

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**

WITNESS:

**MS TAMARA IRISH, BALLARAT ADULT COMMUNITY
PSYCHIATRIC SERVICE**

**BALLARAT
THURSDAY 20 NOVEMBER 2008**

THE CHAIR: Before I call the next witness, if anybody else in the public gallery would like to give evidence, we have a time slot about 12.30, I think it is, and they can register. Anybody else wants to give evidence who are not registered so far, there are forms over there. You can fill a form. Thank you. Next witness will be Tamara Irish, Ballarat Adult Community Psychiatric Service. Good morning. My name is Jude Perrera, I am the chair of the Family and Community Development Committee which conducts this inquiry. Onto my left is the deputy chair Jeanette Powell, member for Shepparton, and to my extreme left is Mary Wooldridge, member for Doncaster, and to my right is Johan Scheffer, member for Eastern Victoria and to my extreme right is Bernie Finn, member for Western Victoria region.

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. 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 followed by questions. Thank you.

MS IRISH: Thanks, indeed. My name is Tamara Irish and I'm the manager of Ballarat Adult Community Psychiatric Services. My role also is responsible for the adult acute inpatient unit, the secure extended care unit, and the continuing care unit located out at Stawell Street, our Eastern View program. Ballarat Health Services provides clinical psychiatric services across the Grampians region, so that takes us north to Horsham and beyond, whatever is beyond Horsham. Across to the South Australian border, down to Bacchus Marsh, and Daylesford. It's a fairly significant geographical area, as you can imagine. We have community mental health programs in Horsham, Ararat, and obviously in Ballarat with outreach programs to anywhere else it needs to go.

I hope that is sufficient to give you a bit of background. What I think we did want to say from the outset is that it's important, if not crucial, to distinguish between the nature of a significant mental disorder and mental retardation. The majority of Victorians – and certainly, it's a reflection in rural Victoria as well – who experience a mental disorder usually do so with the support of family, remain at home, are cared for by their GPs, and very rarely, in fact, require institutional care and treatment. The episodes that we treat are often significant in their biological, psychological, and social impact. They are, however, with optimal treatment, imminently treatable.

Recovery is a reasonable expectation in all instances and, as a result of that, impairment disability and handicap ought to be minimised provided effective clinical treatments are delivered in a timely and orderly fashion. Obviously, early detection, early intervention enhances that. The longer a disorder remains untreated, the greater the likelihood of ongoing problems and difficulty that can lead into issues such as this housing problems. Intellectual disability, of course, organic disorders, and whilst optimal treatment can certainly reduce the level of impact of the disorder, the underlying lesion remains constant. I'm sure I don't need to give you a lecture in clinical practice, but nonetheless, it's important, I think, to cite that difference,

because it does make a difference to what we're about to say in relation to accommodation matters.

Our observations from a clinical perspective in relation to the use of supported accommodation is probably three broad groups that are affected. There is a transient population who have brief accommodation needs. These are folks who do not reside locally, who come and go from communities, move through various parts of Victoria including a range of mental health services and the like. They pose particular difficulties in terms of provision of service, but may well have accommodation issues as well. So often, it's the guest houses and the boarding facilities where these people may stay, albeit for a relatively brief period of time.

It is in the longer term significantly mentally ill population who may well in fact find themselves resident of a facility such as special accommodation houses. These are cases where, increasingly, the disorder has – is effectively – the impact of it is a consequence of, frankly, failure to treat, failure to get in early, and failure to provide the treatments. Notwithstanding that, we do have hopefully a growing smaller – that's a bit contradictory – a smaller population of this particular cohort. As I say, with the effective treatments we should see in Victoria, the reduction of this kind of level of disability and handicap. These folks do, of course, frequently find themselves resident in accommodation facilities that are generally expensive for them to maintain, cost a lot of money for folks to live there.

