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

THURSDAY, 9 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 9.36 am

JOHN HARGREAVES,

MAUREEN SHEEHAN,

PEGGY BROWN and

LOIS FORD 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 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 all understand that?

Mr Hargreaves: Yes, ma'am.

Ms Sheehan: Yes.

Dr Brown: Yes.

Ms Ford: Yes.

THE CHAIR: For the record, could you please state your names and the capacity in which you appear today.

Mr Hargreaves: I am John Hargreaves, Minister for Disability, Housing and Community Services.

Ms Sheehan: I am Maureen Sheehan, Director of Housing ACT.

Dr Brown: I am Peggy Brown, Acting General Manager of Mental Health ACT and chief psychiatrist for the ACT.

Ms Ford: I am Lois Ford, Executive Director, Disability ACT.

THE CHAIR: Would you like to make an opening statement, minister.

Mr Hargreaves: Thanks very much for the opportunity to appear before the committee today to discuss what we all agree is a very important issue. While considerable progress has been made in improving the provision of appropriate housing for people with mental illness and there are concrete plans for further enhancements, this inquiry is welcomed as an additional opportunity to provide input into future improvements.

I am here with officers from my Department of Disability, Housing and Community Services to discuss the issue of appropriate housing. I believe that officials and experts from ACT Health are appearing before the committee at a later date, and I would ask the

committee to be aware that, while we work in concert with health providers, neither I nor these officers are experts—in my department anyway—in clinical mental health diagnosis or treatment; nor are we responsible for the delivery of clinical services.

THE CHAIR: Just before you go on, minister, on that note I would also remind the committee, and any other members who might decide to come later on today, that Dr Peggy Brown, and Amanda Urbanc from health, are here just to assist where possible. But, in order that we don't take up too much of the time in which we'd like to hear from housing, I ask that members of the committee try to restrict their questions to housing questions, and we'll deal with health questions when the health officers appear on 22 March.

Mr Hargreaves: Much appreciated, madam chair, because I think we are all of a like mind. We're agreed that clinical services are clearly the domain of the trained professionals in ACT mental health and health services in general. My department assists Mental Health ACT and provides resources to contribute to the holistic approach to supporting people with a mental illness. However, Mental Health ACT is the lead provider and the lead agency that provides support to people with a mental illness. We see ourselves as a junior partner in the range of holistic approaches to address the quality of life of people with mental illness. I'm quite happy to discuss our junior partnership role in the context of this committee.

One of the main focuses of my portfolio is to work towards sustaining appropriate tenancies for people with a mental illness, and the continuing implementation of breaking the cycle of homelessness, the ACT homelessness strategy, and the government response to the final report of the affordable housing task force. The upcoming housing summit will make a substantial contribution to addressing the issues investigated by this committee. I would encourage the members of this committee to attend the summit.

As you would be aware, possibly, I have had five ministerial forums where I've sought advice from the sector—from clients, tenants and a whole range of people—over the last 12 months or so as a prelude to the summit. The summit, I need to indicate to the committee, is not about policy setting by a very large committee; it is an advisory summit to the government for the development of concepts and ideas that we can carry forward into policy, in much the same way as the health summit was when we first took office in 2001.

I am aware and am quite pleased that each of our members of this committee has received an individual invitation to come to the summit—I hope you take it up—but I would like to extend an invitation to the committee as a whole and, if you could afford the time, I would encourage the committee secretary to come to the summit additionally. I know we all have different approaches, different thinkings and the committee secretary will be able to bring the collective of the committee minds to that summit. If she feels so inclined, I'd be delighted to see her there.

There's still much to be done, though, in realigning the social and supportive housing sectors to better provide assistance to enable the maintenance of sustainable tenancies and communities. By "sustainable tenancies" we mean that people with mental illness are safe and securely housed, with support services provided to enable them to continue their lives in the community in the same way as any other member of the community.

We understand that for any program addressing disadvantage of any type to be successful—mental illness is one example of a significant disadvantage—we need to start from a secure place, somewhere where people feel safe; that sense of place. We all know that, whenever we injure ourselves, we go home. If you get sick at work, you go home, and then you go to the doctor. You don't go to the doctor and then go home; you actually go home to your place of safety and security. We remember that, when we were kids, if we hurt ourselves we went home to mum. We need to make sure that housing is provided to people in much the same way—that that is a place to which they can retreat when they're feeling injured and it's safe and it's secure.

To assist in this, Housing ACT has developed a formal qualification for housing managers, the certificate 4 in government (social housing). Important facets of the certificate 4 are the modules relating to the provision of non-clinical specialist support. These modules provide housing managers with a conceptual framework for working appropriately with clients presenting with a range of issues.

Housing ACT employs five client service coordinators, who work with public housing tenants and applicants with identified complex needs in order to achieve sustainable and stable tenancies. In addition to public and community housing within the ACT, there are currently 213 funded places for the provision of supported accommodation specifically for people with a mental illness. These include 30 medium- to long-term rehabilitation places, 65 group home places, 18 respite places and 100 outreach places.

As far as government-provided accommodation is concerned, we are punching above our weight. It needs to be recognised that the ACT has the highest proportion of social housing in Australia at over nine per cent of total housing, compared with the national average of around five per cent of housing. The government is using a partnership approach with the community sector and the broader community. We are continuing to seek alternative approaches, frameworks and policies that actively engage with disadvantaged individuals, their carers and community supports.

We're happy to respond to the committee's questions. Did you get all those numbers down, madam chair, or do you want a copy of that?

THE CHAIR: I got the numbers, minister, but I have to say that you were speaking a bit faster that I can write. I've just had a look at Ms Porter's writing but I can't read it.

Mr Hargreaves: I'm aware of your valuable time, and I wouldn't want to waste any of your valuable time.

MS PORTER: She can't read my writing; this is the issue.

Mr Hargreaves: There will be little bits missing, but predominantly the numbers are there. I'm quite happy for you to have that.

THE CHAIR: Thank you for that.

Mr Hargreaves: I'm also reminded that a good place to look is on page 17 of the government's submission. You might find some information there that you will find

fascinating.

THE CHAIR: In fact, those exact numbers are there. We'll now go to questions. Thank you very much for your appearance today, and I'd also like to put on the record, minister, the committee's thanks for the department's assistance in showing us around recently Ainslie Village and the lodge.

Mr Hargreaves: Did you go to the Lodge?

THE CHAIR: We went to the lodge.

Mr Hargreaves: Certainly some disadvantaged people live in that place—

THE CHAIR: There are some disadvantaged people living there.

Mr Hargreaves: Well, not really, because he doesn't live there any more.

MS PORTER: Minister, in your introductory remarks you mentioned the homelessness strategy, breaking the cycle. We heard from the Human Rights Office, in their submission and when they appeared before us, that the homelessness strategy, breaking the cycle, doesn't specifically deal with mental illness as a separate group from other vulnerable groups within that strategy. Also we note that the ACTCOSS needs analysis into homelessness in the ACT in 2002 claims that there is a high level of mental illness amongst homeless people but says that statistics are not available—or they weren't available to them at that time. Are there any statistics available now and is there any research planned or under way on the numbers of mental illness sufferers amongst the homeless? I know that it's very hard perhaps to get those stats.

Mr Hargreaves: Thanks very much, Ms Porter. There are a couple of things that I would put to you. Firstly, the national data collection for the supported accommodation assistance program is addressing that issue. We need to just go back a step also, remembering, too, that we work in partnership with the other lead agencies and we do rely heavily on those other lead agencies to let us know the extent to which we need to contribute to a very significant problem.

We could segment the whole of the community up into their various pieces of disadvantage when we start talking about priority allocations and all this sort of stuff. What that can tend to do, though, is to stigmatise and label people and I'm a little bit reluctant to go down that track. But that needs to be put against the background of the conversations that we have, firstly obviously with Mental Health ACT. In the housing forum that I had a couple of days ago, we talked about the provision of housing for people with a disability and, whilst the department has had discussions with people on the degree to which we need to provide specific accommodation to people with mental illness, it was only at that forum that I realised the extent of services that are actually currently being provided, and the range of them, and the things that we need to discuss. And we will be discussing those sorts of issues at the summit, because we need to stitch together exactly what approach we have around the issue of mental illness.

But that is against the background that we are not the diagnostician in this sense. We rely heavily on people with clinical qualifications to tell us when a person is mentally ill or

when a person is suffering from mental dysfunction; they're quite separate issues. Then we need to ask: to what degree is housing an essential part of a treatment program or just something that people would like to have, and therefore what priority will be apportioned? We need to work out in the interests of the person with the mental illness what is the most appropriate accommodation. Public housing out in the suburbs may be the last possible thing you want to give somebody if they are suffering from a particular condition; they would suffer social isolation and that could very well exacerbate the illness that they have. By the same token, another person's condition may be exacerbated if they are in a multiunit complex. Some people require placement in a multiunit complex so that they can have collective peer support and they can access the range of services in the town centres to be able to adequately address their condition.

So there is a range of things. We've got those particular allocations. We also have such things as co-tenancies. We might have, for example, a four-bedroom house, and three people with mental illnesses of different types may be able to exist happily in there. We might have a two-bedroom apartment where one person has a mental illness but the other tenant has not but is quite happy to live in almost a partnership perspective—not necessarily, but it could be. That has a positive outcome as far as the person's mental illness and quality of life are concerned.

Then we need to say: what about home ownership? Some people with a mental illness are quite okay, particularly people who have an acquired illness. For example, they might have exited the work force with a very substantial pension—not a problem. Finance is not an issue—treatment is the issue—and public housing is not an issue for these people.

People who sort of knock on the door of public housing usually suffer two things in addition to the mental illness: one is a very, very low income and the other is the potential for homelessness. We can address the homelessness thing in the context of our homelessness strategy. But we can also talk about—and we will do this sort of thing at the summit I would hope—opportunities for people to own their own place, whether it be through shared equity, interest-free loans et cetera, because we know that ownership is the ultimate security for your home. What we need to do is to allow our mental health clinical experts to operate in the best possible environment, and that's what we're about.

MS PORTER: Minister, at the beginning of your remarks you emphasised that the staff at housing are not clinicians; mental health clinicians and housing staff really are a support in providing accommodation where accommodation is part of the overall plan for somebody to become well or to maintain a better level of health in any case. Obviously, Mental Health ACT staff are clinicians and you're providing a service. Some of the NGOs reported in their submissions and in the hearings that they believe there needs to be more communication across the two departments, Mental Health ACT and housing. How could this be achieved, or have you already got those things in the pipeline, are some of those things coming out from those forums you've mentioned and will they be addressed necessarily in the upcoming summit?

Mr Hargreaves: I can address that with two points. Firstly, we have over recent years recognised that the security of your accommodation and your sense of wellbeing are intrinsically linked. With mental illness, it is possibly the most dangerous one. If it's too acute, we could end up with loss of life, so we're very, very acutely aware of this. To

that end we have established formal relationships with such areas as the police. But significantly with mental health through the ACT Department of Health we have a memorandum of understanding; there's a formal relationship.

It's quite easy for people with barrows to push to say, "You're not doing enough communication here, you're not doing enough communication there." But I would suggest to the committee that there is significant conversation between Housing ACT and mental health. The creation of those five specialist managers is as a result of us realising that there's something a little bit different in terms of acceptance of responsibility. I might mention just offhand and off the top of my head that I'm not aware of any memorandum of understanding that exists between ACT Health and Raine and Horne real estate, Leader real estate and all those other private sector real estate companies who have responsibility, in my view, for sustainable tenancies.

Whilst people may say that we could lift our game a bit, I suggest to you that we have a very, very good record about conversations. My determination that we will do better will culminate at the end of this month in the summit. The conversations that we've had through those ministerial housing forums have been incredibly beneficial to the development of our thinking. I don't know how many people were there the other day, but if it wasn't 90 I'd be very staggered. That is the sort of attendance. Talking about home ownership and sustainable tenancies, we had people from the real estate institute and the banking sector, which is just brilliant. The people that contributed the other day were really fantastic.

In the forum on disability, the issue of mental illness was raised as something we could consider as a priority and we will certainly do that at the summit. There was no comment, favourable or otherwise—and we had almost every part of the NGO sector represented at that table—about the conversations or relationships between housing and mental health. The absence of comments like that led me to believe that those relationships were sound, and I'm confident that they are sound.

