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 J. Anderson, consultant, consumer participant services, Mental Illness Fellowship Victoria.

The CHAIR — Good morning. Thank you very much for appearing before the committee. This is a bipartisan parliamentary inquiry, not a government 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 45 minutes for this session. I invite you to make an oral submission which will be followed by questions from the panel. If you could, please restrict your oral submission to about 20 to 25 minutes so that it can be followed by questions. Please start by introducing yourself and your terms of reference for the Hansard record.

Ms CROWTHER — Thank you very much. My name is Liz Crowther and my role is as chief executive of the Mental Illness Fellowship of Victoria.

Ms ANDERSON — My name is Julie Anderson. I am the coordinator of consumer participation services at the Mental Illness Fellowship Victoria.

Ms CROWTHER — May I begin?

The CHAIR — Yes, surely.

Ms CROWTHER — The Mental Illness Fellowship of Victoria is a major provider of rehabilitation and support services within what is called the psychiatric disability rehabilitation and support sector. We have three main aims: the first is to improve the life and opportunities of people with a mental illness; the second is to advocate and support and change opportunities for families of people with a mental illness; and the third element is to advocate for and improve community understanding of mental illness. It is for the latter that I come to this hearing.

Last year we worked with 2473 people who had mental illnesses and we took over 6000 calls through our helpline, and it is through this information and the now more broadly based community education that I bring the submission to you. In 2007 we led a national consultation on what were the things that most affected the lives of people with a mental illness, and in that we got over 2000 responses nationally. The item that registered most highly in those 2000 responses was housing. So it is that information that I bring to you.

We are very committed to housing. We have developed a number of strategies around it, and we have also contributed to and support 22 houses of our own for people with a mental illness. We have a very strong evidence base that tells us that transitional housing is part of the problem and not part of the solution. We will be addressing the four key terms of reference. Do you want me to read those out or are they taken as given, as per the inquiry? The public housing waiting lists et cetera are what we are addressing today.

The CHAIR — No, you do not have to read them out.

Ms CROWTHER — I would like to make a couple of comments about homelessness. You are probably well aware of this, but I bring it to this conversation — the work of Johnson and Chamberlain in 2008 where they accessed 4000 records through two homeless agencies and identified the number of people who were wanting housing. We know that they identified 30 per cent of that group as having housing needs. We know the work of Singh and others in the 1980s calculated the mental illness population was almost as high as 80 per cent of that population, but in fact that has now been brought down. However, there is a major gap in all of the surveys that have been done — there has never been a capacity to quantify the number of people who are living with family members who would prefer them to live otherwise. So any numbers that are coming out are all underestimated.

We know that on the housing list as at 2009 — and you will have these well in front of you — 8000 people are on the early waiting list and another 30 000 are waiting their turn. In addition, there are another 9000 people who are waiting for public housing. We know from that research the numbers are around 15,000 people who have a mental illness. We know for a whole range of reasons that people with mental illness are underrepresented — I am not now just talking about those people who are living with families, but they are

underrepresented on those lists. Later in the submission we will give you an example of some of the underlying factors of why people are underrepresented on those lists, but it comes to speak to the very personal reasons of the mental illness and why somebody is concerned, why they are afraid or why they ignore participation on those waiting lists.

The example of the complexity of accessing public housing by people with a mental illness relates to where the person is in their recovery process. Somebody might even be working but still struggling with some of the things that happen around housing. We know that the application process is immensely complex. I would like just to give you an example of a family member I saw last week who is beside herself. The daughter has been on the public housing waiting list for seven years; she has an enduring mental illness and she has co-occurring drug use within that. She is currently and has been living for the last four years with her partner, but she has not got any tenancy rights at all in that house.

The mental health service has decided to discharge Michelle from mental health, not because she has improved her health status but because they think maybe her compliance might be improved because she goes to a GP. At the moment she is on the priority 1 list. But now she has been discharged she has lost all of her priority 1. She goes to a GP; her health status has not improved a single bit; her mother is absolutely beside herself and not knowing what to do. My advocacy with her was to ring Gill Callister and to ring the CEO of the hospital because she has spent months and months trying to get some action around this but now sees her and her daughter being homeless in the immediate future. It is a double jeopardy that you do not stay on the list if you are discharged from your treatment regime.

