REPORT OF PROCEEDINGS BEFORE

SELECT COMMITTEE ON MENTAL HEALTH

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At Sydney on Wednesday 29 May 2002

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The Committee met at 10.00 a.m.

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PRESENT

The Hon. Dr B. P. V. Pezzutti (Chair)

The Hon. Peter Breen
The Hon. Dr A. Chesterfield-Evans
The Hon. Amanda Fazio
The Hon. J. Hatzistergos

LEANNE ELSWORTHY, Co-ordinator, B. Miles Women's Housing Scheme, xx xxxxx xxxxx, sworn and examined, and

GERAL WALLWORK, Social Worker and Housing Support Worker, B. Miles Women's Housing Scheme, xxx xxxx xxxx, affirmed and examined:

CHAIR: Are you conversant with the terms of reference?

Ms ELSWORTHY: I am.

CHAIR: And the submission placed before us by the B. Miles Women's Housing Scheme, would you like that included as part of your evidence?

Ms ELSWORTHY: Yes please.

CHAIR: Ms. Wallwork, are you conversant with the terms of reference of this inquiry?

Ms WALLWORK: Yes, I am.

CHAIR: I should warn both of you that should you consider at any stage during your evidence that in the public interest certain evidence or documents you may wish to present should be heard or seen only by the committee, the committee would be willing to accede to your request, but please be aware that the legislative Council may overturn the committee's decision and make that evidence public.

First of all, what would either of you like to make a statement before we ask questions about it?

Ms ELSWORTHY: Thank you very much for giving us the opportunity to address the Select Committee on Mental Health. We are very pleased that this inquiry is taking place and we are willing to co-operate with the committee in any way that we can. Are you aware of our service? Do I need to give any information about what we do?

CHAIR: That would be worthwhile.

Ms ELSWORTHY: B. Miles Women's Housing Scheme is a SAPP funded program offering medium-term supported accommodation to women without dependent children who have a mental illness. We are based in the eastern suburbs of Sydney and have the capacity to accommodate 28 women. Due to the fact that we are a women only program, we are not able to talk confidently about the needs of homeless mentally ill men. Further, as a scheme is based in Sydney, we are coming from a city perspective. We cannot therefore address issues relating to people in regional and rural areas in New South Wales.

It has been our experience at B. Miles that homeless women who have a mental illness are a very diverse group. We have housed women who are GPs, solicitors, nurses, mothers, beauticians, factory workers, taxi drivers, cooks and so on. Some have been homeless for many years; others are experiencing homelessness for the first time. What we have learned from this is that just as the group I am talking about today is diverse, so must be the strategies to prevent them from becoming homeless.

At B. Miles we operate within an environment that is severely restricted. Currently there are inadequate beds in hospital available, insufficient resources within community health and other community agencies such as Home care, restrictive crisis and medium-term supported Housing options, chronically inadequate long-term supported and supervised housing options and extensive waiting lists, both within the Department of Housing and Community Housing. In recent years there has been much discussion within and across various government departments about the need for more flexible options to enable people with a mental illness to obtain appropriate housing and sustain their tenancies. Except for a few pilot programs, such as the Housing Action Team which is known as HAT, and some partnership initiatives such as the Joint Guarantee Of Service, not a lot is actually being done. It is our perception that in reality little has changed over the last six years. This is extremely frustrating.

Ensuring sustainability of housing for people with a mental illness does not have to be a complex task. It can be done. The basic requirements to achieving this are giving the client choice, providing a continuum of services to meet changing needs but not necessarily changing their accommodation; ease of access to Housing and appropriate support services. At an agency level we

should be establishing systems across agencies that ensure adequate assessment of client needs, referral to the appropriate services, coordination of support services by one lead agency.

It is our hope that this inquiry will result in positive outcomes for people living with a mental illness and their carers.

CHAIR: Would you like to make a statement as well, Ms Wallwork?

Ms WALLWORK: No. I will leave it to Ms Elsworthy.

CHAIR: We have got some evidence that the percentage of women who are homeless with a mental illness is higher than that of men. Do you have any evidence about that?

Ms ELSWORTHY: Unfortunately no. Because I work in a very small organisation I do not keep those sorts of statistics.

The Hon. AMANDA FAZIO: Just to start with, I was wondering if you could give us an outline of the average length of stay and the ranges of the length of stay of clients of your service?

Ms ELSWORTHY: It is an interesting point that you have raised. The funding guidelines has changed. Initially we were to house member for 12 months and then approval was given to extend that to 18 months for necessary individuals.

CHAIR: Where does your funding comes from?

Ms ELSWORTHY: SAPP which is State and Federal. SAPP 4, which is the new SAPP guidelines that we are operating under, have actually changed all that. We no longer now are obliged to a time limit in recognition that some people have highly complex needs and may require longer than 18 months. However, we are still using that as a guide because otherwise our system would just get so blocked and we would just be keeping the same people all the time. The majority of our women stay the full length of time but what has been happening is that waiting periods for the Department of Housing have become such that that average time is now extending to two years and beyond.

CHAIR: So when people are really ready to go there is not a place?

Ms ELSWORTHY: That is right, and we keep them rather than putting them out on the streets just because they are waiting for their Department of Housing allocation we actually keep them in the scheme because we think it would be a retrograde step for them to be back on the homelessness circuit.

CHAIR: Are they are on a Housing priority list though?

Ms ELSWORTHY: The majority of them are. We have had a very high success rate with priority housing. Basically in the six years that I have been at B. Miles we have had 100 percent success rate of priority housing for people on a disability benefit, but only on a disability benefit.

The Hon. AMANDA FAZIO: After your clients have moved into Department of Housing accommodation, do they received any follow-up support services from your organisation?

Ms ELSWORTHY: They do. It is an average guide of three months support and in that time we offer five contact visits plus telephone contact. However, that is only a guide. Also, if somebody is getting into trouble after the three months, we are more than happy to intervene. We have developed an authority form that the tenants can sign for the housing provider, giving them permission — if the tenant needs it — to call us in at any stage if the tenancy looks like it is breaking down. We have had tenents that have left the service years ago that have come back for one-off assistance and I have never turned away an ex tenant yet, however, sometimes I cannot help; the problem is such as in one particular case a woman was off her medication, she was totally non-compliant and there was not much I could do to help in that situation. If I can help I will.

CHAIR: What is the percentage of re-admissions?

Ms ELSWORTHY: Into our service? Very low. It would be less than 1 percent. I do take women back but I might have one a year maximum.

CHAIR: During the period of time they are with you when you are preparing them for independent living with supports obviously, do you run a rehabilitation program?

Ms ELSWORTHY: No. We tap into the rehabilitation program that is being offered by community health.

CHAIR: Is that easily accessible?

Ms ELSWORTHY: It is except there is currently a waiting list.

CHAIR: What sort of service is it?

Ms ELSWORTHY: It is the psychiatric rehab program that is run by our local community health centre and it is also combined with aftercare, which is a non-government organisation but they work hand in hand with the rehab team to provide the rehabilitation services in the eastern suburbs.

CHAIR: Do they do any work within your housing scheme?

Ms ELSWORTHY: They do with individuals, yes.

CHAIR: So they do some home visits?

Ms ELSWORTHY: Definitely.

CHAIR: Is that done by the community mental health or the non-government organisation?

Ms ELSWORTHY: That is done by community mental health. They do what I think is excellent, they offer at home living skills development for example which I think is a much more dignified way of a teaching people living skills rather than doing it in a group which could be highly embarrassing for some people.

CHAIR: Do the community mental health provide you with pro-active visits or is that usually done because they all go down to community health?

Ms ELSWORTHY: It depends on what team you are talking about. For rehab we have to make the referral or referral has to be made. They might already be in rehab when they are referred to us. If they are not already in rehab we will make the referral. Because of demand of services there is a waiting time for rehab.

CHAIR: Is that very long?

Ms ELSWORTHY: Not for rehab.

CHAIR: They would want to settle into your place first anyway.

Ms ELSWORTHY: Exactly.

CHAIR: So what sort of time are we talking about?

Ms ELSWORTHY: In terms of waiting time?

CHAIR: Yes.

Ms ELSWORTHY: At the moment it is only a couple of months. It is not very long. Where we are having difficulty is in case management. There is currently no guarantee of case management in the eastern suburbs.

CHAIR: Can you explain what case management means to you?

Ms ELSWORTHY: There is the case management team that operates out of Bondi Junction Community Health Centre. They provide clinical support through a case management worker. That case management worker is usually a psych nurse, a social worker or a psychologist. Their role is to oversee the clinical needs of the client. It can also be to administer medication. But only a nurse is able to do that. That is one of the big problems at the moment: they cannot get enough nurses onto the mental health team. So there is a big problem with having staff that can actually administer medication. Not everybody who comes into B. Miles is eligible for or needs case management. However, a significant proportion of our tenants require case management. The good thing about case management is that it is clinical support in the community. So they visit her at home. They can go shopping with her. They can go on outings. It is not all just going and seeing a psychiatrist, getting your medication and leaving. It is looking at the wider issues around the clinical needs of that client. That is the big difference between our role and their role. We do not get involved in the clinical side because we are not clinically trained and it is not what we are funded to do.

CHAIR: But do you keep an eye on whether they are taking their medication and so on?

Ms ELSWORTHY: We do, and we will alert the case management team or whoever, a private psychiatrist—whoever the clinical supports are—if there are problems occurring. We have a duty of care.

CHAIR: When you alert, is the response reasonable?

Ms ELSWORTHY: It varies. Over the years we have had difficulties with the acute care team, which is the crisis team in our area. But I think we have been able to resolve a lot of that in the last few years. They are now more responsive to our tenants than they used to be. But that took a fair amount—we had meetings, I wrote reports, I complained. I have had to agitate fairly hard to establish that relationship. I know from talking to other colleagues in SAPP-funded services that they do not enjoy the same relationship. We are funded specifically to work in mental health. I have the luxury of being able to focus on those relationships because I am not necessarily working on domestic violence and other issues. So I have the time to keep working away at those relationships. We have now established quite a good relationship with our acute care team. Our problem now is with case management. There is no guarantee that our clients will get case management. We have had clients who we have assessed as being in desperate need of case management and they have been unable to get it. Again, it is a lack of resources. There is no such thing any more as long-term case management in the eastern suburbs. It is now called episodes of care. That worries me because there are some people who have long-term case management needs and who just cannot be treated as an episode of care.

CHAIR: Could you describe what a typical episode of care might be?

Ms ELSWORTHY: My understanding of what they mean by that is that it would be around a certain period of time. Let us say that the person became unwell, relapsed with their illness. The case management would be offered for a certain period of time to stabilise them again; whereas I would argue that there are some people that would become unstable fairly quickly. We are actually causing a lot of unnecessary pain for that person. If they had the ongoing case management maybe they would not go through these episodes as frequently.

CHAIR: I think you said you had 28 clients.

Ms ELSWORTHY: We have a maximum capacity to house 28.

CHAIR: How many of those would be under active management at the moment, approximately half, a third?

Ms ELSWORTHY: I would say half. At B. Miles we house women with personality disorders. Many mental health services will not house people with personality disorders. Those people are not adequately serviced by the public health system. That is why about half of our clients are seeing private practitioners, because that is the only support those people are able to get.

CHAIR: Of the people with personality disorders, few of those would have case managers?

Ms ELSWORTHY: Very few.

CHAIR: With case management of the half that you do have, does that mean they get regularly visited or they regularly visit the person who is their case manager?

Ms ELSWORTHY: It does not mean that at all. It varies for every individual. It also depends on the workload of the case manager. Some case managers have really high workloads and are simply not able to be seeing their clients on a regular basis. So it is very haphazard. It also seems to depend a little on the individual case manager as to how the service is provided.

CHAIR: On page 5 of your report you refer to the inadequate number of beds. To me, the most important part of your submission was that you are seeing more people with higher activity levels and you do not think you can cope without more support. Is that the basic thrust of it?

Ms ELSWORTHY: That is right. For me, the biggest gap in mental health services is that with the closing down of the hospitals as a consequence of the Richmond report there are a small group of people—they are not a large group—that are in need of constant support and supervision. I emphasise supervision. It is not just about support. Civil liberties people might think I am being anti-civil liberties. I am not. These people have behaviours that are extreme and cause consequences for neighbours et cetera. And those people are not going to go away. There is always going to be a group of people that need much higher levels of support than is currently available anywhere.

CHAIR: Say, for example, one of your tenants starts to act out in a fairly difficult way that causes distress amongst your other tenants or to yourselves or to them. What happens?

Ms ELSWORTHY: Sometimes we evict. It depends. If it is the mental illness we try to get them into hospital if that is the appropriate option.

CHAIR: So you call the crisis team or the case manager first?

Ms ELSWORTHY: Case manager first then the crisis team. That is where the systems can break down as well. Because the case managers are very hard to get we can actually have trouble getting the crisis team to come if there is a case manager around and we cannot get on to that case manager, because the crisis team wants to talk to the case manager. We have had situations where the case manager has just not been there and they will not listen to us. That is extremely frustrating.

CHAIR: One of the reasons for that may be that you may not know the full clinical details of your clients.

Ms ELSWORTHY: That is the assumption they make. But I had a client try to burn the house down. We were ringing the crisis team and they were telling us it was not an emergency. This was the day before Easter and we were not going to be there for the next five days. It took hours. This is in the old days. I do not think this would happen now. Because we are not in the health system, we are not health employees, there can be a lack of respect about our knowledge. Because we are not clinicians we can be downgraded in terms of how we are viewed. But, believe me, I know psychosis when I see it.

CHAIR: But you are not different from many people who have put in submissions—other carers or relatives—who have no standing, if you like, because of the Act. Without leading you, do you think the Act should be changed to allow for recognition of the carers?

Ms ELSWORTHY: I definitely think so, because the carer—be it family, be it us—gets to know those behaviours. We have familiarised ourselves with the various mental illnesses. We have done training. We have been responsible in acquiring that knowledge and I think it needs to be validated. The families know only too well what is going on with their family member.

CHAIR: So it is the early recognition bit that you think you are good at?

Ms ELSWORTHY: Yes. That is where we have experienced problems. We had a situation with the early intervention team where we had a young woman—

CHAIR: Is that different from the crisis team?

Ms ELSWORTHY: Yes. It is for young people, the theory being that you intervene early and it improves their recovery rate et cetera. We had a young person through the early intervention team who

was placed in our scheme. Her clinical support was someone from the early intervention team. This young woman stopped paying her rent. So I met with her. It became evident that she was not paying her rent because she was losing her organisational skills. She was wanting to pay the rent but she simply could not organise herself to be able to do it. So we alerted the case worker from the early intervention team. That person told us it was our job, which is completely untrue. It is not our job. And she did nothing. I was there. That woman deteriorated. We were trying to get intervention early to stop this woman from getting too unwell. I had to let the police in. She was handcuffed eventually and dragged screaming by police to Prince of Wales Hospital and ended up having shock treatment. I believe that may have been avoided had the people from the early intervention team listened to us.

CHAIR: What period of time are we talking about?

Ms ELSWORTHY: It would have been over a couple of weeks.

CHAIR: So you had a couple of weeks of gross instability?

Ms ELSWORTHY: Yes.

CHAIR: If the crisis team do not come, you would normally call the police, would you?

Ms ELSWORTHY: Yes.

CHAIR: Then they would take them to the outpatients at Prince of Wales?

Ms ELSWORTHY: Yes.

CHAIR: We are dealing with the police issues tomorrow. When somebody like that goes to the hospital would they normally be admitted or—

Ms ELSWORTHY: It depends. She was and the one who tried to burn her house down ended up being admitted for about three months and was one of the most ill patients Prince of Wales apparently ever had. If there is a drug and alcohol issue she will not get admitted. This is a huge problem for us, if there is a dual diagnosis of drug and alcohol, because they will say it is a drug and alcohol issue. We had a woman who was running around in peak hour traffic saying she wanted to kill herself. She was drunk. She had a mental illness. But she was running around in traffic. We called the police and they took her to Prince of Wales Hospital but she was immediately discharged. This was on a Friday and we do not work on Saturdays and Sundays. If the psychiatric unit was not going to take her I can understand their reasoning for that, but no effort was then made to put her somewhere safe. The woman was completely out of control and nothing was done. She was just discharged back out on the street.

CHAIR: If that happened on a Saturday or Sunday and one of your other residents rang the police it could still happen that she would just be discharged to the front door?

Ms ELSWORTHY: There is no guarantee. We might think that someone needs to be in hospital, but there is absolutely no guarantee that the person will be admitted. There is such a shortage of beds at Prince of Wales.

CHAIR: If she stayed with you for sometime and was no longer drunk and then the assessment is made that she is no longer drunk, she is not mentally ill and you have no way of keeping her voluntarily and she does not volunteer to come in, although you are not a clinician what do you think the hospital should then do?

Ms ELSWORTHY: If it was not a weekend, obviously the hospital should contact us. On a weekend I would keep an eye on her and have the acute care team at least make contact with her over the weekend. Something would have caused that incident.

CHAIR: So the hospital is not triggering the community mental health team, is that what you are saying?

Ms ELSWORTHY: That is what appears to be the case. We are not always told that the women are discharged from hospital, we are not included in discharge planning unless in an extreme case. If one of our women had been in hospital for three months the hospital will probably involve us in the

discharge planning. But if it had been a shorter stay we are completely out of the loop. Yet, I see us as one of the central agencies.

CHAIR: Is there a problem with the mental health Act? Or has the hospital or the community health team made you aware that there may be privacy issues as the reason that you are not told?

Ms ELSWORTHY: I do not think so, because our women sign a form giving permission for us to be involved. We have written authorisation.

CHAIR: Do you have what is called a continuing guardianship?

Ms ELSWORTHY: No.

CHAIR: Have you explored that with your tenants?

Ms ELSWORTHY: No, I have not. That is something for me to look into. It had not occurred to me.

CHAIR: That could kick in when they are not well, and only when they are not well. If someone were drunk and may have a mental illness it would not necessarily kick in. But if the woman was declared to be mentally ill you could be involved with her ongoing care. That is how I understand it, although I am not a lawyer and I cannot give you advice.

Ms ELSWORTHY: It is a definitely something for us to consider with our more unwell women.

CHAIR: Do you have a long waiting list?

Ms ELSWORTHY: Yes, at the moment over 70.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How many beds do you have?

Ms ELSWORTHY: At the moment, 28. There will be more than 70 on the list by tomorrow afternoon.

CHAIR: Where are the 70 housed at the moment?

Ms ELSWORTHY: Some in refuges, some are literally homeless and floating out there, some in boarding houses, and some are living with their family but in highly stressful situations with the family at breaking point. Some are living in domestic violence situations, some are living with ex-partners, some are sleeping on a friend's floor, and some are in the process of being evicted from their current accommodation in the private rental market. A very small number are living in Department of Housing accommodation, but they are the minority on our waiting list. Again, they are the ones that need this high-level supported accommodation. They go into departmental accommodation but it is not working for them, because there is no support there.

CHAIR: You would be aware to some extent of their clinical history. How many of the 70 are under active clinical management?

Ms ELSWORTHY: All of them.

The Hon. PETER BREEN: Do you call them all tenants whether they are in accommodation or not?

Ms ELSWORTHY: Sorry, I call the women who are accommodated at B. Miles, tenants, because that is their legal status.

The Hon. PETER BREEN: How many of those are there?

Ms ELSWORTHY: Our maximum housing capacity is 28. Although we have shared houses we never have the full 28, because there are a lot of complex issues around shared living. But to compensate

for that we also support some women who are living outside our scheme. We actually support more than 28 women at any one time.

The Hon. PETER BREEN: How many more than 28 are there?

Ms ELSWORTHY: Probably about 40 women all up to whom we are giving support at the moment.

The Hon. PETER BREEN: And of the 70 on the waiting list are they for the B. Miles accommodation?

Ms ELSWORTHY: That is right.

The Hon. PETER BREEN: In your submission you said that you spend two hours a week attending to people. To whom were you referring?

Ms ELSWORTHY: Our clients.

The Hon. PETER BREEN: The whole 70?

Ms ELSWORTHY: No, only the women who are currently in our accommodation and the women living outside B. Miles whom we are also supporting. That two hours varies. Some women might have a crisis and we might spend 10 hours with them in one week. We try to be responsive to the individual's needs. If we have someone who requires a higher level of support that means that someone else in the scheme will probably miss out, because resources can stretch only so far.

The Hon. PETER BREEN: Do your services provide counselling?

Ms ELSWORTHY: Officially it is not counselling, we are not trained counsellors as such, but there is a lot of counselling-type conversation. However, if a woman were to disclose something quite serious, such as sexual abuse, we would not attempt to counsel her. Our job would then be to link her to the appropriate service. We do what I call low-level counselling and a lot of crisis intervention work. We identify needs, help her to identify her needs and identify what is stopping her from living independently. We link her up to appropriate services in the community to enable her to develop her skills.

The Hon. PETER BREEN: Is your funding limited to the accommodation services that you provide?

Ms ELSWORTHY: It is.

The Hon. PETER BREEN: You are not paid as an outworker?

Ms ELSWORTHY: Not really, we have just made it work for us; we jiggle. I think there is a huge need for more outreach work, not only with women who have been through B. Miles, but women who are living in Department of Housing, community housing or private rental accommodation. We are well placed to do that, but there is nowhere to get funding to unable us to expand our service to enable us to reach beyond the women who come into our housing.

CHAIR: Does your organisation have volunteers?

Ms ELSWORTHY: No, we do not use volunteers. I have worked in community organisations that extensively use volunteers. I am a bit reluctant to bring volunteers into B. Miles because of the complex issues that we deal with.

CHAIR: Do you have an organisational structure?

Ms ELSWORTHY: Yes, we have a management committee.

The Hon. PETER BREEN: How many people work your organisation?

Ms ELSWORTHY: We have six, comprising four part-time support workers, myself, an administrative officer and we also have a bookkeeper.

The Hon. PETER BREEN: Do any of you live in?

Ms ELSWORTHY: No, all outside. We have properties throughout the eastern suburbs and the office is separate. That is why the women are tenants. Under the Residential Tenancy Act they are declared as tenants, and that is another issue of the complications of the Act and how it can be quite difficult for us to do our job properly. There are restrictions under the Act.

CHAIR: You need a notice to walk in, a notice to visit, a notice to inspect and all of those things.

Ms ELSWORTHY: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you like special legislation?

Ms ELSWORTHY: Yes, I would.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Such as a supportive institutions Act?

Ms ELSWORTHY: Yes. That is needed because under current legislation women can refuse to see their support workers and refuse to see clinical support workers and there is not one single thing I can do about that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If we were to talk about what the forensic psychiatrists call assertive management, would that need a special Act?

Ms ELSWORTHY: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably they would have to be scheduled? That would mean that there was a right to deliver treatment, whether they wanted it or not, to put it bluntly?

CHAIR: The community treatment order would cover that.

Ms ELSWORTHY: It does not cover our involvement.

CHAIR: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It allows only professionals, and you are not considered to be professionals.

Ms ELSWORTHY: That is correct. It allows only treating clinicians, but not us.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If it is any consolation to you, the way that after-hours GPs are treated when trying to get people into mental homes does not sound very much different from the way that you are treated, from my experience.