We have a large population. You would know that we have the largest public housing stock in percentage terms in the country. We've got 11,500 properties in the public sector; we've got 200, 300, 400 or something or other houses in the community sector. It's a very large slice of the community that we're the landlord for in one sense or another. So it's very easy for people to find one, two or three people who fall between the cracks. But in a sense the system is healthy, very healthy. I think the officers of Housing ACT do a superb job, but we are always judged on how we deal with those people that fall between the cracks because they make great media. I think the system is very sound at the moment, and I would like at this point to express my appreciation to the officers of Mental Health ACT for recognising, jointly with housing, that we're about fixing someone who's got a problem and we have various talents to bring to that. The creation of the MOU was not a kicking and screaming exercise; it was really needed by both people and we joined together in a very pleasant marriage let me tell you.

THE CHAIR: Minister, on Tuesday we heard from several non-government organisations that provide services—houses, sometimes SAP services, sometimes other housing services, sometimes other services for people living with mental illness—and a number of them expressed difficulty in accessing housing staff when the need arises. They talked about becoming familiar with somebody who was good within the

department but then that person might move on and they'd have to start over again.

There was a suggestion that there needed to be a community sector liaison officer within the department. Does such a position exist and, if it does, how is that communicated to the community sector? If there isn't, are you considering such a position?

Mr Hargreaves: Firstly, on the business of people moving on, it's a bit of a credit to Housing ACT staff that they keep getting poached by the federal government. I wish all of these officers all the success in the world in their further career, but it is bad luck.

THE CHAIR: That's not a criticism of people advancing their careers.

Mr Hargreaves: I can't stop them moving onward and upward, but I have to say that we recognise that there was a connection difficulty with the community at large, whether it be our tenants or other support groups who were assisting them. Disability groups, for example, proliferate in this town—and so they should, because there are so many different types of disability. We understand that the entree into bureaucracy can be tortuous and that's why we've got those five specialist managers. So the answer to your question is, no, we're not going to have one person to connect—we've got five.

THE CHAIR: There is a follow-on from that in terms of how it is communicated to various non-government organisations. This is not intended as a—

Mr Hargreaves: No, it's a very valid question and one that we've talked about in the forums, but we need to understand a couple of things. Firstly, our relationship is with the tenant; our relationship is not with anybody else in a formal sense, necessarily. We don't have an obligation, as it were. What we do have is a recognition of our responsibility to make sure that our tenants are sustained. The tenants themselves speak with their own supports. Our housing specialists speak to tenants whenever a difficulty arises. We do early intervention if we find that there's a problem with income, a problem with disruptive neighbours or that sort of thing. The housing specialist will go in and talk to people in that way. I'm very surprised that any NGO would not be aware of that particular service.

The five community housing forums that I have instituted in the last 12 months engaged an enormous number of people in the sector. Not only that; they engaged a number of peak bodies in the non-government sector, including ACTCOSS and ACROD. Most of these people are actually members of or affiliated in one form or another with ACTCOSS, and ACTCOSS know about it; they know about what we do. I'm hoping that, if there are a couple of them out there that still haven't heard of the way we do things, given that that's part of the conversation, we will be able to address that in the summit and as a result of the five forums.

One of the things that I did notice, and it was just brilliant, the other day at the disability forum was the number of NGOs that didn't know that each other existed. It was phenomenal. They went around the room exchanging cards, telephone numbers and email addresses, so the offshoot benefit of those communication forums is more information sharing about where people can access supports. There were people providing services who had no idea there was another mob doing the same thing but just slightly differently, and they could actually start trading information. At all of those

forums we have had significant presence from not only Housing ACT officers but other officers in the department.

I'm advised also that we have a SAP forum every six weeks with NGOs. We have a standing advisory committee to Housing ACT, which meets six-weekly. We have community linkage workers in agencies that link to Housing ACT regions, and there are standard funding agreements with the Department of Disability, Housing and Community Services and there is a contract manager for each service. The point is that, if there's somebody out there that doesn't know how housing ticks, if you like, I encourage them to pick up the phone and ring one of us. They can ring me, if they like, because I think they will be very lonely out there.

THE CHAIR: On the issue that you just raised about a number of the organisations not knowing about each other's existence: we heard evidence on Tuesday about programs that had been operating in a council in South Australia. It no longer operates, unfortunately, but it had a fairly good success rate is our understanding. We're seeking more information about it.

We also talked about the move from purchaser-provider. One of the people submitted that purchaser-provider had been not a particularly healthy way for NGOs to operate and that there was a recovery process from purchaser-provider; they were still proceeding down that path. We also were talking about the possibility of the community groups working better together and a point was made that, instead of having an existing organisation start running a new program because they had experience and expertise in a certain area and would know how to operate it, there is a tendency within this town for a new organisation to be set up. I think the comment was that there was a "splintering" of the services. Would you care to comment on that and on ways that you see that that could be addressed.

Mr Hargreaves: Firstly, we have a lot of dialogue with all of these people. It is always frustrating because there are so many to deal with. The purchaser-provider model when it comes to human services was the most disastrous policy ever designed by mankind to inflict damage and pain on another. The fact is that something upwards of 25 per cent of funds provided under the purchaser-provider model found their way into administrative support, report writing and accountability and didn't find their way to the people in pain. The abolition of that saw more funds being project directed into the areas of need.

There's always going to be a teething time between one process and another. But the abolition of that actually allowed us to think a little bit outside the square in terms of how we fund activities out there. In a minute I will get Maureen Sheehan to give you an outline of some of the programs that we do, and the differences, because they all looked alike originally and then somebody would pop up, and somebody would pop up. We rely a lot on some of the peak bodies, too, to sort that out. It's not up for government to say to some little mushroom: "Well, we don't like the colour of you. Go away." We have to say that these people have emerged because of an integrity and a need to help somebody, so we will engage with them.

We would prefer for the sake of administrative ease that they banded together so that, for example, you don't need to have an expert in difficulties with Down syndrome, bipolar and all these things when you're talking about bookkeeping and photocopying. Those

sorts of things could be joined up, but it is not for the government to determine that; it is for the private sector to determine that. Through these forums that I've had in the last 12 months, what we have achieved is a recognition on the part of many in the non-government sector that came to the forums that they have to do just that—and it has come out in the conversations that we've had. For the record, I'd like to encourage them to do that, because there is money to be saved in those efficiencies that can be applied to people in pain.

One of the things that we have noticed—you have probably run up against this once before—is, whether or not you set a program up, people think it's recurrent and it's not, money runs out, and what then. There is a range of different types of support programs that we have, with particular aims. When we create them, it is labelled quite clearly that this is the case. I'll get Maureen Sheehan to let you know about a couple of those, if you'd like.

Ms Sheehan: The community linkages program would be a very good example of what the minister is talking about, and it's also an example that would go to your earlier question to the minister where the claim by some community groups was that government funding went to new groups and not to existing groups. In the community linkages program, which went to tender about 12 months ago, all of the successful tenderers were existing providers who were already providing community linkage programs in the last round and provide many other valuable services to the community, particularly homelessness services. So in fact the government and the department do continue to fund organisations that are providing high-quality services to the community, and community linkages is an example of that.

The minister asked me to explain the way in which the community linkages funding isn't recurrent. There's a very good reason for that. The community linkages program began as a four-year pilot program in 2001, and at that time the general idea was, "What say we actually try to link public housing tenants in multiunit complexes into their existing communities so that we can not only provide a home for people but try to address some of the features that we know are in existence such as social isolation." The range of programs that developed over the first four years was beneficial but they were targeted only at the multiunit complexes, and fewer than 30 per cent of public housing tenants live in multiunit complexes.

They also had a sustainable tenancies focus, but there were small amounts of dollars scattered in agencies all over the community, so that tenants found it difficult to access them because the agencies weren't able to employ a full-time person, so they weren't as available as they should have been. And some of the programs focused on individual case management rather than general community development.

So it was fine as far as it went for the first four years, but we were then able to review the program because it was a pilot and then when we went to tender we were able to do so on the very firm basis of, "We've reviewed the program and we've seen what worked for the tenants," which is, after all, the reason that we had the program in the first place. Then we went to tender for a suite of services to meet the needs of our tenants and to focus on not just those tenants that lived in multiunit complexes but all of our public housing tenants.

I hope what the members of the committee can see from that is that, if we had funded it as a recurrent program, we might not have had the opportunity that we did to review it and then to re-target and re-tender for services that meet the needs of the tenants. Perhaps some of the needs were new needs that were emerging, so we were able to address unmet need. That's the advantage of a program such as community linkages, and a funding arrangement which is not forever but for a specified period of time, during which time you have a chance to evaluate the program. So we're very happy with the new community linkages services. We are very pleased that people that had the experience in the first four years have gone on to provide those services, not just to the multiunit complexes but to all public housing and now community housing tenants as well.

Mr Hargreaves: Can I just add a little bit here. There are recurrent programs and there always will be, but people never bellyache about those; they always concern themselves about whether or not the short-term ones will be discontinued or not. We need to understand that people need to sustain themselves. Short-term programs such as community room activities out at Illawarra Court are brilliant. The people in that complex have now got a certain amount of empowerment themselves and off they've trotted.

Jill Basic runs a service over in the Gowrie Court area and she has marshalled the people there. She has personally lifted the self-esteem of people in Gowrie Court exponentially, with help from Housing ACT people. We haven't barrelled in there and said, "We've got a deal for you." We've actually responded and supported a program for a short period of time while it got on its feet.

We need to understand very seriously when it comes to our tenants, regardless of who they are, that we are not the tenant's parent; we are the tenant's friend. Everybody needs to understand out there in the community that we are about helping people. We're not going to carry the monkey all the time. We can't, and it's inappropriate that we do, because you end up with a dependency, and that is not a positive outcome for human beings. They need to have their own self-esteem intact and they need to feel good about being independent. As long as we continue to have this dependency stuff, we won't be getting any further down the track. That's one of the reasons why we're having this summit. That's one of the reasons why we've had all of these community ministerial forums—to find ways where tenants can be sustained in their home, because they can do it.

THE CHAIR: I've taken up quite a bit of time, but just before I pass over to my colleagues I have another question, so sorry about that. On pages 19 to 22 of the government's submission, you outline housing programs in Australia, Canada and the UK. These programs seem relevant and worth while. Has the department evaluated any of these and/or considered their introduction in the ACT?

Mr Hargreaves: I'm not sure how you would see that sitting in the context of accommodation for mental illness, madam chair. Could you elaborate a bit on that for me?

THE CHAIR: There are programs in there that are mental illness programs.

Mr Hargreaves: Yes. I guess where I was coming from, and with absolute respect, is

that often in conversations like this, in my view, it can be confusing when we talk about intellectual disability, mental illness or mental dysfunction. These are clinical terms. We need to separate sometimes in a conversation where our responsibilities lie. Mental Health ACT have the clinical responsibility for people with mental illness but mental dysfunction may not be their responsibility, so we need to actually work within that context. If you haven't got that definitional difference, I'd be delighted to offer it to the committee, and then get Maureen to elaborate on page 20. Do you want me to go through that?

THE CHAIR: Maybe if Ms Sheehan would just elaborate to the committee on the programs, that would be helpful.

Ms Sheehan: The first model, which is elaborated at the beginning of page 19, is the Keyring Living Support Networks, which is a model which we have adapted for use in the ACT. The department and the government were very pleased to be able to offer capital funding of around $1 million to Centacare and we have a shared equity model with Centacare. We jointly purchased, with Centacare and departmental funds, government funds, five properties in the Belconnen area to form part of a network of 10 properties. So there was a capital grant from the government for the first five properties. The next four properties we were very pleased to be able to provide in partnership through the community organisation's rental housing assistance program—or CORHAP as we abbreviate it. That meant that the government, through capital grants and through headleasing arrangements was able to bring online nine properties to form a keyring network.

In this instance, Centacare had put together the proposal to work with young people with a mild intellectual disability. But the original model from the UK can sometimes involve people with a mental illness, and we would imagine that that would be again highly relevant for the ACT. Centacare reports to us, as they report under their funding arrangements both for the housing and the support dollars they get from Disability ACT, that the network is working very well. So we would hope that that means that the model would have applicability for mental illness as well.

The Abbeyfield model is a model which began for older persons, and Housing ACT does headlease to the Abbeyfield Society two properties for older persons. Again, the government did make a grant to the Abbeyfield Society and it was project managed by community housing, Canberra, to build a home for up to 10 people with a mild intellectual disability. So that's the first modification of that model for another group of people and again that may be an appropriate model for people with a mental illness, but I guess we would all like to wait and see how it goes, having modified it from aged persons to intellectual disability.

