

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Subcommittee

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

Mildura — 6 November 2008

Members

Mr J. Perera

Mr W. Noonan

Mrs E. J. Powell

Mr J. Scheffer

Ms M. Wooldridge

Chair: Mr J. Perera

Staff

Research Officer: Dr T. Caulfield

Witnesses

Ms C. Murphy, manager,

Mr B. Janson, community support worker,

Ms D. McManus, team leader, Home Based Outreach, and

Ms L. Parente, community support worker, Murray Mallee Community Mental Health Services; and

Mr D. Kirby, director, clinical mental health, Mildura Base Hospital.

The CHAIR — I declare open the public hearing of the Family and Community Development Committee's inquiry into the provision of supported accommodation for Victorians with a disability or mental illness. The committee is looking into issues such as the standard, range and adequacy of care in accommodation currently available; the appropriateness of the current service providers; how unmet need is managed in Victoria; the accessibility and appropriateness of accommodation for rural communities, ethnically diverse communities, indigenous Victorians; and the impact of the current service provision on families and carers. The committee is an all-party investigatory committee of the Victorian Parliament and is due to report to the Parliament by 30 June 2009, after which the government has up to six months to reply to the committee's report and recommendations.

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

Before starting the proceedings, I also announce that the committee advertised today's hearing in the local press. We invited local people to register for the comments-from-the-floor session, which is where the listed participants have the opportunity to address the committee for about 5 minutes on issues relevant to the terms of reference and committee members may then ask questions for about 5 minutes. We have some spare spots in our comments-from-the-floor session scheduled to start at midday. If members of the public gallery would like to participate, please see the Assistant Clerk Committees, Bridget, by 11.45 a.m. in order to be listed.

I ask witnesses to introduce themselves for the transcript, give a brief description of the organisation they represent and make their verbal submission.

Mr JANSON — I am a home-based community support worker for Murray Mallee Community Mental Health Services, which is a branch of Mallee Family Care. I will introduce the representatives of this organisation who are at the table: Cath Murphy, manager, Murray Mallee Community Mental Health Services; David Kirby, director, clinical mental health, Mildura Base Hospital, Ramsay Health Care; Deb McManus, team leader, Home Based Outreach and intensive Home Based Outreach support; also Laura Parente, community support worker previously employed in Melbourne. For an introduction of Murray Mallee Community Mental Health Services, I hand over to Cath Murphy.

Ms MURPHY — Murray Mallee Community Mental Health Services is a psychiatric disability rehabilitation support service for people aged 16 to 64, and also incorporates an older persons integration program for people over the age of 65. In addition to these services we also have limited carer support and respite services available. The service is primarily a DHS-funded service and sits within the larger organisation of Mallee Family Care — a non-government, not-for-profit organisation.

Our service model is a psychosocial rehabilitation model which is about increasing people's skills to ensure that they have the same opportunities as those who live without mental illness. Our service operates a psychosocial day program where socialisation is the major focus. In addition, the service provides home-based outreach support for persons recovering from a mental illness. The home-based outreach support model is funded for 4 hours per participant per week or 8 hours per week per participant, depending on whether home-based or intensive home-based support is required. Neither model is really adequate given the often complex, high needs of persons being discharged from clinical services.

Our model is focused on being client centred, and works hard to ensure that the needs of the participants are being met, rather than the participant fulfilling the service sector requirements.

This comes at a cost. Our service works closely with many services to ensure that the outcomes for our participants are optimal, thus enhancing rehabilitation and recovery. Such services include clinical services and various primary health care, welfare, pre-vocational and vocational support services.

In terms of housing, when we think of supported accommodation, our reference is only to a transitional housing model known locally as Degaris and also the pathways program. This is a program that aims to achieve no discharge to homelessness upon discharge from clinical inpatient unit. Although additional hours of support are dedicated to this program, neither of these accommodation options provides 24/7 support. Reliance is heavily made upon sporadic visits from the CAT team given their enormous work loads, and visits from the PDRSS service during work hours from Monday to Friday. For many participants of these programs such arrangements are not suitable, despite the often creative ways in which staff of the northern and southern Mallee manage their time and resources.

