



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

WEDNESDAY, 1 MARCH 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 9.32 am.

PATRICIA PULLEN,

GEOFF HOLT and

FRANK WATSON

were called.

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

Ms Pullen: My name is Patricia Pullen. I am here on behalf of GROW. GROW is a mental health organisation and a registered charity. My position is as a support worker at the GROW house in Narrabundah and I am looking after four residents who have a mental health diagnosis.

Mr Holt: I am Geoff Holt. I chair the GROW branch management team for New South Wales and the ACT. I am a member of the program team. In that capacity I do a lot of work for GROW, two or three days a week sometimes. I come from the perspective of a consumer, if you like to use that term.

Mr Watson: My name is Frank Watson and I have been organiser of five different GROW groups over the last 33 years. I have had a long involvement with GROW and I am very interested in it, so you might say I am a stakeholder or interested person.

THE CHAIR: Thank you. We received your submission last week and we have just authorised it for publication. Would you like to make an opening statement in reference to your submission and give us a bit of an outline about GROW, and we will take it from there?

Ms Pullen: Having never made an opening statement, I am not sure about the actual wording.

THE CHAIR: There is no particular format. The purpose of this meeting is to inform the committee in its inquiry. We are appreciative of the fact that you are here today to help us with the inquiry. We are the ones who are indebted to you and there is no need to be nervous.

Ms Pullen: Thanks very much. As I said, I am looking after four residents. We have capacity for five. We did have five until the end of November last year, but we are back to four. It is a matter of asking people who have been in GROW for at least three months to make application to come into the residential program. They need to have a

commitment to improving their mental health while they are in the group. That means, essentially, sharing problems that they have and being given practical tasks by the other members of the group, an ongoing commitment to become well. After they have applied with a letter, we arrange an interview by a field worker, myself, possibly Geoff or maybe a resident who can be on the interview panel to find out whether this person is really suitable to come into the house.

Our house is medium term, meaning that we do not have people who have just had a breakdown or who are suicidal. We always ask at the interview whether they are suicidal. If the answer is yes, then it is strictly the case that they cannot come into this particular residential. We do have another one in Sydney, at Austral, which would cope with people who are at the very lowest point in their life, and they certainly have strategies and staff to cope with day and night situations.

One of the issues that I have put into the submission is that recently we had a crisis at the house with one resident who did go downhill over the Christmas-new year period. Because of understaffing, meaning that we do not have night staff, we were not able to cope very well with dealing with this particular crisis and what would be the next point of reference because we had called ambulances and the police. We did get the crisis assessment team to come and assess the person. They did administer medication overnight which actually assisted her, but it wasn't the end of the crisis. She did have another collapse and we had to call the ambulance again.

Over this period, she was not admitted to hospital, over nine days in a row. I did nine days in a row because I had to keep resolving situations with her, with the assessment team, with the ambulance. The police did ring me one morning at 12.30 and ask what they should do with her because she had been found on the road. They coaxed her back into the house, but they were not sure what to do after that. Because of the police, the crisis assessment team were asked to come to the house, which they did the following day. This has been one of the problems we have faced recently, and it is an indication of understaffing in the house. I have been trying to deal with these situations on my own because there is only one position for the house itself. We have a field worker who is doing another job. So I have coopted volunteers such as Geoff and Frank to assist me, and others as well, in dealing with particular problems.

I put a proposal at the end of the submission that perhaps our providers may also be in the same situation and there could be an on-call system for people to come in overnight at that particular time. Because we are medium term, this isn't happening all the time, but I just think that at these times when we are feeling a bit powerless to assist the residents who are involved in that.

THE CHAIR: It is described as a medium-term house and you do not take in people who are acute, but has the situation occurred where you have had somebody come in who has been at that stage and has actually ended up in an acute situation, and how do you deal with that?

Ms Pullen: Yes, there have been, before my time.

Mr Holt: I can testify to the fact that there was one such case before Trish joined us in late August 2004, I think. There was such a case. This has forced us into a situation

where we have had to continually refine our selection criteria to ensure that we actually get people who are at a stage of development where they can actually cope to a very large degree with day-to-day tasks in networking. We have helped to facilitate that, but there is an expectation of people who enter the house to take part in the program that they really do have to work hard on themselves.

There is a requirement that they continue to attend a GROW group, and we have five of them in the ACT. It is a requirement that they do that. They must be willing, ready and able to share in the household tasks and in all of those things that go to living in a community, because it is a community. Ours is very much a community ethic. One of the 12 steps to decline in our blue book is that we let competitive motives get in the way of our recovery. So our ethic is a cooperative one which works particularly well in the context of the group which is the forum in which a person raises an issue that they need help.

We are not trained counsellors. Our movement was started by lay people, mental health sufferers or, to use today's term, consumers 50 years ago next year, in fact, in the St George area of Sydney, if you are familiar with it. Hurstville was the first group. We now have some 60 groups in New South Wales, five in the ACT, about 200 nationally, and about 700 worldwide, I think, at this stage. We receive partial funding by all the state and territory health departments, health authorities. The other money we raise ourselves. Typically, in this region, we have a market day four times a year, I think it is, at Fyshwick. We have one-off grants that we apply for.

We were successful in 2004 with an NRMA insurance community grants program. We were one of 12 groups that received funding. We received \$2,500 to run a mental health first-aid course at the house in Narrabundah. It funded 15 places, food and that kind of thing and that helped us to fill in the gaps about what to do when people are exhibiting threatening behaviours, suicide, that kind of thing. That is basically how we function. We feel—I feel certainly—that it filled in a large number of gaps in terms of how we should react, but the program is essentially run by lay people. It is a case of sick people helping sick people to get well.

There have been in GROW's history, particularly in the last 20 years, three longitudinal studies conducted into the efficacy of the GROW group method. We have three essential features. One is the program, the blue book, a program of growth to maturity we call it. We have the group method, which is the way we structure our meetings in a caring, sharing community, which is the way we live out what we believe in, our credo if you like. Everything is brought to the group. I mentioned before that we are not counsellors. We have to have a quorum for a meeting, and that is the traditional quorum of three, otherwise there is no meeting. That is to spread it around to try to bring as much objectivity to bear.

The purpose of the group method, and it is fairly tightly structured, is to provide a focus for people who, when they are unwell, often lack focus. That helps to get things clarified for them. Typically, what happens is people come to the group with a problem that they need the help of the group with and it is the responsibility of the people in the group to give that person a practical task arising from some aspect of the program, learning it and learning how to apply it in that particular situation and giving them something practical, realistic, to do in the week. Our meetings are weekly so they would be asked to report on

how that practical thing was accomplished at the following week's meeting. So it is very practical. The emphasis is on turning people away from themselves, getting them out from being inwardly focused to being a functioning, as much as that can be achieved, human being in a community. The 12th of our steps to recovery is that stage that one has reached where they are ready to take their responsible and caring part in the community again.

THE CHAIR: I am conscious of the time to a certain extent and I know that you have some pamphlets on the GROW programs. You have also mentioned the longitudinal studies that have been done of the GROW program. Could you provide copies of the pamphlets to the committee secretary and give us access to some of the studies to look at?

Mr Holt: Yes, by all means.

THE CHAIR: Before I hand over to Ms Porter, do the residents make a financial contribution?

Ms Pullen: Yes. They pay rent, as they would in the rental market. That covers everything: their food, gas, electricity and the rent.

THE CHAIR: How is the rent determined? Is it based on how much they are earning?

Ms Pullen: It was actually a figure that was decided upon by the branch program coordinator back in 2004 when I began the job. We looked at the figure that Austral residents paid and we dropped it down a little bit. The coordinator felt that it was a little high; so it is \$145 a week but that, as I said, covers everything. From that we take food money and one of the residents does the shopping, so they all take turns. On a rostered basis they go shopping and shop for everyone. It is building that community by being involved in the shopping and cooking aspect where everybody is participating and taking turns, as well as all the other house duties that any other normal resident would be doing in any house. But because it is GROW, we use the program in terms of looking at all the duties that need to be done. We use the GROW program specifically in that regard.

MS PORTER: I have a couple of questions. My first one is about the training that is available. You mentioned that you are utilising volunteers. How many volunteers would work in the house in any given week?

Mr Holt: That would fluctuate basically from day to day. I am in a position where, it is probably fair to say, among the volunteers I would spend more time in the house, which is sometimes two to three days a week. There is a small core of dedicated people. I guess it is the same in other NGOs.

MS PORTER: Are you talking about four or five?

Mr Holt: Maybe, at the outer limit, yes.

MS PORTER: You mentioned the training that you were able to fund, the mental health first-aid course. Is that the only available training which you have been able to provide to volunteers, or have you been able to access any other training and how do you fund it?

Mr Holt: To my knowledge, in my time, that is the only one. The person who was the field worker at the time prepared the submission to the NRMA and we were successful in getting funds. As I outlined, that was an educative process for us, because we had felt that we were a little light on in knowledge as to how to deal with behaviours of the kind that I outlined before.

Ms Pullen: I did actually apply for a grant of \$5,000. I was not successful, but in terms of accessing tutors or people who may be involved in the arts field, I am trying to build the GROW house as a centre with art as therapy. I am trying to involve not only residents but others, too, to come along to the house and build an art and craft type of activity. We did apply to try to get tutors, but I have not been successful in that. But that is probably an aim that we will have, along with the residential program. Also, we do have a group that runs at the house on a Tuesday morning. So it is a centre, but I am trying to build that as more of a centre as well.

MS PORTER: Are you the person that manages the volunteers, or supervises and supports the volunteers?

Ms Pullen: Yes.

MS PORTER: Have you had any access to the training that Volunteering ACT runs specifically for people who manage volunteers?

Ms Pullen: No, I haven't, actually. In our policy and procedures manual there is something there for dealing with volunteers and what we should expect them to do, but I haven't actually done any formal training for that.

MS PORTER: What happens if a person wants a meeting and there is no other person available and it is not the weekly meeting time?

Mr Holt: Typically, what happens is that the person would go to the next available group that meets. We have a cycle of meetings through the week. One group meets on a Monday. Two, I think, meet on Tuesday, one today, two tomorrow.

MS PORTER: So they are fairly frequent.

Mr Holt: Yes, so there is ample opportunity. We have a mix of day and night groups.

MS PORTER: You talked about the fairly high level of functioning that a person needs to be at before they can come in. I think that is demonstrated by the fact that they have to write a letter and they have to face up to an interview. I think that would be a fairly daunting task for anybody, apart from someone who is suffering from a mental illness at the time. I was wondering what happens to people who are not functioning at that level but apply to come into the house. Where do you refer them to?

Ms Pullen: If they are not ready to come into the house, we suggest that they continue to attend their group, because that is where they are finding their mental health improvement, and we just suggest that they continue. We have had people apply who were not able to carry out tasks, would have to depend on someone else to help them. We

can help one another but, essentially, we need to be able to do these things on our own, even if we coopt help eventually. The ongoing attendance at a group is very important.

MS PORTER: I have another question but I will defer to other members and ask it later if I get time.

MS BURKE: Thank you for coming this morning. I know that it is a little daunting, but I hope that you are finding that it is not too bad. Thank you for the information; it has been very helpful. I want to draw us back to the core of what the committee inquiry is about. The background is very useful, but my question relates specifically to the appropriateness of housing for people living with a mental illness. You obviously feel that the model you have works well, given that you have been going for around 50 years. Why would you say that it is so effective?

Ms Pullen: Geoff might want a go, but I will say a little bit. With the long-term GROW program and the effect on people who attend the group over a long period, we have tried to develop leadership. We have organisers' and recorders' positions in the groups. That is really for people who are exhibiting some improvement, showing that they can actually get well, that they are becoming well, that they can help others, that they can then become a person who organises the weekly group, makes sure that there is a reading for discussion, and that they stop people from doing too much irrelevant talking. We have that in the group method. We say, "No, we do not go into personal problem solving at this particular time; we need to be doing this." So it is really somebody who is able to keep the group in order and to keep it flowing for the two hours.

Elizabeth Finn's research is really about the long-term effects of leadership in GROW and how it has reduced hospitalisation for people who maybe had been in hospital initially but the GROW program had prevented them from actually going back into hospital again. Also, just coming back to the house, we have fairly stringent regulations in our handbook and the residents all have a copy of that. They know that they cannot do this or that in the house, whereas perhaps in other accommodation—and I am not sure about the strict information—they may not have enough stringent rules that prevent people from becoming violent. But, at the end of it all, even if people are in this program and they are attending a group, crises can still occur, and that is what we faced over Christmas-new year.

MS BURKE: Frank, are you just a helper to the program? I am not quite sure where you fit into it.

Mr Watson: No, I have been the organiser of five groups over the last 33 years, and I attended a GROW group only five days ago. I would just like to talk about the three studies that have been done, the longitudinal studies. There was one by Professor Julian Rappaport at the University of Illinois. He found that GROW led to 60 per cent less hospitalisation. He and his graduate students went to 1,000 GROW meetings. That was the sum total of all of them. There were 10 graduate students who were probably studying for a PhD at the University of Illinois. They went out to 1,000 GROW groups around Illinois or Chicago. His research found that there was 60 per cent less hospitalisation of those people attending GROW.

Also, there was Lizzie Finn in Western Australia and there was another fellow in

Tasmania, Jim Young; so there have been three academic studies of GROW. We have got a good program which has had a lot of input from Father Con Keogh from the Catholic Church. He had two doctorates, and he had been studying psychology, philosophy, divinity and all this, so he had a lot of intellectual input to our program. It has been proven by a lot of academic studies that it works.

THE CHAIR: It is not a religion-based group, is it?

Ms Pullen: No.

Mr Holt: There is quite a lot of reference to God in the program, but it is certainly not a prerequisite for entry into a group or into any aspect of GROW activity. Because of my new responsibilities with GROW, I have just ended four years of hospital orientations in the region. I often used to make the point to people that we were speaking to that it is not religious.

Ms Pullen: There is something on that in the blue book. There is a specific page for people who are not believers. GROW acknowledges all types of people and it is strictly stated that we do not talk about anything religious. We do not try to convert people to a particular religion. It is stated in the program that we do not do that. Any reference to God is really a universal spirituality type of idea. I think GROW also acknowledges horizontal spirituality. So it is belief in persons, as well as the vertical between persons and God. It is more about how we believe in one another and how we try to help one another with the 12-step program. Consequently, at the end of the meeting, through the week we do 12-step calls. That means we take GROW's message to others in need and we find out how people are going with their practical task and maybe any other 12-step calls to do with GROW.

