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, 22 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 10.32 am.

DR PEGGY BROWN,

MS KAREN LENIHAN,

MS LINDA TROMPF and

MS AMANDA URBANC were called.

THE CHAIR: Good morning everyone. 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. Please start by stating your names and the capacities in which you appear.

Dr Brown: Dr Peggy Brown. I am the Director of Mental Health and Chief Psychiatrist for the ACT.

Ms Lenihan: My name is Karen Lenihan. I am the Director of the Alcohol and Drug program for ACT Health.

Ms Trompf: My name is Linda Trompf. I am the Manager of the Mental Health Policy Unit in ACT Health.

Ms Urbanc: My name is Amanda Urbanc. I am the Director of Rehabilitation and Older Persons Mental Health Services.

THE CHAIR: I'd like to start by thanking you all for making yourselves available to appear today. Dr Brown and Ms Urbanc, who were here previously, know that we had the department of housing before us earlier but we wanted to get a perspective from the mental health side of the equation. Would you like to start by making an opening statement or any opening comments before we start asking questions?

Dr Brown: I don't know if we have anything in particular. We didn't make a submission to the standing committee. We will be happy just to take questions.

THE CHAIR: One question which has been at the front of my mind—I don't know about my colleagues—concerns the relationship between Mental Health ACT and Housing ACT. Obviously you have a number of clients whom you deal with on a regular or irregular basis, depending on the client. Could you outline what contact you have with Housing ACT and any areas where you think there might be improvement, or areas they do well in.

Dr Brown: We have a relationship at two levels—first at the directorate or policy level. I believe we have an MOU with housing and we have some draft protocols around SAAP services. I believe the MOU is in the process of being reviewed. In addition to that level

of contact there is contact at the operational level around individual clients. ACT Housing has housing managers and we have clinical managers. Where there is a need, there is liaison around housing and accommodation issues. That extends on occasions to the housing managers attending clinical meetings, such as our clinical management planning forum where we discuss complex issues. In terms of supporting that MOU, there aren't regular meetings between the agencies at any set interval; they are on an ad hoc basis around issues as required. I am not clear whether the review of the MOU will set a process for regular meetings to support that MOU. We've included that in some of our other more recent MOUs but at present it isn't a requirement.

Ms Urbanc: I can confirm that it is part of the reviewed MOU. It is currently under one of the additions we put in.

Dr Brown: It is under development.

THE CHAIR: For how long have you had an MOU?

Dr Brown: The current one is over three years old, I believe.

Ms Trompf: Yes. The most recent one—the one that's currently being reviewed—was signed in 2003. I understand there was one prior to that.

THE CHAIR: You're looking to redo it—rejig it.

Ms Trompf: Yes.

THE CHAIR: Do you have any ideas as to what sorts of things you'll be looking to change in it?

Ms Urbanc: We were going to, I guess in principle, increase the whole social housing policy philosophy and target things like early debt, which could be an indicator to eventual eviction and having the housing support officers go in with our workers and work to plan how to resolve debt. We're also looking at formalising regional forums so there can be discussion around particular people who may be of issue within the regional area with their relevant clinical managers and the like. There's also the component around housing's agreement to waive ACT tenancy rents during recognised rehab programs, which include many mental health programs. Those are some of the broader issues being covered in the MOU. Most of the others we were quite happy with and there haven't been any major issues experienced throughout the duration of the current MOU. We're just strengthening some of those early warning sign issues.

MS PORTER: With regard to the review of the MOU, a number of witnesses raised the fact that that they believed there was inappropriate placement of people in housing. I was wondering whether, as part of your MOU, you might be considering a way in which you could be consulted about what might be appropriate for a particular person.

Ms Urbanc: Absolutely—and there is the question of whether people might be better housed in ground floor or multiple storey sorts of environments, in respect of their age and their social integration. We're trying to keep people connected with the community. That is one of the principles that have definitely been incorporated into it.

Dr Brown: To clarify that, we would provide input on clients who had a relationship with Mental Health ACT.

MS PORTER: I imagine you would have some more generic discussions when you have meetings from time to time about the kinds of support that might be appropriate for people with mental illness, but they would be more generic discussions. I was thinking more of the specifics around certain individuals or families. On the generic point, in Minister Hargreaves's submission he talks about a number of different options that are available. Part of the mental health strategy and action plan says that appropriate accommodation options should be provided. I was wondering, given the options that have been quoted in Minister Hargreaves's submission, whether or not you believe there are enough options available to people to select from. The submission talks about 30 medium to long-term rehab places, 65 group places, 18 respite places and 100 outreach places. I don't know whether you have had time to think about it, but would you think that that would be an adequate supply for the numbers of people you would see who are needing to be placed?

Dr Brown: This is not a question we have discussed as a group but I can give you my personal opinion. No. I don't believe that is an adequate number as yet to meet the needs of the population of the ACT. I need to qualify that by saying that I am thinking about the need to provide a range of accommodation to meet the social and treatment needs of people with mental illness in the territory. I personally believe we are probably talking more in the order of 400 or 500 as an overall requirement. That's a mixture of services that would be provided in part by health, in part by housing and in part by some of our community agencies—obviously funded by one of the government agencies. That is purely a personal opinion. I am not sure whether anyone else has any other comments.

Ms Urbanc: No. I would be in agreement with Dr Brown.

MS PORTER: Many witnesses talked about some form of sub-acute care, which I guess would be provided through mental health. Not only would this perhaps assist in keeping a person out of acute care but it would also provide a place for them to go, if necessary.

Ms Trompf: Dr Brown talks about the range of services, and we are talking about those sorts of levels as well.

MS PORTER: A step-up, step-down kind of thing.

Ms Trompf: Yes. We are about to go out to tender to have somebody develop a mental health services plan for the ACT and look at the range of services we need to provide. That will be happening over the next few months and will include looking at the range of accommodation options we might need. Through a step-up, step-down approach it will look at all those sorts of things including specialist services and the other support and accommodation options we need to look at.

Dr Brown: I have to say that, in stating those figures, there is no best practice anywhere that you will find in the international mental health literature around exactly what sorts of numbers you require to service a population. My estimates are based on a mixture of figures taken, for example, from the NHS in England and also from some more recent

studies like the Tolkien report done by Professor Gavin Andrews in Sydney. I have taken a bit from each of those to look at what you need in both the treatment setting and then more in the supported community setting. I think it is well above what any jurisdiction in Australia would have at the moment, and probably internationally as well. We also know that most jurisdictions are struggling with this issue.

THE CHAIR: You mentioned the mental health services plan. In earlier evidence Sebastian Rosenberg made the following comment:

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

Do you want to make a comment about that statement?

