

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

**Inquiry into the provision of supported accommodation for Victorians with a disability
or mental illness**

Geelong — 23 October 2008

Members

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Ms K. Spinks, clinical coordinator,

Ms R. Wright, housing and support worker; and

Mr N. Braybrook, housing and support worker, Homeless Outreach Psychiatric Service.

The CHAIR — Good morning and welcome to the public hearings on the committee's inquiry on supported accommodation for people with disabilities or mental illness.

The committee is looking into issues such as the standard, range and adequacy of care and accommodation currently available, the appropriateness of the current service providers, how unmet need is managed in Victoria, accessibility and appropriateness of accommodation for rural communities, ethnically diverse communities, indigenous Victorians, and the impact of the current service provision on families and carers.

The committee is an all-party investigatory committee of the Victorian Parliament and is due to report to Parliament by 30 June next year, after which the government has up to six months to reply to the committee's report and recommendations.

All evidence taken at these hearings is protected by parliamentary privilege, as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments a witness makes outside the hearing may not be afforded such privilege.

We are recording the evidence and will provide a proof version of the transcript to each witness at the earliest opportunity, so that it can be corrected as appropriate.

I have great pleasure in welcoming the witnesses from the Homeless Outreach Psychiatric Service: Karen Spinks, Raquel Wright, and Neville Braybrook. Can you please give a brief description of your organisation, what it does and what it stands for?

Ms SPINKS — Yes, I have brought some copies of our submissions. Thanks for the opportunity. Rachel, Neville and I are a three-person team in the Homeless Outreach Psychiatric Service in the Barwon region here and directly deal with various forms of accommodation.

I refer to the first page of the submission headed 'Supported Accommodation Submission'. Pathways is the largest service provider for supported accommodation in the region for people with a mental illness. There are 12 group homes and 22 housing and support programs, of which Pathways have nomination rights via the Office of Housing. Tenure is long term, aimed at psychosocial rehabilitation. Our team, the Homeless Outreach Psychiatric Service, is a partnership between Barwon Health and Pathways psychosocial support and rehabilitation service. I work for Barwon Health; I am the clinical coordinator and provide clinical support, and Neville and Raquel work for Pathways, providing psychosocial support, housing and rehabilitation.

The program covers the whole of the Barwon region, inclusive of Colac. We operate one male crisis house with three beds and one female crisis house with three beds. The program offers outreach support to clients on these premises, Monday to Friday between 9.00 a.m. and 5.00 p.m. Our current residency stats for the male emergency house shows an increase of 12 per cent from 2007–2008 and an increase of 5 per cent for females in that same period.

The program also manages eight transitional properties from the Salvation Army for HOPS clients — HOPS is us; that is our acronym — for a tenure of three months, for a maximum of 12 months. The average stay has been 21 weeks while waiting for public housing or attempting to find private rental. Within the HOPS program all clients referred are not provided with housing or shelter. The reasons for this are varied and include limited resources at the time of referral — we probably have no vacancy — and assessment for suitability into the program may exclude clients due to their high needs or risk issues. The places do not have staff attached to them; we have an outreach capacity and it is Monday to Friday. If there are any issues around risk — be they violence or drug use — often we may not be able to take people into the program, due to the lack of support available.

Neville will now discuss the unmet demand with the program.

Mr BRAYBROOK — There is a second handout, which I will read too, headed ‘Unmet demand’. This segment of information for the committee addresses a part of the terms of reference that seeks to understand the unmet demand within supported housing and how it relates to our program. It is about how we currently measure this and how that might better inform a system to measure unmet demand in the future.

First of all, I would like to present some graphs relevant to the HOPS program that were created from referral data collected last year and this year. It is important to note that the graphs are a representation of activity in the program and are not necessarily a detailed analysis as such. I would also like to present a blank template of the data collection form that we used to create the graphs. I guess that helps to give you an understanding of how we provide this representation.