The other difficulty that people experience is — and Julie is going to talk a bit more to this later, are you not Julie?

Ms ANDERSON — Yes.

Ms CROWTHER — — is that the housing workers have an agenda that is different from the support worker's agenda. The housing workers have targets to meet and they are wanting to make sure that there is no empty housing, that the rents are being paid and that things are going as smoothly as they possibly can. But the housing workers, if somebody has a support worker, are extremely unlikely to speak to the person with the mental illness; they want to speak with their worker. They actually have a different agenda than the support worker. Unfortunately too many people who have a mental illness do not have a support worker, so the conversation with the person who has a mental illness is very much one way. And it is, 'You will do this; otherwise there are other people who are waiting for this housing, so comply'.

What we know that works for people with a mental illness is stable housing. How you get into housing means that you have to go through a whole period of temporary housing. So the very things that are required to improve somebody's health are the very things that are denied somebody — to get into stable housing.

We recommend that a significant number of people who are currently on those priority lists are provided with public housing. In fact we say that there should be a quota for people who have a mental illness. I heard you ask the question of the previous respondent about what the relationship was between the now DHS and the department of housing. I do not think it has changed much, but the difficulty for the Department of Human Services was that it had to serve all comers. There was an absolute view that it would not provide quotas to people who had a mental illness. From my perspective, the change to Department of Health may assist in giving rightful priority to people who have a mental illness, because at the moment that will absolutely not occur via the Department of Human Services.

Looking at the impact on individuals, I have said that the access to the early waiting list is highly complex and it is difficult to navigate for people with a mental illness. People with a mental illness have enough anxiety about disclosing the contents and the issues surrounding their mental illness to their own treatment teams. They are exceptionally concerned about making that material much more available. There has been a view that if you are going to try to get housing, the likelihood is that you are going to get housing in an area where you do not have your treatment team. So if you are going to go on the housing list and you have got the opportunity to get on it, you are going to have to put your name down for anywhere else.

We have a mental health system that has absolutely been structured around area-based health services so a person can actually get their treatment and get their networks in a local area. We know, and the research is replete and tells us, if you do that, you are going to get good outcomes, and yet we have a housing system that is going to pluck somebody out of those carefully constructed treatment settings and plop them somewhere else where they have absolutely no support.

The second thing that we say is that for many of this cohort, they have histories of poor rental and poor tenancy. It is not because they want it but because they have had untreated mental illness. The likelihood of them being accepted on tenancy lists is limited. Our housing workers spend a lot of time working with people, going from estate agent to estate agent to estate agent, getting support for their housing applications.

Again it is the issue around the length of stay for somebody who is getting home-based outreach support or is in a clinical service. For clinical services it is about 18 months. We know that mental illness is a lifelong event. Looking at our data, we know that a person who has got an average length of contact with a home-based outreach support worker has about three years. We do that because there are people at this end not getting any assistance. But as soon as that person loses their support worker, they have actually lost their support. And so if anything goes wrong with the housing, the likelihood of their housing becoming in jeopardy again is very high.

The problem is so great that we end up finding that people say, 'This is too difficult', and end up back with the family. This committee and others are absolutely replete in the submissions that have been made to them from families about the absolute burden that is happening for them — that children, their partners or their family members are living with them not because the people themselves with the mental illness want to be there and not because the family wants to be there but because there are no other options. Our contention is that it is so immensely difficult to follow the rules, to follow the processes, that people actually fall out and end up unintentionally back with families.

Julie is going to talk about some examples.

Ms ANDERSON — Thank you. As I said, I am the coordinator of consumer participation services with the Mental Illness Fellowship Victoria. I also have a lived experience of mental illness, and I bring that experience to my role and my life. I also access social housing, so not only do I work with people who have issues but I have some of them myself. I am just going to represent to you two stories that perhaps give examples of people at different positions within social housing. I am going to give you a story about a lady living in the western region who was given notification from her real estate agent that she had to vacate her house due to falling behind in her rent for one month.

