# COMMUNITY DEVELOPMENT AND JUSTICE STANDING COMMITTEE

## INQUIRY INTO THE ADEQUACY AND FUTURE DIRECTIONS OF SOCIAL HOUSING IN WESTERN AUSTRALIA

**TRANSCRIPT OF EVIDENCE**
**TAKEN AT PERTH**
**WEDNESDAY, 25 MAY 2011**

**Members**

**Mr A.P. O'Gorman (Chairman)**
**Mr A.P. Jacob (Deputy Chairman)**
**Ms M.M. Quirk**
**Mr I.M. Britza**
**Mr T.G. Stephens**

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**Hearing commenced at 10.05 am**

**WILSON, HON KEITH**
**Mental Health Advocate, examined:**

**HALL, MR STEPHEN LOUIS GEORGE**
**Executive Director, WAAMH, examined:**

**The CHAIRMAN**: Welcome. This committee hearing is a proceeding of Parliament and warrants the same respect that proceedings in the house itself demands. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as a contempt of Parliament. Have you completed the "Details of Witness" form?

**The Witnesses**: Yes.

**The CHAIRMAN**: Did you understand the notes at the bottom of the form?

**The Witnesses**: Yes.

**The CHAIRMAN**: Did you receive and read the information for witnesses briefing sheet regarding giving evidence before parliamentary committees?

**The Witnesses**: Yes.

**The CHAIRMAN**: Do you have any questions relating to your appearance before the committee this morning?

**The Witnesses**: No.

**The CHAIRMAN**: Thank you for coming in. We have done the official bits and we can get into it now that we have the technology sorted out. We will fire a couple of questions at you that either of you can answer, and the members will fire questions as and when they feel like it. Gentlemen, it was reported at a symposium last year in Tasmania that the discharge from hospital of mental health patients without adequate support is a major cause of homelessness. Can you tell us what the situation is here in Western Australia and whether that is true here?

**Mr Wilson**: There have been reports in Western Australia as well, amongst them the two reports by the Auditor General in 2001 and 2005. These addressed specifically the breakdown in the care of people reporting to emergency departments without any ordered follow up on their discharge. In fact, the overall situation is that people with mental illness, having had a stay in hospital of whatever length, need a suitable discharge policy in place which ensures, first of all, that they are enabled to access some support and accommodation. That may be returning home to their family or it may be that they need to be accommodated in supported accommodation that is normally supplied by a non-government agency. However, that area of accommodation is fraught at the moment because the kind of accommodation that is recommended, which in the old terms was called "step-down accommodation", is accommodation where there is a lesser level of support than in hospital but still strong clinical and psychological social support. Those facilities do not exist to any great extent, although the government has, in the budget that has just been handed down, announced that two such facilities will be built at Joondalup and Rockingham. Of course, that leaves country and remote Western Australia, as usual, without any cover, but it is a first step. The problem about this is that when such accommodation is provided, it is never provided on the basis of any assessed need for such accommodation; that is, so many units will be built for Joondalup and so many for Rockingham, but nobody has looked at what the actual level of need is. It is likely that those two units will be quickly filled and then people in need will still be wanting.

This is true about the provision of most accommodation for people with mental health problems; that is, there is no assessment of the actual level of need. There is a sort of stopgap approach to this which does not attempt to address need; it simply attempts to put in place some provision for some people. Then, of course, that step-down accommodation normally only needs to be available for a given interim period as people are stabilised and supported, and to some degree are put on the path of rehabilitation and recovery. The next step is that there needs to be provision for longer-term accommodation support and some of those are in place in the CSRUs that are operating, which are being operated by NGOs contracted by the government. There are other facilities which are less desirable, like private psychiatric hostels, which do not have a high level of support and are not of a very high level of accommodation standard. What is required is a continuum of supported care. Some people, of course, end up in public housing and sometimes they have support and sometimes they do not. There is a maze of programs, which do not seem to be integrated, which apply in that situation.

**The CHAIRMAN**: Are some of those so-called step-down facilities already in Mt Hawthorn and Broome?

**Mr Wilson**: The Mt Hawthorn one has been closed. That was situated at the old Mt Hawthorn hospital. It was only commissioned for three years and it has been closed. It is not being replaced, because what is being placed at Joondalup and Rockingham is more short-term accommodation. The accommodation at Mt Hawthorn was where people could stay as long as they needed to until they were rehabilitated and able to move into community settings. These are more short-term, and I do not know what the plan is for the discharge of those people from the short-term accommodation to more long-term accommodation. I doubt that there is such a plan. What was the second one?

**The CHAIRMAN:** It was Broome.

**Mr Wilson**: I do not know about the Broome one.

**The CHAIRMAN:** According to the budget papers, Broome was already completed and Joondalup and Rockingham are to come on stream, but both of those have been in the budget.