CHAIR: That is an issue for all types of carers.

Ms ELSWORTHY: Another thing that is quite difficult is that behaviours that are quite challenging are not covered under the Act. The Act is about being at risk of personal harm or harming others. I know that there are big issues in housing estates that result from behaviour that the Act does not cover that I do not know what to do about that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you suggest amendments to that Act? People have said that generally it is about police going in with the workers. You and your workers would be in an unprotected State.

Ms ELSWORTHY: Yes, that needs to be looked at.

CHAIR: The protection of reputation and financial position helps a little, does it not?

Ms ELSWORTHY: I sit on the local joint guarantee of service committee, which is a combined program of bringing health and housing together to try to sustain tenancies in Department of Housing accommodation. I am the non-government representative on the Eastern Suburbs Joint Guarantee of Service Committee. I thought that one of the purposes of that was to look at more creative solutions for difficult tenancies. However, every discussion has come down to whether a person can be scheduled, that seems to be a constant response: If they cannot be scheduled, there is nothing anyone can do.

CHAIR: That is probably true. It is not about only harm to oneself and harm to others but the harm to oneself can be reputation or finance?

Ms ELSWORTHY: Yes, those are different matters. That will come up more if someone is being sexually disinhibited, so their reputation is at risk.

CHAIR: Surely losing tenancy is a serious impact on someone's financial position?

Ms ELSWORTHY: I would think so.

CHAIR: But in practice that is not how it works.

Ms ELSWORTHY: Not really.

CHAIR: Maybe the practice and guidelines need to be looked at.

Ms ELSWORTHY: Yes.

The Hon. AMANDA FAZIO: Can you give some examples of what behaviours you are talking about?

Ms ELSWORTHY: From the meetings of the joint guarantee of service, there is a guy who was not taking medication. He was abusive to neighbours because they had a wind chime. That wind chime set of an incredible series of abuse, and fires were involved. He was refusing to see anyone, and he was not scheduled. Yet, I would have thought that there were ample grounds, but the crisis team's response was that he was physically okay and no-one else had been physically harmed, so there were no grounds to go in. I can give countless examples through the joint guarantee of service including people keeping chickens in units and all sorts of things. Because they are not at risk of harm or harming others, no-one was doing anything about it.

The Hon. PETER BREEN: Is it not against law to keep chickens in a unit?

Ms ELSWORTHY: I guess so. But organisations do not want to evict people who have nowhere to go.

CHAIR: With that wind chime example, surely the Department of Housing representative could go to the people with the wind chime and ask them to remove it and explain that the department was trying to keep the fellow settled?

Ms ELSWORTHY: That is great in theory.

CHAIR: The people with the wind chime might respond that they were perfectly entitled to have a wind chime.

Ms ELSWORTHY: Exactly, you've got it!

CHAIR: Maybe you should schedule them also.

Ms ELSWORTHY: Exactly.

CHAIR: It is that sort of co-operation that is needed in the community to allow people with a mental illness to survive, not just to live?

Ms ELSWORTHY: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Other submissions mentioned mentally ill neighbours who made totally unreasonable demands. Some people have had to sell their house and move.

Ms ELSWORTHY: That is correct.

The Hon. PETER BREEN: It is a problem in the community generally, not only for people with a mental problem?

Ms ELSWORTHY: That is correct. It is a big problem in the housing estates, because that is where a lot of them are concentrated. Nowadays basically to get priority housing you have to have a disability. The number of people with a disability on housing estates is becoming very high. The whole thing needs to be looked at.

CHAIR: With such a concentration of people you would think that this would be a highly efficient way of providing committee-based services or SAAP services. But there seems to be a constant lack of those services and that is the problem.

Ms ELSWORTHY: That is right. In all honesty there is a group of mentally ill patients that I do not know what to do with. They are non-compliant, drug and alcohol or poly-drug users. They make life a living hell for everyone around them. I do not know the solutions for them.

I know what some of the solutions can be with the rest of the population, but we really need to look at that group because they are the ones who are causing lots of disharmony on housing estates. But I also feel that enough is not being done on housing estates to educate people. For example, people are reluctant to call the police because they think they will get that person into trouble. They do not understand how the Mental Health Act works. They will not call the police because they think they are going to get the person into trouble. They do not realise that that is the procedure you follow to get that person help.

CHAIR: That is section 24.

Ms ELSWORTHY: Yes.

The Hon. PETER BREEN: But do you have any problems in your houses with those kinds of people?

Ms ELSWORTHY: Occasionally, yes.

The Hon. PETER BREEN: How do you deal with them?

Ms ELSWORTHY: It varies. At the moment I have a situation like this. I have a woman who has moved in who is in a domestic violence relationship. She has moved the man in with her, which is against policy. He has been extremely violent to her in the house. She is in a block of flats that we have. It is causing enormous distress to everybody else in the block. The police are being called there once a week at the moment. I am evicting her.

The Hon. PETER BREEN: That is the answer, is it not?

Ms ELSWORTHY: Yes.

The Hon. PETER BREEN: That is what happens in housing estates, as I understand it.

Ms ELSWORTHY: Yes.

The Hon. PETER BREEN: People whose behaviour is unacceptable and disrupting the neighbourhood have to be evicted. There is no other solution.

Ms ELSWORTHY: That is what I am saying. There is a core of people for whom there is no easy solution.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you believe that woman wants to get rid of the violent party?

Ms ELSWORTHY: I have tried all that. She has a domestic violence councillor, a specific domestic violence councillor who she has been seeing for over a year. We have tried all of that. The police have tried. The abuse is horrendous. I have seen the results of the abuse: biting on the face and on the head. Within 24 hours she is trying to have the charges dropped and the apprehended violence order [AV0] revoked.

The Hon. PETER BREEN: Who owns the houses that you manage?

Ms ELSWORTHY: The Department of Housing.

The Hon. PETER BREEN: The nine houses and the two blocks of flats are owned by the Department of Housing?

Ms ELSWORTHY: That is right, and we head lease them from the Department of Housing.

The Hon. AMANDA FAZIO: Do you think the Department of Housing or, perhaps, the Department of Health should provide more to diversionary programs when they have these clusters of tenants in housing estates, whether they have a mental health problem or mental disabilities, or whether they are fleeing domestic violence? Do you think that would be helpful in terms of settling down the estates?

Ms ELSWORTHY: I think anything like that is worth trialling. I do not see any harm in trialling something. It is so difficult, though, to engage people. The ones who are causing the most difficulty are usually the ones who are the most difficult to engage. But I think it is worthwhile trying anything on housing estates because they are in crisis. It is really hard.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you now making a general statement about housing estates in New South Wales or the eastern suburbs?

Ms ELSWORTHY: Sorry, the eastern suburbs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You can only speak about your own area.

Ms ELSWORTHY: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you are saying that all the housing estates, generically, are in crisis?

Ms ELSWORTHY: Yes. Before this job I worked as the Co-ordinator at Randwick Information and Community Centre for five years, which was the community centre for the lower end of the eastern suburbs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The Malabar area?

Ms ELSWORTHY: Yes, Maroubra. A number of people came to see me in my position there, people living on housing estates who were pulling their hair out because of disputes, complaints, threats and violence. It all happened post Richmond. It was all a consequence of the Richmond report.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What date was that?

Ms ELSWORTHY: I went there in the late 1980s and I was there for five years. It was all because people were being shunted out.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But things were not great there in the early 1980s. I was an after-hours Doctor there in the early 1980s.

CHAIR: That is when it started to happen.

Ms ELSWORTHY: Yes.

CHAIR: You are talking about long-term beds. The medications have got better now, which helps a bit.

Ms ELSWORTHY: They have.

CHAIR: They had some drugs then such as modecate and lithium, but that is about all. But you are suggesting that we still need institutions. We know that there are still 2,500 intellectually disabled people in the system. What sort of institution are you thinking about?

Ms ELSWORTHY: What I am thinking about is not a cheap option. My fantasy is that you would have small places, not large institutions, but we are talking dollars here, I know that.

CHAIR: But we have to think of options. It is not cheap keeping them in the big ones, either, it really is not. It is not quality and it is not what the department or anyone wants.

The Hon. PETER BREEN: It is not keeping them in gaol, either.

Ms ELSWORTHY: Exactly.

CHAIR: No, it is not keeping them in gaol. It is much more expensive. What sort of size and shape do you think it should be?

Ms ELSWORTHY: I am thinking six people, up to 10 maximum.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you talking group home?

Ms ELSWORTHY: No, I would call it clustered housing where they have their own room, their own kitchen, like a little—

CHAIR: Like those little flats out at Little Bay.

Ms ELSWORTHY: Yes, but not a bedsit, bigger than a bedsit. We do not recommend bedsits for mentally ill people. They are too small. People with a mental illness can spend enormous amounts of time at home, especially if they have depression or motivation issues. Bedsits are far too small. I am thinking a little bit bigger than a bedsit with, maybe, separate staff facilities so that they are not intruding in their homes but they are there on site.

CHAIR: Hostel accommodation?

Ms ELSWORTHY: Yes, something like that, but maybe with more than just a little room; with their own bathroom, their own kitchenette.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: For each person?

Ms ELSWORTHY: Yes, they are my feelings.

CHAIR: Kitchen, bedroom and recreation area?

Ms ELSWORTHY: Yes.

CHAIR: But, again, that is a single-bedroom unit, for example?

Ms ELSWORTHY: Yes.

CHAIR: Attached to some sort of community activity, like you would see in some of the better quality hostels, Diggers, et cetera?

Ms ELSWORTHY: Exactly.

The Hon. PETER BREEN: Another comparison might be the self-contained retirement village?

Ms ELSWORTHY: Yes, that sort of thing.

CHAIR: Are you thinking of clusters of six like that?

Ms ELSWORTHY: Yes, clusters because if they are too big you start to get that whole institutional feeling. I would be concerned about quality of care. But I know that what I am proposing is an expensive option.

CHAIR: Yes and no. Look at what people pay to get into some of these hostels, which are run by church organisations and the like. The Diggers homes that Dee Why are outstanding. The Church of England runs large numbers of these high-quality homes where you pay, say, $400,000 to walk in the door, sort of thing. They mobile, retired people. They are able to get about, they have their wits about them, and they have money and cars. They would have to be modified for those deficiencies. We can explore that with the department's representatives when they come. I am aware that there is some planning along those lines.

Ms ELSWORTHY: Good. In my experience in working with women you would have to have some of them as women only.

CHAIR: Of course.

Ms ELSWORTHY: It is very hard to get women into group homes. Nearly every group home I know about is mixed and they are predominantly housing males. I have heard horrendous stories of what has happened to women in those environments. Women do not feel safe.

CHAIR: Often just a man around the place as an AVO person might be enough.

Ms ELSWORTHY: Exactly.

The Hon. PETER BREEN: Earlier you spoke about the Department of Housing accommodation in the eastern suburbs at Malabar, Chifley and those areas. How many people are Department of Housing tenants in that area?

Ms ELSWORTHY: I could not really say. People see the eastern suburbs as this blue rinse, very rich area when, in fact, it has some really large housing estates. There are south Coogee and right out towards the gaol. I cannot tell you, but it is thousands.

The Hon. PETER BREEN: Yes, it is thousands. When you say that the problems in those areas are escalating, what evidence do you have of that?

Ms ELSWORTHY: Anecdotal and through the Joint Guarantee of Service. We have had women who have gone into Department of Housing. In one case in particular a gang of kids ran her out. They literally ran her out of her home. She ended up back in hospital and quite psychotic, back in our scheme, back in housing again in a different area. That was out towards Bilga Crescent way, out near the gaol. That can be a particularly difficult area out around the gaol. We have hot spots that we do not want our women going into because we know they will be difficult areas for them to live in. We will argue with the Department of Housing not to allocate. Generally, we have found the Department of Housing to be fantastic with us. I cannot complain at all. We find them to be responsive. The Maroubra office is particularly good and has a good understanding of mental health.

CHAIR: What about Aboriginal mental health in that area? Do you have any Aboriginal people in your housing?

Ms ELSWORTHY: It has been really hard for us. We have tried every strategy possible. We have employed Aboriginal workers. We have networked with Aboriginal organisations. We have done everything. We have promoted the service through *Koori Mail*. You name it we have tried. We cannot get Aboriginal women to our scheme. We would be lucky to have one each year in our scheme.

CHAIR: Are there any Aboriginal-owned and operated schemes for homeless women?

Ms ELSWORTHY: There is one in Moree that is for Aboriginal women.

CHAIR: Yes, I am aware of that one. But there are none in La Perouse, Redfern or Blacktown?

Ms ELSWORTHY: No, but there is some new, exciting work being done. Killara Women's Refuge has just received funding to concentrate on doing some work at La Perouse. The co-ordinator has very good networks with the La Perouse community. We are hoping to work with them.

CHAIR: Like a partnership deal. But it would have to be Aboriginal-owned and operated. I can understand why it would not work.

Ms ELSWORTHY: Yes.

CHAIR: You talk about a reduction in staff in community health centres, crisis teams and the mobile treatment team. Do you say there has actually been a reduction in the number of staff?

Ms ELSWORTHY: They are having difficulty filling positions and keeping people. There has been a reduction in beds in the area. They closed down Prince Henry Hospital and we lost beds in that process. They have rebuilt the psychiatric hospital at Prince of Wales and built the Kiloh centre. We lost beds in that process. The Kilo centre is not as big as the facility it is replacing. There would be a reduction in staffing there because there is a reduction in beds.

CHAIR: But, surely, that would be reflected in more nurses out in the community?

Ms ELSWORTHY: They are having difficulty filling the jobs.

CHAIR: Did they create more positions?

Ms ELSWORTHY: No, they have not.

Ms ELSWORTHY: What happens in our area is that there is competition for resources between the southern end and the northern end. The St George area is poorly resourced as well, so we have competition within our own area health service. It is my understanding that the money that came through for the area health services went predominantly to the southern end, which, again from my understanding, was more poorly resourced than we were. Any new resources have been going down there. That is my understanding.

CHAIR: You lost beds, but you did not pick up the community mental health premises?

Ms ELSWORTHY: That is right.

CHAIR: But the same people are there, probably increased. I make the point that they are increasing in acuity when you see them. To get into your place do they have to be approved by the Department of Housing?

Ms ELSWORTHY: No.

CHAIR: If you are holding Department of Housing stock and you are admitting only people who have a mental illness, I suppose they would be the sort of people who would qualify for Department of Housing anyway, would they?

Ms ELSWORTHY: Mostly. Some of our women do not. Again, we go back to this issue of personality disorder. Those women may not be on a disability benefit. It is really the ones who are on the disability benefit who are getting the Department of Housing. We have had three women in six years that I can think of who were on New Start allowance who got priority housing. In terms of community housing, the Women's Housing Company is the only community housing provided that is housing our women. We have the Eastern Suburbs Rental Housing Association, but in six years I have not had one woman successfully housed with them. There are other community housing providers that we have applied to in the Inner West, et cetera, but we are not getting a look-in.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you suggesting that the community housing people are quite selective in whom they help?

Ms ELSWORTHY: I do not know why we are not getting them in.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you given any submissions to the inquiry into community housing, which is currently before social issues?

Ms ELSWORTHY: No, we did not. But I have made my concerns known to other forums. I do not know why. They will tell me waiting lists, but the Women's Housing Company has waiting lists too. We did a joint project with the Women's Housing Company and that was extremely successful. In that we provided training, et cetera, and we have now established a very effective relationship with them. They now know that our women are not difficult to house. In fact, they would say that our women are their best tenants because they have been trained by us. They pay the rent, they notify repairs and they are now more than happy to take our women. I think there is fear about taking people with a mental illness.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am a member of the committee inquiring into community housing. The evidence from Housing has been that it can do much better than Health. It is all beer and skittles. It is probably an exaggeration. But the question has been asked about tenant selection that gives this wonderful result, which is in my mind when one group is doing so much better than the others.

Ms ELSWORTHY: That is in my mind, too. We have applied and we are just not getting our women in. I do not know why. I do not know if it is a reluctance to take them. For a long time the Eastern Suburbs Rental Housing Association did not have a priority system. Its waiting list was for four years. Our women are long gone with us. Now I have heard there is a priority system, but I have not seen any improvements in access for us.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you believe that you should give evidence to that inquiry? I know it is beyond our terms of reference, but one ought to take the opportunity when one can. Are you likely or able to have an input into that inquiry?

Ms ELSWORTHY: I would be happy to.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It may mean more beds for you.

Ms ELSWORTHY: That is right, and I would be happy to do so. There are joint projects. Some community housing providers, for example, St George and Hume Housing, are doing a terrific job. They are doing some really good innovative things.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: For people in your tenants' situation?

Ms ELSWORTHY: Yes, for mentally ill people.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are having difficulty with some community housing, but not all?

Ms ELSWORTHY: Not all.

CHAIR: There are other organisations like yours that provide housing. We will deal with shelter shortly. What about housing for young people, young women?

Ms ELSWORTHY: That is a huge problem.

CHAIR: They cannot live at home, the Department of Community Services [DOCS] says that they are 16 and can live separately. They go to DOCS and say they cannot live at home any more because they are being abused. Some of those people have a mental illness.

Ms ELSWORTHY: That is right. It is extremely difficult to find anything for them. We take women 18 years and over. There is a story here about a 17-year-old girl who could not get anywhere to live. We had a situation at B. Miles where we were housing a young woman who had tried some terrible things to kill herself. She had thrown herself in front of trains, that sort of thing. We decided that she was

beyond our duty of care. We could not guarantee her safety with the level of support that we were offering. I could not find anywhere for that young woman to go. Nobody would take her. I tried everything.

CHAIR: Surely if she does a train job she ends up in the mental health system. She is suicidal and a harm to herself, the police come and under section 24 she is admitted.

Ms ELSWORTHY: She was not admitted into the psych unit. She was admitted into the unit for her leg. She was never put in the Missenden Unit at Royal Prince Alfred Hospital.

CHAIR: They treated her bone. What happened after that?

Ms ELSWORTHY: She got discharged back to us.

CHAIR: You could not take her because she was 17.

Ms ELSWORTHY: She was 19, I think. She came back to us. My heart was in my mouth because this was her third serious suicide attempt. I could not get one place that would take her.

CHAIR: While she was in Royal Prince Alfred hospital having her leg fixed, did you make representations to have her mental illness treated?

Ms ELSWORTHY: I spoke with the social worker. They did not think there was anything they could do because they considered she had personality issues. This is an ongoing problem. People with personality disorders are being treated sometimes as second-class citizens.

CHAIR: Because they do not have a psychotic illness?

Ms ELSWORTHY: Yes.

CHAIR: Yet they are suicidal and a harm to themselves. They fit into all the other categories of mental illness but they have a personality disorder.

Ms ELSWORTHY: I could have a client with a borderline personality disorder at B. Miles, I could ring the acute care team and say that she is suicidal and there is absolutely no guarantee that she will get into hospital. Even though the Act says that if somebody is suicidal they should be admitted, if she has a diagnosis of personality disorder it is unlikely that the hospital will take her.

CHAIR: Because she does not fulfil the criteria for mental illness for scheduling—basically she is not psychotic.

Ms ELSWORTHY: Yes, and she is badly behaved and attention seeking.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am not a psychiatrist, but it seems to me that a personality disorder is a disorder of programming as people grow up. They end up with behaviours that are antisocial because of their antisocial programming. In other words, they have a classic developmental problem, not a malfunction of the organism.

Ms ELSWORTHY: You have got it right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I presume that the effort to change the behaviour is poor because they have learnt the behaviour from childhood.

Ms ELSWORTHY: Yes.

CHAIR: What percentage of your clients are in that situation?

Ms ELSWORTHY: A huge percentage.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it a high percentage?

Ms ELSWORTHY: It varies. It depends on how many I will take at any given time. At one point I would say that three-quarters of the people on our waiting list had a diagnosis of personality disorder. That is because word has got out that B. Miles takes them. It has skewed our statistics as well. Most services will not take these people, but B. Miles will. We are getting all the referrals basically. There is a new program that we have learnt about that is very effective in working with these groups. But you have to have private health insurance to be able to do it. That is another issue. People with personality disorders really have to have private health insurance to access this service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does that program involve private psychiatrists talking through the problems endlessly?

Ms ELSWORTHY: No, that is one way. There is a new program call dialectical behaviour therapy [DBT], which is being done through the Wesley Mission. It is extremely effective with borderline personality disorder. It has a very, very high success rate. It is a 12-month program one day per week at a cost of $150 per day. Our women cannot afford it unless they are have private medical insurance. A lot of our women cannot afford that.

CHAIR: Do any of your women have a protective order or guardianship order?

Ms ELSWORTHY: Yes.

CHAIR: Those women who have a protective order would have money.

Ms ELSWORTHY: Yes, but they are more likely to be the ones with a psychotic illness.

CHAIR: Of course, because they cannot get the protective order if they have a personality disorder.

Ms ELSWORTHY: Yes.

CHAIR: That is another issue. They can do the big spending and get rid of all of the money in a flamboyant way without being manic.

Ms ELSWORTHY: That is right.

CHAIR: If mentally ill people have an illness, such as asthma, what sort of support do they get for the medical problem?

Ms ELSWORTHY: If it is a medical problem it is not too bad. We have a woman of non-English-speaking background who has severe diabetes.

CHAIR: And she has a mental illness?

Ms ELSWORTHY: And a mental illness. She is also a devout Christian and it is part of her Christian beliefs to fast. She will fast for various reasons. It is hard to get through to her because of her mental health issues. It is hard to negotiate that point with her. We have tried on many occasions. We recently found out that the diabetes clinic thought that she was getting all the information, that she was computing it, and that she was going home and doing all the right things. She has not at all. Her diabetes is completely out of control. In the end, Geral accompanied her to the clinic because of our frustration that the diabetes was not getting any better. Her management of it was not improving. It was only through Geral accompanying her to the clinic that we were able to get the message across that what they think is happening is not actually happening. I do not think they took into account her complexity and her mental health and how it was impacting on her ability to manage her illness.

CHAIR: Was the diabetes clinic aware that she had a mental illness?

Ms ELSWORTHY: Yes.

CHAIR: Did the clinic talk with the mental health team?

Ms WALLWORK: I doubt it.

CHAIR: It is no good treating the mental illness and not the diabetes.

Ms WALLWORK: Her mental illness is under control. I do not know if the clinic liaised with the mental health section.

The Hon. PETER BREEN: Who makes the decision on whether it is a personality disorder or a mental illness?

Ms ELSWORTHY: Psychiatrists.

The Hon. PETER BREEN: Do you rely on psychiatrists' advice about the tenant?

Ms ELSWORTHY: Yes.

CHAIR: The College of Psychiatrists is appearing before us this afternoon. We will pursue that issue with them.

Ms ELSWORTHY: We are pretty good at picking it now too. We have had so many clients with that diagnosis. I can usually tell within five minutes of a phone call.

The Hon. PETER BREEN: You can tell whether it is a mental illness or a personality disorder?

Ms ELSWORTHY: Yes, because there are similar behaviour issues.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you mean when they ring you?

Ms ELSWORTHY: When they ring me. I know that when the mental health team rings me they will hide it under depression. It is very rare that the mental health team will be upfront with me.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are they trying to sell it?