Dr Brown: I think that, in some ways, that comment is not unfair. There was discussion and there were plans to look at capital works needs. The push to develop the mental health services plan in that broader picture is something I have driven in large part since I arrived in the ACT. There is no question that we need to look at the broader range of needs, so we have articulated the whole spectrum of care but that does not necessarily take away from the need to have those capital works there. The planning for that has been done on an epidemiological model, so I think there is a good evidence base to support that. At one level I think there is something in it when people say we have put the cart before the horse in doing the capital works program, but I do not think that is an entirely fair comment. You can do that, still put it in the full context and have a reasonable outcome. I do not think the capital works planning that has occurred is in any way going to bias the broader mental health services plan.

THE CHAIR: I suppose there is an issue, though, as to how you find the balance between providing the acute services and providing the services to try and stop people ending up in the acute services—reducing the numbers of people ending up in acute services but then leaving acute services when they are not fully well. Obviously people with a physical condition also leave hospital not fully well and go home to recuperate. A question which is being asked by people within the mental health community and by observers of the mental health community who have an interest is: are we releasing people too early? I am making a statement. I am rambling at length here but the question behind it is how do we move from having a focus which seems to be primarily if not solely based on the acute end of the spectrum to one which tries to take it to a more intermediate end so we are providing that support to people when they need it?

Dr Brown: That is clearly what we would like to achieve. In respect of the question of whether people are being discharged too early, I would say two things. One is that our clinicians work very hard to identify the goals of an admission, on the basis that an inpatient admission should value add to what care can be given in the community. Then they attempt to put in place a management plan that works towards achieving those goals. Discharge should be shaped by the assessment of mental status, risk and

achievement of those goals. Having said that, I cannot deny that the pressure on our in-patient unit is enormous. Currently PSU has an occupancy rate of around 98 per cent, which is higher than you would aim to run any hospital facility. There is pressure on our beds.

It is clearly part of our overall goal to work towards having something that can intervene earlier—prior to hospitalisation—where we can put in place a range of supports and interventions that would prevent the need for acute hospitalisation. That might be in a designated facility and it might be in a greater intensity than we can supply in the person's own home or in some other environment. The way to start with that is to have some models and then, obviously, achieve the funding and staffing for that. That is the intention behind having a mental health services plan that articulates what we want. The next level question is: who is best placed to provide that range of services? Is it the public sector mental health services, is it the private sector, is it the NGOs et cetera? Underpinning that is the question: what is the skill base you require to deliver those services and, hence, what work force is required in each of those sectors?

THE CHAIR: You have talked about models. Has mental health had the opportunity to look at and possibly evaluate the model that is used in Trieste in Italy, which the committee has been informed about? Trieste is just one example of the models used in Italy. As I understand it, they have a different overall focus, taking it away from the acute end. In Trieste there has been a significant reduction in the number of people who end up in acute facilities since I think the early 1970s. Alternatively, there is the housing and accommodation support initiative, or HASI, in New South Wales. Do you think either of those models is appropriate for the ACT? Would you care to comment on that?

Dr Brown: I will speak first and my colleagues may wish to comment as well. Personally, I have not been to Trieste. I have been informed about the programs there and I have to say one hears mixed accounts of their success. Some people will speak of it in glowing terms and others will tell you of their experience of going to dark rooms with a whole heap of people with schizophrenia all closeted in one room during daylight hours with not a lot of therapeutic input occurring. I am not entirely sure whom to believe, but I am quite happy to go to Trieste to investigate.

Ms Trompf: We'll all go to Trieste and have a look!

Dr Brown: In fact, I would take some colleagues just to verify my observations.

MS PORTER: We'll go first.

Dr Brown: I am less familiar with the HASI initiatives in our neighbouring state. As a general comment, however, I think the aim of those programs is to look more at moving away from institutional-based care and create opportunities in the community. I have absolutely no doubt that overall that is the way in which we should move. Having said that, my experience in Queensland, where we did a lot of redevelopment of mental health services, clearly leads me to the opinion that there are some individuals for whom institutional-based care has to be the option. Not only is some of that in the acute sector care where they need close proximity to medical services, emergency departments, et cetera but it is also for some people with chronic illnesses who need long-term support and treatment.

In Queensland we had a range of options. We had campus-based facilities and also some community care facilities, which are essentially units built in the community which look like a block of townhouses, for example. They worked very well for the majority of people but without any doubt there were some people for whom they did not work and were not a good option. So I am firmly of the belief that you need a full range of options. The difficulty for ACT is the economy of scale issue. My colleagues may wish to make some other comments about Trieste or the HASI.

Ms Urbanc: I do not know either of them well enough to comment, I am afraid.

Ms Trompf: The HASI model has certainly been discussed at the national level, and I think there are some strengths to that model. I think there are also some similarities between the model and the current arrangements, although they are not formalised in such a discrete way as the HASI project. We have similar arrangements between housing, an NGO and mental health. That is basically what the HASI project is about but they have put some really discrete boundaries around that. I certainly think it is a model we can look at for the ACT. As Peggy says, we are happy to go to Trieste and look at that as well.

MS BURKE: Mine is a broad and far-reaching question which I understand may need to be taken on notice. The government made comment on the funding levels you received in 2005-06, being $47.58 million. Dr Brown, have you any breakdown of that figure as to what we are purchasing for that amount of money? If you don't have that now, I would be happy to take it on notice.

Dr Brown: We could certainly provide you with more detail on notice.

MS BURKE: That would be helpful. Thank you.

Dr Brown: In essence, around $12 million goes to our community agencies.

Ms Trompf: NGOs. No, it is around $5 million.

MS BURKE: That is probably not for the public record. If you wanted to present some figures, that would be helpful.

Dr Brown: We will take that on notice.

MS BURKE: All right. I just wondered—and you alluded to this earlier—if you could give us a walk-through. Once a consumer or client accesses mental health services through ACT Mental Health, what happens to that person?

Dr Brown: That very much depends on the nature of the person's problem and their age range. If we're talking about an adult, there are a couple of ways in which they would present. They may present via the emergency department or they may present to their GP, who then requests input. Currently we have a centralised triage and intake process. From there an assessment is made about the urgency of response. We have five different categories of response. If a response is required urgently, then it would usually be up to the crisis assessment treatment team to effect a response. If, however, it is not required

within a 24-hour time frame then it is referred out to one of our regional mental health teams. They will make an assessment as to whether or not that individual meets the criteria for case management. Contact is then made with the individual and the referrer to make appointments and further ascertain need et cetera. The management from there depends on the outcome of the further contact and assessment that is done.

MS BURKE: From that point, you hand them over to various other organisations. Is that the procedure?

