

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

**Inquiry into the provision of supported accommodation for Victorians with a disability and/or
mental illness**

Melbourne— 30 April 2009

Members

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Ms I. Collins, director, Victorian Mental Illness Awareness Council (sworn).

The DEPUTY CHAIR — Thank you very much for coming, Ms Collins. The Family and Community Development Committee is looking into issues such as the standard, range and adequacy of care and accommodation currently available; the appropriateness of the current service providers; how unmet need is managed in Victoria; accessibility and appropriateness of accommodation for rural communities; ethnic diverse communities; indigenous Victorians; and the impact of the current service provisions on families and carers.

This committee is an all-party investigatory committee of the Victorian Parliament and is due to report to the Parliament by 30 June next year, after which the government has up to 6 months to reply to the committee's report and recommendations. All evidence taken at these hearings is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments a witness makes outside the hearings may not be afforded such privilege.

We are recording the evidence and will provide a proof version of the transcript to each witness at the earliest opportunity.

Ms COLLINS — My name is Isabell Collins. I am the director of the Victorian Mental Illness Awareness Council, which is the peak consumer organisation for people with mental illness or emotional problems.

The DEPUTY CHAIR — You can now present your submission.

Ms COLLINS — The organisation VMIAC receives both state and commonwealth funding to provide individual, group and systemic advocacy; mutual support and self help; consumer service provider and community education around mental illness from a consumer perspective; and also consumer research. Currently the VMIAC staff undertake monthly visits to many of the inpatient facilities to talk to people about their rights and to attend to any advocacy issues that they may have.

We also establish consumer groups located across the state. The VMIAC staff visit those groups on a monthly basis to see how they are going, provide them with support and take up any issues that they might have, individually or as a group.

It is genetic, but I get very verbose as I am passionate about mental health issues, so if you do not mind, I would like to read what I have got to say. The first statement I would like to make is that people with a disability, including psychiatric disability, should not be confined to living in supported residential facilities and boarding houses. I think they deserve better. I think we can afford to provide them with better, and could do that if priorities of government were different.

In relation to my own history, in 1989–90 I was a general nurse who was a member of the ministerial audit team that was required to investigate standards of treatment and care in the 19 institutions that we had. I was the only non-psychiatric trained person on the team, and my job was to interview patients about their experiences in hospital.

Out of the 19 institutions, from memory, there was only one ward in the whole state that you could actually say whose standard was equal to what you would expect in a general ward. The remainder were largely dirty, with holes in the walls and floors. Dampness was such that if you lightly touched it with a pen, bits of the wall would fall away. There were often no doors on the toilets or showers, so people were expected to do their most private things in public. Beds were so close together that if you reached out, you were able to touch the person in the next bed.

Safety for women was virtually non-existent. One of the questions I asked people was: had they had anything traumatic happen while they were in hospital? Many talked about being raped by fellow patients or staff and that whenever they tried to put in complaints, people just did not hear them. The only persistent positive remark about hospital was the peace they found in the gardens. I have to say that that is the one thing we got rid of with deinstitutionalisation.

To say this experience has had a profound effect on my professional life would be an understatement. I was very happy as a nurse, but I have not nursed since. If someone had told me before I actually saw it that this is the way we treat the mentally ill, I would have staked my life on it that there was no way known we would be doing this. But seeing was believing.

While I would never advocate for a change of deinstitutionalisation, one of the things that absolutely horrified me and which I think is a sad indictment of us all is that basically we closed down those institutions only to discharge people, literally, to the streets. I think as a consequence of that, we conditioned people to not expect terribly much in their lives. For example, I once used to advocate for a female client who was 34 years old and who had been living on the streets since she was 15 years of age. She had brain damage due to a long-term use of illicit drugs and alcohol, and therefore could not often remember appointments.

She used to frequent Sacred Heart Mission; and I used to go down there in the hope of catching up with her. While I was waiting to see her, I would sit and talk with many of our people and they would tell me their stories. When I would say to them, 'Would you prefer to be back in an institution where you at least had a roof over your head, a bed to go to and food in your belly?', not a single one of them said they wanted to return to that.

When I thought about that, I thought we have actually conditioned them to feel that they are not entitled to anything other than what they had. They went from one hovel to another and really have not been given that opportunity in many instances to know what good, sound and comfortable accommodation is.

