TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

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

Melbourne — 16 February 2010

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Ms W. Smith, policy and research manager, Psychiatric Disability Services of Victoria (VICSERV).

The CHAIR — Good morning, you are most welcome at this public hearing. My name is Jude Perera; I am the chair of the Family and Community Development Committee, which is looking into this inquiry. By way of some housekeeping, this is not a government inquiry; it is a bipartisan parliamentary inquiry. All evidence taken at this hearing is protected by parliamentary privilege, as provided in 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 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 will be able to make minor adjustments if necessary.

We have a 45-minute session, and I invite you to make opening comments which will be followed by questions. Could you please restrict your opening comments to about 20 to 25 minutes so that we can follow with questions. Please introduce yourself and your terms of reference for the Hansard record.

Ms SMITH — My name is Wendy Smith; I am the policy and research manager at VICSERV. VICSERV is the peak body for agencies that provide rehabilitation and recovery services to people with psychiatric illness. We have day programs, residential rehabilitation, home-based outreach and a variety of other program types that our members offer. We have around 70 ordinary members and 50 or so associate members. In 2009 VICSERV launched a series of papers called 'Pathways to Social Inclusion'. The papers were driven by sector leaders who had a lot of anecdotal knowledge about how things were for people with a mental illness on key dimensions such as employment and education, physical health and housing. They brought together all the evidence they could find to support this tacit knowledge and published it within a series of documents.

I refer to the housing research and some of the things that showed. One of the key things was that two-thirds of people with a mental illness identify housing and housing support as the most important issue in their lives. A really big study showed that having adequate and secure housing has been proven to be a better predictor of reduced hospital admissions and clinical interventions. It is absolutely vital for recovery. Around 30 per cent of people who are homeless have a mental illness. Half of those had a mental illness before they became homeless; half of them developed one after they became homeless. Some 42 per cent of people with a mental illness live in insecure housing such as rooming houses, hotels, rented rooms, emergency accommodation or shelters. One of the other things that the research showed was that only 27 per cent of people with a mental illness are purchasing their own homes, and that compares with 72 per cent of the broader community.

Most people with a serious mental illness are on a pension-level income, typically the disability support pension. That is simply not adequate to pay for private rental, especially in these times with the pressure that is on private rental. There is also some evidence to suggest that people on pensions have difficulty accessing community housing provided by housing associations, so currently public housing is the key solution to the accommodation needs of people with a mental illness and their aspirations to have a secure and stable place.

The pathways papers put forward a number of propositions for actions, and a working group chaired by one of our member agency CEOs was established to take those forward. The working group around housing has representatives from seven of our member agencies, including four of the largest, so the feedback that we provided in our submission to this inquiry and what I am talking on today has come through consultation with that group.

Specifically on some of the issues raised in the documentation for the inquiry, the current segmented waiting lists and the way the segments are organised ostensibly give some priority to people with a mental illness who have ongoing, long-term support and are living in unsuitable housing — that makes them eligible for segment 2 or segment 3. But the reality is that very few of the participants in our members' programs have their applications accepted for those segments. This is evidenced by research carried out by the Department of Human Services which revealed only 9 per cent of early housing applicants qualified for segment 2 of the waiting list. The DHS has a project, which I am sure you are aware of, called the improving public housing response strategic project. They have made a number of proposals specifically around the segmented waiting lists that could give a greater priority to people with mental illness, particularly people who are in mental health facilities and waiting for housing. VICSERV made a submission to the Department of Human Services and gave broad support to the proposed changes.

In terms of the application process, support workers report that the application process is extremely complex. It is confusing, it requires extensive supporting evidence and documentation and multiple assessments are carried

out. Again it is hoped that the Department of Human Services review will address some of these issues. VICSERV has recommended that there be greater clarity around terms like 'in receipt of formal support' and 'unsuitable housing'. We argue that many people with a mental illness live with their parents, and often this is a situation which neither party wants or prefers but there is no other alternative. We suggested that people with a mental illness who are living with ageing parents be considered as unsuitably housed.

In terms of the waiting time on the waiting lists, put simply: waiting times are too long. They can range from several months to a number of years. This is a reflection of the shortage of public housing stock and the enormous and increasing demand for what is available. This waiting time can have a serious impact on people's lives.

As I said, 42 per cent are in unsuitable housing and they remain there, or they are living at home and there is great stress and pressure on the family, or they are in a program, say, they have been through a residential rehabilitation program and are well enough to live independently in the community but there is no place for them to go, so they stay on in that program when they need not be there. Their recovery journey cannot continue and they are taking up beds that are needed by other people.