**Mr Hall**: There is something in the budget about Broome. Just building on what Keith was saying, I think we need to acknowledge that there have been system failures in this area, and there are tragic stories. Of course, there have been some in the media in the last 12 months or so. There are places where the integration works well; in particular, there is a good model out in Swan where the community health sector mental health organisations and the public health sector try to have a seamless approach when working with a client et cetera. There is acknowledgement by government as well as broadly by the sector that there have been major failures in the mental health system, and that is why the coalition government has established the Mental Health Commission and is looking at system-wide reforms as a key part of what they are doing. An additional component in the state budget to what Keith mentioned is the announcement that there will be a pilot of 100 purpose-built Homeswest facilities for people to come out of hospitals and/or Graylands. These are people who are there because they do not have any accommodation, not necessarily because of other needs. There will be a support package attached to each of those that will be contracted out to people like the organisations I represent. I am not quite sure how that will look yet, but that is another component of moving out of hospitals, as well as the Rockingham and Joondalup facilities that are being built.

**Mr Wilson**: I did not realise that included Homeswest accommodation.

**Ms M.M. QUIRK**: Can I ask one or both of you whether there has been any assessment of the needs or a gap analysis? What is your take on how much accommodation is needed in this sphere and how much is available. What are the figures?

[10.20 am]

**Mr Hall**: ACOSS was talking in this morning's version of the online paper about the real shortfall, and the amount of people, in the public health system and hostels, as Keith mentioned, not to mention other kinds of service providers that might be out there. My guess, which is a very rough estimate, is that there are 1 500 or 2 000 plus. I was talking to council official visitors yesterday, and they are the kinds of figures they were talking about, but it is a guesstimate.

**The CHAIRMAN**: Is that houses or people?

**Mr Hall**: It is people with a mental health condition waiting for a house.

**Ms M.M. QUIRK**: Both of you have mentioned the lack of integration of the existing services. Has that evolved over time? Will people set up another service because they believe that one service is not quite addressing one issue, and has there been no coordination or rigorous assessment done into who is doing what and who is not doing anything at all?

**Mr Wilson**: That is absolutely true. There is a range of supported accommodation for people in the public housing sector. There is a program called ILP—the independent living program. As far as I know, funding for that has ceased, or no more units have been allocated to that recently. That was a program in which Homeswest provided the housing and a non-government agency acted as the landlord and rented accommodation and assisted the tenants. In a lot of cases, there was insufficient or no psychosocial support for those tenants. It was very difficult for the NGOs to actually provide a service that it knew should be available to those people because the NGO was largely acting simply as a landlord and was collecting rent and that sort of thing.

**Ms M.M. QUIRK**: Conversely, Homeswest says that its job is not to provide support services but to manage the infrastructure.

**Mr Hall**: That is why I mentioned the Mental Health Commission and Eddie Bartnik, who is the commissioner. The commission is looking at that system because it wants to bring that together with Homeswest and look at how those supports are provided. That is what the 100 units and the support packages are initially looking at piloting.

**Ms M.M. QUIRK**: What types of persons provide the support? Is it everyone from social workers to psychiatrists? What is the spectrum of assistance?

**Mr Hall**: They tend to be psychosocial, not medicalised. Some of our organisations like UnitingCare West and the Richmond Fellowship of Western Australia and the like provide that type of accommodation support.

**Mr Wilson**: Under government contracts.

**Ms M.M. QUIRK**: Are there shortages in those sorts of personnel?

**Mr Hall**: There certainly is a need for more.

**Mr Wilson**: I would say that one of the critical weaknesses in the provision of services is the recruitment and training of a suitable carer workforce. The government contracts are pretty loose about requiring standards of training and care among those staff. I think that is a real problem area. There are reports that some of the people being employed are newly arrived immigrants from different cultural backgrounds with poor English. Some of the organisations that are doing this work with good intent come from aged care provider backgrounds. The provision of aged care—if you know anything about nursing homes—is not that hot, in my view. That is largely because the capacity to recruit, train and supervise staff is very weak.

**The CHAIRMAN**: What do you think those supports should actually look like? It is one thing having a landlord. The landlord is concerned with maintaining the property and making sure that the neighbours are not disturbed. Another part of it is the psychiatric assistance. Can you tell us how that can be matched? How can the landlord be the landlord and match up with providing those services?

**Mr Hall**: There is an inherent tension in that, as there have been in other housing support programs. It is fair to say that no one model fits everyone. We are particularly interested in and focused on a client-centred kind of service delivery model. We are sitting down with the client and/or their carers and working out what is the best package for them. That would be the optimum. I will table this report on mental health housing and the homeless that was published two years ago that goes into some detail about models. I will leave that report with the committee.