There are four attachments at the back: one is the current data collection format that we use; another one is a brief snapshot of the data collection figures; and the other two coloured graphs are representations of the activity. They both represent the same figures; they are just a different type of graph, to provide some variation in how you might view it.

Some of the data I went through was incomplete, so I did an average to gain an overall picture. However, the information presented has been properly accounted for and accurately reflects the demand on the program and the outcomes.

What is clear is that there is a distinct shortfall in the supply of accommodation for people with a psychiatric disability in proportion to the referrals seeking this. Generally speaking the supports can be made available to the clients, but the accommodation is not so readily supplied.

Ms WOOLDRIDGE — Neville, could I just ask one clarifying question, just to understand the context: where are your clients coming from?

Mr BRAYBROOK — The referrals coming in from?

Ms WOOLDRIDGE — Are they coming out of a CCU — what is the status of your clients who are then seeking this sort of accommodation?

Ms WRIGHT — The majority of the clients we have are clinically case-managed clients. That means they are case managed by Barwon Health clinicians, so it will be a community team, or from the housing sector. If it has been identified that someone might have a mental illness, Karen, being a clinical person, is able to do that assessment and we are able to work with that.

Ms WOOLDRIDGE — Thank you; I just wanted to understand that.

Mr BRAYBROOK — Getting back to the referrals coming into the program, for example, of the 393 logged requests for referral and secondary consult over the last two years, only about 116 were able to be housed by the program.

That not only included being housed in our specific emergency accommodation and the transitional housing we have access to, but it also included using other forms of crisis accommodation, such as the Grovedale Motel in Geelong which is run by the Salvation Army. In rough terms this equates to about two-thirds of demand for housing being unmet.

Much of this unmet demand is dealt with by way of referral and secondary consult using creative but nonetheless less-than-satisfactory ways of responding in the absence of available housing.

It is also worth noting that over the same period and using internal data collection methods to track occupancy and emergency accommodation, that there was an increase of 17 per cent from 2007 to 2008. That is tracking a small period from January to August for both those years, so that is a

17 per cent increase over an eight-month period rather than a 12-month period. If you break that down, it is a 12 per cent increase in male referrals and a 5 per cent increase in female referrals.

It is also worth noting that the opinion of us at HOPS is that demand is increasing. For us, one area that is worth watching is early intervention, where supports and services have currently increased, and referrals are increasing from that area, with no corresponding housing support coming along with this.

There is a growing demand for supported housing for young people as well as adults, and they have quite differing support needs. In the meantime there is a significant unmet demand that needs further analysis and addressing.

I have highlighted some examples of the 2007–08 unmet demand outcomes. This gives you an idea of some of the things that happen for people we just cannot cater to. We do not have the capacity to: caravan park accommodation is something that happens for people; crisis motel brokerage; ending up in rooming houses; being referred to maybe a youth housing service, and even they may not have the capacity to house people.

One that is really common is staying on in unsatisfactory circumstances, because there might be quite a lot of difficulties with the family supporting a person, yet they nonetheless have to stay on with the family because there is nowhere else for them to go. A consequence of that is sometimes families take out intervention orders on family members because it breaks down and gets to the point of complete breakdown.

Does anyone know what couch surfing means within the housing sector? Another one that is quite common is moving illegally into other supported accommodation, so we have other people living in supported accommodation throughout the region. People who are homeless know one another and mix in the same circles and often will help each other out, so we are often dealing with that. Sometimes they remain as inpatients, but often there is pressure on beds, so that is not that common, but it can occur.

Some remain incarcerated. People cannot be granted probation or parole, so they remain incarcerated because they cannot get the accommodation, yet they are being referred to us. We are getting quite a few people through the prison system coming to our program.

I put down religious refuges on the list, because some clients are being approached by religious organisations around the town and are being housed in houses around the area. There could be up to six or seven people living in one house. It is not necessarily a good outcome for them, but they are taking it out of desperation.