There are a number of issues that impact on people with a mental illness that I believe I need to raise here today, because the reason these issues exist is, in many instances, directly a result of a lack of government funding.

They are: we have a non-compliance with profession-specific and generic standards of practice; we have regular breaches of the Mental Health Act; we neglect consumers' rights; we have non-compliance with Chief Psychiatrist guidelines; we have non-compliance with government policy; we are refusing consumers clinical services when unwell; we are discharging patients from hospital whilst still unwell without adequate clinical and non-clinical follow up in the community and sometimes into very inappropriate accommodation; secluding consumers who are suicidal instead of providing them with specials; limiting therapeutic interventions to medications only; unrealistic clinical and non-clinical workloads; an overburdened service system; increased stress levels of clinical and non-clinical staff; homelessness; and increased marginalisation and stigmatisation of people with a mental illness.

According to the Victorian government's document *Improving Mental Health Outcomes in Victoria: the Next Wave of Reform*, the economic impact of mental illness in Victoria is estimated to be about \$5.4 billion annually largely as a consequence of diminished workforce participation and productivity. The Boston report articulates that 50 per cent of people with a mental illness do not receive appropriate care; 44 per cent of people with a severe mental illness — that is, a psychotic illness — are not serviced by either the private or public mental health sector; 340 000 Victorians in any one year who have a mild to moderate non-psychotic mental illness receive no treatment for their illness; 19 per cent of the adult Victorian population, at any one time, will experience mental illness of which 12 per cent experience a mild disability, 4 per cent a moderate disability and 3 per cent a severe disability; 27 per cent of people aged between 16 and 24 years of age, 14 per cent of children and 6 per cent of the aged will experience mental illness in any one year.

Victoria provides 23 inpatient beds, 19 residential beds staffed 24 hours a day, and 24 supported accommodation beds per 100 000 of the population; 29 per cent of people in prisons have a mental illness; 4.7 million days are lost due to absenteeism from work each year; 73 000 Victorians are not in the workforce due to mental illness; 36 000 Victorians are on a disability pension due to mental illness; and 40 000 Victorians with a mental illness will present in the emergency department annually. There are 10.5 suicides a year per 100 000 of the population; 90 per cent of those people had suffered from a psychotic illness. Mental illness is the largest single cause of disability amongst Victorians.

There is escalating and preventable deaths through suicide resulting in 21 people committing suicide within five weeks of discharge from hospital in any single year. In Victoria there is an average of 350 reportable deaths per year — that is, deaths that occur while the person was receiving care and treatment in the public mental health care system; 24 per cent of people with a mental illness do not have a permanent bed to sleep in at night; 70 per cent of people who are homeless have a mental illness; and 80 per cent of people with a mental illness are unemployed.

Additional to the above statistics, the Victorian mental health care key performance indicators reveal the following data. There are 21 area mental health services in the state, each providing inpatient facilities for those aged between 18 and 64 years. Victoria provides 1.71 inpatient beds per 10 000 population. Inpatient bed occupancy ranges between 70 per cent and 99 per cent, with only eight services not exceeding the Department of Human Services acceptable bed occupancy level of 86 per cent. I have known it in some instances to be up to 132 per cent.

Readmission rates — that is, people being readmitted within 28 days of discharge from hospital — range between 9 per cent and 23 per cent, with a statewide expectation of 14 per cent. People with a mental illness have a life expectancy 25 years less than people who do not have a mental illness. Finally, while the Victorian government claims to be the leader in mental health in Australia, in reality Victoria has slipped to fifth.

I guess what I would like to tell you is that behind those statistics are people, and they and their families pay very dearly for the lack of government funding. Government funding is not the only problem, but it is a major impediment to people receiving a responsive and respectful service.

In relation to accommodation facilities, I am unable to respond to them in detail, except to say that the number of facilities is grossly inadequate to meet the demand in the metropolitan and rural sectors. Currently there are 20 community care units for 21 area mental health services. Initially these units were to be permanent housing for people with serious a psychiatric disability. As demand outweighed supply the policy changed, and many of these people have been discharged to supported accommodation facilities. Clearly the number of these facilities is grossly inadequate.