Ms ELSWORTHY: That is right.

CHAIR: The mental health team may be constrained. Part of the problem is the ability to divulge information, even if it is in the patient's interests to do so. If the information were provided, you are able to put the patient in the right position. You know what you are buying and they know what they are selling.

Ms ELSWORTHY: Exactly.

CHAIR: That is a very difficult matter. I do not know whether I want to cross that line.

Ms ELSWORTHY: It is a huge issue that you are touching on now. It has happened to me on a couple of occasions where I have been doing an assessment. I do an assessment with each woman prior to her entering B. Miles. I get to the section on diagnosis and if I have taken the referral from someone else I will say, "You have a diagnosis of personality disorder". She will say, "What is that?" She has never been told. She finds out from me in the assessment that that is her diagnosis. That has happened on a couple of occasions and it is horrible.

The Hon. PETER BREEN: Why does she think she has been referred to you?

Ms ELSWORTHY: She thinks she has depression. She has been told she has depression because the psychiatrist has not wanted to tell her that her diagnosis is personality disorder. I am then put in that situation and I hate it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does it make any difference? My experience of people is that if you tell them their diagnosis is X, Y or Z, there is no qualitative difference from their point of view.

Ms ELSWORTHY: It can make a difference as to how they are treated by the system.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In other words, the psychiatrists are protecting them by not telling them?

Ms ELSWORTHY: I think so. The psychiatrists think they are protecting them. A lot of our women with personality disorders will not contact the acute care team because of previous experiences with acute care teams and the way they have been treated. We have overcome a lot of those problems with our acute care team. We are getting a much better response from our acute care team because we have established a firm relationship with it.

CHAIR: Is it related to the fact that there is not any real treatment for personality disorder?

Ms ELSWORTHY: It is difficult.

CHAIR: If a woman is psychotic she can be treated with antipsychotic drugs. For the most part there can be some control and output. However, a personality disorder is very difficult to treat.

Ms ELSWORTHY: The dialectical behaviour therapy is an amazing treatment for borderline personality disorder. It is absolutely fantastic.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you know whether there is any cost effectiveness data on that? We want to treat people rather than put them in gaol. The cost benefits of these programs are important in terms of resource allocation.

Ms ELSWORTHY: Wesley Mission did argue the cost effectiveness with MBF and private health insurance companies. That is why it can be claimed back. If people undertake the dialectical behaviour therapy at Wesley Mission, they can claim it on their private health insurance. Wesley Mission has argued the cost effectiveness of it with private health insurance companies.

CHAIR: People can claim herbs and spices and massage therapy from HCF and MBF. I do not want to share my views on that with the Committee.

Ms ELSWORTHY: All I am saying is that some cost effectiveness data has been done. Wesley Mission would be able to provide that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably only a small percentage of people with personality disorder can claim from MBF. They will claim for dialectical behavioural therapy, as opposed to claiming for running shoes. That is keeping the customers happy. As to the cost effectiveness of the therapy and keeping people out of gaol, the program would have to be in the public sector.

Ms ELSWORTHY: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We would have to persuade Treasury to give money to this program rather than to gaols. As a minimum, we would need cost effectiveness data and then it becomes a political problem.

CHAIR: You have been a worker in this area for a long time. Are you impressed with the results when people come out of this program?

Ms ELSWORTHY: Yes, very much so. In fact, I want to take those clients there because if they are doing the DBT therapy I know that will have a high chance of very good outcomes. These are people who are causing lots of problems in the community. If they are doing DBT I want to take them on board.

CHAIR: Will they still qualify for housing provided by the Department of Housing if they have that sort of money?

Ms ELSWORTHY: No.

The Hon. PETER BREEN: They will still qualify for your program on the basis of the mental problem.

Ms ELSWORTHY: Yes, we do not means test.

CHAIR: I did not know that. Would this be an example of Department of Housing stock being used on a contract basis to aid, if you like, the Richmond report?

Ms ELSWORTHY: Yes. We have houses specifically purchased for B. Miles. Our places are not on housing estates. They are ordinary houses. You would walk past them and you would not know that they were B. Miles houses. We have houses in various locations in the neighbourhoods of the Eastern Suburbs. We have had very, very few problems with neighbours. I can count on one hand the number of complaints I have had in the last five years from neighbours.

CHAIR: Do you talk to the neighbours?

Ms ELSWORTHY: I will if there is an issue, definitely. I make myself very accessible to neighbours because I want to smooth out problems. I do not get into that siege mentality.

The Hon. PETER BREEN: Do the neighbours know in advance that it is a B. Miles house?

Ms ELSWORTHY: They do now. We have been there so long, yes, everyone knows.

The Hon. PETER BREEN: So there is a level of support in the community for your work?

Ms ELSWORTHY: Very much so, actually. Sometimes neighbours have contacted us when somebody is experiencing psychosis because she is running up and down the street and the neighbours will ring us and notify us. They ring us out of concern, not being aggressive. I have had one argument with a neighbour. One neighbour was argumentative and difficult in the last six years.

The Hon. PETER BREEN: They would not have the wind chimes, for example.

Ms ELSWORTHY: That is right. But you would not believe what people argue about.

CHAIR: Another big issue is the post-traumatic stress disorder [PTSD] issue, which is more widely recognised, that is, people with previous abuse, where they are very disabled but not mentally ill?

Ms ELSWORTHY: Post-traumatic stress disorder is also called borderline personality disorder. They are one and the same.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: PTSD has totally different epidemiology.

Ms ELSWORTHY: There is a move to have the name borderline personality disorder removed altogether and to just use chronic post-traumatic stress disorder.

CHAIR: Because it is much more legitimate.

Ms ELSWORTHY: I think because of the stigma.

CHAIR: The disability is recognised with PTSD whereas personality disorder [PD] means something you are born with.

Ms ELSWORTHY: No. Personality disorder is recognised as coming, usually from childhood abuse, or what you were saying earlier about not being taught at the right levels of development, missing out, poor parenting.

The Hon. PETER BREEN: Or some other trauma.

Ms WALLWORK: And a predisposition to being sensitive.

Ms ELSWORTHY: Yes, and there is that genetic factor of being born with that sensitivity.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably, the two would emerge in children at places like Woomera where their childhood is unhappy and traumatic, whereas with PD they are not necessarily connected?

Ms ELSWORTHY: When I hear the reports on the radio I think of my clients. It is very similar behaviour.

The Hon. PETER BREEN: You said that 75 per cent of the people you care for suffer from personality disorder.

Ms ELSWORTHY: No, I said at one point on our waiting list about 75 per cent had that diagnosis.

The Hon. PETER BREEN: Is that still the case?

Ms ELSWORTHY: I have not added it up lately. It would still be high, up there, because, again, we are one of the few services that will take them.

The Hon. PETER BREEN: These are people who psychiatrists have said are suffering from depression?

Ms ELSWORTHY: Sometimes. Five years ago they were not using the diagnosis as much. Over the last five years more psychiatrists are using that diagnosis openly.

The Hon. PETER BREEN: Personality disorder?

Ms ELSWORTHY: Yes.

The Hon. PETER BREEN: Those people you have identified on the waiting list, three-quarters of them have been clearly and unambiguously identified as having personality disorder. Those figures compare, for example, with 45 per cent of women in prison who suffer from personality disorder?

Ms ELSWORTHY: Yes.

The Hon. PETER BREEN: Your figures are well up on those?

Ms ELSWORTHY: Yes. That was an estimation. I would have to sit down with my waiting list and go through it. I would be happy to do that and send the information through so that it is more accurate. I know that a couple of months ago I actually put a temporary hold on taking more clients with that diagnosis because at that point over half of our tenants had that diagnosis and with all of the behavioural issues I was about to have a staff walk-out.

The Hon. PETER BREEN: What is the alternative? What other diagnosis do you get instead of personality disorder?

Ms ELSWORTHY: Schizophrenia, bi-polar, chronic depression.

The Hon. PETER BREEN: Excuse my ignorance, but are you suggesting that these are better than personality disorder?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: More treatable.

Ms ELSWORTHY: It can be easier. Now that we have started to learn about the dialectical behaviour therapy [DBT] it is like I have been given this almighty present of something that works and it is only in recent months that we have started to learn about this. I was desperately looking around and I needed to increase our toolbox of skills because we were not skilled enough and were not managing but now we have the DBT we have finally something that offers us something positive so I am not so worried. I am feeling more okay about it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can your staff become barefoot DBT therapists?

Ms ELSWORTHY: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is too hard, is it?

Ms ELSWORTHY: You have to go to New Zealand to do the training at this point. They do not offer it in Australia.

The Hon. AMANDA FAZIO: Earlier you gave us your ideal mini-institution model and you have been talking about the new therapy you think would be handy. What is your wish list for a range of community support services that you would like to see in place?

Ms ELSWORTHY: There needs to be someone keeping track of people, an organisation that is keeping an eye on how somebody is going, not tied up to case managers. Ideally case managers should be doing that but they cannot because their workloads are too high. Ideally there needs to be agencies responsible for overseeing how the person is going and someone to bring in the services as they are needed. People are episodic and unpredictable. They can be going along great one minute and then all hell breaks loose the next. I would love to see a key agency that oversees the person and brings in home care when it is needed. However, at the moment you cannot get home care because the waiting lists for home care are really long. There is still a cost associated with home care and some women will not pay it. We are not dealing with people who are always rational and sensible.

They need support with living skills such as cooking, nutrition and transport issues. Social isolation is one of the biggest problems. I am also on the management committee of an organisation called the City Women's Hostel, in Flinders Street, which is a crisis hostel for single homeless women. About 65 per cent of its clients have a mental illness and they can get them into housing but they end up coming back to the refuge because they are lonely and that seems to be a really big problem. Another thing is overseeing employment. There is a fantastic organisation in our area called One Two One Employment, which does the most wonderful service for our clients. One of the reasons they are good is because they do not stop the service once the person gets the job, they actually stay on with the clients once he or she gets the job.

The Hon. AMANDA FAZIO: It is like an independent job service for someone with mental health problems?

Ms ELSWORTHY: Yes, it is fantastic, because when things start to go wrong in the employment they can step in and give support.

CHAIR: Do they get Commonwealth funding?

Ms ELSWORTHY: I am not sure. I think they probably do. I would say they do.

CHAIR: If you are developmentally disabled or you have a disability other than psychiatric a whole raft of things are available to you, such as key areas where the Commonwealth pays for the employment part of it and the States pay for other things. Does the same apply for psychiatric illness?

Ms ELSWORTHY: We were actually going to apply through the Department of Ageing and Disability Services for one of the packages for one of our women. As far as I was aware she was eligible but the trouble was when I looked at the application, co-ordinating all this is a huge job and we cannot put in all that effort for one person when we have so many women and only have four-part-time workers. It was a massive amount of work. We were just lucky that she got into a group home and it saved us having to go ahead with the application because the idea of trying to do it efficiently and effectively—

CHAIR: In a group home she would be eligible for that sort of group package if somebody got their act together to arrange the multiple services you have to help pay for?

Ms ELSWORTHY: Yes, but to me it is the whole package that is important, from social activities, through to employment, through to general health. We have many health problems with our women—and I am talking about women with a history of psychosis—where if they have a diagnosis of hepatitis C, it is hard to do work with them on how to live safely because the amount of time you have to spend with them trying to get those messages across is so intensive. If they have a history of homelessness and risk-taking behaviour, it is really difficult and challenging. I keep saying every single person is unique

and I really mean that. Each person requires a different level of support and there does not seem to be that sort of flexibility to meet their level of need.

CHAIR: The Richmond report 1983 recommendation proposed a positive way forward in mental health service delivery. Although many of the recommendations have been implemented their effectiveness from our service perspective is marred through lack of funding, gaps in service and underresourcing?

Ms ELSWORTHY: That is right, and that is pretty much the bottom line of it. B. Miles was set up in the mid 1980s at the time that the Richmond report was being implemented. I happened to be a public servant at that time and I set up B. Miles 17 years ago when I was in the public service. I remember we discussed Richmond at that time because the Richmond report had just come out and we did not even realise then the impact that it was going to have. It has just been devastating. The principle behind it is fantastic but it has been a cost-cutting exercise. That is how I see it and how many people in the sector see it. It was an excuse to cut costs and that money was not redirected back into the system. What we are getting now is a whole lot of pilot programs, one-offs, and it just feels like flicking coins into a fountain.

CHAIR: Have you ever relied upon the rights under the national mental health plan that came out in the mid-1990s in your arguments with the department?

Ms ELSWORTHY: No, but I probably should. I have not thought about that but we have all that information at B. Miles. B. Miles itself is quite well funded. Because we are not health funded we are actually better resourced than organisations doing similar work to us that are funded through Health.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are funded through DOCS?

Ms ELSWORTHY: Yes.

CHAIR: How come DOCS is in that game?

Ms ELSWORTHY: You really want to know? It is SAAP funding.

CHAIR: Supported accommodation for disabled people.

Ms ELSWORTHY: Yes. We were just lucky that we ended up under SAAP because SAAP is funded better than Health funds.

CHAIR: Does Health fund any housing?

Ms ELSWORTHY: They do. We have one in our area and it is so poorly resourced—it is run through community health—I do not know how the staff sleep at night with what they are expected to do with the level of resourcing they have, and they have the really chronically ill people living in their houses.

CHAIR: They have the more clinically dependent people?

Ms ELSWORTHY: Yes. We are talking about people with pretty strong symptoms despite being on medication and how Health is managing to run that, I do not know.

The Hon. PETER BREEN: Are these community houses?

Ms ELSWORTHY: They are Health houses. They have now got the local community housing to provide the tenancy side of things, so they have handed over the landlord functions to them but they are doing the clinical support, but they are very poorly resourced to do it. Also, a lot of the area health services have their own housing. For example, there is a very good one in Darlinghurst that is a joint project with Mission Australia and they can offer a variety of levels of support and all that sort of thing, that is much better. Ku-ring-gai has a fantastic one and they got money through Richmond or Best Practice. It has a team of psychiatrists, occupational therapists and nurses supporting the housing program. However, people must live in that area to be eligible.

CHAIR: Is that not what is meant to happen?

Ms ELSWORTHY: That is the ideal.

The Hon. PETER BREEN: Is it run by the Department of Health?

Ms ELSWORTHY: Yes. It is very good.

CHAIR: Does the better practice grant come from the Commonwealth or the State?

Ms ELSWORTHY: I am not sure, but it is a terrific program.

CHAIR: I think the better practice grants are all Commonwealth funded, but I am not certain.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The better practice grants are mainly to do with general practice, are they not?

Ms ELSWORTHY: It is a mental health housing program in Ku-ring-gai. It was set up through the best practice funding. There was a talk about how it set itself up, which I attended.

CHAIR: It is a demonstration pilot project.

Ms ELSWORTHY: That is the problem.

CHAIR: When they work nobody repeats them.

Ms ELSWORTHY: Exactly. It is like flicking coins into fountains: where is the money going?

The Hon. PETER BREEN: There are experiments going on all over the place and no-one is monitoring them to see what is happening.

Ms ELSWORTHY: Exactly. I am in favour of partnerships across government. For example, I am very in favour of bringing Health and Housing together. I would like to see a joint guarantee of service for the non-government sector that we will get a joint guarantee of service from Health as well. It is anecdotal evidence, but I have had many conversations with people in various SAAP-funded services who tell horror stories about what happens to them when they contact their local mental health teams. It is just horrendous. There must be a really close examination of how the non-government sector, particularly SAAP, is working with Health. There are big problems right across the State.

The Hon. PETER BREEN: Is SAAP non-government in your estimation?

Ms ELSWORTHY: It is government funding but we are considered a non-government organisation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You touched briefly on drug and alcohol issues and said that these problems are very difficult to treat. Are the numbers worsening?

Ms ELSWORTHY: I think so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you not getting more cases only because your slanted casework with people with personality disorders is crowding them out? Are you taking them?

Ms ELSWORTHY: We take them only if they have undergone rehabilitation. Because we are not living on the premises it is too difficult.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The place just degenerates.

Ms ELSWORTHY: Yes. They must have undergone rehabilitation for us to take them. They may still relapse but we can work better with them if they have undergone rehabilitation because they have something to fall back on.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They at least have a norm that they know cognitively.

Ms ELSWORTHY: Yes. However, there is a continuing problem in that, if someone has a dual diagnosis of drug and alcohol and mental health, mental health services will not work with them because of their drug and alcohol issues and drug and alcohol services will not work with them because of their mental health issues. It is ongoing. In this area we have seen a decrease in drug and alcohol services. Langton Clinic no longer does in-house detox; it does at-home detox. When I tried to use that service, it was a case of, "Bring her in, we'll give her a couple of valium and send her home."

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: From Langton Clinic?

Ms ELSWORTHY: That is not good.

The Hon. AMANDA FAZIO: How do you do at-home detox if someone is homeless?

Ms ELSWORTHY: That is a very good point: If they are homeless, how do they do an at-home detox? I am very critical of that system; I think it is totally inadequate.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is perhaps the best that can be managed with the resources available.

Ms ELSWORTHY: I would like to table a paper that I presented a couple of years ago at a national housing conference. It is entitled "Sustainable Housing for People with Mental Illness" and it might be useful.

Document tabled.

CHAIR: It is ordered that the paper be made public. Thank you for your attendance before the Committee today.

(The witnesses withdrew)

(Short adjournment)

FREDERICK KONG, Chief Executive Officer, Richmond Fellowship of New South Wales, xx xxx xxx, and

MICHAEL JOHN STERRY, Counsellor and Board Member, Richmond Fellowship of New South Wales, xx xxx xxx, sworn and examined:

CHAIR: Are you each conversant with the terms of reference of this inquiry?

Mr KONG: Yes.

Mr STERRY: Yes.

CHAIR: Do you wish to include submission No. 159 as part of your sworn evidence?

Mr KONG: Yes.

CHAIR: Should you consider at any stage during your evidence that in the public interest certain evidence or documents that you may wish to present should be heard or seen only by the Committee, the Committee will be willing to accede to your request. However, I should warn you that the Legislative Council may overturn the Committee's decision and make that evidence public. Mr Kong, would you like to make an opening statement or take us through both the services that you provide and the submission that you have made to the Committee?

Mr KONG: A couple of points I would like to make. These submissions that we submitted to the committee were compiled by Chris Sargent who is our operations manager who happened to be acting CEO while I was on leave and I support and agree with everything that she has outlined in the submission. I have also included for the committee's information an information kit outlining the background information about the Richmond Fellowship, various programs that we operate, service configuration and organisational structure.

CHAIR: Would you like that included as part of your evidence?

Mr KONG: Yes, I would like to do that. This is information in reference to the operation of the organisation. Included in the kit also is a document called Relative Needs Criteria for Entry to Residential Programs. I included that simply because that highlights the complexity of the management of referral for people with mental illness into our services and these are some of the problems that have been highlighted in our submission. I thought that could be useful to the committee.

CHAIR: Looking at those dot points on that page, they indicate that you are precisely aimed at providing accommodation for people who have a mental illness and that the "Richmond" would come therefore from the Richmond Report?

Mr KONG: No. The Richmond Fellowship is an international organisation and it started in England. It just so happens it is a coincidence that the Richmond Report occurred in New South Wales and coincidentally we also got a lot of funding initially from the Richmond Report as a matter of fact.

CHAIR: And you are again separate from the Richmond organisation up on the north coast which takes its name from the locality?

Mr KONG: Yes, that is right.

The Hon. PETER BREEN: The fellowship does not have any religious affiliations?

Mr KONG: No, we are a non-religious organisation and we purely provide services for people with mental illness and the board has insisted that is our expertise and we state that to be our core business.

CHAIR: So that is how you operate?

Mr KONG: Yes.

CHAIR: That is the criteria for entry?

Mr KONG: Yes.

CHAIR: Basically what sort of services do you offer to the people who come to you that you accept?

Mr KONG: We accept referrals from a number of sources such as primarily from the hospital setting. As I mentioned earlier, the Richmond Fellowship obtained a substantial amount of funding out of the Richmond program On the basis of that, we accepted all referrals from hospital-based services as an alternative to hospital services at the time the Richmond Report was implemented.

CHAIR: When did you start operating?

Mr KONG: The fellowship started operating in 1975.

CHAIR: Before Richmond?

Mr KONG: Way before Richmond. It was only a very small organisation then. It was operated as a very special interest group. We operated under the interests of the so-called therapeutic community with very particular emphasis on mutual support and individual needs and so on and so forth. It was the advent of the Richmond Report that there were services being developed and I was able to acquire a substantial amount of funding from the Richmond implementation program.

CHAIR: So you have been with the organisation for 20 years?

Mr KONG: I have not been, no. I was actually headhunted by the Richmond Fellowship to join the organisation at the introduction of the Richmond program. I started some good home programs from the Richmond implementation program in 1986 but because that was very controversial at the time—there was a lot of conflict with the hospital-based services—it was suggested that those services that we set out, basically according to the Richmond Report to be community-based, having overcome all the industrial problems that we encountered at the time —having been in operation for over 12 months—the hospital-based services decided they wanted to take the services back in under the hospital setting. So it is on the basis of that that a number of very interested people who are on my board decided that that is not a very desirable thing to do and they made an attempt to transfer all of those services to a truly community-based organisation such as the Richmond Fellowship. I was transferred from that setting to the Richmond Fellowship in 1998.

CHAIR: What sort of services do you offer? Short term, or long-term, big houses, little houses, community living?

Mr KONG: We provide a range of services. Initially the program operated by the Richmond Fellowship since 1975 was a young people's program under the therapeutic community principle but since the Richmond Report we ran a number of services that extended the age group from 18 to 65 for people with mental illness that require support in a supportive setting. We actually configure it according to individual needs and we configure it in different levels. At the moment we configure them into three levels: The high support needs, which represents 24 hour support, up to 18 to 24 hours support for people that require some sort of staff input and support very intensively.

CHAIR: What size place would that be?

Mr KONG: When the Richmond Report was implemented, because of the shortage of funds it was operated in a very large setting. We had something like eight to twelve people in the one facility in four or five bedrooms. With the introduction of the Disability Services Act there is a standard for the Disability Services Act which says that people must be given the optimal privacy. So therefore we no longer can accommodate people with shared accommodation. In other words, they cannot share rooms. All our services are houses with single rooms for everybody and along with that they also say that it must not be developed in a congregate setting. So therefore the size of houses are restricted to no more than six people. All our facilities are no more than four or five bedrooms with only six residents in the houses.

We configure our service structure in such a way that staff provide services where the needs of the residents require. So with high support needs obviously those houses would have staff on the

premises 24 hours a day. We have the second level of support that we call a daily support team. Staff are there during the day 8 to 12 hours a day to attend to daily living requirements. Then we have the outreach team, which drops in to see people in their own home. That could be in a small house of two or three bedrooms or in single units. Staff drop in whenever it is necessary that the people require support.

CHAIR: Are they short-term or long-term?

Mr KONG: They are basically long-term accommodation but we encourage people to develop independence. When they are independent they move from a higher support setting to a lower support setting or, if they are in a lower support setting, they move into their own independent accommodation.

CHAIR: Where you are supported outside?