The Victorian government's mental health reform strategy, Because Mental Health Matters, has an explicit goal around housing, and the goal is to improve access to stable and affordable housing that is linked to flexible, scaled, psychosocial rehabilitation support. VICSERV was encouraged to see this goal as it is consistent with the recommendations we had made to the reform strategy's green paper. Because Mental Health Matters talks about the need to align mental health and housing policy and VICSERV believes this is absolutely critical, it is hoped that the Victorian homelessness strategy that is currently being developed will consider perhaps targeting a percentage of new public housing for people with a mental illness, especially given the high prevalence of mental illness amongst the homeless population.

Recently funding was made available for 50 of these psychosocial rehabilitation packages but they were not linked to housing, so there is still that disconnect between the two areas, between the mental health and drugs branch and the Office of Housing.

In terms of location and tenure, ideally anyone would say that public housing should be well located in relation to public transport, employment and community infrastructure. This is particularly true for people with a mental illness, many of whom do not drive or cannot afford to run a car. Often they are attending centre-based activities and have regular appointments with mental health practitioners and need to be in a particular location. Being close to family is important as the optimum level of care is generally achieved through a mix of formal support and the formal care that is provided by family and friends.

Because of the enduring nature of some of the major mental illnesses such as schizophrenia and bipolar, some people will remain on income support for an extended period or for the rest of their lives. Public housing is likely to be their only option for affordable and stable accommodation, and therefore tenure should be granted for life.

In concluding and summing up, I think it is really important to recognise this strong link between stable, affordable housing and recovery from mental illness. It is absolutely critical. I think the current Department of Human Services project on improving public housing and the proposals that they have made should be implemented, and we would like to see a greater alignment between mental health and housing policy, but overall we still need to increase supply.

There has been a big injection of funding into public housing, but this needs to be sustained over the next decades to even catch up to the levels that we need to have.

The CHAIR — Thank you very much. Do you have any views on housing developments such as the Elizabeth Street new development, the proposed one?

Ms SMITH — The new development at Elizabeth Street?

The CHAIR — Yes.

Ms SMITH — Yes, one of our members, HomeGround, is developing that project. It is one model of a number of models. It seems to work overseas. There are other models as well. It seems good. It is going to have support on site; it is going to have a social mix; it is going to have security at the door so people who do not need to be there do not wander in and out. I think it sounds a really promising development, and we are really watching to see how it goes.

The CHAIR — Thank you.

Mr FINN — I have had similar experiences in years gone by when we have had dealings with people with mental health problems going into public housing. There is inevitably at some stage a reaction by the neighbours, either a pre-emptive strike, as it were, or afterwards, after there are problems. How do you suggest that we handle that? How can that problem be overcome?

Ms SMITH — There is a real need for community education, awareness-raising, anti-stigma campaigns. That is a long-term sort of approach that may change people's minds. That is why it is so critical to have housing support linked to housing for people with a mental illness, to help them, to help people manage to live well in the community, to learn ways to behave, ways to interact with others and things like that. I think that is the really key thing about having the support, but it is unfortunate. Because I think a lot of public housing has become areas where there are the most disadvantaged people there are concentrations of disadvantage and antisocial behaviour, and I think this would impact on anyone's mental health, let alone someone with a pre-existing condition, so ideally new developments should be smaller and dispersed and things like that.

Ms KAIROUZ — On page 5 of your submission one of the bullet points was removing the requirement for wellness from the housing eligibility requirements. Are you able to elaborate on that?

Ms SMITH — Yes. Is that my submission?

Ms KAIROUZ — Yes, VICSERV, yes.

Ms SMITH — That is the paper?

Ms KAIROUZ — Yes, the paper.

Ms SMITH — Often people have to be signed out of a facility or seen to be recovered and well, and we argue the point I was making that housing assists in recovery, so people will get better if they have that housing first up. That is another housing model. Housing First is like the supported housing. Housing First says you get them into housing and then you deal with their issues, problems and needs.

Ms KAIROUZ — As you said, there is a stigma associated with mental illness out in the community, but over the last five years I have noticed there has been a change. I do not know how long you have been involved or doing this sort of work but during the last 10 years have you seen any improvements in programs where the government has assisted, or are there any areas that we can improve on?

Ms SMITH — In terms of — —

Ms KAIROUZ — In terms of people's mental illness and housing, putting them into social housing? Have there been any programs?