What I would say is that the department works in partnership with a number of community organisations. Because we're in the position of owning the housing stock, if the community organisations—and often they are working in partnership with Mental Health ACT—put together a proposal for a supported accommodation arrangement, they then approach us for the properties, and we're delighted to be able to work in partnership on that basis.

Most recently, we were able to do that where Mental Health ACT had funded Richmond

Fellowship for some supported accommodation. Richmond Fellowship formed a partnership with Havelock Housing Association, which, as you would know, is a community housing provider that we provide properties to. We were very pleased to be able to provide those properties. The support dollars which had been put together by mental health and Richmond Fellowship came together with the properties through the Department of Disability, Housing and Community Services and Havelock Housing Association. So we are already operating in a very flexible way and we are very open to new funding arrangements for supported accommodation.

Mr Hargreaves: One of the things I mentioned just before Ms Sheehan addressed the committee just now was the distinction between mental dysfunction and mental illness. That clinical distinction has a very, very strong bearing on the services that we provide to our tenants who are encountering either of those two. I would like to place on the record the distinction between the two, with your permission, and ask Dr Brown, the Director of Mental Health ACT, to do that, and Lois Ford to describe to you the difference in services that we have. Your committee is looking into the housing issues around people with mental illness and what are our responsibilities in a community sense about that, and I think that would be particularly useful for our conversation.

Dr Brown: Mental illness is, in fact, generally defined as per an internationally accepted classification system. There are two of those that are known: the international classification of diseases, which is the UK system; and the American system, the DSM-IV, which refers to the diagnostic and statistical manual, fourth edition. They outline the criteria that are required to diagnose a specific mental illness.

Mental dysfunction is a much broader category of presentations, I guess, that at times does encapsulate intellectual disability, although we do tend to separate that out as well; but, more specifically, the type of person that would fall into mental dysfunction is someone, for example, who may have personality traits or a personality disorder that may lead them to respond to stimuli or situations in a particularly maladaptive way. So there is quite a significant distinction between those.

In terms of what it means for housing, I think it is important to point out that the majority of people with mental illness are able to live in the community without specific assistance around their housing needs. It is only a very small percentage of people, usually those with the more chronic and severe mental illnesses, that require support to access and maintain their housing.

Ms Ford: I think it is an important distinction to make between people who have, in our case, a dual disability, that is, where they have a mental dysfunction which is not curable but certainly rehabilitation and very good support will minimise the impact of that dysfunction, and they also have an intellectual disability. In those instances, it is entirely appropriate for housing and, in this case, disability and mental health to work together over a very long period of time to look at a range of housing options, some of which are in this paper and, as I say, are entirely appropriate for people who would have the dual disability or, in fact, just the intellectual disability.

In those cases, we are looking at people who require support within their homes and generally within public or community housing for their whole of life to maintain their housing and tenancy options. That is quite an important distinction to make between that

group of people and people who, as Dr Brown said, have a mental illness which is curable. With good clinical support and supervision, a large number of people with mental illness live in the community as you and I would live, within their employment contributing economically, socially and culturally to the ACT community.

We do have a program in place called the intensive treatment and support program—at this point in time, that is what it is called—that does recognise that people who have a mental dysfunction, intellectual disability, high and complex needs, require an across-government response and need quite a sustained period of intensive rehabilitation and probably a lifetime of support and supervision but would better manage their intellectual disability and dysfunction by living within a community setting with that range of supports. The ITAS program brings together the housing, the community support and the input from mental health via the dual disability team to assist those people to continue to live in the community in a healthy and responsible way.

Mr Hargreaves: As you can see, the simple solution of more public housing isn't the answer. The answer is a much more complex one and that is what we all work together to try to achieve.

MRS BURKE: The purpose of the hearings today, obviously, is to hear from you and I am really pleased that you have been so forthcoming with information. I have been sitting patiently for almost an hour and I am pleased that the chair has given me an opportunity to ask at least one question. There is so much we could cover, but at the pointy end of all of this are the people on the front line, whom I always have concern for.

Mr Hargreaves: Mrs Burke, when you talk about people on the front line, exactly whom?

MRS BURKE: I am coming to that, minister. People who deal on a day-to-day basis with clients, tenants, people with mental illness and I refer to—

Mr Hargreaves: Are you talking about the housing people. I do not know who you are talking about.

MRS BURKE: Let me finish, minister. On page 15 of your report, you refer to Housing ACT having 40 housing managers who are managing approximately 270 tenancies.

Mr Hargreaves: Yes.

MRS BURKE: How does that pan out and what sort of mix? Do you still continue to work by areas, geographically zoned? If so, is there an imbalance between what one housing manager may be dealing with in terms of cases of people with mental illness as opposed to another housing manager? I do note and congratulate the government on the certificate IV training. I am just worried about the caseload for housing managers and the churn, given that probably six months, as you have told me before, I think, is the usual thing for moving people on. Maybe you are going to say something different about that. Just about the people at the front end and how they are coping.

Mr Hargreaves: Firstly, the six-month churn isn't right. I will get Ms Sheehan to correct

you on that for the record, Mrs Burke. It is a misunderstanding I brought to the portfolio, I have to confess to you, when I came in 12 months ago. I will get that corrected for you. When you are dealing with housing issues with people with mental illness, we have not got them all bunched in one spot. The proportion of tenancies of people with mental illness is something that society has generated. That is where they choose to live.

Also, as I mentioned before, we are trying to target the provision of accommodation where it is needed the most. That has been one of the significant differences over the last few years with regard to Housing ACT's allocation of properties. It is a person-centric process now. We are actually talking about—and this is one of the reasons for the summit, let me say—how we can be responsive to people's needs as opposed to the length of time they are sitting on a list. We know that some people's disadvantage should mean that they should get access to the services more quickly.

With respect to your particular question, it was recognised some time ago that our housing managers, as you say, look after a couple of hundred properties. I could be wrong here, but I think the average would be of that order. Private real estate company housing managers have about 50 or so. Our people manage a couple of hundred of them.

MRS BURKE: That is exactly my point. I am wondering how they are managing their caseloads.

Mr Hargreaves: Remembering, though, that predominately public housing tenants are wonderful people that you never hear from. They actually have been given a home in the system, they have created the most magic home, and that is one of the reasons why we recognise the tenant of the month. Predominantly, we never hear from them. Systemically, we do get the lower end of the socioeconomic group. Eighty-seven per cent of our people are on rebates; ergo, money is not real flash around that particular section. That is why we have the five managers, the specialist managers, and we bring together through things like community linkages those other supports inwards.

In terms of churn, I have actually spoken to the group of housing managers and I think that they are coping relatively well. They are doing a magnificent job. One of the beautiful parts of the synergies of having housing within the context of disability, housing and community services, that joint approach, is that the supports for people in the housing are also available in the department of disability, so we are actually putting in a joint activity when we are talking about the tenants. Of course, all of the MOUs that we have out there bring it all together.

So one cannot compare the ease with which people can manage properties in the private sector with the way in which we manage ours. It is a much more complex issue. But just using things numerically and saying that, if one has 50 and another has 200, the person with 200 is going to be worked to death does not necessarily apply because of the extra supports that we bring to bear: the five specialist managers who are especially trained in this; the relationships that we have with people in mental health, the police, the ambulance service and the NGOs regarding physical or intellectual disability, a whole range of things. All of those engagements need to be taken in total when we are looking at whether or not these front enders are right. Do you want to expand on that?

Ms Sheehan: We do have a formal weighting system for our portfolio for our housing

managers and that does take into account things such as the complexity that you would find in a multiunit property site.

MRS BURKE: Sorry, can you explain what you mean by that?

Ms Sheehan: A weighting system.

MRS BURKE: Not waiting as in time.

Ms Sheehan: No. We weigh the portfolios. We recently reviewed the weight of the portfolios when we implemented an improved career structure for housing managers and we are having another look at the weight now. The feeling from staff is that it seems to be about right.

MRS BURKE: Can you elaborate on that? What does "about right" mean? What percentage of, say, 270 would be high and complex needs?

Ms Sheehan: We have a regional allocation of housing managers and portfolios in the management of our tenancies. A housing manager is in a team of five housing managers with a team leader. What I mean is that a housing manager would look at a colleague in their team or indeed a colleague in another region and say that it looks like the workload that we have is fairly consistent, given the types of tenancies that we are managing.

MRS BURKE: As to high and complex needs, what percentage would you put on that workload of 270?

Ms Sheehan: I'm afraid I cannot tell you what the formal weighting is for high and complex needs.

MRS BURKE: Would you be able to provide the committee with that information?

Ms Sheehan: We can certainly provide the committee with the information on how we weight our portfolios.

MRS BURKE: Thank you.

Mr Hargreaves: I think it is also important to note that burnout is usually the first port of call as to the reason people leave. Dissatisfaction with the outcome and being bored witless with your job are also contributors, but the biggest single contributor to people leaving their jobs in the human services industry, as you would know, is burnout. It is interesting to know that our turnover is less than 10 per cent. It is well below the national average. I haven't got the figure here, but it is below the national average for turnover in that sector.

MRS BURKE: You were going to tell me about the housing managers, Ms Sheehan. I think you were going to say that it is not six months now.

Ms Sheehan: That was the figure, which is that our turnover is down below 10 per cent.

MRS BURKE: Sorry, how long do housing managers stay in a geographical area? The

minister has been on record as saying six months and he has changed. That seems to be a misconception.

Mr Hargreaves: There are a number of issues that go to that. Once upon a time you might have just thought, "Six months, thanks for coming, you can go to another area." That was the way lots of people looked at it. It is not quite that way, because we cannot determine where people with high complex needs live or people who have disruptive behaviours live. We can identify the suburbs where there is a regularity of these sorts of things, but we cannot influence the placement in any meaningful sense, other than one-on-one from time to time, so you will find from time to time when the demographic of a given set of suburbs changes that so too will the intensity of the workload. What we are concerned about is the way in which our housing managers function within the environment that they work. Somebody might be moved earlier than six months.

MRS BURKE: Okay, got you.

Mr Hargreaves: Somebody might be moved later than six months, so it's a norm.

THE CHAIR: I suggest that we move on.

MRS BURKE: I will ask you later about providing more information, thank you.

Mr Hargreaves: Go for it. If you want to stick it on notice, I am happy with that.

MS PORTER: Minister, we heard from the ACT Human Rights Office that there is a need for a review of policies such as the eligibility and debt management policies in light of the fact that policies can inadvertently create the possibility of a breach of the Human Rights Act or the Discrimination Act and, if some of those policies were to be reviewed, that could be avoided. I know that you said that this summit is not about policies.

Mr Hargreaves: It is not about that.

MS PORTER: Do you think that it will come out of that? Maybe it is already happening; maybe those reviews are already happening.

Mr Hargreaves: That is already happening. We have a debt review committee and they address the issue of breaches, they address the issue of outstanding debt, they address the issue of the policy of whether you can transfer with an outstanding debt and whether you can't and they advise us on policy on that sort of thing. You would be aware that the Human Rights Act, being trailblazing legislation around the country, has impacts that nobody is aware of until something like this actually pops up. I can assure the committee that the comments by the commissioner will be taken into account by the debt review committee when we have a look at it.

We want sustainable tenancies. We do not want people with debts, but people get themselves into all manner of trouble. That is why we have early intervention strategies whereby our specialist manager will go to people and say, "You seem to be 20 bucks below in your rent. It is going up to 40 now. What's the go?" When these people go in there with a positive approach to helping with a sustainable tenancy they find out that there is a gambling problem or something like that, so referrals happen instantly. We are

doing a lot of that already now and when we talk about a process or a policy which can breach a human right or that sort of thing, once it emerges as it has with the commissioner's comment we embrace that comment and we look at the way in which we do things. We are looking forward to reviewing that, because to do anything else would be actually contrary to the intent of what we are doing. I am sure you would appreciate, with the advent of the Human Rights Act, that there is whole stack of stuff that governments have been doing since the year dot which have the potential to offend that particular piece of legislation.

MRS BURKE: There is a lot to be asked but I will be very quick as I know that we are pushing for time. We have got you with us until a quarter to 11, I understand, and then we will have a break.

Mr Hargreaves: Madam chair, I am happy to go on until 11 o'clock.

MRS BURKE: That is very generous of you, minister. Referring to page 16 of your report, minister, I am interested in knowing a bit more about the case conferencing project and the success of that in relation to people with a mental illness.

Mr Hargreaves: I thought you would be and I am really pleased to hear the question. Thank you very much for that, Mrs Burke; I have been waiting for it. Ms Sheehan will give it to you chapter and verse, Mrs Burke.