Mr KONG: Yes, and then we provide support outside. It could be vice versa. We do it in such a way that it is an integrated program. We respond to individual needs. If people require more support while they are in a low-support setting we respond to their needs in accordance with their support plan and move them to a higher support setting.

CHAIR: If they are in a low support setting and you think they are ready to go home to a home where there are carers do you still support them in their home?

Mr KONG: We generally do that in the initial stages but as funding is restricted we can only afford to direct the staff support to the people that we are funded for. We welcome the residents who move on to their own independent setting accessing staff support but we do not have an active program to support people that are no longer under our—

CHAIR: Where do you get your funding from?

Mr KONG: For a long time until 1998 we were funded under the Department of Health grants and subsidies section. After the decentralisation program, that was devolved to the area health services. In the kit I included a document issued by the Ageing and Disability Department in 1998. The Premier announced a $66 million boarding house relocation program. The fellowship tendered for services and from then on we were able to access a lot more resources.

CHAIR: That is SAAP funding under DOCS, is it not?

Mr KONG: No. This is a boarding house relocation program.

CHAIR: Who funds that?

Mr KONG: DADHC. Under that program, because of our expertise and experience in supported accommodation, we were able to access quite a number of programs and we extended our services from the central Sydney area to the Hunter area and were able to develop a program to accommodate people coming out of boarding houses. We now receive funding from two government departments. But, as I highlighted in our submission, there are discrepancies in the level of funding that we receive from the two departments. For a long time the Department of Health was able to give us only very minimum-type funding to operate the type of services that we were operating. I would like to go into a little more detail of this in regard to the lack of increments.

Ever since we were funded under the Richmond program we were only provided with an average of 2.5 per cent to 3.5 per cent increment each year. Some years we did not even get that. But costs have escalated. For example, Mr Paul Keating introduced the superannuation guarantee. I think it started in 1991. It started at 3 per cent and it has now escalated to 8 per cent. Our funding has never been supplemented to provide for that. So the organisation has to budget to provide the superannuation that we were compelled to provide for our employees. The only way organisations such as ours are able to continue to provide the services would be to restructure and to consolidate, which represents either a reduction of services or a reduction of capacity. Instead of providing 50 beds we have to reduce the number.

CHAIR: How many high-level beds, how many medium level and how many outreach are you providing—how many clients?

Mr KONG: It is clearly outlined in the documents there.

CHAIR: The yellow pages referred to the boarding house issue, which I am sure we will go back to.

Mr KONG: There are three service structures that outline the service configuration that we provide. For instance, in central Sydney we have 88 beds and 27 of those are high support or intensive support service and 23 are in the daily support and another 44—

CHAIR: Is this on the third page?

Mr KONG: It is on the chart under central Sydney.

CHAIR: It has intensive support in four places. The daily support is at three centres. But how many people?

Mr KONG: There are 23, and 44 in outreach.

CHAIR: So 88 in total?

Mr KONG: Yes. In the Hunter there are 33 residents in the high-support area and 36 in the outreach program.

CHAIR: You have no low level in the Hunter?

Mr KONG: The outreach is low level. The sort of support that we provide is dependent on individual needs.

CHAIR: Depending on the number of hours you provide.

Mr KONG: People with mental illness go through stages of development. Sometimes they are maintained well and they are free of symptoms but there are times when things flare up. That is the time when we provide additional support to ensure that they can cope with the stress that is associated with these symptoms.

CHAIR: You have 70 in the Hunter and 88 in Sydney so the total is about 160.

Mr KONG: Then we have a program in Wentworth. We have up to 180 beds in New South Wales altogether. That is since the DADHC funding made available to us since 1998. That highlights the problem in relation to the disparity in funding. For instance, Health funding up to 1998 was $8,000 to $10,000 average per bed. DADHC allocates an average of about $50,000 per bed. There is a huge difference. Therefore the level of support is quite different.

CHAIR: It is still cheaper than being in gaol.

Mr KONG: My program co-ordinator did a research study in 1998 which is alluded to in the submission. Because of the lack of funding we are not able to extend our program. Many people are waiting to come into the Richmond program. Those people either live in a very undesirable situation or are stuck in high-cost hospital-based facilities. In 1998 hospital beds cost something like $230 a day but in the Richmond Fellowship it was a tenth of the cost. It is not only the cost. That is only a very minor factor. It is really about the quality of life. People living in a community in Richmond Fellowship facilities are able to be independent. They are able to do things that ordinary people do. It is community living. An institutional setting is not conducive to independent living or moving on to develop—

CHAIR: You go through the whole socialisation work, the whole thing?

Mr KONG: Yes.

CHAIR: You do that all for on average of about $23 a day?

Mr KONG: Yes.

CHAIR: What do your high-cost , 24-hour support people cost you per day?

Mr KONG: We have funding on average of about $50,000. DADHC funded the 24-hour support people at $75,000 a year per bed. But in terms of planning it is important to ensure that provision of services such as that achieves some kind of economy of scale. I cannot give the undertaking to provide 24-hour support for one person for $75,000; it would have to be done in collective—

CHAIR: What does it cost you for a four-bedroom house with four people in it with 24-hour care and support and doing all these things like outings and so on?

Mr KONG: It is a minimum of $250,000 to $300,000 for a year.

CHAIR: So it is about $75,000.

Mr KONG: Yes.

CHAIR: That is for the full range—outings, training, living skills, making sure that they take their pills and so on?

Mr KONG: Yes.

CHAIR: What sort of workers do you have for that? Are they professionals?

Mr KONG: We provide a range of workers. We certainly have people with academic degrees in behavioural science studies.

CHAIR: So they are not nurses?

Mr KONG: Some of them are nurses. We have two categories of staff. One is the people with professional qualifications. We also employ support staff. They do not have professional qualifications. We pick them up for their personal attributes, for their suitability to provide support for people with mental illness. We did that also for economic reasons, because we do not always consider it necessary to have people with high qualifications to support people in fulfilling the daily living requirements.

CHAIR: These would be signed off by DADHC anyway and they approve the staffing arrangements you have.

Mr KONG: Yes.

CHAIR: How do you got people to take their pills?

Mr KONG: In a number of ways. Compliance is one of the big factors in supporting people with mental illness. Apart from the legislative thing that we have in New South Wales, we use counselling support, getting to know the residents and being familiar with the changing pattern of behaviour to recognise whether there is any variation in the way they take their medication. As a community-based organisation we do not have any authority or rights to—

CHAIR: You say that you do not provide clinical service. Are your residents tenants or residents?

Mr KONG: They are residents with individual service plans.

CHAIR: But they do not have a tenancy arrangement with you?

Mr KONG: It is a very complex issue.

CHAIR: All the people in the accommodation provided by the B. Miles group are tenants and the Tenancy Act gets in the way. Are your people—

Mr KONG: Under the DADHC funding we accommodate people in houses that are provided by the Office of Community Housing. They are tenants. However, the terms of tenancy is in accordance with the individual services plan, it is important.

CHAIR: They are tenants, but they have to comply with a plan. You avoid some of the problems of the tenancy path by having them on conditions.

Mr KONG: It is important that we have staff who are well trained to recognise any variation in behaviour pattern, so that we can intervene early. In my experience with the fellowship that I have been with since 1988 we have never had an occasion to go to the tenancy tribunal.

The Hon. AMANDA FAZIO: Could to give some detail about the outreach services you provide?

Mr KONG: Yes, they are the people who have attained a very high degree of independence. However, they still need to have a comfort zone. They need to know that if they are under stress they have access to staff to whom they can talk. They have supervision and assistance to help them manage their money. They have assistance with medication and so on. They do not always need staff there every day. Our staff establish their needs and we see them when necessary, but there is regular contact. There is a minimum contact of at least once a week and out of that contact we are able to establish their support needs.

We are very receptive to changing their support needs according to their individual requirements. The outreach houses are scattered throughout the community. Part of the disability services standard is that they must not stand out in the community or be identified as disability houses. We have a responsibility to ensure that they conduct their lives consistent with community expectation.

CHAIR: You keep the gardens and the houses maintained?

Mr KONG: Yes.

CHAIR: But the houses are Department of Housing stock?

Mr KONG: Yes.

CHAIR: The maintenance is carried out by the Department of Housing?

Mr KONG: Yes. Most of them are Department of Housing stock, a lot are under the housing association. From time to time we rent houses for individual residents if they require individual support. On occasions we rent houses in the private market to support them.

CHAIR: Do you subsidise that rental?

Mr KONG: Yes, to a certain degree. It is budgeted for in the overall scheme.

CHAIR: Are those residents eligible for rental assistance from the Commonwealth?

Mr KONG: Yes.

CHAIR: With the Commonwealth support plus what they can afford to pay, is that enough?

Mr KONG: No. They get a disability allowance and whatever amount they pay will also entitle them to some sort of housing subsidy from the Department of Housing. Together with that, we also apply a certain percentage, a levy, to cover their maintenance. We furnish the houses and ensure that all the equipment is kept in good condition. We refurbish from time to time. The Department of Housing requirement is that people do not pay any more than 25 per cent of their income. We put a 10 per cent levy on top of that to ensure that they have adequate equipment and furniture.

CHAIR: They pay 25 per cent of their income and that goes into a pool which you use?

Mr KONG: Yes.

CHAIR: Your submission deals with your interaction with the health system. From a housing point of view I gather that is working pretty well. The DADHC funding under the disability process is

reasonably equitable. Do they have individual advocates to help with housing? Or do you get them straight from the hospital system?

Mr KONG: Not under the DADHC-funded programs. We get them from boarding house closures under the DADHC-funded programs.

CHAIR: Do you get homeless people, off the streets?

Mr KONG: Yes, we do.

CHAIR: Would they be referred by DADHC directly to you?

Mr KONG: Yes, with the Health-funded programs referred to us by case managers.

CHAIR: The cut-off of 65 years makes them a Commonwealth responsibility?

Mr KONG: No, not necessarily. It is the appropriate way we can support people. I think we have people over 65, but generally speaking when our residents reach that age other issues are involved that the support setting which we provide does not necessarily satisfy.

CHAIR: But if they are perfectly healthy otherwise, say an 83-year-old who can garden and walk up the street?

Mr KONG: She will stay with us.

CHAIR: What about those under the age of 18? You started with young people.

Mr KONG: We do not have a program to provide support services for people under 18. We do not profess to have the expertise in child psychiatry to provide that sort of support. The program provides basically adult services.

CHAIR: Your problems include the lack of increase in funding under Health. Are you still funded by Health, or have you moved entirely over to DADHC?

Mr KONG: Part of our services are funded by Health, and quite a large part of our services are funded by DADHC. The problem is the disparity between the two government fundings.

CHAIR: If someone comes out of Hornsby hospital to you, requiring housing, you will get Department of Housing funding. What about Department of Health funding?

Mr KONG: Yes, Health funding.

CHAIR: If they come from a boarding house you get the motza?

Mr KONG: Exactly. That is what happens, and it creates conflict. The health professional will look at our servicing and say that there is a Rolls-Royce 24-hour service in which people are supported very, very well and which addresses all their behavioural problems and there are other services with lesser support structure, but the health referral could access only those beds. They cannot understand why a client requires 24-hour support.

CHAIR: So you cannot sneak one of their patients into a DADHC bed?

Mr KONG: We have to be accountable.

Mr STERRY: There are auditing processes which are very strictly adhered to.

CHAIR: I can understand DADHC being concerned to see that its money is spent appropriately, because it is partly funded elsewhere. DADHC has auditors too, but Health can access only the $8,000-a-year beds?

Mr KONG: That is right. Of course there are spin-offs from DADHC funding. With the DADHC funding we are able to improve our infrastructure. The improved infrastructure certainly has a flow on.

CHAIR: But you cannot use your workers who are funded under DADHC to work in the houses funded under Health?

Mr KONG: That is correct. Nonetheless, we have an integrated structure. The area managers will configure the services in such a way to maximise them. There is a cross-over, but we cannot definitely define it.

CHAIR: What other sources of income do you have?

Mr KONG: Memberships and donations, but with the level of services that we are providing that has diminished to a miniscule scale.

CHAIR: Do any of your clients have protective orders against them?

Mr KONG: A lot of our residents are under the Protective Office and a lot of our residents pay their rent via the Protective Office.

CHAIR: Do they pay for any other services? Could you do a deal with the Protective Office to give you $40,000 a year?

Mr KONG: No. We try to secure community sponsorships and things like that.

CHAIR: If the person has a lot of money in a trust fund—which they can have, they are not necessarily poor—can you get the Protective Office to pay for their full support? Could you go to the Protective Office and say that the person you are caring for under the CTO is costing $40,000 a year?

Mr KONG: We operate under a self-help environment. A lot of the houses have a sharing arrangement and it may create problems if we do that in a shared household, there could be a problem with equity. Someone would ask how come so-and-so has got something and they live in the same house.

CHAIR: If you provide a generic service in a four-bedroom home and it costs you $75,000 per person and one has a capacity to pay through the Protective Commission—he might have $3 million in a trust fund—why cannot you access that on a fee-for-service basis? It would be exactly the same if they provided care in their own home.

Mr KONG: I am sure we can, but such cases never occur to us. All our residents are very, very poor.

CHAIR: Do you access care packages under the disability Act?

Mr KONG: No, the only packages we have access to are the community-based activities [CBA], DADHC allocate funding for community-based activities for every resident. I do not know the formula. For every relocated resident with supported accommodation they have a CBA package.

CHAIR: And recreation?

Mr KONG: Yes.

CHAIR: And that comes from DADHC as well?

Mr KONG: Yes.

CHAIR: Does the Department of Health provide any of that sort of money?

Mr KONG: No. Health will fund other community-based activity organisations to provide services that Health-funded clients can access. For example, what PRA provides and various other rehabilitation to organisations, but Health does not have a set fixed funding formula for that purpose, no.

CHAIR: The Central Sydney Area Health Service provides $1.6 million of NGO funding. And the Northern Sydney Area Health Service provides $1.7 million for those two big areas. That is Health funding into that area of other support. Do you mesh with other NGOs?

Mr KONG: Yes.

CHAIR: When someone is deinstitutionalised from Richmond—and that is still happening—or from Hornsby hospital or the Missenden centre, what happens?

Mr KONG: The case manager will try to research what is available in the community and they may refer their client to us. If that client requires only very close support, chances are we will be able to accept that client into our program very quickly. Hopefully, in three or six months we may be able to do so.

CHAIR: How do they get accommodation? How do they get help from Health if they are not with DADHC?

Mr KONG: They are referred to us and we will assess the referral. People in a high support area generally do not move on very quickly. Therefore, there is very little movement within that setting. People who are referred to us and require high support generally do not get services. They will get referred to a waiting list, which may take a long time. In a high-support area we have people waiting for something like three to five years.

CHAIR: How many people do you have on the list at the moment?

Mr KONG: Nearly 60 per cent of our referrals are in the high-support area.

CHAIR: The waiting list is some three to five years. How many people are there?

Mr KONG: I have about 83 people on the waiting list at the moment who require high-support facilities. Again, these sorts of figures are difficult to assess simply because a lot of case managers realise the futility of this process. If they have a client who needs high-support services they know that the Richmond Fellowship provides it, but the Richmond Fellowship does not have the capacity to take them. A lot of them do not refer them to us anymore.

CHAIR: But if they came with $80,000 in their pocket from Health—

Mr KONG: DADHC.

CHAIR: No, Health, the same sort of dollars, you would be able to open any more number of places?

Mr KONG: Yes, indeed.

CHAIR: You can get the house, you can get the housing from community housing or the department and you have the organisation. You could have 20 more of these tomorrow if you wanted them, which is what we are talking about.

Mr KONG: Yes. The bricks and mortar issue is not such a big issue in providing accommodation for people with mental illness. It is really the support resources that are a critical matter.

CHAIR: Where do they go if they do not come to you? If the people who are waiting three to five years get into some other program where they can get high support, obviously they would come off your waiting list.

Mr KONG: That is right.

CHAIR: The people who are waiting three to five years who obviously have nowhere else to go, where do they end up?

Mr KONG: I do not have such figures. I surmise that a large percentage of them would remain in hospital, taking up long-term rehabilitation beds at high cost. Some of them will live in a very substandard accommodation.

CHAIR: Go to boarding houses and come in under DADHC?

Mr KONG: Yes.

CHAIR: That is the trick. They send them off to a boarding house, then under DADHC you can relocate. I have no problem with that if the system works. But there are still 80 people waiting for three to five years. Obviously, no-one has worked out that you can shuffle them through the boarding house.

Mr KONG: But DOCS are closing down boarding house beds because of the standard requirements.

CHAIR: This funding the Premier gave, was that for displaced people or people who are in boarding houses who have to go elsewhere when a boarding house closes?

Mr KONG: That is right.

CHAIR: Some boarding houses have some DOCS accreditation. If they lose their accreditation, for example, you could pick them up?

Mr KONG: Yes.

CHAIR: But only if they had a mental illness?

Mr KONG: That is right.

CHAIR: But the people who are waiting could be on the street?

Mr KONG: Yes, I would say that some of them would end up homeless, in refuges and so on.

CHAIR: In prison? Do you have any idea where these people are at any one time?

Mr KONG: No, I am not an authority on that.

CHAIR: Would their caseworkers know?

Mr KONG: I do not think we have an extensive data collection arrangement to assess that.

CHAIR: But if you have an empty bed because somebody has died or has graduated down to a lower level and you ring Health to ring up the next person on the waiting list, how do you find that person?

Mr KONG: We have a referral process whereby we assess—

CHAIR: But how do you find the next person? You know that you have the names of 80 people on your waiting list, people whom you have assessed.

Mr KONG: Yes.

CHAIR: How do you find them when you need the next one?

Mr KONG: We have records of their referrals and we contact the case manager that referred to us.

CHAIR: When you do that do you find that the case manager can locate them quickly?

Mr KONG: Not always. The deceptive thing is that I might say there are 83 people on the waiting list and quite a proportion of them are probably still on the waiting list, but when the time comes

for us to contact them the chances are we cannot find them: they have found something else, they have died or something like that.

CHAIR: Do you cross them off the list then?

Mr KONG: I cross them off the list.

CHAIR: So you still have 83?

Mr KONG: Yes.

CHAIR: If you ring the next one and the case manager cannot find them, what do you do?

Mr KONG: We move on the next one.

CHAIR: How often does that happen? With the movement to episode care we have heard other evidence that says that case management is not breaking down, but it is not as rigid as we might think it is. Somebody out there is case managing Mr X, but case management now tends to be around an episode of care. If a person has come out of hospital and that episode is finished and the case manager has found somewhere for that person, whether it is a refuge or something else, how do they find these people?

Mr KONG: We always encourage case managers, because of extensive waiting list, to let us know if their clients no longer need the service. But because of the lack of facilities we rarely have case managers telling us to take anybody off the waiting list, because the waiting lists are long. Regardless of whatever the situation may be, all case managers would prefer to keep the person's name on the waiting list.

CHAIR: No matter where else they are, because you offer Rolls-Royce service?

Mr KONG: Yes.

CHAIR: How many times do you ring up and say, "We will take Mr Z who is on our waiting list" and they say, "He is dead"?

Mr KONG: I do not have the figures to answer that question, but it does not happen a lot. I cannot specify whether they have died or whatever it is. Around 10 per cent of the responses we get from case managers will be that so and so has moved on somewhere else, moved interstate or has their own accommodation.

CHAIR: The 90 per cent of the people who wait, where do you find they have been what they have been waiting?

Mr KONG: In hospital, in very inappropriate settings. An inappropriate setting is very detrimental to their rehabilitation.

CHAIR: It also blocks people coming into the acute system. If there really were a Richmond arrangement where you moved people out into the community, it sounds as though it is a reasonable cost saving.

Mr KONG: It is.

CHAIR: But you have to spend money to save money, do you not?

Mr KONG: It is. The reason we did that research was to highlight to the department that it is actually economic for them to fund us to provide services rather than to have people waiting in high-cost beds.

CHAIR: The Premier has now promised that he will spend $20 million more on beds in the acute system. He also wrote, in a press release that I saw, community beds.

Mr KONG: Yes.

CHAIR: You can buy a lot of community beds a year for $20 million, can you not?

Mr KONG: Over the years we have heard a lot of announcements about enhancement money and increases in this funding and that funding. Over the few times we do not really see the benefit of that. I really need to see what is the cost reference to these beds.

CHAIR: Of the people you have in your care what sort of clinical support do you get? How assertive is the community-based mental health services for your people?

Mr KONG: We need to work with them very closely. It has to be a very close partnership arrangement, without which people do not get the proper support.

CHAIR: You are advocates all the time?

Mr KONG: Yes, we are basically advocates and we access the mental health services for clinical support. We provide only residential support.

CHAIR: When you ask, do you get the lolly?

Mr KONG: Because we have been in the area for a long time we work very hard to develop the relationship. Yes, we get very good support from them but from time to time there have been periods when they say they are short staffed and there is not enough support to provide for us. There we have to look for general practitioners, for instance, to do some of the support. Generally speaking, we work very hard at maintaining this—

CHAIR: How often do you have to call the cops?

Mr KONG: Not very often.

CHAIR: In terms of assertive care, does the mental health team visit regularly?

Mr KONG: Yes.

CHAIR: It is a weekly or fortnightly visit? Or if you notice a change in a person they will come?

Mr KONG: It is our staff who assess our residents in the houses. If our staff recognise that there are changes in behaviour pattern it is our staff's responsibility to contact the mental health service.

CHAIR: And they respond?

Mr KONG: They respond.

CHAIR: Other evidence has gone to the issue of the need to recognise in the Mental Health Act relatives, friends or some sort of carer so that when you contact the mental health system there is some standing by the carer that the mental health people have to take some notice of, or perhaps involving their ongoing care.

Mr KONG: It is a complex area in terms of privacy and individual rights. We respect the wishes of the residents. Some residents insist that they do not want to have any contact with their relatives and they say outright, "I do not want you to contact my mum and dad."

CHAIR: But you as carers, would the mental health team talk to you, do your residents give you access to what has happened with them?

Mr KONG: Yes, although under the new privacy legislation we have to be very careful about our residents giving us permission to obtain information, and also be very explicit about how that information can be used.

CHAIR: Do you have any arrangements with any of your residents when they are well enough to sign an authority for ongoing care?

Mr KONG: Yes, that is part of the condition of entry into our program.

CHAIR: The Protective Commissioner deals with their financial arrangements?

Mr KONG: Yes.

CHAIR: Do they ever give you that power of attorney in terms of property?

Mr KONG: No.

CHAIR: That is always done by the Protective Commissioner?

Mr KONG: Yes.

CHAIR: Do you use the Guardian at all?

Mr KONG: Yes, we use the guardianship services quite a lot.

CHAIR: If you have this consent form for ongoing care when they are not able to make their own decision, why do you need the Guardian?

Mr KONG: It clarifies the framework of support for our staff. We provide purely rehabilitative support. Management of the finances and other things are taken care of by somebody else so that it does not complicate the therapeutic relationship.

CHAIR: For example, none of your staff could give consent for, say, ECT?

Mr KONG: No, not at all.

CHAIR: Would there be guardianship provisions?

Mr KONG: Yes.

CHAIR: You would have your residents with guardianship for the high-support people?