In other circumstances we are not able to house them in our crisis accommodation for duty-of-care and risk issues. It could be that they have a propensity to be violent towards another person, some quite heavy drug use or some other risk factors going on. We are not in our emergency accommodation all the time to monitor the activity.

Another unmet demand outcome could be referrals to drug and alcohol rehabilitation facilities, and quite a lot of other unknown outcomes.

HOPS staff opinion would be that an increase in the availability of supported accommodation would go some way to reducing the cycle of homelessness that we often see in our client group.

Certainly among our client group there is a recognisable repetition of some client names that have surfaced while sifting through files and data. This is not unusual in services such as ours, but is probably an indication of the consequences of not being able to provide housing along with support. Support does not seem in short supply, but with housing there are clearly significant issues with its short supply.

Ms SPINKS — If you can just go back to the supported accommodation submission, I would like to speak a little bit about some of the supported residential services that we attempt to use. Within the Barwon region there are three supported residential services which HOPS attempts to use to access for high client needs with a mental illness. The problem in access for residential placement has numerous points. Firstly, the accommodation is not dedicated to mental illness clients. Vacancies, if available, are very competitive amongst various other groups, including the elderly, the general homeless population, drug and alcohol and forensic clients.

Within one particular area we are using, it started off as elderly hostel-type, and they have taken in different populations. Who knows why? This mix in itself raises many issues, one of which is safety and risk both for staff who work in the environment and clients who live there. Staff within these organisations are not trained in the area of mental health or forensic, or drug and alcohol issues. Termination of tenure is not an uncommon option for SRS management who are unsure how to manage or access appropriate supports in the face of client complexities.

Another issue difficult for client placement is the cost of the SRS accommodation. Most facilities cost the amount of a disability or Newstart benefit. Whilst food and shelter are provided, it leaves no money for clothing, transport, medication or entertainment expenses. As a long-term option, this leaves people with little scope for future planning, quality of lifestyle or goals or any independent living.

We also have people in our program on public housing waiting lists. The common difficulty is the limited stock and the lengthy waiting periods to get allocated housing. As an example, within the HOPS program lengthy waits for public housing creates limited movement to take on new clients. Transitional properties are leased long term due to the housing waiting lists, and our success in the private rental market is limited due to the high cost of rentals and the reluctance of real estate agents to take on unemployed, mental health or pension tenants.

Allocation into dense high-rise flats for clients who are vulnerable as well as limited long-term supports by mental health agencies contribute to the observed breakdown of housing amongst our client group.

In reality, resources for ongoing support are limited. For example, HOPS has limited capacity with 2.5 EFT staff to maintain ongoing support to people housed in the public sector. Within the community mental health teams high-rise density public housing has required staff to attend these premises in pairs for safety. The assessed risk factors for staff, let alone client safety, impinge on the level of support able to be provided. It becomes a resource issue.

While dialogue amongst services tries to address this problem, all agencies within the region express limited staffing levels for support once people have exited their programs.

One thing I would like to bring up is the budget allocation for non-clinical organisations, which was set at 12 per cent 15 years ago and has not been reviewed since. Within Pathways we still only get 12 per cent of the mental health budget.

Mr SCHEFFER — Could you say that last sentence again?

Ms SPINKS — The budget allocation for non-clinical organisations, such as Pathways, is set at 12 per cent of the total mental health budget. This was allocated 15 years ago and has not been reviewed since.

Different approaches that we thought could be considered, or what our program would like to see happen, include hostel-type accommodation with staff and their offices based on site. This need not be a 24-hour support; however, having staff on site from Monday to Friday could assist with intervention, risk needs and ongoing support. For HOPS ideally this would be of a three-month tenure, as opposed to the 14-day model which we currently operate under and does very little to

provide relief for people from the stress of homelessness. We can only sign people up for 14 days, and the reality of us finding anything in 14 days for someone is very limited.

Another model is a cluster of units with common room and kitchen, with staff on site 9 to 5. This would address the gap between the HASP and the SRS accommodation. Clients of HASP properties do not always receive the level of support required, but are not yet ready for residential support where they become deskilled and dependent.

