

**FAMILY AND COMMUNITY  
DEVELOPMENT COMMITTEE**

**MR J. PERERA MLA, Chair  
MR W. NOONAN MLA, Member  
MRS J. POWELL, Member**

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

**MS CHRISTINE McDOUGALL, MANGER, ADULT MENTAL  
HEALTH SERVICES, GOULBURN VALLEY AREA MENTAL  
HEALTH SERVICE**

**MS ANNETTE STEPHENS, CLINICAL MANAGER, GOULBURN  
VALLEY AREA MENTAL HEALTH SERVICE**

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**SHEPPARTON**

**RESUMED**

**[3.15 pm]**

THE CHAIR: All right. Good afternoon. Thank you very much for coming along for the public hearing. I'm Jude Perera. I'm the Chair of the Family and Community Development Committee. On my right is Jeanette Powell, Deputy Chair of the committee, she doesn't need any introduction in Shepparton. To my left is Wade Noonan, member for Williamstown. And that's Tanya, Dr Tanya Caulfield research officer and I think, he's just popped out, he is assistant clerk of the Parliament Richard Noonan. The committee is looking into issues, as you know, such as 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 Parliament by 30 June next year after which 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 provision 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.

So we are recording the evidence and we will provide a proofed version of the transcript to each witness at the earliest opportunity. Now, please introduce yourself all individually and also your brief description of the organisation you represent today and then continue with your verbal submission.

MS McDOUGALL: My name is Christine McDougall. I'm the manager of Adult Mental Health Services for the Goulburn Valley Area Mental Health Service. We are all staff from Goulburn Valley Area Mental Health. I'm reasonably new to this position so I've asked two of the other staff who have been here significantly longer than me to attend with me so that they can assist.

THE CHAIR: Would they like to address.

MS STEPHENS: My name is Annette Stephens. I am clinical manager of the case management function with the adult program Goulburn Valley Area Mental Health.

MS TRIMBOLI: Carmen Trimboli. I'm also Goulburn Valley Area Mental Health Services and I am a psychiatric services officer and I work in the adult mental health department.

THE CHAIR: Thank you very much.

MS McDOUGALL: I did actually have a Powerpoint prepared and I'll give it to you but just to briefly – I've given you a copy of the geographical region that we cover. As you can see, it's quite large. It goes from the border and it goes all the way down to past Wallan. It goes to within about 40 kilometres of metropolitan Melbourne and we go right across to Kinglake and that area so we cover an enormous area. It's 22,000 square kilometres. Population is approximately 160,000.

We've got the largest indigenous population outside of Melbourne and that's primarily here in the Shepparton Mooroopna area. We have an extremely large culturally and linguistically diverse population. There's 63 nationalities. Once again they're primarily located around the Shepparton Mooroopna area. Some people are people with long histories in this region, particularly the Italian population, and some of the other older European populations, but we have a large number of newer indigenous – not indigenous, sorry – migrant populations coming into the area, particularly people from Africa and other areas coming in under refugee status and that has with it all the associated trauma and stress associated with what they've been through previously, war and refugee camps and then moving to a completely different culture.

We've extremely limited public transport. It does exist but it's not ideal. We have a high transient population particularly related to seasonal work. We're also on the Hume Highway and sometimes the police and I in Seymour think that the train stops at Seymour and everybody who hasn't got somewhere to live or somewhere to go falls off and they end up in the Seymour Police Station being assessed by mental health services. The accommodation options that are available for the region that is covered by the Goulburn Valley Area Mental Health Service are extremely limited.

There is one supported residential service in the entire region and that's located in Cobram and that is currently the subject of a DHS inquiry and it has conditions imposed upon it and I can talk about that a bit more later if you like about that particular facility. There was a boarding house which variously operated on a variety – under a variety of other names in Seymour. That was closed last week by DHS. That housed a large number of people. It would house anybody and everybody. It advertised in a number of magazines as a boarding house. It was a peculiar place and I can also talk more about that later if you would like me to.

It was high risk for a variety of reasons and it had a wide variety of people who were living there. People also rented tent space on the lawn. A large number of mental health clients used to go there. There was nowhere else we could place them. We wouldn't necessarily place them there but they would live there. We would continue to see them there. It had no provision for personal care but it did provide meals.