There are also five secure extended care units across the state. Having recently advocated for some residents in these facilities, I would have to say that in general terms they are the last bastion of institutionalisation, where respect and dignity for residents is far from ideal. Reward and punishment seems to be the method of care. While the Mental Health Act requires a least-restrictive environment, I would suggest that seclusion, despite the evidence that there is no therapeutic value and that it causes short and long-term emotional damage to consumers, is used far too frequently.

I got permission from one of my clients to give you an example of something that occurred at Easter. She was sent in from her aunty an Easter gift which was a backpack and some Easter eggs. The staff were present when she opened up her gift and they insisted that she hand over the Easter eggs. I do not know whether you know that a lot of the medication that is prescribed causes ravenous appetite, so that many people with a mental illness are overweight and have physical problems as a consequence. This person is overweight, but she is not grossly overweight. They insisted that she hand over the Easter eggs. When she refused, they called the security guards.

The next day she asked for an Easter egg and was told no, so she swore at the staff member. This person has a psychiatric disability and is borderline in relation to an intellectual disability. So she swore at the nurse. The nurse then said, 'You can't have any cigarettes for the rest of the day'. She rang me at about 4.30. I rang the unit and said, 'Please tell me you didn't do this'. They said that yes, they did. When I pointed out to them that they had no right to take her Easter eggs from her and that they had no right to refuse her a cigarette, they said, 'It's unit manager policy'. When I rang the unit manager and said that, she said, 'Yes, that is the policy, but I didn't tell them to call the security guards'. When I said that there is no provision under the act, she said that they were concerned about her weight. I said, 'I understand all that, but that's open to negotiation. You have no authority to force people to do this'. I was then told that she was on her way home and she would get back to me about it after Easter.

During the Easter break this young woman was allowed day leave to go home to her mum and dad. When she got back they strip-searched her, by all accounts for lollies. Unfortunately she did have some lollies shoved down the front of her pants. She attempted to hit one of the staff and as a result was placed in seclusion. When I said to her, 'Why did you attempt to hit the staff member?', she said, 'Because there were males involved'. She said, 'It was just so degrading'.

This is a shocking way to treat people. What we have is a system that does not provide genuine accountability — does not make services accountable. I rang the office of the chief psychiatrist and jokingly said, 'I think we need an Easter bunny act now'. When I rang them back a couple of days later to find out what had been done, their response was, 'We spoke to the staff and they're concerned about her weight'. Everybody seemed to miss the point. Yes, you can be concerned about her weight — that is a good thing — but you do not have legal authority to be doing these sorts of things to people. That is the sort of stuff that goes on. It is a daily event and it causes dreadful distress.

I have to tell you that I can remember 20 years ago, when I was interviewing in these institutions, going back and saying, 'There's something dreadfully wrong with this seclusion practice. I can't put my finger on it, but there's something dreadfully wrong with it'. Then I interviewed three women one after the other, and then I knew what was wrong with it. It is exactly like rape. They talk about staff, including men, grabbing them, taking them off to a single room, holding them down, stripping them naked, putting a needle in their bottom, putting them into ill-fitting gowns — that is despite what the act says — and then leaving them in a single room on their own and looking through the window every 15 minutes. We made a recommendation 20 years ago that we should not be stripping people naked, and the office of the chief psychiatrist has gone on to say that it is unnecessary. Yet we still do it, and nobody is held to account because, apart from services like ourselves, who take up these things, knowing full well that they are a breach of the act, there is nobody else who seems to want to stand up and say to staff, 'This has got to stop'.

In relation to PARC services, currently the government has eight PARC units across the state, which again is grossly inadequate to meet demand. They are the step-up, step-down facilities. What they are supposed to be is that if you are becoming unwell and you are not sick enough to be admitted to hospital but you are too sick to remain in the community, you can go to a PARC service. In the same way, if you are in an inpatient facility and you are not well enough to be discharged home, you can go to a PARC service. I have to tell you that the feedback from consumers is very positive in relation to those services.

In regard to the number of inpatient beds, it is hard to know whether we have adequate bed numbers, because until such time as we provide adequate clinical and non-clinical supports in the community to assist in keeping people well, it is hard to make a judgement as to whether we need more inpatient facilities or not.