Dr Brown: No. We have four adult regional mental health teams. If, in fact, they do not accept that individual for ongoing care, then a referral may be made elsewhere—to another agency, back to the GP et cetera. It depends very much on the nature of the individual's problems. In any month approximately 10 per cent of the clients who are registered with Mental Health ACT are new clients, so we have quite a significant volume of new contacts each month.

MS BURKE: Thank you. On a slightly different issue—and it may very well be that you do not have the ability to comment—we have heard from a few witnesses about turnover of staff within Housing ACT and the lack of understanding of people within that department of people with mental health illness. Can you make comment about any collaboration that has been done? Is there anything we might look to do in the future for people who work within housing who have regular contact with people with mental illness in respect of ways of identifying and dealing with people with mental illness?

Dr Brown: I certainly couldn't comment about the turnover within housing. Within the strategy and action plan for mental health in the ACT, there has been identification of the need for education packages to enhance understanding about mental illness and, more specifically, around treatment approaches to a number of identified groups. Housing would be one of those groups. In fact, we currently have officers working on the development of those education modules. For example, we have identified housing, teachers and a range of others as being potential recipients of those education modules. So we are working on that. I am not sure whether reference is made to it in the revised MOU. Amanda, are you able to speak to that?

Ms Urbanc: Quite honestly, I can't recall whether that was part of the discussion we had about a month ago but it can definitely be included. It is in build-up form at the moment, so it would definitely go into that.

Dr Brown: Regarding the education modules we have been talking about, some of the content of the fact sheets around mental illness, for example, is generic for workers in general and some of it is targeted to the specific sector agencies we identify which need it. I can't speak of what has been developed for housing specifically because I am not sure where it is at, but certainly that concept is in development.

Ms Trompf: The Mental Health ACT community education officer also does provide sessions for a range of agencies and I know she has done a number of programs with housing staff. So that happens as well. The team leader of the crisis team has provided some sessions for housing staff as well. We do try to hook them in. Also—a discussion I had with our education staff development officer this morning, Peggy; so I am not sure if you are aware of that—with the mental health core education training program, we are

starting to make that more available to people outside of Mental Health ACT, people within other areas of ACT Health and other agencies as well who might benefit from some of the programs that we run around suicide prevention and the identification of risk, those sorts of things. So we are starting to do more in those areas.

THE CHAIR: Do you do any of that with organisations such as Mental Illness Education ACT, MIEACT?

Ms Trompf: Yes. Mental health staff have worked with staff from MIEACT and MIEACT, obviously, work closely with education as well.

THE CHAIR: MIEACT indicated to me more than 12 months ago that they are feeling pressure in terms of having lots of organisations approaching them and saying, "We have heard about the service that you provide where you go out to schools. Would you be able to come out to our organisation as well and speak to us about mental illness, because we have an issue and we would like to be able to know how to address it?" They are saying that they cannot necessarily keep up with the requests for those services, given that they have a number of people who are doing it on a volunteer basis. That was just a statement.

MS PORTER: I have a question leading from what you were talking about. The government's submission talks about risks perceived by the public about people who have a mental illness and who may be living in their street, next door or in their community, that a person with a mental illness is living in their area. People imagine perhaps that such a person is a threat to them or their family. It talks about the fact that the data available shows that that is probably not a problem and that it is more a fear of the unknown than a fact, but we, as members, constantly have people contacting us to say that they have a neighbour or someone else in their street who is causing them distress or that they are fearful about.

We did hear from witnesses about discrimination that people with mental illness experience when living in the community, whether it is in a block of flats or in an ordinary house in an ordinary street. The submission talks about how Mental Health ACT actually provides funding to community groups to go out and provide education. We were just talking about MIEACT. What kinds of community groups are providing it or are you directly providing education to the public at large? It seems to me that it is not necessarily just young people at school or agencies per se, that it is the public at large that are having these issues about someone that lives in their street. When you have that misinformation out there, sometimes discrimination can occur without there being necessarily a problem.

Ms Trompf: If you are talking about major public awareness campaigns, we probably haven't run too many of those locally within the ACT, but the ACT does support beyondblue in their public awareness raising campaigns and has linked into some of the other national public awareness campaigns as well. We also try to do what we can in working with the media in regard to appropriate reporting of mental health issues. We try to work that way to address some of the stigma. I do not think any of us would disagree with you about the level of stigma that still exists and a lot of that is around a lack of understanding of what mental illness is. We know we need to continue to work on that.

We do work through a number of community organisations. We have talked about

MIEACT. The VYNE program provides a lot of education and training and awareness raising in the community, the OzHelp Foundation as well and the Mental Health Foundation. All of them are doing mental health promoting awareness raising programs as well. As well, beyondblue, and we have participated in this, are disseminating a program to provide sessions in the workplace to raise people's awareness about mental health issues and also about how we might have mentally healthier workplaces.

We are involved in a number of ways, but, if you are talking about major media campaigns, we have not done a lot of that, although we have worked with ACT Health's health promotion unit and their vitality program, which has been an initiative that they have had running for a few years and is around the issue of the linkages between physical health and mental health and to actually stimulate some discussion around those issues more broadly as well. I don't know if that answers your question.

MS PORTER: Yes.

THE CHAIR: It is something which we know will be ongoing generally. There was somebody from beyondblue talking on one of the radio stations yesterday about a suicide prevention program which they ran in Gunning or Collector.

Dr Brown: Gunning.

THE CHAIR: They had 100 people turn up out of a population of 600, which they were amazed at because there was the comment that it has been only in the last couple of years that you could even refer to something as being mental illness awareness as opposed to having to adopt a more euphemistic nature, such as saying, "Are you feeling a bit down, mate? Do you want to come and have a chat over a cup of tea?" There is within society more awareness that there is an issue out there.

Ms Trompf: The beyondblue-Rotary mental health safari last year travelled all around Australia and they attracted very big groups of people everywhere they went. I think all of those sorts of initiatives do help to raise awareness and increase the understanding of mental health, but also encourage people to actually seek help, which is the other big thing, particularly in rural areas, where it is not seen as the done thing to seek help if you need it.

THE CHAIR: It is just a totally peripheral issue and I will pass back to my colleagues in a second, but do beyondblue just deal with depression or do they deal with other mental illnesses?

Dr Brown: Their brief is the national depression initiative, so their focus is on depression.

Ms Trompf: Depression and anxiety. They have hooked it up with anxiety, but certainly their focus is on depression and anxiety, the high prevalence of those sorts of things.

MS PORTER: I think that people are starting to understand a little bit more about depression, but I think it is the other kinds of mental illnesses that people are more afraid of than they are afraid of someone who identifies or might show the symptoms of depression.

Ms Trompf: That is true.

