LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND DISABILITY

(Reference: Inquiry into 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, 14 JUNE 2006

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

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

The committee met at 10.30 am.

GORDON, MS NICOLA, Chief Executive Officer, Havelock Housing Association Inc.
DESMOND, MS SONJA, General Manager, Havelock Housing Association Inc.

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 actions such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter. Do you both understand that?

Ms Gordon: Yes, we do.

THE CHAIR: I would like to thank you for making yourselves available to come along. I have to say the committee is very pleased that, as well as making your submission, you have been able to come along to address your submission. I should say at the outset that the third member of our committee, Mrs Burke, is unable to attend at the moment. She has been away at a conference and is on her way back, I understand. Would you like to start by making an opening statement with regard to your submission?

Ms Gordon: Yes, certainly. I will not delve too much into the content of the submission. I will provide a summary of what is already in there. Havelock Housing Association Inc. has been established now for close to 20 years. In that time it has provided accommodation to a wide, diverse range of people, including people with mental health concerns. It has a range of programs, probably about 20 programs now, and nearly every one would have a tenant with mental health concerns in the program.

Not all of those programs are specific to providing housing for people with mental health issues. I guess one of the things that we have come to recognise over the time, as we have become more experienced in managing housing, is that in the programs in which we have specifically formed a partnership to help tenants with mental health issues sustain their tenancies, we have really seen some significant outcomes in comparison with properties in which tenants also have mental health concerns that we know about but where we do not have a formal arrangement with any support organisation, nor with the tenant. Often, to step in at a later stage and assist can be really quite difficult, and monitoring and making sure that the tenancy is sustained is certainly not as successful as when we have purposely set up the program to make that work.

So I guess our purpose in coming here today and putting up a submission is to say that from a housing point of view—and I must make it clear that we are a housing provider; we do not provide support in any way, shape or form—our submission and our feedback is really from the perspective of a housing operation, rather than direct support. But the outcomes obviously are monitored and they are what we want to talk about.

THE CHAIR: I might ask about the relationship that you have with housing and any contact that you might have with Mental Health ACT through the CAN program. If you do have any contact, would you like to comment?

Ms Gordon: The CAN project is the project in which we have a partnership with Richmond Fellowship. Our dealings with Housing ACT are fairly minimal, and that would be at the time that we are receiving the property. It depends on the program. If we have purchased the property through a capital funding arrangement, then our relationship with Housing ACT is non-existent. Our relationship is between the funding provider, being the department of disability, and the partner, being Richmond Fellowship, who then liaise with Mental Health ACT.

If the property is provided through what is known as a CORHAP arrangement, and basically that is a leasing arrangement, then the staff contact with Housing ACT is very operational about maintenance, forwarding rents to and fro, really in a direct reporting sense, rather than a tenant-related partnership with Housing ACT. Anything to do with any work that is involved in sustaining tenancy is generally through Richmond Fellowship. We obviously liaise with them on a very regular basis through their connections and funding body, as well as getting family support involved and basically any other organisation that it takes to make sure we keep the tenants in the house.

MS PORTER: Good morning. I just wanted to explore a little bit more this separation between the support and the management, who does which bit. I also wanted to explore a little bit more how many of the people actually refuse support, as you mentioned in your submission, and how problematic that is. That is the second part of my question. The third part of my question is: how do you see support management playing out outside that arrangement, where you have perhaps those two things being combined in other circumstances?

Ms Gordon: In answer to the first part of the question as to who is responsible for managing the tenancy property et cetera: the different language that we use we will often say there is asset management, which is around the bigger picture of the house, the roofing, the painting et cetera; there is property management, which is responding to daily maintenance requests, doing routine inspections; and there is tenancy management, which is preparing leases, liaising with tenants et cetera. Then we have the support for the tenants, which is through Richmond Fellowship.

So, in answer to your question, Havelock Housing Association has very specific roles in managing the property in a real estate sense, as well as then the tenancy management, which is trying to ensure that the tenant's rights are respected, while they are still meeting their responsibilities under the Residential Tenancy Act, as it is now called, as they would in any external situation if they were renting privately.

The difference, which probably goes to your next question, is how you sustain that during the time when they are on the roller-coaster, where their mental wellbeing is not necessarily as stable as it could be. I do recall that when we were setting up the program, the association talked in depth about separating the roles of the support providers. They were extremely concerned that if there was not a connection of support, the person should not have the house. We took it back to the basic principles and said, "Well, let's just go back to those principles." The principles are that if the tenant has a lease he/she has the right to live in that property. There are certain conditions to living in that property, and they are paying the rent, looking after the property and doing what any tenant is required to do. As somebody who is managing that, our job is to make sure that is happening.

We came up with the solution that if you took away the support and you took away the housing, obviously you are just sending somebody into a spiral of going back to being hospitalised, all that time has been wasted and you have just completely demoralised the person, who has to start all over again. At the time we said: if they are not connected, what will happen? Really, what would happen, and what does happen, if we disconnect the two and say that support is separate, is that we have the right, through an agreement that everybody signs, to liaise with each other. So we will hear from the support organisation if the tenant has decided not to accept support any more. We continue managing. If rent is paid, if we can do routine inspections and all is well, then that is great. If the tenant is self-managing, it is evident. Even from a housing perspective, it is evident.

