce an outcome which is very different to the rest of them. Is that what you're saying?

MS GALE: Yes.

MS REEVES: And largely, that depends on the personal contributions of the people who are running the SRS.

MR FINN: What do you mean by that?

MS REEVES: That they're prepared to go beyond just - - -

MS GALE: What the regulations say.

MR SCHEFFER: So they invest in their business?

MS REEVES: Yes. They invest their personal time and energy and - - -

MR SCHEFFER: Because it's their business and so they're putting into the business and so they get a bit of product.

MS REEVES: I think it's also because they actually care about the people that they're caring for, so.

MS GALE: Absolutely. Yes, you can tell it's not just about making money.

MR SCHEFFER: Yes. But so – do you think – I, sort of, suppose, you know – it's fine if people do things out of the goodness of their heart, that's terrific and that's one thing, but what we're trying to drive at is whether the fundamentals mean that it's reasonable to do it within the parameters of operating a for-profit business. And so you're saying that they can do that within those parameters, or do you think people have probably - - -

MS GALE: I think – no, I think they're really struggling.

MR SCHEFFER: Okay.

MS GALE: And I think that they have real issues with – yes, with maintaining that level. Yes.

MR SCHEFFER: Okay.

MS WOOLDRIDGE: Could I ask a little bit about the – you say you've got 1.2 EFT to provide, that's home-based - - -

MS GALE: Outreach.

MS WOOLDRIDGE: - - - support, is it, for 14 people. And I think you said you had 96 consumers altogether, so they're receiving services not in the home? Is that right, or they're in another setting?

MS GALE: We do have – we have another two programs, so we have day programs, so people come to us and we take people into a community type setting, and we have a youth-specific program within that.

MS WOOLDRIDGE: So what – if you had more resources for home-based outreach, and it's very hard, but do you have a sense of how many people might be able to be in a different setting other than a CCU or a SRS if there were more resources invested in the home side of things?

MS GALE: I wouldn't – I couldn't put a figure on it, but there is evidence to suggest that with support, people can maintain their independence a lot longer, that with that support, they – even if they have an episode, they can return to what was their home and be supported to maintain that rather than if they had no support, very quickly they will become dependent. But as to a number, it's really - - -

MS WOOLDRIDGE: Hard to tell. But there is no issue with you guys going in to SRSs? That is also part of what you're funded for. And is that usually linked in then through the mobile support team? Or, you know, how do you get your clients?

MS GALE: No. Mobile support team is very much a clinical side. We're a non-clinical - - -

MS WOOLDRIDGE: So how do your services get enlisted to support these people?

MS GALE: We would be referred, so – and we can receive a referral from any source from the person, the carer, GP, anyone. The criteria is that they need to be 16 to 65 and have a diagnosed serious mental illness. But yes, we accept referrals from any source.

MS WOOLDRIDGE: So but if they're getting support from, say, the clinical side of things, from the area mental health service, would you be giving them services as well, or does it tend to be sort of once they're out of the clinical side of things, and you guys are on a maintenance? Could be both?

MS GALE: Yes, absolutely.

MRS POWELL: You were talking about what makes a good model is well-trained staff with a mental – a background in mental health. In Ballarat, are you able to attract and retain those sorts of people, do you believe, to work in those CRUs and SRSs?

MS GALE: Well, it's difficult. We find it's difficult to recruit in PDRSS, so no doubt it will be more difficult. I don't know what their salaries are like or, you know, what their remuneration is like, but it's not very good in PDRSS, so I don't imagine it's that great working in SRS environments, so yes. It is difficult.

MS REEVES: Recruitment and retention is a problem in all disciplines across the board. An example, just to highlight that, is probably the Ballarat Health Services are currently short 50 nursing staff.

MRS POWELL: 50?

MS REEVES: 50, yes. They advertised – have an ad campaign ongoing at the moment to try and recruit an additional 50 nurses, because they just can't get them to

work in the hospital, and that is a much more highly paid sort of position than what we would be looking for.

THE CHAIR: How many in your team altogether?

MS REEVES: Ballarat Community Health Centre has about 75 staff, but we've only talked about PDRSS on - - -

MS GALE: And that's 6.8 EFT.

MR SCHEFFER: Can I just ask another question, just to – it's a bit of a broader brush. I think taking a bit of a historical view and seeing what the health service's response to this is, that we've seen over the last period of years a new Disability Act, seen the State Disability Plan, seen individual packages, we've seen investment of some hundreds of millions of dollars through A Fairer Victoria. We've got a Green Paper on Mental Health out, investment of 128 million into mental health. So it looks good at that level, and we're getting positive response from people about that. How does that sit with your experience?

MS REEVES: I think A Fairer Victoria policy has been an incredibly positive policy. It's one of the first government policies that I've seen that has some real action in it and some real outcomes that are sought and able to be measured against, so that policy direction has been really good. In terms, though, of supported accommodation, that is not necessarily something that has been picked up there, but the supported accommodation field is also very much intertwined with what's available Commonwealth-funded, and what's available to support people in their own homes. So it's difficult to, you know, just pull out that one section and say, "In the light of A Fairer Victoria," and some of the other changes. I don't think the SRS area has had all that much attention, and it's one that has been problematic for many, many years.

MR SCHEFFER: What did you mean by the Commonwealth connection? Can you just explain that out a bit more?

MS REEVES: Well, when we're talking about supported aged care for people with disability and for people with mental health problems, fairly often we're actually talking about older people. Not always, but very often. And so Commonwealth-funded low level and high level care, community aged care packages and things like that, are also used to support some people who would be part of the target group for this environment. So that is why I'm saying the context is broader than just what is funded by the state.

MR SCHEFFER: So what does that mean for you in terms of resources?

MS REEVES: Those resources are also very limited. So – and generally, the people who are in supported residential services are there because there is no other options for them when they're pension-only SRSs.

MRS POWELL: Could I ask, one of the areas that we need to look at is the issue of accommodation, lack of or enough, for people with culturally and linguistically

diverse backgrounds and indigenous Victorians. Does your organisation have a clientele of those people? And if not, do you know of somebody else that does support them?

MS GALE: We do have very few CALD in our region. I don't know of any SRSs that particularly look at either Koori or CALD populations, but maybe the Ballarat Aboriginal Co-op may have something – you would have to ask them.

MS REEVES: They have some short term accommodation. The Grampians region, historically, has had very little diversity and the population of CALD consumers until recent years has been under two per cent of entire population, which actually means that those people can be even more disadvantaged because it's really difficult to provide appropriate services for communities that might be two or three people in an area.

MRS POWELL: So your organisation hasn't had to refer on people with a CALD background or aboriginal background.

MS REEVES: We currently provide support in one of our other programs for a direct refugee settlement program, so that numbers and diversity are changing at the present time significantly.

THE CHAIR: Would you like to make any recommendation to the inquiry? Anything at all in the industry?

MS GALE: Well, I think just that it – you need to apply the regulations across the board, that it needs to be broader and whatever regulations, if there are changes, need to encompass boarding houses and other types of accommodation if they're going to be used as supported residential services.

MS REEVES: And need to consider standards that apply to quality of life issues as well as physical. Properties of the facilities.

MS GALE: We're an accredited agency, and I don't see why SRSs shouldn't go through a quality accreditation as well.

THE CHAIR: All right. Thank you very much.

MS GALE: Thank you.

MS REEVES: Thank you.