Mr Holt: There are two very strict caveats. As Trish said, people cannot use the forum provided by a meeting to win people over to a particular belief system, and the other thing is that, because we are lay people, we actively discourage talk about the relative merits of medication and the use of technical terms that are associated with psychiatry.

Ms Pullen: We do not talk about any of that; we do not counsel or do anything like that. Any help in the group is always about suggestions and using the program as part of that. We always must accompany any suggestion with a part of the blue book.

THE CHAIR: I know that Ms Porter wants to ask another question.

MS PORTER: My question was about that.

THE CHAIR: You have mentioned a proposal at the end of your submission. Would you like to expand on that for us?

MS PORTER: That was my question, too. Also, I wanted to know how you saw that being funded.

Ms Pullen: I was not sure about the funding and where it would come from, but I thought that it may be that there are other providers who are also only funded 9 to 5 on Monday to Friday and have this overnight problem at times, that there may be a few

providers who are in the same boat and who could all be part of an on-call system where there is a casual overnight worker who may be medically trained—I don't know—or who is perhaps a social worker or a registered nurse who would be able to come to the house on that particular night. Maybe it would go over two to three nights, however severe the crisis is for that person at that time, or it could be a week, but there just may be a collective of providers who could use the system, perhaps.

MS PORTER: My other question on that was about how you would reconcile differences of philosophy around the different providers if you had someone who was responding to a number of different residential programs. That was just a thought, because you are quite specific in the way you address the growth of your residents, from what you have said, and the development and the health of your residents, and I am just wondering whether that would bump up against other philosophies in other places. That is not to say that it would.

Ms Pullen: It may do. It is possible because of our specific philosophy. Although we are all dealing with mental health, it may be difficult to be in partnership with another provider if our philosophy is very different to theirs. For example, Inanna, being a women's refuge, would have a specific philosophy which was probably quite different to GROW's, but because we are dealing with people who have mental health issues, it may be that at the time of crisis we deal with their particular issues that are happening at the time. Obviously the health is being affected. I am seeing this proposal in terms of trying to allay a crisis, or not let it get any worse.

MS BURKE: It is about having a healthy respect for each other as professionals, surely. Also, one size does not fit all and there needs to be a range of models, with the providers recognising that within each other.

Ms Pullen: That is right. I know that at another meeting I did hear that someone in one of the mental health residential was self-harming, so some system that we could provide overnight. This is a night thing, not for the day, because I am there in the daytime. It is really for when these things happen at night.

MS PORTER: And of a weekend, as there does not appear to be anyone there of a weekend.

Ms Pullen: No, that is not covered either.

THE CHAIR: We have to finish there. Thank you very much for attending today. You will be provided with a copy of the transcript of today's meeting to check for accuracy.

Mr Holt: I will ensure that the secretary gets the extra information that you sought, madam chair.

THE CHAIR: That would be great. If we have further questions, we will be in touch with you and we will keep you informed of progress with the report.

MALCOLM JOHN GIBSON and

VERONICA J BARBELER

were called.

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

Mr Gibson: Yes.

Ms Barbeler: Yes.

THE CHAIR: If you can start by stating your names and the capacity in which you appear today.

Mr Gibson: I will go first. Mal Gibson, and I am representing Carers ACT.

Ms Barbeler: I am Veronica Barbeler. I am a carer. I am here as an individual carer.

THE CHAIR: We have submissions both from Carers ACT and from you, Ms Barbeler. Would you like to start by making an opening statement or statements addressing the issues, and then we can go to questions?

Ms Barbeler: Would you mind if I read mine, because I have so much to say. I have so much to say that I was a bit worried that I would forget some things.

THE CHAIR: That is fine. Whatever you feel comfortable with.

Ms Barbeler: As I was just saying to Mal, I could talk for days, but I will try not to take up days.

MS PORTER: We only have 25 minutes.

Ms Barbeler: I understand that, yes. I am here to present the personal view of a carer. As a carer, I am angry, I am exhausted, I am frustrated, I am depressed, I am financially in difficulties because I care for a young man with a mental illness who has severe physical illnesses as well, and this is all exacerbated now by drug-taking. In the wake of yet another police shooting of a mentally ill young person, I begin by quoting from the recent report on mental health services by Professor Hickey of the Mental Health Council:

In theory, the policy on mental health, adopted as a result of the Richmond report,

that is, closing down mental health hospitals, is sound, but in practice it is a disaster.

I can personally attest to that. It is a disaster. To this I would like to add: it is not only a disaster, it is irresponsible; and it is the abdication of government and society's duty of care to thrust mentally ill people into what is euphemistically called living independently in the community. There is no such thing. It is absurd to pretend that the community can do a task that requires intense, consistent, appropriate professional attention. I am offended by the consistent advice from trained and paid professionals from whom I seek advice and to whom I take this young man. The advice is to abandon this person I care for, save myself and let him drown.

If we can instantly find millions of dollars to provide aid for disaster relief, as we should, how can we, as an allegedly caring society, let people drown? Natural disasters are over very quickly, are dramatic and engender much appropriate sympathy, but mentally ill individuals and their carers are condemned to a lifetime of hell.

In my written submission, I address the issues of access to housing. I won't go there again today.

I want to talk about safety. The person I care for has public housing. It is inadequate. It is not appropriate; it is not suitable for him or for his neighbours. Because of the nature of his illness, he does not know how to, and cannot, function in the general community. His safety is at risk. He suffers from severe social isolation.

Because of this, he has attracted a very unpleasant element in the community, an element of parasites, as I call them, who sussed him out at the Rainbow Room. They decided that he is a young man who has somewhere to live. At this stage he was living in a house which I helped to provide for him. They thought he had a house to live in, he had a car to drive, he seems to have plenty of money. They moved into his house, began him on this course of drug-taking and then proceeded to steal everything that he had—his money, his car, his furniture, running up bills, all kind of things. So he is not safe.

I moved him to what I thought was a secure flat on the second floor, with outside locking and all the rest of it. In the last two months, he has been broken into three times. They drove a car under the balcony, climbed up over the balcony and proceeded again to steal everything he had. They stole his house keys, his car keys and his car yet again. So he is not safe.

I asked housing about security. They said they would provide only the regular security that goes with their houses. That was no use, because these people simply took the security door off. So I had to install Crimsafe security doors and deadlocks, at the cost of \$1,300. That is just an example of his lack of security.

Another issue is pets. People like to have pets. They are not welcome in public housing. They can sometimes be good for people with mental illness.

People with mental illness often play loud music; they are careless about smoking; they are careless about cleaning; they are careless about personal hygiene; and, in my experience, are often visited by the police. Neighbours do not like this at all. They do not like him being there. Some of them are nervous that he is there, sharing the building with

them.

Another example I have from the cleaner I used to employ to clean the young man's house is that electricity is a problem, as is the danger of fire, which endangers not only them but everyone else in the building. There is no supervision. They are left there entirely to themselves.

I know there are some support mechanisms, but I have never seen any. I have tried. I have tried Centacare. They have a SAILS program. That did not work because the person who used to come to visit my young person just was not compatible. It just finished. There was no discussion, no consultation, no substitute, no anything else, no trying to match him up with someone more suitable for a young man with a young man's interests. That did not happen.

There are no support mechanisms from mental health or from anyone at all, not for him. There are some on offer for carers, but I will get to that later. The only support he has is a weekly visit to the health centre for compulsory medication and an appointment with the psychiatrist every three months. All that happens there is that the psychiatrist decides whether to increase or decrease the weekly dose of clopixol.

The kind of support he needs is advice; training in life and social skills; hygiene; health maintenance; housekeeping; appropriate recreation; budgeting; making informed decisions; basic education, because he was kicked out of school at the age of 12; vocational training; and respect for the law and for other people. And none of this is happening. I try to do it, but I am an absolute failure.

Opportunities to involve non-government stakeholders in the provision of appropriate housing is the one I will speak about next. This brings me to community organisations. Under the current system, there are very few community organisations involved in providing appropriate housing for mentally ill clients, although many of them are involved in other activities. But my point about community organisations is that one does this, one does that, and one does something else; there is nobody who does the whole lot and focuses on all of the needs of these people.

There are plenty of community organisations, but that means that the funding is scattered—\$50,000 here, a \$100,000 grant there and a \$20,000 grant there. Scattered funding, in my experience, never achieves much at all. It needs to be focused and centralised. Community organisations are accountable to the government for funding, I know, but they are not accountable to the consumers; they are not accountable to the carers.

A consumer can participate in a community organisation project by the Richmond Fellowship, but the Richmond Fellowship has its own rules. It deals only with people with a mental illness. If you have got a mental illness, that is okay. But if you have got a drug problem, sorry, we won't look after you, and out you go. If you have got a drug problem, we can look after you. But if you have got a mental illness, sorry, we cannot look after that as well. It is either one or the other.

If you break the rule, out you go. I managed to get him once into the respite care house in O'Connor, I think it is, where he lasted one night because it has a no-alcohol rule. He

went out and got some alcohol. The very next day they said, “Go away.”

No-one ever attempts to address the reason why he breaks rules. They just say, “Go away,” which is what happened at school when he was 12. “Go away.” I tried several other schools for him. I might add that I am not his mother; I am a distant relative. He was abandoned by his mother at birth. He has been abandoned and abused by society ever since. He has been abandoned, abused and neglected by her and by her series of partners, one after the other. He was kicked out of school when he was 12. He was kicked out of her home when she evicted him out of the family home when he was 12, to live on the streets. It is no wonder he has a mental illness and all these other issues.

His father was murdered in Sydney. His father also suffered from mental health problems. He lived in a budget hotel in Sydney where he was murdered. No-one has ever been tried for his murder because there is not enough evidence. The police simply are not interested in tracking down murderers of nuisances like mental health people; they are not worth bothering about. I am sorry; I will get back to community organisations.

I want to say that the outcome of this inquiry should be a complete overhaul of the current model. The current model is not working; believe me, it is not working. It drives people like me to thoughts of homicide and suicide; never mind the mentally ill people. I might add that my young person has made three suicide attempts in the last couple of months.

It needs to be replaced with a supported housing model based on that provided for the physically disabled and for the aged—that is, there need to be facilities which consist of the provision of various levels of care and support: for example, self-care units for those capable of some independence; hostel-type accommodation for the less well-able; and then, finally, hospital/nursing home-type care for those who need it but then who, on recovery, can go back to independent care units or whatever. This would provide a holistic approach which would address all their mental, physical, social and emotional health needs and, hopefully, teach them some community responsibility, not to mention the sharing of the enormous burden of responsibility now solely borne by carers, by people like me.

This model is based on the principle of maximum independence with maximum supervision, support and care. I was speaking to a forensic psychiatrist from Sydney, brought down to look at this young person of mine, and he said he had just come back from Greece. He proceeded to tell me about this model which I have been bleating to John Hargreaves, Paul Osborne and other people, long before your time, for years. He said it works well in Greece. If Greece can do it, why can't a small community like the ACT do it? We have got a perfectly suitable—

THE CHAIR: We have heard evidence of the model that is used in Italy and specifically in Trieste.

Ms Barbeler: We could show the whole country how it can be done. I know other state jurisdictions say they are looking at mental health, but here we have got a small, complete community where it would work very well indeed. Mentally ill people must be regarded as sick and disabled, not as bad people who should be jailed or shot.

My research of the *American Journal of Psychiatry* indicates that the majority of mentally ill people also self-medicate with illicit drugs. That is another huge issue as far as the mentally ill are concerned because it involves them in the criminal scene. Eventually, they become involved in the law. They are jamming up the law courts. If you go to the Magistrates Court, as I do several times a month, and sit and listen to the cases being heard, so many of them are mentally ill people, particularly mentally ill young males, who just cannot cope out there on their own. They are exploited by people who know what they are doing, by criminals out there who know what they are doing.

Finally, cost savings: focusing finances, focusing costs, on these community facilities, rather than having a scattergun approach here, there and everywhere, would probably save the health budget some money. Of course people who live in these community facilities would contribute by paying rent, contributing some of the enormously generous \$200 a week that the commonwealth government gives them to live on independently in the community. Try living independently in the community on \$200 a week. You have to have someone like me who has to work to support him financially and then the other eight days of the week be his social worker, his health worker, his lawyer, his housekeeper, his whatever.

I will leave it there. I could go on forever but you do not want to hear any more from me, I am sure. But that is what I want.

THE CHAIR: Thank you for that. It was, obviously, very much from the heart. We appreciate your sharing your experience with us. Mr Gibson, did you want to say anything?

Mr Gibson: Yes. I will make a brief statement. Like Veronica, I won't go back and address the submission. You have had a chance to look at that. Since that was written these issues that Veronica has brought up have become very much the focus of what carers are telling us. I am a counsellor there, so I get to sit with people while they tell stories not at all unlike Veronica's. There are many, many people out there—and there are many more that we are not aware of—who are really suffering alone.

I highlight two points that I took out of Veronica's presentation. The first was that she said she was angry, exhausted and depressed. These are all emotions or the outcomes of trauma if you look at the trauma literature. By and large, the community is prepared to accept that people with a mental illness are suffering a trauma, but far too often they are not prepared to accept that the carers are also suffering from trauma. Carers keep telling us that, if the system just acknowledged their role, even by saying, "This is pretty tough for you too"—even a simple comment like that—it would be a real help. It happens far too infrequently.

Veronica also mentioned being financially stressed, which is another very big issue. People are working full time but do not seem to be getting too much money for themselves because so much is taken in the caring role.

The second major point that Veronica made was about people with mental illness living independently. She used the term "the current system lets them drown". I have not come across that one, but it hits the nail on the head. Carers, particularly those caring for someone with a severe mental illness, tell us many stories about people with mental

illness having had a severe episode. They get put into one of the hospitals, often the PSU of course, and they are let out too soon and without a discharge plan. They are discharged back into the care of the community, which of course means the family because family equals community and because we do not have any facilities that are halfway between. Carers have been saying this more and more.

I heard a story just recently of a carer with a daughter who is very severely ill and was let out of one of the hospitals. The hospital promised that the family would be there for the final discharge talk so that they could have input into the discharge plan. Then, all of a sudden, they found out that their daughter had been released. There was no meeting, as promised, and there was no plan at all. This is somebody who has had a long history of suicide attempts. This particular carer is sick to death of being told by the workers that there is no money and no facilities.

Part of my role of course is to be supportive but also to acknowledge that the workers themselves are doing this pretty tough as well. It is traumatic for them. The facilities just are not there that would enable them to do their job.