Ms Sheehan: We have just completed a pilot project which we called the pre-allocation case conferencing project. The idea is that in order to sustain tenancies it is important that, particularly, people with complex needs are placed in a location and in a property that actually does meet their needs and won't contribute to a breakdown of tenancy. So, as we got to the live pilot, we selected 20 applicants for housing who were at the top of the list or nearly at the top of the list and who already had identified for us that they had support agencies that were working with them. What we did for the 20 individuals was that, prior to allocating a property to them, we had a case conference with each individual and their support providers and the department and we were able to work through with that live supportive group what were the available properties for allocation and which of those properties best met the need of the applicant.

We are now writing up the results of the pilot, but we can say that it was a highly successful pilot, not surprisingly because with that level of support for an individual we were quite confident that we would get a good outcome and we believe that we have been able to allocate properties which really do meet the needs of individuals and we will certainly be intending to use that model for our allocations in the future. The challenge for us will be that we did the pilot with people who already had agencies supporting them. As we go forward, there will be individuals who do not have support available at the time and it will be part of our role to work with agencies to bring that support on line so that we will be in a position to make a really good, informed decision about what properties to offer people and the people will be really comfortable that the property is going to meet their needs.

THE CHAIR: Minister, you talked before about the intensive treatment and support program. I want to ask specifically about an issue which came up on Tuesday about independent living programs. Does the department actually offer such programs for

public housing clients?

Mr Hargreaves: I will get Ms Ford and Ms Sheehan to jump in when they feel so inclined about this, but I want to preclude it by saying that you have to remember that safe and secure housing is a springboard and it is also the rock on which people can make sure that their lives are sustainable and of high quality, but we have to do this against the background that Housing ACT is not the tenant's parent, as I said before, and we have to remember that we do provide assistance.

THE CHAIR: I appreciate that.

Mr Hargreaves: But I would like to clarify something I said before. I was just thinking about it and I think that it can be taken the wrong way. Whilst I accept that sometimes I have been a bit disparaging about the private sector, and I shall continue to do so in certain areas, it has to be understood that the private sector's real estate particularly is about representing the owner, full stop. Housing ACT does not consider itself to be a private landlord and representing the owner, that is, the government; rather, that it is in fact a community resource. We actually represent the community out there and the tenants have a dual role: they are tenants but they are members of our community. That is why these other services are actually brought to bear. With respect to independent living programs, yes is the short answer. I will get you a longer one. We talked about it at that forum the other day. I am sure Mrs Burke has had feedback from her staff member who was present when we talked about things such as co-tenancies.

MRS BURKE: Not yet.

Mr Hargreaves: Sit back and enjoy the show when you get briefed. We talked about the range of ways in which people who are at some kind of disadvantage can live in a high-quality way. We talked about it in terms of disability, but now we can talk about it in terms of mental illness. We talked about co-tenancies, shared accommodation, a whole range of things like that. They are all about independent living. One gentleman spoke to us about home ownership for a person with an intellectual disability, a 30-year-old or something, but it was about living independently and what you need to do as a community and as a society to achieve that. Valuable stuff came out of it in that particular instance.

Ms Ford: In terms of support for independent living, which I understand from the report is around things like cooking, cleaning and being able to maintain yourself in your own home and also to engage with the community to prevent social isolation, those are support services that are entirely appropriate to be delivered either through, in our case, Disability ACT support services or, in the case of mental health, through the mental health services. I will ask Dr Brown to comment on mental illness. Just in terms of disability, the large majority of the support dollars that we expend is around the social and housing tenancy type of support that would enable an individual to maintain their tenancy, to engage in their community, to be able to engage in employment—again, as I say, the social, economic and cultural life of the ACT community.

We do not see those as the function of housing and tenancy. In fact, we see that as really very much blurring the line for an individual. If Housing ACT saw themselves in the role of providing that type of social or living skills support, it would blur the role for the

individual. They would then become confused about what housing and tenancy are about, as opposed to the support they need. It would also blur the role in terms of funding, about how you allocate funding to a housing and tenancy agency whose primary role is to provide housing in the context, in many ways, of community housing and then the role of a support agency such as Disability ACT or mental health services whose role it is to make sure that people who have high support needs or require some form of support can maintain their life in the community, how we deliver our services. We at Disability ACT—I cannot speak for housing, but I know from our direction with housing—are very clear about where those roles intersect and where they do not intersect. I will just ask Dr Brown to comment for people with mental illness.

Dr Brown: I guess I can echo what Ms Ford has said, really, in relation to people with mental illness. We certainly do not see those living supports as being the function of housing, per se. When it comes to those people with severe and chronic illnesses in housing that require support, it is a function that the clinicians in association with the rehabilitation providers seek to provide. The majority of our clinicians don't actually see that as their role, either. But when it comes to rehabilitation and support workers, for example, that is a specified role, but we also do it in conjunction with community NGOs.

THE CHAIR: That leads me to the question of whether the role is being fulfilled by anybody.

Dr Brown: Yes, it is. I think there could be a question asked of how adequate that is. But, yes, there is a role specified for a discrete percentage of our work force and it is one of the factors that we engage in with the NGOs around supporting our client group as well.

Mr Hargreaves: One of the things that I would just like to underscore that Dr Brown and Ms Ford have just indicated to the committee is that where the responsibilities intersect is absolutely crucial to the client, to the tenant, absolutely crucial. We understand that in order for us to systemically support these people, and housing is part of that system, we need to have partnerships out there with people who are experts in the field. That is one of the reasons we engaged with TAS Housing, Community Housing Canberra and Inanna when we talked about the accommodation that we temporarily had available over Christmas for domestic violence. We engaged with those people because they are experts and that is why we rely so heavily on mental health services to say to us, "Your solution to this particular person's problem isn't going to work. This person needs a different type of accommodation." So they are in these partnerships. With mental health services, our MOU gives us the charter to do that, but we have other arrangements in place with the non-government sector.

MS PORTER: We heard from a number of people at the hearing the other day that homeless people often have a pet, particularly a large dog, as a companion and it is probably quite important to them as a companion during their time of homelessness, yet when they are looking for or applying for public housing, particularly if the department is looking to house them in a multiunit situation, having a large dog is probably quite a difficulty, but perhaps separating that person from that dog would be quite damaging to their mental health. Research tells us that living with an animal is conducive to improving your mental health. What do we do about that?

Mr Hargreaves: I will flick to Dr Brown in terms of the therapeutic effects of pets, but I think it is widely recognised that they are fantastic. We have various criteria around whether people can keep pets, not necessarily addressing a particular therapeutic need for it. If, for example, you have a three-bedroom home on a quarter-acre block, you can have a dog and you can have a cat. You can even have a sheep if you want one. We draw the line at camels and things like that. We don't necessarily think they are appropriate. Two or three horses are not regarded as pets. We have no difficulty with people in multiunit complexes having goldfish and budgerigars, even the occasional galah in a cage. We do have a problem with people having sheep in multiunit complexes and, of course, orang-outangs are frowned upon, really, unless they are income tested.

The point, of course, is that the value of having pets in public-provided accommodation is recognised, seriously recognised. In fact, the task force on homelessness is considering just that to make sure that we actually have responsive criteria. I can recall a constituent contacting me over a move from one form of accommodation to another because of a change in the family dynamic. I think her husband had died and the constituent and her child had a cat when they moved from a house into a two-bedroom townhouse complex in Wanniassa.

Strictly speaking, having the cat there was not in accordance with the criteria, but the discretion of the Commissioner for Housing was invoked and it was allowed. But what we see now is an exception to the rule, so it is time now to challenge the rule. That is what we are doing; we are actually examining that to see just what it is. But if we receive a request for assistance from mental health services about housing somebody and they have got a significant pet issue, then we will regard mental health's advice with the seriousness of that clinical advice. Do you want to talk about that, Dr Brown—about having orang-outangs in a multiunit complex?

Dr Brown: Not really.

MRS BURKE: Dogs and cats.

Mr Hargreaves: Cats are fine; they're beautiful.

THE CHAIR: We will leave it at that and go to the morning tea break.

MRS BURKE: Chair, I have one more question, but I will put it on notice.

THE CHAIR: If other questions arise, we will send them off to the minister on notice. Minister, Ms Sheehan, Ms Ford and Dr Brown, thank you very much for you attendance today and your assistance with the inquiry. You will be supplied with a proof copy of the transcript, which you will need to check for accuracy.

Mr Hargreaves: Thanks very much. I look forward to seeing you again at the summit.

Short adjournment.

SEBASTIAN ROSENBERG was called.

THE CHAIR: I will start by reading the card. 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 Rosenberg: I do.

THE CHAIR: If you could state your name and the capacity in which you appear today, for the record.

Mr Rosenberg: My name is Sebastian Rosenberg and I am the deputy chief executive officer of the Mental Health Council of Australia.

THE CHAIR: I thank you for the briefing that you gave to the committee a few months ago. We said at the time we would invite you back in order to get a lot of what you said on the record to help inform the inquiry. Would you like to make a statement and then we might ask you some questions.

Mr Rosenberg: First of all, thank you very much for the opportunity to come back. I should say the council really welcomes the inquiry. I wish you every success in coming up with some solutions. We are happy to contribute as well.

I could start with this approach: I have got in writing some notes for me to present to you today. It was really about the issues that we found. Obviously the Mental Health Council is a national body but, through the *Not for service* report and through our ACT peak body, we have got some assessment of what we see as being issues affecting accommodation for people in the ACT with mental illness. I am happy to share that perspective with you. They are probably things that you have already come across.

But then I thought what was perhaps of most use to you and what appeared to be of most value last time we met were some examples of things elsewhere—models and so on—of particular community-based services and accommodation options that perhaps you are aware of and perhaps you aren't that I could share with you and give you perspective as to why the council thinks they are valuable and why you might wish to look at them further. Would that be reasonable?

THE CHAIR: That would be great.

Mr Rosenberg: Very briefly: in looking at the *Not for service* report, which is the large report that the council presented in October of last year, there were a range of things which came out of that for the ACT. It is fair to say that it appears as though the government was extremely aware of the issues which affected mental illness and services and had reached a critical point in deciding to do something to repair what is a fairly desperate situation in the ACT and nationwide.

Obviously there were issues of infrastructure. There were also some really significant workforce issues which affected mental health services in the ACT. I know you are looking into accommodation specifically, but I am coming at it from the mental health point of view.

The proportion of the budget that appears to be being spent on mental health in the ACT is very much the average for the nation. It is about 7 per cent of the health budget. That is very much the average, which is an improvement on its past performance but is still no better than the average.

The critical areas for investment, for us, appear to be about developing integrated community services and building into that workforce development. According to the *Not for service* report, the Canberra community found a great deal of difficulty in accessing mental health services, including accommodation services that they need.

We are aware that recently the government announced a range of infrastructure initiatives. There is a new adult mental health in-patient unit, a new high-security forensic care unit, a separate youth unit, which is welcome, and a psychiatric emergency care unit is to be established. These are all significant pieces of infrastructure in the mental health service firmament for the ACT.

What is perhaps slightly concerning is that the government is also committed to developing a mental health services plan, which is a comprehensive plan, which Dr Brown would be oversighting. That would involve the usual in-depth consultations with community groups, non-government organisations and other interested parties. From where we sit, we sense that some of this infrastructure and capital outlay is all happening now, in advance of a mental health services plan. It looks as though the capital is driving the plan, as opposed to the plan driving the capital.

I don't know if it is quite as simple as that but, from our point of view, a comprehensive mental health services plan would be a detailed survey of community needs and wishes, the type of which you are really contributing to now in your inquiry. That would, of course, really be looking at the specific needs of the consumers and the carers and would be thinking about what sort of system is going to make health professionals want to work in it.

You would also be looking at deciding which services are to be provided in a hospital and which in the community. You would be looking at determining the level and planning for the level of involvement of community consumer-operated services and the role that community services in the non-government sector would play in a mental health service. You are also looking at not just managing health services of course but also at the sorts of things you are looking at specifically: accommodation options, employment, training, other issues of community services for people with mental illness.

On this basis, you should then be able to make some decisions about workforce and training. *Not for service* highlighted some serious staff shortages which affected mental health services in the ACT. What I am saying is that there is little point in building services that people won't want to work in.

The council would really strongly support the development of the comprehensive mental health services plan which has been announced by the government and which is being invested in. At the same time it is conscious that there is all this capital development—buildings being built and so on—and that is going to have a really significant shape on the plan.