Within the team we devised a questionnaire — the ‘Enquiry into supported accommodation questionnaire’ — which we handed out to clients. We offered it to 20 clients of Pathways and HOPS and actually received a return rate of 52 per cent, which, although is a very small sample survey, is a very good percentage return for a questionnaire.

On the front page you will see that the clients ranged in age from 17 to 49 years. Nine males and two females answered the questionnaire. Their current housing situation was that two were in our crisis accommodation, five were in supported accommodation — like group home style — two were in a public housing unit with outreach support and two were in transitional properties by the homeless outreach service. The cultural backgrounds saw that a majority were Anglo-Australian, with one indigenous client. They all reported being on treatment. Eight reported being on daily medication. Seven people reported previous homelessness, ranging from four days to seven months.

I will give a brief overview of the questionnaire. Data was collected via the questionnaire, which rated responses according to five categories. I have also popped in a copy of the questionnaire for you.

According to categories, they range from ‘strongly agree’, ‘mildly agree’, ‘neutral’, ‘mildly disagree’ and ‘strongly disagree’ and comments were encouraged at the end of each question and have been recorded in the data. I have just presented it here and am going to give you an overview, but certainly if you want the completed survey of all the range of percentages, you can make a request, and we will provide that for you.

Question 1 was broken down into categories, asking clients to rate their experience of supported accommodation in Victoria. In relation to the satisfaction of availability of supported accommodation, a combined total of 63 per cent stated they did not agree that there was enough available supported accommodation.

An overwhelming 90 per cent of clients would prefer not to live in shared accommodation, preferring their own unit. Sixty-two per cent disagreed they would prefer living in a group environment with support workers available. In the face of this statement, 90 per cent of participants stated that they were very satisfied with the adequacy of care that they were receiving, with a further 62 per cent of the clients agreeing that the treatment and the planning process in trying to access supported accommodation was helpful.

Conclusions to this could be interpreted that, although people were highly satisfied with the care they received, they prefer to live with as much independence as possible. Support and care was highly satisfactory; however, it meant that sharing with others who also had a mental illness was necessary as the option of living independently was not available. Whether this is because of low housing stock or the model of care has not been addressed in this survey.

Question 2 highlights implications of those with a mental illness unable to access supported accommodation, and participants were asked how strongly they agreed or disagreed with the following statements: ‘continuing homelessness increases vulnerability to violence’, and 72 per cent stated they strongly agreed with this statement. ‘Continuing homelessness increases vulnerability to drugs’ reported a 72 per cent agreement. ‘Increased vulnerability to other crime due to homelessness’ surveyed 63 per cent who strongly agreed, with a further 27 per cent mildly agreeing, resulting in a combined total of 90 per cent believing that homeless clients with a mental

health issue were at increased risk of crime. It was not explored whether this was a victim or perpetrator role. 'That mental illness may become worse due to homelessness' returned 100 per cent agreement.

Comments forthcoming cited that access to safe, supported housing with increased availability of crisis accommodation was the solution. A positive return of 81 per cent agreed that continuing homelessness caused an increased burden on significant others and their life. They said they lost friends and were no longer able to spend time with family. Interpretation of these comments highlights the increased isolation and marginalisation of people suffering from mental illness who are unable to secure support in accommodation within the community.

Question 3 explored the various kinds of supported accommodation in Victoria; it looked at the three areas of supported housing — community housing, for example, like Pathways, what we provide; the private rental market; and government funded housing, which was public housing.

Accommodation in the private market highlighted a 45 per cent disagreement for satisfaction. Seven of the 11 clients offered comment that the private rental market was too expensive for their income and further comments stated that they felt discrimination was a factor in not being able to access private rental due to prison release or mental illness.

