

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

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Assoc. Prof. I. Minas, director (affirmed), and

Mr D. Oehm, manager (affirmed), Victorian Transcultural Psychiatry Unit.

The DEPUTY CHAIR — Thank you both for coming. This committee is looking into issues such as the standard range and adequacy of care and accommodation currently available; the appropriateness of the current service providers; how unmet need is managed in Victoria; accessibility and appropriateness of accommodation for rural communities, ethnically diverse communities, indigenous Victorians; and the impact of the current service provision on families and carers.

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

Will you both be making verbal submissions?

Assoc. Prof. MINAS — Yes. I would like to make a brief opening statement, if that is permissible.

The DEPUTY CHAIR — Please go ahead.

Assoc. Prof. MINAS — Thank you. First, I would like to emphasise that supported housing is clearly critically important to the success of all aspects of our mental health service provision in the state. I think the importance of supported accommodation has been made clear in the recently released mental health strategy for the next 10 years and has been repeatedly emphasised as a critical component of our service provision. It is an aspect of service provision that really underpins our capacity to provide community-based care which is of high quality and effective.

The other critically important component, particularly in a period of mental health system reform and change, is access to good-quality information about what kinds of services we are providing, about the quality of those services, about who is getting access and who is not getting access to those services and about the appropriateness of services to the particular needs of people with mental disorders of various kinds.

In preparation for speaking with you this morning we have searched pretty diligently for information about access to supported housing by CALD communities. I think we can say with some confidence that there is no reliable information about this issue. I think it was one of the bases on which we were invited to speak with you this morning, that there seemed to be a gap in data. That perception of a gap in data I think is absolutely accurate.

I would like, if I may, to make some general comments about this issue of information about CALD communities in relation to mental health services in general, which I think is quite important. The lack of information about access to supported housing is no different to the lack of reliable information about very many aspects of mental health service provision to CALD communities. I will give you some examples, if I may. It is particularly people who are not fluent in English who are systematically excluded from research. If you look at research publications and look at the section on methods of sampling where it says 'exclusion criteria', almost invariably one of the exclusion criteria is 'unable to communicate in English'. The reasons for it are clear enough and understandable in that it increases complexity and increases the cost of research to accommodate non-English speakers, but the impact of this very general practice is that what we increasingly know about the general community, we do not know about CALD communities in general and about non-English-speaking members of CALD communities in particular.

Some particularly striking examples of that kind of exclusion are in the national survey of mental health and wellbeing conducted in 1997 by the Australian Bureau of Statistics and repeated in 2007. It did not make any specific attempt to include at least members of some CALD communities to be able to say something reasonable about the prevalence of mental illness, the prevalence of disability, and issues about service use in those communities.

Another example is that mental health services nationally are now required to collect routine systematic data on outcome of treatment for people who are in contact with our public mental health services. Over the five or six or more years that that data has been reported, there has been no report on the outcomes of members of CALD communities because that data is much less often collected, and when it is collected, its reliability is questionable. There are very many other examples of that kind of systematic exclusion from efforts that we make to collect good quality data about what we are doing.

I think it is not unreasonable to say that the consequence of this gap in knowledge, which is widening, although unintentional, is a systematic form of discrimination. If we do not know about the particular issues that affect particular communities, they remain invisible. The particular circumstances of those communities do not enter into the thinking about policy development, about implementation planning, and about evaluation of the quality and effectiveness of what we do. As I say, although it is unintended and although the reasons for it are easily understandable, I think it is a form of continuing structural discrimination.

At the Victorian Transcultural Psychiatry Unit we have now been analysing data on access to public mental health services for some time. Those data demonstrate that very many CALD communities use our public mental health services at very much lower rates than does the general community. So we know that many CALD communities have reduced access to our public mental health services. But even that data is very blunt and crude. The only basis on which we can do those analyses is country of birth.

Let us take the example, then, of somebody who is born in Australia, is admitted into either community-based or inpatient child and adolescent mental health services, but their parents are immigrants or refugees and speak little or no English and have difficulties in communicating. The problems that are then presented to a mental health service do not come up in the kind of data that we are able to analyse because of the crudity of the kinds of variables that are available to us and the lack of systematic data collection of more meaningful variables. The impact of this lack of data is that we then have a poor basis for policy development, we do not have information for appropriate implementation planning, and we do not then evaluate the quality of what we do.