We know from the *Not for service* report what people are really going to want. They are going to want community-based services; they are going to want services which are going to deliver prevention, promotion and early intervention. What appears to be being delivered in the ACT is a series of important capital things: once you are already ill; once you already have an acute illness; once you are already in hospital; and so on.

That is a bit of a brief overview, if you like, of where we see the ACT in terms of its mental health service development and issues arising from what we found in the *Not for service* report. So that is a bit of background. Do you want to ask me any questions about that, or should I move on to some models?

THE CHAIR: If you move on to the models, that might be good.

Mr Rosenberg: There is a lot of talk about the establishment and development of community-based mental health services. But the nature and shape of what these things mean are often a bit elusive. I was really going to talk about some examples where we see a real investment in community services, which include not just health services but accommodation and other things, as a package approach.

The one which we talked about before was in Trieste in Italy. I will start by giving you a bit of a snapshot of that briefly and then I am happy to discuss any further issues about it. When I think about Trieste I often think about the comparisons to Canberra because it is about the same size; it is about 250,000 people. Basically, they have made a really significant change which was based on a legal change. Actually, it was based on a philosophical debate about how mental health services should be provided and whether people should be locked up in asylums or not.

That philosophical debate, which was led by a psychiatrist and other health professionals, with consumers, led to the changes in law which more or less banned asylums and forced different regions of Italy into community-based models of care. Trieste is a particularly good one, which is why it often gets talked about.

To give a quick snapshot: 94 per cent of their mental health budget is spent on community-based services, and 6 per cent on acute services. In the ACT we have been having a bit of a dialogue with Simon Corbell on this matter. He was quite clear in saying that the ACT has got one of the highest proportions of mental health budgets spent in the community sector. If memory serves me, it is about 30 per cent. I am not sure about the veracity of that figure of 30 per cent—I would be happy to talk about that further with the minister—but 94 per cent on community-based services and 6 per cent on acute services really shows in Trieste the purposive movement of funding away from hospitals and away from acute care to prevention, promotion and community-based care.

They have four community mental health centres which are their peak, if you like, bodies to which people come for service. There are eight beds in each of these and they are open

24 hours a day. They also have a university clinic. They have a rehabilitation and residential support program which is really critical. I have got another example of a similar type of program to discuss in Australia that you may be interested in as well. There are 11 group homes which provide 81 beds with step-up, step-down care and staffing support. They have a day centre which has got creative workshops and so on.

Perhaps most importantly and very interestingly, when you consider the welfare to work, so-called, reforms of the federal government, they have 13 accredited social cooperatives for employment which is, in some respects, an epitome, if you like, of good mental health—if you are able to carry out a job and be able to function well and contribute to society, be that as a volunteer or in paid employment. They have got a very significant emphasis across those different cooperatives in setting up systems to provide for employment. For example, one of the things they do is run a hotel. If you go to Trieste and stay there, then you can stay in the hotel which is run by one of these cooperatives.

They maintain a small unit in their hospital which is, if you like, an acute care ward. It is a service for diagnosis and care. They have eight beds in total. They have a total of 236 staff which run this service, which is split between 28 psychiatrists, 6 psychologists, 180 nurses and 10 social workers, with 6 psychosocial rehabilitation workers. For this suite of care, the cost is approximately 14.2 million euros per annum which, in today's dollar terms, represents about half the cost of running the asylum, as it was, in 1971. It is ironic and poignant that it is cheaper as well.

Some other markers of the success of this approach to community-based services are that compulsory mental health treatment orders were 177 in 1977 in Trieste and were 20 in 2003. From what I can tell from the 2003-04 annual report from ACT Health, there were 460 compulsory treatment orders in the ACT. This gives an indication, I suppose, of the extent to which people are forced into that situation where they can't get accommodation and can't get services and their mental health deteriorates to the point where compulsory treatment is required. In the ACT that is obviously still a significant issue, whereas in this jurisdiction in Italy it appears to be an issue of far less significance.

Electroconvulsive therapy and restraints are no longer used in Italy; again, another marker of their general success in managing this issue.

THE CHAIR: ECT is not used as a treatment at all?

Mr Rosenberg: That is correct.

THE CHAIR: So people can't choose to have ECT?

Mr Rosenberg: That is my understanding, yes. My understanding is that they can't choose.

THE CHAIR: Some people choose to have ECT.

Mr Rosenberg: They do. I suggest that from a clinical point of view—and I am not a clinician—this is a debate about the efficacy of ECT. There would be many people, including consumers, who would suggest that it is effective. I suggest that Italian consumers may need to go elsewhere or may be able to receive the treatment privately.

Rebuilding a forensic unit: there were 15 forensic patients in 1977 in Trieste. There is one in 2003. But we are building a unit. We need to be careful that the investment is going in the right spot, I suppose.

There has been no increase in crime in Trieste. The suicide rate is a very tricky thing to change, in effect. It is a difficult issue, as you would appreciate. The suicide rate was 22 per 100,000 in 1978 and is 17.9 in 1997. It is a small but significant change, and it is going in the right direction. Also, interestingly, drugs are 0.5 per cent of their total budget.

What I am painting for you is a picture where what appears to be, prima facie, some really significant investment in community-based services and accommodation is a key part of that, with some really significant benefits for the consumers. Then, of course, there are benefits for the community more generally in terms of their capacity to carry out employment, to be productive citizens, to not be a drain on the health service and so on. That is one model to consider. Did people want to ask me questions about that?

MS PORTER: I have a couple of questions. I presume that you are going to say no, but were there any other variables that could indicate that this would have happened anyway because there was some change in other ways of working with people with mental illness and that it is not just the fact that they have the accommodation options and the intervention in the beginning versus the acute care at the other end? Are there any other variables that happened at the same time?

The other question I have, which is related to the provision of services, is: if, as we speak, these other capital investments are being made in the acute end and we have the community out there saying, "When I need a bed there isn't a bed available; there are not enough," et cetera, et cetera—so we can't immediately turn off the tap because people are going to want to have a bed or someone is going to want to refer someone to a bed—how long is the lead time between when you introduce all of these things that you are talking about at the community end and before it starts to kick in, in effect, in that you don't need the beds and the services at the other end?

Mr Rosenberg: That is an extremely good question. If you are looking at a long lead time and you are looking at a staged process, I would have thought something like 10 years is probably what you are thinking about in terms of changing the culture and expectations of consumers and of health professionals. I would have said that was probably about right.

In terms of variables: I can't answer that question exactly, except to say that the change that was made in Italy was so fundamental—and because it came from the health professionals—that they really saw a worsening of trends and that radical action was actually required along the lines that I outlined in order to change and make a real difference to these people. The key variable really was unstinting support by the health professionals, in particular, and the consumers for change. That is something which is around now in Australia and in the ACT but in varying quantities.

I am not aware of any other variables that would have meant that positive changes would have occurred. The trends, to my understanding, were to the contrary; things would have

proceeded to decline; and the mental health of people in that region would have continued to decline.

One other thing I should say is that Trieste is a World Health Organisation-recognised best-practice site. We still have issues about this. I am not suggesting that it is a paragon. One of the questions that we have about Trieste is to do with the level of consumer involvement and the extent to which we are swapping a hospital-based institutionalisation for almost a community-based institutionalisation. What you would like, ideally, is for consumers to be in a position where they actually control and determine their own affairs.

I can't answer the question about the extent that that is the case in Trieste. I know that a lot of the services involve consumers and are based around consumers, but the extent to which consumers actually lead, manage and run those services or whether they are still led and run by psychiatrists, in particular, and other health professionals is the question that would really bear some investigation. Consumer-led services, in particular, is an initiative which is happening across a few places in Australia. That is very exciting and seems to be delivering the type of care that consumers want. An assessment or an independent evaluation of the extent to which consumers in Trieste are happy with the services that are provided would probably be something that would be worth doing. I am happy to volunteer to do that, as you would imagine.

MS PORTER: You mentioned that there was some Australian model that you wished to highlight.

Mr Rosenberg: I have got two Australian models in particular. You may well have come across these. If so, stop me. One of them is HASI, the housing and supported accommodation initiative in New South Wales. Have you seen that? I am more than happy to give you the link which will also take you to the evaluation. I want to quickly outline this one. It is a lovely example because, while it is extremely small, it is Australian, which is great, because you feel that, although there might be some cultural things that might separate us from Trieste, it is not as easy to say that about Sydney. Some might posit that.

In particular, it is also a particularly good or salient example for your inquiry because of the links between the department of health and the department of housing. Basically, HASI, the housing and supported accommodation initiative, is jointly funded by those two departments in New South Wales. It aims to improve the housing stability and community participation for people with a mental illness through community-based accommodation and coordinated support services.

It is really only at a fairly early stage, stage 1, and provides accommodation support places for over 100 people with complex mental health problems and high levels of psychiatric disability. It has been formally evaluated by an independent research program. I am happy to send you the link to that evaluation.

Some of the key findings: there were 100 clients that had very high levels of psychiatric disability and histories of long-term hospitalisations, tenancy instability, limited social networks and limited family connectedness, and minimal levels of community participation. About 72 per cent of the clients involved in the program had schizophrenia

as the primary diagnosis and, in total, the clients spent—I find this staggering—12,486 days in hospital in the year prior to their participation in HASI.

What happened with the partnership model between health and housing was that housing was provided by community housing providers, and the department of health was linked to clinical support from area mental health services. There was also accommodation and disability support from NGOs. There were three NGOs—the Richmond Fellowship, NEAMI and New Horizons—that fulfilled the role of accommodation support providers. They provide a range of support to clients: domestic, emotional, physical health as well, education, employment, advocacy, social and leisure. So this is way beyond health; this is much broader. The clients are independently accommodated in units, townhouses, villas or they are in separate houses which usually have a couple of bedrooms. That gives you a picture of the set-up of it.

Some of the outcomes are that 93.1 per cent of the clients were satisfied with their homes—that is a good thing; community participation levels had improved for most HASI clients; 72.2 per cent had made new friends since joining the program; and 65.6 per cent were participating in social and community activities. You would appreciate that there is a very strong correlation between mental illness and isolation and loneliness.

Eighty-five per cent of clients successfully maintained their tenancy under the HASI program; 69 per cent of the area mental health services case managers reported an improvement in their clients' mental health; and, projected over 12 months, HASI clients spent a total of 1,377 days in hospital, which represents a 90 per cent fall in hospitalisation trends. You feel like weeping, don't you? People are making friends and are committed to the community; and they don't need to go to hospital. It seems so simple. Of course it isn't simple. It requires governments and government departments to work together, which is tricky.

Most clients will regularly see a case manager—92.2 per cent, in fact; 89 per cent were seeing a psychiatrist; 86 per cent were linked to a GP, which is a very high rate when you consider the rate of people that don't see general practitioners or don't receive any treatment at all for their mental illness. People with a mental illness often neglect their physical health. This is a really good sign that, in a holistic way, they are being properly cared for. About 42 per cent had seen an allied health professional as well.

Over half the clients reported improvement in their cooking, in their shopping, in their budgeting skills, along with better diet and use of public transport. A total of about 9 per cent of individuals had exited the program at the time of the evaluation.

It looks as though that is a program which is really worth looking at. It is 100 people; it is tiny. I believe the New South Wales government are looking to expand the program considerably, but it is the type of connected program which seems to be yielding some extremely positive results for people with mental illness—from their health to their employment, to their community connectedness, to their accommodation.

MRS BURKE: One point of clarification, if I could: one of the statistics that you gave—there are an awful lot there, so I am glad that Hansard has captured all that—was 12,486 days in hospital prior to HASI involvement. Was that for 100 people?

Mr Rosenberg: Yes. The cohort of people had 12,486 yes.

MRS BURKE: Over a period of 12 months?

Mr Rosenberg: That is correct. I remember reading somewhere in that report the evaluation, which I shall send to you, that the average length of stay for these people was 270 days or something like that. Most of the year these people are hospitalised. Suddenly they are not hospitalised; suddenly they are in their own accommodation, being helped to begin to learn to look after themselves. Then they find that they can study or participate in the community; they can perhaps get a job; they can start to spend money in the local shop. It is a different world.

THE CHAIR: Has there been any cost analysis of sustaining HASI clients pre and post their involvement in the program, do you know?

Mr Rosenberg: I am not sure of that. I can go back and look at the evaluation and check that out. But I am aware that they have certainly done an analysis of what the 90 per cent fall in hospital days has saved them. It was something like $7 million.

MS PORTER: You said there was another mode?.

Mr Rosenberg: Yes, the other model. The Mental Illness Fellowship of Australia, MIFA, run a specialist residential/rehabilitation program in Shepparton. Have you come across that model at all? MIFA are one of our members and were more than happy for me to come and spruik for them today. It is something which, again, really bears your consideration.