Although 45 per cent of clients agreed that they were satisfied with the government managed housing, this question generated the highest comment response rate. Eight clients gave feedback and comments cited was that there was not enough housing stock and those waiting lists for public housing were very lengthy. They also stated a lack of understanding of mental illness by people working in this sector, with another client feeling that the housing workers did not care. Interpretation of comments could suggest that this area of housing requires increased training in mental health. Ongoing support for clients by the mental health workers in public housing would address the issue of lack of understanding.

An overwhelming 100 per cent of participants reported that they were satisfied with the care and accommodation they received from the community sector. However, comments reported that there was not enough availability of this type of accommodation and that the crisis accommodation was very short term. It was clearly articulated that the lack of availability of housing was a major concern across the three service providers.

Question 6 asked for comments regarding other issues that needed addressing and had not been mentioned in the survey. Two opinions were put forward. One was satisfaction with the affordability of supported accommodation but also mentioned was a feeling of belonging and decreased isolation. In contrast to this, another stated that supported accommodation and sharing was very hard and had a negative impact on their mental health.

Overall the survey highlighted the satisfactory support of services that provided care to the clients with a mental illness. Clients surveyed would prefer to receive this support within their own home as opposed to sharing. The availability of independent housing was seen as a barrier to this ideal.

Ongoing homelessness was identified as having a detrimental impact on a person's mental state, exposing them to further negative influences of crime, drugs and violence. We would like to express our gratitude to all the participants in this survey and sincerely wish their opinions will assist the inquiry to provide resources for housing in the future.

Mr NOONAN — Thank you for the comprehensive documents that you provided, and pass on our thanks to those who participated in that survey; it is very helpful. If time permits, I will ask you a question on that as well.

If I can just go back to Neville's presentation, the first paragraph on the second page grabbed my attention. You referred to one area worth watching was early intervention where supports and services have increased, as have referrals. The question I was wanting to ask is whether or not

early intervention programs at all support a person's need perhaps to go on and require supported accommodation or whether any of that early intervention perhaps keeps an individual in the home or in other arrangements that suit them?

Ms WRIGHT — I can probably answer that. What is sort of happening is: if we have someone who is in their own accommodation, whether it be public housing, whether it be private rental, and they have a link to a service like ours, a phone call or just a visit, that intervention can stop that from breaking down. But if we do not contact people or we are not able to stretch ourselves to that, that might break down and they will reoccur — they will actually be going through our program again. It is sort of a cycle.

Mr NOONAN — I will ask a follow-up: did you want to add anything, Neville?

Mr BRAYBROOK — I think there are probably a few different factors with early intervention going on. Some ways an early intervention could use our service is almost as a pseudo-respite, and that is about stopping family breakdown and wanting to use our service in that way. Although that is happening in a limited way, that is one of the services that we offer.

I think it is probably a little early to even answer your question properly at this point, because what is happening is funding has come into headspace and the early intervention services, and because that funding has come in and workers have come in, the referrals are now starting to come through in greater numbers from that service.

I guess we have not had enough time to really analyse what is sitting behind that in terms of demand for housing, but every referral that comes through from the early intervention services is seeking crisis accommodation and seeking transitional housing. That is generally because the family is having trouble coping with the young person's drug use or drug-induced psychosis, and there is some difficulty going on at home. Does that answer the question in some facet?

Mr NOONAN — Yes. I suppose for the committee's benefit what I am trying to determine is whether additional investment in early intervention will actually assist in potentially reducing the demand for supported accommodation or in fact whether it will increase because —

Mr BRAYBROOK — My view is, and it is hard to know how accurate it is, that it is probably uncovering something that has been sitting there and is just starting to reveal the numbers a bit more, so the demand could grow.

Ms SPINKS — But I think that as far as things go, we had some very young people answering the questionnaire. The supports are there, and there are clinicians to support them, but what they need is housing. The stock is not there. Clinicians are spending a lot of their time doing this patch-up thing trying to keep the family and everything together, and maybe it is just not possible to do that.

There have been a lot of reports lately about the increased violence parents are receiving from children. There is increased violence in the home, and we certainly come across families who have taken out intervention orders against their children, which must be a very difficult thing to do, because there is nowhere else to house them. I think the support is there.