As recently as last week our service had visits from local residents in the community who are concerned about persons in these housing arrangements. They are concerned for the unwell person being put in a vulnerable position with no 24-hour support and they have much concern for their own safety and wellbeing in having people in the community living without such support. Despite doing what we can to avert further incidences, the issue remains the same; persons with such vulnerability are being left in the community with minimal supports, and this sabotages their capacity to rehabilitate and recover successfully from their mental illness. I now hand over to Barrie to provide the orientation of our report.

Mr JANSON — I point out that the running sheet I have provided contains corresponding page numbers for the report that is also in front of you.

From the outset, we have to make it clear that there is no supported accommodation facility here in the electorate of Mildura or Swan Hill for those with a psychiatric disability. We do not have a PARC, a MIND or a CCU. To paraphrase that: we do not have a step-up, step-down from a hospital facility; we do not have an adolescent psychiatric accommodation facility; and we do not have community care units specifically designed for those who have a psychiatric disability. The only model employed here for these people, and in the electorate of Swan Hill, is one of sourcing accommodation independently and then inserting home-based supports into this situation. This model can be highly successful.

If you look at the consumers MK and MC in the report, you will see long-term sufferers of mental illness who are presently stabilised and functioning very well within the community. Closer examination of these individuals, however, will reveal the mass of supports needed to reach this outcome, and an unacceptable time frame taken.

To gain a greater understanding of the situation in Mildura it is important to look at us demographically. As you can see on page 7, geographically we are an isolated regional centre. Mildura Base Hospital services individuals up to 250 kilometres away. In travel time that is 5 hours by car there and back.

Some quick statistics: Mildura has a population of 55 000 people; 5500 of these people will have a mental health diagnosis; 13 000 of these individuals will battle some sort of mental illness in their lifetime. If we include the Swan Hill electorate, that is 100 000 people, or at least 10 700 people with long-term medical and behavioural problems. We have 12 hospital beds in the psychiatric ward.

Our unemployment is above the national average, our average income is below the national average, and our main industry is reliant on irrigation. In fact, 69 per cent of our residents have a low family income, and that is evident in the social indicators report supplied by the Mildura Rural City Council. Of interesting note, you will see that the readmission rate is higher than that of

the rest of the state, and our voluntary patient admission is at 50 per cent in our psychiatric ward. The statewide average on voluntary patients is 30 per cent.

These stats are a direct result of the lack of supported accommodation for those with a psychiatric disability. An expansion of the demographic is available in the report, and I urge you to read the social indicators report also. In the present model available to us accommodation is sourced wherever possible. Both our pathways program and Degaris sign the individual into an independent rental agreement. Accommodation may also be through the Office of Housing, private rental or wherever the services can find it.

Supports in place for the individual will be hospital case management for clinical support, which is a team managed by David Kirby and PDRSS Home Based Outreach and Intensive Home Based Outreach, a team managed by Deb McManus. Our Home Based Outreach and Intensive Home Based Outreach work well if a person has a certain degree of stability.

Let us really think about what this means. I am a community home-based outreach support worker in this team. I have a case load of six people; each of them has a total of 4 hours funding allocated to them per week, and that includes administration. Intensive Home Based Outreach support may bring this up to a total of 8 hours including administration.

Then we have David Kirby. You may be able to add on a possible 4 hours from clinical case management supports. This is solely in regards to a person's medical treatment.

We also have Paul Hogarth, another team member at Murray Mallee Community Mental Health Services. If a person is recovering well enough they may be able to access psychosocial supports Monday to Friday 9.00 a.m. to 4.00 p.m., bringing up their level of contact. And that is it. Let me reiterate, this system works well when a person has a certain level of stability.

Swan Hill is in the same boat and operating under the same system. For those who are unaware, our PDRSS has a branch in Swan Hill and are a part of Murray Mallee Community Mental Health Services. If anything, their situation is a little dire in regards to the fact that they do not even have a psychiatric ward in their hospital. If a person is admitted to hospital, they then go into the general ward, or they get dislocated to Bendigo. Their hospital case management team is understaffed, and let us face it, with no real salary incentives to dislocate to this remote regional community, which staff member is going to go there from the city?

Swan Hill is too busy trying to address basic needs in its clinical system so that it can only dream of a supported accommodation facility. It comes back to rural and regional centres being underfunded and understaffed. We all want a \$2.4 million facility but if it came down to anything, the first thing we would ask for is more staff members working on the ground.