Mr KONG: Yes.

CHAIR: And the lower support people are more responsible for themselves?

Mr KONG: That is correct.

CHAIR: Who do they have to fall back on for that support?

Mr KONG: The more independent residents?

CHAIR: Yes, say, a 48-year-old single man without any relatives.

Mr KONG: We encourage them to have a good social network. Obviously family, friends and other supporters form a very important social network. The Richmond Fellowship employs a category of staff called consumer advocates. From time to time, when it is necessary, we use that facility as well. We generally encourage involvement from other people, whether it be family and friends, other community groups or even doctors. We utilise whoever the resident is prepared or happy to have a relationship with to provide support.

CHAIR: If one of your residents needs care and the crisis team cannot come, what sort of reception do you get if you take him to, say, Hornsby, Royal North Shore or Royal Prince Alfred hospital?

Mr KONG: That is in the area of the mental health services and they can answer the question better than we can.

CHAIR: Are any of your workers put in that situation?

Mr KONG: We purely contact the mental health services.

CHAIR: And they perform for you?

Mr KONG: They come and assess our resident. In consultation with us, providing information and so on, they activate that sort of approach.

The Hon. AMANDA FAZIO: We heard from the previous witnesses that generally neighbours of their tenants are supportive of the service. They do not receive many complaints. Sometimes the neighbours assist by contacting the service if they believe that a resident's behaviour has gone askew. Is that also the case with the Richmond Fellowship houses or do you have problems with neighbours?

Mr KONG: We have a range of responses. We deal with community resentment of services being set up in their neighbourhood. Some neighbours, like the experience of the previous witnesses, are very supportive. It is important for an organisation to talk to the neighbours and reassure them that although the people living next door may have a psychiatric disability, there are people behind them to support them and the organisation takes responsibility for them. If the neighbours have any issues they can contact us and we will address them to the best of our ability. That is important. We found that once we are able to do that neighbours are generally very supportive.

The Hon. AMANDA FAZIO: A great deal of issues have been raised about the over-concentration of group homes and halfway houses in the Inner Western suburbs of Sydney. Have you noticed any difference between the local community response to housing in the Inner Western suburbs compared to the response in other areas where you provide accommodation?

Mr KONG: The disability standards are very good in this respect. The disability standards state that we should not develop services in a congregate setting. Houses are no longer big, which draws attention to them. They are set up in a more normalised manner so that they are more acceptable to neighbours. We have an obligation to provide information. People generally are supportive, but we have occasions where we have to front up to community meetings to talk to them about what we do. Some neighbours are very demanding of the organisation who provide the service.

Also on past occasions we have had to abandon programs because of hostile neighbours. It is not in the residents' interest to put them in a setting with hostile neighbours. It is not very congenial for their rehabilitation. We try to avoid that situation. We do not want to fight with neighbours. We always impress on the residents that they live in a community and they are expected to conduct their lifestyle consistent with their surroundings. The neighbours have every right to have their peaceful enjoyment of their property and they have a responsibility as well. That is part of an individual services plan to achieve that. Neighbours are a problem, but it is important that the workers deal with problem and dealt with it appropriately.

The Hon. AMANDA FAZIO: Do you believe there are our opportunities for people with a mental health problem who are living in the community to engage in activities which prevent them from becoming socially isolated? I do not necessarily mean activities run by the Richmond Fellowship because there is a school of thought that a service should not have total ownership of a client through every stage of everyday living. Do you have any comments on that?

Mr KONG: People with mental illness suffer from stigma. Stigmatisation is one of the impediments to the development and enjoyment of normal community living. It is part of the process that we have work through with our clients to overcome the stigma. Support groups and advocates are always very useful. In terms of employment and other activities, because of the nature of their disability it is difficult for people with mental illness to obtain normal employment. It is difficult for people with mental illness with a very severe disability to be accepted into normal community type activities. Therefore, part of our role is to try to overcome some of these things and look creatively to what other means we can get people to be accepted and destigmatised.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How do you deliver medication? The word "assertive" treatment has been increasingly used in community-based mental health services delivery. It was put to us, or at least agreed to by the previous witnesses from B. Miles, that a better status was needed for people who were not on community treatment orders and for staff, who were not qualified, to be able to deliver mental health services and treatments to people who do not want them. I

also refer to people with personality disorders there, although I am not sure whether they receive treatment. Would you comment on whether there should be a legislative change to allow more assertive treatments or to overcome problems associated with the delivery of those sorts of treatments?

Mr KONG: I do not think I can comment on that, except that I can say that our staff have a responsibility to provide support. They comply and conform with the treatment that is prescribed by the doctors or the case managers. Referring to your earlier question about how do we monitor the medication, we do not have a right to dish out medication to them and make sure they swallow it. It is by way of observation and counselling. We do use various methods such as blister packs and dosette boxes so that workers have visual cues to see if a person is taking medication. Sometimes people still have various ways to overcome that. It is our responsibility to do the most we can to ensure that they take medication. Beyond that, we have to refer them back to their therapists or case managers to monitor the medication.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you say that the case manager, not your troops, deals with any problem with people taking medication?

Mr KONG: That is correct. We rely very heavily on the clinicians from the mental health services to provide that service. It is absolutely critical that we have this partnership with the mental health services. We cannot be successful in supporting our residents, especially the ones with high support needs, without the support of the mental health services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you use the word "support", do you mean you support your residents, not support the treatment?

Mr KONG: Support the residents, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have any comments about changing the legislation with regard to the effectiveness of treatment? Obviously there are civil rights implications, but civil rights depend on a logical cognitive response.

Mr KONG: We prefer people to take their own responsibility. We can only advise them. No, I do not think I can comment on that.

The Hon. PETER BREEN: Would you tell us about your program for young people with mental health and drug problems? I am particularly interested in the program called Quit Cannabis. Is that program are available for people who want to quit cannabis use or simply to reduce their dependence on cannabis?

Mr KONG: It is a bit of both. It was a very successful program but it was difficult to sustain. The program co-ordinator is probably a better person to relay that information to you. It is part of the a harm minimisation program that we have undertaken under the national illicit drug strategy, which we got funding to do, in partnership with the South Sydney Youth Service. We assist the residents to cope with and manage their substance use. How they do that, my expertise does not extend to that area. I would prefer the program co-ordinator answered that.

The Hon. PETER BREEN: Would you tell us whether the funding for the program is ongoing?

Mr KONG: It was funded for four years. It will probably expire in 12 months' time. The future of the program is uncertain, although I got the impression that it is a very well regarded program. The program addresses the dual diagnosis area—the diagnosis of mental illness and substance use—which is a topical subject.

CHAIR: Do your clients under this program have a mental illness as well?

Mr KONG: Yes.

CHAIR: It is still within your area.

Mr KONG: Yes. I believe that we have some very clear indication that the program is highly regarded and it will continue. In what form it will continue I am not able to comment at this stage.

The Hon. PETER BREEN: Would you be able to provide the Committee with the results of the program?

Mr KONG: Yes, certainly.

The Hon. PETER BREEN: That may be very helpful, because the dual diagnosis question constantly arises. If the program is shown to reduce the effects of drugs on people with mental illness, it would be most helpful.

Mr KONG: Perhaps the Committee would be interested to know that the Department of Health at the end of the last financial year allocated some funding for the Richmond Fellowship to conduct a research project to produce some good practice guidelines for the department to set up top support services for people with dual diagnosis. We are in the process of doing that research project.

The Hon. PETER BREEN: How long will that project take?

Mr KONG: The project is for 12 months. We only activated it last month. We are going to do it for about nine to 12 months, at the end of which we will have completed hopefully a very thorough literary search and we should be able to come up with a number of good practice models, a variety of models so that people can see what is appropriate.

CHAIR: Is that under the drug strategy money?

Mr KONG: I do not know under what money, but based on our experience with our program in the Wentworth area where we have dual diagnosis for young people, we were contacted and asked if we were interested in doing something like that and I expressed my interest in doing so and they very quickly responded and allocated $100,000 for us.

CHAIR: This is the South Sydney program?

Mr KONG: Yes. It is a drug program that is funded for four years. The program I just referred to is a special research project.

CHAIR: You said you have an operation in Wentworth.

Mr KONG: Yes. That is a health-funded facility.

CHAIR: You actually have a facility out there?

Mr KONG: Yes, you have a chart there.

CHAIR: Sorry, I did not pick that up as a dual diagnosis, that is all. This page here has Wentworth but it does not indicate that it is a dual diagnoses system.

Mr KONG: You will find that it is a young age group of residents that we look after there. We did not go out of our way to call it a dual diagnoses program but you will find that 80 per cent to 90 per cent of young people in that program would have a substance use problem.

CHAIR: That is where you have 13 people?

Mr KONG: Yes.

CHAIR: Are almost all of those dual diagnoses?

Mr KONG: Yes.

CHAIR: Do you have dual diagnoses in your other places?

Mr KONG: Yes. A high percentage of our residents have substance use, including alcohol, a very high percentage indeed.

The Hon. PETER BREEN: Do you draw any conclusions from that? Is there any evidence, for example, that those kinds of substances, whether they are legal or illegal, assist people with mental illness to cope better with their problems?

Mr KONG: Substance use certainly impacts on the way they cope with daily living. For instance, cigarette smoking is an addiction and is a legacy a lot of our residents inherited from being in hospital. It absorbs a high percentage of their income, it reduces their wellbeing and also has an impact on their medication—it has an interaction, so it is a big problem, not to mention the danger factor in the accommodation. That is one thing. Alcohol, for instance, also is a big problem in our facility and we constantly have to address that. We do not advocate total abstinence but we want people to look at it in a realistic way in managing their problem rather than doing away with it.

The Hon. PETER BREEN: Do you think that people generally with mental illness think that these kinds of substances assist them to cope? Do you think that is a fallacy many of them believe?

Mr KONG: Many of our residents will tell you that smoking a cigarette relaxes them, drinking a cup of coffee relaxes them, alcohol helps them to cope and marijuana heightens their senses, so on and so forth. We need to discuss with them the negative effect of taking those substances. We do not make the decisions for them but we advise them.

CHAIR: But from an objective point of view what they are saying is that almost all psychotics smoke, we do not know why but they will tell you they use it because it helps. It does not mean that everybody who smokes is psychotic. Your evidence was they said it helps them. Is it your observation that it helps them?

Mr KONG: No.

The Hon. PETER BREEN: They think it helps them but it does not.

Mr KONG: They think it helps them. All we can say is if you think it helps you, be that as it may, but the sacrifice, the downside of doing this is worse than the help that you get from it.

CHAIR: So if they smoke marijuana do they go off?

Mr KONG: Yes. I am not an authority to answer that but from my observation for a high percentage of our residents who smoke marijuana it does compromise their treatment and it does create some degree of behavioural disturbance.

The Hon. PETER BREEN: That is why I was interested in your program for young people. The results of that program could indicate that people who reduce or quit smoking marijuana could have a more positive response to other medication and may be able to deal with their problems in a much more constructive way?

Mr KONG: I think we are still formulating conclusions from the program we are conducting. Actually I spoke to the program co-ordinator this morning and she is still trying to evaluate the data and the outcome.

The Hon. PETER BREEN: We would certainly be interested to hear the outcome of that if that is possible.

CHAIR: The Road to Recovery brochure is absolutely up to date—and I think you might have pinched the title from somebody or they pinched your title—

Mr KONG: I think they pinched ours.

CHAIR: It is the story of Simon Chant and what used to be provided in health, namely, you went to hospital when you had your first breakdown with schizophrenia at age 17, 18 or 19, for six weeks where you got unjangled, if you like, and you then went to the Macquarie cottages for a year. Simon said during that year he "began the journey of discovery that gave me hope and vision that continues to influence my life today". It was usual to have the one year of residential supported accommodation where people learnt about schizophrenia, what to do, what not to do and then you went home. People who went

through that process had an extraordinarily good trip for long periods of time and only broke down occasionally. Do you still have that sort of process that Simon Chant went through many years ago?

Mr KONG: What we provide is a rehabilitation process. How they have been prepared before they come to our program we have no control over. I am aware these days that people do not stay in hospital very long and, therefore, generally speaking they would not have gone through an elaborate preparation process.

CHAIR: In the 1960s and 1970s they use to run what was called a therapeutic environment, which is what Simon obviously went through. Do you still provide it and who provides the service who helps people like Simon come to grips with their problem? Do community mental health people come in and assist?

Mr KONG: Yes. It is all incorporated in the program and that is where we formulate the individual service plan. We ascertain what the person needs and we try to co-ordinate activities to fulfil those needs.

CHAIR: You can still provide this sort of service with the assistance of community mental health and your own workers in providing warmth and asylum?

Mr KONG: Yes. It is a collaborative approach, I dare say without which the system would not work.

CHAIR: You still get the virginal person with schizophrenia, the first outbreak?

Mr KONG: Yes, we get that.

CHAIR: How long do they generally stay with you?

Mr KONG: In the young people's program we normally state that they stay with us no longer than 12 months but we do extend it if the need arises.

CHAIR: On average how long do they really need to stay in your environment?

Mr KONG: About 18 months to two years.

CHAIR: It used to be about a year at the Macquarie cottages.

Mr KONG: Different people respond differently.

CHAIR: But that is on a step-down arrangement, of course, for you?

Mr KONG: Yes.

CHAIR: High need for some time and then longer term low need?

Mr KONG: Sometimes they move from one program to another, depending on their needs at any given time.

CHAIR: The last six months might be just under the outreach?

Mr KONG: That is right.

The Hon. JOHN HATZISTERGOS: In terms of the extra money that you contend you are seeking from the Government to account for shortfalls, could you quantify what that amount might be?

Mr KONG: No, it is a general funding level that we are referring to. We get allocated for a certain amount every year. We have no control over external factors, such as increases in insurance, public liability, workers compensation, superannuation, so on and so forth. On average the organisation undergoes an increase of something like between 8 per cent to 10 per cent to accommodate these things and the Health Department generally provides 2.5 per cent to 3 per cent maximum, so there is a shortfall

and the only way we can address that shortfall is by rationalising our services, reducing capacity and diminishing the support level.

Mr STERRY: It is also very difficult when you have a Rolls-Royce service and a bicycle service running alongside each other. It creates not only problems for the residents, problems for the health care people who cannot understand why one person is getting much better care than the other, but it also causes problems for the staff because the staff also have great problems in trying to understand why they can give this person services and a similar person they cannot, so it has really created a lot of problems in our organisation.

The Hon. JOHN HATZISTERGOS: I understand that, but what is the money you say you need in order to provide a consistent standard of service? You must do budgets and so on?

Mr KONG: My rough estimation is that there is an escalation factor for an organisation like ours of 8 per cent to 10 per cent every year. I cannot even begin to estimate this year simply because of the insurance factor. We are still waiting for the public liability insurance projection. Workers compensation escalates simply because of the industrial requirements and there are the occupational health and safety issues. These are all very good principles, they are excellent principles but they impact on the costs of running services.

CHAIR: You have to comply with the Act, do you not?

Mr KONG: We have to comply with all the Acts.

CHAIR: You are really being asked what is the base level, ignore escalation. In 2002 what is the level of funding that would be required for a high dependency, medium dependency, low dependency person?

Mr KONG: DADHC provides an average of $50,000 per resident.

CHAIR: With $75,000 for the high?

Mr KONG: Yes, it ranges.

CHAIR: Do you think that is an adequate or generous level of funding?

Mr KONG: I think DADHC has a more realistic projection and assessment of the funding needs.

CHAIR: And does that have an escalating factor?

Mr KONG: Yes, but the escalation factor is the same. It is treated them similar to Health. They will probably provide 3.2 per cent or 3.5 per cent.

CHAIR: So when Health started at over $10,000 in 1983 that was pretty good?

Mr KONG: Yes.

CHAIR: But over time we went through the 1980s when there was 17 per cent inflation. Now inflation is not so high but the on-costs are going up?

Mr KONG: Yes, and I dare say it is in our annual report that if we did not access programs through DADHC and did not expand the organisation we would not be able to survive. That is quite characteristic of what happened to quite a percentage of other organisations.

CHAIR: It happened a lot on the Hunter. They lost a lot of housing in the Hunter for that very reason?

Mr KONG: They just cannot operate with this very intensive demand.

(The witnesses withdrew)

(Luncheon adjournment)

PHILIP JOHN FRENCH, Chairperson, Shelter New South Wales, Suite 2, Level 4, 377-383 Sussex Street, sworn and examined:

HAZEL BLUNDEN, Policy Officer, Shelter New South Wales, Suite 2, Level 4, 377-383 Sussex Street, affirmed and examined:

CHAIR: Welcome. Are you each conversant with the terms of reference of this inquiry?

Mr FRENCH: Yes.

Ms BLUNDEN: Yes.

CHAIR: Do you wish to include your submission No. 198 as part of your sworn evidence?

Mr FRENCH: Yes.

CHAIR: If either of you should consider at any stage during your evidence that in the public interest certain evidence or documents that you may wish to present should be heard or seen only by the Committee, the Committee will be willing to accede to your request. However, you should be aware that the Legislative Council may overturn the Committee's decision and make this evidence public. I invite you to give us a feel for what you do and to highlight the major points in your submission that you would like us to consider. We will then move to questions.

Mr FRENCH: I will give you an idea of who or what our organisation is. We are a community-based, statewide peak housing body that aims to advance the housing interests of low income and disadvantaged people in New South Wales.

CHAIR: How many affiliates do you have?

Mr FRENCH: We have 119 organisational members drawn from a very broad cross-section of the community, including housing associations for people with disability, housing associations that focus on young people, housing groups that focus on housing for women, and a large proportion of community housing providers, public tenant associations and so on. We have a particular interest in this inquiry because people with mental illness are particularly disadvantaged in terms of housing and are increasingly becoming involved in social housing programs, either as tenants or applicants, with increased targeting. We are seeing some significant issues developing for tenants with mental illnesses that need to be addressed and perhaps are not being addressed properly at the moment.

CHAIR: Thank you for your very good submission—obviously a lot of work was done in preparing it. You identify the fact that you believe many problems are occurring on housing estates, particularly as many of the people positioned on those estates are disabled and suffer from mental illness. Can you please tell us more about that?

Mr FRENCH: In general we are seeing in all Australian jurisdictions increased targeting of social housing programs towards people with multiple disadvantage. That obviously includes people with disabilities relating to mental illness or long periods of psychiatric illness. Increasingly people with psychiatric disability are ending up in social housing programs. That is highlighting some problems, such as poor integration of health services and other community services with housing provision. It is also highlighting some of the problems with the way in which our social housing system is constructed, especially where there are large concentrations of people living on a particular site. If you apply fairly extreme targeting policy to that you end up with a group of people with very high social needs living basically on top of each other and generating a range of social problems not only within the estate but within the community more generally.

CHAIR: We heard today from the Richmond Fellowship that the housing provided by DADHC—the witnesses referred particularly to the closure of boarding houses and the subsequent displacement of people—is meant to ensure that people are not clustered together, they are separate and live in the general community. Do you think we have achieved that aim?

Mr FRENCH: Broadly speaking, those programs rolled out by the Department of Ageing, Disability and Home Care have achieved that.

CHAIR: I presume that your association handles quite a number of those?

Mr FRENCH: Yes.

CHAIR: How many packages do you think you hold?

Mr FRENCH: Our membership would be involved in that, but I do not really have a figure.

CHAIR: Would it be a fairly large number?

Ms BLUNDEN: It is hard to say; I cannot tell you offhand.

Mr FRENCH: The accommodation that is being rolled out by DADHC is provided by specialist disability services rather than housing providers. Community housing providers are increasingly assuming a role in relation to specialist disability programs, but it is still relatively small. When I referred in my opening remarks to the problem of targeting in social housing programs, we are talking about a different group of people who do not necessarily have organised support services. That is where much of the problem comes from—whether it be in public or community housing—in accommodating people with long-term mental illnesses. They are not connected to good mental health support systems or good disability support systems.

CHAIR: So when they go onto the housing list as a priority and the department finds a house for them, it is happy; people are not necessarily sent where there is a good community mental health service.

Ms BLUNDEN: It is not incumbent upon the Department of Housing to seek out those services. Some tenants are covered by joint service agreements—we were not able to obtain figures on how many clients are covered by those agreements—which means that Housing takes care of the housing and the local area health service provides support to people with mental illnesses. You will have to ask the Department of Housing for those figures because we could not obtain them.

CHAIR: When housing someone with a mental illness you would think that Housing, for the sake of the security of its stock and its rent, would seek some sort of support to ensure that that person, first, was an appropriate tenant; and, secondly, taking a whole-of-government approach, had access to the care—apart from simply housing—that he or she needs.

Mr FRENCH: Absolutely. I want to be clear that Shelter strongly supports the provision of accommodation and support services in the community for people with psychiatric disability and mental health problems. We strongly support that policy but it can work only if the essential nexus between housing and support services is recognised and if we have integrated planning systems that ensure that, when housing becomes available, the person who is being provided with that housing is also linked to other necessary support services, be they disability support services or mental health services—acute, rehabilitation or general community mental health services. That is what is not happening for this population group to a sufficient extent and leading to so many problems on the estates.

CHAIR: So the bottom line, if you had to draw a generalisation, you would have to say at the base level, at that ground support level, ignoring agreements which might come in over the top— it depends on two departmental heads— there is a big disconnect.

Mr FRENCH: Yes, we would have to say that we are still to realise the benefits of the joint protocols and the joint planning arrangements which we know are under discussion or have been implemented in some parts of government. You do not see that for most people on the ground yet.

CHAIR: Is Richmond Fellowship one of your organisations?

Ms BLUNDEN: Possibly. I could not tell you offhand.

CHAIR: If one of your organisational or community housing organisations takes on the provision of accommodation for somebody with a mental illness they obviously cannot provide the clinical services.

Mr FRENCH: Do you mean acute mental health?

CHAIR: No, I mean nurses and medication and so on.

Mr FRENCH: Accommodation and support providers do provide a lot of assistance for people to either self-administer or organise medications. Although I do not know their programs in detail I would expect Richmond Fellowship would do that. If the person has an acute episode though requiring quite intensive support either in their own home or as an outplacement perhaps in an acute facility for a period of time or intensive management by a professional such as a psychiatrist or a psychologist, without speaking for Richmond Fellowship, what I think we would say is that many organisations, many social housing providers, find it very difficult to get that kind of support.

CHAIR: So they phone up and cannot find anybody or if they can find somebody they cannot come?

Mr FRENCH: There is an enormous demand on these services. I am sure you have heard evidence that, relatively speaking, there are very few support services of this kind available in New South Wales and we see all sorts of program tensions and failures that result from that. For example, one of the biggest problems that many providers talk about in the social housing area is the difficulty in getting either a mental health service or a specialist disability service to recognise the disability or mental health issue for the person and that is basically a means to manage workload. So even though the person might present with quite acute symptoms, Health will argue that the person is not a person with psychiatric disabilities, DADHC will argue that the person is not a person with a disability within the meaning of its Act, and no one will intervene to provide assistance to the individual or to the people who are trying to support that individual. Now that is a very common experience for community housing providers and it is a very common experience for people working with tenants in the public housing system and it results from a very acute demand for a community-based mental health service and indeed for acute and rehabilitation based mental health services.