Mr BRAYBROOK — Something else comes to mind. While I have been working at HOPS, I have been working with another agency in Geelong, which is a youth housing agency. Sitting alongside this is normal young person development. A lot of these young people are at an age when young people would normally be considering moving on and having their own independence. That normal developmental time is occurring in their lives.

For example, you could have a 22-year-old or 20-year-old sitting at home who is wanting to have that independence, but at the same time there are drug and alcohol issues going on, there are

mental health issues, a whole bundle of that sort of stuff going on, so they do not necessarily have the capacity to support themselves independently for independent living. Yet they desire that as well at the same time. You have that normal developmental stuff going on the same time. They are wanting to have that leap into independence as well.

That sort of stuff is happening in parallel. In that sense the demand for housing will grow because they will want to leave home themselves, the family will be wanting them to leave home, and that is where you start to get individual factors that are maybe separate from the mental health and clinical factors and are just normal social factors in terms of young people wanting independence.

Mr NOONAN — I have a straight yes or no question. More investment in early intervention would reduce potentially the number of people who would be requiring supported accommodation: yes or no?

Ms SPINKS — I do not think it can be a yes or no answer, because we are talking about housing stock. If I was to see you and you have not got a house and I am supporting you but I cannot provide that house for you, what sort of support am I really giving you? If I cannot house you, what am I giving you?

Ms WOOLDRIDGE — I am interested to look at the interaction or the transition between the more treatment-based options like CCUs, PARC facilities — I think there is a recent PARC down here — even discharge from hospital, and then your service. You have talked about community teams. One of the things the committee has heard is you can get up to two years in a CCU but then that is it and what happens after that? Some people go to SRSs. I would just be interested to hear about your context: what is the relationship between the clients you are seeing and what has been happening in the more formal treatment and acute end of the service system?

Ms SPINKS — We find that we get a lot of referrals from the mental health acute unit, the PARC and the CRF. We get referrals from them. Sometimes when people are acutely unwell, families disappear and they are left in the hospital setting. Families think they are secure and they are not. The families say, ‘Well, this is it now. We can’t have you back’.

Ms WOOLDRIDGE — What happens to them?

Ms SPINKS — They are referred to us, and if we have an availability they will come into our 14-day crisis accommodation. We will sign them up for those 14 days and within that time we will apply for public housing. They will go onto the public housing waiting list. We will have a look at the private rental market but we do not have a lot of success, as already stated, and then we will try and put them into some sort of transitional accommodation.

We will go through the SRSs. Sometimes we are putting people in SRSs who are 30 years old and they are in no way ready to give up cooking and looking after themselves, but we have very little option. We are getting a huge number of referrals from the forensic service which has certainly increased in the two years that we have all been —

Mr SCHEFFER — I have a question in relation to the housing issue. I guess it is clear that the lack of general affordable housing also has an impact on the work that HOPS does, it intersects with that. You will appreciate that over the last few years there have been significant changes made to the operational flexibility of housing associations, and we have received information and talked to different people around the work that some of the housing associations are attempting to do to create more flexible models for a lot of sectional needs. Have you worked with any of the housing associations here and is that proving potentially to be positive? How is that working out for you?

Ms WRIGHT — It is still quite limited in terms of how many places we have for our clients. We are involved in what they call the BHAG (Barwon Housing Advisory Group) here in Geelong, so we attend all their network meetings and we are part of the LASN group and we were

updated with housing associations. We have Yarra Community Housing down here and we have had — how many clients?

Ms SPINKS — I do not know.

Ms WRIGHT — We do have clients that can access it, but it is limited.

Mr SCHEFFER — Yes, I appreciate that. That is on the present provision, but I guess I am trying to invite you to look a bit forward. Do you think that has the potential of being able to alleviate some of the issues?

