

**FAMILY AND COMMUNITY**

5           **DEVELOPMENT COMMITTEE**

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**MR W. NOONAN MLA, Member**  
**MR J. SCHEFFER MLA, Member**  
**MRS J. POWELL, Member**

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

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30           **TRARALGON**

**TUESDAY, 21 OCTOBER 2008**

**RESUMED**

**[10.04 am]**

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THE CHAIR: Good morning, Mr Amos.

MR D. AMOS: Good morning, Mr Chair.

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THE CHAIR: Thank you very much for coming along and I'm not going to go through the introduction bit. You have been here, you know all about it. I'll get you to make your verbal submission or any comments and then followed by the questions. Is that all right?

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MR AMOS: Thank you, Mr Chairman.

THE CHAIR: Thank you.

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MR AMOS: Mr Chairman, I'm Derek Amos, the Chief Executive Officer of Barrier Breakers, a systemic mental health advocacy organisation based in Gippsland and we've made, as you are aware, a written submission to the inquiry. Before I commence I just wanted to make a correction. We've noticed a typographical error in our submission on the summary page, first paragraph, under Major Points of Interest, where we refer to a decade. It should have been 1966 to 1976. Obviously it can't be 1996 to 1976 and the reference page was page 4, not page 3 as the error indicated.

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With respect to Barrier Breakers interest in this inquiry, we've mentioned in our submission that we have a nine member board which administers our organisation and can I say that the extensive experience of the board members, the directors themselves, gives us a great insight into the accommodation needs of people with a mental illness in the total Gippsland region, which encompasses the six local government areas in Eastern Victoria. The board experience ranges from a police superintendent, through to doctors, to carers, and indeed, our chairman is the principal of a major employment agency which specialises in finding employment for people with a disability, and quite recently with a change with some Commonwealth Government support, people with a mental illness disability as well.

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So there is a fair range of experience in terms of looking at those needs of people who are experiencing great difficulty in finding accommodation in the region. We refer in our submission, Mr Chairman, to the recent research project that we've concluded into mental illness in the Gippsland region and part of that research indicated some numbers about just how many beds are provided in the region today and what was provided here in the region prior to deinstitutionalisation. As we have indicated, in that decade that we refer to, 1966 to 1976, there were approximately 300 beds available for people with a mental illness in the Gippsland region, compared today with a 40 per cent increase in population, around 200 beds; in fact, less than 200 beds available.

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Our research also has indicated that when deinstitutionalisation occurred in Gippsland there was an effort to begin with, as SNAP Gippsland have indicated in their submission, for the then Housing Commission, now Office of Housing, to

provide accommodation under a supported accommodation program. As everyone is aware, when institutions were closed, it was the intention to look after people with a mental illness in the communities. But unfortunately whilst a program was commenced to provide accommodation – supported accommodation for those who were living in institutions and required accommodation, it didn't continue. There wasn't sufficient to begin with, and as SNAP Gippsland have indicated quite clearly this morning, it wasn't continued.

Subsequently, we have a situation today where there is not one single government agency that accepts responsibility for the provision of accommodation for people with a mental illness. Recently we approached the Honourable Peter Hall, one of the Eastern Victorian Upper House Members, with some questions to ask of the Housing Minister in the Parliament, and specifically what we were concerned to find out were the answers to these questions:

In which towns does the Office of House and Department of Human Services provide public housing for people with a mental illness? How many of these houses or units are provided in each of the towns? What is the waiting list for housing people with a mental illness in each of these towns and how many tenants with a mental illness has the department arranged support services for?

