



**LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY**

**STANDING COMMITTEE ON HEALTH AND DISABILITY**

**(Reference: appropriate housing for people living with mental illness)**

**Members:**

**MS K MacDONALD (The Chair)**  
**MS M PORTER (The Deputy Chair)**  
**MRS J BURKE**

**TRANSCRIPT OF EVIDENCE**

**CANBERRA**

**TUESDAY, 7 FEBRUARY 2006**

**Secretary to the committee:**  
**Ms E Eggerking (Ph: 6205 0129)**

**By authority of the Legislative Assembly for the Australian Capital Territory**

Submissions, answers to questions on notice and other documents relevant to this inquiry which have been authorised for publication by the committee may be obtained from the committee office of the Legislative Assembly (Ph: 6205 0127).

**The committee met at 2.03 pm.**

**KENNETH EDWARD DAY** was called.

**THE CHAIR:** I will read this statement to you before we begin. You should understand that these hearings are legal proceedings of the Legislative Assembly, protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means that you are protected from certain legal actions such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter. Do you understand that?

**Mr Day:** I do.

**THE CHAIR:** Can you state your name and the capacity in which you appear today, for Hansard.

**Mr Day:** My name is Ken Day. I am the executive officer, Handyhelp ACT. I am here to present my experience of service delivery to people with mental health and other episodic conditions, based in South Australia for 10 years.

**THE CHAIR:** Before I open up to questions, would you like to make an opening statement?

**Mr Day:** Certainly; thank you. As I said, I am here to share my experiences from South Australia. What we did over there was, over a period of 10 years, develop a program that provided a more client focused approach to service delivery. The program I managed was funded through HACC for short-term and one-off type support. We covered a full range of services: home maintenance, domestic support, respite, personal care, minor home modifications, home security advice and assistance, transport, shopping, and friendly home visiting social support services.

We worked with other providers in the region to develop a plan that enabled a free flow of service delivery to people who often came into the service sector looking for something but had very minimal impact otherwise. They would have a connection with an agency but demand very small amounts of services. Because of that, they often ended up going through multiple assessments. What we wanted to do was minimise assessments, simplify the process and make it more efficient and client focused.

What the program did was that a number of agencies with the same direction, same motivation, got together. They included Mental Health Services, Northern Doncare, Community Options, Options Coordination, Carers, a variety of support groups, Helping Hand, the ACH Group, divisions of general practice and some individual doctors that didn't want to be involved in that.

The idea was that, where a client was receiving services through another organisation, we would provide them with a free-flowing process of service delivery so that across all the organisations, if Mr Bloggs suddenly came on needing services, if he was a client of Mental Health Services, Mental Health Services would coordinate all the services; they would be the key contact organisation. What that meant was that it was a seamless,

almost transparent service. The client was unaware of our existence in many cases. We were providing the service; it was all being channelled through. That key contact could also refer to any of the other organisations in this group without any further assessment or follow-up. There was total trust across the groups to enable that to happen. It took a lot of network building to make that happen.

The benefits for the client were that forward planning simplified the access and maintained a sense of trust across the agencies, because, the more you do it, the more you trust each other. It meant that agencies could respond more quickly. Certainly our agency, being short-term, one-off support, could respond very quickly and very efficiently to a client's needs.

That was a huge benefit to the client, with no other imposing on them as far as assessment or other form of intervention, other than what they required, was concerned. It was developed around their own desires. They worked on the care plan; they also worked on who was going to be the key agency or the key contact. So they were in control. As I said, it reduced assessment and maintained a flexible, professional environment.

It really needed the maximum support of the government and the funding bodies, because we were involved with Disability Services as well as HACC and other smaller funding agencies. Because of the normal funding output reporting requirements, they had to be tolerant of the fact we wouldn't always meet our outputs, because of certain needs and certain demands. But when we did it for a few years we found that this group probably made up about 10 to 15 per cent of our client population and really had minimal impact on the actual outputs. But it meant we had to get it going to prove that. And we did over a long period of time.

The downside, I guess, was that, because we didn't identify ourselves, one of the funding groups, which was a local government body, decided it wasn't getting value for money because when it did surveys it didn't get much mention of our program. So it didn't think it was getting supported, despite the statistical evidence to the contrary. We couldn't reveal personal information because of the Privacy Act. So they basically, after I had left the organisation, eventually ended up splitting it up and going back to the old menu-driven system, which was sad. There is an area to work on there that organisations need to look at. The other ongoing issue was change of workers, maintaining a healthy environment and a healthy relationship with organisations. But it was very successful over many years, and lots of people with mental illnesses received great benefit from it.

**MS PORTER:** I want to explore a little more this issue of the trust between the organisations and how you developed that. I know that it was between government and non-government agencies.

**Mr Day:** That is correct.

**MS PORTER:** Could you give me an idea of how many agencies at any given time might have been involved and the scope of agencies that had to be brought together? I don't want you to name them. Are we looking at half a dozen, 10—how many? How long did it take to build up that trust and what were the challenges in doing that?

**Mr Day:** There were about eight or nine agencies all up at varying times, plus a dozen doctors in the region. We operated over the whole northern region of Adelaide suburbs, from Grand Junction Road, if you know that part of Adelaide.

The level of trust started slowly. Ourselves and Northern Domiciliary Care, one of the major health provision agencies in the north, got together and started talking about the concept. We held a regional forum, which brought together a number of organisations and started developing the concept. It was then an open invitation to agencies to get on board. That was running in conjunction with our own program's connection with the workers on the ground. Workers would come to us and say, "Can your organisation help with this?" We were getting contact from that end as well and working with them to prove that we could do what we were agreeing to do and taking the risk of making ourselves vulnerable to prove that we could do what we were talking about. That made other agencies start to look and say, "Hang on, he is proving this; we can see that this is happening."

I then went out and talked to a number of individual agency heads to discuss the concept further and, over a period of about three years, developed the whole process. From the government's perspective, it needed a flexible approach, as I say, to our reporting requirements and some understanding along the way as we got this thing up and running and made it happen.

I guess the biggest problem we had was what I tagged the protectionist approach of some organisations and some heads, partly because of their fear of losing funding—if they couldn't meet the reporting requirements, then maybe that would have some negative impact on them—and partly because of historical agendas. They had been going for a long time; they didn't want to deal with this organisation or that organisation. I don't know that we ever resolved all of that, but we certainly broke down a lot of barriers. It was helped by the move towards the funded purchaser/provider where the funding body started to say, "We want regional approaches to this; we want people coming in and working together as groups." So there was a sense of government pressure to make organisations start working together. That helped substantially in developing the relationships.

The other aspect was the fact that the individual organisations started to get too small. Some of them were far too small to really be fully functional, so smaller organisations started to amalgamate and become bigger ones. Some just amalgamated administrations; some amalgamated the whole entity. As a result, there was a new look at the whole process; new people came in, fresh thinking; and we were able to progress.

**MS PORTER:** You mentioned, though, that you ran into trouble with some funding bodies towards the end—that was to do with the outputs—and therefore things went back to the original way of doing things.

**Mr Day:** For that particular area, yes.

**MS PORTER:** I am wondering about those privacy issues that you said contributed to that. How are those privacy issues managed when organisations aren't identifying themselves? As far as a client is concerned, how is it managed?

**Mr Day:** The main issue from our perspective was that I had a strong belief that we shouldn't impose our will and our existence onto the clients. And that was my own failing. What we should have been doing was at least getting whomever the key person was to identify to the individual who was receiving the service that this service was being provided by whoever. That way we would have overcome some of those problems. When that local government entity did their survey our name would have been there. It was just that we didn't market ourselves. We were concentrating on client services. And that was really where the error occurred.

Because we didn't do that, the survey showed that we had very little impact in their area. They were funding about 45 per cent of the local government contribution towards the service and were getting about five per cent of the service, based on that survey. We had statistical evidence showing they were getting 52 per cent of the service, but they didn't agree with that statistical evidence because we couldn't tell them who the clients were. So we could have overcome the problem by simply informing clients more efficiently. And that was a learning curve for us.

**MS PORTER:** How did the clients give permission for your organisation to be involved when they hadn't been told that you were involved?

**Mr Day:** That happened right back at the beginning of the care planning stage. If there was an issue—for example, if there was a complaint—they needed to know that we were involved because of the fact that we had to deal with the complaint. So the care planning stage would be presented to them in writing after consultation between the key person and the client. They would be told which agencies would be likely to be involved to provide the services as detailed in that care plan. So often we could refer them back to that care plan and they would know whom the service was coming from.

We would also share services—for example, with Community Options, with people with dementia. We would use their workers and would fund it. That way there was continuity of service for those individuals. Having the same workers all the time can reduce the pressure on them.

**MRS BURKE:** You talked about South Australia having a more client focused model. You also talked about flexibility with a professional system. First point first: more client focused. Is that to say, from your experience in the ACT, that we are falling short of this mark? If so, why? With regard to the flexibility of the professional system, what would it take for us to achieve that? I know you are going to talk about funding, aren't you?

**Mr Day:** No.

**MRS BURKE:** The minister will be pleased.

**Mr Day:** I have a subjective impression that we had a very good client focused approach in our area. Certainly the way we ran the program was very client focused. That was our driving force; we wanted to be client focused in everything we did. So the client was heavily involved in all the communication at the establishment of the care plan. In the ACT, there are a lot of very committed people who are very dedicated to what they do. But as they are starting to shift in their thinking, they probably need to involve and encompass the idea of having clients more heavily involved in care planning. It is labour

intensive initially, and the assessment process long term is very positive in the outcomes.

**MRS BURKE:** You are saying that clients are moving one way and the department or the government is moving another way?

**Mr Day:** I am talking about the providers, not government. No, I am not saying they are moving the other way. What I am trying to say is that, from my minimal evidence here in Canberra—and I have only been back in the community for just over a year; I had two years with the federal government—the programs, the operators and providers here in Canberra, from what I have seen, are all very dedicated people and are trying their hardest. What they could probably do that would help them become more client focused is involve clients more in the individual care planning, the care planning/assessment stage.

What still tends to happen—and it still happens in South Australia; it happens all across the country—is, because of the complexity of our assessment processes through the community sector, that each agency almost imposes itself on the client, rather than saying to the client, “Okay, let’s have a look at all your real needs. Now we have got a clear picture of your needs, this is what we can do. Where can we help you, or direct you, or guide you to get those other services in?” The client is motivated and involved and owns what is happening to them, rather than having it imposed on them under a menu-driven system. That is the old way of doing it, and it takes time for those things to change. Everybody is moving that way. In every state it is a slow process. Some areas are doing very well at it.

**MRS BURKE:** That goes to the flexibility of a professional system. You believe that an enhancement or a lifting of that client focus, a shift of client focus, more than we perhaps are doing, is needed, despite the committed people. Is that how it will end up looking?

**Mr Day:** Again, this is only my personal observation. What the ACT needs to do is rethink the number of agencies it has got. We have got too many agencies operating in this town.

**MRS BURKE:** I agree with that. There are some really good people, but, yes, I agree.

**Mr Day:** There are too many players in each individual’s life. And you can overcome that by the model that I have discussed and have presented today. To make that happen you need to eliminate some of the personal agendas, historical agendas, that exist. I have discovered, since being in the ACT, that there are a number of those. And you can very easily tread on toes by suggesting amalgamations, mergers, whatever you want to call them, because of those historical issues.

**THE CHAIR:** I was thinking about the comment that you made that the biggest problem that you encountered was the protectionist approach from organisations and historical agendas. I appreciate that you have only been back in the community sector for the last 12 months or so. Do you think that will be a stumbling block which, if we were to try to reform things, we would face in the ACT?

**Mr Day:** I am certain you would face it. People certainly agree with the philosophies, but I don’t know that they always apply them. I certainly have seen lots of evidence

where it is not applied. They can say they words, the rhetoric is good, but it doesn't happen in reality.

**MRS BURKE:** Is that a fear-driven thing—fear of losing their money, their power?

**Mr Day:** Yes, and their jobs. If you merge any organisation, restructure any organisation, positions go; positions change. We all have lives; we all have a comfortable place we work in. And you don't want to see that change. If you have always done it this way, and it seems to work—and the reports come back that 80 or 90 per cent of clients are satisfied, because clients won't speak up for themselves a lot of times—then you are always going to feel like you are on the right track.