In relation to boarding houses, while it has been a long while since I have visited boarding houses, I have to say that in the ones I have visited the standard of accommodation is grossly inadequate. It often reminds me of being back in the institutional days, where some of them are in need of repair, they are unhomey, and they are certainly unsafe for women in particular. The staff of the VMIAC report that many of the supported residential units have also closed down.

In relation to nursing homes, we are unable to comment. We would be able to comment if we were adequately resourced like other services should be so that we could get in and have a look, but we just do not have the resources.

In relation to SAAP services, intense outreach support can occur via that program. But again, we have heard that this service is unable to sustain service demands.

In relation to standards, while standards of practice exist in the clinical and non-clinical sector, they are more often than not ignored. One of the major problems confronting services is how to comply with standards when you are functioning at crisis level all the time. I know that when I was a general nurse,

when you were really busy you would cut corners in order to keep the sickest people safe. But it would last for only a day or two.

What has happened in psychiatry is that it has been at crisis point to such an extent that those cutting corners have now become everyday practice. The impact on consumers and their families, and I think service providers as well, is quite significant. I do not know how many times I have been in an inpatient facility and a nurse has pulled me aside and said, 'Can I see you outside?', and I have gone outside and they have said, 'I didn't train for this. I'm getting out. This is just shocking'. So funding is not the only issue, but it is a major part.

In relation to families, the pressures on families to take care of their adult children because of a lack of affordable and appropriate accommodation and everything else are just dreadful. Anecdotally, because of those pressures we are actually turning carers into consumers. Many of them are developing mental illnesses and many of them are now getting old and really worry about what is going to happen to their kids when their time is to go.

In relation to how much we need, I do not know. That is not my area of skill. I would need to get a calculator.

In relation to rural and remote, again it is really dreadful for them; it is probably worse than in the city. And again there is an urgent need for attention.

In relation to CALD, ADEC, I presume, is better able to assist. The only comment that I would make, and I have recently been advocating for a Sudanese man, is that in mental health we are very quick to diagnose. One of the tragedies for people with a mental illness is that once they get the diagnosis, it does not matter what comes out of their mouth, it is pathologised, and so often they are precluded from having the normal, everyday human reactions that we all have.

I think that for people from a CALD background, their culture is a very different thing; rather than quickly jumping to diagnoses, what we need to do is encourage services to spend time googling on the computer and finding out a bit about cultures — before we quickly jump to conclusions about it being part of a mental illness when in actual fact it can just be culture. To give you a practical example, I am currently advocating for a gentleman from Sudan who says he is an orthodox Christian and that part of that religion is to fast for 14 days — it would kill me! — or 15 days. The service has decided that he is acutely depressed, so he has been made involuntary. When I met with him I went back and googled it, because I know nothing about the country, and up it popped — that is part of the culture. That is just a practical example.

On adequacy of care, put simply, the standard of treatment and care in this state is a disgrace. In 15 years of reform all we have done is change the size of the institutions. We took the culture with us, and that is the culture that deprives some of our most disabled citizens of their right to be treated with respect and dignity. Funding for mental health in the clinical and non-clinical sector is grossly inadequate, and it would not be an exaggeration to state that it has cost lives.

As stated previously, 25 people a year suicide within five weeks of discharge from hospital. If we had that happen, if we had 25 people die of an appendectomy within five weeks of having that surgery, we would have fixed it years ago. But because it is a mental illness there is this attitude that they do not seem to have equal worth to the rest of society.

Finally, anecdotal evidence also suggests that in some instances the quality of food in the secure residential units is grossly inadequate. But when we talk to people about taking that up as an issue, they are fearful because they might lose their accommodation, because the owners of those services have all the power.

What we would suggest as alternative approaches are that people with a disability or mental illness are vulnerable to abuse, and in particular women — we therefore need accommodation facilities that are for women only in order to protect their vulnerability. I am sure that you are aware that many people with a disability have experienced sexual harassment, abuse and rape as a result of those vulnerabilities. In

addition, many have been forced into prostitution as a result of their inability to get by on their pension — for example, I remember one woman in tears telling me how she was stripping naked in front of men for \$10. She felt awful about it, but she felt that she needed additional funding in order to meet her costs. It is not confined to just one woman.