Other accommodation options that are provided down in Lower Hume, which is the Seymour area which covers the shires of Mitchell and Murrindindi is Pathways which is an arm of the Salvation Army. They're currently providing people with tents and sleeping bags and people often sleep by the river, that includes people who have mental health problems and a variety of other psychosocial problems, drug and alcohol problems. The Department of Human Services has approximately four flats in Kilmore and three to four flats in Seymour. These are used by the Mental Illness Foundation, who we have a strong working relationship with and they are to house people with a mental illness – people tend to stay there for a long period of time.

We know when there's a vacancy coming up so that we can get another one of our clients in if at all possible and there's also some in Shepparton managed by MIF but we're not terribly sure how many of that – it's nine. Aboriginal Hostels Limited has a

hostel in town, Geraldine Briggs Hostel. As you're probably aware, Aboriginal Hostels Limited is a Commonwealth Government organisation and they provide a number of hostels serving a variety of different purposes around the country. I know a lot about them because I managed one of their nursing home – their only nursing home for a while.

It primarily caters to indigenous people but they will and are able to take anyone, although it's primarily indigenous. They provide three meals a day. They do not provide personal care and it's an itinerant hostel in terms of it's for people passing through or who are unable to find somewhere to stay. They have family units. They'll have a lot of families who stay there. It's not one of their medical hostels or any – they have education hostels, they have a variety of different sorts of hostels. We could put people in there but they – the comment made to me by our Aboriginal health worker today was that they're not really keen on taking people who have mental health problems.

I can understand that, if they've got people with young children, and they're not equipped to deal with or work with people with mental health problems. The Salvation Army did have transitional housing units, but they have since closed. I thought there were no boarding houses in town but Carmel thinks there might be one or two, these are private boarding houses though and there's only one backpackers hostel and these are the sorts of places that you might- - -

THE CHAIR: In Shepparton? This is in Shepparton?

MS McDOUGALL: This is Shepparton. Yes. There's nothing else anywhere else. I'm just presenting you with what we've got in the region, which is very little. There are no options available for single men. Women with children are more likely to get DHS accommodation so they will get pushed up the list. The following special needs groups have no options. People with dual disability over the age of 18 who are not currently clients of IDS, Intellectual Disability Services. Often you will find these sort of people will come to us often via the aged care service, perhaps our aged psychiatry service and this has been a problem for years. I started working in aged psychiatry in excess of 20 years ago and it was a problem then.

People will have kept their child with a disability at home. They would never have accessed services from government services. They become frail. They become aged. They become demented. They require services. They're no longer able to care for their child with a disability and they may also come in because they've got a psychiatric disability on top of it. They've never been to IDS. There's nowhere that these people can be accommodated. No special service that caters for them and if they can't go back home, because parents may have been placed in nursing homes, we are often in dire trouble. There's nowhere for people with acquired brain injury. There are no supported residential services for mental health clients. There's no emergency accommodation.

The Mental Health Pathways Projects, which is funded by DHS and is run by Mental Illness Foundation, from May 2007 until June 2008, they received 55 referrals. The target set for this service by DHS was 12.5. From July 2007 to June 2008 there were 345 admissions to Wonyarra, which is our acute inpatient unit and from this 48

referrals were made to the Mental Health Pathways Project and they were unable to meet the needs. So that was my brief presentation and you can have a copy of that if you would like it. So that gives you a picture of what it's like here in the Goulburn Valley.

We have a lot of people with high needs. A lot of people with significant social and emotional problems on top of mental health problems. We have a lot of dual diagnosis in terms of drug and alcohol abuse as well as psychiatric problems and we have very limited resources for them once they've been discharged from hospital. We have park and CERT, but I'm aware that they're not to be considered in this review. Park – CERT is like CCU, we have those but they obviously can only cater to a very small number of people as well. So the situation is fairly dire.

We had a situation the other week where a person who had come down from New South Wales had been in our region for an extremely brief period of time, he was extremely unwell and we – I believe that the psychiatric service in New South Wales thought that he had gone back to China. We found out that he was in our region. We went and then found out that he had gone to catch a train and he'd been picked up at the police station. Recommended and admitted to a hospital in Melbourne. When that hospital discharged him and they spoke to our community team in Seymour asking them to follow up and they gave an address and our staff member said that, no, there were no houses out there, that's the abattoir, that's the meat works, they discharged this man to the meat works.