We were specifically referring the towns in the total Gippsland area, those six local government areas that I referred to earlier. The minister's response to that question was quite alarming, but it does confirm the research that Barrier Breakers had undertaken. Firstly, the minister responds by saying:

*The Office of Housing does not reserve a particular number of properties for people with a mental illness.*

And the second response also is of some concern:

*The department does not collect data which identifies the number of tenants with a mental illness who are accessing support services.*

In undertaking our research, what we needed to do was to talk to the support services like SNAP Gippsland and GARSS and talk about the number of supported accommodation units they were providing for people with a mental illness in the Gippsland region. To understand what those figures then mean, you also need to be aware that the nomination rights that were granted back in 1992 to organisations like SNAP and GARSS have no actual bearing on the actual number of units that have the provision of supported accommodation today. What that shows us is that it is very alarming to see that we've got a 40 per cent increase in the population since the decade 1966 to 1976 and at a starting base we've got 100 fewer beds than what we had available for people with a mental illness in the total Gippsland region since then.

The efforts that were made to provide housing and support for people with a mental illness who were expected to go back into the communities has decreased, not increased in accordance with the increase in the population. And there is a direct

5 correlation between the increase in the population and the total numbers of people with a mental illness who require services today. Roughly calculated, at around about 20 per cent of the population is in need of some form of treatment for mental illness. That doesn't mean to say that 20 per cent of the Gippsland population requires supported accommodation; of course not.

10 What we've done in our submission is to provide additional information which shows that in a 3 per cent figure of people that have a chronic mental illness and either require hospitalisation for a short or a longer period, but then go back into the community, require some support of some kind. We've had cases, Mr Chairman, of consumers – people with a mental illness being put into inappropriate housing accommodation models – in other words, just dumped into the community and left without any support whatsoever.

15 Quite clearly what is needed is support. You do need agencies like SNAP and GARSS to provide support for those tenants who are put into communities, not only because of the issue of stigma or the issue of the person's mental illness, but also to ensure that every effort is made to assimilate those people into the small communities in which they are placed. If that doesn't occur then all sorts of  
20 problems arise as we had only a fortnight ago, where a person was located by the Department of Human Services in a unit in one of the Latrobe Valley towns, basically a small village occupied by elderly people, retirees.

25 There was no support provided for that person. Consequently, the tenants were complaining bitterly about being woken up in the middle of the night with requests for sugar and tea and having their gardens destroyed, being pestered and being frightened. That occurred without support. What we've done in our submission, Mr Chairman, is to make a number of recommendations for the committee's  
30 consideration and clearly we do need an urgent allocation of additional units to be made available in the Gippsland region specifically for people with a mental illness.

35 Secondly, we also need some central agency to take responsibility of a waiting list, for looking at the total numbers required and we've given you some indication of those numbers are in our submission. However, we don't have the ability to look under every rock and cranny. The committee certainly does have more of an opportunity to be able to obtain that information from either government agencies like the Department of Human Services and/or other organisations that receive government funding throughout the region for the provision of support for people with a mental illness. Lastly, Mr Chairman, I need to make reference to the question  
40 of institutions.

45 It just seems to many in Barrier Breakers, including those in the medical profession on our board or ordinary members of the association, that there is a lot of fear and misunderstanding about institutions. We weren't talking about the Charles Dickens' model, the asylum on the hill with people dragging chains; we're talking about sometimes the necessity for putting people in a safe place where they can receive proper treatment and assistance and sometimes even short to long-term accommodation.

5 It seems too that people don't seem to worry too much about putting their parents in institutions – nursing homes – because that's what they are - and for those that still have concerns about institutions could I invite them to go and visit a psychiatric ward in a general hospital, like the Finn Ward at the Central Hospital in Traralgon. That is closer to the Charles Dickens' model - the asylum on the hill - than whatever Hobson Park was. Hobson Park was the psychiatric hospital that that serviced the Gippsland region prior to 1991-92 and was closed with deinstitutionalisation. I'm very happy to answer any questions.

10 THE CHAIR: Thank you.

MS POWELL: Derek, you were saying, you were talking about institutions, and it's pretty alarming, the statistics that you gave us in your submission, where you are talking about an increase of 42 per cent and a decrease of - - -

MR AMOS: 62.