The participant and her worker at the time attended an appointment at Werribee Support and Housing office to discuss the situation. It began a process of completing a general housing application together — a segment 1 application. During this time the participant began to couch-surf. However, this became very unstable and this participant became at risk of becoming homeless. In March 2009 she received confirmation that her general housing application had been approved. However, when her key worker in the west began to check on the status of her segment 1 application it was found that the application had not been lodged.

This application process was then recommenced with the aim to have it submitted as soon as possible. Due to her risk of homelessness, this participant was offered Mental Illness Fellowship accommodation, but this was a move away from the western region to the northern region, away from all her services and contacts. This was to be a temporary situation until her Office of Housing application was accepted and she would be placed in stable accommodation.

Though this placement in Richmond was only temporary, it was not ideal from the start. This participant was a very quiet participant. She lived quietly and unassumingly and had severe asthma. The house that she was renting was very clean but her new housemate smoked cigarettes and marijuana inside the house and had two pet cats and a rabbit inside all day and was not the cleanest housemate. On top of this, her housemate often had many people come over during the day to drink alcohol with her. It often meant the house was full of noisy people, but it also meant that the lounge room was also taken over by the drinkers, and once people left, the house was a mess.

In June 2009, after some minor alterations, the segment 1 application was finally lodged. Over the following months we were informed that the regional panel was considering the application and they sought further information regarding the application. The application was approved in December 2009. The participant remains on the waiting list. We were advised to add some additional waiting list contacts or supports in the area to reduce the time. The participant remains living in an unsuitable, temporary, shared situation which provides significant stress in her life.

The issue that this story highlights is the complexity of the nature of the housing and inadequacy of the housing process to get proper, safe, affordable and secure housing. It also highlights the issue around the process not having a healthy effect on someone's mental illness. The inadequacy of the housing model has added stresses that are counteractive to a person's mental health.

The other thing I would like to highlight here is that I do not believe people's rights or responsibilities are transparent in a plain language statement. I do not believe there are proper accountability processes that are understood by people who try to access public housing. Also, in the quality framework, improvements are not happening. There is no communication with people who actually access public housing about the department or its processes; that is understandable.

The other story I would like to tell you is a personal story about where I work. I love my job, I am happy to have it and have the opportunity to work in a flexible environment that supports my health. If I cannot come into work, I can work at home. Employment is pretty good for me, but the issue that always sticks is around my housing, particularly around the episodic nature of my illness and the tenuous nature of the housing.

There is no support in public housing around things we call 'issues within a recovery framework', helping people to be empowered, perhaps to move on from public housing. What supports there are around that in assisting people to take responsibility and, as Liz highlighted, the issues around the treating team and the housing are not being communicated. I would say I am a fairly empowered person but when I have discussions around my public housing the worker still wants to speak to my support worker. They do not really want to listen to me, and being on a recovery journey I no longer have a support worker. Those communications are quite difficult.

The other issue I have, personally, is around mail. I do not open mail, so a situation that happened to me recently was that when my rent went up I did not open the notification about the rent and I fell behind. I then got notification to go to VCAT, which I did not open and so I did not know that there was a hearing. A hearing took place at VCAT, without me being represented, for rent arrears possession and a determination was made. Then I had to go through the process of appealing that determination. At no stage at any time in my housing history have I been given statements, seen or even understood — maybe it happened while I was ill — anything about my rights and responsibilities and what would happen. That situation will be sorted out. It has been sorted out, but you can understand the stress it has placed on my employment and my health. Even providing doctors' certificates has not been adequate enough for me to get a hearing adjourned at VCAT — it can still go ahead.

The complexity and the knowledge around the housing system requires some law reform in line with mental health law. There should be more transparency, there should be more communication around what the housing department is about and the processes. I understand there is a law-reform process around VCAT at the moment, and I am making submissions about that.

In terms of support to empower people on a recovery framework, people often get put on orders and have issues determined about their housing with no-one actually working with them around strategies in terms of dealing with that housing problem and the department, especially if you do not have a support worker.