If we start to find that the rents decline or we go to do a routine inspection and we find that the person has no hygiene any more, that the person is on the phone regularly and not necessarily coherent, we have the right under that agreement to still contact the support person, who can then make contact with the tenant and say, "Look, would you like us to get involved again?" Often the tenant will say no; they are not well enough to acknowledge that.

We have had one particular case where, as a housing provider, we did everything in accordance with the legislation. We issued notices, but at the same time we went around to say, "Look, you are about to lose your housing. There is a way to avoid this. It is because you are not coping in terms of paying your rent or managing to maintain the house and to maintain your health. At the end of the day, you will lose the house through that process. This is what we can do to avoid it."

In that particular case, this person was very unwell at the time and had been institutionalised before. At the time we made a few suggestions and we said, "Let us get the support provider involved again. Let us get your family. How about if we get all your furniture out?" It was decrepit at that stage. We said, "How about if we can get the Salvation Army to donate some furniture? We'll clean it. We'll pay for the cleaning and we'll organise for that to be paid off over a period of time. How about you go back into hospital, get your medication back on track and stabilise and we promise the house will be here for you."

That is what happened. Everybody, the public trustee, the Salvation Army, Havelock and the family came in and helped. The person was gone for probably four or five weeks at the time, and 10 years later he is still in the house. For me, that is probably the epitome of that model. Somebody in any form of housing would have been evicted, certainly in private housing. In public housing I would like to think that the support could have been coordinated. I do not know enough about the systems within public housing, but I think this happened because of the willingness of all these different people to say, "This person can maintain a house. Right now this person is not well and if we can address that, then he gets to remain in the property."

I guess the person at that stage thought he was stable enough and did not need help or support. His medication went down. It was a very nice property. He was in a safe environment. It was a unit that anybody around this table would happily live in. I think that was a bit thing. It became such a secure environment for him that that was the

trigger to allow him to accept support and get back on the medication and stabilise again. So that has been a good outcome.

MS PORTER: You did mention, though, that you do have people who are not actually living in that program but who have got mental health issues. They would not be getting that additional support. What is the difference between those and—

Ms Gordon: I can give an example of a particular person in Havelock House where there are no support mechanisms in place. If there is support, it is an individual arrangement that we are often unaware of. Certainly there is no consent or knowledge about what is in place.

This particular person was unwell. We knew he was unwell and we attempted many times to get assistance for him through mental health and through the crisis team. The end result was his illness escalated to such a point that he really caused serious harm to another person within the building, another tenant. For months we had seen an escalation and we really struggled to find somebody who could, one-on-one, assist this person. He was fearful, obviously, of being hospitalised. I guess the fear of losing housing in Havelock House, as such, was not as great as losing his own unit.

So we were going through the processes of trying to say, "Look, you will lose the housing. You are not coping. You are not paying rent. These are basic things you have to do." We would get other organisations involved to assist paying rent, but it stopped at a certain level where we really would struggle to find assistance. Obviously, in terms of our funding, it is very limited in terms of spending that amount of time trying to connect tenants to support providers as well. So there is somebody who has ended up in serious trouble and seriously harmed somebody else. That is an extreme case.

There are many others who just take off. The debt starts to increase and we have to go through our normal processes. Our connection is with the tenant only, and often if you try to approach them and ask if we can get a support provider, they will say yes and then we find out they have got somebody else. It is messy.

THE CHAIR: You say in the submission that, of the programs that Havelock runs, it is the CAN program that has the least number of evictions and bad debts. Do you want to comment on that? Is there a way in which you do actually manage the financial aspect, especially when people are hospitalised and are going through a bad period in their lives? How do they actually go about managing their finances?

Ms Gordon: I have been on long service leave, so I am not sure if anything has changed data-wise, but I would be very surprised if it has. Sonja is saying it has not, which is good to hear. Certainly there has never been an eviction in that particular program, and I think the example that I gave previously is the reason why.

In terms of bad debts, a bad debt only occurs in terms of our financial record maintenance if a tenant vacates. So we have zero bad debts because we have never had a tenant vacate. We deal with current arrears, what we call current arrears, and that is attached to a tenant who is currently living in a property. But even those are maintained extremely well, as any managing agent would do. If the rent falls into arrears, there are certain notices that are provided.

Again, under the arrangement we have an opportunity to contact the support person. We would then set up a meeting. If there had been any particular issues, we would put in a payment plan. Certainly, if somebody had been hospitalised, we have often approached the Salvation Army and Anglicare to see if we can get some additional emergency support in to pay rent for that period of time.

Again, with the authority of the tenant we have been able to put in a payment plan with the public trustee, if they have got the public trustee managing their funds. So I think they are the ways in which we have managed that. Also, we have not allowed the debt to incur in the first place. It is not as though they are incurring a 10-week debt before they are hospitalised. It is monitored on a weekly basis.

THE CHAIR: This inquiry was started last year, well over 12 months ago now, and your submission to us is almost a year old. At the time of the submission you were looking to purchase an additional five houses. You had also been awarded the management of the Gungahlin singles accommodation, with four of the 20 places being for people with psychiatric disabilities. Do you want to give a bit of an update as to where you are with those two things?