**Mr Wilson**: In some cases, the role of landlord and the role of psychosocial support have been provided by two different agencies so that that conflict does not figure so highly. I was Minister for Housing in the mid-1980s and represented an area as a member of Parliament with a large component of public housing. I lived in a public housing area when I was an Anglican priest. Another thing as far as social housing is concerned is that the Department of Housing—Homeswest—in all the time that I have known it has always been reactive in its approach to tenants. That is the case even in the latest developments in which it has created a disruptive behaviour management strategy and disruptive behaviour management teams. That is a very reactive approach to managing tenants with a lot of complex needs. There is a need for a more proactive approach and there is a model in place that I believe could be adopted. That model is called the people with complex needs project, and has been trialled here and in Victoria. It was trialled and reviewed here and was proved to have very good outcomes. That program operates between a number of departments—the Department of Housing, the Department for Communities, the Mental Health Commission and the Department for Child Protection—and adopts a proactive approach on a case-management basis. In my view, the Department of Housing is not the appropriate department to manage these problems. That is largely because it is not designed to do that; it is designed to be a provider of housing. It always has stated that it does not have a role to play in the delivery of services and supports to the people that it houses. In my experience, the situation has not changed in 20 years. There are problem tenants who are handled by measures that end up with the tenant being evicted. The problem tenants then end up somewhere else and, in the long run, because of media pressure, Homeswest is forced to rehouse them again. It is an endless cycle that gets us nowhere.

In my view, the complex needs project must be established on a broad basis and be a joint agency approach with a joint budget. As much as you talk about a whole-of-government approach, that never happens because each department guards its budget very jealously; that is the way it is. The complex needs program approach is the only one that has succeeded in addressing these complex needs. A large proportion of people in public housing have a whole range of complex needs such as mental illness. It is reckoned that 44 per cent of tenants in public housing have a mental illness. There are also people with drug and alcohol problems. Quite often they are clustered together and you cannot help but wonder if there will be problems that will be repeated over and over. There are people with intellectual disabilities, people who have suffered domestic violence, and single parents. All these people with complex problems are clustered together. That is what creates the disruptive behaviour. That will not change because Homeswest is the last resort of accommodation for people on low incomes or with no income. I think the strategy needs to change. We need a program like the complex needs program, which has been trialled and reviewed and is considered to be successful, to cater for people with that range of complex needs and to provide the appropriate supports. Even when tenants, often elderly or single women, are disrupted and go by the book, they are required to provide court-level evidence before they get an outcome. That is impossible for them because they cannot get corroboration because their neighbours are too afraid to corroborate, and that exacerbates the situation. That is the real living circumstances of a lot of families with lots of needs. There must be a new way to look at this. I do not believe that the housing authority is the best authority to be handling this. I have seen this problem exist for over 20 years, and it has not changed. It has remained the same problem because we have not fixed the basis of the problem, which is that we expect a housing authority to house people with complex needs and problems. We have a model that has been trialled. In fact, that model has been trialled successfully in Victoria and

it has legislated for that program so that ministers and departments are required to have shared budgets and so on to ensure that that integration of support and care is provided.

**The CHAIRMAN**: Can I interrupt you for a minute? You have talked about eviction and people with complex needs and mental health issues. Is there any support for those people from psychosocial services, once they are evicted?

**Mr Hall**: I did a fair bit of work on evictions in the early 1990s, when there was a lot of media and political discussion about it. It is very, very difficult to provide any kind of support when someone is theoretically homeless due to eviction. It is interesting that Keith used the line "houser of last resort" because we do not hear Homeswest using that kind of language anymore. I fully agree with what Keith said about the complex needs program. In the early 1990s I was running a community legal centre and Homeswest was evicting people and family and children's services was giving us money to put them up in hotels. Hello! There was no communication between those departments. Admittedly that was 10 or 15 years ago, but those kinds of situations still exist. We put a lot of work into trying to get those two departments to talk to each other when they had clients in common. There are some real issues, as Keith was saying, about cross-government collaboration. People talk about confidentiality. We had issues with silos in those days. Issues of confidentiality, generally, are not issues that worry clients; they worry organisations. Clients will sign off on something at a community legal centre or somewhere else if they think you can find a solution. We are all looking for solutions, but it is very difficult to provide services for people when they are homeless. I had a real concern a matter of weeks ago, if not a month ago, when the Minister for Housing was talking about a punitive approach. Admittedly, that was about an explosion at a meth drug lab and was a highly emotive issue, but it sounded to me like the rhetoric of the early 1990s was coming back again. Rather than looking at solutions, it was about pushing people out of public housing, but where do they go? They go to caravan parks or stay with friends of family and exacerbate the problem in other people's houses.

**Ms M.M. QUIRK**: There is a whole cohort of people who are so marginalised that they are not getting near the Homeswest list. There is a whole group of your clients that are not even getting to that stage. I would like you to comment on and also on the issue that is happening now, which is a shift away from the department to community housing. Community housing is not bound to take the next person on the list; it can cherry pick a bit. Part of the rationale for that is it can say it is putting it across to community housing because they can provide better supports. If I was them—NGOs are not exactly rolling in dough—I would be inclined to take those that did not have as complex needs, just as a matter of sheer economics.