20 MS POWELL: 62 per cent. I guess with the number of people, you were saying now it's at a crisis stage, what would you see – I notice you've got some statistics in there for the Latrobe Hospital, and it's even decreasing. What would you see as the best accommodation, not as an institute, if you like, but somewhere we can get people into to be able to access the support that they obviously need in a fairly quick area? And your comments about when it was de-institutionalised there wasn't enough services provided out in the community, which has probably exacerbated the problem now. What would your role model be?

30 MR AMOS: I think SNAP Gippsland is correct in identifying that there's a range of accommodation models required, and in all of them they need to be provided with support services as well. But that range includes two-bedroom units throughout the community. It includes, in our view, hostel-style accommodation, and there are a few hostel-style units scattered throughout Gippsland. There are two in particular provided by the private sector, one in Churchill and one in Moe. And there are support agencies like GARSS who provide the support required to ensure that the tenants' needs are looked after. So yes, there is a range required, and I think what we need to do in the short term is an immediate return to the nomination rights program, and for the Office of Housing to make additional housing units available, and for the government to provide the funds for the support agencies to provide that support to the residents.

40 MR SCHEFFER: Derek, you mentioned in your presentation how when during the 1980s the de-institutionalisation policies came in, and then during the 1990s there was a failure to underpin that with appropriate housing provision, which was a big problem, and then moving on to what I want to ask you about, moving on to the 2000 scene after that sort of trough, we now have a new Disability Act. We have disability plans, individualised plans and packages, and we have significant resources now put into mental health, over \$100 million in the last budget, so quite a lot of energy going into it.

The sense we've got from people we've spoken to previously is that Victoria is now in a position where the architecture seems to be there, and it's okay, and people generally give that a tick, but there's a very serious pressure that you've attested to on the resource provision.

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MR AMOS: Mm.

MR SCHEFFER: I just ask you, just for the record, if you could talk to us a bit about how you see that general architecture, the Disability Act, individualised plans, the direction that the mental health budget's going to, and I forgot to mention the Green Paper on mental health as well, just some of those big ticket policy areas. Could you just talk about you see those fitting into the work that you're doing.

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MR AMOS: Well, generally I think it would be true to say that Barrier Breakers supports these changes, and we've made a major submission in response to the government's Green Paper. We are hoping to make some further input in the period ahead between now and when the government intends to implement some of those major changes that it proposes in that Green Paper, and certainly well before the White Paper is published stating a firm government policy. So, there's a move in the right direction, but there is certainly still a lack of resources, a lack of funds, fund allocations being made to attend to the more immediate needs.

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Unfortunately, it's our view too that given those years of neglect its been almost out of sight, out of mind. Unless people complain about not being able to have accommodation, unless they complain publicly, unless they complain to politicians or the media, no-one seems to take any notice. And as Chris McNamara said early, there are no waiting lists. We know from what the Minister for Housing has advised, the department doesn't keep a waiting list. So, if you don't know how many people require support accommodation in the Gippsland region, you don't seem to worry about it, because no-one talks about it. It's not high on the agenda.

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Unfortunately, though, from our research and the anecdotal evidence that's been provided by consumers and by the medical profession we do know that there's a crisis situation in Gippsland, and that's what we were trying to get across today.

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MR NOONAN: Thanks Derek, I was looking at your recommendations, which are on page 2 of your submission, where you've got a summary, and we go to the second recommendation and perhaps ask that you might elaborate on some of the dot points. The recommendation begins at:

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*The community uses its best endeavours to identify protocols for determining appropriate follow-up procedures for people –*

I've got you in the right spot?

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MR AMOS: Yes.

MR NOONAN: I just in particular made a marking against the procedural matters of forwarding requests for supported accommodation to referral agencies, and also

the third dot point in terms of monitoring discharge – discharge patients’ and tenants’ progress, and just wonder whether or not you might elaborate perhaps on those without confining you just to those, but that caught my eye in terms of process-driven matters in terms of finessing these couple of areas to improve arrangements for people who need the services that you refer to in your submission.

MR AMOS: Thank you for the question. I’m glad you’ve asked that, because it gives the opportunity to elaborate on why it is we’ve put that recommendation in.