Ms Desmond: The five properties we got in September last year, I think it was. They have been housed. We have had no issues with any of the residents at all in that one, and Gungahlin has been beautiful. We have got a Richmond Fellowship representative there on a regular basis. We meet with the providers every quarter. Everyone is working really well together in sustaining individual tenancies and creating a community environment out at Gungahlin.

Ms Gordon: When we put the submission in for the Gungahlin Boarding House, it was a time in which Havelock House had a few issues in terms of lack of support. There are a lot of people there that are in desperate need of support. We were really concerned about putting 20 people from the same socioeconomic background in the one complex and how we would do that without creating a ghetto.

This tender provided that there would be four people with a mental health concern. Just using the experience that we have gained over the years, we decided that if we were going to do this, we were going to do it as a multiple partnership arrangement. We had never heard of one before. We were putting ourselves out there and we decided it would be absolutely brilliant or it would fail dismally. We were of the strong belief that it would work really quite well, and it has.

So there are about four or five partnerships there. What we have managed to achieve is a diverse range of people. Even though they are all on low incomes and often have some serious issues that are attached to that, they are different enough that they are getting that diversity without bringing each other down, as such. More importantly for us was that there were support arrangements attached to that as well in a similar arrangement to what we have with the CAN project.

Then, on top of that, we wanted to make sure we could bring all of that together, because that is not what we do. We are a housing organisation. The support organisations do not quite do that because they are dealing with individual cases. How do we actually all

come together as a community and get that participation happening? We have brought on Belconnen Community Service to do that. They have not got that individual arrangement with anybody, but they have got a more holistic approach in making sure that, through those providers and with the tenants and with Havelock, there is a bit of a community feeling happening.

You have to take your hat off to the government on this. They did take the feedback: do not do group housing; allow enough common areas for people to come in when they want to join in and participate and to get out and escape back to their units where they have got everything they need. That has worked exceptionally well. Again, the outcomes and the feedback from the tenants have been so positive and we would like to think that any future development is modelled on a similar basis.

It has worked extremely well and it just shows that certainly group housing is a difficult scenario. It is not what anyone would choose. It is more acceptable as a student, but if somebody said, "For the same money you could live by yourself," quite often they would choose to do that. But certainly as an adult, and an adult who has got enough issues of their own to deal with, living in their own environment with enough support and enough nurturing from a wider community has been so positive for them. Again, that is why we love that program.

THE CHAIR: How do people get access to Havelock housing? Is there demand for Havelock services that cannot be met? Is there a waiting list? If there is a waiting list, what is your recommended solution to the problem?

Ms Gordon: In terms of access, it depends on the program. At any stage anybody can come in to the association and apply for any of our programs. However, the criteria, depending on the program, particularly with the CAN program, requires a tenant to have certain needs that need to be met by a support agency, and we are not the experts in assessing that. So, depending on the program, we will have a two-stage assessment period in terms of whether somebody is eligible to go on the waiting list.

The first step for the CAN program is to go through the Richmond Fellowship application process, and that is to see whether they meet the criteria of their support funding. If that is agreed upon, they are then assessed as well to make sure they meet the asset and income criteria of any tenant on a low income, whether that is public housing or community housing.

So it is a two-stage application process, depending on the program. Otherwise it is just an application through Havelock House. There are very long waiting lists. Some of them are five years or more. We have closed the waiting list over the years. It is open again at the moment. I guess it is not as though we have fulfilled any need in the last few years, but what we are trying to do is determine what is the real need out there and if you close a waiting list you do not get that data.

In terms of how we fix that, obviously provision of accommodation in some format is really important. A fairly poignant issue at the moment is making sure that there is enough funding attached to the service to provide housing in a safe and secure environment, not only for the tenants, but for the staff as well. I think that is going to be a challenge for us in the future.

MS PORTER: My question was about that waiting list, so it has been answered. I just want to pick up what you just said about the staff.

Ms Gordon: I think for anybody who works on the front line, whether it is support or housing, it is a very, very demanding job. I think it is widely recognised that the salaries are fairly low in the community sector and the turnover is extremely high. We are in a job environment or an employment environment in which trying to find quality staff in any area of employment, even in the private sector or in the department, is very difficult.

If you take that down a few steps to the community sector, where the job is demanding and the pay is less, we are finding it very, very difficult to attract staff. Once you attract staff, you have to try to retain staff on the salaries. I talked about the risks to staff. We have to make sure that you have enough training happening, that you are not putting staff in any vulnerable position, and some of them are just non-negotiable. You have to make sure that your staff are as safe as they possibly can be. There are dollars attached to that when you have people on the front line.

THE CHAIR: I think we might leave it at that. Thank you. It has been very valuable having you appear before us today. We do appreciate it. Thank you very much for the work that you are doing out there as well. It has been very interesting. Thank you for your attendance today. We will be providing you with a copy of the transcript when it becomes available. You should check it for accuracy and get it back to us. If we do have any questions, we will be in contact with you.

DALTON, MR JEFFREY, Caseworker, Welfare Rights and Legal Centre

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?

Mr Dalton: Yes, I do.