They're usually recipients of social welfare and benefits and the like, and as such, the likelihood for them to have much money left over at the end of the day to even begin to consider alternative independent living options is restricted. That has all kinds of impacts for people, of course, psychologically, if not socially. There is also the population that we see a number of patients involved in where they have Ministry of Housing facilities – and an interesting comment we'd make here is the growing inclination of urban regions to overflow patients, if you like, which happens as a result of increased availability of public housing. Places such as Bacchus Marsh are seeing an increased amount of public housing, and with that, then a population of significant mentally ill patients are – not admitted – are located in these facilities.

As a result of that, if these people have a pre-existing mental disorder, it's not difficult to work out that removed from ordinary family environments, normal social networks, usual accommodation options, and we put them to the countryside where they may never have left before, the likelihood of significant stress rises and the likelihood of relapse of mental disorder is significant, and it's certainly not wasted on us that we are seeing a greater number of clients in that area. I'm not saying that the relocations are indiscriminate or inappropriate, simply that there are consequences to failure to recognise the impact of wrenching people from their ordinary social fabric and attempting to introduce folk into otherwise rural environments. In relation to CALD issues, we will see an increase in complexity in the Ballarat area.

MR SCHEFFER: Sorry, can I just interrupt you?

MS IRISH: Yes, of course.

MR SCHEFFER: You see, I'm trying to follow what you said. You said there were three groups. You talked about the transient, the long-term.

MS IRISH: Yes, transient - - -

MR SCHEFFER: With significant illness, and what was the third?

MS IRISH: - - - longer term, and then those populations who may or may not have a mental disorder, but who move via accessibility of Ministry of Housing populations.

MR SCHEFFER: So that's the third. Okay.

MS IRISH: Yes.

MR SCHEFFER: Yes.

MS IRISH: Some of those folk do have a pre-existing mental disorder. Some do not, but may well be vulnerable, and therefore the shifts are more likely to impact people's mental health further down the track, yes?

MR SCHEFFER: Yes.

MS IRISH: Is that clear enough?

MR SCHEFFER: Yes, yes.

MS IRISH: Okay, no problem. In relation to CALD, as I say, we will see an increasing issue here in – well, across regional Victoria, but certainly in Ballarat. There is a – albeit slowly, but it's a growing population of African refugees, and with that, we will see the impact in terms of the clinical services that we need to provide. The histories of trauma, abuse, and certainly gender-related issues, is significant, so we will see an emerging clinical frontier there, and dare I suggest that there will be accommodation and residential issues that follow on from that. Our indigenous population is one that is probably typical in many respects in its issues across country Victoria, and by that, I mean that it's an area that we have less than optimal responses to.

My colleagues at the local co-op make it very clear that issues such as housing are challenging and complex, involve youth, certainly women with young kids, and older people, although of course any indigenous in Australia who makes it past 50 years is doing pretty well. We all know that. So the issue is there and it's apparent, but is poorly responded to, and frankly, I'm not aware of any supported accommodation environment that is particularly sensitive to Aboriginal issues and cultural sensitivity. Again, the consequences of that are probably fairly obvious. People are not going to hang around and stay in programs that don't meet their needs, so are lost to the streets or simply lost.

Youth homelessness again is an area which will be growing in Ballarat and, in particular, people with co-morbid disorders. So substance abuse is an obvious one, but equally, acquired brain injury and mental retardation can, of course, co-exist with

significant mental disorder, and those young people involved in that population are of concern. Particularly where there is co-morbid substance abuse. My general observation is that accommodation facilities that do exist are relatively unable to tolerate, deal with, manage co-morbid disorders when behaviours become problematic. It includes alcohol too, of course, so the criteria for entry is often one that says, "You can have a mental disorder and use this facility, but if you use drugs or alcohol on the premises then you're evicted," and therefore the homeless cycle continues.