10 Given that at first glance you can think that it’s not within the terms of reference of this committee, you naturally think that people that exit the mental health care service, the terms of what their follow-up requirements ought to be clearly specified in the mental care service. However, those terms do not necessarily flow on to the broader community. But unfortunately, as Gippsland Lifeline will attest, and by the way, I should have mentioned that we’ve made reference to Gippsland Lifeline in our submission as they are a partner organisation of Barrier Breakers. Gippsland Lifeline expressed a great deal of concern about the number of calls they have from people who have exited the service and who are suicidal and had nowhere to go. Where no provision had been made by that service to follow them up to ensure that they had somewhere to go. Given that there are only 33 acute car beds in the whole of Gippsland for people with a mental illness, the hospital from time to time puts its overload into nearby motels and caravan parks. And people who exit the service very often go into caravan parks, and without the required support that is needed.

25 So, that’s why we’re saying there needs to be a protocol established for determining what are the accommodation needs of these people who exit the service. Is the home they come from before entering the mental health service capable of their return? Sometimes the carers, the parents, are elderly. Sometimes the carers are frustrated beyond belief and don’t want to take the patient back, and won’t take them back, so what happens then? Where does that person go? And that needs to be addressed. And I guess in terms of the protocols that are already there with the Latrobe Regional Hospital they could well argue that: It’s not our responsibility, we’ve discharged the patient. Well, someone needs to take on that responsibility, because as sure as, you know, night follows day, those patients aren’t capable of looking after themselves.

35 MR NOONAN: So, in a really practical sense, and I didn’t mean to dwell on that particular dot point, but in a really practical sense, what does that support service look like, that exit support service look like? So that’s the - - -

40 MR AMOS: Non-existent.

MR NOONAN: Well, no, the question is, what would that service look like? I think you’ve painted a picture about what exists at the moment, but what would that service look like? But also, if you wouldn’t mind just elaborating on the second dot point in terms of the forwarding request for support accommodation agencies, because I’m not sure I understand that well enough.

MR AMOS: What we’re talking about there is, if there was one central agency, it doesn’t have to be a monolithic bureaucratic organisation. We’re probably talking

about one or two people at most working in an office to cover the whole of the Gippsland region, the six local government areas, where a mental health service that was discharging patients had a requirement under their protocol to notify their agency that such and such a patient was being released, that they either had  
5 somewhere to go or didn't have anywhere to go, and that agency, because it had the waiting list, knew where the accommodation units were or were not, and it also had direct contact with a PDRSS service and could make arrangements for support to be provided for that person. That's what we're talking about.

10 MR NOONAN: Sorry to labour the point, do you want to go back to where I started in terms of what would that service look like, what would that exit service look like?

MR AMOS: Well, it would be vastly different to the one we've got today, and so, what it would look like? It would look like an agency responsible for getting that  
15 information and passing it on to the other agencies who would provide the support. What would it look like in terms of what, numbers?

MR NOONAN: No.

20 MR AMOS: What it would look like in terms of where it would be located?

MR NOONAN: No, the monitoring process. So you talk about monitoring discharge patients' and tenants' progress, so - - -

25 MR AMOS: That is normally done now by GARSS and by SNAP Gippsland in this region?

MR NOONAN: Right.

30 MR AMOS: So if they're providing support they know by the outreach program that they administer what the needs are and the ongoing wellbeing of the tenant is?

MR NOONAN: Okay. So it does exist.

35 MR AMOS: They do their monitoring, yes.

MR NOONAN: It does exist.

MR AMOS: Mm.

40 MR NOONAN: Thank you.

MRS POWELL: Yes, I've got one. Just following on from that, I guess it is an issue that we are hearing in a couple of places we have been to, that is that issue of a  
45 person with a mental illness being in supported accommodation, then they leave the supported accommodation, there's nowhere for them to go when they leave that supported accommodation and they go back into caravan parks, inappropriate housing. What we are looking for, I guess, is what will the model look like if there is no private rental. What do you think would be the ultimate area that a person could

go into from supported accommodation, to a transitional stage, before they can actually go back into the community.