Ms SMITH — There have. I think it is called HASP, the housing and support program, and that was a very good program that was getting people into housing with support attached to it, but it seems to have stalled lately. There has not been any growth in it.

But I think one area that does need improvement — and I alluded to it in my presentation — is with housing associations because that is where all the growth in social housing is going to come; it is going to come via housing associations. There will always be public housing and there will always be more public housing, but increasingly the money is going to community-based housing associations. They have a requirement to contribute 25 per cent of the costs of the housing. The way they make that money is through rents and there is a real disincentive to take people on the pension level. Housing associations are required to take 50 per cent of their tenants from the public housing waiting list but not necessarily from segment 1 where people with

recurrent homelessness or very complex needs are waiting. Through the sector and through some of the other peak bodies we work with it comes up again and again that people with a mental illness, and if there is any complexity around that, are not getting proper access to housing associations and it seems to be because of this requirement for the 25 per cent investment.

Anecdotally, in some regions some of our members have good relationships with their housing associations. I guess they can assure them that this person will be supported and they do get some housing, but generally it does not seem as if it is going to be the option that it should be.

Mr NOONAN — Thanks for your submission. A couple of things caught my eye, and I wonder whether you might elaborate on them. I think this committee understands the importance of accommodation because we have just had a very extensive inquiry into supported accommodation for people with mental illness, so we have spent a lot of time looking at this issue. On page 1 of your submission you talk about there being:

> … a strong association between housing and clinical improvement, and stable housing has been shown to be a better predictor of reduced hospital admissions than clinical interventions.

Because it is not referenced I wondered if you might give us some further information in relation to the evidence base for that statement as it would be useful for our committee.

The second issue that caught my eye was on page 2 of your submission and related to waiting lists, and you touched on it in your verbal submission as well. You suggested that most of those who have a mental illness are currently eligible for segment 1 of the waiting list but research by DHS in December last year indicates that in reality most go to segment 3 of the waiting list. Could you elaborate a little further for me on those two issues?

Ms SMITH — The reference to the housing being a better predictor of reduced hospital admissions than clinical interventions is referenced in the housing paper we submitted with our submission — the 'Pathways to Social Inclusion'. Marlene has a copy of it, I think.

Ms KAIROUZ — Yes.

Mr NOONAN — We have all got a copy.

Ms SMITH — It is referenced in there. I do not know if I can elaborate more on it other than to say that this was one of the findings. I guess again it is a little bit like the Housing First model where people are housed and then their lives seem to improve and things become more stable.

Mr NOONAN — There are a couple of references in that paper — they are dot points — but if there was an academic reference or a study, I think that would be of value. That might be something you might want to take on notice for us and follow through because I do see it there.

Ms SMITH — Yes. Further on in the document is the background research, and all the references should be there but I am happy to track that down and provide it.

Mr NOONAN — And the second part?

Ms SMITH — The Department of Human Services contacted us with a discussion paper so I am taking the information from that discussion paper.

Mr NOONAN — I think you quoted a 9 per cent figure in your verbal submission.

Ms SMITH — Yes, and that came from their discussion paper. They had done research that showed that even though a lot of people apply for early housing, which is segments 1 and 2, their applications are not accepted; they are not classed as eligible. That is partly because of the requirements for so much information, the lack of clarity about what unsuitably housed means and pressures like that.

Mr NOONAN — Is it clinical information that they require? It would really be insightful from our point of view if you could try and give us a sense of why that might be.

Ms SMITH — One of the requirements is for people to have support attached — a support worker or a case manager — so if they do not have that, they will not be eligible. There is a lot of evidence required about the person's condition because there is also the criteria around the need for medical care and things like that.

Mr NOONAN — The role of the Office of Housing is to place people in housing. Its staff are being asked, essentially, to make judgements about clinical information and medical information they are receiving. I wonder whether there is a level of confidence in their capacity to work their way through that, from your point of view.

Ms SMITH — I do not know if I can comment on that because I am not a practitioner so I have not been with a client through that process, so I am not sure. I am not sure specifically what the requirements are other than workers telling us they have to provide a lot of supporting evidence. They say things like psychiatrists reports. A person might go into transitional managed housing and a further assessment is done. I guess I just took on face value what DHS was saying as a statistic without really going into the reasons for it and putting forward VICSERV's support for the proposals they were going to make. They are going to have people residing in a mental health facility who will now be eligible for segment 1. People in secure units — and again that still needs a little bit of clarity about what is a mental health facility — will go straight into that first priority group.