In the journal of VICSERV, which was published just this month, is a brief paper I wrote proposing — —

Mr SCHEFFER — Sorry, what is that journal?

Assoc. Prof. MINAS — It is called *newparadigm*. It is a journal on psychiatric disability services, and the publisher is VICSERV. I put a proposal for a Victorian mental health and cultural diversity task force, and if I may, I would like to leave that with you. The reasons for making that proposal were the ones that I have just said — that we have very little information, and we now have a new 10-year strategy for improving our mental health services. There is a commitment with this 10-year strategy that there should be an all-of-government effort, because it is now clearly acknowledged that issues such as housing, access to employment, access to education and so on are all critically important for the mental health of the community.

The purposes of such a task force would be to remedy some of the deficiencies that are identified in what we know about CALD communities, and to provide better quality information for us to be able to think about policy development more clearly, to plan implementation in a more intelligent way and to evaluate the quality of what we do for all Victorians who have a right to the public services that we provide.

The basis of the proposal is a rights perspective. It goes through the international human rights instruments, that we accept, including issues such as the thinking that is now going on about changing the Victorian mental health legislation as well as new policy developments. That is a preliminary opening statement. In terms of whether we are able to provide information or data about access or quality and so on in terms of supported housing, I am afraid such data does not exist.

The DEPUTY CHAIR — Mr Oehm, would you like to make some comments?

Mr OEHM — I guess I will be reiterating some of the points. One of the first ones is that in looking at what information we would give, the big problem was really a lack of an evidence base. It is something we grapple with in our work, because our role is to build the capacity of the state mental health services and specialist accommodation services to cater for CALD clients. A lot of this is done in some ways on a lack of an evidence base, because the research is not there.

Anecdotally we hear that there is low usage of the accommodation services by CALD clients. What we are not sure of is the extent to which families are picking this up or whether there are barriers to access for CALD clients. Some of the things we hear are that the models are very Anglocentric and based on the individual, less on viewing the collective role and the involvement of families in CALD communities. But we have not got any evidence on models that work. I have recently heard that there may be one place that is doing this, and we are going to have a look at what it is doing.

But we do know from our data that it is across the system. The data that came out of the unit shows that CALD clients are not accessing mental health services at the same level, so that would have some impact on the number then accessing supported accommodation services because that would be often one of the pathways. I would re-emphasise that there does not seem to be the same emphasis on CALD issues now as there was perhaps 10 years or so ago, and that one of the problems that we have in that regard is that these competencies are not mandatory across the services.

Our role is fairly persuasive in trying to push the fact that people need to be able to cater to different cultures, need to have the ability to work in diverse situations and provide flexible services. I guess part of that is systemic; sometimes it is hard to provide that flexibility in the service. But we can certainly say that there is not such an emphasis on the development of flexible community models where we would tend to capture CALD families or clients having difficulties, because they do not always access services for reasons of stigma or language or any other social factors. Their experience with services where they come from may be another reason. But it does appear that there is inadequate use of interpreters, whether sometimes that is simply because people are not using them or because interpreters in those languages do not exist.

The lack of emphasis goes right back to the undergraduate level. The emphasis is not there in undergraduate courses so by the time people become professionals in the field, the idea is not there that developing cultural competence is an issue required in the workplace. Once again it is a persuasive role that we have there.

There is really not much more that I can add except to say that it is the evidence base and it is something that we are hoping to find out more by looking at models that are working, and that will happen through our work with the PDRSS.

The DEPUTY CHAIR — I thank you both very much. We might open it up to questions.

Mr SCHEFFER — I wish to ask a question of Professor Minas just by way of clarification. I would in no way have the expertise to dispute what you are saying about the research but you told us that one of the criteria for excluding the sample is people's capacity to speak English, and that employing interpreters was expensive and so forth. But does that measure in itself mean that the whole of the CALD cohort would be excluded from sampling in that there are clearly a lot of people in the CALD area that would have a sufficient competency in which to be able to communicate some of those issues?

Assoc. Prof. MINAS — You are absolutely right. In those cases where English is not a problem, then those people are not excluded. But the effect of it is that those who do not speak English are more likely to be recent arrivals or who have integrated not as well into the community for a variety of reasons, or who may be refugees and so on. So in a way they are likely to be among the most vulnerable end of the community, the part of the CALD communities that we really need to make an effort to learn more about to be able to respond more effectively to.