5 MR AMOS: Well, one of the models that has been referred to, and I hope I don't misquote SNAP here, is that under the Nomination Rights Program, a house is made available, the tenant with a mental illness moves in, is supported by the agency and may reach a stage where that person is able to live without support. With medication and a return of their health, they may be able to stay there, in which case there needs to be another unit made available.

10 MRS POWELL: That was actually my point.

MR AMOS: That's right.

15 MRS POWELL: There is a number we can get back into the community, but there is obviously some, and we don't like to talk about institutions, but obviously there is a certain number of people with a mental illness that are never going to be able to, without support, go into the community. They are going to need that safety, security, people looking after their medication, someone there to support them, because maybe  
20 their mum and dad have passed away. So there is probably going to be some people that do need, not an institution, but some form of long term support.

MR AMOS: Support.

25 MRS POWELL: Support, but in a permanent area and not with a one on one because you are not going to be able to – you know, we would all love to have the Rolls Royce situation, but I guess if we don't like institutes for people who are going to need to have that long term accommodation, what would it look like if you have something that is going to be cost effective, but beneficial to the patient that does  
30 have that long term, the serious long-term mental illness.

MR AMOS: That is why we say there has got to be a mix of accommodation models and including hostels. As there are limited numbers now, but that's – and whether you call that an institution or not, I don't think makes any difference. As I  
35 said earlier, for all intent and purposes, a nursing home for aged people is an institution and we have no problems about that.

MR SCHEFFER: Yes, Derek, I just wanted to come back to changes that have occurred in recent times and you would be aware that the role and flexibilities of  
40 housing associations in recent times has been broadened, so that they can raise capital and they can enter into partnerships to build various forms of affordable housing. We have talked to housing associations and a number of them, or that they would be interested in moving into the area of providing appropriate housing for people with disabilities, including mental illness. Have you, has Barrier Breakers  
45 talked to them about the options?

MR AMOS: Yes, we have.

MR SCHEFFER: Could you talk to us about your discussions.  
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MR AMOS: We have – I think we have made reference in our submission to Community Housing Limited.

MR SCHEFFER: Yes, you did indeed.

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MR AMOS: Yes, we have met with Community Housing Limited. They provide a range of accommodation for people under their care and they make them available to organisations like SNAP, but there are no specific allocations, for people with a mental illness. Now that is a matter that we need to take up directly with those associations.

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MR SCHEFFER: But that is not ruled out, is it? That is just it hasn't got that far yet.

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MR AMOS: Yes, it is. Exactly. So it is an evolving development.

MR SCHEFFER: Are you optimistic about the potentiality there, because I noted before you talked about the role of the Office of Housing and it would have seemed to me – I haven't researched all that – but it seems to me that maybe the Office of Housing isn't the way to go with it, but the way to go with it is the housing associations and the investment in appropriate accommodation for people with mental illnesses in this instance.

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MR AMOS: Well, yes and no, accepting that community based organisations like Community Housing Limited, couldn't be expected to keep waiting lists themselves. Like, they are providers of housing, they don't provide the support required for people with a mental illness, nor would they be expected to keep a waiting list for those people, that category of tenant, that may be in the community. There is still this need for government to accept responsibility to have a central list of the demand itself. Whether the government then uses community organisations - - -

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MR SCHEFFER: Yes, but that wasn't – what I was asking you to talk about is the potential role of housing associations in providing the range and breadth of accommodation models.

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MR AMOS: They can play a very major role, yes, indeed.

MR SCHEFFER: Yes. Yes, and so – okay.

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MR AMOS: I agree with that.

THE CHAIR: Just a quick clarification. When you talk about from institute to going to deinstitutionalisation you spoke about coming down the bed numbers from 300 to about 200. Have you factored other support services which came with the like

individual packages, Outreach services, because that could have compensated for loss of beds in an institute?