**Mr Hall**: Granted. There is also an issue with Aboriginal people in particular who have been in public housing for a long time, possibly for generations. Some people in the department have a long history with individual families, and it does affect how cases are handled. I have looked at some files—admittedly, it was 10 years ago—and seen a trend with particular families and how the department deals with them. There is a problem there.

**Ms M.M. QUIRK**: Would you go so far as to say there is some systemic racism, or is that being a bit —I know there was a report —

**Mr Hall**: There were certainly issues and have been issues in the past. As to what the issue is now, I would not care to make a comment.

**Mr Wilson**: I would not think it is racism. I think it is just frustration with families that are totally dysfunctional. I can remember Aboriginal grandmothers—matriarchs—who would take on large numbers of grandchildren because no-one else was around. Usually the house was wrecked as a result of that. You cannot really blame the grandmothers; they are doing their best, but they do not have the support. I do not think it is racism. I think that Aboriginal families are in the worst situations and they are the hardest to deal with and, therefore, that is why officers would have that kind of feeling about that type of dealing.

**The CHAIRMAN**: I have experienced that exact issue of a grandmother taking on more and more kids, which brings on the issue of overcrowding in the house and other family members coming to the house and causing problems, which ultimately the neighbours complain about and it ends up in eviction.

[10.40 am]

**Mr Wilson**: It is a long, tortuous process.

**The CHAIRMAN**: It is a long, tortuous process; it is probably 12 or 18 months. But, at the end of the process, you find that the 60 or 70-year-old grandmother is evicted and winds up homeless and then does not have the wherewithal to support the accommodation for all those kids. But, by the same token, is it fair that those in the community around them who have bought their houses and who expect that they will have quiet enjoyment have to contend with that? Is there a way of dealing with those issues?

**Mr Hall**: I think there are some important issues. One is the fact that, generally, a number of government agencies are potentially working with different people in a house like that. It might be the education department because kids have moved from schools; it might be Meals on Wheels, mental health workers or accommodation support workers. There is a real lack of coordination between those services. When we talk about these kinds of households, we are not talking about thousands; we are probably talking about a few hundred households with multiple people with very complex needs. There almost needs to be a case manager attached to the house who can coordinate and set up group conferences so that all the caseworkers are talking to each other, because they are not. We talk at a level when departmental heads get together, but when you get down to what is happening in that house in that street, the police and health, education and mental health services might be there, as well as the community agencies associated with some of those, but how they talk to each other is really, really critical.

**Ms M.M. QUIRK**: Quite often when people first come to the notice of the authorities, it is through the police, and that just starts a whole chain of events that really has nothing to do with the underlying problems. Is that another issue? How you get dealt with depends on what door you go through. Is there any training for police or any form of diversionary program that should be put in place for some of the issues that arise in mental health?

**Mr Hall**: There are certainly issues around police training in the mental health area that need to be addressed. There also need to be some protocols when police are called out to difficult situations, such as advising the mental health emergency team of the situation that they are going to. Obviously, there was the shooting in Armadale a couple of weeks ago. I am not saying that it was public housing, but that is the kind of case in which a mental health emergency team should be on-site, not just police.

**Ms M.M. QUIRK**: Police complain quite often that they are not available.

**Mr Hall**: The other real worry at the moment for family members—it is not necessarily a public housing one—is that if they have a situation in the house in which they previously would have called the police to intervene, such as a volatile child or adult, now they are not calling police because they worry about mandatory sentencing for the assault of public officers. It puts those family members at further risk. I heard as I was driving to work this morning that a Greens member in the upper house, Alison Xamon, is introducing a private member's bill to address that issue. It is a really important issue and I do not know that it was fully considered when the legislation for mandatory sentencing for the assault of public officers was brought in. It really needs a good look at, because you now have high-risk situations in which families, other carers or whoever are not calling police because of the fear of the consequences.

**Mr Wilson**: Of course, the problem is that it also signals a weakness in mental health service provision because quite often people ring MHEL, which is the mental health emergency line, and they are told to call the police because they cannot handle it. It is not just the police.

**Ms M.M. QUIRK**: Cannot or will not, Keith?

**Mr Wilson**: Whatever; it could be either. They do not have the capacity. In situations in which there is likely to be violence, they would rather the police went. But, as Stephen says, there are situations in other jurisdictions in which people other than the police are empowered to be present. New South Wales has just passed legislation to allow that to occur. The Dutch have always had a system whereby the police never go to such situations without mental health support teams.

**The CHAIRMAN**: Should these cases not be well and truly known to the housing authority, police and mental health services? You are saying that it is in the hundreds, not thousands.