The government recently announced it was going to replace PSU. On behalf of all the carers, of people who have had somebody in there, we absolutely applaud that; we think it is fantastic. The sooner PSU is done away with, the better.

I put on the record that I hope whoever is looking into that and into the plans for the new facility visits the Chisholm Ross centre in Goulburn as an example of a facility which has been built based on a lot of input from the staff who showed me around a little while ago. The staff were absolutely bursting with pride that their particular expertise had been called on. They got themselves dressed up as policemen, as consumers, as carers and all the rest of it. They walked through little models, and their input was listened to. The result is something that is so far different from PSU that it is not funny.

It is wonderful to replace PSU but, please, we also need these facilities for housing people upon discharge where they are just not well enough to go back into their homes or their families or into their own units. With an appropriate discharge plan, they can get, as Veronica pointed out, regular and consistent support and not fragmented between services. That is clearly what the community is crying out for.

There is a fair bit of concern that maybe governments are not quite hearing that; it is all about bricks and mortar; if we can get a really decent acute-care hospital, then that is really solving the problem. It is certainly addressing a significant part, but the real problem is getting these community supports, halfway houses, step-down facilities, whatever you want to call them, where they can go. They can go into those before they crash and end up in PSU, and they can be discharged back into them. Then, when they are well enough, they can then be put back into the community.

THE CHAIR: We do not have much time. Both of your statements have been very comprehensive. I am happy to pass over to my colleagues if they want to ask a quick question.

MS PORTER: A very quick one: it was about the model that De talks about in the submission where older carers and the older people they care for could live together in

some form of complex. Can you enlarge on that a little bit?

Mr Gibson: It was just an idea. It was some years ago, actually. It was before I worked for Carers ACT. I was working for the Bureau of Statistics on the first carer survey. I was talking to a carer in New South Wales. Her son was mentally and physically disabled. She told me at the time she thought that there was a model in Scotland. I have since gone looking on the net for this model, but I could not find it. It was some years ago. She had some material which I wish I had taken from her. She said it was in Scotland; it was a complex, and it was mainly for physically disabled. The parent could go with the cared-for person. Obviously, their number one fear—isn't it?—when they get older is: who is going to look after them when I am dead?

You would move into this facility. It would be like the self-care type concept, to start with, but you would be living there with the cared-for person. Then, as that person got older and older and the carer got older, then maybe they could go off to the hostel. It is on the same campus. They are still there. Then they can move on to the nursing home or whatever, but the disabled person, the person with disabilities, would equally be supported in the same model. It is all together.

It sounded like such a simple idea, obviously expensive, like all these accommodation options are. As I say, I have gone looking for it in Scotland but I cannot find it. I do not know whether you had anything given to you along those lines.

THE CHAIR: No, we have not.

MS PORTER: No. I know that someone from Carers was going to Scotland to do a swap with somebody else over there, I believe.

Mr Gibson: Carers Australia?

MS PORTER: No, from the organisation here. Someone from Carers was going over to Scotland to work and someone was coming back here. That was my understanding. That person from your organisation who is currently in Scotland might be able to find out about it.

Mr Gibson: Not from Carers ACT, I do not think. I am not aware of any person. It might be Carers Australia.

MS PORTER: De and I were talking about it. Yes, it may well be.

THE CHAIR: Thank you very much. We need to move on. We appreciate your coming in today. You did not seem to be at all daunted; you did very well.

Mr Gibson: Thank you for the invitation.

THE CHAIR: We appreciate it. We will be in contact with you with the transcript of today's proceedings so that you can check it for accuracy. If we have any questions that we need to ask, we will be in contact with you. We will keep you advised of the committee's progress with the inquiry. Thank you very much.

MARIE BENNETT and

FIONA MAY

were called.

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

Ms May: Absolutely.

Ms Bennett: Yes.

THE CHAIR: Thank you. Would you start by stating your name and the capacity in which you appear today, for the *Hansard* record?

Ms Bennett: I am Marie Bennett, Executive Director of Lifeline Canberra.

Ms May: I am Fiona May. I am a policy officer with Lifeline Canberra.

THE CHAIR: Would you like to start with an opening statement?

Ms Bennett: We would like to thank the committee for inviting us to speak to you today. I am aware that the members of the committee are familiar with the work of Lifeline Canberra, so I will not provide detailed background regarding our services.

The two services most relevant to this inquiry are the Lifeline crisis line and the Canberra Emergency Accommodation Service line, the CEAS line. Lifeline do not provide housing solutions to people in crisis, but we do act as a support and referral point for them. The CEAS line offers information on available and appropriate emergency accommodation services, as well as counselling around any related issues.

In talking to callers we learn a lot about their housing situations and also about the other factors that have a significant impact upon their housing opportunities and choices. People living with mental illness have more difficulty choosing, accessing and maintaining secure, appropriate and affordable housing. Yet this stability can help prevent further episodes of mental illness. As such, I commend the committee on identifying, as a priority, the housing needs of people with mental illness.

Many calls on our CEAS line identify as living with schizophrenia, bipolar disorder or other mental health conditions. In a crisis situation these conditions can make it harder for the person to stay focused on following the steps required to get the support that they need. The CEAS service provides phone numbers to available emergency

accommodation but someone in the midst of a mental health crisis may not be capable of making a call or even of writing down the number to ring. They therefore need access to immediate practical assistance focused on their housing situation as one element of a strategic intervention aimed at their overall wellbeing.

Lifeline is aware that for some callers their mental health condition has been a contributing factor in their becoming homeless, but it can then go on to limit their options in accessing emergency accommodation services. The person may describe being kicked out of their accommodation with family or friends, from hotels, refuges or other shared accommodation because they were unable to live up to expectations.

People with mental illness face particular challenges in social situations and this can exacerbate their housing crisis. Comorbidity and/or drug and alcohol issues are often mentioned to our counsellors. They are used as a means of self-medicating to cope with their illness and the social isolation that it causes. These factors further limit the opportunities available to them for emergency accommodation.

The CEAS line also takes calls from family members who are calling to find accommodation for the person with a mental health issue. This is often prompted by a high level of distress in the family over living with the behaviours of a person with mental illness. These callers are in turmoil. They care for the wellbeing of the person but are coming to the end of their own ability to tolerate living with the behaviours. Their dilemma may be compounded because whatever they decide may not be followed through by the person in need. A person with a mental health condition can end up sleeping in a car, in a shed, in a park or on the street after going through all their options with family and friends. This is even more concerning if they have a partner and/or children, as the whole family can then become homeless.

I wish to focus my remaining comments on the broader issues that our callers tell us have an impact on both their mental health and wellbeing and their housing options. Out of interest, on one day last month we counted how many of our callers to the Lifeline crisis line chose to disclose to the counsellor that they were receiving treatment for a diagnosed mental health condition. On that day, 50 per cent of the callers self-identified as having a mental health illness.

Since then we have kept an occasional eye on this figure and it hovers anywhere between 25 and 50 per cent of callers. This is, of course, an under-representation of the number of callers with mental illness because they may choose not to disclose to the counsellor. That Lifeline is being used daily by so many people with a mental health issue speaks to the importance of our service to these vulnerable people in our community.

What we have learnt from our callers is that each housing crisis is a result of other issues, such as domestic violence, family breakdown or mental illness. It is not possible, therefore, to resolve the housing crisis without also resolving or addressing these other issues. I therefore encourage the committee to keep this broader perspective in mind when considering solutions to housing needs.

We also know that there is a critical shortage of many other support structures that people with mental illness require and that may themselves also work towards preventing future mental health crises. The mental health crisis teams are only able to respond to the

most severe crises. This means that many individuals with more moderate or emerging crises are not able to access help. We know that without access to immediate support, such as face-to-face counselling, mental illness symptoms tend to get worse before they get better. Our system currently encourages people to have a full-blown crisis, as this is the only way that they can qualify for help.

In considering the housing needs of people with mental health issues, I urge the committee to also take into account the difficulty of a person experiencing a mental health crisis, the comorbid dependency issues that they have in meeting the eligibility criteria for many emergency accommodation services, the shortage of face-to-face crisis counselling services, the need for intervention services focused on client wellbeing as well as addressing a range of factors in addition to housing. Thank you.

THE CHAIR: Thank you. Do you want to ask a question, Mary?

MS PORTER: I do. First of all, I have a question around the stats, if you will. The ones that you collected, were they from the CEAS line or from the overall or from both of those lines?

Ms Bennett: On the day in question, it was from the crisis counselling line, so the Lifeline line.

MS PORTER: Have you also done some measurement of what percentage of people ringing in through the CEAS line—

Ms Bennett: It is also around the same, around the 50 per cent mark.

MS PORTER: The same. At the beginning you said that when people ring up and you give them information on the CEAS line, often they are not in a state where they can even write down the phone number. You said they need practical assistance at the time. How do you see that being provided, given that the person is on the other end of a phone somewhere and may not even tell you—

Ms Bennett: What we would say is that one of our difficulties and one of the frustrations for our telephone counsellors is that it is very difficult for us to assist people to access services because the services are not there. So it is a constant frustration for people. The feedback in their reporting is how frustrating it was that there just did not seem to be anything that they could offer to people.

We have trained our telephone counsellors in techniques to deal with a person experiencing a psychotic episode at the time, and that will work to bring them down from that to a degree. However, there is no guarantee that that impact is going to continue once the call ends and it really is very difficult not to be able to provide any kind of support or assistance.

Often what we will do is actually attempt to be the intermediary, to provide an intervention. So through a process—not just off the telephone counsellor's own bat, but through a process—the organisation may try in fact to get the mental health crisis team to get out to someone to make an assessment. We have minimal success—almost none—at that. If the person is not known to them, if this person has not been identified as having a

full-blown crisis, the mental health crisis team simply do not have the resources to go out. So 99 out of 100 times we will be turned down. Again, that is another frustration. There is nothing that we can do to help the person who is having a full-blown psychotic episode.

MS PORTER: Can I just explore that a little bit more?

Ms Bennett: Yes.

MS PORTER: So if someone is ringing and you believe that you have not got anything that you can offer them, firstly, because they are experiencing a crisis and you believe that they are not able to actually access something themselves at the moment anyway or, secondly, there just is not anything happening, do you have an idea of what percentage it may be where you just do not have suitable accommodation to recommend to them or, alternatively, they are not ready to take something up? Which of those is it mostly?

Ms Bennett: Certainly the callers to the CEAS line, the vast majority who cannot be helped at all, are families. There is minimal accommodation for families. The problem often is that children, once they hit teen years, are not able to access the emergency accommodation services. So the majority of callers who do not receive assistance are families.

Families who are at risk of homelessness because of a mental health illness are one step further behind the eight ball than individuals. What we try to do for the people that we cannot help with accommodation is provide them with information about places where they can at least get food and places where they can perhaps get some blankets and some clothes. We will offer other referrals that perhaps will address the very basic needs that they have. Certainly there are very few referrals to a counselling service for people in a full-blown psychotic episode. They cannot even get there or take up that option. They are not in that place. For those people we attempt to access the CAT team. As I say, that helps very rarely.

MS PORTER: Do you keep stats on how many people you are unable to help at all, such as these families? What percentage of the families would not be given any assistance? I am not saying not given any assistance, but not able to be housed.

Ms Bennett: We do keep those stats, and I do not have them with me, but off the top of my head it is somewhere between 33 per cent and 50 per cent.

MS PORTER: It would be very good, I think, for the committee if we could have those statistics.

Ms Bennett: We can certainly get that for you, yes.

THE CHAIR: We would appreciate that.

MS PORTER: Thank you very much.

THE CHAIR: Just before I hand over to Jacqui, I have just got one question that I wanted to ask. I know that you speak with your counterpart organisations in other states

on a regular basis. Is there a comparison done of the issues from state to state and territory? Can you give us a picture of that?

Ms Bennett: I certainly can. It is perhaps not specifically connected to housing, but I can certainly tell you that every time the Lifeline centre managers get together as an association, the significant issue is mental health callers. More than 50 per cent of callers to the Lifeline service across Australia have identified mental health issues and are unable to access perhaps more professional services at that moment, whether they are people who are on the equivalent of CAT team lists and who right now cannot get anything. The people that they turn to are Lifeline.

MS BURKE: Good morning, ladies. Thank you for coming. You have probably answered part of my question. I wanted to try and get a handle on the enormity of the problem from your perspective. You are going to give us those stats and it will tell us 50 per cent of what—50 per cent of 100 or—

Ms Bennett: Yes. We average around 300 calls to the CEAS line per month. On the Lifeline crisis line we are taking 100 to 110 calls a day.

MS BURKE: A day. But you will provide those—

Ms Bennett: We certainly will provide that information.

MS BURKE: The other thing I wanted to ask you is: from your experience and from what you have told us this morning, would you agree with my comment to you that the disparate nature of services in the community and the lack of coordination from one service to another are compounding the problems?

Ms Bennett: We have a desperate need, yes.

MS BURKE: I am sorry. I said “disparate”—the disparate nature of services. It must be my accent. But I agree there is a desperate need, yes.

Ms Bennett: I am sure you are aware it is a desperate need. I am really not sure how much is compounded by a lack of coordination. We have always found any service that we attempt to access to be as helpful as they can be.

MS BURKE: Sure. But you know where they are and your clients do not.

Ms Bennett: That is true. Certainly there would be a proportion of people that would turn to a service like Lifeline and, I presume, a service like Canberra Connect to identify where services are or what services are available. Often it is not something that lives in a person’s awareness until the need for a particular service becomes acute, whether it is domestic violence or the CAT team or whatever. People would not actually carry with them the knowledge of how to access those services unless they need them.

MS BURKE: Finally, just as a quick extension to that, are there too many services now so that it is confusing for people? With everybody trying to find the problem, they are popping up for funding. It is something one of the submissions said.

Ms Bennett: Yes. I do not really have an opinion on that, Jacqui.

MS BURKE: Okay. Thank you.

THE CHAIR: You were talking before about the difficulty of finding services for the people who actually ring you up, and this relates to night-time versus daytime callers. Are the majority of your callers at night-time as a general rule?

Ms Bennett: Interestingly enough, the majority of calls to the CEAS line are during the day. I suspect that there is a level of awareness in people that, if you have a housing crisis, it can only be resolved during the day, when the department of housing or the shopfronts are open. It is really quite interesting. Sixty per cent of the calls to the CEAS line are during the day. Of those, the bulk comes between 9 am and midday. So the person has received the eviction notice yesterday and they start to try to do something at 9 o'clock the next morning.