But you are absolutely right. Where English is not an issue, of course people are not excluded on the basis of country of birth.

Mr SCHEFFER — But even though they are included, their value would only be tapped if the right questions were asked. Could you comment on that?

Assoc. Prof. MINAS — That is true, and very often the right questions are not asked. It depends on the particular purposes of any specific study but very often there is no emphasis on the issue of either cultural background or country of birth, or experience prior to arrival or settlement experience and the impact that that might have and so on. In any case the conclusions that can be drawn will be applicable only to those sections of that particular community that are able to participate — often sections of the community that have been here longer or are in a different place in the socioeconomic scale and so on.

The point that I make is that although all of these studies are presented, for example the national survey, as telling us about the Australian population, that they are representative of the Australian population, there is a minority of the population that is not represented in those studies. Very often that is the portion of the Australian population that is most vulnerable or less likely to use services or whatever the issue is, and we simply do not know about those groups. The studies that are done with those groups that specifically focus on refugees or a particular CALD community are often very small scale studies so what we can learn from those is rather limited.

Mr SCHEFFER — Just one more follow-up question: you said also that there has been a decline in public policy attention on those issues, over the last decade or so I think you said. How do you account for that? How do we put it back on the agenda?

Assoc. Prof. MINAS — Daryl said that he thought there was a public policy decline. I agree with this. But I think that part of the reason for that is that our mental health services throughout the country have been under enormous pressure. From some of the work that we have done on looking at access, the demand on our public mental health services has grown enormously.

From our figures, if you look at the number of people who are in contact with Victorian public mental health services — and this was in 2005 compared with about 9 or 10 years before — it had grown to about 1.6 times the number of people who were in contact almost 10 years before. But no part of the services, whether it is number of staff employed or capacity to respond, had grown by that same amount.

We know that our public mental health services are under enormous pressure. Some of that increase in demand, although I do not have evidence for this, is actually a product of some of our successes — that is, we have been able to reduce stigma, we have been able to improve community awareness of mental illness and of availability of effective mental health services with organisations such as beyondblue and a whole range of other activities.

So we have been able to stimulate demand, if you like, for the services but have not been able to keep up with supply, in terms of response. We have seen some of the consequences of that in the Senate report on mental health and illness, in the *Not for Service* report that was published by the Mental Health Council of Australia, and so on. So I think some of those increasing pressures have pushed other issues like culturally appropriate response a bit more to the margin because services are struggling with dealing with even the most basic capacity to respond. I do not think that it is any lack of will or even of goodwill on the part of either clinicians, services or government. I think that the pressures have really been growing quite quickly in recent times.

The DEPUTY CHAIR — I would like to ask a question about refugees. Obviously there has been an increase in refugees coming into Victoria, and their needs are probably more specific. They have come from war-torn countries, and they have issues of trauma, torture and trauma. Is the clinical assistance available for their needs, given that it is obviously an increasing need, and that it is not something we have had before — people coming into the state with absolutely special needs? Are they falling through the gaps?

Assoc. Prof. MINAS — I think we have probably the best service anywhere in the world — Foundation House. The Foundation for the Survivors of Torture I think is the best service anywhere if you look at the UK, the US and the European countries with large numbers of refugees. I think what is striking

though if you look at the Foundation House services is that they are dealing with an increasingly long waiting list. They are not a clinical mental health service so they need to work in conjunction with specialist mental health services — and they do that very well.

Although I think we have made in Victoria a very particular effort to respond to the needs of refugees, and that effort has been very successful in so far as it goes, if you look at the waiting list and the capacity of an organisation like Foundation House, it is also clear that it is only people with the most urgent, the most severe issues who are getting access to those services, and there are very many others who are either waiting or are not getting onto the waiting list at all.

The DEPUTY CHAIR — Can I just follow up very briefly? You were saying that some people who have a bad experience of a service may not use these services again. Is that anecdotal or do those people have somewhere that they can go to make their complaint? Or do they just get lost to the system and not use the services again?

Mr OEHM — When I said that, I was referring to services in the country that they come from, not the services here.

The DEPUTY CHAIR — And I guess that is the same with refugees? They are fearful of authority and being out there, so they probably would not use the service if it was not friendly to them?

Mr OEHM — Yes.

The DEPUTY CHAIR — You are talking about the bad experiences they have in the countries — —

Mr OEHM — That they have had in their home countries, yes.