Ms SPINKS — Yes, I think it has the potential to alleviate them. I just recently went to a bit of an emergency meeting with Yarra Community Housing. Their issue is that once people are placed in there — they offer us the position and supports then step back. They have been left floundering as to who to contact when complaints are made about clients within these supported accommodations. What came out of that meeting was that when they are placed in there — other services like Bethany and ourselves just do not have the resources to continue that ongoing support — people are left in these situations often unsupported, and it is creating a problem for the community housing.

Mr SCHEFFER — So in your work with the housing associations, what do you think needs to be strengthened?

Ms SPINKS — Long-term support. But the difficulty is that once people are no longer acute, services do not — —

Mr SCHEFFER — Sorry to interrupt, but would it not be the housing association's role to do anything later in the service?

Ms SPINKS — No.

Mr SCHEFFER — That would be providing the kind of flexible accommodation that you have described. In relation to producing what it is that a housing association can produce, what do you think needs to be done to make their capacity greater?

Ms WRIGHT — Offer support for the accommodation. Offer some sort of support.

Mr SCHEFFER — Thank you for that. We are a bit pressed for time here, but I absolutely appreciate what you have described — it is serious; there is no doubt about that and I am not going to ignore the evidence you have provided to the committee — and I want to ask you to reflect on some of the changes that have occurred over the last few years with the introduction of the revised Disability Act 2006, the disability plans, the individualised approach to supporting people with mental health issues and people with other disabilities, and also considerable investment of something like \$128 million, I think, in the last budget in the mental health area. I just ask you to perhaps reflect on that and whether you think this is taking us in the right direction or whether it is maybe not so well geared?

Ms SPINKS — Personally I think the questionnaire addresses that, whether 100 per cent of people said they were completely satisfied with the service that was actually provided by workers. They just did not think there was enough stock. I guess that that is fairly well covered.

Mr SCHEFFER — Thank you.

The CHAIR — You mentioned that the main issue is the shortage of housing stocks. Apart from that, for the record, could you recommend any other models apart from investment in housing stocks? Are there any other ways to improve the situation?

Ms WRIGHT — We talked about a hostel model whereas at the moment we have two different houses. They are both three-bedroom houses in the community. We are able to accommodate three people in each but the support is only from 9.00 a.m. to 5.00 p.m. and not on weekends; that's it. We are looking at a model that would be like a hostel situation where workers would be based. We would be able to sign them up for three months, giving our team a little bit more time to work with people and get them partnerships.

Ms SPINKS — More partnerships within the organisations instead of the stand-alone the Salvation Army has there — partnerships that pull all the resources together. We are only a tiny partnership between the non-government and government sectors but it works really well. We get more of a flow of communication.

Mr BRAYBROOK — Certainly the crisis housing model needs to be expanded because the 14-day model we are pursuing at the moment is really impractical. That is just a triage or damage control model because it is about having a limited capacity, trying to jam people into those 14 days. It is a really unworkable model. There needs to be some expansion of that time frame so that you can actually house people for three-month blocks in emergency accommodation. And there certainly needs to be an expansion of the transitional housing model because there is such a lag in getting people into more stable housing beyond transitional housing as well.

We are finding we are putting people into transitional housing for a 12 month period while they are waiting for an offer from the Office of Housing. It can take even longer than 12 months, or even greater periods to even get to the Office of Housing. Basically our emergency and transitional housing is constipated, if you like, because there is nowhere for people to move beyond that.

You cannot separate out the words 'supported housing'. I think there is housing and there is support; the two go hand-in-hand but the huge issue across the whole state and across the country is housing. We are really stuffed for housing. The impact on people from a lack of housing is huge. We have seen people who are really unwell just cycling through the system because of a lack of housing. I guess that is my closing point.

Ms WRIGHT — What is basically happening is we have the HASP program, which is housing and support and is public housing stock. The condition for people who are housed in those houses is that they have to have long-term support so case managers are only able to support so-many people and that's it. There is no movement. What happens to anybody else who is applying for a service? There is no availability.

The CHAIR — All right. Thank you very much for your presentation.

Witnesses withdrew.