In terms of emergency housing, some of the need of a night will be the people who have experienced domestic violence or the young people who have had a blow-up at home and walked out. They are the sorts of people who access emergency accommodation, if it is available, at night. They are the ones that come at night, where the cause or the risk is a blow-up, rather than "we're facing this at some point in the future".

THE CHAIR: What is the percentage of calls to the general number at night-time versus daytime?

Ms Bennett: It is a huge number at night. It is probably the reverse of the CEAS line situation. Sixty per cent of calls that we would take come between 5.30 and about 2 am.

MS PORTER: You mentioned young people. Would the Youthline have a similar kind of experience with these statistics? Have you actually studied whether or not you are getting the same kinds of percentages of people who identify with a mental illness?

Ms Bennett: The Youthline was actually closed down a couple of years ago, Mary.

MS PORTER: I am sorry. That is very lax of me, not knowing that, isn't it?

THE CHAIR: Not commenting.

MS PORTER: I did not realise that that happened.

Ms Bennett: We did a review of the Youthline service and identified that we could better use our funding as an outreach program. So the Youthline moved into that.

MS PORTER: I completely went off the radar. Have you an idea, then? I know people do not necessarily have to identify who they are. They can be anonymous callers.

Ms Bennett: That is right.

MS PORTER: Have you an idea of how many of these people are young people, say, under the age of 25?

Ms Bennett: Again, we could provide you with that statistic. I do not know it off the top of my head, but I can certainly provide you with that information.

MS PORTER: How many are repeat callers, do you know?

Mr Bennett: If the issue were only accommodation, the kind of blow-up, “I’ve walked out tonight,” we would give that caller two or three or four options. Generally what will happen is that if they were unable to access emergency accommodation a very small proportion would call back. I guess the sense is: “Well, they’ve given me what they can and there’s nothing available so they’re no more help to me. It would be a waste of a call to ring back.”

It does happen but often the telephone counsellor will be quite up-front and say, “There isn’t any accommodation for you tonight. You don’t fall into the criteria where there might be some beds available.” We do what we can. We provide them with whatever information, referral and counselling we can provide them with. I guess they would see that would be the end of what we would be able to offer, so there is little point in calling again.

We always make the offer: “Call again if none of this works out for you.” But, really, if we have given them what information and what referrals are available, my presumption would be that they would say, “Well, what’s the point in calling again?” We will try to explore other options with them if they do call again. Generally the second call is to family and friends—can they sleep on someone’s lounge room floor. That is a preferable option that deals with the immediate crisis on the night. It is not a long-term solution, of course.

MS BURKE: I want to thank Lifeline as well for your priceless service to our community. I really do thank you. I wanted to drill down a little bit into maybe some of the specifics. You may not be able to give me this, but I am interested in what problems specifically people are facing when they ring you in relation to their accommodation or housing situation. Is it location, is it the appropriateness of accommodation, is it money or is it all of the above? Can you identify?

Ms Bennett: Yes. It is all of the above. We get calls from people who have received eviction notices. There are more and more of those. They are at risk of homelessness; they are not necessarily homeless tonight.

MS BURKE: What is the cause? Is that debt-related?

Ms Bennett: Often it is not paying their rent or the landlord wants to resume the property. Often for those people it is actually trying to get something in place before the worst happens.

MS BURKE: Sure.

MS PORTER: We just heard from Carers ACT. How often—you may not know—do you have people who are caring for a person with a mental illness ringing in about an accommodation problem?

Ms Bennett: It is not a high proportion, but we certainly have had experiences of it. Again, I cannot give you that figure exactly, but I could find it out for you. Usually, when we get calls like that, it is about the family's distress, where they say, "We can't cope any more," or the person experiencing a mental health situation right now will not cooperate and the family have tried for so long and so many times that they are just worn out. I do not think the intent of the family is: "Well, he had better not come home tonight." It is not like that. It is: "What on earth can we do? We are desperate. We need some relief from this situation."

THE CHAIR: As a follow-up to that, a previous witness who spoke to us really as a carer raised the issue of dual diagnosis, the use of illicit drugs. How often does that come up as an issue?

Ms Bennett: What we find with the callers who are experiencing the dual diagnosis experience is that it is relatively frequent and it is around self-medication. The oblivion of drugs or alcohol is infinitely preferable to the mental health experience they are having. The second thing, of course, is that so many people with mental health conditions experience loneliness, extreme loneliness. Other people struggle with their behaviours, they struggle with their own behaviours and they are socially isolated. So they are the two things that I guess from our perspective prompt those kinds of dual diagnosis issues.

Ms May: If I may, the other thing about that is that it makes it harder for them to find emergency accommodation. Quite often that comorbidity will mean that they are not eligible for the accommodation services that are out there. So that makes it difficult.

MS PORTER: Is it your experience, though, that there are some types of accommodation that will take people with dual diagnosis or that there are not any? What is your experience?

Ms Bennett: We would have to check with the coordinator of the CEAS line. I do know that one of the referrals that would be given would, of course, be the comorbidity service that is run by drug and alcohol. But getting someone who is currently affected by drugs or alcohol and/or a mental health issue is almost impossible, extremely difficult. I do not know that we would ever have had any success at that. I can check that and we will get that information for you.

THE CHAIR: We might leave it at that. Thank you very much for coming in today. We will forward on the transcript of the hearing so that you can check it for accuracy. If we have any further questions, we will get in contact with you. We will also keep you informed of the committee's progress with the inquiry.

Ms Bennett: Please do. Thank you very much.

MS PORTER: Thank you.

ARA CRESSWELL and

LLEWELLYN REYNDERS

were called.

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

Ms Cresswell: Yes.

Mr Reynders: Yes.

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

Ms Cresswell: I am Ara Cresswell, Director of ACTCOSS.

Mr Reynders: I am Llewellyn Reynders and I am a policy officer at ACTCOSS.

THE CHAIR: Thank you very much for your submission to the committee. Would you like to start by making an opening statement?

Ms Cresswell: I will. Thank you for inviting us here. You have a submission from us but we will add a few points to that, summarising some of the main issues from that submission. We have also recently completed a project with ACT Shelter about affordable housing in the ACT. That has been sent to all of you. We have brought extra copies with us today. That's quite relevant to the work we are doing and certainly to the work you are doing here. I'd like to draw you to four of the main issues in our submission and then we will be happy to take questions.

The first of those is the lack of affordable housing—hence we note our report to you. The overarching problem in Canberra at the minute that is affecting everyone on low incomes and all disadvantaged people is the lack of affordable housing. It is a serious concern and was raised as a big issue yesterday at the housing summit. This means that mental health consumers are finding it much more difficult to manage households and to find suitable accommodation that they can afford. It includes growing public housing waiting lists, SAAP services that are not only full but also have lengthy waiting lists and an increasingly inaccessible private rental market.

The second point is that not enough attention is paid to living and personal support. Neither Housing ACT nor Mental Health ACT directly provide psychosocial support services. This gap must be filled by the community sector. Another problem with the support services is that they are still not joined up, so there are difficulties in communication between those support services—between mental health services and

housing managers. The approach is still not client focused and the support is often attached to housing, or to the acute need. So, if a person moves on, or if they become well, that support will fail because it will be left behind with the service.

The third point is that coordination is improving but there is a long way to go. Both DHCS and Mental Health ACT have begun drawing up MOUs with each other and with various community organisations, such as the SAAP sector. I am happy to talk about those and where they seem to fall short or have not been progressed, but it is only the start in addressing the problems and they are not a solution by themselves. That leads me to a subpoint of that. Getting cooperation and collaborative client management between front-line staff is incredibly important, particularly in the combined areas of housing, mental health and community providers. That's why we need the MOUs operating at a higher level to ensure that we can get that cooperation and get that collaborative client management so that at the other end a person comes out of it having a whole service delivery.

The fourth point is prevention and early intervention. While government policy documents state that prevention and early intervention are priorities, the bulk of the resources continue to go to the acute end—they are all at the pointy end. We need to start looking more seriously at prevention and early intervention. It creates a disincentive to get well and it means that consumers are still not getting access to services before they get sick, or adequate assistance to prevent a relapse. Often, consumers will ring and ask for help—but they are not sick enough. We need to develop a system where people do not have to be so sick that they need crisis help. We need to be able to help people when they start reaching out. That's all we will mention about our submission, but we are more than happy to take questions from you.

THE DEPUTY CHAIR: You said you would talk a little more about the MOUs. You said you saw that path as just a mechanism, I guess, and not as the answer. I was wondering if you could talk a little bit more about the MOUs, as to where you see the cooperation breaking down, if it was ever happening in the first place. Could you tell us how you see the community itself being brought into the triangle of housing, mental health and community groups and how we can better coordinate that? Notwithstanding the MOUs, or in addition to the MOUs, how do you see that happening? We have also heard from some people this morning that there are perhaps too many community groups providing too many different types of services. I was wondering if you could comment on that.

Ms Cresswell: I will start with the MOU issue and use the SAAP sector as an example. The SAAP sector have been working really hard to develop an MOU around mental health and SAAP. As we know, it is the SAAP sector that picks up the crisis accommodation around mental health. That is the place where people with mental illness fall when they are homeless. The SAAP sector are quite clearly telling us that they cannot meet the needs of the mental health consumers. They reach out to Mental Health ACT, who do not have the resources to deal with the crisis at the time. As I know only too well, SAAP services are often told, “You can deal with that,” or “It's lucky they're at your place,” or “They're in the right place then”—because at least they are captured somewhere and not homeless on the street.

What is crucial is that the mental health sector begin to understand that the SAAP sector

reach out at crisis point, or when they see that a person is becoming sicker. The SAAP sector deal with mental illness incredibly well and they deal very well with crisis mental illness. But, at a point, a SAAP worker knows when it is beyond their capacity to deal with it; they know that the person is becoming sicker; they know the person's life is at risk or they know other people's lives are at risk. That's when they reach out.

It is really important that there is an understanding between mental health and SAAP so that those people can be captured before something serious happens. Sadly, on many occasions in this town, something serious has to happen before we get those two areas working well together. Hence work has been done. It has been coming out of the ACTCOSS office from the SAAPRADS project that we run to develop an MOU between SAAP and mental health. The work has been done; however, it needs to be both top down and bottom up. It has to go both ways. At the moment it's bottom up. It needs to be owned at a much higher level. We would like to see government say, "We want these services to work together; we want this collaboration at a very high level," so that staff at this level know that what they are doing is feeding into the government agenda.

We do not want isolated strategies; we do not want isolated ideas; we do not want isolated policies. We want to combine those so that the person in the middle, who might be being looked after by the SAAP sector and might be being looked after in the mental health sector, is taken care of—not sometimes pushed between them—and holistically dealt with. That's where the MOU is incredibly important, but it needs to be owned. It needs to be owned at a very high level, because if it is taken carriage of at a high level there's capacity for that to filter down. Certainly staff on the ground do their best. They do the best they possibly can with extraordinarily limited resources. SAAP and mental health are both incredibly under-resourced and the need continues to grow. That's why it's important that we get it all ways and start to really bring things together instead of being very disparate.

As to your second point, I would be very cautious about saying there are too many groups. I know that various consumers will link with various organisations, and that is incredibly important. One can never overestimate the importance of a personal link that someone makes in a service. It might be one service they go to where there's one worker. When an Aboriginal person with a mental illness goes to a service and finds an Aboriginal worker there, the link will be made. A person goes there and somebody understands that it's about sexual assault as well as everything else. That stuff is so important in the lives of people. We have long been supporters of small agencies. Many of them are founded by people who either have mental health problems or are mental health carers. They are founded because there is a gap. I'd be cautious about saying there are too many and let us try and pull them all into one. We probably need to investigate who thinks there are too many, where those services are and what the consumers themselves are feeling.

THE CHAIR: On that point, a carer appeared before us earlier. I think that is what Mary was asking about. It was more the issue of the lack of coordination between the different groups that provide services and the crumbling down of the funds between all the different groups. Did you want to talk about how ACTCOSS assists with coordination—I know that a number of these groups are members of ACTCOSS—and also refer to the coordination that goes on between those groups in the first place? Prior to today, we heard from another person who appeared before us. He was talking in terms of the group

wanting to retain control over things. So there is that issue—and people working in silos has been referred to.

Ms Cresswell: It's a very difficult one. I do not know a community agency that says, "We have so much time on our hands, I think we will go and create a link with these people over here." Every community agency I know is saying, "We can't meet the needs of the people we are dealing with." When another agency says, "We will take that," they say, "Thank you very much; we really need that." At the moment, all our member services are telling us they are operating at overcapacity. They were telling us a couple of years ago that they were operating to capacity; they are telling us now that people are working extraordinarily long hours, often unpaid—all those extra hours are unpaid—because the need is so great. They are incredibly committed.

We probably don't have the mechanisms to bring them together. ACTCOSS will certainly always try to bring our members together. That happens through our training forums and our governance projects. We get agencies to talk with each other. If an agency comes to us with an issue—say it's a governance issue—we might suggest that they meet with another organisation that we think could benefit them. It is hard to have a lot of organisations, because what that means is that incorporated organisations have voluntary boards of management. That's a lot of people. We are asking for a lot of voluntary people in the sector. But there are an awful lot of committed people in this town who will help run those organisations.

I do not know how we bring them together better but perhaps in trying to break down some of the silos we need to look at some best practice examples. That will be by using the MOU system, bringing people together, finding ways to do it. I think it was South Australia where there was a recent ministerial statement—and I do not know about this; I might be wrong—about mental health. That brought together housing, mental health and the SACOSS. I will check on that. I might be wrong but I thought they brought those together and made some high-level commitments saying, "We will work together to address the issue of mental illness."

THE CHAIR: You will check on that and let us know.

Ms Cresswell: I will check that when I get back.

Mr Reynders: I would just add that I also think there's an element that the sector is still getting over purchaser-provider, in some senses. Purchaser-provider, of course, put services in competition with each other and broke down a lot of that cooperation, and that cultural change in rebuilding those collaborative networks is something that's an ongoing process. The other point I'd make is that certainly some of the work that our SAAP team does in trying to bring together services in SAAP forums and various training programs is assisting with those collaborative processes. I also note that a service was set up to help coordinate service provision in terms of referring people to where there were beds available.

The other thing I want to bring up—I understand I have to double-check—is that New South Wales is currently implementing a technological solution to some of these problems, which is allowing SAAP agencies to have almost like those "last-minute book a hotel room" services online where the referring agencies can bring up an internet

screen which says where the places are in the sector and can refer people to somewhere where there's a bed.