I believe in a continuous improvement approach to life: always consider there is a problem, so look for it and try to resolve it; give people the opportunity to speak out as freely as they want without any retribution. When things have always been done a certain way, then people get comfortable. That is what has happened, from my observation—and I stress this is my observation—and what is happening in the ACT. There is a bit too much comfort amongst some of the organisations, and they need to rethink.

I have had communication with a few organisations in the ACT which have indicated they are considering working more closely with other organisations. So there is also an element here that is working towards that, that is starting to think that way. The emphasis from the government is certainly more that way, both the federal and the territory governments. We are at a good time for things to happen. But, yes, there will be resistance.

**THE CHAIR:** Forgive me if you said this at the beginning. Did you say there was a specific model that the South Australian model was based on? How did it come about? What was the history?

**Mr Day:** There was no specific model. I guess the nearest model that would probably indicate a basis for it was a Community Options model. The principles of SRV, social role valorisation, come into play strongly in the thinking. We had that ideal and then worked out how we could try to make it happen, rather than try to get some model from somewhere and impose it. It was more a case of what the clients want, what would benefit them most, what would enable the outcome we hope to achieve to come about.

There was a lot of involvement with the consumers, the clients, asking them what they were looking for. That happens a lot, but I don't know that we always listen or we always hear what they are saying. We hear what we want to hear and then go off and do it. It requires that constant feedback: we are doing this; is this working better for you and is this more what you were looking for?

We found that involving them at the early assessment stage, with an agency they had already developed a relationship with or with an individual within an agency they had already developed a relationship with, was a very strong contributor to the success of the whole thing. One, they only had to deal with one person. In 99 per cent of cases they only ever got assessed once, and they already had the relationship built with that person because of the agency connection. That was very strong in Mental Health Services and in Community Options with people who had specific needs.

**THE CHAIR:** That was South Australia wide, was it?

**Mr Day:** No. It was initiated in the northern regions, the suburbs north of Jepps Cross, which mainly is the Salisbury and Playford councils and Gawler council, to some degree.

**THE CHAIR:** You said that this was your experience of 10 years. It was going for 10 years?

**Mr Day:** No; sorry for giving that impression. I commenced the program as one of the team and then it was over a period of 10 years. Within the first year I was the manager of the program and then, for the next nine years, I managed the program. We had the philosophy in place in day one, but it took about three to four years to implement it and get it working. And then we had the ongoing maintenance of it. It was probably running effectively for about five, 5½ years, before we had problems.

**THE CHAIR:** You said that they are not using this approach anymore; they are using a many-phased approach

**Mr Day:** In the Playford local government area, the workers in that environment decided that they weren't getting their value for money and we couldn't convince them. I managed to convince one of the workers who had trust in me as the manager of the program and presented enough evidence for her to say, "Okay, I will go back to the council and say that this is all okay."

We then started to try to get clients to let the council know. But in the interim period of about 18 months, they changed the person who was the project officer for the council and that person clashed with the director of our community service area. There were always going to be problems. When I left and went to the federal government to work, the consequences of both the personality issues and this ongoing battle of trying to prove the program was effective basically backfired on us and it all fell over.

**MS PORTER:** My question is about the communication. If there is only the one person that is coordinating, how does the communication happen between the different players? For instance, if you have three or four agencies involved and there may be three or four different workers going in at any given time providing a service, there are obviously messages that might need to be passed from one to another. Did that work?

**Mr Day:** Logically, yes, it did. It took a lot of work. Basically, everyone had to trust whoever the key worker was. That person would coordinate all the services; they would set the required dates. That would be put across as a care request to whichever agency was expected to provide the service, or the combination of agencies, and then they would take those requests, see if they could fit them into their schedules and feed the information back to that coordinator or case manager.

**MS PORTER:** I was thinking more about, for instance, if you went in and the client had been unwell that day and you needed to let the next worker who was coming in from a different agency know that the client had been unwell and hadn't taken their medication or whatever—those kinds of pieces of information and those kinds of messages.



**Mr Day:** Certainly. For the ones that work well, we had a visitors book, a message book, in their houses.

**MS PORTER:** They kept that and that wasn't, again, a privacy issue.

**Mr Day:** It was agreed to before. Some of them didn't want it, and they are the ones we had some problems with. But most of the people through Mental Health Services have no problem with that, and it worked very well.

**MRS BURKE:** I am sorry for asking this, but I don't have it in front of me. What is your current level of funding from the ACT government?

**Mr Day:** Our total funding, including client contribution, is \$1.2 million.

**MRS BURKE:** I did have it. Are the demands placed upon Handyhelp steadily on the increase? Is it exponentially rising? Would you say it has been a big leap since you have been there or is it steady?

**Mr Day:** Certainly on the increase. The biggest cost increase for us has been cost of services. Contractors are upping their prices fairly significantly.

**MRS BURKE:** We talked about that.

**Mr Day:** But we kind of expected that.

**THE CHAIR:** With relation to the model utilised in South Australia, are you able to direct us to any documentation that the committee could have a look at?

**Mr Day:** I would have to get back in touch with the people at the council, the local government, and see if they will release that information.

**THE CHAIR:** It would be helpful for us to have a look at the model as it was used.

**MRS BURKE:** Maybe you could do it through the minister in South Australia.

**THE CHAIR:** No, it is a council thing; it is not a—

**Mr Day:** Yes, it is local government.

**THE CHAIR:** It is local government, not South Australian government.

**Mr Day:** Basically the model was a growth thing that grew progressively over a period of time. There is no actual formula or fancy model that is drawn up and says, "This is what it is." The experience is what we have. By contacting the director at the local government, I could try to find out if they have got any documentation still on file that can help you in what you are trying to achieve.

**THE CHAIR:** We will follow it up with a letter to you about that.

**Mr Day:** Yes, certainly.

**THE CHAIR:** Any help you can give—

**Mr Day:** I will try to get you whatever help I can.

**THE CHAIR:** That would be great. We might finish it at that point. Thank you very much for making yourself available today. We will be back in contact with you anyway. Once we have got the report written we will definitely be back in contact with you then.

**Mr Day:** That is fine. I appreciate that. Good luck with it all.

**MS PORTER:** Thank you.

**MRS BURKE:** Thank you very much.

**THE CHAIR:** We will of course send you a copy of the transcript for you to check that we haven't misquoted you.

**Mr Day:** That is okay.

**DR ROWENA DAW** was called.

**THE CHAIR:** Thank you for appearing before us today, Dr Daw. You should understand that these hearings are legal proceedings of the Legislative Assembly, protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means that you are protected from certain legal action, such as being sued for defamation, for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter. Do you understand that?

**Dr Daw:** Yes, I do.

**THE CHAIR:** I know that you heard it last week. For the record, please state your name and the capacity in which you appear.

**Dr Daw:** My name is Rowena Daw. I am the human rights legal adviser at the ACT Human Rights Office.

**THE CHAIR:** I would like to place on the record the committee's thanks for the submission which the ACT Human Rights Office has put in. Would you like to make an opening statement?

**Dr Daw:** Yes. Firstly, I should state that we do not claim to be experts in the provision of housing. The right to housing is not in the Human Rights Act in the ACT. It is only as a result of indirect ways of interpreting the ACT Human Rights Act that rights to housing, I think, come within it. Of course, our broader mandate in a sense is to look at the economic and social rights which may or may not end up being part of the Human Rights Act. So I think that, by necessity, ours is a broad-brush approach, and one of our aims is to try to help people understand the human rights framework within which we consider any of these discussions within the ACT should now take place.

As a result of that, in the work that I did on this submission I took as read in a sense the information received from various other submissions, most particularly ACTCOSS' submission, and some of the work done in other parts of Australia. On the assumption that that may or may not be an accurate reflection of the situation, I said what we thought would be the human rights implications if that is indeed the case. I just needed to point out at the beginning that that is where we are coming from.

I might raise just a few pointers. At the ACT Human Rights Office, of course, we have particular concern for the most disadvantaged members of our society. We have chosen to prioritise our time and concerns for those groups from both human rights and discrimination points of view. While we do not receive a large number of discrimination cases and while, of course, those are confidential, we are aware that there are particular issues for people in receipt of housing, mostly in the sense of a failure to make reasonable adjustments or a difficulty in understanding the particular issues that people with mental health problems can present.

It seems that, in terms of disability, the needs of people who are wheelchair users or people who have other disabilities, from our general knowledge, would appear perhaps

to be better understood than those of people with mental health problems. That is a very general comment which, I think, applies in relation to ACT Housing, but also to the private sector as well, because obviously discrimination covers both sectors. There is a particular problem, of course, for people wishing to make discrimination complaints if they have in fact been evicted from housing because, if they become homeless, it is very difficult for them then to make a complaint because they lack the address from which they can make the complaint. That has been a problem in some circumstances in the past.

In the written submission I give a couple of examples of discrimination case law. But, as a human rights office, our concern is, of course, with, if you like, a holistic issue, which is that so many human rights get brought up by the kind of cycle, the vicious cycle, which occurs for people with mental ill health. When they become ill, they then can become homeless because of a range of different factors, either from the private sector or from the public sector. They are likely then to lose employment, to become obviously even poorer and, if indeed homelessness has resulted, clearly to have worsening mental health. That, of course, can lead to suicide.

Obviously, human rights legislation is very relevant in lots of ways in terms of privacy, in terms of right to life, in terms of right to home and family life and, if there are children, in relation to the protection of children. Given that a whole cluster of human rights, we think, are involved here, this puts a particular obligation on the public authorities to take innovative and carefully targeted approaches which draw on an understanding of the fluctuating nature of ill health for people with mental health problems.

I will quickly list some of the rights, if you like, apart from those I have mentioned. The Human Rights Act, in that sense, has a duty to address homelessness. It does provide a duty to prioritise children and families. It does have a duty to ensure that policies do not inadvertently discriminate or produce homelessness and, perhaps less clear, that there is a system that promotes independence, capacity and autonomy. Sometimes I think the approach of the public authorities is too heavy-handed and policies need to be there to promote that capacity to control one's life. That means one's finances, one's housing and one's choice in housing when one has the capacity to have that choice. What sometimes happens is that the Office of the Community Advocate is drawn in when somebody is in a situation where, because of ill health, they have lost the ability to pay or are in arrears and, rather than evict them, the Office of the Community Advocate can come in. Sometimes, of course, that is the appropriate and caring response and sometimes perhaps it is too heavy-handed and takes away the autonomy.

That is all I was going to say. I do not want to go on and on. I have obviously listed here a number of the issues that have occurred to us as maybe needing to be addressed.

**THE CHAIR:** I will start. You have talked about international jurisprudence and jurisprudence under the United Kingdom Human Rights Act 1998. There have been cases brought as a result of that Human Rights Act where people have been evicted. You talk about the case of *Anufrijeva v Southwark*, where the claimant was homeless and faced separation from a child, and say that that it made clear that failures in the administration of public housing schemes which were culpable and serious and which also had a significant effect on private family life could engage the United Kingdom Human Rights Act. You go on to talk about the United Kingdom Human Rights Act

being narrower than the ACT Human Rights Act. That raises in my mind whether the ACT faces the possibility of actions against, say, ACT Housing for evictions on the basis of rental arrears of people who have gone through a psychotic episode. Would you care to address the possibility of that?

**Dr Daw:** Yes. Going back to the short text I put in, *Anufrijeva v Southwark* was complicated by other issues, immigration status issues as well, but, had it not been for the immigration issues, the problem there was culpable delay in finding accommodation for somebody who was in high need, and the culpable delay was to do mostly with administrative inefficiencies, not just to do with lack of housing. If it had been simply that there wasn't housing stock, it is unclear. That was part of the issue. The other part was that they really made a mess and they delayed and delayed and the situation for this particular family got worse and worse.

Had it not been for the immigration issues, then I think there would have been a clear finding that there had been a breach of the Human Rights Act. If we translate that situation to here, I think that it would indeed be possible in a situation where somebody was homeless and urgently needed accommodation that the Human Rights Act might be engaged. In terms of evictions, we would be looking at the possibility of discrimination being involved in that case, I think, as well as human rights.

**THE CHAIR:** With that, you talk about balance, you talk about the rights of neighbours who have to deal with aberrant behaviour.