MRS BURKE: I guess I have an ongoing uncomfortableness, if I can put it that way, with the Privacy Act in relation to people with a mental health problem. The Privacy Act obviously does not allow Housing ACT to contact support agencies unless the client gives permission—I am preaching to the converted now—or there is a health and safety risk. The concerns I have, I guess, are with the interplay between the three acts—the Privacy Act, the, Mental Health (Treatment and Care) Act and the Residential Tenancies Act—and how they do not support interventions. I would just like your views on that. The Privacy Act is a massive problem in lots of ways. Protocols can be developed with families and carers, I appreciate, but I think that there is a very fine line that people like you and people like Housing ACT staff, who are under great pressure, have to travel. What are your thoughts on all those things?

Dr Brown: I can only express a personal opinion here, but I guess that at one level I share your anxieties. I think it is a difficult course for workers to traverse. Essentially, the approach that we take is to share information within the treating team. The question is whether or not you can regard other supporting agencies as being encompassed within the treating team.

MRS BURKE: You would think so, if we are talking about an holistic approach to mental health, wouldn't you?

Dr Brown: Yes. I guess in practice what you will find is that people put their own interpretations on that and will do slightly different things. I think there would be potentially some benefit from the legislation being a bit more explicit in allowing that sharing of information which is critical for both agencies to do their job. But clearly it has to take account of the basic right to confidentiality and the need for that information sharing to be limited to only that which it is necessary to know to actually safely undertake the functions that you are doing, whether it is in housing or in anything else.

MRS BURKE: I do not think we would dispute that at all. I think confidentiality has to remain, but how do we weave through, for example, people going down a downward spiral into debt? I face all the time clients coming to me who have just gone there. It is nobody's fault; this is not finger pointing. It is just, I think, a glaring fault with the system we have that we are so rigid. There is no flexibility, it would seem.

Dr Brown: I think that the amendments to the Victorian act around the sharing of information give us something to look at, because they were a bit more explicit in providing for the sharing of information to carers and support agencies for the purposes of providing information that they need to be able to actually undertake that care and support. That does not speak to what is in the Residential Tenancies Act. I am not familiar with the provisions of that, but certainly from the health side I think that the Victorian legislation is more facilitating than ours.

Ms Trompf: Certainly, that is one of the areas that have been flagged as issues to be looked at very closely in the review of the Mental Health (Treatment and Care) Act which has just commenced. It is certainly an issue that has been raised and will be flagged for us to look at. Like Peggy, I am not familiar with the Residential Tenancies

Act, I am afraid, but it is something that we will be looking at in the review of the mental health act.

THE CHAIR: My question is a bit of a loaded question, I suppose, but I want to draw a few things out of it. Given that this inquiry is about appropriate housing for people living with mental illness, what do you believe to be the appropriate types of housing, that is, cluster housing or a boarding house? Does the ACT have the range of public-community housing needed, in the opinion of any of you? In the last lots of hearings, we heard from one group that there should be cluster housing, one-bedroom houses around a central courtyard where people can live on their own and speak to other people if they need to, and recently we heard from somebody who did not think that that was the way to go, who thought that a boarding house option was a better idea. It is a bit of a loaded, question, as I said, but if you could perhaps address it.

Dr Brown: This, in a sense, is almost going to pre-empt our mental health services plan; so you can pay me, Linda, instead of paying the consultants. I can give you a personal opinion. I think we need quite a large range. Going from the treatment sector, I think we need a step-up, step-down facility. I think we need acute inpatient facilities. I think we need rehabilitation facilities, some of which are geared more for a short term, relatively rapid throughput, others which are much more clearly slow stream or longer term. I think the majority of those we should aim to have in the community, but some I think actually need to be campus-based.

There are models for actually having consumer or, as they are called, peer-led services where former consumers of mental health services actually provide services and there are models from crisis teams to acute care facilities, step-up, step-down facilities, et cetera, so you could put that into the mix as well. In terms of accommodation in the community, I think that if you move away from 24-hour staffed facilities, which I would regard more as treatment facilities, to those facilities that are not 24-hour staffed you could have a range of options.

I think cluster housing does serve a purpose for some. I think that for some individuals there is a place for the old boarding house, if it is a well-established, well-run facility which isn't primarily motivated by the monetary interests of the owner. I think there is a place for that potentially as well because some people need and would prefer, in fact, a level of oversighting and assistance with things and just prefer to have their own room, but to have meals provided, for example.

Clearly, we need a range of housing options to be available for people who do not wish to be living in clusters, et cetera, so individual units or houses that meet their needs but still with support going in. I think the level of support may vary from anything up to daily or on-site for a certain number of hours a day to much less frequent contact, so it is a pretty broad spectrum.

Ms Trompf: I think I would support that. There are some people for whom I think cluster housing is a good model and for some it won't be. Certainly, we have had a fair bit of feedback recently to say the group home concept, while it can work for some, is not as effective for people living with a mental illness as it might be for people with physical disabilities. As to the issue of cluster-type houses or boarding houses where people have their own rooms, as Peggy says, I think we need a range of options and I

would not want to pre-empt the outcomes of our consultation around the service's planning by saying that we would go one way or the other. I think we probably need to look at them all.

Dr Brown: The other thing, of course, is that you need crisis and respite places as well. I guess we haven't really discussed those of our client group who also have substance use problems, and that is actually quite a significant percentage in this day and age.

THE CHAIR: I hear some of them do not see it as being a problem.

Dr Brown: Indeed, that is probably true, but from our perspective it remains a problem because it is a significant contributor to relapse.

THE CHAIR: That was a bit of a glib comment on my part.

Ms Urbanc: If I could just say in addition to the previous point, people with a mental illness have varying responses to the treatments and what they might require today could be quite different in a couple of years time throughout their process of recovery. So, while we might have the best range, we have also to enable mobility throughout that range of services because we do try to instil hope of recovery in our folk so that they actually are improving.

THE CHAIR: I think that is a very valid point. We heard from Jim Snow last week about his daughter Natasha's situation. She was on a new form of medication which was starting to work and, ironically, she felt incredibly lonely because she had been accompanied by these voices for half of her life and, in his words, she was having these imagined physical illnesses. She did have a physical illness. She had a hernia problem which needed to be operated on but she had all these other physical ailments which she was imagining, which she perceived that she had. She was despondent. My interpretation of what was said last week was that she felt that she was finally starting to come out of mental illness, but that she was going to be encumbered by all these physical illnesses for the rest of her life and she had no future.

MS PORTER: My question reflects somewhat on what you were just saying. It is about people who feel or believe or whose case manager believes they are now well. It is the aim that hopefully people living with mental illness will eventually get well and be able to live independently and quite happily, but a number of witnesses reported that when a person was perceived to have got well they suddenly found themselves without a case manager or someone that they could ring up or contact quickly if they needed somebody. So, when they contacted an organisation or when an organisation was aware that they needed somebody, there was no identifiable person that they could contact quickly.

