TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into the adequacy and future directions of public housing in Victoria

Melbourne — 11 February 2010

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Witnesses

Mr S. Biondo, executive director, Victorian Alcohol and Drug Association, and

Mr P. Matthews, manager, supported accommodation, vocational training and financial services, Odyssey House Victoria.

The CHAIR — Welcome to the public hearing. This is a parliamentary inquiry, not an inquiry commissioned by the government. All evidence taken at this hearing is protected by parliamentary privilege, as provided in the Constitution Act 1975, and is 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 states and territories. Any comments you make outside the hearing will not be afforded such privilege. We are recording the proceedings and you will be sent a copy of the transcript, to which you are able to make minor adjustments, if necessary.

This session will be for about 45 minutes. I invite you to make a verbal presentation and, if you could, please restrict it to about 25 minutes. It will be followed by questions from the committee. Before beginning, please introduce yourselves and also your terms of reference.

Mr BIONDO — My name is Sam Biondo. I am the executive officer of the Victorian Alcohol and Drug Association. To my right is Peter Matthews from Odyssey House. Peter is the manager of supported accommodation, vocational training and financial services. Peter is very much the hands-on person in this presentation.

I must thank the committee very much for the opportunity to be heard here today. It is a critical and very complex issue for the Victorian community, and I think the community will be very grateful for the amount of time and effort that is going in to hearing from at least a fair smattering of representation in the community on this particular issue. Obviously we will be speaking with an alcohol and drug slant. That is the part of the spectrum we are focusing on.

As the peak body for the alcohol and drug treatment services, VAADA's submission focuses on the public housing needs of people experiencing problematic alcohol and drug use. It is well recognised that housing provides the stable base from which people can engage in drug treatment services and the best place to effect change in their lives. Without access to safe and appropriate housing, the opportunity for recovery from drug dependence is reduced and people's health and wellbeing are placed at continued risk.

We are firmly of the view that AOD (alcohol and other drug) clients need public housing options that support recovery from dependence, rather than being set up for a fall and destabilising efforts, to reduce harm and to effect positive changes in their lives. So housing availability is integrally linked with rehabilitation. Supporting drug users to access appropriate public housing will deliver positive returns for the individual user, drug treatment providers and their efforts, housing providers, and the broader community generally.

The way I would like to go through this presentation is to segment it as to your terms of reference and make a comment on each. I am not sure that I need to bother you with some statistics which I have gathered in the general area. You may be familiar with the broad waiting lists and the difficulties of people accessing, so I will just leave that.

VAADA contends that for AOD treatment clients, public housing waiting times are prohibitive to recovery. Many in need of housing are unable to access properties due to excessively long waiting lists and the lack of diverse housing stock. There is a serious lack of one and two-bedroom houses for singles and small families; it has been suggested that single people can expect to wait up to seven years for a public housing property. AOD service providers indicate that particular groups of AOD clients, namely young men, singles, people exiting correctional settings or those with a history of offending, face disproportionately lengthy waiting times.

There is a lack of affordable housing options, particularly for AOD treatment clients who, with drug users, are currently in rehabilitation services or in transitional housing properties in Victoria. Renting privately is expensive and difficult to obtain for this particular group, and many AOD clients only receive a disability support pension which barely covers rent, where they can afford it, and other basic necessities.

Many clients rely on food vouchers and food parcels from material aid organisations. A lack of affordable housing is a significant contributor to AOD treatment clients being housed in inappropriate dwellings such as rooming houses, caravan parks, hostels, couch surfing and rough sleeping.

In regard to the impact of the segmented waiting lists, we believe that the current Office of Housing system for segment 1 housing is complex and time-consuming for applicants as well as for workers assisting them. The lengthy wait time for accommodation often means that many clients give up waiting for an allocation and enter

into inappropriate and insecure temporary housing with a whole range of other attendant issues associated with that.