**Dr Daw:** Yes. If we look at the discrimination angle first of all, it is a little hard to give a very specific legal position on the basis of a general set of facts, but it is at least conceivable that the failure to make a proper, reasonable adjustment to the procedures for evicting someone if somebody has a mental health problem is indeed a breach of the Discrimination Act. I think that is fairly clear. So you would need to make reasonable adjustments if, for instance, someone's worsening mental health meant that they did not pay the rent on time. Even if you did not know for sure that they had mental health problems and you should have known, then that could well be a breach of the Discrimination Act.

Indeed, very often the OCA gets involved in that if it is a public housing situation. If it is a private housing situation, then they are probably not going to. So that could indeed be a breach of the Discrimination Act. If we are looking at the Human Rights Act, of course, we are looking at ACT Housing or public sector providers, or at least providers under statute. If somebody is evicted in that situation and made homeless and if there were children involved, I would suggest it might be possible to invoke the Human Rights Act as well as the Discrimination Act on the basis of a judicial review of the administrative action.

It is an untested area, for very technical legal reasons, because the wording of the section on private family and home life under our act is different from the wording in the UK act. The UK act has more of a positive duty on the state to ensure that this does not happen. However, some interpretation under the International Covenant on Civil and Political Rights of the wording that we have would suggest that that change of wording is not significant and that there is a positive duty on the state to prevent this situation. But I have to say it is untested waters from a legal point of view how far we would go in the

ACT. I would say it would be open to the judges, to the courts, to say that that was a breach.

**THE CHAIR:** Can you—

**Dr Daw:** Have I not answered the question you asked?

**THE CHAIR:** No, it has just raised another question in my mind. That is looking at it from the territory's perspective. As you have already pointed out, the UK takes a much more positive role in terms of the state providing housing and having an obligation to provide housing. Referring to the ACT, you are referring to ACT Housing, I suppose. In the submission you talk about landlords possibly breaching acts if they evict.

**Dr Daw:** I probably meant that that was the Discrimination Act. Private landlords would be more likely to breach the Discrimination Act in certain circumstances whereas ACT Housing, being public sector and under statutory duties, is more likely to involve both the Discrimination Act and the Human Rights Act.

**MS PORTER:** You said in your submission that you thought that there was a very clear need to separate the management of housing from the support services. Do you think that that would prevent some of these things that you talk about occurring in the first place? If so, how would you see it preventing that?

**Dr Daw:** There is a limit to what we can say about that. Again, we are coming from a point of principle here in the sense of there being potentially almost a conflict of interest, if you like, if the housing department is also providing the support services. But, leaving that issue aside, how would it prevent some of these issues? Central to this concept of capacity and autonomy is the idea that if you have a separate support, whether through advocates or whatever form of privately or publicly-funded support services, you are empowering the individual to help them to make choices and help them to indicate when they need help and how they need help.

I think that central to mental health is the fact that everybody's circumstances are different. I should say that before my job here I worked with mental health, for mental health service users, for about five years; so partly, I guess, I am drawing on that experience. Of real importance to the individual is being able to be in charge of what they need in terms of a return to complete independent living where they are, maybe requiring supported accommodation for a particular period of time. So the support person being independent from the housing will, I think, enhance their human rights because it will help them to have a better ability, with the support of the support person, to manage their own affairs, to express their needs and their choices, and perhaps also to prevent that kind of escalating situation that occurs when you have maybe housing providers who are not well trained in mental health and who do not understand necessarily the nature of the behaviour, who misinterpret it, and you get this escalating bad situation where there is a breakdown of communication.

**MS PORTER:** Nonetheless, you would still suggest that the housing worker should be given some additional training.

**Dr Daw:** Absolutely. That is certainly one of the things that have come across to us in

the kinds of cases that we get, that it seems to be so much about lack of training and lack of understanding of mental health issues that causes some of the problems, that then leads to problems. For instance, if you have, if you like, a tenant who is displaying difficult behaviour and perhaps the neighbours are having problems, understandably, with that, the role that housing or indeed a support person can play in that situation to de-escalate, to bring about a better response—maybe a reallocation, maybe not—is, I think, very critical and very effective. I guess I am drawing on experience from working in the mental health field in saying that.

**MS PORTER:** You also say that there is a need to look at how we could review the policies to make them a little more flexible to deal with individual need.

**Dr Daw:** Yes. I was struck in looking at ACT Housing policies—the debt management policy and the eligibility for public housing assistance policies—that they haven't yet gone through the human rights assessment process. They haven't been reviewed through the lens of the Human Rights Act. Nor, I would suggest, has the homelessness strategy gone through that proper process. Just looking at it from the point of view of this particular group, I could immediately see that there could be problems because there are particular issues that are not addressed.

**MRS BURKE:** I have heaps to ask but we are stuck for time. At page 6 of your report you rely on the 2002 report of ACTCOSS on a needs analysis of homelessness. There are a couple of points that I would make on that. First, at the bottom of the page, you talk about the case of a person who said that she had been banned from refuges and wanted to get back to Quamby as that was where her friends and the people who understood her were. At point 7, referring to the need for an effective ACT response, you talk about there being an inadequate supply of housing. What do you actually mean by “inadequate”? People say that they are adequately housed and I ask them whether they are appropriately housed. I noticed words in here that reflect that, too.

You also talk about current patchy and poorly coordinated support. I suppose it is probably not one that you can answer, either, but I am thinking of people's human rights in terms of there being a range of options for people with mental illness. I know that I had a discussion with the former minister on this and he was very agitated by it because I think he could see a need for a separate building—let's not call it an institution—where people could go, be it for time out or whatever. From your perspective, is that what you are alluding to perhaps here?

**Dr Daw:** Yes, it was.

**MRS BURKE:** I think we get so stuck on the word “institution”, but obviously this young girl feels “safe” at Quamby, and that is a sad state of affairs.

**Dr Daw:** Yes.

**MRS BURKE:** What do you mean by “the inadequate supply of housing stock” on page 7? Does that refer to that same feeling as well, or were you talking about quantity or quality?

**Dr Daw:** I guess I am talking there from what I could understand from the papers that I

had. It was simply about quantity. I was really drawing back to the general notion that, if you look at all these human rights together, it does impose on the ACT government, I think, an obligation to make some funds available. I gather much of the time consumers of mental health services will say that you really have to be homeless, however ill you are, before you can actually get into that top priority housing, even though there are other categories.

**MRS BURKE:** That's right.

**Dr Daw:** That is a bad situation. In human rights terms, particularly given the high level of mental health problems among the homeless, if you put all those issues together, if you are only able to provide housing for somebody in priority one if they have already become homeless, not if they are facing eviction or any of the other categories in that top priority, then you are in a fairly bad situation it seems.

**MRS BURKE:** I guess that's right. You are talking about the human rights of the individual with mental illness, but we also have to consider the human rights of people who are living next to these people if these people are being left without support. This is what you allude to as patchy and poorly coordinated. Could you expand on that given your experience?

**Dr Daw:** I can't, really. I need to take that on notice because I need to go back and look at some of the material.

**MRS BURKE:** I am just interested in having something that would back that up, support it. It would be helpful to have information on that.

**Dr Daw:** I would be very happy to provide that.

**MRS BURKE:** Thank you.

**THE CHAIR:** We will leave it at that. I thank you very much for your appearance today, Dr Daw. We will be sending you a copy of the transcript so that you can check it for accuracy, et cetera. We will be in touch with you when we have a report. If we have further questions, we will write to you.

**Dr Daw:** Sure. I should have said at the beginning that Dr Watchirs apologises for being unable to come this afternoon.



**LISA McPHERSON** and

**IAIN BROTHERSON**

were called.

**THE CHAIR:** You should understand that these hearings are legal proceedings of the Legislative Assembly, protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means that you are protected from certain legal action, such as being sued for defamation, for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter. Do you understand that?

**Mrs McPherson:** Yes.

**Mr Brotherson:** Yes.

**THE CHAIR:** Please state your name and the capacity in which you appear.

**Mrs McPherson:** I am Lisa McPherson from Work-Ways.

**Mr Brotherson:** I am Iain Brotherson, also from Work-Ways.

**THE CHAIR:** Thank you very much for your attendance today. That was just the formal part that we needed to go through. We do that with every witness. I understand that this is the first time you have appeared before a committee. Do not be nervous. We get a bit blasé about it these days, having done it for such a long time. Would you like to make an opening statement about your organisation and what you do?

**Mr Brotherson:** We are from Work-Ways. We are funded by the Department of Employment and Workplace Relations. We run two programs: the employment program—you have a brochure there—and the personal support program. It is a disability employment program and we specialise in mental health. I guess you invited us today because of our clientele and the stakeholders are working with people with mental illness. We assist people with mental illness into employment and then we assist them in maintaining that employment.

The personal support program is a program whereby clients come through the Centrelink pathway and are allowed two years off their Centrelink obligations to work at their more broader life issues and non-vocational barriers. In doing that, that might take shape through counselling primarily, advocacy representation and support. I guess an ideal outcome might be that by the end of the two years of the personal support program they move over to the employment program, for example. That is how the two programs operate. They are funded through DEWR. I guess that is why you asked us to be here today, because we specialise in mental health.

**THE CHAIR:** Do you have people who move from the personal support program to the employment program and move back to the personal support program? Does that actually happen? Do you cater for that?

**Mrs McPherson:** It can happen. There are really tight guidelines from DEWR around that and what can actually happen. If the person moves over to disability open employment, they go on a three-month suspension with PSP and then they have that option of moving back in that three months. If, for example, after that three months they wanted to get rereferred to the PSP program, they would have to go back to Centrelink and get a referral from one of the psychologists or one of the specialists in Centrelink. That would not necessarily mean they would come back to Work-Ways' personal support program. They may go to another provider.

**MRS BURKE:** Obviously, our purview today is to look into the appropriate housing for people with mental illness and the basic premise for anybody to get on their feet is a roof over their heads. In terms of the ACT, how much is the housing situation impacting upon your clients? From your perspective, how are you seeing the delivery of services and support to people, other than the good support you give them, and how do you interface with the ACT government and its service deliverers, the interface between you from a federally funded perspective and the local government scene? If you have ACT clients, how do you interface and how do you perceive housing to be at the core?

**Mrs McPherson:** Specifically ACT Housing to start with?

**MRS BURKE:** Yes. We are just looking at people in the ACT.

**THE CHAIR:** Have you seen the terms of reference for the inquiry?

**Mrs McPherson:** Yes. I guess I meant ACT Housing, as in government housing, versus community housing priorities.

**MRS BURKE:** Primarily, but you have both. The ACT government has an ability to control public housing, but you have both.

**Mrs McPherson:** The main issue that our clientele face with going onto the public housing list is obviously the waiting list. It is a huge waiting list. We have people come to us who might be staying with friends and having to move between different housing options as they cannot actually get into public housing at that time because of the housing lists. One of the big issues that a lot of our clients have, especially on the personal support program, people coming through who are often homeless at that time and we are trying to assist them into housing, is that a lot of these individuals have a pet, which is a huge issue for them because it is their companion and it is a really great companion for someone who may have a mental illness, but when we try to refer them to public housing they are not allowed to actually take the pets and it is very difficult to get properties that allow pets. So that is one of the huge issues.

**MRS BURKE:** I thought that, under special circumstances, you were allowed one small dog or a pet.

**THE CHAIR:** That is a question we will need to put to the minister.

**MRS BURKE:** That is interesting. If that is your understanding, it is not my understanding.

**THE CHAIR:** Let Mrs McPherson finish.

**Mrs McPherson:** You will find with a lot of our clientele who come through, who bring their dogs up, that they aren't small pets, they are quite large dogs, and they will actually choose to stay homeless and live that lifestyle rather than be taken away from their pets. That is one issue. Obviously, not having the stability of housing if they are on the waiting list is another factor that is detrimental to people's mental health, because they need that security and when people are waiting for a long time and are not actually sure what is going to happen to them there is another issue. Another issue that we face is that we cannot get access to or find out about the debts of people wanting to get back into the housing system. They may have debts because of their medical condition. They may have been unwell, gone through an episode and maybe smashed a hole in a wall, for example, and incurred a debt from that and when we are trying to get them back onto the housing list we are told that they cannot because they have a debt or they have to pay off their debts. There does not seem to be an open policy on debts, how they actually get waived, or what we can do around that process. It would be good if we could gain that information, with the client's consent obviously, so we can actually find out what is happening in that area.