THE CHAIR: They need it now for crisis accommodation.

MS PORTER: Carrying on from what the previous person was talking about, one of the issues that she raised was that she believed that consumers and carers did not have enough voice in the community groups—that was her experience—and she felt that the community groups needed to listen a little bit more to consumers and carers, or that is what I heard her saying. Karin is right; she was expressing, I guess, some disquiet that there are small amounts of money scattered around a number of groups which could be a result of the purchaser-provider model, as you were saying before. It could be a result of that, because a lot of people are out there bidding in competition with one another, instead of joining together. So how do we help groups talk to one another given that they are all so busy just keeping on with the job? My experience, when I was in the community sector, was that often they will not come to training groups and things that you offer at ACTCOSS because they just do not have the time. How do you reach out to them? How do you go to their workplace and help them deal with those myriad issues? How do you bring people together when they just do not have the time and how do you help them refocus some of that money on service delivery rather than them all reinventing the wheel as far as maybe governance or administration and all those other things are concerned?

Ms Cresswell: ACTCOSS has auspiced the Mental Health Community Coalition, which is the consumers and carers coming together, until it grew legs and walked by itself, and also auspiced the Mental Health Consumer Network, so brought together the consumers. We facilitated an enormous amount of work between the consumers to develop the Mental Health Consumer Network and eventually, in the last year, the Mental Health Consumer Network left from under our wing and very cautiously took steps out by themselves and really have done an amazing amount of work with consumers to bring the consumer voice to the table and to keep training the consumer voice. They do a lot of training consumers to make sure consumers feel okay to step up to the table and say what they need to say and be heard—an incredibly important voice for mental health consumers. Our work was really to bring together the consumer and carer voice in unison, through the Mental Health Community Coalition, to make sure that we brought those two groups to the table, because often those two groups have some difficulty—often they can go head to head about issues; I know that one only too well—so we worked very hard to bring that together, and that voice is there. I am not sure where that comment has come from that you have heard earlier, but there are groups out there who are doing it—and are doing a very good job of it.

THE CHAIR: The person that we heard from today is a carer for a young person with a mental illness, so right at the coalface and not necessarily able to step back and get a perspective. Their perception is that they have a young person, who doesn't live with them but who they care about and assist, who continuously is in a cycle of crisis—goes from one crisis to the next—and has a disparate group of people who attend different needs but do not necessarily talk to each other.

MS PORTER: There was one model of cooperation that was brought to us by another group that was here this morning, too, which was an interesting concept. I am just

wondering if you want to make a comment about this. It relates to groups in residential care that do not have enough money to be able to provide 24-hour care. Weekends are often a time when they cannot bring staff into that equation, either volunteer staff or paid staff, because of a lack of funding again. They suggested that the groups might come together and hire one place where you can get 24-hour care. I know that happens with veterinary practices, where vets come together and hire one place for 24-hour care. The model suggested was one person or some persons who could go around to these different places and provide the 24-hour care when it was needed, on evenings and weekends.

They also did say, though, when I raised it with them, that sometimes different philosophies may bump up against one another. I was wondering if you wanted to make some comments about (a) the concept and (b) that difficulty of the different philosophies of the different groups.

Ms Cresswell: I think the concept would require some research, really. We'd need to go out and look at whether it could work, who would be involved, how it would work, how it would be funded and where it would operate from. I think we have to look at this point in time at any measures that might address the gaps. The reality is, though, that the need continues to grow—it is ballooning; it is monumental—and we can't fill that need. Certainly the community sector cannot fill it because we can't pay decent wages and conditions now; we certainly could not do that if it were weekend work. Work needs to be done to find out what it would cost, what it would look like, how it would be funded, how we could possibly make a system like this work and whether it would fill the need. It would be worth finding out. I'm sorry; I cannot remember the second question that you were asking.

MS PORTER: This group had a definite philosophy about the way they worked and the suggestion was to have a person or persons, who trawled the different groups in the evening, being available on call. I was asking them if they thought it would be difficult for that person to be able to meet the needs of that organisation, the way they worked with their client group, if they were going from there to another place that had a totally different philosophy and way of working. They suggested that if the person was in crisis it did not really matter what philosophy you were coming from. I just wondered if you had any comments?

Ms Cresswell: I do not know that I am equipped to make a comment on that, but I do know that you always need to be careful with mental health consumers in crisis. Bringing a lot of strangers into the equation can exacerbate a situation. Mental health consumers need to know that they have stability of care, that there are people that they can go to and they know who it is. It can even throw them if they are expecting to see, say, Gerald and Gerald is sick on that day, so what I would not like to see is us set up a system where every night they see a different person and have no idea who's coming. It's really important for them to get a clear outline of what's happening.

Mr Reynders: I guess that ties in with some of the questions about the diversity of the sector. That diversity is really important for addressing a whole lot of different types of need. Services do use different service philosophies and service models, because some of those models work with some clients and others work with others. Trying to push that all into one type of service delivery is probably going to miss an awful lot of people. So there probably would be issues with that type of casual service delivery and I guess it's

really going in the other direction to what we are trying to get, which is a continuum of service where the service is joined up with other services and there is an understanding and a collaboration between people, rather than someone just walking in and saying, “Hi. I am dealing with the crisis tonight.”

Part of the problems with the carer you spoke to this morning is that once again agencies are funded to provide basically crisis care. We are seeing in housing that they are targeting tighter and tighter to people in quite desperate need. We are seeing mental health really only taking the extreme end of the caseload. Indeed, SAAP agencies are now also dealing with increasingly multiple disadvantage as well. What we are seeing is that, because all the resources are focused at that crisis end, people hit crisis, the crisis is dealt with, but then they go and disappear off into the ether again—and come back into crisis.

We need to look at models that join up that service and continue to follow people through different tenures and through periods of both sickness and wellness. We would hope we can start getting to that, rather than just putting more and more resources into crisis management, because it really is not a long-term sustainable solution.

Ms Cresswell: There’s no question that one of the things we have seen work very well in this town is when a person identifies that they are getting sick. It does not happen so much anymore, because there’s so much strain on our SAAP services, but it happens with a couple of services. I know of people ringing up, saying, “I am starting to get sick,” or “I am hearing the walls talking.” They would go into a SAAP service for relapse prevention management, they would spend a bit of time, they would get their case worker in, they would talk with people, they’d get back on their medication, they’d get themselves on their feet and go home. They did not end up in hospital, they did not get evicted; they kept their housing and the crisis was alleviated.

We do not have the capacity to offer that relapse prevention model so much anymore, but some of the outreach services are really important there. Toora has one of those outreach services and that service is really there to make sure that the women they see do not end up hospitalised, unless it becomes unmanageable, and do not end up losing their housing. That’s incredibly important early intervention management, which takes the stress and strain off the hospital system and off the SAAP system.

MS PORTER: What about the other end, when they are coming out of hospital? We have all heard from so many people—I cannot remember whether in fact you mentioned it—but how do you see that being played out?

Ms Cresswell: I do not know how it is operating today. I know that there have been huge problems in the past with people—goodbye, shut the doors; you have gone from hospital. I do not know what the management system between the hospital and, particularly, the crisis services is, but I have long said that there needs to be a plan of action and a housing plan; that a person should never be released from any mental health facility homeless or at risk of homelessness. They need to leave hospital with a plan for housing that’s really clear, because it’s so unsettling not to have housing. It’s scary for people. They need to know that that’s sorted. Being sent to a homelessness service, crisis service, is not giving a person a home; it’s giving a person a roof over their head for a night. There is a real problem at that end—I know there always was a problem—about how

someone leaves, particularly, hospital services.

MS PORTER: We have heard from a number of people that they see a similar kind of arrangement to what you mentioned before with a place where people can go beforehand—a similar kind of arrangement, a similar kind of place, where they can go afterwards if they are not ready to go home to where they were before.

Ms Cresswell: That certainly happened with the SAAP sector. I do not know how it operates at the moment with the SAAP sector, because it does not have so much capacity to do that kind of work. It happened with drug and alcohol dependency too. But with that relapse prevention a person would say, “I think I am going to start using drugs” and the answer would be: “Why don’t you come in? We’ll see what you need to do and spend time with you so that you do not have to do it.” So a person comes in for that crisis management time and the relapse prevention works around it: “Are you ready to go home? Why don’t you go home for a day and work it out? We’ll keep your bed.” These days, I think it’s much harder to keep a bed when beds are so desperately needed. I think it’s much harder to manage that transition both in and out of any service.

Mr Reynders: I certainly understand that the PSU has employed two discharge planners now, which we have heard is an improvement but not necessarily filling all the gaps in terms of helping people being discharged from the PSU to find secure accommodation on exiting. Another suggestion that has been made by a number of our member organisations is that a gap in the system is some type of step-down facility. At the moment there is a cohort of people for whom something like Hennessy House is not really appropriate but who are not capable of living with family or alone. That intermediate option of some type of supported living arrangements where they can be taught living skills and provided with peer support and psychosocial support is certainly what we are hearing is an element missing in the system.

MRS BURKE: I have just had to smile. Obviously, our inquiry is into appropriate housing for people living with mental illness. I notice the title of your submission is “safe, secure and affordable housing for people with a mental illness”. In part that certainly says what it’s about. My question is very broad, and answer it with the time that we have: do you think the current system is appropriate? If so, why? If not, why not?

Ms Cresswell: Which part of the current system?

MRS BURKE: The appropriateness of housing for people living with a mental illness.

Ms Cresswell: The current system is struggling to meet the need for everybody, not just for people with mental illness.

MRS BURKE: Can we focus on people with a mental illness now.

Ms Cresswell: I do think there’s a problem. The people who are being housed in public housing currently are those on the early allocation 1 list predominantly. There are certainly many people with mental illnesses who are housed on the EA1 list. Often they go into housing without adequate supports. It’s the adequate supports that we need to keep them in housing, because so many people lose their housing simply because they have not managed to pay their rent because they were in a psychotic episode. They need

someone to go around and say: “Have you had your medication today? What are you doing about food? Have you managed to pay the rent?” Those kinds of things are really important around maintaining housing. I know Llewellyn will want to add to this one.

Mr Reynders: With the current housing environment, what mental health consumers are finding difficult is, firstly, finding well-located housing. Some of the public housing that’s on offer is not necessarily in an environment conducive to maintaining mental health, or, if they are forced to look in the private market, there is not necessarily anything that’s well located near support services, near living services like hospitals and supermarkets.

MRS BURKE: So we are talking adequate versus appropriate, aren’t we, really? That has always been a bit of a tug and pull; they are adequately housed but are they appropriately housed. That’s what you are saying.

Mr Reynders: Exactly, and whether the location is appropriate is one issue. I guess another big issue, which is similar, is the social isolation that mental health consumers continue to face, particularly if they are in a one-bedroom bedsit somewhere and have no existing social connections. The services simply are not being provided to try to connect those people into social networks.

MRS BURKE: That was your point with regard to the step-up, step-down—whatever we want to call it—facility; there’s a gap, a really big gap. We are just sending people out of hospital, without a care plan, into the wide world—to be independently living, which is a bit of a furphy but the way things currently stand. Is that your view of it?

Mr Reynders: Yes. Those people are simply at risk of becoming sick again and becoming homeless again.

Ms Cresswell: Which is why we need to focus our resources on early intervention. We need to deal with that. If we support people, give them the early intervention and work with them, they do not end up so often in crisis.

THE CHAIR: Thank you very much for your attendance today. We will be back in contact with you with a copy of the transcript of the hearing today so that you can check it for accuracy. If we have any further questions, we’ll get in contact with you, and we’ll also keep you informed of the committee’s progress with the inquiry.

FAYE BROCKELSBY was called.

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

Ms Brockelsby: Yes, I do.

THE CHAIR: If you can state your name and the capacity in which you appear, for Hansard.

Ms Brockelsby: My name is Faye Brockelsby. I am the Chief Executive Officer of the Coalition of Community Housing Organisations of the ACT.

THE CHAIR: Thank you very much for your appearance today and for your submission to the committee. Would you like to start by making an opening statement?

Ms Brockelsby: I will start by explaining a little bit about community housing. It is housing for people on low to moderate incomes and is basically housing for the community by the community. Inherent in that is a respect of people's right to be able to determine the best way in which their property might be managed and how their lives might interact with their housing situation.

Community housing essentially started off as a grassroots movement of people forming cooperatives based on a philosophical alignment of ideas and lifestyles and providing support in a community or communal atmosphere. As time has gone by, it has taken a slightly different direction, as it has been seen as an opportunity to provide housing for people on low to moderate incomes that might meet their needs in a more appropriate way than public housing could traditionally do.

With that, though, have come changes in the population. The allocation of housing in the public housing system has seen a move towards targeting of people with high needs. That has also had an flow-on effect into community housing. There are a variety of reasons for that—and I could go into it—but, essentially, it has meant that we probably have more people living in community housing now than we have had in the past or would have traditionally seen as our population or client base. A lot of those people have mental health issues, amongst many other issues.

Part of the reason why I chose to put a submission in is to, hopefully, get a recognition that community housing was traditionally funded to provide housing which was tenancy, management, maintenance, repairs and maintenance and things like that; it was never funded to provide support to people living in those properties. We would never assume that we had the skills, the attributes or the knowledge to do that appropriately and effectively.

The problem is that at the moment there is a disconnect in terms of how you link in the

housing of people with accessing those support services. We in the disability sector now accept more broadly that housing and support need to be separated, that it is not appropriate for any one organisation or agency to provide for that whole-of-life support. That is okay in the disability sector because in some ways you can actually see where the support is meant to come from. It may not always be funded, but you can see where it is meant to come from and you can understand the connections.

It is a little bit harder when it comes to assisting people with mental health issues. That support is not as clearly documented, from our perspective; it might well be in the mental health area or in the health system. From a housing perspective, trying to get into that system to access health is not as easy to do.

We find that it is difficult for us in that a lot of organisations talk about privacy; so they tend not to want to engage with us as a housing provider. We will go to somebody potentially seeking help for a tenant that we know is living in squalor or is having difficulties; they are behind in their rent; or you know that there is an issue there and you know that they need help that is beyond what you can do within the constraints of your skills and within the constraints of your budget. Actually accessing the right and appropriate help for people is really, really difficult et cetera.