What we would say is that the likelihood for the need of supportive accommodation in the population with a significant mental disorder decreases when one provides optimal treatment. Take away some of the factors that contribute to homelessness, which is uncontrolled and poorly managed mental disorder, and you've got problems. If, however, we do our job properly, work with our patients and their families to provide optimal treatments, then the need for supported accommodation diminishes, and I think we can't underestimate the value of, I think, your earlier comments in relation to the value of the mental health matters, documentation and the like, all of which augurs extraordinarily well for the future.

So we keep on keeping on around all of that, do the work that needs to be done. Clinical logic tells us that the need for, if you like, remedial social interventions such as, you know, high level of supported accommodation should reduce, which I understand is a bit, sort of, provocative to say something like that, but nonetheless, that is our clinical perspective. As a result of that, I think it's interesting, then, for us to consider from a clinical services perspective as to how we work in a cooperative and engaging and dynamic fashion with the public housing sector, but also to include special accommodation facilities and the like in order to, again, manage the, in particular, the social, the psychological impacts of mental disorders in those environments, so that people, in fact, are enriched, are able to better manage their health, and therefore able to manage their financial affairs and so on and so forth, remain connected with their families, return to their homes of origin, because the best place to live is at home, and the best people to live with is family. And the best place to manage a mental disorder is in a well-connected social environment. That is about all I had to say.

MRS POWELL: Thank you.

THE CHAIR: Thank you.

MRS POWELL: Tamara, you were talking about the transient group of people, people who might not be able to find accommodation and move to another town or to another service provider.

MS IRISH: Yes.

MRS POWELL: With the mental health organisations, is there some sort of link so that if somebody – if a client comes there, you can actually check if they've been to another agency in another town, or another state? Is there some way of keeping control or case-managing that person as they move around you?

MS IRISH: In Victoria, from a clinical psychiatric perspective, there is a statewide database client management interface, so we can quite simply get on the system and, if a person has a history of involvement with the public psychiatry system, then they can be readily identified, their last episode of treatment, their diagnosis and so on and so forth can be identified. So for example, if a young person gets off the train, goes to a nearby accommodation facility, is – that facility contacts us, and they do regularly, we've got very good relationships with those folks. They've got good low thresholds for referral for problematic behaviours.

We can then determine if that person has been treated in the past. And that can impact the way in which obviously we go about then providing the clinical services. We, of course, then can contact other clinical services and so on and so forth, and work then starts to hang together, so you start to know who's been involved with the person and the like. So that is up to the clinical work, and it works well.

MRS POWELL: Can I follow up from that? Do warning bells ring when, if you have a client that has been to a number of agencies right around and still can't find accommodation, because I quite agree with your comments about early detention, early treatment and so forth – if that person has been lost in the system, is just moving around, at what stage does somebody say, "this person has been out there for two, three years, and obviously they're still not finding somewhere, so we have to get a hold of that person, find somewhere for them to stay so we can actually treat them?"

MS IRISH: Yes. Yes. It's a very fair point, and I think that is – it's a crucial part of the responsibility of the area mental health service to identify that particular person who has the mental disorder and to consider the effect that the disorder has had on the transient behaviour. It's not uncommon for a person, a poorly treated psychotic disorder, to have delusions that compel them to move on. The requirement, then, for us is to (a) recognise that, and (b) ensure that the treatment and services are provided, and in the extreme circumstances, that does include the use of restrictive mechanisms such as community treatment orders with residential orders.

The residential orders are infrequently used and rightly so, but they are there, and they are occasionally used for that particular kind of population. So the characteristic patient in that cohort is exactly that person. The person who hops around. That may or may not be related to their accommodation, however, so the primary driver is the inadequacy of the provision of treatment, but it's not uncommon to see marked in housing problems with that as well.

MS WOOLDRIDGE: Just to get – how many SECU beds do you have?

MS IRISH: 20 – 20.

MS WOOLDRIDGE: And they're all in Ballarat?

MS IRISH: Ballarat.

MS WOOLDRIDGE: Yes. And CCU?