That gets us straight to the problem. There is nothing wrong with the current mode of operation in itself. We have many stabilised and high functioning citizens with a psychiatric disability in this model. The problem is in the gaps in key service delivery and the fact that the present model is picking up the workload from these gaps. The current system is designed for a person who is stabilised and does not need additional hours on top of the 8 hours described above. The problem arises when a person becomes unstable.

I am not here to describe the nature of mental illness, but if we take for example a person with bipolar, who suffers from a cycle of manic, depressive and stable states, then we can see where lapses in service delivery are highlighted. There are two choices for a person becoming unwell: they can either be admitted into hospital or remain in the community. People with insight into their illness explain why we have such a high voluntary readmission rate. If a person remains in the community, this then places extreme pressure on the community organisations that must bear the brunt of this person's state.

There is a third option, an option which is used only as a last resort. If a person does need that extreme 12-plus hours of support per day, then a CCU may be used in Bendigo or elsewhere. I do not need to explain the problems that arise with such a dislocation. There is no emergency care available except for the hospital. If you read the case studies, you will see a 24-year-old female consumer whose primary carer was hospitalised into ED at 6:30 a.m. Despite many attempts no solution was found by the services involved that day. A PARC with an emergency bed would have suited this individual.

Looking at the statistics, you can see that our revolving door is spinning at an alarming rate. Readmission rates are up and length of stay is down. This is quite simply because there is no alternative. Our hospital system is good; we are lucky to have it. But it is another example of a service weighed down by taking the load from the gaps in our service delivery. The hospital system is for people who are acutely unwell. A person who needs observation while undergoing a change to medication or who is stabilised but homeless or who is becoming unwell and volunteering for a medication change does not need to be in hospital.

In terms of the solution, the ideal answer is to build a PARC, a MIND and a CCU. If you look at these case studies at the end of the report, you will see that the 24-year-old female would have functioned very well in a MIND unit while her carer was in hospital. The 50-year-old male would make full use of a CCU in times of psychosis, and the 24-year-old male would spend time in a PARC while his carer was assessed. It is a given that each of these consumers will be using valuable tax dollars in the foreseeable future. If only the answer was that easy. We do not need large facilities; we need smaller satellite facilities picking up the complex needs of our community. But whatever the service delivery is, it has to be flexible and individually located.

Examining the individual submissions in the report you will see common themes. Everyone would have benefited from a supported accommodation facility. Everybody wants the situation to change. We are all tired. We can all see clear ways to improve, but I guess I have to be realistic. We need Mildura and Swan Hill to be on the radar. The mere fact that this inquiry was meant to be about supported accommodation when it does not exist here shows how far we have fallen. We need to be taken seriously. We need to be treated the same as any other electorate, and we deserve to have the right to the same services as anywhere else. Our statistics should be on par with the rest of the state. Until that is a fact, Mildura and Swan Hill's applications for facilities should be at the top of the pile, Mildura's applications for further funding should be at the top of the pile. We are not asking you to think for us, we are asking you to take us seriously, listen to our voices, trust us, and then let our applications through.

The positives of the current approach are the relationships between clinical and non-clinical services. These have to be utilised. We are an isolated regional and rural community that has many burdens at this present time and we need to be taken seriously. Please, hear our voices, remember Mildura's psychiatric system when you are back in Melbourne and make sure everybody knows the situation here. Thank you.

The CHAIR — Does anybody else want to make a comment?

Mr KIRBY — I will tell you a little bit about clinical mental health services and what I can speak on for that. My title is the director of mental health services at Mildura Base Hospital, which is responsible for the Northern Mallee Area Mental Health Service. It is one of 22 area mental health services in the state and it provides, in its own way, exactly the same service as every other area mental health service in the state.

Just to expand a little bit on some of the points that Barrie was making, the only accommodation options that we have access to as an area mental health service is our inpatient unit. In that we have got 12 beds, 10 of which are adult and two of which are funded for aged persons. Our catchment area extends over 25 000 square kilometres and 70 000 people. We have also got cross-border arrangements with New South Wales, with the next available inpatient units or beds

being in the Broken Hill hospital, which are not psych specific. From there, the next closest facility is Orange. We take people from as far away as Balranald, which is about 200 kilometres along the border. In addition to our 25 000 square kilometres, we then also take in quite a large population in New South Wales as well — trying to fit all those people into 10 inpatient beds. As Barrie was saying, the options from there for any type of supported accommodation are non-existent. It puts us in a very, very difficult situation.