CHAIR: The big issue found in quite a number of the submissions is that a person may have a problem identified and that they might be scheduled to an acute hospital, either a general hospital or a psychiatric hospital; then after a period of treatment they are released appropriately with a care plan that is negotiated with the person concerned by the community-based mental health service. They then have to find them accommodation. Now what is the experience that you as a peak group have heard about (a) the wellness of people when they come out of those acute interventions and (b) the level of support that the community mental health teams are prepared or able to provide?

Ms BLUNDEN: The only thing I can really add to that is that people who are in the Department of Housing and who are hospitalised for a while, after six months they lose their rights to their Department of Housing premises.

CHAIR: Six months?

Ms BLUNDEN: I think so. Unless you negotiate otherwise. There is an ad hoc negotiation. If it is known that that person is having some sort of treatment, then they may be able to hang onto their premises for longer. They may be reduced to $ 5 a week if they have no income. But often the person is told that they are losing their premises and they have to reapply when they come out of hospital.

CHAIR: They go back on to the priority list and have to wait?

Ms BLUNDEN: They go back on to the priority list and they probably do not have to wait that long but still what happens to their furniture is a big stress on them.

Mr FRENCH: In relation to discharge planning, there are formal procedures around discharge planning of course and sometimes that works very well for some people but I would have to say that there is a great number of people for whom that discharge planning policy is not applied at all or is not appropriately applied. Speaking as a member of Shelter now rather than as chair of Shelter, our organisation deals on a very regular basis with people without discharge plans in place who are discharged into nursing homes, into boarding houses and so forth, where they do not have anything like the support services that they need. That leads to all sorts of social interaction problems where a person who may be still quite unwell assaults an elderly person in the nursing home environment or perhaps is involved in incidents within the boarding house, gets chucked out of there and ends up in a crisis accommodation

service, they cannot get back into the mental health system because the mental health system says "You are no longer a person with mental illness". We see lots of people like that every week.

So, yes, there is a policy around discharge planning but, no, it is not applied consistently in practice. If there is a discharge plan, what is the chance of people getting good community-based mental health services? Again, some people do get very good assistance in the community. But I would have to say that in our experience they are in the minority. There is enormous stress on community-based mental health teams. It generally means that they are only able to target their assistance to a subset of the whole group that needs the assistance, and many people do not get any assistance at all.

CHAIR: Where do you get most of your money from? Does it come out of Health or DADHC or from Housing?

Ms BLUNDEN: For community-based mental health?

CHAIR: Yes, for community-based mental health accommodation services, which is what you do, is it not?

Ms BLUNDEN: No, we are a peak social housing—

CHAIR: Some of them do not deal with mental illness people at all. Of those who deal with mental illness people, do they get their money for that sort of supported accommodation from the Health Department, from DADHC or from—

Mr FRENCH: It would be a range of programs. In the homelessness area, we have a large number of member organisations that provide short-term or medium-term accommodation—youth refuges, homeless persons refuges, women's refuges and so forth. Many of them would receive assistance from the Department of Community Services under the Supported Accommodation Assistance Program, which is a joint Commonwealth-State agreement. DADHC would provide funding under the Disability Services Act for a much smaller group of agencies and the rest, to the extent that it comes at all, comes through the Centre for Mental Health under the Department of Health non-government funding program.

CHAIR: Is that administered through each of the areas?

Mr FRENCH: Yes.

CHAIR: It does not come centrally?

Mr FRENCH: Some of it does come centrally, yes.

CHAIR: Do you have any idea how much?

Mr FRENCH: No, I do not offhand.

CHAIR: On the level of funding for non-government organisations, I was looking through the table that the Department of Health has provided us with earlier this week. Central Sydney gets $1.3 million out of their whole budget for that sort of support, Northern Sydney $1.4 million, and South-Western Sydney $330,000 or thereabouts. Obviously, Health is not a big player in this area.

Mr FRENCH: I would have to say that the Government, to its credit, has appeared to recognise that its investment in community-based mental health has been well below par and started to increase it. So the Government ought to be given credit to that extent. I think you have already heard evidence that there is a three-year program involving about $107 million in growth funds currently—

CHAIR: Do you know how much of that went to the non-government organisations?

Mr FRENCH: The problem with that program is that most of it is going into what someone like me would regard as either acute or rehabilitation-based health programs rather than going to the non-government sector.

CHAIR: Yes, $455,000 as identified NGO funding out of that $107 million.

Mr FRENCH: To that extent it has not addressed the crisis that we have been talking about to date. If it signals that the Government does understand the need for increased investment in this area we welcome it.

CHAIR: Do you have any details of the money that the Premier announced on the weekend—the number of acute beds that are being funded and some community options?

Mr FRENCH: No, I have only read the Premier's press release. I do not know anything more.

CHAIR: The Government does provide a large amount of money which is relatively hidden. The amount of money that Housing provides is taken as a given but it is still government money. It is still part of the provision of accommodation for the mentally ill. It is unfortunate that we have no idea of how much that is. If you are in an institution today, which is all paid for by Health, and you go to Housing a lot of the housing costs are picked up by Housing. It is still the Government paying the money and it is still for mental health but it is not identifiable. It could have been a large and growing amount of money over the last few years which is simply not able to be seen.

Mr FRENCH: Yes. When Hazel said that we were not able to obtain statistics of the number of people receiving this sort of assistance it was not because we did not do our homework to try to find out that number; it was because those statistics are not available. A broader question for our human service planning systems is how they identify this group of people. Until you know what number of people you are talking about, where they are located, and their general profile of needs, it is very difficult to plan an effective community-based support system for them. The issue you highlight is a significant one not only because it would be good to know that information generally speaking, because it would mean that the Government gets greater credit than perhaps some people would be prepared to accord; it is also important to make sure you get the most effective use of the funds that you are putting in there.

Intensive tenancy management costs a great deal for the Department of Housing. Responses to homelessness, whether that be crisis accommodation or medium-term accommodation, cost a great deal of money. A stable accommodation placement in a social housing provider, whether it be public housing or a community housing provider, with timely mental health services provided during periods of crisis, is not that costly. If we had a system that functioned well there would be more money to spread around. As it is, most of our systems are oriented towards very high tertiary services provided at a time of absolute crisis rather than to prevent crises arising or to ameliorate problems when they emerge. We are spending more than we need to.

CHAIR: That then raises the question of what evidence there is that community mental health services are providing an assertive, anti-interventionist, if you like, process?

Mr FRENCH: As I have said, the community mental health system is stretched beyond reason. There are examples of very good practice in the provision of support services to particular people. If you are asking me whether the population group generally receives the assistance that it needs then the answer is clearly that it does not.

CHAIR: Given what you have said about supported accommodation and early intervention, that would save us huge amounts in the tertiary level?

Mr FRENCH: It would. We would still say that there is a major need for continued growth in mental health services. There is not enough money in it currently to make it work effectively. But it is certainly true that the dollars that we currently invest could be more effectively deployed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You talked about intensive tenancy management. In a sense that means keeping people on the rails with their rent, their neighbours and their medication, even if it means liaising with other support services if needed. In the disability inquiry we looked at a model in the Hunter with the acronym CAST—

something about supported tenants. They paid rent and did shopping and stuff. That must be relatively cheap. Since I have been on the housing inquiry I have noted that the co-operative housing people believe that they can keep people as tenants who the housing department cannot. It has been said that this is because they have selected tenants rather than because they do it better, depending on who you talk to.

Can you comment on how housing co-ops and the Department of Housing deal with this problem in their relationship to mental health support services?

Ms BLUNDEN: You would have to look at the priority list. When you fill in a form for priority housing you have the option of putting in a medical form. On that you have the option of saying what your illness is. It could be a mental illness; it could be a physical illness. The figure you would be wanting to look at is how many people indicate when they apply to the Department of Housing that they have a mental illness. What the Department does with that information I do not know. That would be a way to better plan support services, if you used that information effectively. There are 98,000 people on the waiting list of the Department of Housing. The priority list is smaller but a large number of people are on the priority list as well. You should be able to plan services more effectively if you look at the data that is already in existence.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably, middle-class, well-educated people fall off the register. They fill in those forms perfectly and are completely honest about it and negotiate their way through. But, presumably, people who are not literate or who have mental health problems are unable or unwilling to provide that information. You do not lead with your weakest card: I am mentally ill, please help me.

Ms BLUNDEN: It is better if you are applying for public housing to indicate that you are a priority case because then you are housed more quickly.

The Hon. JOHN HATZISTERGOS: If your application is accepted.

Ms BLUNDEN: Yes, if you are a low-income person.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is procedurally the case. Beyond that, how does it work in practice? Is it very variable and can you make any general statements about it? This morning we had a great deal of praise for the Department of Housing and the housing co-ops. I gather that some are really good and some are quite discriminatory in the other way.

Mr FRENCH: I think we would say that generally Housing is pulling its weight as a social housing provider for this client group. Of course, there is a vast unmet need for social housing. But if we are looking at the relative proportion of housing that is going to people with high needs, including people with mental illness, I do not think you could criticise Housing for what it is doing. While we cannot get specific statistics about the number of people with mental illnesses who are being supported by Housing, we do know that something like 40 per cent of current social housing tenants and applicants are people with disability of some kind and high needs. So a goodly proportion of those would be people suffering disability and mental illness.

CHAIR: Gabrielle Kibble certainly keep this process along, did she not? She was outstanding.

Mr FRENCH: Yes. You cannot say that Housing is not pulling its weight to that extent. The problem comes when you understand that housing is only one part of the support system that people need. Housing is the key to providing effective services to this client group. No-one ought to misunderstand that. Until you have stable accommodation it is very difficult to provide any other sort of support service that will work for the person. They are itinerant and so forth. So housing is the key. It is a necessary but not a sufficient condition for people to live effectively in the community. What is not happening is a good matching of community support services, whether they are provided by Health, DADHC or whoever it may be, with people who are living in these housing systems. You asked me what sort of reaction to community housing providers have to people with psychiatric disability. It is mixed. There is some excellent practice within community housing organisations that perhaps meet the needs of this group better than any other service provider that I have seen. But it is also true that there is significant discrimination against people with mental illness in some community housing providers and indeed in the community generally. One of the biggest issues with the move of the Commonwealth towards housing assistance provided as income support through rent assistance is the difficulty that people with mental illness have in obtaining accommodation in the private market. It is true to say that there is enormous discrimination against people with psychiatric disability within the private rental market. It often means that they are able to obtain only inferior or short-term tenancies and there is high turnover in those tenancies, which makes the problem worse and worse.

CHAIR: The Victorian situation is quite different, is it not?

Ms BLUNDEN: I understand that program has been trialled and it has been successful. It is not extensive.

CHAIR: You say that in 1995 it had 700 people. Do you know whether the number is more or less than that now?

Ms BLUNDEN:I am not sure what the latest with that program is.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Even before this inquiry started I had a lot of complaints from the neighbours of Department Housing tenants. This effectively is in a response to special needs clients presumably not being adequately managed in that group. The B. Miles and Richmond witnesses this morning said that they do not have a lot of neighbour problems because they think that their tenants are sufficiently supported. Is it then an endemic problem within the Department of Housing that they are getting concentrations of people of high need and yet they are still acting as if they are postwar battler tenants who, whatever else, at least pay the rent and electricity and do not disturb the neighbours?

Mr FRENCH: One of the major issues for the Department of Housing is that they are currently managing housing stock that was developed for a different group of people in a different time. A lot of the available public housing is in inner-city high-rise or in large horizontally dispersed estates in the outer western suburbs that concentrate people together. Another major issue that the department is facing is the increased targeting as a social policy, which is bringing people with higher needs together. Those two things operate very poorly for people who may have social interaction problems.

If you are trying to effectively support a person with a mental illness who may from time to time had an episode of yelling or screaming or have other behaviours which people may find as socially offensive, the best place to house them is not in an estate with 40 other people within a stone's throw. But that is the nature of the housing stock that we have, particularly in the inner city. The Department of Housing is under enormous pressure to provide accommodation for people in this general target group or profile.

What stock does it have available? Most of it is tied up in large housing estates. What problems does that produce? It results in people with very high needs being accommodated basically on top of each other often with an older public housing population group that moved into those housing environments in the 1960s and 1970s and who are now in their sixties and seventies. They find it very difficult to relate to the new group of people who have a high need. If you are asking us where our complex come from, they are often from that sort of clash in policy and programs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you make any suggestions as to what could be done?

Mr FRENCH: The solution is relatively simple. You take a person-centred approach to planning accommodation and support services in that target group. If the person has social interaction problems the accommodation you provide for that person should not be in a large community environment where they are likely to come into contact with other people who might find the things that they do offensive. That requires some transformation of our social housing system, there is no doubt about that. But that is the solution. The other thing that would greatly assist is better integration of health, disability and other community services with housing. Even in the current environment much more could be done to assist people.

The Hon. AMANDA FAZIO: What support do people need in the community? Your organisation, Shelter New South Wales, focuses mainly on accommodation issues. As you are probably aware last weekend the Premier announced 118 new supported accommodation places, distinct from the 108 new mental health beds. What is the best way to co-ordinate the non-government organisations role in supporting people who live in those supported accommodation places? This morning we heard from the B. Miles group that there seems to be a bit of an issue over the placement and support of people with personality disorders, that they were being referred to that group as suffering from severe depression.

They had been labelled as an easier to deal with form of mental health problem. Those people are being placed in supported accommodation places and you would have a range of organisations

providing that support. Is there any way you would like to see that done so that the clients could be maintained in independent living as best as possible?

Ms BLUNDEN: You have to find out the person's needs and make sure that they get the assistance they require to maintain their tenancy. I am aware that the Department of Housing is moving towards that as well and looking at tenants assistance initiatives, et cetera. It might be as simple as organising a direct debit for someone's rent. You would be amazed how many people fall into arrears because they have an episode and forget to pay their rent. A lot of simple things can be done to make someone's life a lot easier. Semi-supported accommodation in which someone can drop in, or there might be a worker there for part of the time. There are a lot of different things that could be trialled.

Mr FRENCH: The crucial thing is to analyse the different components of an effective support system for people. Clearly accommodation is critical. An effective casework system that might involve in the course of a month relatively low-level assistance to the individual may be something that would help them manage their tenancy. During periods of unwellness the person might need greater levels of casework assistance, perhaps to pull in home care support for domestic activities of the person is not able to do. Clinical support is also critical. You have to have an effective mental health community team structure, which means that the person can get acute mental health assistance when they need it during an episode of acute illness, or whatever it may be.

How would that initiative the best rolled out? It seems to me that it would be best rolled out in a way that ensured that the accommodation and other support services were integrated at the time that the new services were planned. There should be a clear role expectation across all the relevant agencies about what they will do for that tenant from their respective role. We do not argue that accommodation and support must be provided together. In fact, we say that there are strong policy reasons should be separate from support services. The key thing is that they need to be integrated.

The Hon. AMANDA FAZIO: You mentioned the changing levels of care that a person might need if they are having an acute episode. A few of the submissions mentioned that there seems to be a lack of flexibility in altering the level of support provided to a person. From a planning point of view that is a very difficult issue to tackle. Do you have any ideas on how that could be managed?

Mr FRENCH: One of the most important things that we would need to do first, from a disability service system perspective, is recognise that there is a group of people for whom a unit cost approach to costing services is not effective. We need a much more flexible arrangement that allows the level of assistance provided for someone to change in accordance with the nature of their episodic condition. For example, if you are looking at accommodation that is currently funded by DADHC for people coming out of boarding houses, that is costed on the basis of the person's support needs taken as a moment in time, and assuming that that would be constant.

That is not effective for people with mental illness because this week the person may require four hours assistance, next week the person may require 60 hours if the condition deteriorates. Part of the problem is planning effective support services for people with mental illnesses. The system has to recognise that the level assistance required is not static, it needs to be able to flow in a much more flexible way to people. That means funding infrastructure rather than individuals.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The problem seems to be that the Department of Housing has to produce a large number of houses and that is the measure of a good Housing Minister. The measure of a good Minister for Health is how many hospital beds he provides. We have a problem that acute services, or measurable services, get a lot of resources and the more diffused community-based ones do not. Can you suggest a model for more graded services? Can you suggest a way of getting to that formula, and how it could be developed? It seems that the problem is that everyone is frightened to have anything other than acute highly measurable services.

Mr FRENCH: I will take that question on notice. One of the biggest problems in the health system is that not only most of the money goes into acute services, although to some extent they remain insufficient in some areas of the State, but that we do not have a clearly articulated system that says that a person with a mental illness—taking their human service trajectory—will need services that relate to their acute health care needs and services that relate to their rehabilitation and services that relate to the community care needs, which are non-acute but which relate to domestic assistance because of a lack of skill.

At the moment we see a lot of territory disputes between DADHC and Health about who is responsible for which beat. We are not seeing a clearly articulated community-based service system for people with a mental illness being publicly supported, or even a community-based rehabilitation system, or people with a mental illness being publicly supported. Health says that it is responsible for acute health care needs, that is putting it at the extreme. What it does not do is effectively invest in community-based rehabilitation services. DADHC is saying that this is a new population group for it, why should it have to stretch its dollar to this new group of people because it is having enough trouble meeting the needs of the group of people it traditionally has been responsible for.

CHAIR: Health recognises that it is responsible for rehabilitation of the mentally ill. That was in the first part of its submission.

Mr FRENCH: I recognise that that is its public policy position. But does that carry through into financing for non-government agencies to provide that service? You have already made the observation that it does not. Yes, at a level of formality everything is fine. If you try to analyse the question from what services are available on the ground, there is a major problem.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are saying that the problem is that there are turf wars. Is the problem co-ordination between departments? Should all community-based services be rolled into one? Are you saying that if that were done those turf wars would disappear and there were just be a ping-pong game between community support and hospital-based services? Are there structural things that should be done to address that? If so, what?

Mr FRENCH: There is a level of total resourcing to each of those systems, all of which are under crisis. Although it is true that better planning and co-ordination would produce efficiencies, even then they would be substantially underresourced. First, the Government needs to continue to recognise that these systems require additional resourcing. Second, better integrated planning systems would produce much will effective results, there is no doubt about that, particularly where that is integrated at a casework level. Third, it is very important that the person's health needs are distinguished from their community support needs.

One advantage that people should be able to take on is the opportunity to live in the community without being seen as a person who is sick, or is a patient, or whatever. But they need to be able to get an acute health service when they need it. That would probably argue against a health based system being responsible for all of the person's support needs. I would have thought that a disability support community-based system ought to see a large responsibility as well.

CHAIR: This morning the representatives from the Richmond Fellowship identified that if they got a DADHC supported accommodation package it would be worth about $75,000, depending on the level of support need, but if they got a Department of Health package that will be worth only $8,000 a year. To what extent is the NGO sector, your members, trying to provide supported accommodation for the $8,000 packages?

Mr FRENCH: As you pointed out, there is very little money actually going into non-government agencies for accommodation support anyway. That is part of the problem.

CHAIR: But there is some money, because the Department of Housing produces the housing. You must get some money to manage those properties. A lot of your properties would have housing that they manage on behalf of the department, or are they owned?

Mr FRENCH: It is a broad mix.

CHAIR: But some of them would have housing that is provided by the Department of Housing?

Mr FRENCH: Yes.

CHAIR: That they then manage as their stock, like B. Miles and Richmond Fellowship. All their housing is provided or purchased by the department and they manage them, collect the rent and forward the money on. Money is going in. The $8,000 package that goes on top of that money that the Government has provided, is that enough?

Mr FRENCH: It may be for some people with no needs who require small casework intervention from time to time, but it is clearly not sufficient to provide an effective support system.

CHAIR: Someone who has been institutionalised for the last 20 years at Rozelle, has a long-term mental illness and is now coming out into the community, their support needs are going to be quite high, are they not?

Mr FRENCH: Yes, generally speaking they will be.

CHAIR: Because all the easy ones have now gone. They have died or whatever.

Mr FRENCH: Yes.

CHAIR: But people who would otherwise have been kept at Callan Park or otherwise are still coming into the system?

Mr FRENCH: If Richmond is talking about the group of people who have been progressively moved from licensed boarding houses into supported accommodation—

CHAIR: We will come to them shortly.

Mr FRENCH: So you are talking about—?

CHAIR: The sort of patients who used to be locked up, or provided with accommodation, at Callan Park, 1,000 people at a time, long term, stay there for ever and a day—Lidcombe had the same sort of system—then go out into the community. Over time some of those people die and some of them are in nursing homes. But there are still people out there of 40 or so who may have got sick in only the last 10 years who would otherwise have gone to Richmond who would need that long-term support.

Mr FRENCH: Generally speaking, $8,000 would be significantly below what the cost of providing an effective support system would be.

CHAIR: Does Health produce higher packages than that?

Mr FRENCH: Yes.

CHAIR: Where would we find those sort of housing support packages from Health? What sort of programs are they?

Mr FRENCH: They tend to be packages that are negotiated around a particular individual in a crisis situation. You will have to ask them how they keep statistics on that, but certainly I am aware of examples of packages quite significantly higher than those that have been negotiated for individuals with high needs to the health system. Whether it is an effective funding program, I would have to say that it probably is not one.

The Hon. PETER BREEN: I was interested in the submission you made, particularly in relation to group homes and boarding houses. You indicated that for some people group homes or boarding house-style accommodation, combined with sustainable support services, can result in sustainable tenancies. There is an ongoing concern in that the Committee is aware of about boarding houses. I wonder whether boarding houses come under the umbrella of Shelter?

Ms BLUNDEN: There are licensed and unlicensed boarding houses. If it is not a boarding house run to look after people with specific needs, then it is just a private operator and you find that a lot of people who live in those places have either substance abuse problems or a mental illness. They are not protected by tenants rights. If they are evicted from the boarding house they usually end up in crisis accommodation. If they leave crisis accommodation without somewhere else to go they might end up in another boarding house. We have been asking for legislation for some time, for the State Government to pass some protective tenancy legislation for those people.

The Hon. PETER BREEN: Those people presently are not under the umbrella of Shelter?

Mr FRENCH: To the extent that our member organisations provide assistance to people in those environments, yes, they are. Private operators who operate boarding houses are not members of Shelter, no.

Ms BLUNDEN: Tenancy services advise boarders and lodgers, but all they can say is, "Sorry, we can't really help you because you can be evicted with no notice at all."

The Hon. PETER BREEN: Can you tell us whether there are other boarding houses, besides privately owned boarding houses, that accommodate mentally ill people?

Mr FRENCH: There are a couple of examples of social housing providers, community housing providers or refuges and so forth providing boarding-style accommodation that has worked very effectively for some groups of people. A particular model called the foyer model has worked well for high-need, young people and it is being discussed with the Department of Housing at the moment. There are examples of that.

CHAIR: Almost all of the crisis accommodation would be boarding houses, would it not? It depends on how many bedrooms they have.

Ms BLUNDEN: It varies in style, there are either government or NGO-run places that might offer single rooms with, maybe, a communal kitchen. But I am talking about private boarding houses. It is not the model that is bad. We say that perhaps there should be a better model and we should expand on that model. Some people like living in one room and having communal areas staffed by somebody else.

The Hon. PETER BREEN: What is the distinction between a group home and a boarding house?