**Mr Hall**: I am talking about complex needs, such as the case Keith mentioned about a grandmother looking after children. People who work in that area were talking about 200 to 300 households with multiple occupants with those kinds of high needs. It is not just mental health; it is a complex range of needs.

**Mr Wilson**: The point is that the police, mental health services and child protection services may know, but they do not link up. That is a real problem. It would be possible to have a common database that would assist agencies to act more in alignment with each other in such situations. But, again, issues of privacy arise. A colleague of mine has suggested that they should use a numbering system that locks into the disability services pension that would enable all agencies to have more common information about people living in these situations. I am sure that that would be opposed by civil libertarians, but it would be a good practical approach to a problem that is residual.

**Mr Hall**: Even winding back from the broad whole-of-government thing, if we had a comprehensive system of information—you can create barriers for certain information—and the public health system and the community sector were working with the same client, you could see the latest contacts with an individual. There might be a common system with Homeswest, the Mental Health Commission, the health department and the community sector. There are systems like that around, but not here. Wraparound Milwaukee is one that Eddie Bartnik has been talking about. They have developed this computerised system and the client will sign off on the confidentiality issue because they realise that, at the end of the day, it means better services for them. The Mental Health Commission has information on that.

**Mr Wilson**: The Mental Health Commission website has details of that program.

**Mr Hall**: We need to look more at models such as that just within mental health and housing, let alone within child protection, health, education and various other departments so that we know. You can closet some information that may be confidential, but you would have some sense of who had talked to that family last.

**Ms M.M. QUIRK**: I think the silo issue is a huge one, and that can be overcome by state privacy legislation, which we do not have. People have an abundance of caution and either rely on their own governing legislation or use it, frankly, as an excuse not to do anything. The privacy act has been quoted to me a number of times and I have asked, "Which privacy act and which section?" and they were unable to tell me, because there is no state privacy act. Just going back to fundamentals, what percentage of the homeless do you think suffer from a mental illness? What is a generally accepted percentage? Is there one from research?

**Mr Wilson**: It is in the range of 40 to 50 per cent.

**The CHAIRMAN**: From your point of view, what would be ideal to deal with homelessness, mental health issues and the complex needs of clients? If you could change legislation, wave the wand or do whatever you liked tomorrow to make it work in the way that you want it to work, what

would be the best outcome for you? What is the best way that you see of doing it based on your experience?

**Mr Hall**: It is independent accommodation, adequate powers and adequate support which is locally based and which links into the services that the person needs. There will be different models of how that works, but, in essence, that is what it is. We could talk about the number of houses, but that is a bit theoretical. It is really about the integration of support. Keith was saying the same thing about disruptive behaviours. It may not be mental health, but it may be. It is putting in place the right package, because, at the end of the day, eviction does not solve the problem for anyone; it just shifts it somewhere else. It could be community sector organisations working intensively with the tenant initially and maybe phasing down as time goes on, or a series of organisations that are working in some kind of collaborative model with a coordinator who has responsibility for that. Some of that work has been piloted or tried at various times. The Department for Child Protection has had a number of name changes in the last 20 years, but at one stage it was looking at an integrated model, particularly for Aboriginal families. I am not quite sure what happened with that, but that is probably going back five or 10 years or so.

**The CHAIRMAN**: Can I ask possibly a stupid question? When does the support stop? Is there a point at which you can say that you no longer need to support people with these complex needs and issues of housing because they are now functioning in the community and it is time for them to move out of supported accommodation?

**Mr Hall**: I think the simple answer is that, from one end of the continuum to the other, some people will be well down the path of recovery and will need less and less support and some people with complex needs will have complex needs for life. Some people might go down to one visit a month after six months instead of one visit a week, and then in two years you could sign off and say that they are okay, while other people will need constant support, whether that is daily, weekly or monthly. There is no single answer to it, because it all comes back to the individual's needs.

**Mr Wilson**: One thing that is for sure is that, initially, it needs to be intensive and, secondly, all these programs need to be configured around outcome standards so that there are designated outcomes for all programs that are measurable. That would give an indication of the range of support needs over time. But very few government programs have designated outcome standards that can be measured; therefore, we really do not know what we are getting for the public dollar from most social programs. We just put the money in and hope for the best, because we do not have those outcome standards available and we do not work to them. I can give you two examples. That complex needs program works on that basis, and that is why I would strongly endorse its adoption across the board for that clientele. The other one is a mental health program that is for children but that involves families. That is the MST—the multiple services development program. It is operated only in the northern metropolitan mental health region. It is based at Joondalup.

**Ms M.M. QUIRK**: Is that similar to the thing that corrective services is operating? It is Minnesota or something?

**Mr Wilson**: Yes, it is. They have their own, which is a shame. Different departments having their own similar services seems a waste to me. They have very definite outcomes that are measured and followed up. They have intensive periods of involvement with the whole family, not only the child. The child is referred to this program by their school, which is a very good way of referring problems.