You might be able to access for those people some of the more basic community services like advocacy, to get them to be able to engage with you. But to actually get support for somebody is a whole different ballgame. That is our frustration, primarily. I have providers that have said, “We can ring up the RSPCA and they will be out there that afternoon to look after the dogs but, when it comes to looking after the individual, we cannot get there; we just cannot get into that link.” That is primarily the point that we make at this stage.

It is an awareness that we need to make those links much stronger and we need to know how to access it. And there needs to be that awareness. One of the other things we find—it is probably not really relevant but I will say it anyway—is that, being the housing provider, you are often seen as the person who is the enemy of the tenant; that somehow you do not want that person to sustain their tenancy; that it is not in your interest to do that; and that we are going to be ruthless and throw this person out. That is the last place that we come from in the community housing sector, as does public housing. I am quite sure of that too. There is still that conception that you are not working for the good of the tenant because you are somehow not interested in the outcome.

THE CHAIR: The ones that we hear about in the media are always the ones where the people are being evicted. You do not necessarily see that much about this tenant being with this particular property or being supported by ACT Housing or community housing for 20 years and they have never been to the media because they do not have any issues.

Ms Brockelsby: That is right.

THE CHAIR: It does not make good print.

Ms Brockelsby: No, it does not. And it does not get the media there.

The other part of it is that—and this is probably more my assumption rather than any

hard facts on it—sometimes people are going on this path and we try to support them and prop them up. In doing that, that might possibly allow them to continue to think, “Things are okay. I have still got a roof over my head. I am still doing it.” But there is a lot of support going into sorting that out. It is when that support gets to the end—when there are no more options available and they get to this end point; it is a horrible, messy place to be—that other support can come in to support them through that process. If that makes sense.

Sometimes it is easy to say, “I have still got my roof over my head; so what I am doing is okay. It is still working for me because I am still existing.” It is when they get to that end point that they are aware: “Maybe what I am doing is not okay; maybe I need to get some help here to work towards looking after me in this process.”

MRS BURKE: I asked the last people this, so my first question for you is the same, to try to zoom in on the essence of this committee hearing today. It is in regard to the appropriateness of housing for people living with a mental illness. Do you think the current system is adequately providing for people in that category? If so, why? If not, why not?

Ms Brockelsby: The housing system at the moment is probably not adequately providing for a large number of people because (a) we do not have enough houses to begin with; and (b) the support needs of people in a range of different areas need to be more adequately funded. Whether it be disability, whether it be mental health, whether it be any of the other issues that people bring in with them as part of their lives, they are not adequately funded at the moment.

As I said, there is a connection between that support and the housing. The people with mental health issues can sustain tenancies provided they are given the right support external to the housing provider.

THE CHAIR: You are the fifth witness, and we have two more to come after you.

MS PORTER: Things run into one another.

THE CHAIR: That is right.

MS PORTER: One of the things that seem to have been coming out this morning is perhaps the lack of coordination between all the players—Mental Health ACT, housing, the community providers, be they supportive accommodation providers or be they community housing or other providers.

Ms Brockelsby: I would agree that that was the case.

MS PORTER: How would you see that being addressed?

Ms Brockelsby: I came into this sector in 2003 from the private sector. My background is probably more the private real estate sector and a rural leadership organisation. It is a diverse background. But when I came into it, it was just at the changeover from the old style of contractual arrangements with the department, where there was a purchaser/provider, to this partnership arrangement. In that process of changing, we did

not get the new rules of engagement with us as a community sector. We agree on a certain number of things and, together, we will stand solid on a whole range of issues.

But when it comes to going that extra step in that partnership concept across the sector, there are still some adversarial matters. You used to have to compete for funding. We still do, to a large extent. You used to have to really compete for funding, as far as I understood it. It was almost like you had to not connect with any of the other organisations if it meant that your funding was going to be threatened.

Of course, we would all stand together if we were being threatened by somebody outside of that. But internally that was the way it was played out then. There has been a progression since then. We are getting more of that partnership concept and that working together. I stress it was not that we were not working together before; the rules of engagement were slightly different. We are moving to a new way of working together in the community sector or a stronger way of working together in the community sector. That is a cultural change that might take a little while to get there. Sometimes things are not perfect. Always saying that it is bad does not mean that it is going to get better; it is about how you get things to get better.

MS PORTER: So you have not got any suggestions about how that might be achieved?

Ms Brockelsby: I hesitate to say “more public meetings or groupings together” because we do a lot of that. Our front-line people are stretched to the bone now, as far as I can understand. They are working very hard out there, and it is in very difficult circumstances.

MS PORTER: You are still in shock from yesterday.

Ms Brockelsby: Yesterday was a big day. We are trying to do lots of things in our sector. I imagine other peaks are trying to do things in their sectors as well about educating and skilling up the employees of our member organisations.

I do not know that group meetings are going to be the way forward. A better understanding is required of the roles and responsibilities of ACT Health and a better cross-fertilisation of what ACT Health does, perhaps. We are community housing and we do not pay a lot of attention to what health is doing in that sense, apart from when it affects us in doctors queues, possibly. We are interested in what is happening in the mental health area and what responsibility the department sees when it comes to providing support to community housing organisations or the public housing organisation, for that matter.

We would like to see the departments probably, in the first instance, get a clearer understanding of what their roles and responsibilities are, how they interact with one another and how important funding for medical health outreach services is to this community; and doing that in consultation with us, obviously knowing what we want and need.

Once that starts happening, I could imagine that there would be that kind of crossover. It is all about funding, about how those contracts are arranged and what people see as their roles and responsibilities. At the moment it would seem there is a disconnect between

what is needed and what is actually happening.

MS PORTER: I do not know whether you mentioned this when I was out of the room; I apologise if you did. There was some discussion that, at night-time, when people go into crisis, there does not seem to be enough help; that there is not anyone available for those people within these services; and that there could be a shared system where you could have casual workers or roving workers that could go between different services to provide 24-hour and weekend support.

Ms Brockelsby: It is a valid point. We have two major housing areas, both Ainslie Village and Havelock House. There are a lot of people living in some fairly close quarters in those areas. It is not as easy to access after-hours health care.

My understanding—and this is very limited—of how the health system works in terms of mental health is that it is almost like you have a worker and that worker is allocated to you under a specific program. But if you are having a high-stress incident, it is not as easy to get that support at that time if you do not really have something already in place for it. Yes, that sounds like it would work quite well. That is based on my understanding of the system and how it works.

MRS BURKE: At page 3 of your submission you put out some key issues and recommendations. You talk about a range of housing models. What would they look like, from your perspective?

Ms Brockelsby: From my research into this, there is a recognition that, depending on the severity of the incident for the person—if it is a mild situation, then obviously that person would stay in their house and would continue getting the supports into the home—things would trundle along nicely, and they would get to some point where things are working well for them again.

When it comes to bigger issues—and it is probably not my area of expertise—my understanding is that, in different episodes, the treatment is going to take longer. It is very difficult for someone to leave their house for, say, six months for some treatment or if they are going away for some rehabilitation or whatever they are doing. It is acknowledging that they still need a home and need to continue to pay rent on that home. It needs to be safe and secure. They are leaving their belongings behind for six months, if that is what they are doing.

It is acknowledging that there needs to be some flexibility, if we recognise that community housing is going to be not the housing provider of choice but a housing option for people with mental health illness and issues and that different things might be required for different people at different times. That sounds very vague. It is not as specific. But it is about being flexible.

MRS BURKE: Case management, isn't it, really?

Ms Brockelsby: Yes. It is about response, being flexible and acknowledging that, for the time being, they might need this particular living environment because it is the most appropriate. But that is not going to be where they need to be all of the time, and we need to be able to move through a system of things that reflects their needs, as opposed to our

saying, “This is what we have to offer.” I know that resources will mean that is probably how the system will work. “This is what we have to offer. You can have it or leave it.”

Ideally you would be saying, “This is what you need; these are the things that we can do for you during that progression through there,” to give people some surety that, at the end of the day, they won’t have lost their home or they won’t have lost their sense of belonging to a community.

MRS BURKE: On that note, do you think that discharge planning currently is adequate for people with a mental illness coming back out into the community?

Ms Brockelsby: I am probably not very—

MRS BURKE: From your perspective, have you got any evidence of that?

Ms Brockelsby: I guess it is the people I have been speaking to. I have spoken to some of our providers. To a large extent, from the providers that I have been speaking to, it is actually the people that have been in their housing for a long time; they are not coming back into our sector because it is harder to get in. Ainslie Village might have a slightly different perspective on that, and I am certainly happy to go and get some more information if that would make it easier.

THE CHAIR: We appreciate that you are coming from the community housing sector; you are not coming from housing specifically for people living with mental illness. It is not your area of expertise or knowledge.

Ms Brockelsby: Ainslie Village is now becoming a community housing provider. It deals with a lot of people with mental health issues, people on release from jail and things like that. So I am aware that that is probably going to come bubbling up, probably to the extent that—until December community housing was not open to us—now it is coming from that direction; so we would probably be in a position later to comment probably in a bit of detail on that.

THE CHAIR: One of the issues that you have outlined is the need for adequate training for organisations. Ainslie Village is to become a community housing facility. Is it available at the moment?

Ms Brockelsby: I am so glad you brought that question up. About 12 months ago, probably in January last year, there was an incident that happened in the community housing sector that we took an interest in, obviously, because it raised a whole lot of these issues. Amongst the many other things you do, you are aware that you need to do some mental health awareness training. Accepting that we are not going to be delivering the service to people, but knowing that a person might need some assistance here and being able to identify issues and to be able to guide people into seeking assistance, we started this process of trying to look for a training package to help people understand those issues. I know they are out there, and I know they exist.

It has been difficult, to a large extent, for us to access it in the way that we want to. It is a random process in some ways. They say, “You might try this organisation.” You ring them, and they say, “Yes, we can do that, but we do it from this perspective.” Then you

say, “You can try this organisation.” We still have not got the training we want.

I won’t say I have concentrated on it seven days a week, 52 weeks of the year, but, when I get to it, it still has not evolved as easily as I would have liked it to have evolved. We are getting there. The training that we needed was, I think they now call it, medical health first aid, recognising it and doing the very basics until you can get into the system. So we were keen to understand early recognition and some of those issues that people might present with.

Then the second part of that training is to get an understanding of how the actual system works, what we can do, what we cannot do, what are our roles and responsibilities, what does the mental health consumer tribunal do—I am not sure of its exact title—how does it work, and all those things. I know that a part of Health ACT does that area. But it has not been as easy, not because of anyone being difficult, to connect as we would have liked it to have been.

THE CHAIR: Because it is not their focus?

Ms Brockelsby: That is so. Maybe you have picked that up from the other presentations. I was not sure why we had not been able to get into it. You sit there and think, “Wow! Am I doing something wrong or approaching it from the wrong angle?” But that is what we want, and we have not been able to get it.

THE CHAIR: I do not know that it has been so much of an issue for the other people who have submitted to us, because they are dealing with it on a day-to-day basis. A number of them speak to us. They know that if you are a carer and you have got somebody who has been diagnosed with a mental illness, then you know what that is about. If you are living with it and you are a mental health provider of some sort, then you know what it is about.

Ms Brockelsby: Absolutely.

THE CHAIR: That is what your training is in. You do not necessarily think about it. You come in, having, I suppose, all these assumptions that everybody else will know what that is about, and you do not necessarily get around to what the rest of the community is thinking.

Ms Brockelsby: If you take that one step further: I was in a shop the other day at Civic and this gentleman came in. He was obviously distressed and behaving in a way that might indicate there were some issues that he had. I was looking at the shop assistant. She was doing the very best she could to deal with that circumstance. I wonder how many people in those circumstances are really getting the opportunity for training and awareness, particularly if you are working in the Civic or Ainslie areas or something like that. Where is that training on offer that could be packaged for those people? It has got nothing to do with housing, of course. It is just an observation that, for the broader community who come face to face with a lot of people, there is not that training out there; it is just general training.

MRS BURKE: Do you think that is a consequence of letting people out of hospital or acute care too soon, too early, without a plan? I will get back to that plan. That is an

interesting point.

Ms Brockelsby: It is still not my area. But I tend to agree with you that there is that possibility. I have had specific tenants come to me. You make friends with people over the years and things like that. They have been having issues. You know that they know they are in trouble. They know that they are either at the top of the high or they are at the bottom of the low. They are looking, and they just cannot get back into the system until they take it to the most nth degree. They don't want to go there; they have got children and things like that. They have got homes, families, jobs, but they know that they are not going to get that support unless they get to a crisis situation. My understanding of how you get back into the system is that you have to almost go out to the extreme of it to get back in.

THE CHAIR: You are around. You have similar organisations interstate. Would you say this is an emerging issue for your counterpart organisations?

Ms Brockelsby: Yes, I would. I do not think it is unique to the ACT, by any means. Again, most of our organisations started off with a very different client base. The change is in the fact that we have moved away from institutions and moved into targeting for public housing. Most of our eligibility criteria are based on public housing. Whilst we are not forced to accept people in any category or any type of person, there are more and more people presenting with those issues, regardless of why. Yes, it would be widespread amongst everybody, I would say.

MRS BURKE: You talked about adequate and flexible funding of community-based mental health workers. I do not ever think there will be adequate money, but I am interested in the flexibility side of it. What do you envisage that looking like?

Ms Brockelsby: It was my understanding that, again, the Richmond Fellowship, as far as I am concerned, is funded to provide mental health support to certain groups of people. Some of that support is in housing that is managed by the Havelock Housing Association. That works well; that is a nice connect.

If you are not in one of those programs, how do you get that support within your housing context so that you know that the housing provider can say, "We have got somebody here who we think is having some issues. Is it possible for you to come and talk to us and talk to that person?", but in a flexible way so that that person does not have to be signed up to a program or does not have to be on some support agreement? It is just: "Gee, we think there is an issue. Here is a way that we can start exploring it. Where to from here?" I do not think that there is that flexibility in the system as it stands now. You have to be part of a program or something.

THE CHAIR: Thank you very much for your appearance today. We will back in contact with you with a copy of the transcript of the hearing today so that you can check it for accuracy. If we have any further questions, we will also get in contact with you. We will also keep you informed of the committee's progress with the inquiry.

Ms Brockelsby: Thank you.

ANITA PHILLIPS and

VICTOR HUGO MARTIN

were called.

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

Ms Phillips: I do.

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

Ms Phillips: I am Anita Phillips, Public Advocate of the ACT.

Mr Martin: I am Victor Martin, Acting Deputy Public Advocate.