**THE CHAIR:** That raises a question for me as to your relationship as an organisation that works with people with mental illness and how easy you find it to represent their needs when you are dealing with ACT Housing. Can you give us your thoughts on that?

**Mrs McPherson:** I think it is like every government department. If you find a good contact in a department, then you work quite closely with that person but, as a general thing, I think it needs improvement. Most of our clients are willing to give us permission to speak with somebody on their behalf. So I think it is about maybe an overall policy on how to deal with organisations that are wanting to represent people on their behalf, because it seems to be always that you will find a good contact and that person will assist you all the time but if that person goes you do not have that contact any more and it is hard to get back into that department and work with them.

**THE CHAIR:** We heard from the last witness, who was from the ACT Office of Human Rights, that there was a belief that people within Housing ACT needed more training to understand better the needs of clients with mental health issues and how to deal with their needs. Do you have a comment on that? Are you aware of there being a dedicated person within Housing ACT who deals specifically with people with mental health issues?

**Mrs McPherson:** I am not aware of that, no. From my position within Work-Ways and from working with the client base previously, I believe that once upon a time I saw a position advertised that was going down that area, but I have not actually had any further contact with that person or know anything further about that.

**THE CHAIR:** How about the issue of training, which was the first issue that I asked about?

**Mrs McPherson:** I think that training needs to be ongoing. I do not have a great deal of contact with the department of housing, but I would suggest that it is probably similar to

Centrelink, where they have a high turnover of staff and they need to have ongoing training to keep up to date with what is happening and also to deal with people who have mental illness.

**MS PORTER:** Thank you both for being here today. Do you both work in the same area or does one of you work in the personal support program and the other one work in the unemployment area?

**Mr Brotherson:** I work in the disability employment area solely and Lisa is the executive director, so she oversees both programs.

**Mrs McPherson:** I am the executive director and I oversee both programs, but previously I have worked on both programs as well, have client contact, yes.

**MS PORTER:** My question is around when a person has already got accommodation of some description and then becomes ill or has more ill health, their mental health deteriorates in some way, or they become unemployed when they previously had a job and that affects them financially and maybe emotionally and maybe also makes their mental health deteriorate. Is it your experience that they may find at that particular time that the accommodation that they have does not particularly suit their needs?

**Mrs McPherson:** Definitely, yes.

**MS PORTER:** Could you explain in what way that happens?

**Mrs McPherson:** I went to a forum the other day and we had the same discussion about whether public housing should exist as a complex, with all the houses in one area, or whether it should be public housing in different suburbs and streets. Often we go to people's houses to commence them on the personal support program and hear that, because of the specific location that they are living in, they live next door to people who may be dealing drugs, committing crimes or whatnot. Lots of people with mental illness may be taking drugs for whatever reason, often to mask some of the symptoms of their mental health. So, being in those specific areas, they find that very difficult to deal with as well. I go to some of the public housing complexes and get very concerned about the condition of the houses. I am not sure of what the policies are around the conditions and how they have to be maintained, but I think that needs to be looked at as well. We often hear from the clients as well that they do not want to live in the area because they are scared to live in that area, or of their neighbours and the people who live around them.

**MS PORTER:** You mentioned that you had gone to a particular seminar which was exploring whether houses should be scattered in the suburbs or be in clusters. What was the conclusion that you came to?

**Mrs McPherson:** One of the DEWR suggestions was that, if houses were actually in a cluster as such, maybe housing could tap into the work for the dole scheme and actually get them maintained from that program as well. The discussion that we had was more about the ways that we can engage people from specific backgrounds in employment. One of the issues that we raised was housing, how it was difficult for some of the clients. That is where that discussion came from. It was not really conclusive on whether it should be in a cluster or individually but, as I said, the suggestion from one of the

DEWR representatives was the use of that program to maintain the housing if it was in clusters.

**MS PORTER:** But it was not suggested that, if the houses were in clusters, they would be able to obtain more emotional or personal support from each other.

**Mrs McPherson:** No. I guess the problem is that if it is in clusters, unless it is maintained at a very high level and there are very strict guidelines, the issue happens that our clients talk about that they are living next to people who they do not feel comfortable with.

**MRS BURKE:** I mentioned, but I am not sure what your answer was, the interface between the ACT government per se in terms of how you coordinate what you do with what they are trying to do to support people. I think you have hit on a very valid point about multiunit complexes, as we call them. You call them clusters. They are similar. Often we find people being isolated with no support. I am just wondering about where you get your client base from. Do we have ACT Housing working over here with mental health or whatever and you working over there, and ne'er the twain shall meet, or do you coordinate? Do you come together at all or do you talk to each other about who is doing what?

**Mrs McPherson:** No. I would say in a nutshell, no.

**MRS BURKE:** So it is very hit and miss, isn't it?

**Mrs McPherson:** Yes.

**MRS BURKE:** I suppose it is that privacy thing that we are all bound by and how we work around that.

**Mrs McPherson:** Yes. I guess that part of the role of the personal support program is to be that link, but then you have to have somebody that you are able to consult with within housing to be able to maintain that link and that is very difficult when you are just going in on a customer service level and you are just getting whoever happens to be on the desk or whoever answers the phone.

**THE CHAIR:** So housing does not currently have a community link, such as a liaison officer.

**Mrs McPherson:** They may have, but not that we are aware of, or not that we have had dealings with.

**MRS BURKE:** They do not link with you if they do.

**Mrs McPherson:** No.

**THE CHAIR:** There is a problem if you do not know about it.

**MRS BURKE:** Have you made yourself known to them in a formal way? Have you approached them to take a more formal and proactive role in working with them?

**Mrs McPherson:** The personal support worker does, because obviously she is contacting them a lot, but we still have not got that link as a one-on-one community liaison worker or somebody.

**THE CHAIR:** We have applied that acid test to housing. I want to apply the same acid test to Mental Health ACT. Can you tell us how you find yourself working with Mental Health ACT and if they have a dedicated contact person for you to deal with? You might also like to make a comment on the issue of caseworkers within mental health itself.

**Mr Brotherson:** Can you break that up as there were a few questions there?

**THE CHAIR:** Sure. If you start off with your dealings with Mental Health ACT, we might go from there.

**Mrs McPherson:** I will start with our dealings with the crisis team. I am probably saying what everyone here knows, but we have concerns about the crisis team and the assessment process, if somebody is suicidal or not well, and about how long it takes to actually get an assessment through ACT Mental Health. I find that, once people have case managers, we generally have a pretty good link with the ACT case managers and we do some case management together. That seems to work quite well. I guess it is just the whole thing again, that mental health teams might have a couple of case managers that we have really good relationships with and then there are the people that we do not have those relationships with. Generally we have developed great relationships with mental health and we do work with them.

With both of our programs we get referrals directly—or are supposed to—from Centrelink. Sometimes we do not get a lot of referrals from Centrelink, but we do have a good relationship with ACT Mental Health and we get a lot of referrals through to our program from them.

**MRS BURKE:** So nobody refers to you from a local level?

**Mrs McPherson:** At the moment there is still the dual pathway, so they can. However, we have to take them back through a Centrelink endorsement process.

**THE CHAIR:** Can I ask you about your awareness of all the organisations within, say, the ACT, because that is where you are working, that provide mental health support? Are you aware of the other organisations? How well do you work in with each other? I know that Mrs Burke just asked a question along those lines. I had vaged out for a moment, so if I have crossed over what she has asked, I apologise to her and to you. One of the previous witnesses was talking about the issue of more cooperation between organisations interstate, in South Australia. It is a very general question—

**Mrs McPherson:** I think we have quite good relationships with the other ACT mental health providers, whoever it may be, the mental health foundation or community housing or other community-based organisations. I guess what is happening at the moment is that the government is almost making a little bit of a conflict for us working with other places that deal with people in employment with mental health issues, such as other job network members and other disability employment agencies.

**THE CHAIR:** You are talking about the federal government there?

**Mrs McPherson:** Yes, sorry. I will make my point again. The different KPIs that they are putting on us at the moment are creating that barrier to developing those relationships. There is that competition element added to it of meeting the KPIs and getting the outcomes for people.

With community organisations in the ACT I think there is always room for improvement, but we do liaise with them quite often. Part of the role that we take on, even though we are not funded to do it, is to provide that referral base because we do get a lot of clients who just come to us. They may not be ready for employment, but they need to be referred on for mental health support.

**MRS BURKE:** Just before we go too far away from it, you were talking about your dealings or associations with the CAT team, the crisis assessment team. I have always found them to be really good and helpful, but I deal with them on the case management side. Is there a resourcing issue for them? Is it the process, the relationship? It is a bit like with housing. People come and people go. What is it that is not working?

**Mr Brotherson:** It seems that it is a resource issue from—

**MRS BURKE:** Human?

**Mr Brotherson:** Yes, from the CAT team. It has happened that we have called them with extreme examples of our clients who are suicidal, and nothing has come of it. That is an extreme example, but that has happened on more than one occasion. I imagine it is not because they are not doing their job properly. I imagine it is because they are just under funded.

**MRS BURKE:** No. There are committed people there. Is that on the increase, do you think, Ian?

**Mr Brotherson:** Is that on the increase?

**MRS BURKE:** Instances of dilemmas that you were having trying to get assistance through them?

**Mr Brotherson:** It is hard to say. In my time it has been steady. The crisis team, the CAT team, when they can, help out, but that same issue continues to arise from time to time where they are just unable to respond immediately, which is what is needed when you are calling the crisis team.

**Mrs McPherson:** I think there is a huge gap there of what is defined as “crisis”. Someone usually has to be at that very crisis state where they are suicidal and about to commit suicide. There is a huge gap of people that are left who do have very serious mental illnesses that do really affect their lives. They could not possibly work and they cannot manage life, but because they are not suicidal at the time they cannot receive assistance from the mental health teams because they are not in crisis or they are not seen as a high enough risk.

**Mr Brotherson:** The signs are ominous and we can see where they are going to end up. If that support could cut in earlier, then it might protect against that.

**MRS BURKE:** I think Ms MacDonald asked about your relationship with mental health as a whole. Again, is there a greater need for synergy with you or a tripartite agreement between you, Housing ACT and Mental Health ACT? If something more formal were to be set up, would that help?

**Mrs McPherson:** Yes. I think formality is good. Policies are good because—

**MRS BURKE:** A bit more structure.

**Mrs McPherson:** that adheres to a bit more structure. It allows people to actually continue to carry that out when people leave.

**MS PORTER:** Is there a high turnover, do you find, of workers?

**Mrs McPherson:** Yes, there is quite a high turnover. I would say, with my five years at Work-Ways, it is probably improving, but I think there is still a long way to go, especially around that crisis assessment team. You will hear that numerous times from the clients who come in who have called for different reasons.

**MRS BURKE:** I guess the level of people with mental illness is exponential now throughout Australia. I think that is recognised in a very bipartisan way.

**Mrs McPherson:** Yes.

**THE CHAIR:** Would you care to comment on how much of the load of living with mental illness that is borne by the families of the people living with mental illness could possibly be alleviated by these people being provided with their own housing?

**Mr Brotherson:** So how much could family support networks take care of these people outside of—

**THE CHAIR:** Would it be preferable for the person with a mental illness to actually be in their own accommodation, rather than be living with family?

**Mr Brotherson:** It is hard to put a figure or a percentage on it. There are examples of people's mental health being made significantly worse as a result of their living arrangements. One of the things that can aggravate mental health is living arrangements, even if it is with your own parents, say. In some situations it is very important for people to have some space from their family and support network. So there are examples where that is imperative. It is hard to put a percentage on what—

**THE CHAIR:** Yes. I am not necessarily looking for a percentage.

**Mr Brotherson:** Yes, an amount—

**Mrs McPherson:** I would like to add also that I would like to see, maybe through



ACT Housing, some independent living program arrangements or some services offered so that people can learn independent living skills while living in ACT Housing. I know there is community housing that provides similar services, but a lot of our clientele may not have the skills to be able to live independently in an ACT Housing property. So I would like to see some sort of independent living program offered through housing.

**THE CHAIR:** That is a very pertinent point.

**MS PORTER:** What is the make-up of the client group that you work with? Are the majority of them single and younger or have you got a mixture of—

**Mrs McPherson:** We have a really huge mixture of—

**MS PORTER:** So you have families?

**Mrs McPherson:** We have families. We have school leavers who are still living with their parents. We have a lot of people who have been out of the work force for a number of years and are looking at getting back into the work force. They may be living independently. A lot of people who are in the older age bracket, I guess, are still living with their elderly parents because they do not have those skills to live independently. So, yes, it is a very vast range.