Ms CROWTHER — Thank you, Julie. We make some recommendations in our submission that mental illness should absolutely be considered, as Julie has outlined, similar to a strategy called Housing First — the principles that sit with Housing First are in the submissions that you have received — which combines all the services around the person. The person is central: you bring the services around them. Again, the evidence is absolutely there that you get very much better outcomes.

We have made comment about the safety and location of Victorian public housing, and we have again referred to the fact that it is a scattergun approach. It is quite right that it is, but where people can access it is very often

not safe for them because it is outside their networks. We recommend that public housing be located close to public transport, employment opportunities and community support and that it always brings with it home-based outreach support, but we know that is not the case. We know that in this state home-based outreach support has not increased substantially over the last six years. We know that there are some small packages that have been introduced in this budget, which is absolutely wonderful, but if we are going to make an impact on housing people with a mental illness, that support must be there.

Looking at the impact of public-housing need on people, again we are arguing that there needs to be priority access and a quota for people to get into public housing. It should reflect the need. These people are adults and they should not have to share, but Julie has given the example of somebody sharing with a rabbit and a cat and whatever else in student digs. People are adults and they should be able to have single accommodation.

The wretched outcome of this is that we know 68 per cent of people who have got a mental illness are going to be single. They are single not by choice, they are single because of what has happened within their relationships. We know that 33 per cent of people who have a mental illness have children, but only 8 per cent of them have got their children living with them.

Ms KAIROUZ — If I can interrupt, for those who are sharing, what would be the alternative?

Ms CROWTHER — Single accommodation.

Ms KAIROUZ — But what if there was none? They would have to wait for it, so where would they end up?

Ms CROWTHER — In fact you have absolutely led me into my last recommendation, and I have stated it further on. It is that there is never going to be enough public housing for people; it is just not going to be there. We know that there have been the NRAS project and others to increase public rental. The Housing First project, which comes from New York, is absolutely working on that principle around private rental.

I have put forward a proposition to you to get a housing pilot started here. I am proposing that we rent 50 one-bedroom houses on the open market. We should treat it as permanent housing for people with mental illness. The tenants would become established and the mechanism should then be self-sustaining over a five-year period.

The difficulty is that we know there is about a 20 per cent gap. If you add in rental assistance and pension, between that and the rental market we have got a 20 per cent gap there. We seek support, at this stage, whether it be from a combination of state and federal governments. I am not even talking about where that source comes from for that 20 per cent gap to support people in their housing, above the current mechanisms. The state government then commits the support that goes with that housing over time, so that you are not moving people from one place, you are actually building communities and you are supporting them.

In this I have given some examples of maybe organisations like St Vincent's, ourselves and Housing Choices. I mean, this is just a proposition at the moment; we have done some talking, but it is really a straight proposition. We would assess the outcome of that project, with a mind, if it does work, to roll it out more broadly. We have said that the additional costs for that would be to cost the option at 50 per cent standard home-based outreach support and 50 per cent intensive home-based outreach support, and that has a cost of around $80 000 annually for one EFT. The standard is about 12 people per EFT and the non-standard is between that and six people, so on a sliding scale. We estimate that the cost to subsidise each person on top of the current subsidy would be about 8 grand. Our rough back-of-an-envelope was $8200. But again it will depend on where the rental is for this property. So the cost for the total support would be about $411 000 or $412 000 to have that occurring for the 50 places, and the home-based outreach support is $600. So your total cost would be about $1.6 million per annum.

Mr SCHEFFER — Did you say you discussed that model with Housing Choices?

Ms CROWTHER — We have been discussing it with them and just sort of flying the idea at the moment, because it is getting the housing, it is putting the collaborations together. We are trying to create an interest in this model. Yes, we have discussed it with Housing Choices, but we have discussed it with other agencies as well. I have used these names as exemplars rather than as people who are actually in a project per se.