We found him . We tracked him down and we believe he's gone back to China. We're still looking because we're not too sure. It's a major problem. As long as someone's got an address, whether it exists or not and it's a bit like let's get them out of our region because we haven't got – because I'm under Parliamentary privilege here I can say these things – let's get them out of our region and then they're not our problem and then they come up here and then they become our problem and I think it's reprehensible that these people are allowed to be discharged from hospital with nowhere for them to go and I think the closure of - this is a personal view, and I'm expressing my personal view now, not necessarily the view of Goulburn Valley Area Mental Health – I worked as an SRS adviser back in the late 1990s for two and a half years in the southern region of Department of Human Services at the time when they introduced the bed guidelines, and I spent a lot of time going around and measuring bedrooms in supported residential services.

I believe that was one of the most misguided things that the Department of Human Services ever did. I know why it was done and I think that the intention of it was good but what it ended up doing was closing down a lot of SRSs that in fact did provide a good service. There were a lot out there that provided an extremely dodgy service and there are still a lot out there that provide a very dodgy service, they just happened to have bedrooms that were big enough and services were closed down and people were left homeless and they've closed down so many and if they had spent the money that they spent on us going around and measuring up bloody bedrooms on actually giving a bit of money to supported residential services who are under state government control and registration, then we would be able to provide a better service.

I think that, you know, in some way there should be if you were to do that sort of thing – but the government was never going to do that or certainly DHS was never going to do that. I don't know if they give them some money now but a lot of SRSs closed their doors because they couldn't afford to change things. They couldn't afford to come up to standard. It all became far too hard. They were very heavily regulated – well, they were supposed to be, depends on which area you're in and it depends on how vigilant the SRS advisers are. But that's where most people end up or used to end up from psychiatric hospitals and now there's nowhere for them to go with nothing to replace it.

Ten beds in a CCU and 10 beds or eight beds or something in a step-up step-down unit, is not going to accommodate people who are trying to rent on the open property market when we all know how outrageously expensive it is to rent – well, I certainly do, having just moved back to Victoria and trying to rent a property. These people can't afford to rent those sorts of properties that are available out there. They are extremely marginalised. They've got very compromised skills that we try as best we can to work with in terms of work, in terms of their socialisation, managing their money, all of those things and the indignity of having nowhere to live, just strips it all away from people.

They are left with nothing and if you've got nowhere to live and you can't find anywhere to live and having only experienced that very briefly and lived in the caravan park here for a while, at least I had somewhere to live and I could afford to pay for it but I would sit there and think: now, what if I was somebody who didn't have – couldn't afford to pay for this and you have to look after yourself and you have to cook your meals and take your medication and deal with the demons in your head. You just can't do it. It's my little speech, sorry. I get a bit carried away.

MS STEPHENS: I think the thing to consider too, seeing we only do have one supported accommodation house available, which we refuse to refer to because of the substandard care that is provided and it is under investigation at the moment, is we actually, against our philosophy of care and we like to be a consumer family focused organisation, is we've actually had our hand forced to send people out of our region to the likes of Delaney Manor in Bright because we know the care there is of high quality and it's conducive to the person's health outcomes and well being and socialisation and social inclusion.

So our hand is being forced to working at some of the standards that we really value as an organisation and that we're actually more marginalised than most people because they're becoming more separated from their family and community so it's actually quite a sad story for some people that have lived all their lives in this area but got – but have no other options and even though those numbers might be small in terms of the population, they've also been people of our community, however they're seen, and they're being forced out because there are no other alternative options as well. So that affects both the family and the client in the long term.

MS TRIMBOLI: I'd have to agree with that. There is absolutely nothing in the region at all that can support these people. It's really quite difficult. It makes our job very difficult.

THE CHAIR: Thank you.

MRS POWELL: I guess that's one of the reasons the committee is actually here because we've been hearing this for a number of years about the lack of supported accommodation and the lack of flexibility out there and the need now – the words “crisis and dire” have been coming through a bit where organisations like yourselves, where do you send people to get help. Some of the other areas – you didn't mention caravan parks but some of the other people are saying that they're putting some of their clients in caravan parks which is probably totally inappropriate for some of them.

MS STEPHENS: There's a black list that gets around the caravan parks about our clients and it's shared between the caravan parks.

MS McDOUGALL: I lived in the caravan park.