**THE CHAIR:** I think we are going to have to finish it there. Thank you very much for your appearance today. It was very helpful. We will be sending you today's transcript so that you can check it for accuracy and make sure that we do not actually get anything wrong in it. If we do have any further questions, we will be in touch with you. We will also be in touch with you when we have the report written. Thank you very much for your appearance.

**Mrs McPherson:** Thank you.

**Mr Brotherson:** Thank you.

**Short adjournment.**

**LINDA ROSIE** was called.

**THE CHAIR:** Good afternoon. You should understand that these hearings are legal proceedings of the Legislative Assembly protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means that you are protected from certain legal action, such as being sued for defamation, for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter. Do you understand that?

**Ms Rosie:** Yes.

**THE CHAIR:** Could you start by stating for the record your name and the capacity in which you appear today?

**Ms Rosie:** Yes. My name is Linda Rosie. I am the Executive Officer of the Mental Health Community Coalition of the ACT.

**THE CHAIR:** Thank you, Ms Rosie. Would you like to start by making an opening statement?

**Ms Rosie:** When it comes to addressing the issue of housing for people with a mental illness, there are a few things that really are of critical importance. It encompasses far more than just providing a roof. It encompasses the whole essence of what that roof provides. That roof provides stability, it provides permanence and it provides safety. It is important that the accommodation we provide provides all those things, along with those resources that enable the person to stay in that house, that permanent home, with that stability. They are the major issues that the coalition sees could be addressed in a better way than they are at the moment.

Along with all that goes the ability to choose where you live. Because people have a mental illness does not mean to say that they do not have preferences in the type of accommodation they want to live in. Often they will choose those places that are quiet and conducive to good mental health, and often those accommodations are not available to them.

The supports that people need to maintain their accommodation are the supports that they need to maintain good health. They range from the sorts of things that the housing program looks at in New South Wales—and some of the issues are already dealt with well in the ACT, but need to be extended—as well as the recovery focused philosophy that is prevalent in the community sector that encourages people to be well, to stay well and to be a full part of the community.

At the moment the delivery of services for mental health in the ACT is much more focused on the acute end of service, rather than on the recovery focused end. Housing plays a large part in that. The permanence, the safety and the security are all tied together, along with the different sorts of accommodation we need. I mentioned choice, but I am talking about permanent homes there. I am talking now about the types of accommodation we may need for a short term to enable people to avoid acute episodes or recover quickly from an acute episode. At the moment service is delivered when people

are acutely ill. That means suicidal. It does not mean seriously ill and recognised as such; it means suicidal. Then people are admitted to the PSU.

They are still seriously ill when they come out of the PSU. They are just not suicidal. At that point they go back into whatever accommodation or lack of accommodation they have had without any supports. I am suggesting that we have something called a step-up facility. That means that, to avoid going into the PSU, you can choose under your own steam to say, “I’m becoming unwell. I need a safe, supportive environment.” That hopefully, with the documentation, will avoid an acute episode of illness. Conversely, if you have had an acute episode of illness, rather than just being discharged from the PSU when still seriously ill, there is somewhere to go where you are maintained and encouraged into that wellness before you can go home. The estimate from overseas is that is often up to a three-week period of time, both before and after.

**THE CHAIR:** Can I ask just about the notion of a step-up facility? That is a facility that people choose to go into. How often do you think it would be an issue that people who could actually utilise this service choose not to because they will try and ride it out themselves?

**Ms Rosie:** Well, it is a possibility. In some cases, especially where you have complex needs involved, it is a possibility. But we are talking about people, before they get to that stage, actually recognising it within themselves and being responsible for their own wellness. This is a matter of turning mental health service provision on its head and people with mental illness recognising that there is actually somewhere to go to become well, rather than just having to get to the acute end of things. So I think in a transitory stage there may well be more of that sort of situation than there would be in the longer term if we had the facilities available to deal with that situation.

**THE CHAIR:** This committee has had a look at some of the facilities in Victoria.

**Ms Rosie:** Yes.

**THE CHAIR:** So we did actually see a facility.

**Ms Rosie:** Parkwood at Shepparton.

**THE CHAIR:** Yes, we went to Parkwood, the place that used to be the place for wayward girls. That is the sort of facility that you are actually envisaging so that people can avoid the hospital setting?

**Ms Rosie:** Or avoid getting to that sort of life or death situation. They have become acutely ill and take a very long time to recover. It is a personal responsibility thing, too. You acknowledge when you are becoming unwell and take steps to avoid it. It is empowering. Again, it will take a while for that situation to really become an established expectation within mental health consumers because the facilities do not exist at the moment, but I think it is something that we could really work towards.

**THE CHAIR:** Before I pass over to my colleagues, do you envisage that there would also be a step-down facility post-hospitalisation?

**Ms Rosie:** Two separate facilities for choice, yes.

**THE CHAIR:** Two separate facilities. So it would not be the same facility?

**Ms Rosie:** No.

**MS PORTER:** Mental illness appears to be a growing problem in our society. It may be that it is being better diagnosed and better identified. I do not know. Anyway, it appears to be a growing problem in our society. Resources will always be scarce because, no matter how much you pour into the health system, it seems to suck up whatever resources you can supply. Could there be a danger, once these facilities are established and become generally known—and this is a devil’s advocate question—that people could use them rather like a crutch? They could say, “This is a nice welcoming place where I can go. I do not have to manage by myself. I can just go there. I do not have to manage by myself when I get out of hospital either. I can just stay there and not have to face the big bad world.”

**Ms Rosie:** I think there will always be abuse of any system you put in place. As I said, in the United Kingdom they have generally found that three weeks is about the length of time people choose to stay. It is a difficult thing when you are envisaging a completely different mental health system. I envisage one that is recovery based where we do not actually get into the acute end of systems and service delivery and people are maintained well in the community and the resources are there for that. It is not about building more and more acute beds, which is what we appear to need. In fact, what we need is to have those resources to keep people well so that they do not go into the acute beds. Then they can function better in society. They can have jobs. They can maintain families, mortgages or whatever.

I see the whole focus of delivery of service to be completely upside down from where it is at the moment, although we are moving in that direction. One of the things I would like to highlight to this committee that I did not include in the submission last year, because I did not know about it, is something that has been developed in the UK and has been evaluated and found to be very effective. They are called support, time and recovery workers.

This is a national initiative with a training scheme support mechanism. Basically the employed people are there because of their knowledge and experience in mental illness, the training that they have acquired along the way. They service those needs to maintain people in the community. They give the support. They provide the time. If we had that sort of system, the PSU would be empty. The CAT team would be sitting there learning how to knit—in theory.

It turns the whole delivery of service on its head. It turns it much more into personal responsibility and personal fulfilment—actually staying out of the PSU and staying well. It is an ideal scenario. This is an evaluated system that is working that really I would like both the ACT and Australia to look into in a more fundamental way to see if it would work here.

**THE CHAIR:** Thank you for mentioning that. We will certainly have a look into that. It sounds very interesting.

**MRS BURKE:** Thank you for appearing before us today. We have talked to people appearing today about their relationships with the ACT government and other stakeholders. I was looking at page 9 of your report and you mention Mental Health ACT and Housing ACT. You talk about a memorandum of understanding. You say it is perceived to be inadequate or not adhered to by all Mental Health ACT staff. Can you elaborate on that a little bit? Where is it breaking down, and why?

**Ms Rosie:** I wrote this document after having individual consultations with service providers, consumers and carers and coordinating their responses. The things that were consistent went into the document. That is why it is a bit all over the place.

There are a number of MOUs from mental health and between various organisations. One of the problems with MOUs is: do people know about them? The other one is: how do you activate them? They are common problems with all MOUs. I think those issues need to be looked at and addressed so that the MOUs that are there become effective.

Some of the MOUs do not cross all service delivery. They will cross the government side of service delivery, but that does not involve the community sector. It is one of those divisive things again. So the establishment of MOUs can be very beneficial, but they can also be very discrete and formulated just to keep the status quo as it is. So there are many issues around MOUs. I am not the most knowledgeable person on them.

**MRS BURKE:** I have another question. There is so much we could ask. In your submission you also talk about a range of housing options here. Are there enough housing options, do you think, for people with mental health? Is it just that we do not coordinate well or is there a lack of support or is it all of the above?

**Ms Rosie:** I think it is all of the above.

**MRS BURKE:** Talk about the housing options first.

**Ms Rosie:** I think the first thing is that we, all of us, like to choose where we live. I do not see that, because you have a mental illness, you should not have that right as well, especially when good mental health is maintained best in an environment where you feel most comfortable. Those options are not there or they are very few and far between. If you choose to live in a quiet leafy street, be it in a one-bedroom flat or whatever, we do not really have those options available in the quantity that we perceive would be needed. We do have many small flats in large complexes where there are a lot of issues and needs and noise and chaos, and those things do not help people maintain stability or good health.

In terms of housing options, we seem to have lost a lot of accommodation, and some of the accommodation was not good. But we do not have the number of roofs that we had, say, five years ago. We do not have that number now. That is highlighted by the case of a young person coming back to the ACT a few years ago. Within a few weeks she was housed. Now, even if that young woman is on the priority list, the last time we spoke to someone from housing it was a minimum of eight months. If you talk to the community sector, it will be a year before that priority person is housed. So just in the service provision we have lost the stock to some extent.

**MRS BURKE:** I think the Productivity Commission report would back up what you are saying there. What has changed, then, in terms of the housing stock? Some has been sold off. How has it fundamentally shifted or changed, and over what period?

**Ms Rosie:** Over the last five years we have lost Lachlan Court and Burnie Court. They were not good places to live, but they did provide a roof over your head. We do not seem to have replaced them with anything. I do not think we have the same amount of housing stock we had those years ago. We have just lost the numbers. But, in terms of choosing where you live, you did not have the choice then; you were in one of those places. But we still do not have that now.

**MS PORTER:** You said that at the time of writing this there was no clear mapping of many health community services in the ACT. Has that work been done since, because the community sector obviously identified that as one of the things that they wanted to do?

**Ms Rosie:** Yes.

**MS PORTER:** Has the community sector itself provided any information to the government about—

**Ms Rosie:** One of the problems is the funding of the community sector. Mental Health ACT will know all the services that they provide through the granting process, as will housing, as will disability, as will every other funding body. But that shared knowledge is not coordinated into one area. I got a student to actually enter data on community organisations—we had a program written for us—that would also collate all the collaborations that were going on, organisations they are referred to and referred from. This is our biggest problem—a student for two days a week. Because we do not have the resources to try and raise the issue, the community sector itself does not actually know how few programs are happening over here and over there because of the different ways in which they are funded. That is one of the information trails that you can go down. The funding bodies can tell you who they fund and what they fund. But there are all sorts of little things that get funded for a year or two and then disappear in the way in which we allocate resources in the mental health sector. One of the problems is the lack of permanency.

**THE CHAIR:** In your submission you mentioned the purchaser/provider model being quite damaging and that it would take time to recover from that because it set up provider against provider and that, while this has been replaced, it has not necessarily been replaced by the most ideal situation for the community sector. How far down the track do you think the community sector is in terms of recovering from that sort of damaging situation?

**Ms Rosie:** I think the situation is a lot better than it used to be. Basically it was setting up one community organisation against another in competition, and that does not encourage linkages or collaboration or whatever. There is a lot more cooperation and collaboration going on within the community sector, both in terms of service delivery and in terms of setting up projects and wanting to work together. I think there is still a long way to go. Once we get over that whole hiccup, hopefully that information will be more accessible

to enable more people to know what services there are, and where, and who provides what.

We do have a large number of small project-based organisations in the ACT. We are a small community and we have many, many organisations and, while we need the choice, we tend to set up an organisation rather than make it a project of a larger organisation. It is very difficult to actually collate it all because you have got small resources in a small organisation. They do not have the time or the energy to do more than provide a service, let alone let the rest of the community know what they are doing.

**THE CHAIR:** While we are on this issue, we heard earlier today about the issue of training for staff within Housing ACT, as well as the possible need for a community liaison person within both Housing ACT and Mental Health ACT. Would you care to comment on that?