THE CHAIR: Welcome. We received your submission yesterday. We just authorised it today so we have not actually had a chance to read it through. The committee secretary is an early riser, so she has actually read through it. Would you like to start by making an opening statement?

Ms Phillips: Certainly. Thank you. While there is a range of services available in the ACT for people with mental health disability, there remain a number of instances where gaps and shortages of service leave some of the most vulnerable citizens at risk. Our submission focuses specifically on the Public Advocate's experience, and we have identified three groups of people with specific accommodation needs that we believe currently are not being met.

Those three groups are: people with a mental health disability who are involved in the criminal justice system, and that is what we call forensic clients or forensic patients; people with a mental health disability who are eager to move back into the community but who have unmet accommodation or support needs, and they are loosely termed, I suppose, mental health people in need of rehabilitation; and people with a mental health disability concurrent with an intellectual disability who are dual disability clients. We think those three groups particularly are not accommodated by the current services.

In our submission we support the need to urgently address the particular problems of these three groups of people who have unique issues of concern and lack adequate assistance or support. The Public Advocate has always given high priority to these clients, who are subject to state intervention, including involuntary detention in a mental health facility. Our forensic patients require intensive, ongoing, across agency support to resolve their mental health and accommodation issues. They have a distinct absence of supported community accommodation and are likely to serve a longer period in custody

than the normal prison population.

Aside from the emergency refuge Samaritan House, forensic clients released from periods in custody have limited accommodation options. The absence of a targeted accommodation facility presents a significant difficulty for forensic clients and places them at a high risk of reoffending. Facilities are required that provide support within the context of medium-term accommodation as a transition to community reintegration.

For mental health rehabilitation clients the delivery of mental health services is based on the notion that most clients will choose to live in the community either on their own or with family support. The Public Advocate supports this approach where it provides the person with the necessary care, accommodation and safeguards to meet their mental health and associated needs. Many clients have resided at the Brian Hennessy Rehabilitation Centre, which is supposed to be the facility for mental health rehabilitation in the ACT. That includes the extended care unit for very extended periods of time so that the unit ends up serving as their long-term home.

Although patients or clients who are there are generally happy with the care at the BHRC, many residents report to us that they would prefer to live in a setting that better promotes their independence in the general community, which is only reasonable. The availability of group house options provided by non-government services providers such as the Richmond Fellowship is limited. The amount of care available at these group houses is less than is required for many of these seriously disabling mental health disabilities.

The third group is clients suffering with dual disabilities. ACT Health and the Department of Disability, Housing and Community Services have identified clients with an intellectual disability compounded by a mental illness as requiring specialist support services. These services, including accommodation services, are provided on a voluntary basis and underpinned by principles of choice and self-determination. That is all very fine, and, while this approach is appropriate and desirable, in many instances there are circumstances where the nature of existing accommodation options in fact contributes to the difficulties experienced by the client. Living with low levels of staff support in close proximity to neighbours may contribute to the issues associated with an intellectually disabled person's mental health disability.

Furthermore, disability support staff are not trained or experienced in the management of chronic mental health issues. Where an intellectually disabled person's deteriorating mental state is marred by aggressive behaviour, for example, the only existing available options for their interim care, outside of their home, are the psychiatric unit, the BHRC, the police cells or Belconnen Remand Centre. The establishment of a step-up accommodation facility would allow service providers to offer services appropriate to the needs of a person who has high and complex needs, even on a temporary basis.

Finally, the provision of community-based support services cannot be divorced from the provision of suitable accommodation for those with a mental health disability. The two must be considered and planned with the other in mind. This is the case both for those who live independently in the community and for those living in supported group settings, such as group houses or long-term accommodation.

While we appreciate that many people with a mental health illness have unique accommodation needs, these three particular groups that we have detailed represent a large proportion of the Public Advocate's client groups and, as such, are our major concern. Thank you.

THE CHAIR: Thank you for that, Ms Phillips. You have just mentioned in your statement the issue of providing a step-up facility. Did you also want to make a comment about a potential step-down facility?

Ms Phillips: Yes, certainly. Both are necessary. I suppose I mentioned the step-up in relation to the dual disability clients because usually their intellectual disability is identified as the primary disability and so disability services become their primary service provider. What I was saying in that context is that when their mental illness takes over they need more care than can be provided. They need a step-up. They need a facility that is a little bit more therapeutic, but not to the extent of a psychiatric admission to the ward.

That group need an interim step, but I suppose that is the same as a step-down. It is also that interim. It could even be the same facility, but what I am saying is that these people need a step-up before they need the psychiatric unit. There is definitely a need for people coming out of the psychiatric unit, out of Brian Hennessy, out of the BRC, who need that step-down before they can go back into the community. It is a very real lack in ACT services.

MS PORTER: You said that a significant proportion of the people you work with have a mental health issue. Have you an idea of what that proportion is? Is it 90 per cent, 50 per cent, 75 per cent?

Ms Phillips: It is difficult to quote statistics in that manner. The mental health act requires that the Public Advocate be advised of a whole range of issues for individual clients. We get referrals to us where patients are taken into the psychiatric unit under an order, a detention order or a treatment order, or when they come to the attention of the tribunal or when they need to receive ECT. In all of these cases we are notified. We could use those as statistics of involvement. If we were to do that we would say that, yes, a high percentage of the notifications we receive are in relation to mental health patients.

But, in truth, in dealing with clients one-on-one, they would probably only amount to about 30 per cent of our workload. That is still very high when you consider that our caseload covers all children in care and all people for whom we are legal guardian or for whom we become emergency guardian because of medical issues, and that can be about 40 people at a time. So the percentage of people that we are dealing with who have a mental health illness is quite high.

MS PORTER: You also mentioned that some people, when they find themselves in Brian Hennessy House, stay there for quite a long time and it virtually becomes their home, their residence, rather than being a step between somewhere. I think you said at one stage that there is a group of people that are not encouraged to leave there because they become too dependent on the support that they are receiving. Is it possible there could be a group of people who cannot progress beyond that point?

Ms Phillips: Yes. That is more, I suppose, from my general experience in working in the community. My philosophic point of view is that there will always be some people—I said I was not going to use the term “institutional” and I have—who need more secure and permanent accommodation, rather than being accommodated in the community. So I think there is a need for that. Mr Martin might like to just tell you a little bit more. He has had experience working with the people at Brian Hennessy, as well as some of our other places. He might tell you a little bit about his experience of working with particular people there.

Mr Martin: Generally speaking, many of the residents in villas 1 and 2—they are called A and B—have been there for an extended period of time. Some of them have been there for only a couple of years; others have been there since the facility was established. With the introduction of the extended care unit, there was a shift in focus by Brian Hennessy more to a rehabilitation focus. There was an idea that there should be some throughput of residency at that facility.

The difficulty remains, though, that some of the residents that reside in the non-secure villas really have little prospect of moving on to somewhere else. Certainly there are instances where individuals move into supported accommodation of varying degrees. Some of them, in fact, move into independent accommodation with drop-in support from ACT Health mental health teams.

The prevailing experience of residents at those units is that they have stayed there for extended periods of time. The nature of their mental illness and the nature of their support needs means that to provide for their support needs in the community would be an expensive endeavour and to date ACT mental health has not been able to provide facilities outside that unit. Certainly I know that non-government accommodation providers are not able to provide the amount of support necessary to effectively meet the needs of this group of people.

MS PORTER: You obviously know that we are going to have a correctional facility in the ACT. Where do you see our challenges lie in respect of people who have a mental illness who may be coming out of part of that complex and the particular specific needs that they may have? How do you see us taking those people from that point to perhaps living in the community?

Ms Phillips: I see them as part of the group of people we have been talking about, who have a chronic mental illness that needs specially designed services and support, as is the case at the moment. There are some people in Brian Hennessy who in fact are forensic patients; that is, people with an interaction with the justice service, who have been on charges. It is not an appropriate facility. It is unlikely that the numbers of those sorts of people would increase because we are already accommodating those people within the ACT.

Some forensic patients are transferred into New South Wales at the moment, and that possibly would not happen with a correctional facility. But I do not see the numbers increasing exponentially. What I do think, though, is that they will highlight the lack of services for people with a chronic mental illness. Their behaviour has been criminal, against the law, but a lot of other people in that same category who have not come into contact with the justice system to the same extent have the same needs.

THE CHAIR: On page 4 of your submission, under “Forensic Clients”, the fourth dot point, you have talked about the issue of experiencing unstable accommodation or homelessness. Did you want to address that in terms of contribution to mental illness and possible mental instability and also ending up in a cycle of going back around the system, whether it be back to the Belconnen Remand Centre or to Brian Hennessy or—

Ms Phillips: Absolutely. As we say there, those are the figures from 2003-04. They would only have increased in recent years. As it says, this is a group of people that I do not think the ACT is unique in identifying for whom the services do not meet the needs. As we have said there, they are young men, usually single, who have unstable accommodation, who either cannot live or do not end up living satisfactorily in the community and end up homeless. A lot of these people have drug or substance abuse problems in addition to their mental illness disability. One often affects the other.

Often young people suffering schizophrenia then see the taking of illicit drugs as some kind of a way out. Sometimes it is the reverse and the long-term taking of drugs contributes to a mental instability. Whichever is the case is not really as relevant as the outcome, which means that we have a lot of young men who do commit maybe minor crimes, end up back in a facility and then are discharged from that without adequate community support. Their cycle just keeps on revolving.

THE CHAIR: You have given an example of a young man with a mental health disability who refused to take his medication. This is not an uncommon issue. I am diverging a little bit in terms of its relationship to housing. In order to maintain housing and not be evicted from your house, part of that is actually keeping yourself mentally well. They are reliant on each other. The courts can actually order them to stay on medication. Do you want to talk about that a bit?

Ms Phillips: Yes. The Mental Health Tribunal can in fact order somebody to be subjected to a psychiatric treatment order. If they default on this or breach it, they can be put in a position where they have to receive the treatment. It is usually for their care or to prevent self-harm or harm to others. It is true that there are a number of people who do default or breach a PTO, but it is a small percentage.

When somebody comes to the tribunal and is put on a treatment order, there are usually supports put in place to enable the person to continue to be involved or to receive the treatment. It might be attending a clinic weekly to have injections or case managers from mental health ensure that the person keeps on taking their medication. But we will always get those people who will refuse to take the medication or whom mental health cannot assist.

I suppose this is just another subgroup of our community for whom we need to have the services available. At the moment if we do have people who refuse to take their medication, they can end up in the remand centre, which is highly inappropriate. It is not a health facility. Therefore, it is very difficult to have treatment administered there. It is the last resort. Again, I would ask Mr Martin, who has recent personal experience, if he would like to comment.

Mr Martin: I might just expand on a couple of the comments that Ms Phillips has made.

The difficulty that ACT Housing at times experiences is that, although a person might present as being mentally ill, it may not necessarily coincide with presenting a risk to themselves or to the community. So they are effectively flying under the radar of the scope of the Mental Health Tribunal and their powers to make the mental health orders.

There have been instances where a person's mental illness has disabled them to such a degree that they are not able to cope with the responsibilities of managing their tenancy but does not impose on them an obligation to receive treatment. Whilst the relationship, the connection between ACT Housing and Mental Health ACT over the last couple of years has improved, evidenced by the reduction in number of our own attendances at the Residential Tenancies Tribunal, there will still be instances where a person with a mental illness is in the process of rendering himself or herself homeless for failure to meet their obligations as a tenant. Addressing that small number of people is a very difficult job. It is very labour intensive for ACT Housing, for Mental Health ACT and, quite often, for the Public Advocate.

THE CHAIR: A slightly different issue that was raised by the immediately preceding witness is the issue of training in awareness of mental health issues and identifying people. Do you have a comment to make about that in terms of other organisations, both within the community sector and the ACT public service?

Ms Phillips: I do not know if it is so much a lack of training. It is certainly a lack of resources for the sorts of people that Mr Martin has been talking about. We need more case managers in the community to be able to monitor so that these people do not get themselves into the difficulties they do. One of the outcomes that he referred to is that people end up living in squalor.

It takes a long time to get to that stage and we would hope that there are case managers in the community who are monitoring people with a mental illness so that they do not get to that situation. But, in our experience, and with some cases we have been dealing with recently, that does not happen. These people, as Mr Martin said, just do not come up on the radar. Initially they are not at risk of harm to themselves or to the community, but then they end up living in a situation where they are.

The department of housing probably could usefully have some training in dealing with people with a mental illness. I suppose it is a community awareness, too, of how to deal with people who might be at times not suffering from a particularly difficult period or a psychotic period but who are just manifesting a little bit of odd behaviour as much as it is dealing with those who are in desperate need of treatment.

MS BURKE: Do I have time for a question?

THE CHAIR: Yes, you do.

MRS BURKE: Thank you, Chair. I am interested in the MAP project, the management assessment panel, on page 4. Obviously you are the guardian of last resort. I was very interested to read about the functions of your role, for example, in making substitute decisions. Can you see that working outside the Office of the Community Advocate? I just had a thought. If you have got that working well, would that model be easily replicated elsewhere? We have had a lot of discussion this morning about lack of

communication or people not coming together. How would you see that working?

Ms Phillips: Well, as it happens, prior to becoming the Acting Deputy Public Advocate, Mr Martin was the executive officer for the MAP, so he would certainly be the most appropriate one to answer your question.

Mr Martin: I am happy to do it. With respect to how the management assessment panel takes on its coordinating role in the Public Advocate's Office, our experience is that quite often the missing pieces of information are around knowledge of what services are available, both government and non-government, how the agencies approaching us should be approaching those services and how they better need to make their case.

I think that sometimes, although people may have made referrals to different agencies, they have not pushed those referrals or sought out additional support services. I am part of the working group for complex needs, which is seeking to spread the message, if I can use that term, within ACT government and non-government service providers so that senior managers and managers can more readily approach other agencies at different levels to improve the outcomes for different clients through collaboration and cooperation. So that is an effort that is going on right now. The process is still in its early stages, but the intention is to improve the outcomes for clients specifically with complex needs.

MS BURKE: I was just thinking of working smarter, not harder, and as you have already got something up and running—

Ms Phillips: To clarify that, their clients or people with complex needs are not necessarily our clients.

MS BURKE: I understand.

Ms Phillips: These are, as you mention, people in the community who might be identified by an agency or by the hospital or by some other organisation or by the family themselves as people who need help, and then the MAP team can come together.

MS BURKE: Yes. Thank you for that.