Mr NOONAN — Thank you.

Mr SCHEFFER — My question is close to where I think Wade started. On the second page of 'Housing and support: a platform for recovery' you say halfway down:

> We know there are cost savings to be made in a range of areas including clinical, emergency and crisis services through the provision of stable, appropriate housing.

And it is the 'we know' that I want to come back to in a minute. A bit further down under 'Our call for action' you refer to 'Economic modelling of costs/benefits of stable housing', and later, on page 12, there is a summary of proposed investments and you suggest there that there should be a study done on economic modelling and you allocate some figures to that — ageing carers and housing risk — so it is clear you have a sense there of what forward research should be done. But my question is: is there an evidence base for this? You say, 'We know'. It stands to reason, but how do we know that? I think these are important questions for us to tackle.

Ms SMITH — I think again it is tacit knowledge. There is some research around. One of the famous ones is — I am trying to think of what his name is — Million-Dollar Murray - in New York, a homeless person. A study was done over a five-year period of all the services that he had to access — hospitals, shelters and things — and they amounted to $1 million, whereas if he had been accommodated, there would have been huge savings to be made. That is why we are proposing to do the economic modelling. I guess 'we know' is what is taken for granted, this tacit knowledge, and we want to build the evidence base behind that by doing some economic modelling.

Mr SCHEFFER — Our interest in that is clearly that we will be putting recommendations to government and this seems to be an area where there needs to be further research to get some quantification around that. Thank you.

Mr FINN — I was very interested to pick up on your point that 20-something per cent of people with mental illness are buying their own homes. Obviously it would be impractical in certain circumstances to suggest this, but how could government assist people with these illnesses to get into a position there they can attempt to buy their own homes?

Ms SMITH — I think people are able to buy their own homes because they have recovered from their illness or they live well with an illness so they are working and get a mortgage. They would be eligible like anyone else for any government programs that are available — first home owner grants and things like that. I do not think there is a need for any more or specific assistance from government.

Mr FINN — Do you think it would be fair to say, though, that the ideal situation would be that as many people as possible would own their own homes so that they would not be dependent upon bureaucracy or outside influences for how they live for the rest of their lives?

Ms SMITH — Certainly it would, but I do not know that that is practical or in any way achievable.

Mr FINN — In certain instances I am sure it is not, but I am sure you would agree that it would be preferable that as many people as possible be in that situation.

Ms SMITH — Yes, and that is what people's families and their carers want. Amongst carers of people with a mental illness, home ownership is quite high. They prioritise outright home ownership so their loved one will have permanent accommodation when they go — so absolutely, because that is their biggest fear: what will happen to my loved one when I am not here?

The CHAIR — Following on from that, if 27 per cent are leading a normal life, are working and have a mortgage or are buying a house, are they still classified as mentally ill people?

Ms SMITH — I guess in some ways that would be their own self-definition and understanding. I have bipolar disorder but I do not consider myself mentally ill or psychiatrically disabled, because I live very well. I have postgraduate educational qualifications and a management position, like many people. Once you get your medication right and have the right supports and things like that, it is possible. I am a person with a mental illness, but I would not be classified anywhere like that.

The CHAIR — You have to be classified as a person with mental illness to get into that statistic of 27 per cent? The statistics says that 27 per cent of mentally ill people own homes.

Ms SMITH — Yes, that is right.

Mr NOONAN — Can I ask one last quick question again in relation to your submission. You talked about the Because Mental Health Matters paper, and I could not help but notice that in your submission you talk about the need for parts of government bureaucracy to perhaps better work together around this. I guess from my point of view mental illness is still very much an emerging issue and therefore the responses that are coming are in response to those who are working in the area, such as you. I am wondering whether you are seeing some early signs of that working or whether or not there is a huge disconnect in terms of, as you say, divisions of the Department of Health such as the mental health and drugs division and then quite separately the housing and community building division essentially within a department of government which was joined up until late last year.

Ms SMITH — I have not seen any particular evidence of it. Word is that the two divisions are working together on a joint work plan to take forward the goal in Because Mental Health Matters about increasing access to housing and the housing support attached to it but are still waiting to see anything or hear anything more as indeed the sector is waiting for an implementation plan for Because Mental Health Matters to see how these things are going to be actioned and what sort of dollars will be attached to them. So there is no real evidence of that, but we have certainly put forward the view that that is what needs to happen.

The CHAIR — We are running out of time. Thank you very much for your presence here.

Witness withdrew.