Also, you were talking about the fact that some of these places where people might live may not need to have 24-hour care for seven days a week. Many of the not-for-profit organisations that run residential programs do not have staff on call for those particular times of the day. So, should a crisis occur, there is nobody to deal with somebody who presumably was well one day and not well the next and it appears that the CAT team may be so stretched that they just cannot get there, that they cannot respond. How are we going to manage the situation where people are deemed to be well and suddenly get unwell?

Dr Brown: Just as a starting point in responding to that, I guess we work more on the concept of recovery rather than wellness per se, and recovery does not necessarily mean the absence of symptoms. It is more an ability to manage one's own illness, albeit there may well be ongoing symptoms. In terms of responding to your question, the resources are limited, and the demand is quite large. So there is a need for throughput through the system, without doubt. A well-functioning mental health service would, I think, at the point of working towards discharge develop in collaboration with their client what you might call plans, relapse prevention plans and crisis plans.

The intent behind crisis plans is to develop some clear strategies or instructions on what to do in the event that you are becoming unwell. The relapse prevention is more around aiming to prevent becoming unwell. I hasten to add that some of our consumers don't like that terminology, but I will use it for the purpose of clarity today. A crisis plan may well talk about contacting the CAT team, but in certain circumstances it may be about contacting a GP and it may be about identifying other agencies that can be of assistance at the point of becoming unwell. They may be mental health-specific agencies; they may be more general agencies. They may simply just be community groups, church groups, identified mentors or supports, et cetera.

Ideally, that is what our service would have in place for every client that was being discharged. We would have a recovery plan that actually articulates those components quite clearly, the relapse prevention plan and the crisis plan. At the moment, I have to say to you that we do not have that for all of our clients. It is something that we are working towards developing.

MS PORTER: And what about people who are aged and are living within a residential complex that is specifically for older persons, a generic kind of complex? What services are provided by Mental Health ACT to those kinds of complexes to assist people who are residents of those kinds of complexes?

Dr Brown: Our older persons mental health team operate in the community and they have a well-established relationship with the majority of the nursing homes and hostels in the ACT. They provide a consultation liaison service to them with quite a rapid response time. They go in, make an assessment, provide assistance and support. It is generally for a time-limited period, but it varies depending on the needs of the individual. I think there is a high degree of satisfaction with that service on the whole. In addition to that, of course, if they are not available, then the crisis team is able to respond to calls of that sort as well.

Ms Urbanc: That team also does some longer-term clinical management for people who have been identified as having quite disabling illnesses. But they have also, at a second level, developed some training programs for aged care staff. Again, they are not highly sophisticated because we are not always talking about clinical nursing staff, but they are programs designed to increase their skills in managing people with mental illness. They have developed a number of modules that they are actually piloting in, I think, two or three of the nursing homes as we speak. The intent would be to evaluate that program and then roll it out across the ACT, with resources obviously needing to be considered. But education is quite a significant component of the role of that team.

THE CHAIR: We have talked quite a bit today about the mental health services plan and I have asked you lots of questions in pre-empting that. When is the plan likely to be finalised?

Ms Trompf: We are just finalising the request for tender at the moment. It has just been signed off. I am hoping that it will go out next week. We will allow people 30 days to put in tenders and then we hope to get a consultant on board fairly soon after that and the work started. We are actually hoping that we can get that done in about three or four months once we have got a consultant on board. We will be looking for a consultant who can actually dedicate enough resources to it to get it done in about three months.

THE CHAIR: Hopefully, they will have a report which will feed into it as well. That would be a good thing, I am sure. We might even give thought to getting you to come back once it is finalised and brief the committee on the mental health services plan. That would be a useful thing to do down the track.

MRS BURKE: I would like to move forward a little to something that perhaps Ms Lenihan can talk to us about, but also more broadly the forensic mental health issues. The government's report bears out that a disproportionate representation of people presenting with mental illness enter the judicial and corrective services systems. The government did a review in March 2004. My question to you is about the package of initiatives that the government announced from that. I understand that we are still going through to about 2007. In your view, is that working? Did the review achieve what it set out to achieve? Is it working in terms of improved options for accommodation particularly and support for those people? After all, this committee has heard that people are released from PSU or other forms of care and just placed into the most affordable accommodation, being public housing, which is a keen interest of mine. Aligned with that, Ms Lenihan, I would probably ask you what your program is actually doing to help facilitate some of the recovery or to work with some of those clients that have been taken out into the community.

Ms Lenihan: Can you just clarify that? Do you mean clients who have been through alcohol and drug program services?

MRS BURKE: Yes, and who have a mental health problem, because I am not quite sure of your role and how you dovetail into what is happening here today.

Ms Lenihan: Just to take a step back, we try to work very collaboratively with mental health services in terms of having a group of clients who have both ongoing alcohol and drug issues and a substantial mental illness. We try to work quite collaboratively across the two systems. Traditionally, it has been a system where people have fallen through the gaps to some degree. So we are trying to increase collaboration, increase on a service provision level some of that communication that needs to occur with individual clients and with our population generally. In terms of accommodation and in terms of following up and working with them on an ongoing basis, we do have case managers who work with the clients of our service and who will coordinate things like accommodation. At mental health, we do not have a memorandum of understanding with housing, but we do, as I said, work collaboratively with mental health services. So we will piggyback on that. We are a much small service, so we will piggyback on that.

In terms of this particular group of clients, there is a small group who are quite chaotic, who are quite mobile, who are problematic in terms of their drug use, and whom we do try to work with to stabilise but they can be quite difficult. I think that they are the clients who occasionally will present to the community as being quite aberrant or deviant in some way, and so will create some concern. I haven't got the exact figures, but they are not a very large group of people but they are a substantial group of people in terms of their needs base and their complexity.

MRS BURKE: Do you come across clients who are in this category of being in a forensic situation as well? Dr Brown, you may like to expand a little on the forensic side of it.

Dr Brown: In terms of the suite of measures that the government announced, my recollection is that there were four major components of that. One was around enhancement of the extended secure unit at Brian Hennessy. Certainly, since the works have occurred there and there has been closer liaison between that unit and the community forensic unit, that unit has dealt with a number of forensic clients, I think up to five or six.

Ms Urbanc: Up to seven; not all were within the ECU at the time.