THE CHAIR: Thank you very much for appearing today, Mr Dalton. We do not have a submission from you. I should state at the outset that the third member of the committee, Mrs Jacqui Burke, has been away at a conference and I understand is on her way back, so she apologises for not being here today. Would you like to give us a bit of an overview of your organisation and what you do?

Mr Dalton: Certainly. I would like to say at the outset that the nature of our centre is that it provides legal advice and assistance in the areas of public housing administrative law, residential tenancy law and social security law. We also have the disability discrimination legal service and the night time legal advice service. In our daytime service, in our core areas, at least 50 per cent of our client base is comprised of people with mental health problems, sometimes it is higher.

To begin with, we would like to offer the following preliminary points by way of background, no doubt covering areas that have already been covered by other witnesses. There is a clear causal link between mental health and homelessness, leading to significant demand on public housing resources. This is not the only group. There are also existing tenants who require rehousing because of their mental illness. Just dealing with homelessness first, there are reliable estimates that 80 per cent of homeless people suffer from poor mental health and that 41 per cent of public housing tenants nationally have a disability.

They will turn to the public housing system because of their desperate situation, the unaffordability of the private rental market in the ACT and often adverse reporting on tenancy databases. This means that laws governing the provision of public housing, and those administering them, need to take account of the following barriers that people with mental illness experience. They often have no capacity to get together essential documentation regarding identity and income and are severely exacerbated by their homelessness. A Senate select committee found that there was a clear problem for people with poor mental health effectively relaying information to service providers.

Other barriers are a complete lack of awareness or inability to grasp the detail involved in making an application for housing; difficulty in keeping appointments, aggravated by a disconnection from social and supportive networks; prejudice and stigma associated with perceived madness; an inability to grasp the meaning of decisions made about their circumstances; and a requirement to navigate complex issues that even lawyers can have trouble making sense of.

Complicating these barriers can be inappropriate advice or information given at the initial contact phase with the housing provider. For example, sometimes they are refused to be housed based on a previous debt to the housing authority without giving information as to how a statutory discretion can be used to overcome that problem, or a system whereby a debt that has been properly raised can be waived because of the circumstances surrounding it being incurred. It is now an informal, unguided system, despite the success of the debt review pilot project.

Other complications of the barriers that people with poor mental health face are a serious reluctance on the part of many to engage with housing authorities, based on previous negative experiences, with strong feelings that they have been previously abused, and poor levels of knowledge and skills amongst staff about dealing with people with a mental illness, often not even countered by obtaining adequate community support.

A further complication can arise from the extreme reluctance of health professionals to provide written reports outlining the person's mental health status. In fact, it is often a straight-out refusal. This is despite the fact of the clear causal connection between poor mental health and homelessness. It can be safely said that the mental health will not improve unless suitable housing is found and so it can be seen as part of the treatment. It should be noted that there are notable exceptions to this general reluctance. Nevertheless, we do think that there are some strong signs of territorialism, in the adverse sense for this august body, between government agencies. The cost of a psychiatric report is prohibitive. Homeless people with a mental illness often do not have sufficient proof of their identity, let alone proof of a diagnosis.

For existing tenants, many of the same barriers exist, especially the impact of previous negative experiences or being told that they won't be transferred until a debt is paid off. But the problem with the program, the public rental housing assistance program, and determinations made under it is that the allocation system can often have people with a serious mental illness, for whom their current accommodation has become unsuitable, waiting endlessly on a priority list that rarely, if ever, moves.

They also have to cope with the double stigma of being a public housing tenant and a person with a mental illness, leading to cases of victimisation. Putting a roof over someone's head is an important first step but, unless the premises are suitable, the tenancy will not be sustainable and then the tenant is in danger of becoming homeless and so the vicious circle starts again with the individual becoming seriously at risk and unable to cope once more. These problems can be alleviated, and have been in other jurisdictions, by measures such as the Queensland public housing protocols, which identify at-risk tenants at an early age and then try to involve community agencies on a collaborative basis to resolve whatever issue is threatening the tenancy.

I would now like to move on to another area that we think is very important; that is, decision-making standards of public housing authorities. People with poor mental health are often on the receiving end of poor decision making for the reasons already outlined, so they are heavily reliant on appeal mechanisms that are founded on the principles of administrative law and give them a clear right to challenge and pursue their rights, usually only possible with the assistance of an advocate.

It is not good enough to say that you would improve your internal decision-making

processes. They should be of a high standard anyway. In our experience, there has to be an informal first-tier review by an external or quasi-external body that will review the decisions made by internal decision makers. Face-to-face contact is essential in many of these situations. There are things that you just cannot pick up by deciding appeals on the papers.

Appeals mechanisms are the way that the rights that people with mental health problems can challenge wrong decisions, can ensure that laws such as the program, the public rental housing assistance program, are properly administered so that any flexibility is sufficiently available, especially when they contact a service like ours. For people who have great difficulty dealing with bureaucracies, and for bureaucracies who have seemingly great difficult assisting them sometimes, appeal mechanisms are the advocate's primary tools.

The planned abolition of the current system gives us great concern. The disadvantaged people, especially those with mental health issues, will be the losers. We understand, via the grapevine, that very significant changes have already been made and are about to be implemented in the way in which decisions will be scrutinised, but, despite a written request from us four months ago, in February of this year, for a meeting to discuss these changes, we have not even had the courtesy of a written acknowledgment of our letter, nor of the 13-page submission that we included in that letter, relating to housing appeals mechanisms.