THE CHAIR: Thank you very much for your attendance today. We will be in contact with you with the transcript, which you can check for accuracy. If we have any further questions once we have actually had a look at the submission we will contact you. We will also keep you informed of the committee's progress with the inquiry. Thank you also, Ms Phillips, for coming along with us some time last year.

Ms Phillips: Thank you. Thank you very much for that opportunity, it was wonderful to be able to do that.

MARY GAYS,

JUDITH MARY BENTLEY and

JENNY WHITE

were called.

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

Ms Gays: Yes.

THE CHAIR: If you could start by stating your names and the capacity in which you are appearing today.

Ms Gays: My name is Mary Gays. I am the Executive Officer of the Mental Health Foundation.

Ms Bentley: I am Judy Bentley. I am a member of the Mental Health Carers Network and the Mental Health Community Coalition. I am here to support the Mental Health Foundation.

Ms White: I am Jenny White and I am a member of the ACT carers and also the ACT carers network.

THE CHAIR: Thank you very much for your attendance today and thank you also for the submission which you put in last year. It seems like a long time ago now. Would you like to start by making an opening statement?

Ms Gays: Thank you very much. Thank you for this opportunity. It is really great that mental illness and housing have been recognised by the ACT government as a really important issue to have a committee on. I would like to talk about a couple of things from my perspective as part of a small community organisation. We have one housing program, called Friendship House. It is long-term supported accommodation, and long-term to us means permanent.

We are under pressure because there is such a need within the community to get people in and get people out, whereas we really believe there is nowhere else for these people to go to. So long-term to us means permanent. We only receive a small amount of funding under a government contract with Mental Health ACT, so we provide low levels of support. An accommodation program providing low levels of support is really crucial and it is needed as well as more support or crisis intervention and different models.

One of the issues that we faced within the past year was that one of our tenants was

particularly unwell and needed to go to hospital. Initially, he went to PSU and he eventually ended up in Brian Hennessy House, a rehabilitation place at Calvary. While people are in Brian Hennessy, their rent is not paid. While people are in hospital, their rent is paid. So our community organisation had to pick up his rent and his household bills. We do not get a huge amount of money for that program anyway, so for us it is a huge issue.

We are not talking of hundreds and hundreds of thousands of dollars; we are talking of small amounts of money, but for us it is an issue. The house that he lived in we lease from an organisation called Barton Housing Cooperative and we managed to negotiate with them that the rent would be \$5 a week, the same as what Housing ACT do if we are supporting people in group homes. But then we had to pick up the household bills because the other two residents that he was living with also have a mental illness and we couldn't pass those costs on to them. The Friendship House program that we run lost money last year and then we have to take that out of other programs, because that is the only way we get money, or we have to fund raise for it ourselves. That, to us, was a significant impact.

Jenny would like to talk about the need for aged care, living with a mental illness and having suitable accommodation for aged care. The Friendship House program looks after seven residents in two three-bedroom houses and a unit, a flat. These are people that have all been through the system for quite a number of years and they are essentially all in their 50s. They are all getting more ill. They are all men living with schizophrenia. They are now very overweight, and so all of their health is slowly deteriorating. We know that we won't be able to support them forever, so we have decided to put all their names down to look for aged care and then in 10 years maybe they will be at the top of the list. So lots of forward planning, because we know when we get there then potentially it would be hard, although I have also heard stories from people that people living with schizophrenia get to the top of the aged care list and, because it is schizophrenia, they are knocked off again because there are easier people to house. That is anecdotal evidence that I have heard from different people. So we will face that when we come to it in 10 years.

Ms Bentley: I am totally disorganised, having tried to print out a statement this morning. I don't know what I pressed, but I pressed the wrong button and it turned into little squares across the page. If you want a statement, I would be happy to try to retrieve it and send it in. It was a personal statement. I have got a son who is now aged 24. When he was 20 and halfway through a chef apprenticeship, he became mentally unwell, quite seriously. It ended up with him making a violent attack on me. We had to get him taken into the PSU as an involuntary patient.

They wanted to discharge him the next day, even though he hadn't been properly assessed. We had to fight that battle and insist that he was very unwell. We were able to get a mental health treatment order. He was in there for about three weeks. We were asked to take him back home and we said, "Look, he doesn't seem well." They agreed that he was not well, but said, "We need the bed. Will you take him home?" I feel very uneasy about that. Part of his psychosis means that he does not recognise me as his mother and he thinks that I am trying to harm him. It is a dangerous situation.

There was nowhere for him to go. The social worker at the hospital tried to find

accommodation. There was nowhere in Canberra in 2001. In that year, and towards the end of 2002, as a member of the Mental Health Carers Network, we did a survey of all the supported accommodation services in Canberra to say, “Would you have accommodation available for somebody exiting a psychiatric facility and in need of accommodation?” In 2001 and 2002 there was not one bed available in Canberra for anyone leaving a psychiatric institution and in need of accommodation.

I do not think that the situation is much better. Our son has had three psychotic episodes. The situation has been the same each time. When he becomes sick, he becomes more violent. He is not violent to other members of the community, but he is to me. After his second discharge, because we could not get accommodation, he left Canberra and drove to Adelaide, which was quite a dangerous situation in itself. He thought that Adelaide would be better—we have family over there—but, of course, he couldn’t manage.

As soon as he left the ACT, his treatment order stopped. At that stage it did not cross borders. He left the treatment scene, he was not supported in any way, and he became sick and had to come back. Again, no accommodation. My eldest son, who had an old house that he was using as a studio, agreed that our son would live there. It ended up with our son deteriorating again because he was not getting adequate treatment. He damaged the premises to the tune of about \$23,000 or \$24,000 because he believed that there were evil spirits coming through the walls. They were asbestos walls. He has ended up with severe physical damage to his body.

There are two problems here. One is not having accommodation that is supported, where he can be kept an eye on, and just treatment. With treatment, with proper care, I believe that he could get back to being a useful member of society, as we judge it, to get off benefits, to get a job. He wants to work; he was halfway through his chef apprenticeship. We are left in an awful situation. Our eldest son is left with a bill of \$25,000, which he cannot claim from insurance because the insurance company is saying that my son took him back voluntarily, even though he knew he was mentally unwell. That is a battle they are fighting with the NRMA, which seems terribly wrong.

Our son, after his last discharge, was put into accommodation at Waramanga run by mental health services. He was there for three months, although it was supposed to be temporary until they were able to find him somewhere to live. He got behind in his rent—they weren’t taking it out of his benefits—and he was ejected, evicted, one night in June, at 4 o’clock in the afternoon when most services were closed. He went and slept in his car for three nights.

I think this is a terrible situation. If we have people who are physically unwell, if they have heart disease, cancer or whatever, we do not evict them without supported accommodation. I think it is terrible that we are doing this to people who have mental illness. After a few nights in his car, he was able to get into the Ainslie Village, and that is working okay. It is not the place I want to see my 24-year-old son. He is not getting the support that he needs to get back into the work force, or into socialisation even, but we are grateful for a roof over his head and the fact that he may be getting a meal occasionally.

It is not a good situation. We wish it were better. We wish we could have supported accommodation, a house where he could perhaps learn to cook again, to live again, to

socialise again, but he needs assistance to do this. He needs somebody to walk alongside him, not all the time but some of it. I guess that is what I want to see. In our experience over nearly five years there has been one setback after another. A lot of the issues come back to safe and appropriate housing. I do not think that Ainslie Village really is providing that, but it is the best that we've got at this stage.

THE CHAIR: Thank you for that, Ms Bentley. If you could provide that statement to us it would be great; pass it on to the committee secretary.

Ms Bentley: Yes, I would be happy to.

Ms White: My story in lots of ways is similar to Judy's. My sister is 58 years of age. She has been a mental health patient in the ACT under city mental health for approximately 33 years. She has had huge family support through all of those years and for a good part until 2002, probably for a good 15 years, she was quite stable, living in a flat independently, on her own. However, she did have a major episode where she was hospitalised in 2002. She had a cardiac arrest at that time because she is epileptic as well. Following that time, she was returned to her flat because there were no other alternatives and, by nature, she is impossible for anyone to live with family-wise. There were certain situations she could cope with and manage quite well.

However, since then her health has deteriorated greatly. She had two ACAT assessments which both, a year apart, suggested she needed full-time hostel care. Following the last assessment, I was given an instruction to contact the Moreshead home at Lyneham. I think that mental health have 10 beds in that particular home that are accommodating mentally ill people. She was told that she would have to be fully self-sufficient. She could be secure there at night time, because she has no security at night because she thinks she will have a fit, have a heart attack and die.

However, when we contacted them for a placement, they said, "No. Firstly, she is 58 years of age. She has to be 65 to come in here and, yes, she does have to be fully supported." The ACAT had done the test. I skipped a bit there. The ACAT lady, having assessed her for full hostel care, then suggested that I try this place where she had to be fully independent, which I thought sounded a bit strange.

The mental health aged care team then just flatly said, "No, we can't accommodate her here. You will just have to register her as a hostel patient or nursing home patient, put her name on the list and wait for something to come up." She is 58 years of age and she is not going to fit into the everyday hostel situation because she is going to have mental problems that will affect the elderly who need the care, as we know, in these normal nursing home or hostel situations.

So, following through from that, further advice through doctors led me to the Ainslie Village last week. My sister had experience in Kenmore, where, after three years, she returned to Canberra. She went to Watson hostel and she had a really reasonable placement in Watson hostel until she was accommodated in her own flat. Prior to that, coming back from Kenmore, she went to Ainslie Village, which was absolutely horrendous because it is a man thing and for her it was just a nightmare. Where did I have her? Yes, Kenmore, then to Ainslie Village, then to Watson hostel. I believe that was the sort of place that she required and there were people there even then at her age

now, and she was quite young, as I have said, in those days, but I know they did have lots of people who were of the age she is now. We no longer have Watson hostel.

So, investigating Ainslie Village last week, I pricked up my ears and said to the person in ACT Health that I dealt with, who has an involvement with the better mental health project that is going on at the moment, “I don’t really think that’s going to be the answer. Ainslie Village? You’re telling me to go to Ainslie Village?” She said, “Yes, the lodge at Ainslie Village. Go and suss it out. Don’t be negative about it. Go and talk to the people, see what they say.”

I have a friend in church who lives in the lodge. He is a gentleman in a wheelchair. He is quite normal. He has all his faculties. He has lost a leg and he is homeless, basically, so he lives in the lodge. They have recently been trying to remove this person from the lodge to a normal nursing hostel because, as I understood it through my minister at church, they are trying to turn the lodge into a mental health facility for aged care consumers. So I thought, “Okay, Charlie is going to have to come out of there. Okay, I won’t be negative. I will go and talk to them and find out what is going on. It might be a bit longer down the track, but if that is going to happen, that will be great.”

Last week, I spent a couple of hours talking to staff at the lodge, who said, “Why were you sent to us? That’s ridiculous. Here is our brochure. It is for men between the ages of 18 and 65. You can see for yourself looking around this lounge room the types of men we have got here. They are all homeless. They have got mental health issues, yes. We have been campaigning for years to get a facility like this for women in your sister’s situation and it hasn’t happened, and you are telling us that they told you that they are about to oust the person that you know to make it a mental health facility for aged care. Well, you are telling us something we didn’t know.”

As I said to Mary and Judy, I am on the campaign trail now because of how I feel. Our whole family have talked to doctors, we have talked to psychiatrists, we have talked to the justice system. My sister has had Mental Health Tribunal orders. I have talked to everybody and everybody passes the buck and we get to the end of the conversation with me saying, “I’m really sorry, I know you are underresourced. I do appreciate your side of it as well.” But I am nearly a mental case myself because I am trying to find an avenue for my sister and all my other friends and family that I know. In my own family alone we have epilepsy, we have obsessive compulsive, we have got just the general psychotic kid, and my sister is bipolar.

With all of that, I have been involved with lots of avenues where people are dealing with similar issues to Judy’s and my own, and now we are getting to the stage, as Mary said, that these people are all ageing and people are turning their heads. We have got no more Watson hostels. The village, I know, are doing their best and Anglicare are doing their best, as are Friendship House and Hennessey House. All these people are doing their best for the ones that they have got in their immediate care, but what about the new ones coming on board? Where are they going? They are all going to go through what I have gone through for 30 years, looking for appropriate places for my family, and it is not good and it has not been good.

I did mention it to a member of the Assembly at a childcare meeting over at Parliament House. I thought that it was my chance to say, “What about mental health?”

What are you doing about that?” He said, “Don’t talk to me about that,” and just walked off. I thought, “Wow, he didn’t like me saying that.” And why would he? Why would he like me saying it, because no one has got any answers? I just said to Mary and Judy— shut me up if I am going on for too long or too much—“I have come back on deck. I’ve finished work now and I want to follow this through and I want to help wherever I can and be part of anything I can in terms of foundations or networks to get something on the run.”

But we have got so many: we have got carers, we have got a carers network, we have got a mental health foundation, a million others, all these places. Why aren’t they all under one umbrella? City mental health say that they can’t deal with it and you have to go to Gungahlin or Belconnen. There are all these people. Over 30 years, we have had the run-around so many times. My brother had a stroke last week and he is my sister’s first carer and I am her second carer. Recently, I got to the stage where I had to go to the doctor and get antidepressants. I said to the psychiatrist at city mental health who was dealing with my sister, “I think I’m going mad, too, so soon you are going to have another placement to make.”

That is what it is like and I am not alone. I know I have got friends out there. Judy has just told me that she is at that point, too. My minister at church has a son in a very similar situation to Judy’s at the moment. He is homeless right now. He is having a psychotic episode in hospital. He has sisters who have taken out violence orders against him, his mother has been hit in the jaw and knocked silly and she is saying, “Jenny, where can I go? Can you give me a name, someone who’ll help me?” Sorry, but that’s how it is for us.

THE CHAIR: I will stop you at that point and, because of the time, rather than us putting questions to you which you would not be able to answer properly, I suggest to the committee that any questions be put in writing to you. Thank you very much for your appearance here today. We do appreciate your taking the time. We will send you a transcript of today’s proceedings so that you can check it for accuracy and check that you have not been misreported terribly. Also, we will get in contact with you if we do have further questions and we will also keep you informed about the committee’s progress with the inquiry. Judy and Jenny, you have given us very personal accounts. We do appreciate that you and many others experience those things on a daily basis and I think I am speaking for all members of the committee when I say that it is the hope of the committee that we will be able to provide some direction to the government in terms of a way forward with support for people who are in such situations.

The committee adjourned at 1.03 pm.