MS STEPHENS: The price is quite high and the prices go up during the seasonal work so they're going to give it to the people that can afford to pay and cause not many hassles. So there's a list that goes round. It's been going round – I've been here since '91 and that list has existed for all the time I've been here.

MRS POWELL: So what does the list do?

MS STEPHENS: It's a list that some of the owners of the caravan parks have about clients that they do not welcome back to that caravan park and they'll share it with other businesses.

MS McDOUGALL: Or they'll put them in Seymour. Joan was telling me that there was one caravan park, and it really is – there's some nice caravan parks in Seymour and some really horrible ones – they'll put them, you know, a couple of clients in one caravan, no running water, long, long way from the shower blocks, the toilet blocks. Treat them really substandard accommodation and charge them a lot of money for it as well.

MRS POWELL: I guess the area here – I guess a number of regions have their own unique areas. This area here, as you touched on, we've got the highest population of Aborigines, we have huge multicultural people and now we've got the refugees, the Sudanese and Congolese and Iraqis. Do you think that there's going to be issues in the future that we have to start dealing with now about supported accommodation because even with some of those people they've been through war-torn areas so obviously they have their own demons to deal with and perhaps might get impacted on in the future, that we're going to have to find some sort of supported accommodation for people like that and how do we do that in an area that's – putting them with other people as well but meeting their needs as well.

MS STEPHENS: I think part of the issue has already started. There's people come out with these different cultural beliefs and values that don't fit the Australian way and we come across families – we've got five families living in the one house with all these children. Like our current housing doesn't fit their cultural mould so we're already not meeting their need let alone all the psychological trauma that might come

out with past history in their country let alone what we might be creating in our own country for them as well. So I think that's already an issue. Whether it's fully identified or not is another matter but we get quite frequent people through the assessment team that have a multitude of family living in the same house.

THE CHAIR: This is – you're talking about normal people, not people with mental illness?

MRS POWELL: Some of those do have a mental illness because - - -

MS STEPHENS: That's right.

MS McDOUGALL: Mental illness

MS STEPHENS: A member of the family.

MRS POWELL: - - - of where they've come from and - - -

MS McDOUGALL: The single member but there might be five families living in that house with a family member who's quite psychiatrically unwell so how do you manage that and then you've got the cultural issues of treatment and care and gender sensitivity issues and how you manage that as a service let alone how you house them appropriately and where in the community do they best fit as well.

MRS POWELL: So with the Aboriginal community, if you have somebody there presenting with a mental illness, if you can't take them to Percy Green, where do you – where's the accommodation for them?

MS McDOUGALL: Do we ever have much – I don't know that it's a significant problem or it is.

MS STEPHENS: Basically the indigenous people tend to look after themselves. They're a fairly closed group. They have strong links with the elders, with Rumbalara and the like so they tend to look after each other fairly well. We do have a number of open cases within our case load and those are the people that don't actually identify themselves strongly with that community anyway. So they don't mind.

MS McDOUGALL: There's an indigenous nursing home in another region. I was talking to Andrew McKnight, who is our ALO this morning and he – he didn't identify somewhere to live as being a significant problem in the indigenous population here. They're very – Rumbalara is very strong. They've got a lot of very strong programs. There's four ALOs work at the hospital, including Andrew, and I think they have a very strong program and a very strong network and they're looking at setting up some other stronger networks which we discussed this morning. I think it is more with our – often more younger males.

MS STEPHENS: Our current case load in Shepparton, we've got about 100 open cases and about nearly 70 per cent are those of single males, roughly in the age groups of 20 to late thirties. No children. Burnt their supports with families. We've had some that have lived on the river bank for years. Become unwell because of their

isolation and our inability to service because where do you go and how do you do it as well so there's an issue with how you provide service in those scenarios and how do you do it safely and effectively also.

So there is that group of men and I think it's only going to grow. If you look at the co morbidities coming through the door with mental illness and drug and alcohol use, let alone the forensic issues that are coming through the door now, probably about 40 per cent of our case load are forensic issues or past forensic issues. It becomes a real dilemma because they have no supports and we have very few 24 hours services in this area. It's ourselves, ANE or the police.

So that group will become isolated and become more problematic in how we manage, house and access and usually they're under VCAT for administration orders or guardianship orders as well. The ability to sign a rental agreement – it's becoming more common we're having to go for guardianship just to have someone sign for a rental agreement let alone the affordability.