MS IRISH: Sorry no, I'll withdraw that. The CCU has about 20 beds and there is 22, I think – I'd have to check that, Mary – yes, in SECU.

MS WOOLDRIDGE: Okay. But they're all Ballarat?

MS IRISH: All Ballarat-based.

MS WOOLDRIDGE: The question for me is, given the vast geographical area that you cover, including significant populations in Horsham and other areas, having those higher level clinical services and accommodation - and CCU is the longer term option as is secure extended care – how does that work with, you know, you've talked about the dislocation of people being removed from their social networks, but here you have them sort of, you know, centrally located and have to do that. What's the dynamic around that?

MS IRISH: Yes. That is a very fair point, and historically, of course, when a client has been admitted to CCU beds or certainly SECU beds, it's been a long stay indeed. We are revising and looking at our models of care in our eastern view program. That sees that as: whilst a longer stay facility actively ensures that connections with community mental health teams and families is promoted and engaged. We facilitate financial support for families to attend those program areas, to be involved in clinical interventions such as multi-family groups, and of course, you know, one of those greatest of inventions is video conference facilities.

Our consultant psychiatrists remain constant in the patient's care event. So, for example, the consultant psychiatrist who's working in the Horsham community may well admit to those beds but remains responsible for the clinical care. The treating clinician in that environment also maintains an involvement, so those family connections are maintained. In SECU, a number of the clients there, as we know has been, historically been the case, are folks with very significant intractable disorders. The challenge to maintain family engagement and connectedness is probably greater. I'll be frank, however, and say one of the greatest pressure on those beds for us in rural Victoria now, however, is the demand for admissions from other area mental health services. Like it or not - - -

MS WOOLDRIDGE: Because they haven't got - - -

MS IRISH: They ain't got the beds, and the pressure is now on the rural sector to not have all of those beds available for their local communities and, in fact, be accepting cases from out of area areas, and I would say there would be, I think, at least three, four patients currently on our waiting list for a bed here in Ballarat who do not reside in this area. So effectively, they are out of area proposals.

MS WOOLDRIDGE: Can I ask on that, then – so waiting lists for your SECU, you've said three or four outside of the area. How many sort of within the area? You know, what's the waiting - - -

MS IRISH: One or two at most.

MS WOOLDRIDGE: Okay.

MS IRISH: One or two at most.

MS WOOLDRIDGE: So - - -

MS IRISH: I would have to say that - - -

MS WOOLDRIDGE: That they wouldn't get a bed when they needed it?

MS IRISH: Yes. Absolutely. Yes, yes. I would not support the notion that casting more dollars at secure extended care units or community care units is necessarily a desirable way forward from a clinical point of view. From where I sit, quite frankly, what it does is simply promote that as a means of service delivery rather than say, "What's a preferred option?" which, of course, is home-based care by competent, capable clinicians who know how to do their job and get the kinds of outcomes.

MS WOOLDRIDGE: So – sorry, just ask – the difference between the two, though, is CCU is 24 hour care and home-based care is one, two, if you're lucky a few more than that, hours a day, and there is a big distinction between an individual who needs that sort of level - - -

MS IRISH: Indeed.

MS WOOLDRIDGE: - - - and, you know, a couple of hours.

MS IRISH: Yes.

MS WOOLDRIDGE: And the pressure that puts on families. So I'm just trying to reconcile that distinction, I suppose. Is it actually having home-based care that has more hours? Maybe 10, 12, you know, 14 hours versus what, you know, what we're currently seeing.

MS IRISH: Yes, absolutely. I'd certainly agree with that view that where the requirements are for clinical care, the greater the resource base to provide that in the home, the better off you are. There is also the issue, then, about collaboration with other service providers, so PDRSSs can and should have a role in relation to psychiatric rehabilitation. They can and should be home-based. So one could find, you know, with improved provisions of that kind of home-based care – in fact, a very high level of home-based care can and should be able to be provided across, you know, the clinical domain, the disability domain, and the like. And, you know, housing officers and whosoever else, people who have got an awareness of a mental disorder and its impact, so I don't think it's beyond the pale that with the appropriate kinds of configuration and relationships, that that kind of high level of care can, in fact, be delivered.