The current system, whether it be Office of Housing or transitional housing, places enormous pressure on applicants to choose broad-band areas that are quick for allocation. When faced with such restrictive choices and the desire to be housed, health considerations become secondary. The consequence of this is the inevitable relapse back into substance abuse which mitigates against the rehabilitative efforts that clients of support agencies have been through.

There are a range of pressures faced by transitional housing tenants who also feel pressured to move into less-than-ideal housing when it arises so that property or a room is freed up for someone else. Consequently many AOD treatment clients move to rooming houses, caravan parks and other unsatisfactory accommodation. The weekly rent for one bedroom in a private rooming house can range from $170 to $300 a week depending on location.

For AOD treatment clients who get generally more expensive private rental or rooming houses, there are often severe financial consequences and the likely removal from the public housing waiting list, so there is a double jeopardy situation. If nothing else, an overhaul of the segmented system is long overdue, given the difficulties with access.

It would be appropriate to allow people to explore self-reliant options, including the ability to establish employment, without risking their access to public housing. In addition, the current high and unmet demand for public housing properties has created longer waiting periods and reduced options for AOD clients exiting crisis transitional housing.

Ten years ago the average stay in transitional housing would be three months. In 2010 the stay for a family and singles averages from a 18 months to five years. VAADA recommends flexibility in transitional stock management, including the capacity of some transitional housing to become long-term tenure where individuals, families and children have settled into a suburb and a school.

VAADA makes three comments in relation to adequacy, quality, standards and safety location issues: firstly, there is simply an inadequate supply of housing stock and as a matter of urgency the Victorian government with the support and assistance of, I suppose, the national government must significantly increase public housing stock. Secondly, current and future housing stock must be diversified to better meet the needs of the Victorian community, including the needs of AOD users. At the present time many AOD clients are placed in unsuitable housing that is situated in environments with high levels of drug use. Thirdly, public housing must be integrated with appropriate social supports and service provision, and this is vitally important for people experiencing harms associated with alcohol and drug abuse.

In relation to the safety and location of Victorian public housing estates, from our perspective many public housing estates are grossly inappropriate for people exiting treatment and recovering from drug and alcohol addiction. While our comments are specific to AOD, we acknowledge that this population is only one of many groups with specific public housing needs. We would therefore argue that an overarching principle of public housing allocation should be to match housing to people's needs. This is no easy task but we need to improve the capacity of housing services to match housing to need, inasmuch matched to a healthy and situationally appropriate medium.

With respect to the impact of public housing need on specific groups, today's evidence seeks to emphasise a number of issues for AOD clients: one, that urgent action is necessary to increase public housing stock for Victorians in need of housing support; two, greater diversification of housing stock is required, including single-bedroom accommodation; three, housing must be better matched to people's needs; four, public housing must be integrated with service infrastructure and linked with a range of social community services available to support people in addressing their drug and alcohol issues. Most importantly, AOD clients need public housing options that support recovery from dependence rather than destabilising efforts to reduce harm and to effect positive change in their lives. I will leave my comments there for the time being.

The CHAIR — Thank you very much.

Mr SCHEFFER — Thanks for that, Sam. We have heard pretty clearly from people about the housing stock situation, that there is not enough. We are right on that and understand that part of it, so that is one point, but I would also add to that that you would be aware, as we all are, that there has been a huge push on that area so that we are going to be seeing some changes in that area. Keeping that in mind, as well as that, there has been a whole, I think, huge lift-off in policy initiatives and certainly public-debate perception around alcohol and around other drugs in the community. There are lots of innovations going on there.

Could you paint a picture for us about how a person who, for example, finds themselves coming out of a rehab process, how they then interface with the housing situation? What is available to them? What can happen positively and what can happen negatively for them?

Mr MATTHEWS — I am coming from a transitional housing base, I run supported accommodation programs. We would hope, with my Odyssey hat on, coming out of a rehab if you have been there for 12 months that you might re-enter the private rental market, and you have got a job and you have done all that. We would have a percentage of people exiting that way.