5 MR AMOS: It did. It made some, yes, Mr Chairman, it did make a difference because Outreach programs were provided and did provide a degree of support and assistance to people that were moved back into the community. And I can recall, I was the local member here when Hobson Park was still operating and during the latter stages of the 1970s there was a move then, to move people back into the communities and there was a limited Outreach program that was arranged.

10 Indeed, my own brother was a patient of Hobson Park – a long term schizophrenic patient – and was moved out of Hobson Park to a one bedroom Housing Commission unit in Warragul. But all that Outreach program provided then was a nurse to ensure that my brother received his regular injections, took his medication. No one  
15 provided any assistance for ensuring that the rent was paid, or that the garden was kept tidy, or the neighbours weren't complaining too much, as they did about disturbing behaviour. So the limited provision of services that accompanied deinstitutionalisation wasn't sufficient then and it has just grown worse in the period since then.

20 MR NOONAN: Could I just be absolutely crystal clear on your view about whether there is a place for a larger bed facilities. We have been talking about institutions because that is what we can relate to from the past. In the mix, as such, because you have sort of referred to it a number of times, but I am not absolutely clear about  
25 whether you see that there might be a role for larger bed facilities for people with long term mental health problems in the future, and if so, what would be some sort of capping on how big that facility might be.

30 MR AMOS: I do see the need for a larger hostel type accommodation unit or units being made available for people with acute mental illness, a chronic mental illness, who aren't receiving in-patient treatment at a general hospital like Flynn and who can't be expected to live in any decent accommodation condition on their own or out in the community, without major support. When I spoke about there is a need for a mix, a variety of accommodation models, that was certainly among the models that I  
35 was referring to.

MR NOONAN: And how large would that, could that facility be, in terms of beds?

40 MR AMOS: Well, how long is a piece of string? First of all, we need to determine the numbers and from what we have seen with our research to date, there is a great number of people now, people with a mental illness, living in caravan parks - - -

MR NOONAN: But in terms of - - -

45 MR AMOS: Who would be prime candidates for being, if you like, tenants of the largest style hostels?

MR NOONAN: So, in terms of size – because you could build a number and they could be capped at a particular level or you could build a larger facility and I think

what you have said is that you are supportive of that within the mix, but it is useful for us to understand as a committee, how large that facility might be.

5 MR AMOS: I suspect that it would need to be kept relatively small, small rather than large.

MR NOONAN: So, say up to - - -

10 MR AMOS: Again, because of the stigma that is associated with mental illness and again because of the stigma associated with the word institution.

MR NOONAN: So no greater than 20 beds?

15 MR AMOS: Well, I would think that would be about right.

MR NOONAN: Thank you.

20 MR SCHEFFER: Just on that, the mental health facility, the 14 bed, I think, CRU – how is that travelling? Is that about right?

MR AMOS: Yes, that is a longer term facility, as you know; people who are exiting the system and still require, you know, a greater degree of assistance and supervision. But yes, that is about right.

25 MR SCHEFFER: Yes, okay.

30 MRS POWELL: Yes. I'll just go back to the part where collecting of data is not happening at the moment, so it makes it really difficult to say what sort of accommodation you need and where it is needed. When you are collecting data, I guess, trying to find data on somebody with a mental illness is more complex given that there may be an alcohol addiction, a drug addiction which may mask the mental illness. Would you see the data being collected on people who are receiving supported benefits, or, I mean, there is obviously some in the community that have not been assessed, but still may have a mental illness with some sort of other  
35 addiction. How could you see that data being adequately assessed given that often there are people in the community that might have a mental illness, that we really don't know, that may need help. So the data collection is going to be really important.

40 MR AMOS: I think there are probably two main areas for determining that waiting list, that central list. One is clearly the exiting from the mental health service. As I have said before, we need to know those who exit that service, how many of those people require support, how many of them require accommodation. That is one area of getting that data. The other area is from support agencies throughout the region  
45 who have people calling on a daily basis looking for accommodation. So they would

then refer that information, that waiting list that they compile, almost on a weekly basis, even a daily basis, to that central agency.

THE CHAIR: Thank you very much, Derek.

MR AMOS: Thank you.