MR SCHEFFER: Yes, the – I thought I heard you say before that with the improvements in treatment, that in the longer or medium term, we could see a – struggling with my words here, but we could see a decline in the kinds of needs that people with mental health issues face in the future. So the reduction in demand, which would then have an impact on the sorts of issues that Mary is raising on the

levels and types and mix of services into the future, can you just take us on a forward look on what that might mean over the next period?

MS IRISH: What we can and should be providing are the very, you know, well-established, well-known, evidence-based clinical treatments that affect the course and outcome of a significant mental disorder. The kinds of outcomes such as the chronically psychotic, socially dysfunctional, disengaged person who has marked levels of disabilities and handicaps, is and should be on the wane. Look, compare if you like, the skin cancer programs, you know. We work on prevention, we work on prophylaxis, look at the results that we've achieved in a domain such as that, sort of carcinomas, blah blah blah, you know.

It doesn't mean that from time to time, there isn't going to be a case that doesn't respond to the treatments, but provide the treatments, and that particular population, those in-state clinical syndromes if you like, will in fact decrease in their incidence and frequency. The consequence of that, of course, is significant. Now, I'm talking – that's long term, okay, and I'm not saying for a moment - - -

MR SCHEFFER: What do you mean by long term?

MS IRISH: Well, I would hope in the next, you know – if we in Victoria better manage our mental health services in terms of the delivery of clinical services and clinical staff are suitably trained and capable and competent, we should be able to see those sorts of turnarounds in 5 or 10 years.

MR SCHEFFER: And are we doing that? Are we going to be able to – do you think we are sufficiently tooled up to be able to better it?

MS IRISH: I don't think we've got any choice but to do that. Things like - - -

MR SCHEFFER: Yes, but that is not answering my question.

MS IRISH: No, indeed.

MR SCHEFFER: We may not have a choice, but are we doing it?

MS IRISH: I think in some quarters, we are. I think the mental health matters documentation is important in driving that. What that doesn't do necessarily, though, is tell any of the mental health services how to do it, how to manage the workforce; that is, progressively improving, okay, so we've got a better mix of dynamic, competent, clinical practitioners across the disciplines.

MR SCHEFFER: So facing the right direction, a lot more to be done.

MS IRISH: Absolutely, yes. But we do need to tackle head on the business of incompetent, unskilled clinical staff who can no longer perform a service and are, frankly, still providing care.

MR SCHEFFER: How serious is that?

MS IRISH: I think it's very serious in Victoria. I wouldn't be sitting here today having this conversation with you. This is the outcome of failure to treat. It's forgivable if you don't know what to do. It is no longer forgivable because we know what the best practice treatments are and we know how to get the outcomes. The research and the literature is abundantly clear on that. Now, the wherewithal for area mental health services and, dare I suggest, you know, the governments of Victoria to drive it, is utterly compelling. Do all of that and bear the costs. You know, if you just simply want to be a financier about it all, it gets cheaper. You know. People are living and working and they're paying taxes. They're doing all those sorts of things.

MR SCHEFFER: And when you said, in passing, "Victoria", was that a comparative remark or just a throwaway?

MS IRISH: In - - -

MR SCHEFFER: When you said "in Victoria", did you mean "in Victoria completely?"

MS IRISH: No, I'm just confining my comments to Victoria, yes.

MR SCHEFFER: Okay.

MS IRISH: We should see it universally, though. I mean, quite frankly, you know, a diagnosis of schizophrenia paranoia type is the same clinical syndrome in Ballarat as it is in Sydney or wherever else. There may well be, you know, different factors that influence the course and outcome of the disorder, but that is usually about the treatments that we provide rather than the nature of the disorder itself.