Dr Brown: No, but substantial numbers, and I think it is doing a very good job with those particular clients. The second measure was around the development of a secure inpatient facility, and that work is proceeding, the planning and the capital works bid for that. We would dearly like to have a secure inpatient facility because the absence of it does create problems for us, without a doubt. The third initiative was around the enhancement of the community forensic team. The forensic mental health service has three components. They have a court assessment and liaison service. They have a detainee mental health service, which provides input as to people detained at the Belconnen and Symonston remand centres, and then there is the forensic outreach service, which is a community-based service.

They provide essentially a consultation liaison/co-clinical management model. If there is a client in the community with a forensic history and mental health problems, they are attached to one of our four adult regional teams, but the community forensic team comes in with their specialist forensic perspective and adds to the overall management planning. Just who takes the most prominent role will depend on an assessment of the client's individual needs. So it may well be that the community forensic team takes on the case management in the first instance and then transitions it to the regional mental health team. It may be the other way round, that we ask the regional mental health team to take on case management from the time someone is discharged, for example, or released from Belconnen remand, but just with support and back-up from community forensic.

The community forensic team has only been established for a short while and it is probably fair to say that there have been some teething problems in just firming up that model and how it is working, but I think that we are getting to a position of greater clarity around that. We have only just, in the last week, done up something to go out to all of our staff to try to enhance the understanding of that model and how it is working. But I think that is a valuable addition to what was available before and I am sure we can look forward to even better results as time goes on.

The fourth component, as I recall, was around training to agencies that are in contact with these individuals. Again, that initiative is ongoing, it starts off and builds. I know that some of that has been occurring through our community agencies and through the community forensic team in particular. They have taken a training perspective as part of their role.

MRS BURKE: Are human resources an issue for you in implementing that range of initiatives?

Dr Brown: The work force is always an issue for us. Certainly, when it comes to staffing a secure inpatient facility, we are going to have to look at recruitment issues from a very early stage. Again, I can speak to having been involved with this in Queensland, where we built an additional high-secure unit and two additional medium-secure units in provincial centres and then found ourselves having to staff them. It is a challenge, but it can be done. In terms of the community forensic team, they do have some vacancies from time to time, but on the whole it is seen as a reasonably attractive work option for many of our staff.

MRS BURKE: The government has spoken of the identification of improved options for accommodation. Do you see that happening in reality under the new initiatives?

Ms Trompf: From my perspective, I think that is something that has not been fully addressed. Some of those options will be through Housing ACT and some of them will be through community organisations or other providers. So, along with our exploration of a range of options more broadly, I think we do need to look at the range of options for these particular clients as well.

MS PORTER: My question is about the Maconochie centre. What liaison are you having as to these groups of people with regard to the Maconochie centre which is being planned at the moment?

Dr Brown: We have had significant input to the development of the health plan for the Maconochie centre, in conjunction with community health and the corrections health people there. Currently, the proposal is to continue to provide the equivalent, I guess, of the detainee mental health service, a service that actually reaches into the prison, as it does currently into the remand centres, and provides a range of treatments as required to inmates who remain in the prison setting or the remand setting, as may be.

In addition to that, there will be a crisis support unit which will be staffed by correctional staff but supported by the mental health staff. That will deal with people with acute behavioural disturbances for whom inpatient mental health treatment is not required. It has been identified that, where inpatient mental health treatment is required, that will be provided in a health facility off site from the prison and hence the need for progression on the secure inpatient facility.

MS PORTER: Currently, how are you working with, say, Goulburn, with regard to people who are about to be released from that facility back into the community and who may have an identified mental health issue? Do you liaise with Goulburn? Also, are you working—I presume you are—with our own youth corrections centre here for young

people?

Dr Brown: Yes. Indeed, we have two workers who are based at the Quamby youth detention centre as part of our child and adolescent mental health service. They are, as I say, part of a child and adolescent service, not part of the forensic team, but I guess there is some cross-fertilisation there. In regard to Goulburn, we do not have specific liaison with them; it is done on a case-by-case basis. If, for example, there is someone that comes from the ACT with whom we have had involvement and that we know has been sentenced to Goulburn, we will have liaison with the health authorities there. We ask always for liaison in return when there is an expectation about discharge planning or release planning. On some occasions that occurs and on some occasions it does not.

THE CHAIR: We will finish there. I thank you all for appearing. I think it has been very informative and valuable to have you here today. Thank you very much for making time available to the committee. We will provide you with a copy of the proof transcript, which we ask you to check for accuracy. We will also keep you informed of the progress of the inquiry. This was supposed to be our last public hearing today, but a few other people have come out of the woodwork and want to speak to us, so the committee will need to decide whether to have another hearing or two. We will certainly keep you informed of progress and let you know when we have a report to go. I hope that we will have something to feed into your plan.

Meeting adjourned from 11.42 am to 12.02 pm.

NICK STUPARICH and

BOB WILSON

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 both understand that?

Mr Stuparich: Yes.

Mr Wilson: Yes.

THE CHAIR: If I could ask you to state your names and the capacity in which you appear, for the record.

Mr Stuparich: I am Nick Stuparich. I am the president of the Social Justice Committee of the St Vincent de Paul Society for the Canberra-Goulburn Archdiocese.

Mr Wilson: I am Bob Wilson, chief executive officer for the St Vincent de Paul Society of the same archdiocese.

THE CHAIR: Thank you for your appearance today. Did you wish to make an opening statement?

Mr Stuparich: Yes. Our interest in appearing today is related to our involvement with disadvantaged people, people on low incomes, that the society visits and helps on a daily basis. Therefore, our focus on people with mental illness is on people with mental illness who are on low incomes. The first priority is the availability of housing for such people.

We have noted that, for people on Newstart and the minimum wage, in particular, there is no private rental housing available in the ACT, according to a study done by the Tenants Union of Victoria on rental housing affordability, so that people in this situation are dependent on the availability of public housing. Again we note that, from government publications such as information paper No 2 that they released at the time of the ACT ministerial housing summit, there is a long waiting list for public housing accommodation.

People in the out-of-turn category, for example, which is absolutely the highest category for assistance, have to wait something like six to seven months before being allocated accommodation. There are over 3,300 people on the waiting list altogether. People waiting for accommodation who are on the standard allocation categories need to wait up to three years. The point is that the availability of public housing in the ACT is obviously inadequate in terms of people having to wait for long periods before they can be

allocated a place.

At the same housing summit, another paper, information paper No 4, on financial viability, also related to the focus of public housing on people with greatest need. Eighty-eight per cent of the allocations during 2004-05 were for people of the highest priority. The corollary of that was that these people were receiving assistance with their rent and were receiving rebates, and therefore the income into housing had become lower from rental income.

The perspective on funding means that, because more housing is aimed at helping those in greatest need, the government is less and less able to afford to provide housing for them, which is a nonsensical situation. What we have put forward at the housing summit and what we put forward here is that what should happen is that the rental rebate should be quantified and should be shown as an expenditure out of the ACT budget and made available to Housing ACT as part of their income, so that public housing could be viable and could provide housing for all the people on the waiting list.