**Ms Rosie:** There are some excellent people in all these organisations. There are also some people who have little understanding of mental illness. My cure-all to all this is these STR workers. It is that sort of knowledge of mental illness and that reduction in the stigma of mental illness that has got to go community wide and just be fundamental within the organisations themselves to have the culture of an understanding of—I would not say mental illness; I would say complex needs. While some organisations are getting an understanding of mental illness and its effects, they have very little understanding of complex needs of people, say, with drug and alcohol issues as well. That in itself brings a whole heap more understanding and a need for that reduction in stigma.

**MRS BURKE:** I have a question in regard to culturally and linguistically diverse communities. We see indigenous people with mental illness. We all know there are differences, but not a lot of people can articulate what those differences are. We all say there are differences. Where are we falling behind the eight ball on that? In your valued opinion, what can we do to boost that, repair it or reinvent it? What needs to be done?

**Ms Rosie:** I do not know what the solutions are. I just know what the problems are, really. The added problem of the language and the cultural and linguistic divide, depending on culture and the language, is that they are just added barriers to everything that is in my submission. Just using a telephone, getting the CAT team and trying to make yourself comprehensible on the phone when it is your second language and you are stressed, can be a nightmare. I do not think I could come up with a solution.

**MRS BURKE:** Is there an increased level of need for an interpreter service to be working more closely with such organisations, given that it is such a key issue for them to try and get that point heard, particularly when you are trying to get a roof over your head?

**Ms Rosie:** I think one of the issues is actually picking up the telephone, rather than whether or not a particular culture would automatically take the first resource. It is not just a case of how you would access service in these circumstances. Would you access service? Would it be an enclosed thing within the family or within the community? It is that knowledge of the different cultures and working within those cultures to identify from them what their needs are.

**MRS BURKE:** It goes back to training, really, does it not?

**Ms Rosie:** It does, but it is going back to asking the people what they need, saying, “How can we help you?” That simple question will often come up with the most amazing answers that have nothing to do with what we think the answers will be.

**THE CHAIR:** Ms Rosie, thank you very much both for your submission and your appearance here today. We really appreciate it. We will be sending you a copy of the transcript so that you can check it for accuracy. If any further questions arise, the committee will correspond with you. We will also let you know when we have a report. Thank you very much.

**MRS BURKE:** It was an excellent submission, by the way. I probably did not say that well enough. It was really good.



**HEIDE SEAMAN** was called.

**THE CHAIR:** Welcome. You should understand that these hearings are legal proceedings of the Legislative Assembly protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means that you are protected from certain legal actions, such as being sued for defamation, for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter. Do you understand that?

**Ms Seaman:** I understand.

**THE CHAIR:** For the record, would you state your name and the capacity in which you are here today?

**Ms Seaman:** I am Heide Seaman. I am the assistant CEO of the Richmond Fellowship of the ACT Inc. I am also the coordinator of the adult program.

**THE CHAIR:** Thank you very much for your appearance today, Ms Seaman. I would also like to put on the record the committee's appreciation for your allowing us to come and visit your facility, however long ago it was now. It was last year. I remember it was hot. Would you like to start by making an opening statement?

**Ms Seaman:** I have prepared something, but I prefer to answer questions first and if there is something that has not been covered in the questions, I could do that at the end. Would that be acceptable?

**THE CHAIR:** It often helps us to ask questions if we go off an opening statement. Even though we are aware of your organisation, from having visited, as we said on the day, it would be good to actually get some of that information on the record.

**Ms Seaman:** When we met last I think I gave an overview to everyone about what the Richmond Fellowship provides and services. I have done a little abridged version of answers relating to the various terms of reference. If I just read them out, would that be okay?

**THE CHAIR:** That would be great. Thank you.

**Ms Seaman:** As far as support mechanisms for people who are currently living in public housing, the Richmond Fellowship provides support and rehabilitation to people with a mental illness who live either in a public housing property managed by Richmond Fellowship—and we have 13 places—or in a property managed by Havelock Housing Association—and there are 34 places—or in public housing managed by the Department of Disability, Housing and Community Services. The number of clients in public housing varies. We had 17 clients this January who lived in public housing flats.

We are contracted to support a minimum of 42 mental health consumers at any one time. Our average is between 42 and 59 clients at any one time. Our support is provided through staff visits to the individual during business hours and from contact after hours.

All our clients have an individual support plan that is based on their own personal agenda, and we work to accepted psychosocial rehabilitation principles. So these are some of the support mechanisms that we can provide to people who live in public housing or in housing managed by other agencies.

I want to mention some of the opportunities to involve non-government stakeholders and the provision of appropriate housing. It is my belief that housing is best provided by non-government agencies. I think the role of landlord and support provider should also be separated, wherever possible. It makes better sense not to have a landlord who is also your therapist. Most people with a mental illness want to live in their own place eventually and, except for a small number of people, that goal is possible.

Our group houses are full of people who want to live without group house rules and without having to share living areas and having staff coming in who insist they clean up after themselves. That is not real life. It does not happen to other people. We need to plan for those people who want, and can manage, to live in a place by themselves.

The Richmond Fellowship has been fortunate to have a partner in housing who has worked with us to make that possible, but we need more of these places. Our successful partnership with Havelock Housing Association as an alternative housing provider has been in operation since 1997. We have developed a service agreement that is seen and signed by each new client who is housed by Havelock. Our first 10 properties were a mix of housing stock and private properties provided by Havelock. Today Havelock is the landlord of 28 properties leased to mental health consumers only and it provides another six places in a special unit at the Havelock Housing complex in Turner.

All of these tenancies started out with support provided by the Richmond Fellowship. Over the years the majority of tenants have managed to become independent of support services while maintaining their tenancies. This is a highly successful housing scheme and many consumers have told us that their housing has been a major factor in their increasing independence and ongoing wellbeing. People with a mental illness need a benevolent landlord who considers their special needs and ensures that housing is of good quality. All the units we have received through Havelock Housing have been of an exceptional quality.

My next point concerns the feasibility of alternative support-based housing models. I think one of the major concerns for most of our clients is social isolation and many of our clients depend on staff for human contact. So any support-based housing model should consider the isolation experienced by people who live in large blocks of flats and are fearful of neighbours. We would like to see more housing provided in a similar way to aged care units, with small one-bedroom units in a block of four or six, close to facilities and with a small outdoor area each. This would allow for small communities to be created where people can look out for one another without encroaching on each other's living space. This would be just one example of increasing housing options for consumers.

The recent development in Gungahlin has proved extremely popular amongst our clients. The project, known as Gungahlin Singles Accommodation and managed by Havelock Housing Association, provides a joint management model of the provision of supported accommodation in long-term sustainable accommodation for people with

mental health issues. We presently have four places for mental health consumers in that complex. We need more of this type of accommodation, particularly for people who have substance abuse issues as well as mental health issues.

Our present program for young people with these issues operates from one of our group houses. The program, although presently under-resourced, has been highly successful in offering young people the opportunity to address their substance abuse in a supportive environment. Some of these young clients are ready to move to their own place, but there are no suitable places available and our concern is that these young people, who will move out because they feel they have gained sufficient living skills to live in a place of their own and find group house rules somewhat stifling, are likely to end up in an environment which will put them at risk. Many months of hard work may be undone because under the present system of priority allocation through public housing they are likely to end up in an area where there is a high incidence of drug abuse.

There are also a small number of people with mental health issues who would benefit from a type of boarding house accommodation. We have looked at the Abbeyfield model because this model allows for a resident housekeeper. There are two Abbeyfield houses in Canberra for the aged, but I understand a new Abbeyfield house for young people with intellectual disabilities is about to be built this year.

One other important issue relating to housing for this client group is financial resources to turn a place of accommodation into a home that one can be proud of. When we received the first 10 places in 1997, we also received a grant that allowed us to help people with household necessities, white goods and linen. The money spent was minimal, but the long-term benefit has been considerable. At present we are managing a similar scheme under our adolescent program for young people leaving home, which is called transitional independent living allowance and allows people who leave home for the first time to have some set-up costs met by a fund that is administered by us.

**THE CHAIR:** Thank you very much. I think that was very good. I am glad that we started with that. We had an issue raised with us earlier—I can't even remember who it was now because you're the fifth person we've heard from today and it's starting to all blur into one—about some people with mental health issues preferring to remain homeless because they couldn't go into ACT housing with their pet—a dog or a cat; large dogs I think specifically were the issue. This hasn't arisen before, but do you have provision for people to have an animal with them?

**Ms Seaman:** Not in our group houses because we find that the pets that we have allowed initially to live in our group houses have created tension amongst people who were allergic to or didn't like pets, or the pets were neglected and whatever. However, in our arrangement with Havelock housing we have one young man who has a dog. He cannot live without the dog, and he has been waiting for a place with us through Havelock housing. We found a place and he lives there with his dog. The dog has a big enough backyard and it's an excellent supportive partnership between the two. This young man moved in there, I think, about 18 months ago and within three months no longer needed mental health or our services. He maintains himself very well with the support of his dog and any other sort of support arrangements that he can organise for himself. So it is possible, but it needs to be the right landlord. Havelock, in our case, have proven to be very understanding.

**THE CHAIR:** I suppose that's where the issue of having complexes of four to six individual living units, for want of a better term, for people with mental illness could play a part, so that they could have communities and if they wanted to have a pet it wouldn't annoy anybody else.

**MS PORTER:** It seems to me that one of the issues is that, whilst a person could live individually for quite some time, something needs to be there to allow flexibility to move into some other form of accommodation—not necessarily crisis accommodation but some other form of supported accommodation—quite quickly. How flexible can we be and how can we enable people to move from their individual circumstances into something more supportive for a brief period of time and yet not lose continuity with their individual home, which they're obviously renting? How do we manage that complex situation for individuals?

**Ms Seaman:** I'm aware of a number of cases where people have become unwell to the point where they've spent considerable time either in hospital or at the Brian Hennessy Rehabilitation Centre and they've maintained their flat by paying the minimum amount of rent so they had somewhere to return to. That may not always be feasible. Our program—and we call it Network for exactly that reason—allows for people who may need more intensive staff contact or may need to have some people living around them to leave their own place of accommodation and stay in our group house for a period of time and then we'll try and assist them again to return to their place. So there is flexibility in moving people in between properties, but the continuity of care is there because the same person will see them in the house or wherever they happen to stay for a period of time.

There are some problems because we are charged by housing, so any place we occupy we pay rent on. So, if somebody lives somewhere else and has to pay rent there and that person came to us, they would also need to pay rent there. So it's always a financial issue that perhaps keeps people from being able to move around and spend time in different places where there's either more or less support depending on what their needs are. We have a large number of people now who have been with us since 1997—I've got the figures here—and most of them no longer have our support. Did you want figures on that?

**THE CHAIR:** Yes, that would be great. Thank you.

**Ms Seaman:** We had a total of 39 consumers in a total of 34 places. Fourteen received support from the CAN program and 15 of those live independently now. The majority of those have lived independently for over two years.

**MRS BURKE:** Sorry, you said 14 received support from the—

**Ms Seaman:** Yes, from our staff, and 15 live independently.

**MRS BURKE:** Yes. That's a program?

**Ms Seaman:** It's the CAN program, Community Accommodation Network, from the Richmond Fellowship.

**MRS BURKE:** Great, thanks.

**Ms Seaman:** Under the Community Accommodation Network, which is the Richmond Fellowship program, we have three properties that we rent from public housing, as I mentioned earlier on, and we have a number of properties that are allocated to Havelock housing, where they are the landlord. Between those two, we can have some movement. Where people have lived a long time in a flat but feel they're not doing very well, in certain areas—in particular, Strathgordon Court in Lyons seems to have a regular turnover—they need to move out and so they may spend some time in our group house and then we try and get them into other housing, or they return to their flat if they want to go back there. So that is possible, and we've had a few instances where that has been the case.

**MRS BURKE:** You just mentioned Strathgordon. That would be a good area, I suppose, in many ways but not in others. It's near a regional centre and that sort of thing.

**Ms Seaman:** Yes. It has the advantage of being near services, and the disadvantage of there being a high turnover. There are quite a number of priority allocations, which make for not such a stable population.

**MRS BURKE:** Yes. I have another question that I've asked of other people today. Relationships with other agencies seem to be a common theme and how we can improve and enhance them, make them work better and enforce them, if you like, for want of a better word, with memorandums of understanding—the way in which we interface or you at Richmond Fellowship interface, particularly, obviously, with people like the mental health crisis assessment team and Housing ACT. You've explained that you have a pretty good relationship with Housing ACT but what about other agencies, government and non-government?