The DEPUTY CHAIR — So they do not want to use the services when they come here?

Assoc. Prof. MINAS — But it is important to say that very many members of CALD communities will not be aware of the kinds of complaints mechanisms and opportunities that are available to them and are most likely to vote with their feet. It is anecdotal. We do not have clear evidence about this, but if people have a bad experience, they are likely to stay away and use some other kind of avenue of dealing with their problems. I do not know off the top of my head whether the health services commissioner or other complaint avenues that are available provide data of what proportion of complaints come from members of CALD communities in relation to services.

Mr NOONAN — Thanks for your presentations. You almost paint a picture of supported accommodation for people with mental illness not being seen and dealt with in isolation. The challenge for this committee is that we have got terms that require us to look at the provision of supported accommodation in isolation. I wonder, given your experience and expertise, what recommendations you would give to this committee in having to assess the issue of supported accommodation without disconnecting it, I suppose, from the clinical environment and other out-services? I think that is an important question which we have not yet grappled with.

Mr OEHM — My experience, as you could guess, is that a lot of people with psychiatric disabilities have a lot of needs in accommodation services which it is very difficult for those services to provide for without strong support from some of the mental health or clinical services. Problems often arise, and they settle quickly, but it is often done in close liaison with a mental health service. Of course this depends on the issues for a particular client, but there is a need for close links between the two arms of the service to cater for those clients, because it is a lot to expect people who are not necessarily professionally trained in this field to be able to deal with all the complex issues that arise.

As you mentioned on the question of trauma, all of the services are grappling now with the increased diversity of the community and the increased needs they have to cater to. There are a whole lot of new cultures, and people coming from war-torn countries and environmental disasters have a lot of special

needs. I think it would be very difficult to de-link them. It would leave the supported accommodation services out on a limb without the back-up of the mental health services.

Assoc. Prof. MINAS — Can I add to that? I think it is important too that in the mental health arena the kind of course of mental health problems can be very variable, unlike a situation where somebody might have a physical disability which is gradually increasing in severity, where it is relatively predictable what the course is going to be. Somebody who is in a special accommodation service may very quickly, as Daryl has said, require acute clinical care, and when that is resolved can come back into the special accommodation service. It is a very dynamic kind of situation in relation to special accommodation services for people with mental health problems.

The other issue is that the impact of mental illness is of course very broad, on members of the family and on staff working in those special accommodation services, so a very close link between clinical services, psychiatric disability support services and housing or special accommodation services is absolutely essential.

Mr NOONAN — Given your response to this and your opportunity to assess the mental health strategy which is a longer term strategy, how would you rate the strategy based on the terms that we need to look at and whether or not the government has got the mix right in terms of the way you are describing it?

Assoc. Prof. MINAS — Whether the mix is right will not be clear until the implementation planning is done. The strategy at the moment, like all policy, is a statement of intent. We do not know yet how much in the way of resources is going to be allocated to the different components of the strategy, and I think it is at that point that some judgements can be made about whether the mix is right or not, but at the level of a policy statement, my own opinion is that the strategy is absolutely right.

It recognises the social and cultural dimensions of providing mental health services, it recognises the importance of early intervention and those different components of early intervention early in life, early in the course of an episode, early in illness, and so on. It recognises the need for linking the different elements of the service matrix much better than has been the case before. But I think most importantly it also recognises the need for consumers, carers, community organisations to be centrally involved in the continuing thinking about the further development of the strategy and also the implementation planning.

The problem that we come across there is again the same. As that implementation is unrolled, what we will find is that, probably unless we make some specific efforts to change, the situation is what we have now, and that is, where involvement of consumers and carers is now recognised as not an option, it is just absolutely essential, we cannot proceed with out it. But if you look at how many members of CALD communities are on advisory committees or management committees of service delivery agencies or are involved in consultations in a systematic fashion — they are almost non-existent. Again, the gap continues to widen.

We have done a terrific job in terms of engaging in a respectful way with consumers and clients where it is no longer a matter of consultation, it is joint decision-making, but representatives of CALD communities are absent from many of those areas. That will have an impact on the shape of the implementation planning.

The DEPUTY CHAIR — Thank you both very much. You will receive a copy of the transcript of your evidence and you will be able to make any minor changes to that. Again, thank you for your evidence this morning.

Witnesses withdrew.