What we are saying is that it is not one size fits all. We absolutely want a quota in public housing, but we also have to use other market levers, which is the private rental market. A lot of our people are squeezed out of the private rental market, of course, because of their pension and stuff. But also the private rental for one-bedroom flats is escalating, as you well know. Thank you.

Ms ANDERSON — Can I just make one last comment? As I am sitting here today, six or seven years ago I was a revolving door mental health patient. What encouraged me around recovery was safe affordable housing. I built up treatment networks in my area and I sought out employment, and I was able to maintain that housing. Recovery is possible for people with mental illness, and when we talk about social inclusion it is those things like housing, employment and stable relationships. Housing is a huge factor in the equation, as well as building those ongoing treatment and therapeutic relationships in an area. I cannot stress that enough — that recovery is possible and housing is a big factor in that equation.

The CHAIR — Thank you. Earlier on you made a strong statement that transitional housing is part of the problem, not part of the solution. Can you elaborate on that? Can you say why?

Ms CROWTHER — Yes. The project — I keep on quoting the Housing First project — has done a lot of work at looking at the transition of somebody who succeeds in housing and of somebody who does not. A person with a mental illness needs stability and, as we have just described, they need networks, and they need to create their base and treatment setting in an area. If you have got a house for just weeks or 18 months or two years, you have to uproot all of that groundwork that has been done and recreate it in another place. It often means that you have to get a new treatment team, you have to get a new pharmacist and you have to get a new home-based outreach support. Everything that is keeping you well is actually uprooted when you are moving from temporary housing each time. Again and again they are the examples that we have, and often it is either in public housing or in rentals where people end up back home, and so the whole family system is again being negatively affected.

The CHAIR — Transitional housing is until a person finds a permanent place, so if they cannot find a permanent place quickly enough, then where would that person go?

Ms CROWTHER — Yes, I hear that, but again it is the ambulance at the bottom of the cliff. We spend an inordinate amount of money in just having people rotate; we actually do not settle them. I am not pollyanna and I am not young, and I know it is not going to happen overnight, but a strategy that actually begins to work to have long-term effective supported housing and that uses the rental market and those other levers is what we are going to have a better outcome from. You know, you got the homeless stuff from SAAP, and exactly the same recommendations are made — that we spend an inordinate amount of money supporting people out of housing. Put that money back into where somebody lives and create the networks, and you are going to have a different outcome.

Industry has been built around transitional housing. Let us build that industry around permanent housing. I do not expect that to happen in one year, two years or whatever, but with a long-term strategy you are going to get very different outcomes.

Mr FINN — I have so many questions, I am not sure where to start. You mentioned the very real problem where people with mental illness find themselves — for example, back with their parents or other members of their family, even though neither party might want that. It seems to me that in circumstances like that the issue of respite might be even greater than it would otherwise be. What is the situation with respite for people with mental illness in that situation?

Ms CROWTHER — There is absolute respite available, but it is limited. Normally the rules around respite are that you would probably get two episodes of respite a year. I am talking now about residential respite, and that is not for all areas; it is for some. That would be a five-day overnight — —

Mr FINN — So it is twice a year?

Ms CROWTHER — Twice a year.

Mr FINN — For five days?

Ms CROWTHER — Yes. You can get what is called in-home respite, where the person with mental illness gets some support and then the family is able to go and do their things. But it does not alleviate the situation. I do not know whether or not you have ever had a family situation where you have thought, 'I'd better stay at work tonight; I don't want to go home there'. It is not a lasting problem, but for these families there is no end to it. And for elderly parents, they are terrified of moving their loved one out of the house because their experience of them falling out of housing in the past has been terrible and their family member has got into terribly dangerous situations. So they will put up with situations that are just not tolerable. Does that answer your question?

Mr FINN — It does to a certain degree. There would be, I am sure though, families who are in urgent need of respite and cannot actually access it.

Ms CROWTHER — Absolutely, there are.

Mr FINN — To what degree are we faced with that problem?

Ms CROWTHER — There has been the new commonwealth money that has come in through respite, and the difficulties with that are that some of the rules around that are that you cannot necessarily provide it to the person with the mental illness; you have to provide it to the family. It does not get the person out of the house. The state-provided respite does do that, but it is limited. There are organisations that have camps away, but again they are a week away or they are day activities. So having your house to yourself as a family is a very rare event. It is an ongoing issue. Yes, respite is really important, but it is not enough.