MR NOONAN: Christine, you mentioned about the Park and the CCU. I think you made reference to they're not considered part of this inquiry. This committee has actually visited the Park facility and the CCU.

MS McDOUGALL: Yes. They're very nice.

MR NOONAN: Yes. I just wonder whether or not - - -

MS McDOUGALL: Gorgeous.

MR NOONAN: Whether or not you might talk about – I'm not from this area – talk about that accommodation service that's provided and it's value in terms of your work, particularly given that Park Services is a short term – a transitional sort of arrangement.

MS McDOUGALL: I will let Annette do that. I have only been here for two and a half months in this position.

MR NOONAN: Sure. That's all right.

MS McDOUGALL: She can talk about it with a little more knowledge. I could talk about it but I will let Annette do it.

MS STEPHENS: Thank you very much.

MR NOONAN: 1991, did you say?

MS STEPHENS: Yes. I've been in Shepparton since '91.

MR NOONAN: Excellent.

MS STEPHENS: Basically I see Park Services as an extremely valuable point to discharge out of the ward, speed it up, get the person back into independent living scenario so we can assess that but it also gives us, as a service, some breathing space

to look at some bigger picture stuff. Do they function well in independent living? What's their social circumstances. Do they have support structures. So it gives us just a breath to go, right, what do we need to actually get them back into the community that's going to be sustainable because I think where the downfall has been with the inpatient unit is we think we know a lot about them but until we actually get that more thorough assessment, we actually set some people up to fail.

MR NOONAN: How many bed is that facility?

MS STEPHENS: Ten.

MR NOONAN: Right.

MS McDOUGALL: There's the step-up aspect of it as well too.

MS STEPHENS: The step up, we can actually admit people into the Park facility to prevent hospitalisation and that works well too but we probably use it more for step down because the risk management side is the known factor and if you get someone new coming through the door that you don't know very well, you're going to err on the side of caution so the majority of the cases at the moment are case managed clients because they're the known factor. We've got a bit of history on them and we know what hasn't worked in the past so it's a really good opportunity for that holistic assessment and to look at what other supports we need to put in from the broader community and family.

MR NOONAN: And the CCU?

MS STEPHENS: CCU - - -

MS McDOUGALL: That isn't a CCU.

MS STEPHENS: It's not a CCU, it's a modified CCU.

MS McDOUGALL: We've having a union argument.

MS STEPHENS: We'll be careful about our language.

MS McDOUGALL: Yes. Very careful about our language.

MS STEPHENS: It's different to any other state's CCU, it's not staffed by clinical staff. It's staffed by PDRS, Mental Illness Fellowship and that's been going since 2002 roughly so that's a 10 bed also on the same site as Park and it's a throughput model so unlike other CCUs, when you go into a CCU your case management stops. Case management continues no matter where you are in the continuum of care so someone is still pushing you through so it's not bottlenecking like other CCUs. It's up to a two year stay. Average length of stay is seven months. So it's still the pointy end of the stick.

It's still the people with protracted admissions, readmission rates, severe debilitating illness but because we – and it's framed on the Boston model which is run by Parham

Mission so it works on the strength model rather than illness and we work with Mental Illness Fellowships so they provide the psychosocial rehab and do the social inclusion community linkage, education needs and we provide the clinical support so that partnership actually works really well to set someone up to move to independent living and a good outcome also where someone is placed appropriately.

MS McDOUGALL: I think the other part that we have linked into that and also linked into people in the ward, is our My Work, which is also through - -

MS STEPHENS: That's through a partnership arrangement.

MS McDOUGALL: That's through a partnership arrangement and we have Jillian, who works five day a week and she works with clients who are looking for work. She looks for their strengths. She works with them in preparing them for the work that they need to do, preparing them for interviews, looking for jobs, helping them find positions in certain places and she has quite a number of people on her books.

MS STEPHENS: She's got an open case of about 30 at the moment.

MS McDOUGALL: Yes, and has had a reasonable success rate of placing people in work and engaging employers in the community who are prepared to take on people with a mental illness so that's a very valuable part of the service as well so that people can become self-supporting.