THE CHAIR: Was that to the department?

Mr Dalton: Yes, to the chief executive. Much of what we had to say in our submission was based on our experience of representing disenfranchised people. I have to say that we don't put our time and energy into assisting government projects for fun. I don't know if the committee is aware, but there is a new public rental housing assistance program. We only became aware of it yesterday and it has been in existence for over a week. We are deeply concerned with some of the changes to the program and that they will adversely affect people with mental health issues.

Firstly, the new clause 3 in the new program requires people to demonstrate an extraordinary need before being eligible. It is a much higher barrier than before, indicating that people could have a further burden to prove. Next, and these are brief points, given that we have only had a short period of time to look at the new program, priority categories are to be changed to needs categories, but we have no idea what they are going to be.

Under the new clause 10, the breadth of notification requirements that will be placed on people who are on any of the lists is, in our respectful view, going to be too much for people with a mental illness, especially the concept of advising the commissioner "immediately". Also in that clause is the introduction of two concepts, we think, of a priority status and a needs category. We are concerned about the potential punitive effects that those new provisions will have.

The changes to income eligibility limits are something which we have warned about for some time, given the commonwealth's changes to social security law, the so-called welfare to work. This will mean, and the changes are specifically designed to mean, that

people will go on and off the job market with very great ease and their social security payments could be withheld, suspended for long periods of time, based on whether or not they are prepared to accept a job at a very low salary. We think this will have very adverse effects on the income position of public housing tenants, especially those who will go from being on the disability support pension, as it currently is, to the new basis for the disability support pension which will exclude many people who have episodic disabilities, and that will largely be people with mental illnesses.

Clause 12 causes us very great concern. The new clause 12 is, in our respectful view, designed to do nothing other than to knock off the most disadvantaged people from the housing lists. It changes a system whereby people could be removed from the list for a couple of reasons, but it gave the capacity for their name to be restored. In the case of a deemed withdrawal of an application, that meant effectively if housing had sent someone a letter and they hadn't responded to it within 28 days, say, then they would withdraw their name from the list. You could get your name back on the list if you found out about it within six months, went down to housing and said, "Terribly sorry, I didn't get the letter" or "I forgot about the letter" or something like that, and for people with mental illnesses this happens all the time. They don't keep track of their correspondence. You could go down and get your name reinstated, provided you did it within six months. If you had to move out of the ACT for at least one month and were taken off a list for that reason, you had 12 months to get your name back on the list.

It is now going to be one month and the month is going to run from the time the decision is made. Many people who are homeless, particularly those with a mental illness, were assisted by those provisions that existed in the previous program. They will now be punished by being removed from the list entirely if they do not contact housing within one month. That is one month of the decision having been made, not one month of having been notified of the decision. Even if you had that kind of distinction, people with mental illnesses who are homeless lounge surf, they move around from place to place, and so do lose track of their correspondence. To have them being taken off the list if they don't do something about it within a month means that they will have to go through the application process all over again. It is a serious error of judgment on the part of a government that has a social justice commitment, in my view.

The upshot is this: if a person is considered eligible and then ceases to be resident in the ACT for any period of time, conceivably less than a month for a homeless person with a mental illness, they will cease to be eligible and therefore cease to be able to be on any of the lists and they will be under a legal obligation to immediately advise the commissioner. Even if they do comply and immediately advise, they will find themselves removed from the list, but they may—I stress "may"; there is no guarantee—be able to have their name restored, not within one month of being notified of the decision, but within one month of the decision having been made.

THE CHAIR: The effect of this would be that if somebody was able to get a sofa to sleep on for a week in Queanbeyan, Yass or Murrumbateman, if they had a friend who said that they could come and stay with them for a week, because they have moved literally just over the border their name can be removed from the list.

Mr Dalton: That is correct, and there is no requirement for it to be a month. The requirement is for where they are resident. We have had clients who have had to go to,

for instance, the Queanbeyan caravan park because it is the only place they can afford. They will be taken off the list. They could find out about it if they were lucky, but if they have moved, if they are lounge surfing or they have not notified the housing authorities of their new address, the letter won't get to them. Even if they got their name restored to the list, they are not guaranteed that it will be restored in the same position as it would have been had their name not been removed. We are at a loss to know what the rationale behind this is and we are very concerned that it has been done under the cloak of changes made to the program because of the budget, which we all understand is a difficult budget, but to have these kinds of changes included in it is a matter of very great concern to us.

The final thing I want to say is that, because of some of these changes, there is going to be greater reliance on very broad discretions that are built into the program for the commissioner to exercise. One of the amendments that have been made is to make them non-reviewable decisions. The exercise of these discretions will be non-reviewable decisions, which means you cannot appeal against it. The two clauses in question—three, really—that I draw your attention to are the new clause 9 (a) in the program, formerly clause 16, and the new clause 13 (4), which is now regarded as the out-of-turn allocation.