To come into our programs, there is the transitional treatment program which is not really after rehab, it is more coming from the courts and coming from the homeless sector. We will take you in and theoretically I can hold you for about 12 months. The system, as it is at the moment, sort of works for me if somebody has children in — I have forgotten the formula — 24 per cent of their care or something like that.

So everyone who comes in ends up being eligible for segment 1 housing. It is very rare for us to get someone who would not be eligible for segment 1 housing, and usually we can house a small family or someone in those circumstances within about a year. My head is adjusted to: that is how long it takes to get an Office of Housing property.

What I cannot do, and this was one of my big concerns, is do that for single people. If I take in a single person, I am likely to have them for five to seven years sitting in one of my properties which I cannot do in a 12-month-type program. I am almost discriminating against single people.

I have had situations where someone might be applying to come into our program, for example, from a boarding house, and I will make sure that at an assessment point we have sat down and had a very clear story about what we are going to achieve in seven months. My time lines are dictated by leases, three months initial lease, 120-day notice to vacate for no particular reason. Sometimes I am not sure that we would not disadvantage our clients by bringing them in, offering them some stability for a short period, and then probably putting them back into the boarding house where they came from.

Mr SCHEFFER — Can you describe how that affects their treatment and dealing with the drug or alcohol issue, knowing that they have a year but really the signal is that there is nothing going to happen after that. What happens during that year, to them?

Mr MATTHEWS — To them, on an individual basis, we will take some people in because — when they are coming from being about alcohol or drugs it is usually not just dealing with the substance, they are somewhere in that story, dealing with that. Then you have got, 'Have you ever worked before or how long since you have worked?' and all that sort of stuff, so that is the next part of the picture. Then there is, 'Have you ever rented a place?' and all that sort of stuff.

It almost depends where you are in those stories. We can move some people in, we can get some people into employment when they are well on their way to recovery though in that process. There are not always good endings at the housing point. Sometimes they are going back to family et cetera.

But that is what I was trying to say before. I might actually suggest that somebody does not come into our program because I do not think we can do any better for them than where they are now because I do not think I can deal with all their alcohol and drugs, employment and housing issues in a seven-month window. I do not think we would be able to do it.

As a backstop, I have 40 beds in metropolitan Melbourne, I have 10 in Shepparton, and when I wrote this I had 40 people on my waiting list to come in. At that point, when people start ringing in and you say it is going to be at least three to six months before we even talk to you again, your waiting list starts to stop anyway because

people think, 'What is the point?'. We go through a cycle like that. I never have to advertise. I am always running a long waiting list to get in.

Mrs POWELL — With the waiting lists, obviously when people want to get off drugs and alcohol, they make a decision and if there is too long a wait, then obviously that moment has gone, and you have lost them.

Are there times when you can have somebody deciding that because they are homeless and they have made a decision, that they do not want to be homeless on the streets any more, they want to get help, that you are able to get them into some sort of help and maybe some accommodation straight away?

Given, if you are successful and they go through, and you have dealt with their problems, is there somewhere that they can go into as a transition? Or is that what you are talking about, because a lot of people might decide that they are quite happy with what you are doing and might want to stay there rather than move on, because they know that someone is looking after them, giving them all the support, and once they get out to the big bad world, they are on their own. How do we deal with that so that you do not have that cycle of them coming back all the time?

Mr MATTHEWS — Given alcohol and drugs are chronic relapsing conditions, we are always going to have a percentage of people who re-present. We have some people for whom we are the transition in that sense. We sort of know, by the time we have got you, if it takes 12 months for your Office of Housing to come up, whether you are going to make it not, by that time, because if you were not going to make it, you have usually relapsed and got very messy before then. If you are still in good shape, we would do a handover to local services where the Office of Housing property was, and then I do not have much follow up. I have only a six-week window to do a handover, and then I am back down the front end. So I do not always know what happens in the long term.