MS WOOLDRIDGE: Can I ask a follow on question to that, and this might be a little bit unfair, but I'll throw it out there anyway.

MS IRISH: That's all right.

MS WOOLDRIDGE: 22 area mental health services. How many of them do you think get it?

MS IRISH: Maybe a couple if you're lucky, Mary.

MS WOOLDRIDGE: And that is the context, I suppose, of the challenge.

MR SCHEFFER: Yes, that's right.

MS IRISH: And the – one of the ironies in their supports is that there are 22 area mental health services, and you can go to all of those area mental health services and see different models of clinical care. You can see different ways of approaching clinical management. You'll see, you know, a failure to provide what we know are the evidence-based treatments that work. You'll see a failure of those area mental health services to meaningfully provide education, training, and supervision to the people to provide the treatments.

MR SCHEFFER: So we're an all party parliamentary committee, as you know, and we're going to make recommendations to the government. Now, on the basis of what you're saying, do we say, "So far, so good. Keep doing what you're doing, but a bit more of it, or a bit faster," or do we say, "In some areas, you've fairly not got it right. You've got to shift focus."

MS IRISH: I would say that in generally – generally speaking, I should say – that things are heading in the right direction, okay? And that has been going for a fair while, okay? We know that. The problem is not a failure of what drives it, it's a failure to deliver it, okay, and that is where the area mental health services – that is where the management teams and the clinical services must get their acts together and drive it. What they need, however, is, you know, an absolute commitment that sits behind them in terms of, you know, the government who deal with the consequences of managing non-performing services which are many and varied, you know, from the industrial to otherwise, but give us the tools and we do the job.

MR FINN: So are you suggesting that they perhaps feel that if they stick their necks out and they have a go that the back up might not be there to see – allow them to see it through?

MS IRISH: That has happened.

MR FINN: Okay. Is that a regular event? Is that something that - - -

MS IRISH: I couldn't comment for other areas, but from time to time, one hears of cases where services or senior managers are advised to back off in relation to industrial issues.

MRS POWELL: One of the issues that we've heard with the CRUs, particularly with people that have the disabilities, and I guess if it's a dual diagnosis of somebody with also a mental illness, is the fact of they see that place of residence as a workplace rather than the person's home. Is that an issue – I mean, even with mental health issues, the staffer who is there sees very much that they don't have to do this, they don't have to do that, because it's their workplace and they're worrying about the workplace occupational health and safety rather than what's in the best interest of the person that they're caring for, and we've heard about a number of areas who are saying that there are some people who really don't support the people who are in there, and it's about the non-competence and the need for training. We've heard some best practices and we've heard some worst practices. How do we deal with non-performing people? Is it a matter of retraining, or - - -

MS IRISH: I think it's – there are many and varied approaches to that, Jeanette. I mean, I think it includes training and education, but right back at the very beginning. You know, defining the kinds of skill set that are required to do the work, okay? Being clear about what the work is, all right? Seeking out and finding people who are able to do the work, training them, supervising them, supporting them within the role and continuously improving. You know, being open to the literature, open to the research, you know, retaining good people to do a good job and performance manage – frankly, performance manage those people who fail to deliver.

I mean, that is a very harsh way of putting things, but that is the reality of it. But I don't – it's interesting to note our experience here is that historically, the clinical psychiatric services could not attract and retain Allied Health staff. The current view, essentially, is that we fail to make the right efforts and the right directions around that. We now have something like – I think it's nearly 65 – psychologists working in the area mental health service. It's about creating an environment that gets people there, are being clear about what you require them to do, and then supporting and training and teaching and supervising them to do the job that is required, and rewarding the sorts of work that is best done.

And that is not just about how much you pay people. You know, a real professional is about, you know, seeing optimal outcomes of patients. That is a fundamental reward for people, giving people the kinds of authority to do the clinical work that they've been trained to do, access to, you know, top quality education and other developmental opportunities. They are the things that attract and retain optimal clinicians, not simply – I'm not saying that people shouldn't get paid, but you know, it's – remuneration is only factor.