MR NOONAN: If you were sitting on this committee listening to your submission, you could be excused for thinking the way to solve all problems is in bricks and mortar to build facilities and, of course, that's part of the solution as you're advocating but it would be worth us understanding, as you've gone to that initiative, whether or not there is underinvestment in other areas which may prevent someone getting to the situation where they are such in crisis that they're essentially homeless. I know that's a broad question but it would be worth us understanding, particularly in early intervention services or other initiatives which might prevent someone from getting to that crisis point when it perhaps, in some cases, it's really very, very difficult to place people. Even if you can place them, to stabilise them, I think in my language, stabilise their situation so that they can have another go in life.

MS McDOUGALL: I think we often get people, from my experience and this has been my experience wherever I've worked, we will get people when they've already reached that stage. If we're able to maintain them where they are through all of the interventions that we do, we will maintain them. I think where we rise and run into the problems is that we get people when they're already homeless or when it's already broken down because when they come into hospital it costs them nothing. They don't pay anything for being in hospital. Carmel does a lot of work with assisting people but they've also got the capacity to keep paying their rent while they're in hospital because their money is coming in and it's been there.

We have people, people like Carmel, who will set up things like direct debits and all of those sorts of things. They can be done for people so that they're not going to go out and spend their rent money when it's already been directly debited into their account and all those sorts of things but we get people whose life has fallen apart. I

can give you an example of somebody I saw – I don't actually do clinical work except that we're so short-staffed at the moment and we provide a 24 hour on-call service so I've been filling in in Seymour and doing some of their on-call and they seem to have planned it that every time I do an on-call I get called out at 12.30 at night and have to go to Seymour and assess somebody in the police cells. I saw this woman down there the other night who is extremely unwell and we admitted her to hospital.

Now, she's essentially homeless because – the same with this Chinese boy – he can't live at an abattoir. We get them when they don't have anywhere. This girl was living with a chap and I rang him, in the middle of the night, and was giving him details of where – he said, "I've been trying to get her to go for months" and he'd encountered her living in a hostel-boarding house-guest house in Queensland where people were picking on her because she was so peculiar and he felt sorry for her so he was protecting her and she's been following ever since for 12 months.

He didn't sound like he was the brightest star around but, you know, he was sort of caring for her and he was working 12 hours a day on the pipeline and he really would have liked to have gone a long time ago but I don't think he could bring himself to kick her out. He has now categorically stated I don't want her to come back here. So she's effectively homeless. So we get people like that and there's nothing that we can do to stop them becoming homeless because they come to us like that. I think we are proactive if people are looking – if they're case managed and things are looking tenuous then their case manager will certainly become very proactive employing everything that we've got so we do work very proactively there. We get people – would you agree with that, if they're homeless they're already homeless or they've burnt so many bridges that we're not able to repair them any more.

MS STEPHENS: I think the development of the likes of the primary mental health teams with the high prevalence disorders may have addressed some of what you're referring to, how do we prevent it getting to the end point, and I think through the primary care partnerships and the like there are services now being provided that weren't in the early to mid nineties. We're not getting the worried well, as such, through the door with the high prevalence disorders, we're getting the seriously mentally unwell now.

And how do we get in there earlier? I think there's a few strategies the government is trying to get on board like the care directions with the dual diagnosis strategy and the like and sort of the one-stop shopping but that – we're not at that point yet. We're still getting people dual capable in mental health and alcohol and other drugs and the like and I think that might be a path to go and how do we then transpose that onto prevention and it may be how we're structured, I don't know, but I think at the moment I think the crisis point is we have got people on the books and bricks and mortar, great. It's there. You can see it. It's visible. It's easy.

MS McDOUGALL: The other thing, I think, that we do and I don't know whether it needs to be expanded on, is we have – I don't know if you're aware of this – the carers fund and we have a carers fund which we can use reasonably creatively and it has to be for the carer, who is the carer of someone with a mental illness and they have to have a case manager and I'm sure Carmel makes lots of referrals for this and we can provide for people to have respite, to have a holiday. Some areas have respite

houses. They've got this gorgeous one up in Warrnambool called Time Cottage. It's like some really swanky bed and breakfast which is just beautiful, you know, and you can just go for a weekend because it's hard work living with someone with a mental illness and to provide a carer or to just – what other things do you use it for?

MS STEPHENS: Reimbursement of fuel, like even a weekend away or meals.

MS TRIMBOLI: Payment of bills if people are at risk - - -

MS STEPHENS: Yes, bills.

MS TRIMBOLI: - - - because they're getting their power disconnected or the like so it can be used for that emergency.

MS TRIMBOLI: Rent arrears if they find themselves in financial difficulty, unable to manage their funds.