Mrs POWELL — But if that person relapses and comes back through your system, do you take them back or do they have to go somewhere else?

Mr MATTHEWS — No, we give people another chance.

Mrs POWELL — A couple of times?

Mr MATTHEWS — But it is not just about that. It will be about detoxes; it might be, 'Look, my housing program does not work for you. We think you need to go to rehab 24 hours for a period of time and then come back and talk to us'. There are various issues.

Mrs POWELL — But the housing is critical, isn't it? They need to have a stable, secure base for you to be able to get those services to them?

Mr MATTHEWS — Yes.

Mr NOONAN — My question is similar to Jeanette's: it is about this notion of a revolving door and how much housing creates that revolving door situation. That is the first aspect. The second aspect is that I have a couple of high-rise towers in my electorate. How could the system be improved? Is there a flagging system with their application to ensure that in some way people who are not appropriate in terms of their situation do not go into high-rise accommodation, so that situation is not created in the first instance?

Mr MATTHEWS — We do that. I do not think we can get people into your high rise; it is too good a view. This conversation about whether you would put people in high rise, we know where they all are. So when we are putting in segment 1 applications, we tell people not to put in 'this region' and 'this region' and 'this region', because 'You might end up in a high-rise flat'. That is how we would do it as the drug and alcohol agency. I do not know if everybody does that; I presume they do. So you do not have to flag anything because we know where we do not think it would be healthy.

Mr NOONAN — So they flag a broad-band area?

Mr MATTHEWS — Clients have the choice and then we would have a conversation with them about the choices.

Mr NOONAN — But should it not be in reverse? If the system worked properly, you would not be deliberately manipulating your application, or those who use your service manipulating the process, in order to avoid a high rise where you say that there is a problem?

Mr MATTHEWS — If the system worked well.

Mr NOONAN — If this committee were to make a recommendation, are you suggesting that we ought to perhaps look at that area?

Mr MATTHEWS — In terms of our clients going into high rise? I do not think you should cluster our clients anywhere probably, as a general principle.

Mr BIONDO — One of the fundamental problems that occurs is the clustering and then the vortex that is created when you get a concentration of complex, difficult people conglomerating on one site. In my limited experience I have seen what happened in the 1990s in the inner city and in Fitzroy. It just went up in smoke.

Mr NOONAN — In a sense, Sam, it is difficult because essentially they are ready to move into public housing, but I do not suspect there is any way to flag the fact that they are rehabilitated or are in the process of being rehabilitated in order to find their way forward. I am wondering how you might correct that in the system to give those people the best chance.

Mr MATTHEWS — We will be on the application as the supporting agency, so hopefully people know who we are. As a drug and alcohol treatment service we would be on the application, so there is a way of recognising it, if that is what you are looking for.

Mr NOONAN — It is somewhat artificial, though.

Mr BIONDO — What Peter was describing earlier was giving their practice wisdom where people might get a better life chance by choosing one area over another area where there is not a concentration of problems. Also given people's desperation to get housing, they may take what is quick to get and thus that increases their chances of affecting their health and other issues.

Mr NOONAN — Thanks.

Mrs SHARDEY — Thank you for your presentation. I want to ask about the whole picture of alcohol and drug supported accommodation. Can you paint a picture of how many beds there are across the entire system? Is it operating as a kind of a step down? As much as people are talking about step down for mental health patients to try to stop readmission, in a sense is this sort of supported accommodation able to act as a step down from rehab to try to stop people going back into the cycle?

My second question is about high-rise towers. What would you suggest as a way, in a policy sense, to approach changing what is there and what is obviously not good for anybody?

Mr NOONAN — I would dispute that, too. Seriously.

Mrs SHARDEY — What? That it is not good for anybody?

Mr NOONAN — Yes. You cannot make a broad statement that high rise is not good for anybody.

Mrs SHARDEY — No, though we have talked about specific types of high rise, which are noted in this submission and particularly referred to by Peter.