**Ms M.M. QUIRK**: It is multi-systemic therapy.

**Mr Wilson**: That is it; yes. It was meant to be rolled out, but it is still available only in the northern metropolitan area, and people have to live there to benefit from it. They have this intensive early intervention with the child's whole family for five months. They enable the family to deal with the child's problems. After that, they follow it up for another, I think, six to 12 months to see how that

is progressing. They document their outcomes very well—better than I have ever seen anywhere. It is really a standout program. In fact, the trouble is that it exists only in one region in Western Australia. It is always on the verge of being slashed because of funding considerations. Some bureaucrats would say that it is too expensive, but it is expensive because it works; it gets results. I am saying that it is possible to have that kind of intervention on a case-by-case basis, as Stephen said, with good case managers. They cannot be housing officers, because that is not the job of housing officers.

**The CHAIRMAN**: Keith, can you tell us what some of those outcomes are that describe success for a mental health support service?

**Mr Wilson**: You have to work them out in terms of a contract that you let or in terms of the individual assessment of a particular person. They can be outcomes that show that, over a certain number of days, a person has been able to operate successfully in simply caring for their house or their personal hygiene. It gets down to those levels of individual care. They have been able to maintain their rent, their electricity payments and so on. It has to be very specific like that, because it has to be a real measure of that person's capacity to live a normal life. Unless you get that kind of feedback about the public dollar investment, a lot of money will continue to be wasted, in my view.

**Mr Hall**: The thing that is important to remember about mental illness—obviously, there are different levels of mental illness; some are extreme and some are more episodic—is that at times it can be episodic; people can have big periods of their time when they are well, but then things go off the rail. It is not like a disability, which someone lives with every day of their life; people with a mental illness can be well and unwell. I think sometimes people fail to see that distinction, and we really have to always remember that. People might function well for 11 months of the year and then whatever happens happens, and they go into a very high-needs state. That is when we need to be ready to kick in the resources and supports that are there.

**The CHAIRMAN**: Can I be particularly cruel? We are looking at social and affordable housing. I think most of us now accept that there is a continuum in housing. Social housing is required when you are falling off, you need support and there is nobody else there, and the government provides it. As you said, it is a measure of last resort. That is when you get on the bottom rung and then you move on. Ultimately, the ideal is to purchase and own your own home. That is the continuum and everything in between. Should we expect that some of these people with highly complex needs should be able to get on that continuum and move through it, or is it a case that we have to accept that, no matter what we do, we will always have to maintain a certain proportion in the last resort—the Homeswest house or social housing?

**Mr Hall**: You immediately raise issues of poverty. For some people, even getting into the private rental market is not achievable due to levels of income, let alone the ideal or dream of owning your own house. That is just the poverty-related stuff. There is a whole range of other indicators of disadvantage obviously, but I think that some people, although they may aspire to own their own home, will never be able to.

[11.00 am]

**Mr Wilson**: The other factor is that there are blockages in their way. I will quote a case some of you may know about, without naming anybody. This is the case of a youngish woman who has lived in a block of units in North Fremantle for 15 years. She has done her best to make something of her life. She lives with a mental illness. She is quite gifted, as many people with mental illness are, and highly intelligent. She has gone to lots of training courses. She has tried to equip herself to get employed. But she lives in a context of drug-affected families, and people who are violent, who exercise power by threat and who are always looking for ways of getting money to feed their habits. She has tried to get maintenance done to her property without any success. That whole area of maintenance is another fraught area. The way that maintenance is carried out is terrible. She has done her best. She has tried hard to make a life for herself, to get a job and so on, but she is

constantly impeded by the surroundings in which she lives. Her levels of stress are raised by the circumstances in which she lives, so that her mental illness is constantly exacerbated. There are people like her who aspire to a better life and who have tried to progress up the scale and get a job and a home, but those circumstances just are a complete wet blanket to that occurring.

**The CHAIRMAN**: Is that not where the landlord—and I assume it is a housing and works situation—has to intervene?

**Mr Wilson**: They do not.

**The CHAIRMAN**: And with the other supports. Ideally, from what you are describing, she wants to get out of the environment.

**Mr Wilson**: In a way, because she is very conscientious, she refuses to be transferred. She believes—and she speaks for other tenants who are similarly placed to her—that she should not have to transfer and that there should be interaction and intervention which sort out that situation. That might mean some programs of intervention and support for people who need them.