In regard to the workforce, given the vulnerability — many are living in boarding houses, supported residential units, community care units et cetera — we would recommend that consumer advocates be employed to provide advocacy and support to those individuals to ensure that abuse is eliminated. While the VMIAC provides this service, our ability is grossly limited by the resources provided for this service. Alternatively, consideration could be given to employing consumers on the premises to support staff to monitor and assist people in their day-to-day living et cetera.

Currently rehabilitation programs are largely established by local psychiatric disability rehabilitation support services, and they often do not meet the individual needs of the person that are more about meeting the needs of the service. In other words, one of the problems here is that the department funds services so consumers have to fit into those services, and services are not holistic in nature. What we should be doing really is finding out what people need and then wrapping services around them, rather than expecting them to choose to fit in with the services.

The DEPUTY CHAIR — Isabell, we only have about 10 minutes left. Unless there is something specific you would like to say, we would like to ask some questions and perhaps tease some of that out. I think there are a number of members who would like to ask you some questions.

Ms COLLINS — All right, I am willing to do that.

Mr SCHEFFER — You have presented a very, very bleak account of your experiences working in the sector. You take us through the period of institutions through de-institutionalisation and then into the present period. Could you describe what you think the character of the change has been over that period of time, because I get the sense from you that basically it is the same as it ever was?

Also, within that very bleak picture you have given us is there some light and shade in there? What are the better performing initiatives and what are the worst performing initiatives? When I talk about the present I am thinking of things like the government's mental health strategy, which I have asked many witnesses about, and also objectively the very large increase in the mental health budget and documents like A Fairer Victoria.

Ms COLLINS — I would have to say that when you sit down and talk to people who work in the sector, they are good people. I guess after this audit I spent eight months pacing the lounge room thinking, 'How does this happen? How do good people end up doing not so good things?'. The thing that I came up with, which I think is in all of this, is habits of practice. If you see something often enough, you cease to see it. If you hear something often enough, you cease to hear it. If you do something often enough, you do it without much thought.

I guess we only ever pick on those who are in a less powerful position than ourselves. Often when we see abuse we tend not to get involved unless it is a loved one. That is the thing that is in all of this. I want to stress that 99.9 per cent of the people who actually work in the sector are trying to do a good job. There are pockets of really good service. The step-up facility is a very good one. It is just inadequate.

Mr SCHEFFER — Inadequate because there is not enough of it?

Ms COLLINS — There is not enough of them, yes. The peninsula inpatient facility has a new unit manager who decided that she thought the culture was horrible. She set to work on that and they have done some really good stuff down there. The Thomas Embling Hospital, which is the forensic inpatient facility, probably delivers the highest standard of treatment and care in the state. They get funded. They are a very good demonstration of how if you adequately fund a service, they will give good support. I think the initiatives around consumer participation in the sense of employing consumers in the area of mental health services has been a very good one but again it is inadequate.

We have had these reforms in batches of five years and what I say to people is you constantly build consumers' hopes up that you are going to do something — only to let them down. I say, 'We are constantly breaking consumers' hearts'. I sit on the ministerial advisory committee and I say, 'You are not conning me this time. I am not going to get involved'. But it was very hard not to say, 'This is really good stuff'. The people who put together *Mental Health Matters*, the stakeholders that have been involved and the bureaucracy in particular, have worked so hard in putting together what I think is a really good document, and I absolutely fear that come the budget, you are going to break our hearts again by not providing adequate funding.

There are really good people in the sector, really good leaders, but you can only do so much with so much resourcing. It is awful to see the neglect that goes on. Like the average age of the nursing workforce now is something like 47. Why would you work as a nurse if you cannot perform as you know from the depths of your soul you should function. Of course they are getting out.

I have this mental picture: if we do not get it fixed in 15 or 20 years' time, many of the nurses will be in wheelchairs because of their age, not looking after people in inpatient facilities. Part of that is around the fact that we never, ever unpack. We use what I call a defensive reasoning approach to problem-solving; it is a well-documented management way of dealing with things where you address the result of the problem rather than the root cause. It is about protecting the service at the expense of genuine learning and policy change.