In terms of our isolation, although we have access to statewide beds, we are also required at times of emergency to take child and adolescent admissions. We have access to beds at the Austin Hospital, but again, there is the dislocation between a child and their family — or a lot of the time the unit will insist that the family accompany the child to Melbourne, which is financially difficult for the parents on top of all the emotional upheaval of having a child admitted to a psychiatric unit away from their environment. Then the handover from the metropolitan units and services back to the rural services is always problematic because the case managers are not involved in their care whilst they are an inpatient. We simply do not have the flexibility to put the kids somewhere else.

We basically run a cradle-to-grave service from within our inpatient unit. It does not make for a good therapeutic environment for anybody who has got to be in that unit. We do admit approximately 50 per cent voluntary patients, which compares to 70 to 80 per cent of involuntary patients in other units throughout the state. Again, that is a consequence of not having any alternative. If you are looking at somebody who is voluntarily agreeing to treatment in a mental health service, that is it — they have got the inpatient unit and no other option. They may be in there with people who are being secluded, who are in high-dependency areas, who are extremely unwell. It is not a good introduction to mental health services, and not the way that the Mental Health Act was intended to be used. The underlying principle of the Mental Health Act is to try to treat people in the least restrictive environment. We simply cannot do that because we only have one option.

Other options that we have available to us are through Bendigo, as Barrie was saying. If we have somebody who requires a longer-term accommodation and rehabilitation option which is staffed 24/7, they are currently required to go to Bendigo. I have been in Mildura six-and-a-half-years and we have successfully been able to admit one person to the CCU in Bendigo, and I believe in the last 10 years we have been able to admit two people to the Bendigo CCU. It is not so much through a lack of trying but simply through a lack of availability of their beds. They have got their own inpatient unit sitting there with its patients, so they would probably see them as a priority. I should not speak on behalf of the Bendigo psychiatric services, but of course if they have got an inpatient unit there, they will be directly discharging them to a CCU. That is the type of situation we are in. On top of that, we do not want that type of dislocation of families that occurs if we have to send someone 450 kilometres away. We are better off going to Melbourne in a lot of respects because of flight availability. It is much easier for people to get to Melbourne now rather than Bendigo because of that isolation.

Unfortunately we have got a high readmission rate compared to the state average. The health services agreements are 14 per cent. We are up to 16 per cent readmission rates to our inpatient unit and we do have a lower length of stay than any inpatient unit. That is also because of the number of voluntary patients that we have in there. It is always that balancing act between keeping people in until they are well enough to be discharged home or you are looking at a higher readmission rate, and that is what we are up against at the moment. We would still not clinically discharge somebody if we thought they would be a risk to themselves or others in the community but because of that bed pressure that we have we probably speed up that process more than we would like to.

What else was I going to say? The types of accommodation that we are then discharging people to are always less than what we would like. The pathways program that we have working with the PDRSS is one alternative for people who are homeless or at risk of homelessness. Other than that, we are looking at people going to hostels, caravan parks or whatever might become available to

us. There is one particular place in town which seems to attract a lot of itinerant people. There are generally vacancies there, which is a good thing but you can imagine the reasons behind there always being vacancies. It attracts people who are itinerant, perhaps aggressive, who have mental health problems already, and so we have to expose our vulnerable patients to that environment, as I say, if not to a caravan park. You could not really think of a more isolating situation than to send somebody who has a mental illness to a caravan park, because the mental illness in itself creates that isolation for a person.

We have to send our staff out. Our CAT team will do three-times-a-day visits to try to support people in the community. But we are also sending people after hours into vulnerable situations. Again, we only have two staff on in the evening and at times we will have a single staff member going out to different environments. There can be drugs, alcohol on the premises and they do not know what sort of situation they are walking into as well. That is a huge concern for us.

The PARC-type model would be an ideal situation for us as a clinical mental health service in that we could look at prevention as well as recovery and rehabilitation for our clients. We have anywhere between 350 and 400 admissions to the inpatient unit a year. As I say, it is not the best place for recovery and rehabilitation.