Under the new clause 27 (1) (a), "A decision about an application for assistance, not including a decision under clause 9 (a), clause 13 (4) or clause 32 (2)" is going to be a reviewable decision, excepting for the decisions under those clauses. So you are going to have a system where those discretions are going to be relied on even more, but they are going to be non-appellable decisions. You can't ask for a review of them. There have been some important cases under the discretion as it formerly was in the program that have gone to the AAT. So not only does this mean that you can't have an internal review; it means you can't take it to the AAT either, because of the way the AAT jurisdiction is structured through its own legislation.

MS PORTER: You mentioned before that you had written to the department about the abolition of something, but I did not quite catch what you said.

Mr Dalton: This was the abolition of the appeals mechanisms in ACT Housing. There was a paper issued in November last year proposing the abolition of the appeals mechanisms and instituting a new one. We were invited to make a submission. We made one, and that was the letter in February where we sought a meeting to discuss what we had proposed would be the best system. Without getting a response, we heard this week on the grapevine that most of the changes are being implemented on Friday of this week.

MS PORTER: And they are the changes that you have just been talking about.

Mr Dalton: They were the changes that we addressed in our submission in February.

THE CHAIR: Would we be able to get a copy of the letter that you wrote to the chief executive?

Mr Dalton: Sure.

THE CHAIR: We would be very interested in having a look at that and following up on why there has been no response to your letter on that, given that you wrote it in February. Four months seems like an excessive amount of time.

Mr Dalton: It does seem like an excessive amount of time and it is made a bit irritating when you hear that decisions have already been made, so what is the point of having a meeting now?

THE CHAIR: Unless there is anything further that you want to add at this time, you have given us a lot to digest and I would like to go back and read the transcript. We might be back in contact with you to follow up on the issues that you have raised with us today because there were several issues there which would be of great concern, I should imagine, to the entire committee, but the five minutes left will not allow us to pursue that and we do have other witnesses waiting to appear and then we have to go to an in-camera hearing. It might serve us better to go back and look at the evidence that you have given us today and follow up that information with the department as well as a start.

Mr Dalton: If it would be a help, just let me know if a written submission would be better in some ways. Maybe the evidence that I have already given will be enough.

THE CHAIR: Yes. What you have read out to us will come up in the transcript as well, but giving the committee secretary a copy of the notes that you have read from today might facilitate the committee's further questioning of you. We do appreciate your making the time to come and appear before us today and it has been most interesting to hear what you had to say. Thank you very much.

Mr Dalton: Is it okay if I provide it by my email?

THE CHAIR: Yes, that would be fine.

TONGS, MS JULIE, Chief Executive Officer, Winnunga Nimmityjah Aboriginal Health Service
BOYD, MISS KACEY, Co-ordinator, Dyiramal Migay Young Aboriginal and Torres Strait Islander Youth Refuge

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?

Ms Tongs: Yes.

Miss Boyd: Yes.

THE CHAIR: I would like to start out by saying thank you for appearing before the committee today. I am glad we finally got you to appear before us. I would also like to apologise at the start: Mrs Burke has been at a conference, so she is not able to be with us today. She is an apology for today. I'm sure she'll be reading the transcript with interest. You have seen the terms of reference for the inquiry. Did you want to start by addressing the terms of reference or by making a statement?

Ms Tongs: Firstly, I think the big issue around appropriate housing for people living with mental illness is the lack of understanding of mental illness, particularly drug-induced psychosis. There's real discrimination, I believe, against people who have a drug-induced mental illness because, as soon as you mention that it is drug-induced, people don't want to go there.

Speaking from a service perspective, at Winnunga we've had 1,200 occasions of service for clients with schizophrenia in the last nine months—now that's a huge number of people—and these people have very complex needs. I'm not into blaming mental health, housing, or drug and alcohol, but unless we take a whole-of-government approach to these issues, then I don't believe anything is ever going to change.

There is no flexibility, I believe, in the criteria for gaining access to public housing. We know that there is a long waiting list for housing. In my own experience, I have a son with mental illness. He's got two children that have just been placed in my care. We rented privately for him, and one of Kacey's friends lived there and helped look after the kids. As his illness starts to escalate he becomes very chaotic. They become delusional and very hard to live with and manage. He ended up in the psych ward. I tried to get him into public housing, but because he was in private rental they took him off the housing list. Then I paid up the back rent on the house, but it's happened again. I just think it's really difficult. People with mental illness, and particularly psychosis, are very hard to manage.

We have a lot of people with personality disorders as well. Even just getting them to pay their rent and do things like that—there's got to be another way of being able to manage that. My son's lucky because he's got a supportive family, but I can understand why

families actually can't cope, or don't cope. We have a lot of support around us, but I feel that people with mental illness become isolated, and they become sicker because they're not taking their medication. Often the mental illness comes before the drug problem and, unless they're in a house, or have a roof over their heads, it's difficult to address the underlying issues, which are the mental health and the drug.

Particularly from where we sit at Winnunga, we believe that the mental illness comes before the drug and alcohol. A lot of people are self-medicating. A lot of people that suffer from depression and other mental illnesses will "doctor shop". So it's bigger than just housing and mental health. There are a lot of other indicators and a lot of other services that need to be involved.

That's just one experience. That's not in isolation of other experiences that we have with a lot of people at Winnunga—Aboriginal people that have a dual diagnosis or are mentally ill and homeless, or they've got a brain injury, a personality disorder, schizophrenia or whatever. It's probably one of the biggest issues facing our service.