Mr FRENCH: Basically, the number of people who live in it. Typically in New South Wales we refer to group homes as being accommodation for between three and six people. People will argue about the numbers, but that is the general size of them. But boarding houses tend to be for much larger numbers of people, certainly in excess of 10 people. We have significant concerns about the placement of people with high needs in the boarding house system because its means that there needs are not met and it leads to all sorts of social interaction problems within the group, which exacerbate the problem.

CHAIR: What used to happen in the old days, I do not know whether it still happens, is that people would take in one border. That used to be very common right through the 1950s and 60s. It seems to be less common these days.

Mr FRENCH: Yes, it is certainly much less common. The concern I am expressing relates to large congregate care environments, not those sorts of arrangements. You might have 30 people with significant support needs living on the same site, perhaps in a geographically remote location on the Central Coast or wherever it might be. There are all sorts of social problems associated with those kinds of models.

The Hon. PETER BREEN: But if it is run by a church group, for example, or a social group as opposed to a privately run organisation would your concerns be less?

Mr FRENCH: Some of the concerns may be less, but the environment itself would still be problematic in the sense of the social interaction problems that it produces and the tendency, perhaps, for that group of people to be isolated from the community. There are more effective ways of meeting the needs of this group of people who congregate in care environments. As Ms Blunden said, single-room accommodation is, for many of the group of people we are talking about, their preference, their preferred way of living. There are ways that that can be provided without congregating people together.

The Hon. PETER BREEN: It was suggested to us this morning by the B. Miles group that the preferred model for people who were involved is some kind of hostel or accommodation along the line of nursing homes, for example, where they had their own facilities, a bathroom and, perhaps, one room that is bigger than a bedsit but not as big as a standard unit. This type of accommodation seems to be the model that the people themselves preferred. The communal environment offers support and social interaction that they would not otherwise get out of the community. Would you agree with that?

Mr FRENCH: We think that a mix of housing environments is the best public policy approach, but we would be very cautious about congregate-care environments for this group of people.

CHAIR: They are talking about groups of eight or nine.

Mr FRENCH: I think they were also talking about that in terms of long-term accommodation for people with more acute problems rather than as a substitute for independent living.

CHAIR: Yes, they were. They were talking about the high-needs people who could have a unit, perhaps seven or eight people, but then there would have to be on-site staff and that sort of stuff.

Mr FRENCH: Broadly speaking I think that we would be supportive. I did not hear their evidence, so I am struggling a bit. But, broadly speaking, I think that we would be supportive of more intensive environments that might have a slightly larger number of people in them than other environments that might be flats or bedsits where there is support and casework provided on an in-reach basis.

CHAIR: Boarders became an issue just before the Olympics when legislation was proposed for their protection. Did you get to comment upon that proposed legislation?

Ms BLUNDEN: It was commented on by Shelter and by the Boarders and Lodgers Action Group.

CHAIR: What did you think of it?

Ms BLUNDEN: I think that there was a review of the legislation.

CHAIR: There was no legislation.

Ms BLUNDEN: A draft bill was presented.

CHAIR: That is so.

Ms BLUNDEN: But the bill was never passed.

CHAIR: What did you think of the proposal at that time?

Ms BLUNDEN: I think that people were broadly in favour of it. They might have had a few suggestions about things, but what we wanted to see in the bill was some sort of protection against immediate eviction.

CHAIR: Yes, of course. The caravan park legislation has that in it.

Ms BLUNDEN: Caravan park tenants are better off than boarders and lodgers, yes.

CHAIR: But they are not as well off as tenants, are they?

Ms BLUNDEN: Nearly. It depends what sort of park tenants they are. The long-term park tenants are reasonably well protected. They have notice periods, et cetera. Relocation costs even have to be paid.

Mr FRENCH: In the end I think that comes down to a particular case that was determined in the Residential Tenancies Tribunal, which interpreted legislation protecting that group of people in a way that was stronger than was expected.

CHAIR: Legislation went on for a few years, but it eventually got to the stage of the most recent changes by the current Government for more tenant protection. But are there concerns that if that legislation had come in that it would have been the end of boarding house?

Mr FRENCH: We take the strong view that no, it would not have been. It is appropriate that this area of activity be regulated to some extent and that the people who live in boarding houses—

CHAIR: Because of the nature of the people who live there?

Mr FRENCH: Because of the nature of the people who live here and because they have moved on and people who are in the position of a consumer are entitled to some form of consumer protection and tenancy rights. We would see boarders and lodgers legislation as an essential component of an effective public policy response to the general issues that have been inquired into by the Committee. Is a legal response sufficient in itself? Well, no, it is not. Other things are needed. There needs to be a better support service, better integration and all of those things. But protecting the tenancy rights of boarders and lodgers is critical.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You say you wanted some legislation to protect the tenancy rights of boarders and lodgers. In a sense that often transfers the problem of an unsupported person to the private landlord. Community housing people have said that they take a head lease and then manage the tenancy, and that is a problem. The private landlord is a private agent who, basically, is not therapeutic so they might make them get out.

Ms BLUNDEN: Are you talking about a head lease as a separate—?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am talking about head leasing. It means that if you make things harder for private landlords without support, they just cope with that by increasing the gateways to getting in.

Ms BLUNDEN: That is probably true, and I would like to see more social housing perhaps in a boarding house-style as well.

CHAIR: You would?

Ms BLUNDEN: Not just for people with mental illnesses, necessarily, just generally.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have an economic model for that?

CHAIR: What sort of size?

Ms BLUNDEN: Some people prefer living in a boarding house-style place. I think that the same problems would apply that Mr French has already referred to. If you have a lot of disadvantaged people living together very close by you can get social problems.

CHAIR: But what sort of size? Not 30, 40 or 50, you are talking about how many, eight, 10, five?

Ms BLUNDEN: I guess, yes.

CHAIR: The residential landlord living arrangement?

Mr FRENCH: Yes, but a person with a mental illness may be only one of those nine or 10 people. They are not grouped together because they have acute social support needs, they are grouped together or the person might be placed in there because it is a style of accommodation they like and have taken a person-centred approach to it, and it is clear that they will not have social interaction problems with the other tenants.

CHAIR: Could SEPP 5 that the Government has brought in for aged-care units, which is causing so much stress in the community, be varied to allow development within communities of small numbers of units, five or six units?

Mr FRENCH: I did not hear the first part of your question.

CHAIR: State environmental planning policy [SEPP] 5 has caused a great deal of trouble by allowing people to build retirement units on blocks of land in ordinary residential streets. In other words, SEPP 5 has been abused substantially. The units were meant to be for older people or people with disabilities. Could SEPP 5 be used for the development of a small number of units?

Mr FRENCH: Shelter New South Wales strongly supports the policy thrust of SEPP 5. We acknowledge there have been examples where that policy has been abused. Unfortunately, that seems to be placing that very positive government policy at some risk at the moment. On a broader level, we say there should be a whole range of interventions that lead to affordable housing for people on low income and in low socioeconomic circumstances.

CHAIR: Do not get us wrong. You have said a number of times that there should be available a broad range of housing, that people should be able to choose. Just because people are disabled or have a mental illness does not mean they should not have a range of choice of the type or location of accommodation. We do not deny that. We need advice about models that are not available at present that would be useful or models that are available but are not useful.

Mr FRENCH: You asked me whether SEPP 5 is a way of producing affordable housing for this group. The answer is yes, as one of a number of affordable housing approaches.

CHAIR: You will be provided with a transcript of your evidence. We will put your evidence onto the web uncorrected. Would you correct your transcript when you receive it? If when reading your evidence you believe there are parts where we have missed the point or you have not fully answered as you would have liked to, send us that information separately and we will include it in your evidence by adopting the document. We may need to recall you later. If we have any further questions as a result of other witnesses evidence, would you be willing to provide us with answers?

Mr FRENCH: Certainly.

(Short adjournment)

JONATHAN MONTALT CARNE, Psychiatrist, Level 4, 9-13 Bronte Road, Bondi Junction,

GLEN RAMOS, Assistant National Co-ordinator, National Association of Practising Psychiatrists, xx xxx xxxx, and

RACHEL FALK, Consultant Psychiatrist, Post Office Box 12, Arncliffe, affirmed and examined:

CHAIR: We will now hear evidence from representatives of the National Association of Practising Psychiatrists. Dr Carne, are you conversant with the terms of reference?

Dr CARNE: Yes.

CHAIR: Mr Ramos, are you conversant with the terms of reference?

Mr RAMOS: I am.

CHAIR: Do you wish your submission to be included as part of your evidence?

Mr RAMOS: Yes.

CHAIR: Dr Falk, in what capacity do you appear before the Committee?

Dr FALK: I am the New South Wales representative of the National Association of Practising Psychiatrists. I am a consultant psychiatrist.

CHAIR: Are you conversant with the terms of reference?

Dr FALK: Yes, I am.

CHAIR: If any of you should consider at any stage during your evidence that in the public interest certain evidence or documents you may wish to present should be heard or seen only by the Committee, the Committee would be willing to accede to your request. You should be aware that the Legislative Council may overturn the Committee's decision and make that evidence public. I ask you to make an opening statement, and then the Committee will ask you questions.

Dr CARNE: My concerns are, in essence, about the inadequacy of funding and resourcing of mental health services in New South Wales. My concerns are based on about 15 years experience working as a psychiatrist in New South Wales, particularly working both in the public health system and in the psychiatric services attached to the prisons. My observations have been that over the last 15 years there has been a significant decrease in the resourcing of mental health services. As a result, it has been my observation, and I am supported by research, that increasing numbers of mentally ill are failing to get the treatment they should be getting either in the public or private mental health system and that increasing numbers of mentally ill people become homeless and disorganised. As a consequence of that and the prevailing criminal laws, increasing numbers of mentally ill people become criminalised and come before the legal system and enter gaol.

It is my concern that there has been an increase in the prisoner population in New South Wales from 1980 to the present of almost 5,000 prisoners. Amongst these prisoners there are increasing numbers of mentally ill. The access to mental health services within the prisons is of such a low standard that it is in breach of the United Nations conventions, to which Australia is a signatory. It fails to meet the standards set out by the Burdekin report, the 1993 national inquiry into mental illness. In my opinion it fails to meet the demands stated in the New South Wales Mental Health Act. Those are my introductory remarks.

CHAIR: Dr Falk, do you wish to say anything at this stage?

Dr FALK: I would reiterate what Jonathon has said. I was working in the public health system when the Richmond report came out. I was a registrar at that time. I was present when that was occurring. We made a lot of predictions at the time. We were concerned because they actually closed down the institution before they provided accommodation, treatment and services in the community. It has been both affirming and disheartening to watch those predictions come into play. I should state that

from my point of view no-one is looking to the good old days. The psychiatric care in the old institutions was appalling. Everyone would support the move to community care but the resources just are not there. The philosophy of putting people in the community has not taken into account that some people will need hospital care for some period of time. Also, we cannot treat all psychiatric patients to a point of cure. Some people will need ongoing care for the rest of their lives. I do not think that has been incorporated in the philosophy of community care.

CHAIR: I make a couple of observations first because we have had the benefit of a large number of submissions. One was that in 1960 the number of beds provided by the Mental Health Service was 256 beds per 100,000. That also included some of the intellectually disabled. As of 1998 there were 38.5 beds per 100,000 in New South Wales for both acute, medium-term and long-term beds. They are physical beds in institution or general hospitals. Of course, a lot had moved from institutions to general hospitals, which is part of Richmond as well, so there has been provision of acute beds over time but we have moved fairly substantially. A lot of that happened before Richmond. Some evidence the department has given us is that from the 1950s when chlorpromazine and lithium hit the markets that got rid of a lot of people who were chronically housed. Lithium was just one of the revelations, being an Australian invention. In the Hunter area a lot of that stuff was being done well before the Richmond report. Today the Richmond Fellowship said they were taking people out of housing well before 1983 so Richmond was a continuum of what was happening around the world. We received evidence that the Italians did this and realised that it would be more expensive, not less expensive, if they were to provide that care in the least restrictive circumstances and they led the charge for southern Europe and we followed the northern Europe experience.

Dr FALK: I actually started my psychiatric training in the Hornsby-Ku-ring-gai area and the Hornsby Psychiatric Centre was the foundation in community care, and that was long before Richmond. The Richmond Fellowship started in our area, so we were involved with the foundation of that scheme too.

CHAIR: So the model is not just part of the mental health plan but is the benchmark across the whole world of community-based care in the least restrictive environment?

Dr FALK: But it is a starvation of that model, having worked with—

CHAIR: But some things we have to agree on first before we go forward?

Dr FALK: Yes, absolutely, but we had a large number of community nurses. Everyone in our area was known by the service. With the Richmond Fellowship we had community houses which were very highly resourced. If patients became ill they were immediately attended to. If they needed admission, they were admitted to our unit and they were admitted for the length of time they needed to be admitted. If some patients could not be accommodated in the community or in the acute unit, they were sent to a chronic unit for the time they needed. It could have been six months but most people did not need that because the level of community support was sufficient to keep them well enough before they got that ill, but they were resourced. We had the funds and the treatment.

CHAIR: This is not just the honeyed spectacles?

Dr FALK: No, I was there. One had to witness it. These were not honeyed spectacles. It was extremely efficient and humane. People got therapy if they needed it and they got proper care. It was community based and Lindsay Madew was the founder. He was one of the initiators of the Richmond Fellowship, which was a British scheme. We had staff and the resources, enough acute beds and that just does not happen these days.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was it actually dismantled as it was at Hornsby or is it still existing?

Dr FALK: As a skeleton, as the resources were moved out there was less staff available. Because it was such a satisfying area to work in, we had ongoing staff that were in the system for 20 years. They knew all the patients. The population grew. The population of psychiatric patients has changed as well, I should say. There is a lot more drug use and it is a much more unstable situation, so what we were talking about in those days, if people became acutely ill, their psychosis was becoming more active or people became more depressed. Now you have much more drug use and it is a much more unstable, violent population so the population has changed as well, but the resources have changed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you say "more unstable", you mean that the dual diagnoses is now what percentage of the population you are dealing with?

Dr FALK: I could not tell you.

Dr CARNE: The figure of 50 per cent is used.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: A ball park figure.

Dr CARNE: Yes.

CHAIR: Fifty per cent of people with mental illness have dual diagnoses of drug and alcohol?

Dr CARNE: I am reluctant to use the term "dual diagnoses" but I can say that about 50 per cent of people with mental illness have as well a serious substance abuse or dependence problem.

Dr FALK: That is fairly recent.

Dr CARNE: And those figures are fairly accurate around the world.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Shoot me down if you will, but my memory of psychiatry is that it was one-third depressed, one-third schizophrenic and one-third alcoholism, with everything else being a small percentage. That is how it was 25 years ago. Is that right? Alcoholism was not really a mental illness in the sense that they tended to fall into that system but most of them were not mentally ill beyond their addiction.

Dr CARNE: I think you will have to qualify what you are referring to when you are using demographic data like that. I am not sure how fruitful demographic discussions will be. You have to talk about whether you are you looking at the proportions of mentally ill people presenting to a general practitioner or the proportions of mentally ill people if you do a random community survey and so on and so forth.

CHAIR: He was probably meaning in hospital?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Dr CARNE: In hospital the figures will, of course, vary depending on the social area that the hospital works in. I worked for years in St Vincent's Hospital, which deals with an inner city, impoverished, homeless community. I have also worked in the lower North Shore, which deals with a very different community. Backing up what Rachel says, what one noticed in the lower North Shore was that there was much better service available per mentally ill person because there was a much lower index of social deprivation in the lower North Shore, so if you simply fund a service based on raw population figures or even average figures of the prevalence of mental illness, you will not sufficiently fund a service in an area of deprivation and you will fortuitously overfund a service in an area of social wellbeing. So the lower North Shore area, for example, was able to offer much better resources to each individual mentally ill person than the Darlinghurst-inner-city service was able to offer.

CHAIR: It is still the case.

Dr CARNE: Yes.

CHAIR: If we can just stick to the dual diagnoses of drug and alcohol first because that has been identified by other people as being the most difficult to treat and the group where they fall between two holes where the split of drug and alcohol from mental health in the 1960s or 1970—

Dr FALK: In the 1970s.

CHAIR: There was a split in the way the department dealt with drug and alcohol and with mental health. Previously they were combined but they were then separated and they have been for a long time. If you have a mental illness and you are on drugs the mental illness people do not want to see you.

If you have a drug problem and you have a mental illness, the drug people do not want to see you, so what happens?

Dr CARNE: In reality if the person has a dual problem, as you describe, and they are being treated by a psychiatric service, inevitably the psychiatric service will attempt to deal with the drug and alcohol problems as well, but naturally they have not been funded to do that so, of course, that creates an increased burden on the psychiatric services. In practice, for example, if you take a community health service, you will find that there are drug and alcohol counsellors and there are mental health staff and often they work together but the reality what is lacking are the rehabilitation facilities and acute detoxification facilities. In addition, there are insufficient dual diagnosis facilities. In other words, in practical terms if I have a patient who has schizophrenia and a serious heroin problem, I find it very hard to find a rehabilitation place for them because most of the rehabilitation services will not accept a patient on phenothiazene or modecate or any of the anti-schizophrenia drugs. The same applies to a patient who has a depressive illness who also has a drug problem. It is very common. Most of the rehabilitation services in which the person would need to be an in-patient, a resident—it is not a hospital but it is a rehabilitation service—most of them would reject a patient who has been referred to them and who is on antidepressants. That is a very serious problem and an enormous lack. I am forever trying to find a bed for someone with a dual diagnosis whose schizophrenia is stable but whose drug problem needs to be managed.

CHAIR: Given that a large percentage—even 50 per cent—of people who come to acute services have both problems, would it not be sensible to again combine drug and alcohol and mental health services?

Dr CARNE: Yes, as long as that did not lead to defunding—in other words, if it does not lead to someone saying, "Okay, we have X number of dollars here and Y number of dollars there. They will be in the same spot so we won't give them X plus Y, we'll give them X plus Y over 2."

CHAIR: Dr Falk, when the Richmond report—which is what we are inquiring into—was released in 1983 it identified savings for Treasury. Are you aware of that?

Dr FALK: I do not know the details.

CHAIR: With the implementation in 1986—this is evidence from the department—the rollout of the program, which was meant to take three years, was delayed because of negotiations about conditions of service of the remaining staff. Did that have a serious impact on the ability of the department to roll out the Richmond report? Do you remember those days? It is only 20 years ago.

Dr FALK: I know. I was young then and I was not really at a level where I was involved with policy.

CHAIR: We will address that issue with the department.

The Hon. PETER BREEN: Dr Carne expressed concern regarding dual diagnosis. There is some conflicting evidence about what people are referring to when they use that term. Are you concerned about the diagnosis of different kinds of mental illness?

Dr CARNE: This is why I was reluctant to use the term "dual diagnosis": it is used in the number of different ways, including to refer to individuals who suffer from mental retardation and schizophrenia. Rather than using that term, we should say exactly what we mean. I referred before to the fact that a large proportion of people with major mental illnesses, such as schizophrenia and depression, also have a serious drug problem. Does that clarify the situation?

The Hon. PETER BREEN: Yes, thank you.

CHAIR: Is there an acronym we can use instead of saying that every time?

Dr CARNE: We will have to invent one.

CHAIR: Let us do that; we cannot keep saying that.

Dr CARNE: We could talk about the "substance-dependent mentally ill"; would that help?

CHAIR: Yes.

Dr CARNE: I could not pronounce the acronym: SDMI.

The Hon. AMANDA FAZIO: Dr Falk, you said in your opening remarks that there seems to be a lack of recognition in the current system of the fact that some people will never be cured of their mental health problems and cannot be cared for appropriately in the community. You said something along those lines. What do you believe would be the most appropriate form of care for somebody with an ongoing, perhaps sub-acute, problem who is not capable of living independently or living with community support—given that nobody wants to return to the days of the 400-bed institutions?

Dr FALK: I preface my answer by saying that the range of resources needed is not available. Every case is different. Some patients who need 24-hour care could be managed in the community. The philosophy of trying to normalise people's lives must underlie all management decisions. I think some people would live better in an institution where the pressures of daily life are not on them. Some people will need 24-hour-a-day care. There is also the problem of cost. Do you have small facilities all around town that house five people who need 24-hour-a-day care? Is it more cost-effective to house them in large institutions? They are the issues that must be considered.

The reality is that some people will need care 24 hours a day; it is not a large percentage, but they exist. A lot of them sleep on the streets or are picked up by charities that simply cannot cope. We must confront the reality that some people need highly intensive care. Another group will need intensive care for shorter time for rehabilitation. I do not hear in debates on these issues a recognition of what happens to people who are acutely ill or psychotic. They are in a state of disintegration and it is not enough to give them a drug and to send them out into the community again. They need asylum, whether that is provided in a house, in the community or in a hospital. Some people are in the state of disintegration— they are psychotic—and they cannot cope. They need less pressure and more care. They need to be looked after, and we know that they are not well provided for.

Very sophisticated medications have brought many changes but they cannot address the basics: peace, quiet, care and an ongoing relationship. People who are offered those things often get better. We would save a lot of money if the high percentage of revolving patients who are not being treated at present because they go in and out of acute units were allowed asylum for the required length of time. It is an around-about process, but I think individuals need assessment. There is no universal answer: one patient will live quite well in the community while another needs more sheltered environment. Some people do well at home with their families.

CHAIR: One of the submissions said that in the past if a young person first exhibited schizophrenia at age 17, 18 or 19, he or she would go to an acute hospital for six weeks and then to Macquarie cottages for perhaps a year. The Richmond Fellowship gave an example in its literature of a person who was offered asylum and spent a year with the fellowship, being supported and learning about his illness and how to live with it. According to the submission, that person was then good for 10 years until he had a relapse—as happens with a major relapsing chronic condition—and ended up in an acute ward. He was kicked out after 10 days, got on the merry-go-round and things got worse and worse until he committed suicide by burning down the house.

Dr FALK: That is common; it is not a one-off case—as is the story that, if patients are given time to reintegrate with support and care, some of them never break down again. The old statistics are that one-third of patients who suffered a psychotic breakdown never get ill again. I do not think we would say that these days. That is what happens when care is provided.

CHAIR: Can people spend six weeks in hospital after their first admission and then spend the year recovering? Is that sort of care available?

Dr FALK: Most services are very stretched. In principle, there are some beds like that. Some people are in acute units because there is nowhere to discharge them to—even though they would be better off in a sub-acute area.

CHAIR: Do you think some acute units are silting up with people who should not be there?

Dr FALK: There is no doubt. I telephoned a colleague the other day who said that there were five patients sprawled on the floor of the lounge room who should not be there. He said, "They are in five acute beds and I have nowhere to send them." They were there for months.

CHAIR: The problem is then that people cannot get in.

Dr FALK: They clog up acute beds. That is not the only problem in the acute system. There is an absolute shortage of acute beds, but there is also a shortage of the sort of facility that you have described where people can spend time, receive the appropriate care, treatment, rehabilitation and support and be removed from the pressures of life. They can get themselves together and return to the community. There are just not enough of those facilities.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What is your opinion about the numbers of acute beds, sub-acute beds, long-stay hostels and committee services? Does one depend on the other? The problem is that the numbers seem to be determined by dollars rather than by any analysis of need so nobody even speculates about what mix might be good.