MRS POWELL: Job satisfaction.

MS IRISH: Absolutely, yes.

MRS POWELL: So is it harder in country areas where it is harder to attract that type of person that has the passion and the commitment and the want to help those people?

MS IRISH: I think the reality is in what we see, and again, the evidence is pretty clear, is that the youthful professional population is a mobile one. The behaviours of, you know, the 24 year old occupational therapist these days is fundamentally different to the one that was around 20 years ago. That's a reality, okay? That is a problem in urban areas as well as in rural areas. Folks in Melbourne just simply go to a different area mental health service. I don't personally believe that we have any greater problem than any other area and any other industry, for that matter, and I do not believe that the distinction between metro and rural is, in fact, reality-based. I think where a lot of the problems come from is when we're not on the money in relation to our recruitment and retention strategies, okay? And if we're not thinking dynamically about that, then we're waiting for a problem to come rather than saying, "Okay, what are we going to be doing about our workforce into the future? Where are our patterns of movement?" You know, "Where are our client bases increasing? What's the services that are going to have to be provided." And get on the front foot around all of that. But I don't fundamentally believe that. And my personal experience in rural practice does not reflect that.

THE CHAIR: I'm interested to know whether there are any new challenges presented to you with the growing population of African migrants because of their trauma, where they come from, and the gender-related issues and also their desire to congregate rather than move into a – relocate into a place where there is eventual – housing is available?

MS IRISH: Yes, I think we're not yet clear on what will come out of that, but what will be evident – and I saw this happen in southwest Victoria as well – is that the

issues do tend to emerge and they show up in public behaviours, core behaviours or otherwise, and the capacity for areas to respond to that is not necessarily all that ideal. You're talking about relatively small numbers of people, and we're talking about an inability for us to access very swiftly what are known models of best practice in relation to this particular cultural cohort. So I'm not quite sure where it's going to head. What I do know is, it is going to grow and we will need to respond to it, because the consequences are significant.

So I don't think we necessarily have got our, you know, transcultural stuff happening in the way it ought to. I think it's in rural Victoria, the mythology around populations into its cultural mix is not as well understood or appreciated. You know, the mix of, you know, be it indigenous Australians, Africans, be it, you know, whatever the population might be. Italian, Greek, whatever era you want to come from. It's quite significant, you know. Look what's happened – I mean, look at Shep. You know, I mean fantastic Italian background, you know, I mean that sort of thing. And those things are significant, but we still, I think in Australia and certainly in Victoria, hold on to the view that all multiculturalism extends to the urban areas only and there ain't nothing past Tullamarine.

And that is just not the case. Just not the case. You know, rural Victoria is as culturally diverse as any other part of Victoria. The numbers, of course, are the things that always beat it. We can never beat metro areas because they've got big numbers, but the consequences for, you know, the food bowls of the state, for the massive areas of land that are involved, are significant. And it's such a jolly pity that so much is simply driven by numbers.

MRS POWELL: I have one more. Just briefly – you were talking about the ethnicity, and you talked about some of your refugees that could become an issue into the future. Is anybody looking at best practice at how to deal with that now? Because obviously, there are other areas in Melbourne and Shepparton who have those African refugees. Is anybody actually looking at where they can be housed, how they can be housed, and what's the best treatment for them?

MS IRISH: My knowledge, thus far, is that some of the primary care partnerships are starting to consider that in a general global kind of a way. We do obviously – area mental health services have involvements with the primary care partnerships and so that, as I understand it, is where those matters are starting to be considered. But that tends to be – have a strong social and cultural component and connectivity within the community. They're not a strong – pure clinical perspective, if you like. But that will flow so long as we're involved.

MS WOOLDRIDGE: I'm interested in this long term sort of intractable mental illness, perhaps from failure to treat. And really, secure extended care and community care units are meant to be up to two years.

MS IRISH: Yes.