Child and adolescent mental health is even bigger. We've got a lot of young children that are living with parents with mental illness, and they too suffer. They become the carers. These kids are grown up before their time. But they also get abused in amongst all that. A lot of it is emotional abuse. When people become delusional they start talking: it could be a bikie gang or it could be whatever, and they think that their kids have got earpieces in their ears, or they've got a camera in their eye. What they see on TV becomes real. They say, "That's your uncle there," or whatever. The kids find it hard to believe, so they're damaged as well.

We've actually just applied for funding for child and adolescent mental health workers so we can start addressing the issues with a lot of the young people in our community. A lot of our young people are angry, so we're looking at running anger management programs. We want to try and address the needs of these young people before they get older and those needs become even bigger. But Kacey might like to talk about what she sees at Dyiramal.

Miss Boyd: I work with young girls from 12 to 17 at Dyiramal. Some of the biggest factors for these young women are depression or personality disorders, and some have drug-induced psychosis. One of the biggest things for the younger kids is self-harming, and it can really get out of control.

Late last year we had an incident where we had three girls in at one time and they were all susceptible to self-harming. One tried to hang herself and then one ended up cutting her wrist. They call it a blackout and they don't realise what they're doing. They're just blank as they're cutting themselves, and that can be quite severe. So we ended up in hospital with her.

Then we had another one who, once again, was self-harming. So it's a real spiralling effect for these kids. It just makes you wonder what these kids have been through to try and commit suicide at the age of 12. Even though they've got supported accommodation with us, it's trying to stabilise them, whether they go back home or what.

Even now we've got a case of a 17-year-old who is unable to go back home. Once the

placement at Dyiramal can no longer be, we're going to have to get her into housing, and we're going to have to try and support her in that process. I think that maybe housing need to look at setting up a model where there are nurses or mental health workers or something on site 24 hours a day, whether it is in a flat complex or within a group of little houses, just to contain them in stability.

One big thing with them is not wanting to have their medication. They'll go really well, they'll feel great, they will be real settled, they'll be able to think clearly and stuff. They think, "Well, it's not the medication that's doing this. I'm going to stop that now. I'm fine, I'm fixed." Then as soon as they go off it, it's not even a couple of days and they're just right back down there. Then it can take up to two months again to restabilise them. That can be just from missing a couple of days.

I feel it's really hard dealing with these kids because a lot of them have issues with their own Aboriginality and don't feel strong with it; plus, on top of that, they've got the name of being a mental health client. Even in our own Aboriginal community a lot of people don't understand what mental health is. So automatically they're outcasts from their own community. They don't know where they fit because they're just getting it from every which angle.

MS PORTER: I just wanted to ask how long the supported accommodation lasts with you, Kacey. How long can a person stay?

Miss Boyd: It can last from three to 12 months, of course depending on the case, but I'm not saying that we'd ever put someone on the street after 12 months. Depending on their needs, I'd fight to keep those kids in there, to keep them stable for as long as possible, but in the end we need a good outcome for these kids.

MS PORTER: How many can you take at one time?

Miss Boyd: We can take up to six at any one time.

MS PORTER: How do they receive support in the house? What other kinds of things do they get apart from the physical house?

Miss Boyd: We do a living skills program, running the house as well. We teach them how to look after themselves in terms of being able to wash their clothes and being able to cook themselves a meal. We have chores on the weekend and stuff to try and get them stable into doing things that anyone else would take for granted. With these kids, it's a new learning experience for them.

We run a program every Tuesday night that we call a cultural night. We'll watch a DVD like *Yonglu Boy*, *Rabbit Proof Fence* or something like that, to get these kids to open up with their feelings and their issues around what they're seeing or how they're feeling—stuff like that. Definitely one big thing we give them, or try to give them, is to help them with their own self-respect.

The biggest thing with dealing with them is, I believe—and it always happens—a good case plan for these kids. That's with every service that we're dealing with—sitting around the table and listening. Some services may see them for an hour and they see

they're going fine or whatever. But we live with these kids and we really know what's going on with them. So we really like to have a good case plan involved so that all the other services are aware of what's going on with them as well.

THE CHAIR: This is a question for both of you. You would have the same people who are going through the services of Winnunga, would you not?

Ms Tongs: Yes.

THE CHAIR: Obviously you don't want to force people out after 12 months, but do you find there is a shortage of places for young girls with these issues?

Miss Boyd: There is a big shortage of services, especially for young women, I believe in the ACT. A lot of those ones that are specially catering for young women either run to the same age group as we are, or it's domestic violence only, or it's mothers with children. Once they've hit the age of 17 or 18, or whenever they leave our service, there's nowhere for them to go to continue to have that support, because all the other services out of that age group only either deal with domestic violence or women and children.

Ms Tongs: Dyiramal is auspiced by Winnunga, and the young women at Dyiramal access Winnunga services, whether they be the GPs or the psychiatrist or whoever. I had a phone call before Christmas from one of the magistrates, Shane Madden. He'd just put one of our young women into Quamby. He was really concerned about her mental status and asked if I could get either Dr Sharp or our psychiatrist, Dr Harrison, to go over to Quamby and see her.