The Goulburn Valley Area Mental Health Service and the Mental Illness Fellowship of Australia are working in partnership to deliver some services. Their partnership started in 2001. The Mental Illness Fellowship has been able to provide residential and rehabilitation support. The Goulburn Valley Area Mental Health Service provides treatment and clinical rehabilitation. It focuses on people that have higher needs that have not been able to be fully met in the absence of a 24-hour longer term mental health facility.

The paucity of services that are available to people with mental illness was really writ large in the *Not for service* report. It is really terrific to be able to point to these little islands of excellence in Australia; we don't have to go overseas. These people are developing these systems because of the paucity of services. They are coming up with new ways, creative ways, to overcome the lack of services.

The specialist residential/rehabilitation program enables people with a mental illness to learn or relearn living skills in a supportive and safe living environment. It assists people who require more support than can be provided by people who just visit. So these people are actually residential. The residents build social and living skills through shared learning with others and accept responsibility for themselves within a supportive environment.

The program also fosters vocational and educational connectedness in the community.

The program helps individuals achieve their maximum potential in gaining skills with daily living through, again, learning to cook, meal preparation, budgeting, personal care, sharing a house and learning how to look after a house. Wherever possible, the program involves all the stakeholders in the development of a rehabilitation plan.

That is a quick summary. Again, I am more than happy to send you information which has a link to their website and which tells you more about how the system operates. But the point is that it is knitted into health care; it is not just accommodation alone. As we know, once the asylums were closed and deinstitutionalisation occurred, we had this phenomenon of what is called unsupported deinstitutionalisation where people were really moved out into accommodation of various types, often fairly shabby, and then left alone.

What you are finding in Trieste, in HASI or in Shepparton are examples where in fact that has been reversed and you have got supported deinstitutionalisation—people being able to live out in the community, with due care—and not just health care or living skills but also vocational learning, educational opportunities, training and so on, leading to perhaps employment.

It is also reasonable to say that Australia's national record and capacity to be able to employ people with mental illness is about half the OECD average. So Australia is failing in its capacity to create a situation where people with a mental illness can be gainfully employed.

THE CHAIR: Since we last saw you we had a trip to Victoria. We didn't go to the Goulburn Valley area; so we didn't see the MIFA program. But we did see the PARC program, prevention and recovery care program, which we found to be very good. They are starting to have a bit of an effect there. We have got a lot of food for thought.

Mr Rosenberg: When you think about a comprehensive mental health service plan for the ACT, I would like to certainly see it imbued with these kinds of things, these kinds of approaches: what is working elsewhere; where you can demonstrate that programs have led to decrease in hospitalisation, increase in social participation, increase in the general health of the mentally ill community. These are markers that you would like to see as fundamental principles of the plan.

I am not suggesting that beds and thing are not important. There will always be a requirement for acute care. That is something which we don't want to take our eye off. What I am saying is that the ACT is perhaps slightly better than other jurisdictions but still mirrors the general chronic lack of investment in community-based services, based on proven models of care.

THE CHAIR: We might leave it at that because we have gone a bit over time. Thank you very much for your attendance today and, as I said earlier, previously. We will be in contact with you and pass on the proof transcript for you to check for accuracy. If we have any further questions we might be in contact as well. Thank you very much.

Mr Rosenberg: Thanks for the opportunity. Good luck with the rest of your deliberations.

The meeting adjourned from 11.38 am to 12.02 pm.

IAN MORISON and

BERNETTE REDWOOD

were 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?

Mr Morison: Yes.

Ms Redwood: Yes.

THE CHAIR: Would each of you start by stating your name and the capacity in which you appear today? I understand you have had a name change, so you might like to tell us about that as well for the record.

Mr Morison: I am Ian Morison, President of the Mental Illness Fellowship of the ACT, which was formerly known as the Canberra Schizophrenia Fellowship. This is a name change that has been occurring with our sister organisations in a number of the states, although not yet in New South Wales.

Ms Redwood: I am Bernette Redwood. I am the executive officer, the recent executive officer. We have an acronym now, like everybody. We are MIFACT. Basically I am here very much because I have worked for 30 years in mental illness, even though I have not worked in Canberra for any length of time.

THE CHAIR: Thank you very much for that. Would you like to start by making an opening statement?

Mr Morison: Yes. As our written submission says, the fellowship is a community based, volunteer resourced non-profit organisation. It seeks to provide effective assistance to people affected by serious mental illness. It does this by providing direct support, information, and advocacy.

MIFACT volunteers manage a number of core programs, only one of which is funded by government, and that is the vocational rehabilitation program. Its other programs include: consumer support for patients at Canberra hospital, a telephone assistance program for people who are seeking information or advice to deal with pressing issues relating to mental illness and programs aimed at better informing members of the public on the wider issues associated with promoting awareness, understanding, self-help and improved management of mental illness.

It is the direct experience of fellowship members with mental illness that provides the

basis for our submission. Our submission looks at the range of conditions that people with mental illness are experiencing on their road to recovery. People in these different situations need different types of housing. However, like the rest of us, they should to have a final form of housing which they can call their own for the rest of their lives, if they wish, rather than, for example, being in group houses, which are essentially for young people who are learning how to cope with life.

In the context of that range, I would like to comment on two things. Perhaps that is sufficient for the opening statement, unless you would like me to go on and elaborate on those two things?

THE CHAIR: That is fine.

Mr Morison: Given that we have a pretty severe housing shortage in the ACT, a number of families of people with a mental illness are themselves seeking to make provision for their member when it comes time to actually leave the parental home. A lot of them are in a form of accommodation that can only be temporary, or should only be temporary. Given that they cannot often get into public housing or not supported housing, these families are purchasing units themselves.

However, the government treats that as a commercial investment and charges them land rent, which can be quite substantial. What we are advocating is that some sort of agency be set up to make exceptions in cases like this so that those fees are not charged. It probably requires an agency that is separate from the body that charges land rent in order that the land rent rules exceptions do not have to be made by that agency, but instead by some other body that is fully aware of the situation and can also keep track of whether the person who is ill with a disability is continuing to live in that place so that what we are advocating is not rorted.

We would add that people in that situation, where families make the investment to cover the accommodation of their member, could also get the same level of support for that person that they would get if they were in supported public housing—in other words a full recognition that families who are making their own investment in the future of the person should be given the same sort of support as people who rely on the public housing system.

The other point I wanted to elaborate on is the need for residential hostels. There is currently a gap in the housing spectrum between Hennessy House and group houses in the community. That is a huge jump for people in Hennessy House, particularly those who may have been there for quite some time and who have been strongly resistant to, or unable to take advantage of, the rehabilitation efforts of Hennessy House and who therefore still have few life skills or insufficient social skills to cope with living in a group house.

A group house demands that people be relatively compatible, that they can cooperate in the buying of food, the cooking, washing up, housekeeping and all those things. It is hard enough to get young people who are perfectly sane to do all those things, let alone people with a serious illness, particularly those who have been resistant to rehabilitation efforts while in Hennessy.

Group houses can be a make or break situation. My own son was in various group houses. He happened to learn from that and became quite skilled in social interaction and cooking. He can now live on his own perfectly well. That is the idea of group houses. People graduate out of them, because group houses are really only suitable for fairly young people anyway.

However, there are people who fail under that pressure. They cannot cope with the pressure of a group house, get booted out by the others and end up either back with their parents, making their lives a misery, or getting admitted to a Richmond Fellowship unit where they do not cope with their living. I know of one young man who did get a CAN unit—and you are aware of what I mean by CAN?

THE CHAIR: Yes.

Mr Morison: He just got rid of all the furniture, the refrigerator and everything, because that was his problem. He ended up with nothing. He had nothing to cook with, so he went back to his mother. After a couple of years of having to cope with this, his mother did manage to get him into Hennessy to get fairly intensive counselling and rehabilitation. However, it does not seem as though it is working. So now they are proposing to put him in a group house, back to that situation, which is obviously going to fail.

There are plenty like that boy. I have heard that 20 per cent of people in Hennessy are like this. They cannot go into group houses. Group housing would be a disaster for them. What is needed is a residential hostel where somebody does the cooking and general housekeeping. They can have a room that they can lock and get away from things, if they want to. They probably have quite good skills at getting around the town, but very bad social skills, poor social skills. They do not have life skills.

I am sure Richmond Fellowship yesterday would have explained to you what they imagine or believe this kind of residential hostel—they may have called it a boarding house, but I think that has got such bad associations that we are calling it—

THE CHAIR: They did actually—I am sorry. Keep going.

Mr Morison: a residential hostel, or we can call it something like what is being provided for aged units, groups of units with common facilities.

THE CHAIR: I was going to ask your opinion about this. Richmond Fellowship came to see us on Tuesday, and we also visited Richmond Fellowship a couple of months ago. Ms Seaman mentioned that she would like to see—and she believes there is a need for this—the building of single bedroom units in groups of four to six around a common living area so that people can have their own living space but can also socialise if they feel the need to do so, so that they are not socially isolated, which she may or may not have said sometimes happens when people are actually placed in flats or units on their own.

Ms Redwood: She called it a cluster, did she not?

THE CHAIR: Yes. She did call them clusters, Ms Redwood.

Ms Redwood: Can I mention something that is sometimes overlooked? We talk about one bedroom units, but people with a mental illness do get married, do have permanent relationships and do have children, and I think that aspect needs to be remembered. People have families. They should have the opportunity to be near other families with young children. All of us with young children like to have that support. I think that is an important aspect that needs to be addressed when we are looking at options for housing, that they do not all need to be one bedroom. I mean, probably not as many, but it also needs to be considered.

Mr Morison: Yes. If I can add to that, my son is in the Roystonvale units in Griffith where there are a number of people like him scattered through the complex. I think they have all got one bedroom units, but there are two and three bedroom units there as well. So it is a form of discrimination, I suppose, that they should have been allocated the smallest ones, which cannot provide for setting up partnerships or anything.

THE CHAIR: Did you wish to add anything else?

Ms Redwood: I would like to talk a bit about the global aspects. Obviously Ian has mentioned very specific ones that are very important. That is one of the issues that I see. I sometimes think that, although we concentrate on specific people having needs, which is great, we also need to look at the broader picture. One of the things, for instance, that is an ongoing and common problem is that as soon as you talk about setting up a house for people with a mental illness in a normal neighbourhood—and I use the word "normal"—people immediately get quite hysterical and say, "We're all going to be killed with axes."

I think that part of it, obviously, when we look at setting up housing, is that we also need to look at setting up some form of education so that that is not a problem. I know of instances where people have had pot plants and things thrown through their windows by supposedly "normal" people because they are so anxious about—

THE CHAIR: Yes. That is a good point.

Ms Redwood: That makes people with a mental illness more anxious and less likely to behave in an appropriate way. So it all becomes a bit of a cycle. Also, in regard to children, I think the aspect of housing has to be looked at. Is it near a school or a preschool? There is almost no point in setting up people miles away from any school, miles away from any shopping centre or miles away from anything. These are important issues. We should not just think about the physical building, which is obviously important, but we should look at the environment.

All the issues that Ian talked about are really important for that progression. I have a friend who is a university professor who has a severe mental illness. We have got to look at which people need support, which people need support for a period of time and which people need support for a longer term. Again, I think what I am trying to say is that sometimes there is a danger of slotting people in and not having an overview of them as people and of their lifestyle, and I think this is a fairly important aspect, really.

As Ian was saying, a lot of money is now put in—I think very appropriately—to

supporting aged people in their homes. Probably the same amount of support on many occasions is needed for people with a disability, with a mental illness. We talk about aged people with Alzheimer's, and while that is not regarded as a mental illness, it is certainly an illness that affects them mentally. I think we need to look at that to see what is working so that we can take on the good bits and, to some extent, use that as a model. I think that is probably all I wanted to say.

Mr Morison: I would like to add a couple of points on the general scene. It is well over 10 years since the Burdekin report came out and governments were closing down institutions with the idea that people would live in the community. Well, we all know that what happened is that nothing happened in the community and we have had pretty disastrous conditions ever since.

But now I think we are at the beginning of the second leg of what was proposed back then, in other words, recognising that it all has to happen in the community. The psychiatric wards are very specialised. They treat people only for a few days and they go back into the community. So it is in the community where everything after that has to happen. We get plans for specialised services costing a lot of money to build up the psychiatric inpatient area, and it is not that we do not need some of that, but we do have to increase substantially funding in the community.