**Ms Seaman:** Yes. We have a memorandum of understanding with mental health services and we have a memorandum of understanding with Havelock housing, and they both work reasonably well.

**MRS BURKE:** How do you make that work? What makes it work for you?

**Ms Seaman:** Patience, understanding of the pressure that people are under, and constant communication. It is quite difficult to maintain a good and cooperative atmosphere at all times when you quite clearly know somebody else is not doing their job. But everyone has an off day or can't meet obligations. I think we all have to be tolerant in that. It is time and energy consuming. I heard the previous speaker, Linda, commenting on that. I think the atmosphere, as she said, has changed in terms of competitiveness amongst NGOs, which was mainly due to the tender arrangement.

**MRS BURKE:** The purchaser-provider model, yes.

**Ms Seaman:** Yes, the purchaser-provider arrangement that we had before. But to have those relationships one needs to foster them and that takes quite a bit of energy. Some time ago I set up a sort of very casual interagency—let's get together and just support each other on the grassroots level. We maintained that for about 18 months, but then it slowly—

**MRS BURKE:** People got busy and—

**Ms Seaman:** Yes.

**MRS BURKE:** So it needs somebody to drive and coordinate—perhaps the MOUs we were talking about. One suggestion that has been talked about is a community liaison officer or something. Do you see that being of help? Would that help to—

**Ms Seaman:** I don't know. It's another position that may not reach—

**MRS BURKE:** Yes, that's true. It's just another layer, yes.

**Ms Seaman:** to everyone. We've been fortunate enough to have a person who worked for us for three years who ended up in housing. So this person is now not so much our spokesman but certainly brings the understanding and knowledge of people's needs to that particular department, which has been helpful. So the liaison officer may be one solution. I think there are others. I think people just need to have the opportunity and be encouraged to talk more to one another.

**THE CHAIR:** You're fortunate in that you have somebody who understands the work of Richmond Fellowship, which is very good—don't get me wrong—so they've come with an understanding and gone into housing, but it's dependent on that person rather than a position having that training. Do you want to make comment about training of staff within Housing ACT with regards to people with mental illness?

**Ms Seaman:** Yes. I've done some of that in the past in housing, when it was called social security, but people in there change and then some of that is lost. It's really an ongoing process. If people are trained in there, people still need to take some ownership—organisations like Richmond Fellowship and others—to maintain some contact with any agency. Our relationship with housing has been exactly that. Whenever there was a query or whenever somebody said, "Look we've got this client, it's highly confidential, but could you give us some tips," I would immediately offer whatever knowledge I could bring to the table and say, "I'm happy to be part of the discussion, where it's needed." So I think it needs a lot of good will and I'm not sure that's always there because people are just so pressured for time.

**MRS BURKE:** We talked about Mental Health ACT. Your relationship with them?

**Ms Seaman:** It's good. There are certain individuals who we will never have a good relationship with, but it's more a personality issue.

**THE CHAIR:** That's life, I suppose.

**Ms Seaman:** Overall, it's pretty good.

**THE CHAIR:** Other questions?

**MRS BURKE:** I do have one. Because we've seen you before and we've spent a lot of time with you, we may not need to use the full time, chair, but there was just one thing.

You talked a little bit about the independent living arrangements and how it's working well for you. That's in terms of Richmond Fellowship giving the support to people in those properties that you talked about?

**Ms Seaman:** Yes.

**MRS BURKE:** So it's really a little bit of a community that you have, isn't it, with Richmond Fellowship and your clients? So you wouldn't really know external to that, or do you, in your travels, come across other people that it's not working for, that are not clients of yours, that sort of help you improve your service—that's what I'm trying to say—and identify gaps in service delivery somewhere else?

**Ms Seaman:** When it's not working for people, it is quite often the area where they're living; that has been our experience.

**MS PORTER:** In terms of geography or in terms of type of housing?

**Ms Seaman:** Perhaps a bit of both. I think people accept housing because it's the best they can get, and then find that this housing actually contributes to them becoming unwell: they have difficult neighbours; they are intimidated; they are moved from their support networks and have no money to catch buses to get there. In some of the cases that we deal with, young people live near friends that supply them with drugs and they move away from that area and are able to maintain—if not abstinence—some kind of more responsible drug use because they're not that close to their supplier. Then something happens and they end up in an area again where it's very easy to access drugs and they become unwell again. So it's a number of issues. I'm not aware of other systems, but, because ours is so spread over the whole of Canberra, people do make contact with other agencies and we encourage that, because our aim is to become unnecessary in their lives.

**MRS BURKE:** You have a high success rate, and I guess that you could be a model; they could take a leaf out of your book and pass it around. Going back to the support thing, the independent living arrangements and the things that do break down, is it a case of not enough support workers out there, is it case management, or is it both of those things, as well as the housing?

**Ms Seaman:** It's probably a mixture. It's probably that people need more support over periods of time, but also I think the lack of clinical management is becoming a little bit alarming. I do think that people are being discharged from mental health at a very rapid rate. I understand that could be because of lack of resources or they concentrate on the really unwell people, which I think is their core business. However, they will end up with a lot more unwell people if this keeps going, because if all agencies step out then somebody will deteriorate quite badly before somebody steps in, and then the road of recovery is much more arduous and longer than it need be.

So I think it's really about timely intervention. We say to everyone who we exit—we try not to say “discharge” because it sounds so medical—who leaves us, that they can return to our service at any time if they feel the need. Even if that is only having phone contact with one of our staff, we try and make it possible that there is some contact, which will give them the message that, if things don't go well, we are here to assist in any way we

can. That isn't always possible if people are discharged from a system and there is no follow-up and people fall in a hole. Then it becomes far more difficult to pick them up.

**MS PORTER:** You were in the room when the previous person was talking about the step up, step down. Do you see that as part of the suite of options that could assist you in managing those sorts of situations: they would come out of the acute facility but they would have another option to go to?

**Ms Seaman:** Yes, I think that's highly desirable. In the ACT the gaps between the various services are just too big in terms of support. Brian Hennessy Rehabilitation Centre really focuses on rehabilitation now, so people don't stay there for a very long time. But there is a small group of people that have been psychiatric clients for a very long time; they have a 20- or 25-year history of mental illness. Their living skills and their cognitive skills are severely impaired and there is no place for them. For that group too there needs to be something that takes care of their daily needs. When they go to Hennessy there is a rehabilitation program, but these people are already rehabilitated to the level that they can function; there is no higher level. So they don't qualify for that one. The same when they go to hospital: on discharge there is nothing out there. What used to be provided by Brian Hennessy is no longer available because they focus on rehabilitation. So people who come out of hospital and cannot return to their home really have difficulty in managing, and often relatives then become responsible for maintaining them.

We often get people discharged on a Friday afternoon back to our group houses who have had a serious suicide attempt. We are not notified. That in itself to me presents a serious gap in the services, because we then rely on other group house residents to either notify us or to support that client over the weekend—because there's no staffing on the weekend at our houses at present—to make sure this client doesn't end up back in hospital. So the gaps between hospital and community are too big, and there is definitely a need for a step up, step down service because people can no longer access Brian Hennessy in the way they could before where that was provided.

**THE CHAIR:** That sounds very much as though there's a need, when they're discharged, for the discharge plan to notify the appropriate people in organisations?

**Ms Seaman:** Yes, we don't get notified.

**MS PORTER:** Is that somehow tied up with the privacy legislation, or is it just bad communication or poor communication?

**Ms Seaman:** It's bad management, yes. I think quite often the pressure of weekend admissions looms, so they free a few beds. They look at people who can go home and they send them home, which can be very alarming when we come in on Monday morning and someone who was seriously unwell the week before is back at home—has been back in our place for two days and we didn't know. They could have gone straight home, gone up into their bedroom and killed themselves—nobody would know. So the lack of communication is one of the biggest issues, and I don't know how that can be overcome.

**THE CHAIR:** We'll have to leave it at that. Thank you very much for your attendance



today. As you have heard me say to the previous witness, we will be sending you the transcript so you can check it for accuracy. If we have any further questions that arise in the course of the proceedings, we will be in correspondence with you, and we will also notify you when we have the report. Thank you very much for everything that you've done to assist the committee.

**Ms Seaman:** Thank you for the opportunity to speak to you.

**Short adjournment.**

**SUSAN MARY MACLEAN** and

**SONJA OSFIELD**

were called

**THE CHAIR:** You should understand that these hearings are legal proceedings of the Legislative Assembly protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means that you're protected from certain legal actions, such as being sued for defamation, for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter. Could you please state your names and the capacity in which you appear today.

**Ms Maclean:** I am Susan Mary Maclean and I'm the CEO of Canberra Community Housing for Young People.

**Ms Osfield:** I am Sonja Osfield and I'm a specialist counsellor with Canberra Community Housing for Young People.

**THE CHAIR:** I'd like to start by thanking you both for appearing today. We appreciate you coming to assist us with our inquiry as we want to hear from the community providers. Would you like to make an opening statement as it often helps us to get the questions rolling.

**Ms Maclean:** I thought I'd just give a little background into the organisation for those who don't know much about us. Canberra Community Housing for Young People was established in 1990 as the ACT response to the Burdekin report into Australia's homeless youth. We've got two distinct arms to the organisation, one of which is our SAAP program, where we're funded to provide supported, independent accommodation to young people aged between 16 and 23. Support is provided as an outreach service.

The second program is our community housing program, which has very much the same eligibility criteria as ACT Housing. As a member of Community Housing Canberra, our organisation has received 47 properties under the stock transfer program and subleases these properties, with a minimum of 22 places allocated to young people. A further six properties are on a CORHAP arrangement with ACT Housing. At present we're housing 45 adults and 25 children in our community housing program, and 24 young people in our SAAP program. Currently, we employ three staff members. I joined the organisation in 2002. Rory, our other worker who isn't present today, commenced in 1996, and Sonja in 2001. We've been very fortunate to have that kind of stability in our workplace. That gives you a background into the organisation.

**THE CHAIR:** Yes, thank you very much. That was good. You're the sixth of a string of people who've come before us today and we haven't had a break, so if we appear a bit shell-shocked that's why.

**MS PORTER:** The young people that you deal with don't necessarily suffer from or experience any kind of mental illness?

**Ms Maclean:** I would say, with the exception of two, most would be suffering from some form of mental illness or trauma—some not officially diagnosed—because we're housing quite a number of refugees at the moment.

**Ms Osfield:** And also behavioural problems, as well as drug and alcohol problems, so it's the whole gamut.

**MS PORTER:** So how many of them, Sonja, would be counselled by the counselling arm of the service?

**Ms Osfield:** We don't actually have a counselling arm of the service; we have a support arm. What we do is support them in their tenancy. I work as part of the SAAP program and every single one of our SAAP clients receives support. We have approximately 24 SAAP clients at the moment.

**MS PORTER:** How long is the time usually that they are either in the SAAP program or in the individual supported accommodation?

**Ms Maclean:** We're seen as a SAAP exit point; we're medium term. The department, our funding body, likes to think we could skill them and move them on within 18 to 24 months, but we're finding now, especially with refugees, that 24 months is not sufficient. They are somewhat flexible with these arrangements. For instance, if we've got someone who's finishing school, studies, an apprenticeship, we'll keep them on. We won't move them on at a crucial point in their development.

**MS PORTER:** Have you got other people backing up, a waiting list who are wanting to join?

**Ms Maclean:** We do. We never have a problem filling our properties. But because we're a SAAP exit point often young people that come from crisis aren't ready for our organisation; they need the next step, which is the likes of the Castlereagh or Tumladen, or some sort of program where there's a more structured support in place.

**MS PORTER:** Do they sometimes exit back the other way?

**Ms Maclean:** Very rarely.

**MS PORTER:** They usually keep going?

**Ms Maclean:** They move on, yes. Let's say we've got our runs on the board with our SAAP program. We've had some very, very good results and very positive results in the last couple of years.

**THE CHAIR:** Did you mention an age that you go to?

**Ms Maclean:** From 16 to 23.

**THE CHAIR:** Sorry; if you did mention that, I missed it.

**Ms Maclean:** Having said that, a lot of 16-year-olds, especially 16-year-old males, aren't ready for our style of program. They just don't have the skills to manage the lifestyle in the large flat complexes, with all the temptations, the drug culture. They can't distance themselves from that.