We did that, but our resources are stretched to the limit because we're seeing more and more people with mental health problems. A lot of it stems from very early ages around abuse, neglect and stolen generations—all those things that have impacted on the social and emotional wellbeing of our people—and it's not easy. Not having access to appropriate housing is a big issue, it's a big problem, and it needs to be supported accommodation. People need to be supported.

I think that sometimes too many services can get involved. With mental health clients you've got mental health involved, then you might have drug and alcohol involved and the police get involved. You've got all these other services, and that frightens them. It's kind of scary for them because they don't understand, they don't even realise. They think that we're not well—it's not them, it's us.

That's the dilemma we have. They get really frightened by people knocking on their door. They say, "I don't know what they're doing here. I wish the mental health people would go away." Then I guess if they've got kids, you've got child protection and family services. So you've got everybody involved, and it is really overwhelming and quite frightening.

I think we at Winnunga work really well with our clients, and even those clients that are in public housing that we know are at risk, in trying to work with them before they actually get evicted, or going to the tribunal and working with those clients and trying to keep them in housing, rather than having them evicted. We had that eviction a few years

ago. It was very public and it wasn't nice—not for the family, not for the government and not for us at Winnunga. I think relationships have improved since that happened, but there's still a long way to go. We really do need to be looking at the specific needs of people with mental illness and what's appropriate housing for them.

You can usually tell when somebody is starting to escalate or become delusional. Usually they're well-organised and things are going okay. As soon as they become unwell they get disorganised, they don't pay their rent, they don't pay their bills and they go out and spend their money on silly things. I don't know how you manage that, really. I think it's about giving people skills, but it's also about keeping people on their medication.

A lot of people admit that they've got a drug problem, but they won't accept that they've got a mental illness. So, often, if they've stop taking the drugs and then they need to be medicated by the psychiatrist, they won't take their medication. It's either that they're on everything or they're off everything. So they think that they don't have a problem. That's why people then become really unwell again. As soon as they start to feel okay, if they are on the medication, they'll go off it and then we're back to square one again.

With public housing I think the last thing you need to do is put people in a high-rise building somewhere, particularly if they've got a mental illness. They become suicidal, or if they start to become psychotic they could jump or whatever. I guess no matter where they live they're going to be at risk, but I think they are at an even greater risk if they are in a high-rise building, or on the second or third floor of a building or whatever.

MS PORTER: You just made a statement, Julie. Early in your address to us you talked about the lack of flexibility in gaining access to public housing. I wondered if you wanted to talk a little bit more about that.

Ms Tongs: I don't know whether it's because there is a shortage in housing and there are so many people on the waiting list but, as I stated before, obviously if you are renting privately you're not deemed as suitable for the housing.

MS PORTER: That's the main sticking point, or are there other things?

Ms Tongs: There are other things. I know that the social health team at Winnunga do a lot of work with their clients around trying to get housing for them, or trying to keep them in the housing that they've already got. A lot of that is to do with people being unwell. Like I explained before, if they're unwell they stop paying their rent. They don't understand that they haven't been well. I said to my son, "Look, you haven't paid the rent for seven weeks." He said, "Yes I did." Then he brought the receipts out and I said, "No, look, you haven't." But he thought he'd been paying it.

I don't know what the trigger is, but obviously people are living in a different world. They're not really understanding, they're disorganised and they've got no idea, really, what's going on. A lot of the services I talk to have really got no understanding of mental illness and about how people react or behave, or that they're not well.

MS PORTER: When you say "a lot of the services", are you talking about government services and non-government services or a mixture of both?

Ms Tongs: A mixture of both, yes, definitely. They think: why can't they pay their rent, why can't they do this, or why can't they do that? We try to explain to them that the reason they're not doing this is because they're not well.

I know that you can go to Centrelink and you can fill out forms, but some people actually get to the bank before. They hit the bank at the same time as the payment. Therefore they get the full amount of money and that rent money hasn't come out—or they'll cancel it or whatever. I just don't know. Do you get the Public Trustee involved, or how do you manage that?

A lot of people living with mental illness don't have any family support, and that's really difficult. Then they become even further isolated from the community. Often they might end up doing something like putting a rock through a window and then come into contact with the criminal justice system. Before you know it, they're probably going to be locked up in Goulburn or in BRC. We do do prison health at Winnunga. Our doctor, Dr Sharp, and an Aboriginal health worker from Winnunga actually go to Goulburn jail and to Cooma jail fortnightly and also out to Belconnen Remand Centre. Ninety per cent of the people in jail are there because they're got mental illness and drug and alcohol problems. Really it's a health issue.

Unless we've got good infrastructure, like housing, and supports in place I think it's only going to get worse. I think the whole system has been let run down over the years. People used to be institutionalised in places like Kenmore. They weren't nice places, but the thing is we need to be able to stabilise people and try and educate the community that this is an illness. Don't isolate them all or make fun of them because they're sick.

THE CHAIR: Thank you very much for coming along today; we appreciate your attendance. Julie, you know the drill; you've been here enough times. You'll be getting the transcript. Please check it for accuracy. If there's anything else you want to add, just get in contact with the committee secretary and we'll be happy to hear anything further. Of course, if anything arises out of the transcript we'll be back in touch with you. Thank you for making yourselves available.

The committee adjourned at 11.56 am.