Added to that there is now a view that recovery is possible, and people used not to think that. Recovery orientation is part of the language of the ACT Mental Health strategic plan, but recovery is not well understood. Some of the things we have been saying show that housing is a very important support or element in people's rehabilitation or recovery and can play a much bigger or better role than it has done. Better housing will lead to more recovery, and that must reduce costs on emergency services. The psychiatric wards need to expand their services. That is the context also in which we talk about step up and step down.

THE CHAIR: Ms Porter has some questions.

MS PORTER: First a very quick question. With the change of your name, have you changed your emphasis at all or are you still dealing with the same client group?

Mr Morison: Our mission is still exactly the same because we always did have a mission to foster support for serious mental illness.

MS PORTER: So that has not changed?

Mr Morison: No.

MS PORTER: That was just a quick one. The other one was in regard to the hostel concept that you are talking about. What optimum number of people would you see—you may have said, and I am sorry if I missed that—occupying such a complex of either clusters or units or whatever?

Ms Redwood: Again, there is a real danger of just putting people back into an institution.

MS PORTER: Yes, that's right.

Ms Redwood: I would see a residential hostel with probably no more than six or eight in each unit, shall we say, or each hostel, because we are talking about an opportunity for support. So we need to look at where people are given a fair amount of support. Where there is a large number of people it becomes much more difficult for that to happen.

Mr Morison: I think I might have said somewhere up to 12 but I would like to amend that downwards. I can also comment that Ainslie Village has one unit—I forget what they call them; a unit for 10 people—reserved for people with a mental health problem. But Ainslie Village is not an example of the standard you would want to follow in the future.

THE CHAIR: You are talking about the lodge?

Mr Morison: Yes. So their maximum is 10 but the standards are not good.

MS PORTER: The other question I have is again for clarification. Would it be somewhere where people went for a particular period of time and then went on to somewhere else, and could the person presumably come back again if necessary?

Ms Redwood: I think one of the things that again is important—and I keep talking about flexibility—is that people could come back to all of these stages. People with mental illness fluctuate in their illness. Some people just go out to work and get on with their lives and a number of years later become unwell. We do not want those people to just be lost again in the system, which so often happens. So often people come out of a hospital situation and they are just left there and "okay, now you manage". So if there are these supports people can go into their own homes and whatever. But there needs to be the opportunity for them to go back to get more support, more skills, whatever, because otherwise I think there is a real danger.

We have got X number of people through the system now. That is very nice and, yes, they fell off at the end but again it needs that. That is why I think there needs to be some sort of linking for people in hostels, group homes, whatever, not so much if they are living independently. But again, as Ian was saying, people who might find that living in group homes is not appropriate may go back to a hostel but then may look at going back into a group home or that sort of thing. So I actually think that is quite important, to be honest.

Mr Morison: I think the important thing is not to have any hard and fast rules about them having to move on, because living in a residential hostel could suit some people for the rest of their lives. But it depends on the individual. If they want to get something more private, then, of course, they would want to move out. But as Bernette says, that might not work out either, so they might have to come back. So flexibility is the answer.

MRS BURKE: Thank you for appearing today and for your time. On page 2 of your submission you talk about suitably qualified people. With my shadow minister for housing hat on I can see that what you have said here is right in that I think the nature of training has changed, and I congratulate Housing ACT for the certificate IV to try to upskill and suitably qualify people. What in your experience would you say is "suitably

qualified"? What are we talking about? What sort of a qualification and person are we talking about supporting?

Ms Redwood: Are you talking about people who are going to care for them?

MRS BURKE: Yes, supported housing for the people who are going to be helping people of high need?

Ms Redwood: I think that is quite an important thing because I think one of the things we need to avoid in one way is having nurses and doctors in residential hostels, so we just move one medical model into another one.

MRS BURKE: Yes, that's true.

Ms Redwood: But then, on the other hand, we need people who are skilled and qualified. Volunteers are all very nice and whatever but we need people who are going to understand about their need for rehabilitation and address that accordingly.

Mr Morison: There was a forum recently held by the Mental Health Community Coalition at which someone, I think from Queensland, who is a peer support worker spoke. She made the point that people who have had mental illness and are now pretty well functioning can be excellent support workers because they understand. I do not know what sort of formal qualifications peer support workers would need to have but I should think that their experience plus a fairly commonsense interview would be the way to decide if someone has got the qualifications—small "q" qualifications—attitude and qualities to be a good support worker. And that probably applies to all support workers. It is not academic qualifications that count. It is what sort of people they are.

MRS BURKE: Yes. I was interested from your perspective that you raised it as an issue. Of course, I think we have seen since Burdekin people going out into the community with that lack of adequate support, but I am just trying to get a feel for what that support looks like.

Mr Morison: Well, we need a lot more people with the right attitudes who can be employed to provide these supports. We just do not have enough of them.

Ms Redwood: That is right. One of the things I feel very strongly about—and I try to initiate in almost every aspect people going to independent work or whatever—is, in fact, mentoring. People who have had a mental illness, who are well and who do have an understanding—I think the ideal option is that these people are paid, even on a temporary basis. I think particularly in housing we talk sometimes about the problems of people coping. If there is someone who has had a mental illness previously who is prepared to visit them on a casual basis and give them support and say, "Hey, mate, you're doing fine," I think that can be as significant as having a professional person involved.

MS PORTER: I have a comment in response to what you said. I think there are some programs that Mental Health ACT are funding currently through the community sector where they are providing those kinds of supports. I guess what you are saying is that you would like to see maybe those increased and certainly make sure that their training is maintained. I believe that in the ones that I have come across, the training and the

support have been quite excellent. One-to-one mentoring and one-to-one support that a volunteer, a peer support person, can provide can be quite critical, as you have just said. Obviously, the key to it is choosing the right person and making sure that they are professionally supported. I do not believe you need to be paid in order to provide a professional service, but that is probably coming from my experience with Volunteering ACT a long time ago.

Ms Redwood: Can I say something in that regard?

MS PORTER: But I take your point about the need to make sure that those volunteers are properly managed, resourced and skilled to be able to provide the service that you are describing in peer support.

THE CHAIR: Ms Redwood and Mr Morison, it is fine that you should comment. However, I am conscious of the time, so could you make your comments fairly brief.

Mr Morison: I do not think they should be regarded as just volunteers. They should be paid and have standing as support workers. There has just been too much reliance on volunteers.

THE CHAIR: Mr Morison and Ms Redwood, thank you very much for your appearance today. We will be in contact with you with the copy of the proof transcript for you to check for accuracy. If we have any further questions we will be in contact with you. We will also let you know when we have the report. So we will be in touch at least once.

Ms Redwood: Thank you for the opportunity to appear.

Mr Morison: Thank you.

KERRIE TUCKER was called.

THE CHAIR: In the interests of time—I know that you were here before when I read the card and I also know that you are familiar with it—I will not read out the contents of the card to you. But can I ask if you understand the contents of the card that I read out earlier and do you have any issues with that card?

Ms Tucker: No, I do not have any issues and I understand the contents.

THE CHAIR: Thank you. For the record, would you state your name and the capacity in which you appear today.

Ms Tucker: Kerrie Tucker, representing ACT Shelter, peak housing group, and advocating for people on low income and their housing needs.

THE CHAIR: Thank you. Would you like to make an opening statement?

Ms Tucker: Yes, I would. Basically, I think it would be clear to the committee already that people who are living with mental illness are incredibly vulnerable in all respects. But in terms of housing, as was stated in the last discussion, post-institutionalisation there has been a great lack of support for people in the community and you will find that people living with mental illness are highly represented in the homeless population as well as in prisons. So it is a really good thing that you are inquiring into this issue again.

I would refer you—and I note that you are doing this—to basically any committee inquiry of this Assembly over the last 10 years that has looked at social issues, and the question of housing is raised in those reports. It is not a new issue although it has become a more pressing issue over those 10 years because of various influences of reduction of funding from the commonwealth, the increasing rent in the private market, et cetera, et cetera. But whether you are looking at reports that deal with children, with women, with indigenous people, with disability, with criminal justice, you will find that housing is a problem and that is because it is so basic for people. Adequate housing is the foundation on which people build their lives. It is also, I would argue, a foundation for a healthy community that citizenry actually have access to adequate housing.

Given that the ACT government has a commitment to human rights, including social rights, I thought it might be useful to point out to the committee that, as you are aware, Australia is party to the International Covenant on Economic, Social and Cultural Rights. In 1991 the UN Committee on Economic, Social and Cultural Rights published its general comment 4 on the right to adequate housing and described the seven aspects of the right that they consider to be protected under the covenant. I raise this because regardless of what you think of the human rights framework—and I know there are different views around this table—that is actually not the issue at all. I think it is a really useful framework if you want to look at how you define adequate housing.

I will summarise those seven principles, which you can easily find on the website of the United Nations Committee on Economic, Social and Cultural Rights. The seven principles include, firstly, legal security of tenure. That is basically saying all persons should possess a degree of security of tenure which guarantees legal protection against

forced eviction, harassment and other threats. The second principle is availability of services, materials, facilities and infrastructure—that is water, energy, sanitation and so on. The third principle is affordability—that the costs of housing should not threaten the capacity to satisfy other basic needs. So that is around the definition of affordability. Principle 4 relates to habitability—that there is adequate space, protection from cold, damp, heat or other threats to health.

Accessibility is dealt with in principle 5. Disadvantaged groups must be accorded full and sustainable access to adequate housing resources. Thus disadvantaged groups such as the elderly, children, physically disabled, terminally ill, HIV positive individuals, persons with persistent medical problems, mentally ill, victims of natural disasters, people living in disaster-prone areas and other groups, should be ensured some degree of priority consideration in the housing sphere. The sixth principle or aspect is location—I notice that came up in the previous submission—allowing access to employment options, health care services, school, child-care centres and other social facilities. And the seventh principle is cultural adequacy—that is, allowing expression of cultural identity and diversity of housing. Listening to the last submission, I can see how that is a useful framework in which you could interpret what has just been said to you by that consumer representative group. All of these aspects are important.

Supply of affordable housing is obviously an extremely pressing problem for Canberra. In the view of Shelter it is also very important that the government becomes much clearer about what its definition of affordable housing is, what the need is in Canberra and what are its affordability objectives. This is a fundamental concern for Shelter and its member groups. Obviously, currently public housing is under unacceptable pressure and the private market continues to fail to provide affordable housing.

Affordability is covered at length in our recent budget submission. We will be producing another document with ACTCOSS in the next couple of weeks and I am happy to ensure that a copy of that will be forwarded to you. We are doing that in anticipation of the discussion at the housing summit. You started this inquiry quite a while ago and I am not sure whether I sent you a budget submission. I don't know if I sent you our last one.

THE CHAIR: The committee does not have it in relation to this inquiry. So no, I don't think we have it.

Ms Tucker: I thought I emailed it. I will email the most recent budget submission as well. That will give you a lot more detail than I can give or that I gave in that submission to this inquiry about what we think should be happening generally about housing.

This week there was a ministerial forum on disability. There were a number of issues that were raised there that would be of interest to the committee. I am wondering if you have seen or have access to the discussion paper that informed that ministerial forum. If you have not, I have got a copy. You can get it. Basically, it is really relevant to your inquiry.

There are a few proposals that came up from government for dealing with accommodation needs of people with a disability. The definition in that discussion paper is a little vague in terms of what they mean by "disability". At the beginning it describes "profound and severe disability". Basically, the issues are quite similar in lots of ways. It

would be interesting if the committee were to have a look at the proposals that were made in this discussion paper. Once again, the previous witnesses raised a couple of the issues that came up.

I want to address a couple of things that came out of that forum which are relevant to this inquiry, too. Basically, there was a proposal put up by government for discussion—it is not a decision, it is a proposal—that there be what was called ring fencing of some housing stock for people with disability. What ring fencing does not mean is a fence around a group of houses with a particular target group in it. That was immediately what everyone thought it meant, and they were very alarmed. It does not mean that, apparently. The explanation is that it is more like quarantining of public housing stock, with a separate waiting list for a particular target group.

I had some concerns about that and I asked the question at the time, "Is the government considering ring fencing for other target groups as well?" There could equally be arguments from mental health consumer groups or parents that they want ring fencing for people living with mental illness. You could argue it is also the case for young people, refugees or indigenous people.

Right now we have an allocation system where the majority of the housing is given to people who are deemed functionally homeless. If you get into a situation where there are proposals from particularly vulnerable groups to ring-fence, in some way, public housing stock, you are setting yourself up to fail once again. One person who is extremely vulnerable in their housing needs said to me, "I don't want to be caught in this competition of misery." What it takes us back to is this: we do not have enough affordable houses. And you cannot get away from that. That is looking at public housing supply as well as the private market and its failure to provide affordable housing.