I guess my conversation is that is really important when things are not working, but let us get them working and let us actually address the issue rather than address the symptoms.

Mr SCHEFFER — Thank you very much for your submission. It is very informative. I refer to section 8 on the housing policy framework in Victoria in 2008, and on page 22 in the middle paragraph there you give an account of the policy and the development of housing associations, which incidentally have been pretty well welcomed by all the witnesses we have had, even though some of them have some tweaking issues with it. You set that out, then you go on to say in the subsequent paragraph:

> An enduring view held by organisations involved with housing and people with mental illness is that the nub of the homelessness problem is the same as it has always been, viz. a problem of insufficient housing supply …

It is generally agreed as well that it is fundamental, but most witnesses have welcomed — and I think you did too in your presentation — the substantial injection of funding in new stock both for public housing and for housing associations at the state level and then at the commonwealth level. We have probably been in a unique situation for very many years.

Ms CROWTHER — Yes, absolutely.

Mr SCHEFFER — So that is agreed. However, they do say that that injection is a good start. You then go on to say, though:

> Hence recent strategies to improve consumers' access into housing are seen to some extent as a distraction from the central issue.

Why do you see the issue of access as a distraction from the central issue of housing supply? I would have thought we needed to walk and chew gum at the same time.

Ms CROWTHER — We do, absolutely. I guess what we are saying there is that we cannot just concentrate on public housing, that we have to in fact get access into the private market. We are absolutely delighted with the money that is coming down, but I am also very worried that it is top of mind at the moment and that as politics move on and look at another issue, people with a mental illness are going to be seen to be done. Yet there is an absolute growing need for accommodation that will not be met through this process. We really need to look at it broad stroke.

If you have a look at some of the commonwealth projects, which are wonderful, you can get into some of them with a household income of $70 000. So you are looking at people who have a moderate income. The people

we are talking about are nowhere near that. The people we are talking about have a pension, and they are not going to get out of that pension track until they get some stable housing. It is that issue that I am talking about.

We are really talking about the social housing end. Julie is just so wonderful in her personal explanation. She was somebody who was considered a revolving-door patient seven years ago. Get housing, get a job and you change somebody's life opportunities totally. But we get missed out in the access issue because our funding is not enough.

Mr SCHEFFER — Okay.

Ms KAIROUZ — Elizabeth, that was very informative, and Julie was very good as well. You spoke about quota three times. During last week we had two full days of submissions. We had women with domestic violence issues who needed help, we had people who had to look after refugees, we had the indigenous community, and the list goes on — and of course we should not forget the elderly. Do you have an idea of how we can assess this quota?

Ms CROWTHER — This is exactly the issue, and it is exactly why DHS have a real difficulty in setting quotas. I am going to be bold and brutal with this. If you have a look at the numbers of people who are homeless and the numbers of people who have a mental illness in that homeless group, that is prima facie the reason. Some of them may well have been violated against, some are women, so some fit in all those of the groups. But we have an underclass of people who have a mental illness who come across in any stat, wherever you like, as not getting into housing and with no future of getting into housing. I don't know, but I think it would be 30 per cent. It is up to the regulators as to how they manage the other quotas. I do not for a second think that intergenerationally unemployed people are in a good situation; I do not think that at all. But the health statistics for people who have a mental illness tell us that their life expectancy is exactly the same as that of the indigenous population. You have a group of people who are serially disadvantaged, and if we do not address this group of people, it is going to get worse.

Ms KAIROUZ — Julie, you have been in social housing for how long; did you say seven years?

Ms ANDERSON — Yes.

Ms KAIROUZ — And you are travelling really well, and you have the support that you need. Would there be a stage where you could go out and rent on your own? Obviously you are working and doing well.