MS McDOUGALL: Purchase a refrigerator.

MS STEPHENS: Fridge, washing machine.

MS McDOUGALL: Washing machines, things that make it easier for the carers and, you know, those sorts of things – I think if you can ease the burden of the carers they will keep people for longer but it is – you know, you go out to people's houses to see your client and you see the parents or the wife and it's very hard for them and they don't – you know, as a case manager your primary responsibility is your client but you also give as much as you can to the carers as well and we have a carer representative and we will refer carers to her. We have consumer representatives. I think those good things are all in place. Whether we've got enough of them, I don't know.

MR NOONAN: Sorry, how do you resource the carers fund? Where do you get the funds from?

MS McDOUGALL: DHS. DHS gives to everybody – every service gets it. Every mental health service gets carers funds. I'm not exactly sure what ours is - - -

MS STEPHENS: I wouldn't know the dollars.

MS McDOUGALL: - - - each year. I haven't seen the dollars on the budget but it's usually a reasonably – I only knew when I was in aged mental health and I used to get something like 38 or 40,000 a year and that was for a small aged mental health service so it's a reasonably significant amount that you can – there's other things that we can access to make things easier but we're not allowed to use the money for – we can get money for clients but we're not allowed to use that to pay their rent or the bond, are we?

MS TRIMBOLI: It depends, I guess, on the circumstances. How you word it.

MS McDOUGALL: Yes, how you word it.

MS TRIMBOLI: The circumstances.

MS McDOUGALL: Strictly speaking, you're not able to, yes.

MRS POWELL: I'd like to talk to you about – you were talking about how you prepare people to get back into independent living and you put the support services behind them. We've spoken to a number of organisations and they're very frustrated because you can get somebody, whether it's 10 months or 12 months, into a position where they are - they have got some life skills, they are ready to move that step into independent living, and then there is just nothing there for them.

MS McDOUGALL: That's right.

MRS POWELL: They either put them into rooming houses which aren't appropriate, caravan parks, which aren't appropriate. Do you find that happens here in country areas and what do you do with those sorts of people.

MS STEPHENS: I think the difficulty is that we get people to a certain point of wellness and independence and once - - -

MS TRIMBOLI: Discharged.

MS STEPHENS: - - - that happens then we've got to manage our books. We've got to – you know, we've only got limited resources and if the person is only requiring a visit every fortnight that the GP can provide then where do you go because you've got to service other people. So there is that downfall in the longer term sustainability of that person and it gets particularly difficult with the adult age group because until they turn a certain age they're not allowed to get into aged care services which might provide some of those other services plus their finances are limited.

It's great now that we've got bulk-billing GPs in town, it's fantastic. That has made a significant change in people's independence and their willingness to come on board with their own treatment and care regime so that has been a fundamental turning point, I believe, in the Shepparton area. So that's worked really well and people are more engaging but how do you keep services going to keep them independent? It usually falls back on the family at the moment. You know, by that time we might have mended a few bridges with the family that people have burnt but in terms of if their psychiatrically well, not showing any symptomatology, we're not really providing a service.

It's a service that the GP can go. So we have our case managers speak to the practice managers and when we discharge we set up a safety net. If they haven't turned up ring triage or ring the family or - but they've got to keep that going themselves too so there is a safety net - - -

MS McDOUGALL: There is a point where you've got to let people go.

MS STEPHENS: There's always loopholes to it and I suppose it's - where I come back to that sort of one-stop shopping is I think it's a community responsibility about

how we check against our people of our community and get in early and do the referral and the like whether it be Centrelink or Maternal Health – Child or - - -

MS McDOUGALL: But I suppose somewhere to live. There is that problem, there is and I don't know - you know, in some ways it would be good to have a couple of SRSs but you don't because that becomes an institutionalised thing as well and if we're trying to work along the model of more independence and working in a recovery model and a wellness model, we want people to be able to be more independent, to pay their rent, to manage their own money, to cook their own meals. There are some who are not going to be able to manage that.

There will always be a small group of people who will need to be in supported accommodation or somewhere where they're getting help but there isn't even the availability for one-bedroom units that are at a reasonable price. The ones that Park used to occupy are in Maude Street in Shepparton. They'll be rented out and they'll probably rent out at figures that people with a pension will be unable to afford.