We have the potential in this state to fly, and the only thing that holds us back is government's genuine commitment that if you have, and I think it is a 27 per cent disease burden of mental illness and you can only fund 27 per cent — —

Mr SCHEFFER — Just very quickly, because I know we have got to move on, where does that potential sit? When you said we have got the capacity to fly but government lets us down, what is the good thing that can enable that lift-off — just in a word?

Ms COLLINS — Commitment, genuine commitment.

Mr NOONAN — My question really goes to the heart of this inquiry needing to look beyond our borders. I have made it my business to ask a range of witnesses about where we should be looking beyond our borders. You made a statement, which I recorded, in terms of Victoria's position slipping to fifth. I just wonder whether you might tell us who is ahead of us, in order, if you could, and why they are ahead of us.

Ms COLLINS — I can say that Queensland is ahead of us now. Why are they ahead of us? I do not know why other states have made a decision to pour more money in. I think part of that is around the fact they have had some pretty dreadful tragedies. I would not want her to know this but I think Gill Callister is really good.

Mr NOONAN — We won't tell her.

Ms COLLINS — I have got a reputation to maintain.

Ms WOOLDRIDGE — It is on the public record.

Ms COLLINS — Aaron Groves is the director of mental health up there, and he gets it; he really does get it. I think he has tried very hard. They had Ruth Vine there beforehand. Let me be very clear — if all psychiatrists treated their patients the way Ruth Vine treated her patients, I would have retired long ago. I would have gotten out of mental health because there would be no need to stay. I cannot tell you the other states. I just know that we have slipped.

Mr NOONAN — Are you essentially saying that Queensland is ahead of us because they put more resourcing into the issue?

Ms COLLINS — Yes.

Mr NOONAN — Is that all it is?

Ms COLLINS — No.

Mr NOONAN — Or is it because they are using different methods in order to tackle this issue?

Ms COLLINS — I think they are not pretending that they deliver world's best practice. That they are being more realistic about it is obviously one of the reasons. I think we in Victoria have got to stop pretending. And, as I say, they get it, although they still have got a long way to go. Some years ago I used to be an Australian Council on Healthcare Standards surveyor and so got to travel the state looking at mental health services. There are pockets in every state that do it better than Victoria but there are things that Victoria does better. Our PARC service is far superior. The provision of psychiatric disability rehabilitation services is far superior to the other states. We still have other states that have still got the institutions going.

Mr NOONAN — New South Wales, for one.

Ms COLLINS — Yes. And I think South Australia is another. So there are pockets of good stuff here but there are also pockets in other states. Mental health is a social issue and to me it is not a government issue; it ought to be an issue for Parliament. I often say that one of the tragedies here is that we do have Liberal and Labor and never the twain shall meet. Governments need to recognise that this is a genuine social issue.

If you look at the fact that one in five people has a mental illness, and look at the suicide rate that we have and so forth, then you can see that Parliament needs to come together, Parliament needs to develop the white papers together, rather than the way it happens currently.

When we did the audit of the 19 institutions we had a significant number of recommendations. One of those was about developing standards for accommodation. What happened is that the Liberal Party got in, and any of the recommendations that had been made, it seemed to me because they had been done by Labor, went out the window, and so we got all this appalling accommodation. Those recommendations did not happen. Labor does that to Liberal, too. I think that this is a significant enough social issue that it should be Parliament that is establishing the policies, so that you have a continuity. Things cannot be fixed in five years. It is going to take years and there needs to be a coming together.

If I could make an appeal — I am an adoptee and I chaired the 10-year celebration of being allowed access to your natural family. There were Labor, Liberal and National politicians on the committee. It absolutely put a warm glow in my tummy to see these politicians bragging about the legislation. That legislation was put together by a Parliament that everybody was committed to, and 15 years on, it is still world best practice.

You as a Parliament can fly in relation to mental health if we could only stop that party politics stuff of: if it comes out of a Labor mouth, the Liberals are going to disagree, and if it comes out of a Liberal mouth, then Labor is going to disagree. It is too important an issue now for it to be a party thing.

The DEPUTY CHAIR — You will be pleased to know that this is an all-party committee. We have Liberal, National and Labor members here.

Ms COLLINS — I appreciate that.