**Mr A.P. JACOB**: Will not that mean evictions at some level as well?

**Mr Wilson**: Not necessarily, no. But it may end up in that. She has had cases where problem tenants with drug problems have been evicted, but that process takes months and months. In the meantime, the person concerned can exact retribution on the person who has made the complaint. Problems like that are very complex. People who are trying to make a life for themselves in that context are dogged because they are not supported. Homeswest will simply say to them, "Give me evidence of that. Where is your evidence? Can any of your neighbours corroborate it?" They will not, because they are scared. It is an impossible situation. Maybe it is always going to be impossible. As Stephen says, "As the Man says, the poor are always with us." There are solutions, and it does not lie in loading up the housing department with providing the solutions. The solutions have to be provided in terms of a social support system that gives these families a chance to get off that bottom rung. While people may say that is difficult and expensive, it is possible; and in the long run it is less expensive than continually repairing wrecked houses and the court proceedings involved in evictions. There has got to be a stronger intervening agency that protects good tenants and assists those who need assistance. There is no other solution to this problem.

**Ms M.M. QUIRK**: Is that a role for the Mental Health Commissioner or not?

**Mr Wilson**: The Mental Health Commission might be involved as one of the concerned agencies.

**Mr Hall**: My guess would be that they would probably purchase those services, rather than provide them. I do not see the Mental Health Commission as a service provider.

**Mr Wilson**: It is not, no.

**Mr Hall**: With Child Protection or Homeswest, they may come up with a package of dollars that says to an Anglicare or someone else, "We want you to look after these people." It may be to look after one household—"Here is X dollars"—or it may be to look after 10 households.

**Mr I.M. BRITZA**: Yesterday I went with the Minister for Mental Health to my electorate, and we had a person who was vision impaired, who also had a mildly intellectual disability, and who was living by himself with a carer coming in every day.

**Ms M.M. QUIRK**: That is disabilities, not mental health.

**Mr I.M. BRITZA**: I thought it was mental health. He had an intellectual disability as well as being vision impaired.

**Ms M.M. QUIRK**: That is disabilities, not mental health.

**Mr Hall**: She is the minister for both, disability services and mental health.

**Ms M.M. QUIRK**: She was there in that role.

**Mr I.M. BRITZA**: I am talking about the success stories of people with mild mental or intellectual disabilities and the fact they can be on their own in an excellent facility. But I did not know who was responsible for putting them into that kind of a home.

**Ms M.M. QUIRK**: It is disability services.

**Mr Wilson**: Disability services would probably contract an agency, or they may do it through a self-funded package whereby the person or their family actually engages the service. That is what they are talking about.

**Mr Hall**: The Mental Health Commissioner is talking about developing similar kinds of packages for people with a mental illness.

**Ms M.M. QUIRK**: I have a series of questions to complete the picture. It has often been said that there are a number of people in prisons with mental illnesses, so there is this whole cohort of informal housing provision through the prison system, and I would like your comment on that. Secondly, when we went through the deinstitutionalisation movement in the 80s, or whatever, there were the so-called hostels, which are no longer fashionable. Is there any role for some hostels to be reintroduced as part of the —

**Mr Wilson**: Do you mean psychiatric hospitals?

**Ms M.M. QUIRK**: As part of the transitional phase of moving into other forms of housing.

**Mr Wilson**: You would not want anybody you care for in one of those.

**Mr Hall**: If I could pick up on your question about the prison first, last year, or either 2009 or 2010, the WA Law Reform Commission launched a report on diversionary courts, like the Drug Court. Chapter IV of that is dealing with diversionary courts for people with mental illness, intellectual disability and acquired brain injury, because there is a an acknowledged problem that lots of people in those three categories are ending up in the prison system through lack of alternatives and, quite often, for minor offences for which you and I would never get locked up. That report stands. It is interesting that there are models of diversionary courts of that kind in other parts of Australia. I think it is Victoria —

**Mr Wilson**: It is Queensland.

**Mr Hall**: Queensland, is it? I understand that the present Minister for Mental Health sees this as a key area of reform that she is looking at, and I understand that the Mental Health Commissioner has someone working in this area. That is a watch-this-space one, and it is certainly one that we are actively interested in monitoring. But also there is the issue of when people with mental illness are released from prison, and juveniles as well. Quite often they are released and they are going back into the same situation. After-care is not the right word, but there is no transition. Maybe the cohort of young people with a mental illness is a good place to pilot something about offering support services when people are released from the prison system. I am speaking to the former Minister for Corrective Services, of course.

**Ms M.M. QUIRK**: I was just fiddling around with the basics, like beds and roofs.

**Mr Hall**: It relates to a 16 or 17-year-old who has problems with substance abuse and mental illness. There has been a review of health services in prisons. The issue of mental health care within the prison system is an interesting one, which that report probably did not hit that well, but the cohort of young people who are —

**Ms M.M. QUIRK**: The hit was called the Treasury wall and it bounced off it.

**Mr Hall**: Where young people are leaving the care of the Minister for Corrective Services, for want of a better term, and going back into the same situation, maybe we should be looking at some transitioning kind of support—I do not have a view on whether it should be out care or someone else—rather than just saying, “There’s the door.”

**Ms M.M. QUIRK**: See you later!

**Mr Hall**: And they are back in court in six minutes or six months or whatever, because there is no change in support for them, or the lack of support.