Ms ANDERSON — I would love to, but the nature of the illness is episodic, so it affects my work in episodes, but I have a flexibility around work that supports that. Housing does not. Firstly, I do not have a credit rating, so how would I apply for housing? Secondly, there are whole lot of issues with private rental, and if I could be supported and they could be addressed, I would love to get out. The risk of me being homeless is greater in private rental than in public — —

Ms KAIROUZ — That is right — if they do not get their rent. You mentioned that you do not like to open your mail. You are the first person who has told us this. Many people have said they receive mail and they put it aside and do not open it. Can you think of other ways in which we can communicate with them?

Ms ANDERSON — I have had this discussion: via text, via email or via a nominated person maybe, if I could do that. There has been a situation where I have nominated a person and someone has tried to contact them but that person could not be contacted. I get letters about it; it is difficult. The difficulty is in housing workers understanding mental illness and a person with a mental illness having a reputation as a bad tenant or being non-compliant, so every approach a housing worker may make to that tenant is not a positive one.

Ms CROWTHER — That is why we are pushing this idea of a rental, because the rental would be taken over by an agency, and I just use Housing Choices as an example; it could be any other agency. It shields — and the department do some of this — the person from the individual tenant. We take on the risk of the housing, but we support the person in it. That is part of the pilot.

Mr NOONAN — Just a quick final question. We have had two submissions this morning, and the themes are similar. I am still trying to come to terms with the issue of mental illness and where it might appropriately sit in the segmentation list, and we will have an opportunity to talk to the Office of Housing tomorrow, but

obviously mental illness is extremely complex. Individuals require different levels of support. Looking at the current segmentation and the statistics you provided you have at the very highest level the recurring homelessness category, which is the segment 1. According to your statistics — and you have provided a number in your submission — homeless people are by and large disproportionately represented in terms of mental illness in that category, yet our last witness told us that the evidence from DHS showed that only 9 per cent are getting through on that segment 1. So rather than a quota system, in terms of this committee's recommendations, is there an argument we can make around a recommendation for that segmentation not working appropriately around mental illness?

If we are right, how do we fix it? If the Office of Housing's role is to find people a place to be sheltered yet they are also charged in that application process with sifting through medical diagnoses and expert advice, that is a very complex situation. I cannot see how a person who is charged with the responsibility of housing someone could have or could be expected to have the expertise to make judgements about whether or not people should be in segment 1. You might enlighten us in terms of the two submissions; we have heard one from you and one from our previous witness this morning.

Ms CROWTHER — The previous witness is in fact proposing some of the things we are absolutely aware of and we are struggling with. People in their droves refuse to go onto the waiting lists because they are frightened of the detailed disclosures they have to make. They fear they are going to be plucked out of the region and end up somewhere else, so we know we have a major problem with that.

As to solving it: a magic wand? No, I do not think that is going to work. I have not actually thought about how that quota system works. I would be doing it off the top of my head, and that would not be fair.

Mr NOONAN — But in a sense if we do not go to a quota system and we correct what seems to be something that needs correcting, is that a better way for the committee potentially to approach this issue?

Ms CROWTHER — I must say all I had thought about was a quota; I was just trying to get a stake in the ground. Any recommendation from this committee that says the current situation is not working and that there is a problem and there need to be some clear strategies developed around it would be absolutely wonderful.

Ms ANDERSON — I would just like to say that I have no issue about having a landlord. The Office of Housing is my landlord, and it has every right to be a landlord. What I have issues around is when you say, 'I have a mental illness; these are my issues', and they are not taken on board. You are automatically put in a category that is difficult and treated as such. The issue is around getting people adequate support. When I know I have that support, it is safe for me to come away and take managed risks and live my life, because I know I can come back to that support, if needed, whether that is in public housing or in private rental. It is safe for me to come off a DSP or whatever or come away from a psych disability rehabilitation service and not receive that support any more because I know I can go back. I can go back to them and say, 'This is the issue I am having at the moment. I just need this amount of support; I am not going to be with your agency forever and a day'. That makes it safe.

Mr NOONAN — Thank you.

The CHAIR — Thank you very much.

Ms CROWTHER — Thank you very much for having us.

Witnesses withdrew.