The DEPUTY CHAIR — We are running short of time but I do not know whether the next group of witnesses have arrived yet, so we might continue with our questions.

Ms WOOLDRIDGE — I think it is worth putting on the record that we still have two institutions in Victoria. Of those 19, there are still 2 left, and they need to be addressed. Specific to the issue of accommodation, there seems to be a huge gap between CCU accommodation, which is a structured environment with 24-hour care from specialists, and what happens after that, which is the SRS and the

rooming houses that you have talked about, which is essentially zero structure and care. So you are going 100 miles an hour and you have got great support, encouragement and care, and then you go to nothing. What could go in the middle of that? We have heard from the PARCs that people do not tend to get discharged from a CCU to a PARC because a PARC is really short-stay accommodation whereas the CCU is for about six months. What could go in between the two that would actually seek to address that? You need some care and support — perhaps not as much and not as intensive as the CCU-type environment — that would help the transition back into the community?

Ms COLLINS — I think it is all down to providing people with support in the place where they live, and we do not have enough of that so you get somebody a flat.

Ms WOOLDRIDGE — So it is public housing, is it?

Ms COLLINS — It is public housing, but whether it is public or private, it has got to be affordable and it has got to be safe. You wrap the service up around the person in the home because it is hard to know sometimes what comes first, homelessness or the mental illness. I understand, and I have not read it but I have heard, that often people who are homeless and who do not have a mental illness will get a mental illness. It is about being practical and providing those supports for the person in their home to help keep them well.

Ms WOOLDRIDGE — Why is that not happening now with community care teams and all that sort of thing? What is the gap that that is not happening?

Ms COLLINS — There is not enough. There is not enough funding to employ adequate enough people to provide those services, and I think that there has to be some flexibility. One of the things I would like to say too is that we are obsessed about outcomes, outputs and throughputs, and all of those sorts of things. Community care residential units are a good example of that. We are not concerned about process, and it is the process that is letting us down in the sense that it used to be that people who lived in community residential units were going to be there permanently because they are people who are significantly disabled, and then somebody decided that we needed them for younger people and so we would have to move these people on.

Then the measure becomes what is the turnover in the community residential units. And so people were being inappropriately discharged from those community residential units into boarding houses and SRSs, and they were not safe, and tragedies happened. What we have also got to say is that outputs and throughputs are fine but let us make sure that the process is also safe and adequate and complies with some standards. If you are going to discharge somebody, you do proper discharge planning and you do not discharge people into caravan parks, which is quite common now.

Ms KAIROUZ — Thank you for that; it is heartfelt. You said twice that the system does not make people accountable or nobody is held to account. If you were to make one recommendation in relation to that, what would it be? Just off the top of your head, even though you probably have not considered it. How do we make people in the system accountable if we were to put in a recommendation?

Ms COLLINS — Every act needs to have accountability clauses written into it to ensure that the people who are employed to do things actually do them and that they report to Parliament. I believe there is no such thing as an independent agency in this state, whether it be the Office of Chief Psychiatrist, the Ombudsman or the Office of the Public Advocate. The reason for that is that they have to rely on government for funding. I know, having worked in some of those places that cover-ups go on. It is about 'We cannot take up this issue because we have just put in a funding application for the Department of Justice and if we upset the government we are not going to get that funding'. So in my view any independent service, whether it is Health Services Commission, or all of those, must be appointed by Parliament, funded by Parliament and report to Parliament on an annual basis.

If you take consumer complaints, for example, they should also have to report the number of complaints that they have received, and the number that were upheld. We also should be gathering data about the number of people who request a service and the number we turn away, because sometimes when we turn

them away they just go and kill themselves. We have got anecdotal evidence of that, but there is no data and hopefully with those things, if they were reported to Parliament, we might have a more parliamentary approach to these matters, rather than a government approach to these matters.

The DEPUTY CHAIR — Isabell, sadly we have run out of time and our next witnesses are here. Thank you very much. Obviously you have a large breadth of knowledge in that area and many years of impassioned commitment, and we thank you for your discussion with us. I just wanted to let you know, again I reiterate, that this is an all-party committee and we do care about this inquiry. We very much want to make recommendations that matter. We will be taking everybody's comments into account. Thank you very much for your time.

Witness withdrew.