THE CHAIR: You mentioned some ..... budget services and also you mentioned that some cannot keep up and they close. So where has it gone wrong? Is there a problem with the regulatory framework or what?

MS McDOUGALL: I don't think there's a problem with the regulatory framework. It's a very, very difficult area. There's - I suppose it - when I was an SRS adviser - it's how you - it's really, really hard work, I didn't realise how hard it was until I started doing it. I'm a psychiatric nurse so I - you go and you visit these places and they have to be interviewed, they have to be licensed. It's very, very stringent. They have to meet - it's more or less like how nursing homes get inspected. We used to go and inspect the entire building, everything. We used to say, you have to have this completed by such and such a time and we could place conditions on it but when people do really bad things and you decide, right, they need to be prosecuted under the Act - there was an SRS that I had in Toorak that I - charged - this was back in 1998/99 - charged \$800 a week for people to stay there and they didn't even have en suites.

It was an outrageous place. I walked in there one day, it was 40 degrees. The only person in the building was the cook who only spoke Russian and was mad, I think. I found two people so severely dehydrated that I had to send them to hospital in an ambulance immediately - one of them was almost in renal failure. So I sent them both off in an ambulance. I then spent six weeks solid gathering all of the evidence and putting together a legal brief to prosecute the owner, who had been particularly dodgy in a previous SRS and had very, you know, constantly in trouble, and what happened was I put this brief together, massive brief, sent it off to legal services at DHS and it came back to me saying it won't hold up in court, you didn't do it properly and I had to confess that I did probably crack the shits then to be quite honest about it and said, "I'm a psychiatric nurse, not a solicitor."

I shouldn't be expected to do this but I had to do it and there's problems with the one up in - it's being able to prove it. SRS advisers have enormous powers. You can go in 24 hours a day and visit an SRS and demand to see anything. You may take things from the premises as long as you give them a receipt and you can look at any of their

books but actually getting it proved and in the courts proven, which is what you have to do, is very, very difficult. So you can do all this work and it just gets stopped because, you know, you haven't done the interview properly with the three tape recorders and – so it's very hard and there are lots of very strange things.

You know, you can walk in and look in their cooking pans and all of that but if they know that you're coming, then they'll have a lot of food on the premises but you could walk in and find people getting one dim sim and that was their tea. This is what happens up at Moyashera.

MS STEPHENS: We've – the likes of Cobram we've reported for a number of years, the concerns to the department in relation to - - -

MS McDOUGALL: That's all been written up in the paper.

THE CHAIR: Nothing happened?

MS STEPHENS: Pardon?

THE CHAIR: You complained a number of times. You complained and nothing happened.

MS STEPHENS: A number of times about the care and level of supervision and nutrition provided - - -

MS TRIMBOLI: It's under investigation now.

MRS POWELL: That's with DHS?

MS McDOUGALL: It would go through the regional office and through the SRS advisers, whoever is in that position – I think they're still called SRS advisers, they used to be called nurse advisers. Yes, they're very difficult jobs and there's a lot less SRSs but there are a lot that are very good. I have to say there are a lot that go over and above and beyond.

MS STEPHENS: In terms of our area we will not refer there and we haven't done for, probably seven-odd years I'd say now. The difficulty with that is there is no means of screening who goes in there. You've got people who are in their late teens through to the mid eighties, early nineties, all living in the one environment. It's a dangerous mix. You've got intellectually disabled, you've got physically disabled, you've got the psychiatrically disabled. They're all in the one environment. Some are in shared rooms. Supervision is minimal. There's no screening process. So if we're not referring and there's a push for accommodation in the state, those referrals are coming from out of region so whether it be from Bendigo or Peninsula, those - - -

MS McDOUGALL: Or across the border.

MS STEPHENS: Across the border, those beds are filled and then they become our care responsibility and we have had open discussion where we've said to the proprietor, "Do not accept this person, they pose too high a risk for your environment

and for the other clients in that environment.” It’s accepted because it’s dollars. It’s the bed filled. So there’s no control in terms of who’s appropriate to come in, what’s the gender mix, what’s the age mix, what’s the disability mix and it’s a real concern and that’s why we won’t refer there on top of the substandard care.

THE CHAIR: Okay. Thank you very much.

MS STEPHENS: Great.

MS McDOUGALL: Do you want this?

MRS POWELL: Yes, please.

**ADJOURNED**

**[4.05 pm]**