While it is important to have the opportunity to look at specific details on what is adequate housing for particularly vulnerable groups of people such as you are looking at at the moment, I also sincerely ask you to remember that the key problem is that there are not enough houses that people can afford. If we had more houses that were affordable, these discussions would be much more fruitful because we would be able to provide the choice and options that we obviously need to provide.

It comes out clearly in every submission that has been put forward to any inquiry of this nature that everybody is different; we have a diverse community, whether it is within a particular group or right across the community; and you want to have options that support that diversity. That means you have to have enough houses, but then it means you need to have systems that support that diversity.

One of the issues that also have come up is the rental system in public housing for co-tenanting. A proposal that came up from the government itself on accommodation for people with disability was the co-tenanting proposal. One of the issues there is the rent collection policy and practice in Housing ACT. What happens is that the tenant is responsible for the rent of the house they are in but if there are other people living in the house their income has to be declared—they are qualified as other residents—and the rent changes accordingly. You can have quite a number of complex-income households, multiple-income households, who are paying market rent.

You need to understand that, if you have the actual tenant responsible for paying that market rent but there is no legal relationship between that tenant and the other residents in the house, they are put in a very difficult situation because they have to collect rent but there is no legal relationship between them to collect rent. Quite often there are very complex relationships within that household and sometimes imbalances of power.

That has come up as a real concern for people in both the disability and mental illness communities. And it is something that the minister acknowledged as an issue at the disability housing summit. So I am hoping that that will be progressed.

A bit of a red flag I would like to alert the committee to is that, once again, you have a lot of different pressures when you have public housing squeezed to the degree it is. We are all aware of the disruptive-tenant conversation that occurs. In New South Wales they now have acceptable behaviour agreements—two pilots. I cannot remember the locations. I think one is in Wagga and one is in northern New South Wales.

The interesting question that has to be addressed with the acceptable behaviour agreements is: whom are we talking about, on the whole, who are the disruptive tenants? I attended the national housing conference in Perth where the public servant with responsibility for that area in New South Wales said that the majority of people had mental illness, intellectual disability or an acquired brain injury.

The point is more about what services exist to support people who are working with these issues in their lives. It is also something for you to be aware of in this committee. If you see initiatives coming out of housing, I really urge you to suddenly take an interest in it, look at it in terms of what that means for the people you are representing and in terms of the links.

Another point I make is that housing is basic, and we really need, I believe, to see a much more integrated governmental approach. I understand that there is a high-level group of public servants—I do not know whether there is a ministerial grouping—that deals with these issues. I would recommend that—and I understand it has happened in some states—so that you get a conversation that includes all ministers and all portfolios. Definitely health should be part of that integrated conversation.

The point about home ownership that came up from the previous witnesses also came up at the disability forum. Key barriers exist at the moment for that to occur. Once again, I urge you to link up with that policy development area in disability, because they are exactly the same issues as were expressed by the previous witnesses. Greater support for families, of course, consists of respite and so on. I am sure that has come up already.

The responsive landlord model is also an issue that is now getting fuller attention through the disability forum. The responsive landlord model is another way that you can assist people when they are in periods of illness, to have someone there on the case, in a way, to support them to maintain their tenancy. Once again, that is equally relevant to your inquiry as it is to disability. The concern about stigma that was mentioned by the last witnesses can be addressed to some degree by having that responsive landlord model, because if people are starting to get really unwell there are issues. You could say that this is case management. There is an interesting overlap there about where it fits, but that is part of the discussion.

We have an accepted policy in the ACT that you separate tenancy management from human service support. So if you accept that policy as given, then you do have a framework in which to look at where would a responsive landlord responsibility lie and where would mental health support lie. I do not think it is that difficult, but it does need developing. I would recommend looking at the housing model in disability if you want to look at a responsive landlord model. I think I have covered everything.

THE CHAIR: You might let us ask some questions now, Kerrie.

Ms Tucker: Yes, happy to.

THE CHAIR: What you were talking about was very interesting. I know you were not saying that it was necessarily a model approach because we need to look with great caution at the acceptable behaviour agreements. The comment was made by the previous witnesses about supposedly normal people throwing flowerpots through windows. So acceptable behaviour goes on more than just the person who has a tag attached to them. Do you know how long the acceptable behaviour agreement pilot has been operating in New South Wales?

Ms Tucker: It is fairly recent. I do not know that there has been an agreement imposed at this point because there is such, as I understand it, a concern about whom are we talking about here. There has suddenly been a very strong effort to bring in the support services that are necessary to stop it reaching this point. It is a very unfortunate legislative model in New South Wales where even the onus of proof has been reversed when it comes to a person proving they did not actually breach an agreement that was imposed. The onus of proof has been reversed in New South Wales. It is quite a concerning response in New South Wales, particularly given the profile of the people involved.

As I understand it, from that briefing at the national housing conference, what had happened was that, in fact, services had been brought in pretty quickly to try to stop these things happening. I do not know now. You would need to talk to New South Wales to find out. As I understand it, it was a year.

THE CHAIR: We might follow that up. It might be something that we look at closely.

Ms Tucker: I hope I am making it quite clear that this is not something I am recommending. I am saying, "Look at whom it affects." It is a way of further punishing.

THE CHAIR: We might look at imposing it on all citizens in society is what I was going to suggest, rather than just one section.

MS PORTER: I have a question on your comment about some models that we saw in Victoria. Please, other members of the committee, tell me if I have got this model wrong. It seemed to me that the community sector itself could be funded to be the property managers for properties where they go out themselves and seek—not necessarily just seek—standalone housing stock but complexes that could be turned into cluster housing where people can share and support one another in some ways to the degree that they want to. Therefore, instead of just looking to the government to continually provide

housing stock, which could be quite expensive for government to continually provide, sometimes the community sector itself, through arrangements by being property managers, et cetera, and having the funding to be able to get themselves started, can in fact obtain more accommodation at a cheaper rate and free it up.

Ms Tucker: Are you talking about not-for-profit providers such as Community Housing? Is that what you are talking about?

MS PORTER: Supported housing.

Ms Tucker: Are you saying that they would be able to use the properties they own as equity to borrow money to increase supply? Is that what you are saying?

MS PORTER: Yes.

Ms Tucker: That is certainly one of the issues generally in provision of affordable housing that needs to be explored. Community Housing Canberra, obviously, in Canberra is the organisation that has done that to a degree. It is something that has to be definitely explored because, at the moment, mainly we have public housing or the private sector. Neither is able to supply at this point what is needed in terms of affordable housing.

The not-for-profit sector is a third potential source of affordable housing. It is something that certainly Shelter is asking the government for. And they are themselves looking at it. They have put a fair bit of time into working with COACT to look at different ways. But community housing is quite a small sector, obviously, across Australia but in the ACT too. As I understand it, there is government conversation going on with Community Housing Canberra as we speak about how that might work. It involves handing over titles for some properties and other conditions. I prefer you ask the government where they are up to with that.

MS PORTER: I am asking for your comments about how you see it working.

Ms Tucker: I see that definitely the not-for-profit sector is a potential source of affordable housing. Right now there does not appear to be any clear guidelines about how they could develop themselves. This really relates to the lack of affordability objectives of the government and clear definitions of affordable housing.

Right now, if you look at the community sector developing housing, by charging 74.9 per cent of market rent—the term "affordable" is applied to that—74.9 per cent of market rent to someone on some kind of benefit is totally irrelevant. If you want a sector such as the community housing sector to become a major provider of affordable housing, you have to tell them what affordable housing means. Then you can work out the sustainable financial plan for seeing this thing work.

If you are going to say, "We want x percentage of higher needs tenants not paying more than 25 per cent of their income; we think that you can have a range of rents that you collect; and we will give you some seeding money," then you can start to have a conversation because the community housing sector knows what it has to deliver and the government can work out what its investment has to be. Then it would be really good

if that was related to what the need is in terms of affordable housing and what is the level of housing stress in Canberra.

What Shelter is recommending is that—and there is a census this year—there is research commissioned after that to break down what is happening in Canberra. Bill Wood used to quote the 9,200 families in housing stress. That is my recollection. Do not quote me. It was around that. That came out of the NATSEM report. We need an update of that. We need to know what is happening in Canberra, how serious is the housing stress and where is it. Then you can bring in and build in to your government's plan and opposition's plan, or whatever, what the affordability objectives are and you can find ways of doing it and delivering it.

That means you can bring in the non-government sector, the not-for-profit sector, and find out what is going to work, what is financially and socially sustainable. You want to maintain the ethic of community housing and the social objectives of community housing, but if you want to have them as major players you have got to have a really clear picture of what they are meant to provide. And they are interested. I think that is what is going on.

I am hoping that, in the background paper that the government is producing for the housing summit, they are going to give a summary of what came out of all the ministerial forums that have led up to this housing summit. There was one specifically on community housing where there were some very interesting conversations on these issues. The 14th of this month, as I understand it, is the date. We will get a background paper for the housing summit which will give the government's understanding of the conclusions of what came out of those forums. I am hoping that that discussion is being progressed, because it certainly is, as I understand it, recognised by the government as an important area to be progressed and a potential place for affordable housing. Of course the private sector has to be addressed.

There is one thing I would say. I know we are wrapping up. With regard to the private market, I noticed in the Sunday paper an item about the most expensive property sold in Canberra, $2½ million or something at Kingston. The comment from the Housing Industry Association, I think it was, was: if you look, evidence will support that wherever you have got a highly regulated planning system you have got a lack of affordable housing. They did ask me for a comment on that in the *Canberra Times*, but it was cut out.

What I would say to that is: what is delivered depends on the highly regulated planning system. You can have a highly regulated planning system that is geared towards providing affordable housing or you can have a highly regulated planning system that does not do that. And it is not a single market. I cannot stress this too much. It is not the case that the housing market is a single market. Because you have an oversupply at the top end of the private market does not mean you will get an increase in affordable housing at the other end. You might get slightly cheaper rent at the top end, but you are not going to end up getting, suddenly, a whole lot more affordable housing for people who are trying to live on 200 bucks a week.

It is a specific area that needs government attention—people on low income and their housing needs. Your inquiry is obviously dealing with a group of people who are

included. Quite often people with mental illness are not able to sustain a high income. The nature of public housing also needs to take that into account when you have policies on market rent. If you have proposals on market rent being a qualifier for eligibility or not over a period of time, when people have illnesses which are episodic, that is scarily difficult. You need a complex medical diagnosis. That was the point that was also made by the previous witnesses.

Recovery is a very complicated issue. It is not clear. If you are in public housing and you are paying market rent over a period of six months, you might say that, if you pay market rent for more than six months, you have got a job that gives you that much money and then you can move on. It is much more complicated for people with an episodic illness. It would involve complex medical diagnoses as to whether or not that is fair.

The other point is: the stress of losing your secure home can trigger episodes. People in the community living with mental illness are very clear on how fundamentally important to their mental health security of their home is. I will finish there.

MRS BURKE: I wanted to ask you a question, but we are going over time.

Ms Tucker: I am happy if you want to and if the Chair is happy.

MRS BURKE: The minister maintains that there are good relationships between mental health and housing and so on. From the consumers' perspective, Kerrie, because you are at the front end of this, what is your view? People in different places have different views of things. Do you see people working well together? We have had people say that it is not working; it is falling down in terms of mental health liaising with housing and so on. Do you know what I am asking you?

Ms Tucker: I would talk more to the mental health consumers network in terms of the day-to-day implementation of any memorandum of understanding that is in place between mental health and housing. The point I would make is: at the systemic level I do not think it is integrated. At the systemic level I do not believe it is enough. I would like to have seen every minister come to the housing summit with a brief. I give credit if there is some high-level group of public servants working together. But that is not appearing to be translating into an integrated policy perspective. That is why I am urging you to link up with this work for disability. It will save you time because a lot of the issues are similar. You have got the government working on that, which is good.

THE CHAIR: Thank you for that, Kerrie. We will certainly have a look at that.

Ms Tucker: I will send you the budget submission and the other one.

THE CHAIR: We look forward to the housing summit as well; it should be a very interesting discussion taking place there. As you know, we will be in contact with you with a copy of the proof transcript for you to check for accuracy. Your voice will be appearing a lot in that. Thank you very much for coming along today and for your submissions. We will be in contact when the report is due to come out.

The committee adjourned at 1.05 pm.