MS WOOLDRIDGE: I suppose firstly the factual thing. Have you got many longer stay clients in your two facilities, and you know, I suppose the broader question on

that is: for those who won't ever be going home, what's the appropriate accommodation option for them for the future?

MS IRISH: Yes, okay. Just – I'll take those separately, Mary, if I could. Historically, here in Ballarat, it is very fair to say that the community care unit and the SECU were long stay, if not whole of life experiences. That is the reality of it. The two year things are nonsense, okay? The current reality, however, is that those program areas are – in particularly the last 12 or 18 months, or probably two years or so – are now being fundamentally changed in their clinical emphasis so that they're actually starting to provide some treatment, which makes a difference. And people are going home. So we've probably had minimum 60, 70 per cent turnover of clients in the eastern view program, okay?

And that is quite simply related to just getting on with the of mental health services. In the SECU area, some similar things have occurred, so patients who, in fact, had perhaps lower levels of disability and handicap have been discharged from those facilities. They do, however, tend to find themselves in supportive accommodation environments which still may well be different to the home of origin.

MS WOOLDRIDGE: Like an SRS.

MS IRISH: SRS, yes. We would hope that in the future, that as we skill up that particular area which we're starting to turn our attention to, that we would start to look at the sorts of numbers that you're talking about. And it would be kind of nice if we could do it for our population, as I say, versus the burden and worry that comes with, you know, pressure from out of area. But we'll manage that as best we can. But the models of care – generally, and psychiatrists like any other clinical service, you know, the stuff that gets, you know, the research and the attention is often, you know, by the squeaky wheels or particularly attractive clinical syndrome so, you know, young people, acute pathology, so on and so forth, gets lots of research, lots of dollars, and lots of, you know, support from be it government facilities or wherever else.

That client population that perhaps takes a lot more work, a lot more skill, a lot more time – a capable, careful, and cautious clinical environment where the rewards are, whilst absolutely substantial, may well take longer and the numbers may not be as great. It's difficult to get the kind of support that is needed for that population, because it just ain't as sexy.

MRS POWELL: What is that population?

MS IRISH: It's not profound in its numbers, okay, and in a region such as this, I would say you would be – you'd be pushing it to say that that population has anything more than 20 patients at any given time.

MS WOOLDRIDGE: And so is the long term option for them that there is a subset of the SECU and the CCU that will always be longer stay?

MS IRISH: Yes. I think that's a reality base position to assume.

MS WOOLDRIDGE: Or is there an alternative option? Or - - -

MS IRISH: Yes. I think the idea of non-community-based, non-family supported accommodation for people in which delivery of treatment occurs as well as the provision of accommodation is always suboptimal, so if we move from that position, we always need to be looking at alternative models. The community care units are a possibility, but I do think there is room for consideration of those folks in between that, you know. And if you like the idea of – it's a nonsense of a notion in some ways unless you get it really right, but the idea of step-down SECU is not such a bad idea, because the movement from what is, in fact, you know, a very contained, very restrictive environment is quite difficult for people.

Our response to that locally has been to – whether it's, you know, the correct thing to do or not, you know, others will perhaps form views - but is to transition clients out of SECUs with the support of the SECU staff. Okay? So that those people are kind of actually engaging in a little bit of community psychiatry as well, getting the community teams involved in those patients discharge planning care well before the discharge takes place is obviously important. The likelihood, then, of a successful placement is much greater for obvious reasons.

MS WOOLDRIDGE: Into an SRS or something like that?

MS IRISH: Into an SRS or wheresoever else, yes.

MS WOOLDRIDGE: Right, okay. And the step down SECU, like the model at Austin, that Austin is proposing – is that - - -

MS IRISH: I'm not familiar with that name.

MS WOOLDRIDGE: Okay, all right.

THE CHAIR: I'm conscious of the time. Thank you very much for the opportunity.

MS IRISH: My pleasure. Thanks very much. Thanks.