The other factor I have just noticed on running sheet is the drug and alcohol rehabilitation. We do not have any withdrawal units in the area. We do admit people who require withdrawal from drugs and alcohol to the general hospital but because of their acuity, and numbers of patients through the door, they have difficulty accessing beds there as well. Quite often by default the person gets to a stage where they become so frustrated that they can often come to the attention of the mental health services. By default we are doing drug and alcohol withdrawals on the ward — as long as you do not tell my regional DHS people that.

Ms WOOLDRIDGE — It is recorded.

Mr KIRBY — But quite simply we have to. We have to provide that flexibility within our services to look after the people in this area. I think they were all the points that I wanted to make.

The CHAIR — Thank you.

Ms WOOLDRIDGE — I would like to ask about the implications for the CAT team, and you have touched a little bit on that. My observation is the CAT team is under pressure, especially overnight. Mostly overnight they are operating out of the hospital — is that what the CAT team is doing here? So actually they are not able or it is very difficult for them to be able to leave. It is usually a ‘Come into the hospital and we will deal with you here’ sort of model, given that you have no other alternatives on discharge. Your CAT team is then under more pressure than what we are seeing in an already pressurised system across the state. Could you comment a bit more about the reliance on them, and whether they are equipped to be able to do it?

Mr KIRBY — They are equipped to do it, and I think they do a wonderful job. However, because of the lack of the 24/7 support, at best it is only going to be a half-hour visit three times a day. That is as far as we will go, and most CAT teams will not do that. We will go out to support them three times a day because we have the PDRSS there to support us. But we have trouble recruiting to clinical services anyway because we only have a limited pool in the area. After hours we have only two people on an afternoon shift and quite often one will be doing an assessment. From 10 o’clock at night until 8 o’clock in the morning we work on an on-call recall system. Basically that is where the person is at home in bed and if they are required to come and to see somebody they will be rung at home and brought back into the hospital to do that assessment.

Mr JANSON — That includes weekends as well — Saturday and Sunday.

Mr KIRBY — We have one person on Saturday and Sunday, morning and afternoon.

Ms WOOLDRIDGE — You really have a staffed 8-to-10 service and on-call after hours?

Mr KIRBY — Correct. They will do the additional visits if someone can be treated at home, because we still look at the least restrictive environment. We quite often have to do that.

Mr NOONAN — I wanted to thank you for your submission. It is very comprehensive and given time I will have an opportunity to work through it. Thank you for this as well. Part of the issue for a committee like ours is to try to find some solutions because we very much get a snapshot about the challenges in terms of our hearings. One of the things you pointed out are the positives that are associated with the current approach in terms of your relationship between clinical and non-clinical services. I just wonder whether you can expand on that, because that might be something that is less well evolved in a metropolitan environment in a place like Melbourne as opposed to a regional area.

Ms MURPHY — I guess we have the advantage of making the most of our isolation and in that we work very closely with clinical services. We have always done that but that has been recently formalised I guess through the alliances that are all over the state of Victoria. That is looking at policy and practice issues in bringing services closer together to achieve those optimum outcomes for our consumers.

Mr NOONAN — Can you bring that to life a little — the alliance locally in terms of how that works in a very practical sense?

Ms MURPHY — We will sit down and we will look at intake procedures. We will look at the pathways for each of those services and try to make them as seamless as possible. A lot of our work around the seamless service entry I guess has also been linked into the dual diagnosis initiative, which has been a program for about the last six years in the state of Victoria. That has certainly enhanced the bringing together of our services, not only between clinical and non-clinical in terms of PDRSS and the hospital, but also throughout our community health service centre that has the drug and alcohol service. So you have three key players that are very keen to make the entry points and the experience of receiving service as seamless as possible.

Mr KIRBY — To add to that, the council has commenced a community engagement framework; that came about after the original *Mildura Social Indicators* report came out in 2006. From that there is the governance level of the community engagement framework, and from that there came five operational groups and one of those was the mental health operations group. The original specific idea of that group was to try to reduce the number of psychiatric hospital admissions, and sitting on that group is the PDRSS clinical medical health services, Sunraysia community health, the Mildura Aboriginal Cooperative, New South Wales mental health services and Robinvale mental health services.