Obviously, that involves money—that is always a problem—but we consider that this is a question of setting priorities and that, if the ACT government or the ACT cannot provide housing for its people, this is an indictment of the government. This is a basic requirement and, therefore, should be a top priority and should be a higher priority than some other projects that have been pursued.

Also, we have noted that this type of arrangement, which is known as community-social obligation, is adopted in the case of public transport in the ACT and in the case of government utilities. So it is not a precedent and there is no reason why in principle it could not be carried out.

At the same time, another issue that we raised at the summit was the question of borrowing by ACT Housing on its asset base. It seems only fair that, if the government expects Housing ACT to operate as a commercial operation, it should be allowed to borrow. Private developers carrying out a similar activity would routinely borrow against their asset base to carry out those activities. Therefore, it seems only fair that that should be allowed. That should be looked at again.

Getting back to the question of people with mental illness, the most important factor after the issue of availability of housing is, in fact, the availability of adequate support. This has been very much lacking in the community. The recommendations of the Richmond report many years ago, closing down mental asylums, also included recommendations of community support. Those parts of the recommendations were really not adequately taken up, and this is an area that needs far more attention. In our daily visits, we come across a lot of people living in public housing who are really not able to look after themselves without a lot of support, and yet they are expected to.

The National Mental Health and Homelessness Advisory Committee of the St Vincent de Paul Society made a submission to the inquiry by the Senate Select Committee on Mental Health in June 2005. We have provided you with a copy of that. In that submission, the society made 15 recommendations, several of which referred to the need for accommodation. In particular, recommendation 8 talked about the establishment of a task force as a matter of urgency to investigate all aspects of the massive

accommodation crisis. It talked about the need for there to be a commitment to create at least 1,000 accommodation places nationally per year for the next five years. In recommendation 10, they talked about the establishment of asylums as secure retreats for people with a severe mental illness who cannot be cared for in the community. You can get more information by visiting the Vinnie's website as well.

You probably would have heard about this. The New South Wales government has a housing and accommodation support initiative, HASI, dealing with accommodation and support for the mentally ill. There has been an assessment of the initial operation of that program. We have also given you a report that was produced by the University of New South Wales on how that program is going. It seems to be a successful program. That program is done in cooperation between the New South Wales Department of Health, the Department of Housing, community housing providers and accommodation support providers and—what is it called?—the mental health clinical services. So it is a cooperative effort to provide support to, in this case, a hundred people of high need so that they could live successfully in the community. Most of the indicators show that it has been a successful program so far.

THE CHAIR: Thank you. Did you wish to add anything, Mr Wilson, or shall we go to questions?

Mr Wilson: Not at this stage, no. We will go to questions and answers now.

THE CHAIR: Thank you for providing your submission to the Senate inquiry. We will circulate that later and have a bit of a closer look at it. We might find, after looking at it, we need to get back in contact with you with some questions.

I asked this as a leading question of the previous witnesses who were from Mental Health ACT. Because you have talked about the need for more housing, and given that this inquiry is about appropriate housing for people living with mental illness, what do you believe to be the appropriate types of housing? Do you think it should be cluster housing or boarding house type arrangements? Do you believe that the ACT has the range of public-community housing that is needed at the moment?

Mr Wilson: My view is that it should not be boarding house type housing. It needs to be housing where people can live with some dignity and be able to access the support that is needed for them to live independently. So we need to have groups of houses similar to what we have, for example, in one of our services at St Judes. People that are living with mental illness are not all single people. Some of them have got families and children. Sometimes it is the children that have the mental illnesses. It is people like that that need to be housed independently, not clustered in a group and being identified as mentally ill.

Mr Stuparich: In the HASI project, they have tried different models. Some people are housed in units, and some people are housed in separate housing. They have also tried having a number of people with mental illness living in close proximity, the argument being that they can identify with one another's problems and it helps them to form a community. Others have been put out in the community, not together with others, and have been encouraged to take part in general community activities through the support services providing for activities, involvement and guidance. So there seem to be different models that are being tried out in New South Wales. But it certainly is clear that what

they are doing is independent housing, not putting people in a room in a house with other people with mental health problems.

Also, one of the findings was that, once people who were causing problems by being noisy or disruptive to the neighbourhood, and complaints had been received, were moved from a unit to a house, the problem disappeared. They are some observations.

THE CHAIR: I am unfamiliar with St Judes. I know that at least one other person on the committee is. Can you give us some information about your facility at St Judes?

Mr Wilson: It is a family support service. The ACT government 10 years ago gave us seven three-bedroom houses. They are located in Gordon. One of those houses acts as the office for the coordinator and the two case managers, and the other six houses house families independently. There are homeless families—husbands, wives, partners, wives and children—that are accommodated in each house. They are not sharing their accommodation with other families.

It is funded under SAAP, the Supported Accommodation Assistance Program. It has its problems in terms of people entering the service and agreeing to receive the support of the case managers. But once they get accommodated and have got a roof over their head, sometimes they refuse to accept that support. That creates problems because then we try to avoid just being a community housing project. We are a supported accommodation service. The people that come there have agreed to accept the support. Sometimes that support is very intrusive and they object to budgeting or disciplining their lives or things.

But for those families that have gone in there over the past 10 years and have accepted the support, there have been marked improvements in relationships with their children, relationships with their partners, and a general acceptance that they need to be part of the community. When they have left St Judes, they have gone out and accepted a bit of outreach support from that service as well. Those that have done that have done it very successfully.

THE CHAIR: How long do people stay at St Judes for, on average?

Mr Wilson: Up to 12 months they can stay. Some have stayed almost 18 months. Some have stayed six to 10 months.

THE CHAIR: And have you had people with mental illness staying there?

Mr Wilson: Yes.

THE CHAIR: Does the service that is provided end up liasing with mental health services?

Mr Wilson: They help the family to access the professional services—mental health, drug and alcohol support. We allow them to access all the outside support that we cannot provide and assist them in accessing that support.

THE CHAIR: How in-depth is that? Do you put them in contact with people in Mental Health or do you have meetings with people in mental health services?

Mr Wilson: The meetings take place with the family and the coordinator or the case manager of the service. Sometimes there is a case manager allocated by Mental Health or another organisation and there is a cooperative path that is followed that allows things to happen for that family.

THE CHAIR: I am conscious of the time so I will allow other members to ask questions.