**Mr Wilson**: There is no use in having court diversion if you do not have the facilities to provide the service to those diverted.

**Ms M.M. QUIRK**: Sure.

**Mr Wilson**: That is always the soft end of the deal, unfortunately, because it is the hard part of the deal.

**Ms M.M. QUIRK**: In fact, you almost need a housing officer sitting in on the court hearing.

**Mr Hall**: Was the second part of your question about deinstitutionalisation?

**Ms M.M. QUIRK**: Yes and whether there is any role for us to recommend about hostels or something.

**Mr Hall**: There is quite a lot of published material in that area and the failure of the deinstitutionalised model of 20 and 30 years ago and where we have ended up now. There are papers like this, and I am sure countless others, that go into some detail about that.

**Mr Wilson**: The thing is that there are 600 beds in private psychiatric hostels in Western Australia. No government is going to willingly say, "Close them", because there is nowhere else for those people to go.

**Ms M.M. QUIRK**: What about St Bart's or something like that?

**Mr Wilson**: St Bart's is an NGO that provides accommodation services under government contracts.

**Ms M.M. QUIRK**: I was not necessarily suggesting government, but some sort of transitioning.

**Mr Hall**: There is a distinction between the St Bart's and the Richmond fellowships and the private-for-profit hostels, of which there are about 600 beds that ultimately will be phased out. The question is that somehow or other you have still got to find beds or accommodation for those 600 people

**Mr Wilson**: And those who are coming along—the additional ones. That is happening to some degree. There are a number of CSRUs—community supported residential units—that were first developed by the previous government, and have been followed through by this government. They are group houses placed in the community and run by NGOs. Some are run by churches and some by NGOs. How many of those we need, nobody knows. Again I say that nobody has assessed what the actual needs are. They are probably going to build more from this budget—I am not sure—or maybe that is the hundred houses that Mr Hall has already referred to, I do not know. Steady progress is being made there, but it is still not enough to answer the actual level of need. With emergency accommodation, there is a very great scarcity. I talked to the housing officer in the triage department at the Alma Street mental health clinic in Fremantle recently. He said that when he is trying to place people who are being discharged from hospital in accommodation, he goes the rounds with the emergency accommodation providers, and often there is nothing. The options are very limited in those circumstances.

**Ms M.M. QUIRK**: The final question I wanted to ask was: are there any mental health services currently being offered to homeless people or are they only being dealt with once they are in some form of accommodation?

**Mr Hall**: I am shooting in the breeze, I think, but I am pretty sure Ruah works with homeless people as well to accommodate people, but I will have to check that and get back to you.

**Mr Wilson**: There are some programs like that. They are called wraparound care programs. Ruah does provide some of that on a fairly limited basis, because it is very intensive care and costly. You have programs like the Street Doctors, who would obviously be treating some people with mental illness I guess. Other than that, probably not.

**Mr Hall**: Just flicking back to your previous question about prisoners and prisoner release, Ruah does have a program working with young women who have been released. It would be interesting to see how that could be morphed into other areas.

**Ms M.M. QUIRK**: Our main concern is that when this report comes out, people do not say there are complete gaps in it and we have not addressed something that is a real need. Are there any areas in what we have talked about today, or that we have not talked about, that you think is a glaring hole or that we would be negligent if we did not at least make reference to it?

**Mr Wilson**: In terms of accommodation?

**Ms M.M. QUIRK**: Yes.

**Mr Hall**: The big one is the question of adequate housing and that mental health people are not seen just as a population, but as a priority population and the need for support services, and that sometimes they will be well and at other times they will have high needs—it is episodic. That needs to be acknowledged. Keith's point is that Homeswest cannot be the provider of support services, whether it is another government department or services like the ones I represent are funded to deliver. I really think that is one of the key issues. Prisoner release is another huge one.

**Mr Wilson**: It is hard to answer the question because there is so much, and I wonder who will take any notice of your report anyway.

**Ms M.M. QUIRK**: So cynical for one so young!

**Mr Wilson**: Sorry!

**The CHAIRMAN**: We have been priding ourselves on the fact that most of the reports done over the past 10 years by this committee have been taken up and have resulted in some action, although we have not been too overly enthused about the response to a couple of the more recent ones.

Gentlemen, from your point of view, is there anything else you would like to say to close off before I read you the final statement?

**Mr Hall**: A benediction! No, I would just like to table this report, and I look forward to reading your report.

**The CHAIRMAN**: Thank you very much. Again, thank you for your evidence before the committee this morning. A transcript of the hearing will be forwarded to you for correction of minor errors. Could you please make these corrections and return the transcript within 10 working days of the date of the covering letter. If the transcript is not returned within this period it will be deemed to be correct. New material cannot be introduced via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on any particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. Thank you very much.

**Hearing concluded at 11.17 am**