Mr MATTHEWS — First question: I am not sure how many supported accommodation beds there are across the state. It is a messy system. If you were to speak to mental health and drugs about a definition of supported accommodation, they would give you the definition you just mentioned in terms of it is a post-residential treatment program and for reintegration back into the community.

My programs are funded through the national illicit drug scheme and therefore my priority clients come from courts — they have to have a legal issue, have to be homeless to be eligible for the housing and have to alcohol and drug problems. I do not see those as step down; I see those as, 'I am walking right into complex clients and

you are asking me to put them in houses in the community and take responsibility for that'. There are a lot of judgement calls made along the way as to who fits and who does not. We have messes in our system regularly with people relapsing. As a treatment agency there is not much I can do about that because they have tenancy rights, so, 'As long as you pay your rent, I cannot ask you to leave'. That is one of the dilemmas. Then of course there is the percentage of people who use it the way it was designed and hoped for and move on into the community either into private rental or into Office of Housing properties. There will be some who make some improvements, but we have got to do some more work. I hope that answers your question.

I get some people from residential programs, particularly the shorter term ones rather than the long-term ones. The rest of the people come from the community, the courts, drug and alcohol agencies et cetera.

Mrs SHARDEY — And the other issue around the high-rise properties and estates where there is seen to be a drug and alcohol problem focus? Can you suggest a way that any government could approach making changes that would relieve that problem?

Mr MATTHEWS — Not easily. When I talk about them being an issue, I hear about problems on estates and people drinking and taking drugs. My problem usually relates to dealing and dealers located in them. I know some of my clients go to certain buildings for dealing. I presume that is a police issue.

Mrs SHARDEY — I am talking more about the long term.

Mr BIONDO — May I make a comment about that? There are programs that have been run over recent years in rehabilitating some of the estates and bringing back dignity, ownership and participation. A lot of that community development initiative that has gone back onto estates gives dignity and respect to the individuals living there, and that sense of pride and respect really helps. But it is a complex amalgam, and you have all that happening at the same time as you have huge demand with people's very complex problems getting priority to enter into certain forms of housing and then getting that concentration.

You are obviating one set of problems by doing all this positive stuff, and then because of the huge demand and lack of currently available stock — and some of that pressure could be relieved in the near future — you end up taking one step forward and two steps back. It is a backwards and forwards thing. If you get a concentration of certain problems coming in, it is very easy to affect that general environment.

I think the government, the Office of Housing and local communities are really working in a way that was not occurring some time back to address and nip in the bud some of the problems. But it is much more difficult in some rural and regional environments and in some city environments compared to others. In the long term I think there are real positives about the diversity of who is in those housing estates, so you have a diverse make-up in the socioeconomic sense rather than a concentration of people from just one segment.

Mrs POWELL — Can I just make the point that the issue of people with drug and alcohol problems is for them to be able to access the public housing they need to be able to have their treatment or their problem sorted out. I have visited Odyssey House in Molyullah a number of times, and people have said that it is their last chance; that if they do not get clean, then they will not be able to get housing. One of the women there said she would lose her children. It is that dire that they have to deal with their problems. If they are in a revolving door, how do we make sure they have access to programs which allow them to get clean so they can have access to the housing they need and so we are able to give them some positive movement into their lives?

Mr BIONDO — That is very resource intensive, and our treatment services are under tremendous pressure. There is a lot of lip-service given to family intensive-type services, but there is not a lot of financial support coming to our treatment services. In my view the capacity issues are quite critical. You are dealing with some of the most complex individuals, and in relation to the skill base we do not even pay people properly. There are some big problems there. If you mix that with the factors that might stabilise a person and the complexities of trying to fit them somewhere and get them stable, it is very difficult.

The CHAIR — I think we will have to wind up there. Thank you very much for your presentation.

Mr MATTHEWS — Thank you.

Witnesses withdrew.