MS PORTER: This is a quick question on cooperation between agencies—between yourselves and, say, Housing ACT or the department that you get your SAAP funding from or Mental Health ACT. Numbers of witnesses have expressed some disquiet about the difficulty they have with so many disparate groups providing so many different services, particularly in the community sector, and the flow of information that can be made available because of privacy and all those kinds of things. How are you able to cooperate with one another? Is that something that you find satisfactory between yourselves and, say, government departments and yourselves and other community organisations?

The second part of the question is: are the support workers available 24 hours a day, seven days a week? If not, when you need something in a hurry, perhaps on a weekend or an evening, how do you access that?

Mr Wilson: At our services where we provide accommodation—women's refuges, the men's shelter at Hackett, and St Judes—if there are any issues of privacy we always get the client to sign a form that allows us to pass on information to other people. That happens every day of the week with people in this situation. So I do not see that there are any particular problems that way.

Sometimes it is difficult to get the information back into the service. We have had situations where we have been providing assistance to someone and then found out that another organisation has been accessed by that family or that individual. Somewhere down the track, in an interview, that comes out. It has almost been counterproductive to what we have been doing within the service. So those issues have got to be addressed sometimes. I guess that gets around the privacy, confidentiality, problems that come about.

We had 24-hour services in Caroline Chisholm and Monica House women's refuges, but 18 months ago we restructured those two services because the government were not happy about the fact that, if you provide a 24-hour service, it is a big wage bill and a big draw on the money that is available to support the people that are living in the service. We restructured those services and went back to 9.00 to 5.00, with an on-call service afterwards. At St Judes, it also is 9.00 to 5.00, with an on-call service. People can access us if they need to after hours. At Hackett, where our men's shelter is, it is a 24-hour service. The men always are there and there is always someone on duty at that place. Is that okay?

MS PORTER: If you needed someone in a hurry, the CAT team for instance, what is your experience?

Mr Wilson: We have had responses. More at Hackett, we have had responses for that. With the men's shelter, Samaritan House, they have always responded quite well to us in that service. I am not aware that mental health has had to be called urgently in any of the other services.

MRS BURKE: Thank you for coming to see us today and presenting your case. In order to try to identify how big the problem is from your perspective as a community organisation and service provider, and what the solution or solutions may look like, away from the other practical things that you have suggested in regard to public housing per se, this puts more of an emphasis on mental health and delivery of services, from your perspective, to people presenting with a mental health problem.

Can you quantify how many people would be presenting to you on a monthly basis with mental health problems who are not living in appropriate housing or accommodation and are not receiving the care and support they need? Any ideas? If you do not know or you can get back to us with that, we are happy to take that on notice.

Mr Stuparich: In general terms, the national submission mentions that 75 per cent of St Vincent de Paul people visiting people in the community encounter people with mental health problems. Bob will probably be able to tell us more in general terms about the ACT. But from personal experience in the area that I am involved in, we meet people with mental health problems every week as we go out.

We do not know how much support they are receiving because that is not information that is made available to us. But we can see that they are struggling to handle their day-to-day activities—paying bills and staying on top of their financial situation, in particular—and some of them have problems coping with life as a whole. To us, it does not look like they are receiving much support, but that is just a perception. Bob has got something else.

Mr Wilson: Our society members that are volunteers working from the parishes, the Catholic parishes in the ACT, visit over 11,000 homes each year, that is, families and individuals, and that equates to about 55,000 to 60,000 people including the children. If that figure of 76 per cent is equated to that, there are quite a few people that would be having some difficulty in this area of mental health.

MRS BURKE: What about the accommodation side? That was the other part to the question. Can you put a number on the people not living in appropriate accommodation? What is the number of those sorts of people presenting to you?

Mr Stuparich: We have a lot of people turned away from Samaritan House, for example.

Mr Wilson: Samaritan House has 12 beds. Some of the men that come there are self-referred, some of them are referred from prisons in Canberra and the surrounding district. Ainslie Village is another place where there are quite a number of people suffering alcohol and drug addiction. Mental health issues are prevalent in the Ainslie Village area.

I suppose one of the concerns we have got about Ainslie Village is that there is

a perception that Ainslie Village has been crisis accommodation over the years. The minister has this vision for Ainslie Village that it is not to be crisis accommodation. Consequently, they have gone into community housing, with Havelock House managing the tenancy for people there. That transition is causing some concern amongst the residents because it is a change, for a start. Change is not easy for people to accept.

How they will manage the tenancy with people who perhaps lose their key or lock themselves out of their room and whether they are available as a 24-hour service or whether they are only available Monday to Friday are things that residents are trying to comprehend. There are some difficulties being experienced in that area.

Mr Stuparich: The point is that, although you are looking at accommodation, accommodation is only one part of a very complex picture in that accommodation, without adequate support, in other words, will not work.

MRS BURKE: Those were the two parts to my question: support and appropriate accommodation.

Mr Wilson: The type of support that the St Vincent De Paul Society would be looking at providing would be the non-clinical services, making sure that we are there to help people through a particular problem. If food is their problem, we can provide them with food. If the education of their children is a problem, we can assist them with the education so that the children have got a uniform and look the same as the other kids when they go to school and that they go on the excursions. They are the sorts of supports the society provides—that non-clinical, crucial assistance.

MS PORTER: A quick question on training for your paid staff and your volunteer staff: you are saying you have a fairly high percentage of people that you are seeing on a weekly basis who would be experiencing some form of mental illness. How much training have you available for your staff as well as volunteers who are dealing with this?

Mr Wilson: As we speak here now, we are in the second day of the mental health first aid course. We have provided mental health first aid courses four times now over the last 12 months. We became aware of it when we had a congress in October last year and brought all of our society members together. It was a key issue of that congress that we need to address mental health issues. Since October, we have run four courses in mental health first aid. We will keep them ongoing because they have been very valuable to our conference members and to our people that are employed in the special works.

THE CHAIR: Whom is that run by?

Mr Wilson: It is run by a group of professionals. Helen Burfitt is one of the ladies. There are a group of four of them. I am not sure whether they have an organisation as such that they call themselves, but I can get back to you and let you know. I have got a card at work.

THE CHAIR: That is all right; you can get back to us.

Mr Wilson: Yes, I would be happy to do that. That has been very valuable, very professional and very well received by volunteers and staff.

THE CHAIR: I will finish it there. We will be back in contact with you with a proof copy of the transcript for you to check for accuracy. As I said before, if we have any questions in relation to the submission that you made to the Senate inquiry, then we will be back in contact with you as well. We will keep you informed of the progress of the inquiry.

This was supposed to be the last hearing date, but we may well have one or two more. We have got to discuss that as a committee because we have had a few other organisations that have come out of the woodwork. We do not want to cut them off from being able appear before us. We will of course let you know once the inquiry is completed and we have a report which is about to come out. Thank you very much for your appearance.

The committee adjourned at 12.35 pm.