The key thing that we were looking at originally was how to prevent the number of psychiatric hospital admissions, which as we have seen from the social indicators report is roughly double that of the state. We have actually got a mapping exercise under way at the moment to try and identify some other gaps, but the lack of supported accommodation in the area was just a void that was too big to be ignored. We are putting together a submission as well to the mental health branch regarding a PARC-type model. It was just too big a gap to avoid. We are working together really well in that structure as well. We have got the support of all those key members as well as the local council, which is a fantastic platform to push any initiatives through.

Ms MURPHY — Just to highlight the united front that the alliance has evolved with is the fact that the director of the PDRSS service and the director of mental health services clinical meet together on a fortnightly basis, and I do not think that would happen anywhere else in Victoria. We are on top of the issues that are occurring and we work very hard and diligently to address those.

Mr JANSON — Being a regional centre, we try and have partnerships and relationships with any organisation in the community that will be involved with a person who has a psychiatric disability. These partnerships will extend through the other organisations that you will see before you today. We also try and include things such as education facilities. We have recognised that an important part of the solution would be appropriate mental health training for any members of the community who deal with a person with a psychiatric disability. This could be done through making sure that mental health first aid is provided for anybody and any organisation out there that may deal with these consumers. I believe we are also looking for a certificate IV in mental health work to be widely encouraged through everything from Centrelink, TAFE workers, and the other residential agencies. They need to have a person on the floor who is trained in dealing with psychiatric disabilities.

Ms WOOLDRIDGE — Barrie, you talk about staff. You actually say, ‘While we need lots of facilities, we actually need staff desperately’. You have not gone into that and I wonder whether you guys could elaborate a bit on the challenges you have with staff in terms of attracting and retaining them. What are the issues specific to this community?

Ms MURPHY — I guess with a PDRSS model, we certainly have more flexibility in terms of who it is that we employ. Certainly the baseline would be a certificate IV or a diploma in a health and welfare-type orientation or an allied health degree such as social work or psychology. But we certainly have more flexibility because from that point of view we are not under the Mental Health Act, whereas the hospital has to employ disciplines that are named under the Mental Health Act. I guess what we are doing in terms of trying to bolster the community and have more staff trained is bringing courses such as certificate IV in mental health work up to Mildura next year to increase our workforce in the PDRSS situation, and to include, as Barry said, other services to make staff more mental health-competent in their delivery of services and more aware of the issues that impact on people with mental health issues.

Mr KIRBY — We have got a range of different initiatives that we use to try and attract staff. There is the Bringing Nurses Back into the Workforce program. We also have spotter fees for other staff. There is a \$500 spotter’s fee if you can actually attract somebody and they stay for six months. It is desperate.

Ms WOOLDRIDGE — Have you got vacancies now?

Mr KIRBY — Yes.

Ms WOOLDRIDGE — How many vacancies across how many positions?

Mr KIRBY — I have got about 50 EFT at the moment. I would say I have got about eight vacancies. I have more trouble recruiting to specialist areas like aged persons mental health services and child and adolescent mental health services, rather than new generic, adult-type CAT teams and case management services. I have trouble with the inpatient unit as well. People in metropolitan services can quit and not leave their home and they can go and work in a different service, whereas here it is a complete change from Melbourne to come to Mildura. It involves upheaval of children, finding accommodation. It is a whole package that has to go along with that. To try and find more experienced staff to come here is very difficult, and our workforce is mainly made up of the less experienced staff or staff who have been there for many years.

The CHAIR — Do you know that a lot of TAFE colleges in the city and other schools offer community welfare courses, and a lot of overseas students are studying community welfare? There are a lot of overseas students because that is one way to get permanent residency here. In the next two, three or four years, there will be a lot of community welfare diploma-holders coming out of those places looking for work in country and regional areas as well. It does not matter for them where they settle.

Ms MURPHY — That is right.

Mr KIRBY — Also, the other educational opportunities up here have been quite limited. I know for nursing courses, there has only just in the last five years been an undergraduate nursing course run in Mildura and that was through Latrobe and Monash, and I think Monash has just folded its course due to lack of numbers and the expense of running the course in Mildura. That is a pool of staff that we have not got or we have not had, but we are starting to get a few people through that area.

Ms MURPHY — We do have the social work course through Latrobe University at our local campus here, and whilst that is a very good and notable course the barrier to people choosing Latrobe over a distance education is the fact that Latrobe does not do RPLs — they do not do recognition of prior learning — so they would not look at somebody's diploma of community welfare and therefore advance somebody through the course. You have to start from scratch. That is quite a barrier, and it is something that our director of Mallee Family Care is addressing with Latrobe at the moment.