**MRS BURKE:** With the properties that you have, do you just have to take pot luck, or do you ask for a particular type of accommodation, geographically and otherwise?

**Ms Maclean:** Our properties are mainly in the inner north. We've got one block in Kanangra Court; there are 12 bedsits there. We have flats in Northbourne Flats. We have only one on the south side, in Discovery Street in Red Hill. Most of them are around inner Canberra—Bega Court—

**MRS BURKE:** So they're all occupied?

**Ms Maclean:** We've got two vacant at the moment, but they're undergoing maintenance between tenancies.

**THE CHAIR:** Can I ask about your relationship with, first of all, Housing ACT, and, secondly, Mental Health ACT? Would you care to comment on that? It's a very broad question, so feel free to go wherever you like with that.

**Ms Maclean:** It is very broad. I did a case study that will reflect some of the problems we had around a tenancy issue that started 12 months ago when we had complaints to the CEO of Community Housing, Canberra, to the Minister for Housing, and constant complaints to our office, regarding one of our tenants in a cul-de-sac in Weston. We started by actioning the complaints regarding the welfare of the children and the pets—cleaning up the property, the yard, that was causing the neighbours to be upset—and trying to negotiate with our tenant to modify her behaviour, but it wasn't forthcoming and the neighbours were getting very, very restless.

I thought the situation was going to escalate into something that would be quite violent and dangerous, so I spoke to mental health, having been privy to information that our client was known to mental health, and she was. They said the file had been closed, that she didn't have a mental health problem; she had a borderline personality disorder, so she was badly behaved but not mentally ill.

The problems got worse. She assaulted her partner and he was badly injured, and she was threatening the neighbours' children. I wrote to Brian Jacobs and asked him if he would reopen the file, contact me, acknowledge receipt of the correspondence and what action he planned to take. That was on 15 March last year. I'm still waiting for a reply. He received the fax—his staff acknowledged the fact that he'd received the fax—but never acknowledged it. We had to seek legal action. We didn't quite know how to handle this because she was paying her rent and her property inspections had always been fine in the past. Our legal representative said he didn't think the case would be upheld in the tribunal on the grounds of harassment of neighbours and bad behaviour.

His course of action was to give her a notice to remedy and a no cause notice to vacate. So we brought the neighbours in, had a roundtable meeting with them, explained that this was what we were doing and really left it up to them whether they wanted us to take the

matter to the tribunal or to go to the 26 weeks. They decided they didn't want to do the affidavits and to appear at that stage before the tribunal, so we went the 26 weeks.

The children were taken away. The dogs were taken away. The day in November arrived when she was supposed to vacate the premises; she didn't. We waited for a hearing in the tribunal. This matter went on from 5 January till 15 December, and when we finally took possession of the property it had been completely wrecked. It cost \$4,000 to remove the garbage and to clean up the house so that the painters and tradespeople could go in. So it was 12 months with absolutely no support except our paid legal representation, which was \$9,000.

**MRS BURKE:** Sorry; you said no support?

**Ms Maclean:** No support from mental health. We just couldn't get support from any avenue. No-one was talking to anyone on the matter. The only people that were cooperative were the RSPCA, who always are when animals are involved.

**Ms Osfield:** In fact, we often don't get support. One of the things that does happen is that we house people; they come with lots of support—that's an undertaking because we provide tenancy support for SAAP clients; community housing tenants are slightly different, but they may come with support and an undertaking for support. However, it's not unusual, once they are housed, for that support to disappear completely.

**MRS BURKE:** You know about the support going, or do you find out after the event?

**Ms Maclean:** We find out afterwards.

**Ms Osfield:** It just disappears. Mental health may stop seeing the client. I can give you just a very brief example of one client, 17 years old, with a borderline personality disorder. She was diagnosed, she was in the psychiatric unit and she of course wasn't going to be released until she had an address to be released to. She was released to us. We did house her, and for quite a long period of time there was provision of services and that included mental health, Richmond Fellowship and so forth. Then, when she turned 18, everything stopped because she was an adult; she was no longer entitled to that support. Until then, we had her not living the same way as we would live but for her she was certainly being sustained. She was maintaining her property, paying her rent and she was reasonably compliant with medication. From the time she turned 18, everything literally fell apart and she became non-compliant. She was always cutting up but her attempts at suicide increased. The way she kept her property was quite appalling. She drank more and she was out all night. It just unravelled to the point where she became violent, aggressive, threatening, and eventually she did leave. That's not an unusual scenario. We have clients from—I've just jotted them down very briefly—Sierra Leone, Ghana, Ethiopia, the Sudan, Kenya, Afghanistan, the Middle East, South-East Asia and Bosnia, as well as clients who live within the ACT.

**MRS BURKE:** On that point, how do you deal with culturally and linguistically diverse communities and the Aboriginal community, indigenous community? How do you cope with all of those groups? What makes it work for you?

**Ms Osfield:** I think our staff are actually very skilled, professional staff who have

experience in quite a diverse range of areas.

**MRS BURKE:** Well-trained staff.

**Ms Osfield:** Well-trained, experienced, professional staff.

**Ms Maclean:** They have worked in other areas before they've come to the sector, which I think is really important. They have got something, a background and skills, in other areas. They haven't just come through a youth program, done a six-month CIT course and come into the sector.

**THE CHAIR:** We heard earlier that possibly some of the issues would be resolved by having a community liaison officer within both Mental Health ACT and Housing ACT. Do you have a comment to make about that idea?

**Ms Maclean:** I think that would be an excellent idea—a direct point of call, someone that we know will respond to our request. I think that could work quite well. When there are complaints to the department—

**THE CHAIR:** Which department?

**Ms Maclean:** Disability, Housing and Community Services. We hear from our contract manager and then they brief Mr Hargreaves if it's a housing issue. But there is turnover in staff there all the time. Occasionally we don't even know who we're supposed to be speaking to on these matters. Then we'll brief someone; if we know that there's going to be a complaint to the Minister for Housing, we'll ring the department and say "Look, you'll be hearing this, and this is the action we've taken up to date" so they're not on the back foot when they receive the complaint.

**Ms Osfield:** We try very hard to maintain professional integrity, so we do work slightly differently to other organisations that house people with mental illness.

**MS PORTER:** Could you explain what you mean by saying that?

**Ms Osfield:** We try to run a service that's professional so we have professional boundaries. Clients come in to see us and we do a roundtable with clients. Instead of working as their friend, we're working from a professional perspective, so that we're looking at all of the issues that they may face. Then we try and find solutions to the problems, if that's at all possible, and maintain the client within their own home if it's possible. So we work with both the public health system and the private health system. We try and tailor solutions to them and we do it all from a professional point of view, so we might be working with the courts, the police, doctors and paraprofessionals. We try and work with the client with the knowledge we have and engage all sorts of different services within the community.

**MS PORTER:** I just have a couple of questions around those case studies, if you wouldn't mind. With the one that you were talking about, Sue, you said the dogs eventually went and the children eventually went. So were family services involved?

**Ms Maclean:** Family services were involved from day one, which was 5 January. When

I first had a phone complaint, I rang the Child Protection Agency immediately, and I was notified subsequently by fax that they had received my alleged offences—I couldn't say whether they were happening or not—that the information was received but that the matter would not be appraised at that time. It was April before the children were removed from those premises. That was after I had written to Dr Jacobs, and I outlined my concerns about the client. I said that she'd injured her partner, she was making violent and threatening sexual behaviours towards her five- and seven-year-old daughters, she abused a neighbour in her place of employment, three of the neighbours had to take AVOs out against this client, and we couldn't do anything. Our legal advice was that we couldn't evict her.

**MRS BURKE:** Was the minister aware of this—health minister and perhaps housing minister—or have you let anybody know that you didn't get through, or are you still waiting for a response, or—

**Ms Maclean:** I haven't discussed this in depth with Mr Hargreaves, but we're just going through a very, very similar case at the moment. It started on exactly the same day. We're up against the same problem. Mental health won't speak to us. Our client's caseworker has virtually said that her mental health is none of our business and won't discuss it with us. We've asked that she be hospitalised to be stabilised: "No, she's not bad enough." She is noncompliant with her medication. The neighbours are fearful for their safety. She's living in a flat complex and has no perception of day and night, so she's up all night banging and moving furniture and smashing the outdoor furniture. We've been told, "Don't go there, because she is violent, and tell the neighbours to call the police." That's the response from mental health.

Yet again today the neighbours have contacted the minister's office, and they're going to the *Canberra Times*. We've got to go through the legalities. We have given her a notice to remedy, but she has not remedied her behaviour. She's not aware of her behaviour. She should be institutionalised till she's stable. She's drinking—she's an alcoholic—while on medication and, according to the neighbours, smoking marijuana. So she's just got no idea of appropriate behaviour whatsoever.

**Ms Osfield:** And we've had several hearings with mental health and case management and they didn't even want to let us know what medications she was on. One of the things that we try and do is to get a medical history. It doesn't stop us from housing people, but it certainly gives us an understanding of what needs may arise, what needs remain unmet for our clients and how we may anticipate what type of support they might need immediately and in the future. One of the things we are trying to do right now is to get access to medical reports so that we can understand it, to have better communication with organisations so that we can house people as appropriately as we can, because not everybody is suitable for our organisation.

**MS PORTER:** I know we're running out of time, but I just want to quickly ask a question about whether or not, when you were dealing with the refugees, you were having communications with and getting support from the refugee support services through the federal government.

**Ms Osfield:** I'll just give you a really, really quick example and the quick answer to that is no. The short answer to that is no. We have very little support from refugee services,

and sometimes the support is not appropriate. I'll just go through this very quickly. An example is a client from Sierra Leone, who arrived in Australia, alone, approximately three years ago, aged 21. Mother and father, as far as I understand, were both killed in the war. He established himself initially in a house in Belconnen with his uncle. The house was overcrowded—there are huge family problems, as there often are, even when they come to Australia—and it became untenable.

We provided housing. He's a lovely young man. He has managed very well and secured an apprenticeship as a mechanic. He is now in his third year and he is very successful. The support was often inappropriate, and he does have trauma related illnesses—post-traumatic stress of some sort—and needs regular contact with each of us. It doesn't matter who answers the phone as long as somebody is there just to say hi. During his tenancy, we've had to deal with family feuds, financial problems, post-traumatic stress reactions, two court cases, problems with the witch doctor in Africa, domestic violence issues, runaway children, medical conditions and cultural differences. On that, we have had very little support. He needs support in varying degrees depending on what's happening for him at the time. He does live successfully with a partner. However, we have a lot of difficulty with workers who become very personally involved with clients and do not remain objective. In this case it did happen, and it happened even in the roundtable court conference that we ended up having. It split the family in two. It created a situation where children ran away from home. The family have split in the meantime, and it put little children at risk. The workers actually aided and abetted that family situation, and some of that comes back to inexperience and not being professionally trained in the right areas to be objective. So that's not an unusual situation for us to be dealing with.

**Ms Maclean:** Can I just add something to that, too. With support agencies, they foster this dependence, then they'll go on leave—extended leave in a lot of situations—and there's no handover of the client. There's no feedback to us that they're no longer in the country. In one case, one of our young men from Afghanistan was accused of sexually assaulting his neighbour. He had no boundaries when it came to females; he didn't know appropriate behaviour. He was very mentally disturbed and we sought to get him into a private psychiatrist for treatment, which we did. The support agency stepped in and said: "No, he's not to see that psychiatrist. We're his main support source and he will see our counsellor." Well, I think he was well beyond counselling at that level, and he could have ended up charged over this matter.

**Ms Osfield:** And no support was ever provided. There was no follow-on counselling.

**Ms Maclean:** And then his main support worker was on stress leave—away for three months—so he was left high and dry.

**THE CHAIR:** We are going to have to finish it there. Thank you for your appearance today. We will be sending you a copy of the proof transcript, so that you can check it for accuracy. If we have any further questions, we will be in correspondence with you. Actually, I just had one final thing: do you have a brochure about your services that you could provide to the committee?

**Ms Maclean:** It is in print at the moment, but we can get you one when it's available.



**THE CHAIR:** If you could, that would be very helpful to us. Thank you for your time, and of course we'll be in contact with you when the report is done.

**The committee adjourned at 5.04 pm.**