The CHAIR — You mention in your submission that the Mildura population is 55 000 and 5500 of these people have mental health diagnoses. That is a huge number. There are 5500 patients around.

Mr JANSON — If you look at the statistic that is taken from — it has a page reference to the report — you will see that is actually people with a chronic psychiatric or behavioural diagnosis. Chronic is long-term, and that is at 10.7 per cent. That is a population statistic. It is not adapted to our rural and regional isolation. It does not take into account our socioeconomic circumstances, it does not take into account financial status or our unemployment status or even our drought status.

The CHAIR — Where are they? Are they living with the families at the moment?

Mr JANSON — The weight is on the carers right now. Essentially the system is surviving because of the wonderful work done by the carers. Carers are providing 100-plus hours of support to their loved ones, and that is essentially what is holding this system up in regards to supported accommodation. It is unacceptable but that is how the system is.

The CHAIR — How many of these 5500 should be accommodated in a CCU or other supported residential unit?

Ms MURPHY — I guess that is showing the potential terms of numbers blowing out. Those numbers are showing the potential in terms of the crisis that we are facing. It is always about a case-by-case scenario.

Mr JANSON — As a PDRSS, I think we have 170 participants. A bulk of them would be surviving through carer support, but if you looked at them individually, you would probably find that most of them would have benefited from supported accommodation, either as a step-up or step-down from hospital or an alternative to hospitalisation. As part of our service, a person does need a primary diagnosis to become a participant, and a person is usually couched through the hospital system.

Mr KIRBY — We generally have about 400 registered clients with our service at any one time and, as I said earlier, anywhere between 350 to 400 inpatient admissions. That is on the pointy end of things of people actually requiring inpatient admission. But at any one time, it is 400 people. There are always people being discharged and new people being admitted to the service as well.

The CHAIR — Have you raised this lack of facilities here before with the Victorian Disability Advisory Council or any other organisation?

Mr KIRBY — Not in my time.

Mr JANSON — We have done applications for things. I guess it would have been stressed in that.

Mr KIRBY — I have been sitting in this role for about 12 months, and it has not.

Ms WOOLDRIDGE — And you have not applied for the PARC yet? That PARC application is just going in, is it?

Ms MURPHY — Yes.

Mr JANSON — Part of being a rural and regional community is that we are a close-knit community. We do know our own people and we do tend to try to help ourselves rather than reach out, which is also a bit of a problem in the community.

Mr KIRBY — I know we are running out of time, but the other thing that I think it is important to bring up is the indigenous community here. The statistics that we get through the bureau of statistics indicate that there are about 1200 indigenous people living within the Mildura Rural City Council, whereas I know the Aboriginal co-op here in town has got around 5000 people registered. We all know the difficulties that we have had in trying to get accurate statistics on indigenous people, but when you look at that, about 10 per cent of the population in the area is from an indigenous background. That would also be indicative of the business that we do as well — about 10 per cent of our businesses is Aboriginal indigenous people coming to mental health services. They are also a group that has very limited housing and supported accommodation options in the area.

Mr JANSON — In regards to the report we do have a good relationship with the Mildura Aboriginal co-op. When contacted in regards to the report I was informed that they presently did not have an indigenous mental health worker for me to negotiate with and get a report from.

Ms WOOLDRIDGE — Could I just ask on that point — obviously once again you are back to the mental health acute beds — do you see different needs for indigenous people with a mental illness, or can that be supported through the broader system?

Mr KIRBY — We employ an Aboriginal. We have an Aboriginal health unit at the hospital — so it is 3 FTE, and one specifically for mental health services. We try to make the area as indigenous friendly as we possibly can, but there must be a better alternative than mainstream mental health and a public hospital for admissions. We put our staff through cultural awareness training. Whenever there is an Aboriginal person, the Aboriginal health unit is notified. It is up to the individual whether or not they want that involvement.

We have good links with the Mildura Aboriginal co-op. It has certainly identified that the Aboriginal community has specific needs that could only be serviced by them. So we either have them going to the Aboriginal co-op or to mainstream mental health services. But I think there is a large population out there that is very reluctant to come to mainstream mental health services. We are looking at tightening up some memorandums of understandings between ourselves and the Aboriginal co-op and see how we can better service that community. I know there is a lot of work going on in Robinvale at the moment as well, due to a number of recent tragedies there, about how we can better provide care for the Aboriginal community. A number of community consultations have said that the service that we provide has not been meeting the needs. That is aside from the accommodation aspect. We still have a lot of work to do.

Mr JANSON — Culturally, a lot of indigenous people tend not to access the clinical services or what is just termed a 'white system'. That is being addressed. Also while we are pointing this out, I would also like to point out that we do have a very large community of immigrants here in Mildura as well. This immigration community is tending not to access a lot the services. We just had a report on that where I think it was indicated that like something like 4000 immigrants or new residents are coming into Mildura or are in Mildura presently. That would also

be quite a large community that is not being fully accessed. We can put the same 10.7 per cent figure on those ones as well.

Mr NOONAN — Can I go back to the home-based outreach support, which is a big part of your work. Your reference in your submission states it is funded for 4 hours per participant per week, or 8 hours per fortnight, which is not adequate — that is what you are saying.

Mr JANSON — Yes.

Mr NOONAN — In addition, you say that the service works closely with other service providers in areas such as clinical services, primary health care, health and welfare, pre-vocational and vocational support services. What would be useful for the committee is just to get a sense of what you might deem as adequate in terms of those services — which I suspect will not be in hours, but it might be easy for us to understand in hours. Across all of those services, could you give us a sense of how big the gap might be in terms of what you might deem as adequate?

Mr JANSON — Can I just draw the distinction here as well between a person who just has a primary psychiatric disability and a person of dual diagnoses, who might have an intellectual disability, an ABI and a psychiatric disability as well. A person with a dual disability does have the opportunity of accessing other organisations such as the intellectual disability organisations.

Ms McMANUS — ‘May’ have the opportunity for that.

Mr JANSON — Yes — that is not a given.

Ms McMANUS — Basically, as Barrie was saying, someone in that situation would receive services from ourselves, from clinical mental health. If there was that dual disability we would be accessing services like a disability service to put in supports as well, if that person was able to be accessing that service. If there is funding there for them, they can access that.

There can be issues around drugs and alcohol as well. We would be looking at accessing services to help fulfil those hours as well. But because we are rural, we are isolated, we are only small, we cannot really put in the huge amounts of hours that are required. As an example, the pathways program, which is discharge from mental health — so we are looking at where there is no homelessness — within that, the most that we can offer a participant is probably 15 to 20 hours a week with the supports of all those services. That is our service and then the services on top of that that we could be bringing. That is even including vocational assistance as well.

Mr JANSON — If we looked at employment support, you could provide an extra 8, 16, 24 hours for a person in supported accommodation. Not only would that enhance their quality of life, their self-worth and their income, but it would also be providing the important support hours for that individual. At the moment employment support is done through an organisation called Access Employment which does primarily deal with other disabilities.

Ms McMANUS — But that is even saying that a person is at a level for that. At the moment we are not even being able to get to that level for a lot of our participants, because we are not able to have the supports in place.

Mr JANSON — It comes back to our system is built and designed for a person who has a certain level of stability.

Mr NOONAN — I am not sure that I understand clearly enough what might be deemed adequate supports. If you can get a snapshot of where the situation is at at the moment, that would be useful for us to understand.

Mr JANSON — If you look at a person’s ADLs, or activities of daily living, there are definite supports needed in nutrition — nutritional requirements that are met, which is the cooking

support, shopping support. Then you would also look in the ADLs at a person's hygiene. Hygiene supports are extremely important, especially on a psychosocial and social level. These are supports for a person, making sure that they are groomed, that they are showering. If you look at any individual's needs, that is an extra hour a day to 2 hours a day needed for supports to that. This is for a person who is quite unwell.

Then you would also look at supports that may be needed to integrate with other services, whether this is contacting Centrelink, contacting their landlord or whatever. Then there are those other interagency supports. That may also include such things as going to the dentist, fulfilling your check-up or having a GP — so supports needed there. That is just looking at the ADLs.

The CHAIR — I think we have gone a bit over time. Thank you very much.

Mr NOONAN — Thanks very much for your submission.

Witnesses withdrew.