Dr FALK: It should be determined by need. It is also messy in that in the acute system—keeping that as the focus for the moment—many patients are revolving-door patients. They do not receive enough care to integrate in society. Keep the Richmond Fellowship example in mind. It is a very costly solution—like sending patients to prison.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I gather that New South Wales has much the same number of beds as Victoria but, because Victoria has much better community services, it might have enough beds at that level whereas we do not. Therefore, simply increasing the number of beds in this State might be a very expensive, and not the smartest, solution if you were to put a limited number of resources into the system.

Dr FALK: There is a general acknowledgement that there is a shortage of beds; it is not just that the community resources are not available. I do not think anyone working in the system who knows the system would dispute the fact that there are simply not sufficient beds. Even the Health Department report confirms that. We do not have enough acute beds, many of which are clogged up with patients who need to be moved somewhere else. Our prisons are being clogged up with patients who are not being treated appropriately in the community for an acute illness. It becomes a very expensive system when you treat some psychiatric patients in prison and when patients keep being re-admitted. It is much more expensive to have a patient in an acute bed than in a sub-acute rehabilitation bed. That is why it is hard to tease it out: it must be viewed as a whole.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There is a big shortage of both psychiatrists and mental health nurses. It has been put to us that there should be a greater number of less-qualified staff who could be used as support people in the community—getting people to take their medications, liaising with relatives, fixing accommodation or whatever—under the supervision of psychiatrists in teams. This would provide a more outreaching service. Should psychiatrists merely head, or be part of, teams such as that? If so, how many should be in a team? If you do not want to talk about beds, can you talk about how many patients per psychiatrist or how the team should be constructed to do that outreach work?

Dr FALK: I cannot do that either, but I can criticise something that you have said. The philosophy that anyone can do anything—the notion of the generic health worker: someone to supervise medication, for example—is very dangerous. Mental health requires treatment and expertise. The philosophy behind getting the cheapest worker to do the cheaper jobs is very flawed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: On the other hand, if there is an absolute shortage of mental health nurses, with very few coming into and very few staying in the profession—

Dr FALK: Who will do the work?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have no option.

Dr FALK: I think the problem with mental health nurses and the system is appalling.

The Hon. JOHN HATZISTERGOS: It is not regarded as particularly attractive work, is it?

Dr FALK: It is not. It is not attractive work, but the system itself is disheartening. If you talk to people who work in the system they will tell you that they are forced to discharge patients while they are still ill. If they actually say in meetings, "If we discharge Mr X there is a high likelihood that he will suicide", and then he does, what does that do to staff morale? Patients need treatment and it is just not available. The morale of staff in the system is extremely low. We must address that issue and say "There aren't enough people in the system." There is a cause for that. There is a general nursing shortage, and the same applies to nurses in general hospitals.

The Hon. JOHN HATZISTERGOS: Leaving that aside, there is also the problem that you are dealing with very challenging and difficult clientele.

Dr FALK: But if you have adequate resources, adequate staff; if you have support for that staff; there are techniques to manage the patients that needs adequate resources.

The Hon. JOHN HATZISTERGOS: Is it easy to recruit people into the service?

Dr FALK: I think it is becoming increasingly difficult as the system has become more and more dysfunctional.

The Hon. JOHN HATZISTERGOS: We heard of a similar problem in drug and alcohol. Even though there are plenty of positions around it is extremely difficult to recruit people into this area because of the similar sorts of matters that you have raised. I imagine in your case it would be even more difficult.

Dr FALK: Yes but if you have acutely disturbed patients and not enough staff it puts the staff in danger. It is a circular argument but it is very important to address and that is what makes it more of a challenge. You actually need enough staff; you need trained staff and that staff needs support to do their task. If it is provided they will do it.

CHAIR: One of the staggering things on page 7 of your submission is this table at the bottom where if you happen to be a person from Wentworth Area Health Service in the Blue Mountains then the Blue Mountains health service is paying almost $1 million worth of bed days at $230,000 per day— and it might cost even more than that— out of area, let alone what they are spending in area. That means that people are being trucked all over the place. If you cost that 3274 bed days at $200 a day it is $750,000. That is the sort of outflow of money that is going from Wentworth Area Health Service just for the Blue Mountains local government area, let alone Penrith. The people of Wentworth Area Health Service can probably even double that figure to more than 1 1/2 million dollars of outflow of patients who cannot be treated locally who are being shunted all over the place. Is that a common experience?

Dr FALK: It depends on the area. Some areas are better resourced than others.

Dr CARNE: Again I can only talk from my experience and what I can say is based on three types of experience: One is working as a staff specialist psychiatrist in public hospitals and public community mental health services; the second is working as a consultant psychiatrist in the gaols; the third is working on the courts diversion programs attached to the local courts that were recently set up in Sydney. I know from the two community positions that staff are often telephoning around the whole of New South Wales to find an acute bed for patients and in fact firstly, if they find the bed it is very hard to get a patient into a bed in a distant area because the policies of the area are that they should keep their beds for the local people; and secondly, it is often the case there are no acute beds at all for an acutely sick, mentally ill person anywhere in New South Wales. That is the level of severity.

CHAIR: What sort of time does it take if you have got an acute patient who turns up to be scheduled or they come in with a schedule, they come in with the police on a section 24; they go up to the admissions centre of the public hospital, through the emergency department where they are triaged by the emergency department psychiatric nurse; they then get their schedule confirmed or their section 24 converted into a Schedule 2, if they are lucky enough to have that. How long does it take to find a bed?

Dr CARNE: Again of course that is a terribly broad question, but it may be that there are no beds and that person does not get admitted into hospital and a very second rate level of care has to be arranged because they are acutely disturbed so they have to go home or, if they do not go home, they go

to a homeless person's hostel where the acute team or the crisis team would attempt to follow them up. Often, because of their disturbed behaviour, they would be evicted from the hostel and then be on the streets. That is actually what happens.

CHAIR: But the law of a schedule says they are to be admitted into acute care. The duty of care required by the department for that person must be absolute.

Dr CARNE: But it does not happen because there isn't a bed.

Dr FALK: One thing that can happen is they are kept in casualty for up to 24 hours and someone else is sent out who is not quite as acute but is still terribly disturbed.

Dr CARNE: It depends on the severity of the illness and the staff on duty. The other phenomenon that happens is, as Rachel said, mentally ill people who are in hospital being treated be discharged to admit someone who is perceived to be more acutely mentally ill. I have worked in units where I have been asked each Friday to name the patients who were well enough to be discharged. I make the point that if they were well enough to be discharged they would have been discharged. Nevertheless, if I do not make a list of people the duty doctor on the weekend may well discharge one or two of my patients in order to admit someone, to the extent that patients are being discharged from hospital more sick than they would have been when admitted five or 10 years ago when there was not such a crisis. The system is actually collapsing.

CHAIR: We have got lots of evidence from relatives. Should relatives be included in the Mental Health Act as named people so that they can advocate for relatives? They often say that the mental health team take absolutely no notice of it. They ring up and say "He is putting the spoon upside down in a cup again. I know he is going to go off the edge next week. He does that every time".

Dr CARNE: Of course they should be considered.

CHAIR: How do you make sure that they do get considered since the huge bulk of evidence is that they are not? They are the people who write to us so they might be the only 40 or 50 dissatisfied people in New South Wales. But the evidence from ARAFMI is the same, that they have no standing and they can be disregarded and they are disregarded.

Dr FALK: I do not think you can legislate for that. Even if you did, it is a question again of resources. If the community health team actually are so pressured that they have nowhere to put these patients and they ignore them, I think the problem is one of resources. As a psychiatrist I have talked to the community health team and I tell them "So and so needs this and that" and they will ignore me. I maintain I can make that assessment. They do not have the resources.

CHAIR: So how many section 24s do you get with police bringing them in?

Dr CARNE: It depends where you are. If you take the Caritas unit at St Vincent's hospital there is sometimes a queue of police vans in the driveway of the Caritas unit. You could have three or four a day. In fact I looked at the figures when we were setting up the court diversion programs and there could be four or five a day; some days there would be none. It is impossible therefore to say how many. That is an area where there is a lot of social deprivation.

CHAIR: You use the same process as the emergency departments and have no admission days or shunt days where you shunt them off to other places?

Dr CARNE: The reality is if you have not got any beds you cannot admit people.

CHAIR: So the police turn up with a section 24, you say "No, go to St George"?

Dr CARNE: Again it depends. If they have come from court and they cannot be admitted, often they go back to court and they go to gaol. If they come in under a section 24, they come in off the street. A section 24 is somebody who is committing a disturbance and often the police take them to court if they cannot be admitted. What actually happens is at the doors of the hospital there is a junior staff member who often assesses them. These are trainee registrars. They are under pressure from the senior staff who they are working with. If the place is full they will do their best to try and find the person healthy. This is the reality. If the place has five beds free it is much easier to get in. In fact the level of

severity of the person's condition under the counter is actually dependent on the amount of resources available.

CHAIR: So that person then goes to court or they get locked up, charged, because they go to the hospital and the hospital says "No, they are not mentally ill so we are not going to schedule them." Therefore they are responsible for their actions, therefore the police charge them and put them in the police cells. They cause havoc that night; they are obviously—if I can say it—away with the fairies. Then the next day the police, who have these people in custody, where they cannot provide them with treatment— nor are they entitled to do so—they go to the court and they are found to be mentally ill if, as you say, they are lucky enough to get a court liaison person there. Then they get shunted into the mental health service.

Dr CARNE: Or they get remanded in custody into MRRC Silverwater or to Parklea Gaol. They actually get gaoled at times. What happens is the magistrate is faced with a dilemma that there are no beds — and this happens often time and time again — that the same person will be sent back to a psychiatric hospital on more than one occasion; they might be sent back from Caritas, sent to Rozelle and then sent back from Rozelle. The magistrate does not know what to do. The legal aid lawyer is trying to find a course of action. What happens is that person is remanded in custody.

CHAIR: Are you saying that the magistrates do not do what their public duty is? If they are faced with somebody who is clearly mentally ill they say they are not mentally ill because there are no beds?

Dr CARNE: The magistrates are not in a position to identify whether someone is mentally ill.

CHAIR: No, but they get the evidence from the psychiatrist who says "This is a person who is mentally ill".

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They do not. They have been sent from the hospital by your trainee registrars.

CHAIR: I am saying if they have got the court liaison person there, as they do in Darlinghurst, and they appear before the bench --

Dr CARNE: And there are no beds.

CHAIR: Doesn't the magistrate just dispassionately say "This is a judgment. This person is mentally ill and needs treatment and does not need to be in gaol"? Because that is meant to be part of the Act.

Dr CARNE: Yes, and what happens is there is no bed for them. Let us take an example. They are homeless, there is no bed for them. What then happens is the legal aid lawyer or the courts diversion nurse will try and find a bed for them in somewhere like one of the homeless hospitals and then link them up with the Darlinghurst Community Mental Health Service. That may work. The person, however, may be so disturbed that in fact that is an inadequate level of care. Nevertheless that sometimes happens. The alternative is there are no beds and the magistrate is concerned both about public safety and the mental health of the individual and they are remanded in custody for mental health care because the magistrate knows that there is Long Bay hospital. The magistrate does not know that there is a 40 bed and three-month waiting list for Long Bay hospital. The magistrate also knows that there is a mental health team in the MRRC Silverwater. So these people are often remanded in custody for psychiatric treatment. As a result the prisons have become the asylums of last resort.

CHAIR: But the reality is that if you are mentally ill, with all the covenants that we have signed and the law, you are meant to be treated in a facility for the mentally ill, not in a prison or in a police lock-up. Isn't that what is meant to happen?

Dr CARNE: Absolutely.

CHAIR: These people have a right to that. That is actually written in case law and is law. How do the magistrates tolerate something which is obviously a perversion of the law?

Dr CARNE: They are extremely distressed by it. I think you have to ask the magistrates this question. I cannot speak for the magistrates.

CHAIR: We will ask the magistrates. One of them has made a submission to us and we will ask them.

Dr CARNE: They are extremely distressed. I have given lectures to magistrates in in-service training; I have given lectures to all the magistrates in New South Wales and they are extremely distressed by what happens. They are very disturbed by what they see. They are well aware of the fact that there are inadequate mental health services for mentally ill offenders. My observation is they are virtually up in arms about it.

CHAIR: Clearly the Chief Magistrate should understand that with a person having that sort of background, surely this is a matter for urgent action.

Dr CARNE: It is and that is why we are here and that is why this committee is standing.

Dr FALK: Just on that point, I think when things have been going on for a long time people become, in a sense, institutionalized. They become used to it. I think it is that factor that you are actually not addressing in your questions.

Dr CARNE: People become desensitized to this.

Dr FALK: They become desensitized. That is the way it has been; that is the way it is. That is the way it carries on.

The Hon. PETER BREEN: In a sense they have to become desensitized to cope.

Dr FALK: Maybe to cope, that's right.

The Hon. JOHN HATZISTERGOS: These are the sorts of options the magistrates confront, not just in this context, they confront them in all sorts of scenarios. For example, deciding whether to give a prisoner periodic detention. There may not be those facilities available so they then have to consider other options because the prison system is full.

CHAIR: But it might be full of mentally ill people who should not be there in the first place.

Dr CARNE: And that is the case.

The Hon. JOHN HATZISTERGOS: Some time ago a judge told me that when he was dealing with bail applications there was room for only so many on the truck back to gaol and he was handed a note from the Corrective Services person, "For God's sake give the next bloke bail because there is no more room in the truck."

Dr FALK: It is a very important issue.

CHAIR: That is a separate issue. The difficulty is that there are international covenants and there is a lot of angst about this. We pass laws about it to make sure that people who are mentally ill are treated as mentally ill and not as prisoners.

Dr CARNE: In my experience New South Wales is in breach of the Burdekin report, it is in breach of the Mental Health Act, it is in breach of United Nations Resolution 46/119 and it is in breach of the United Nations standard minimal rules for prisoners. In my opinion New South Wales is acting illegally and in breach of international covenants. It is in breach of the Mental Health Act and it is in breach of the Burdekin report. It is acting illegally.

CHAIR: But it is aided and abetted by the magistrates. I was going to leave this until tomorrow but you are indicating to me that the magistrates are compliant with breaking the laws.

Dr CARNE: The magistrates have their hands tied. They cannot find a bed if a bed does not exist. They cannot arrange for psychiatric treatment if there is not a rehabilitation bed. So what do they

do? They are making decisions day in, day out. We have about 1,000 mentally ill people in our gaols. Central Local Court handles about 5,000 matters a year. We saw 250 mentally ill people in the first year of operation of the diversion program. Magistrates are dependent on the advice they get and on the recommendations by the defence lawyer. If they are told by the mental health nurse that the person needs admission and there is not a bed the magistrates ask what the next thing they can do is. The nurse will say that they really should be followed up intensely by the area mental health service but there is no bed. As you know, mental health services are attached to locus. So if there is not a bed in Foster House, Campbell House—you know the names of the places because you have spoken to the Shelter people—you cannot get the local mental health service to agree to see them. So the magistrates ask whether, if these people are remanded in custody, they will get to see a mental health nurse in gaol. You have to say that they will because it is true. They do get to see a mental health nurse in the first day or two. So a mentally ill person is locked in a cage. That is actually what is happening. This is in breach of all these standards. But it is happening in New South Wales.

CHAIR: Then in a few years time will the magistrates be guilty of war crimes?

Dr CARNE: I do not believe it is the magistrates' fault. When I have discussed these issues in public fora—I give lectures about this to the Schizophrenia Fellowship and so forth—they are the most supportive group of people I have discovered in advocating for the welfare of the mentally ill. They are well aware that there are mentally ill in the gaols and the last thing they want to do is have the mentally ill in gaol, but there is simply nowhere else to put them because of the shortage, as Rachel said, of acute beds, community mental health services, support and housing and rehabilitation beds. All these things are lacking. The system is not in crisis; it is collapsing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You were attached to Central Local Court were you not?

Dr CARNE: I was the consultant psychiatrist who set up and supervised Central and Parramatta Local Court diversion programs as part of a two-year pilot research study setting up court diversion in Sydney for the first time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably, you wrote a report on that two-year project?

Dr CARNE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that report publicly available?

Dr CARNE: The report went to the Corrections Health Service. I wrote a one-year report. The two-year report has not been written. The statistics are still being placed on the computer. I subsequently resigned from the Corrections Health Service and I do not have access to that data any longer.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the report for the first year available?

Dr CARNE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably, you would have reached most of the conclusions within 12 months and the statistics to be added for the second year would be a clerical function rather than supporting hugely different conclusions?

Dr CARNE: The picture would change a little but there were no significant social changes in New South Wales which meant that what happened in 2001 would be any different from what happened in 2000.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the report of one year available?

Dr CARNE: It was submitted by us to the Corrections Health Service. They would have a copy of it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So we could request that, presumably?

Dr CARNE: Of course.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But it is not publicly available otherwise?

Dr CARNE: It was submitted within the Corrections Health Service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it is an internal bureaucratic report?

Dr CARNE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So we could get that, hopefully?

Dr CARNE: I am not in a position to say you could.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Theoretically?

Dr CARNE: Theoretically, yes. It exists.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you tell us a bit about what was in that report beyond what you have already said or have you already come to the nub of it satisfactorily?

Dr CARNE: The nub of the report was that more than 90 per cent of the 250-odd people who were referred in the first year—these were referrals not from psychiatrists but from lawyers and magistrates—had a serious mental illness. Most of them had schizophrenia. In those who did not have schizophrenia a high proportion had substance dependence. There was a small but very worryingly significant proportion of people with brain damage and developmental disability. There was a very high proportion of people who had two diagnoses: people who were drug dependent and mentally ill or had developmental disability and brain damage who were mentally ill. Fifty per cent of the people who were referred to us were then diverted out of custodial options into some form of treatment and we were quite successful in getting that treatment. But remember, this was a pilot study and I at the time was both the psychiatrist supervising the court service and the staff specialist psychiatrist at St Vincent's Hospital. So I was able to swing transfers of patients between services that would not have been possible on a large scale. So from my direct experience there were significant numbers of mentally ill people coming before Central Local Court who ought to have been diverted out of custody. Many were, but many were not, because there were no facilities for them or because the magistrate, who has to balance up his concern for public welfare and public safety with his concern for the welfare of the mentally ill, would remand some in custody and expect that they would be treated in prison.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What percentage of the people coming were mentally ill and thus divertible, if you like? If 1,000 people came to the magistrates and 100 go to gaol, 200 are fined and 700 are let off, whatever the percentages are, how many of the ones that could have gone to gaol could have been diverted if there were resources to do so? In other words, could prison beds have been simply transposed into mental health services? What would be the percentage?

Dr CARNE: I cannot answer that question accurately because I do not have the data in front of me.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you could give us a ballpark figure?

Dr CARNE: In general terms, the imprisonment of mentally ill people was caused by the lack of community mental health services. When I say community mental health services I include in that term public psychiatric hospital acute beds, rehabilitation services and drug and alcohol services—in other words, the full range of mental health services. In principle, you could have diverted every single one of them if in addition to what I have described we had a State forensic service, which every other State except us has—in other words, if we had what are called medium and high secure hospitals. None of those things exists. Every single patient could have been diverted if we had, as well as a properly funded public mental health service, secure hospitals.

CHAIR: I will have to intervene. There will not be sufficient time to deal with all the issues raised in your submission today. Would you be available to appear before the Committee tomorrow at, say, 3.30 p.m. to talk on these forensic issues?

Dr CARNE: I am happy to return tomorrow.

The Hon. JOHN HATZISTERGOS: There is a proposal for a forensic hospital, is there not?

Dr CARNE: There is a proposal for a State forensic hospital.

The Hon. JOHN HATZISTERGOS: Outside Long Bay?

Dr CARNE: Yes. I understand that it will be actually attached to the wall of Long Bay.

The Hon. JOHN HATZISTERGOS: So it is not going to be within the prison?

Dr CARNE: It will be very close to the prison.

The Hon. JOHN HATZISTERGOS: It is 135 beds, 120 forensic beds?

Dr CARNE: Something along those lines, yes.

The Hon. JOHN HATZISTERGOS: And 15 high secure non-forensic beds for difficult and dangerous prisoners?

Dr CARNE: That is correct. That will probably be built in about five years time.

The Hon. JOHN HATZISTERGOS: How do you know that?

Dr CARNE: Because that is the planning time from the department and that is what the document that I think you have there will show. It will be up and running in about five years.

CHAIR: I think the department says that it will be completed within three years from today.

The Hon. JOHN HATZISTERGOS: That will replace the prison hospital, will it?

Dr CARNE: I do not see how it could possibly replace the prison hospital. With the population that New South Wales has, the need would be for approximately 300 medium and high security forensic beds. A forensic hospital is a psychiatric hospital that offers psychiatric care to the same standard as is available in a good quality psychiatric acute unit but which has a secure perimeter so patients cannot escape. It is not a prison hospital.

CHAIR: In fairness, those 350 beds are not all acute beds. Some of them are for long-term support of people who are covered by the forensic section of the Act and administered through the Governor's pleasure via the Mental Health Review Tribunal.

Dr CARNE: The Governor's pleasure still exists. But the majority of patients have a determined sentence. We have two units like that. There is one in Cumberland hospital and one at Morisset, with a total capacity of 40 or 50 beds. But it is still far below the level that our population needs.

CHAIR: The Government has plans to extend those two long-term, more asylum step-down care. Given that the Mental Health Review Tribunal is responsible, you might talk about the length of time they stay at an acute facility such as ward A or in step-down facilities such as Cumberland, or step-down further such as Morisset or even step down into the community being dependent on the Mental Health Review Tribunal making recommendations signed off by the Minister for Health and then approved by the Governor-in-Council. So the Government still dictates where you sit on that continuum of care and, as I understand it from evidence that Beverley Raphael gave in her briefing, for not just the acute beds that John is discussing but also some more extensive beds at that low level, more the asylum-type beds.

Dr CARNE: That is correct but we are talking about the situation as it is at the moment.

CHAIR: Does your 350 number include all of those beds or are you talking only of acute beds?

Dr CARNE: I would say around 300. For the population, in view of other States and countries with a reasonable forensic service, and the number of prisoners we have, we would need about 300 high and medium security beds for individuals with mental illness who have offended and who would be in—

CHAIR: That is the security level, but what about the treatment level? There are 135 acute level beds attached to Long Bay. Are the beds proposed for the facility adjacent to Long Bay meant to be high dependency, that is acute mentally ill, or will some be more moderate?

The Hon. JOHN HATZISTERGOS: The submission by the Department of Health states that 15 are for particularly difficult people, 120 otherwise. It is proposed to replace the hospital at Long Bay with an 85-bed facility. The submission, B5, states:

> The proposed forensic hospital would have a 135 bed capacity comprising 120 forensic beds and 15 high security non-forensic beds for difficult and dangerous civilians who cannot be managed within the mental health acute system. The hospital would be located outside Long Bay Correctional Centre changing the model of care from prison to health facility. This development will bring New South Wales into line with both national and international best practice where the management of forensic patients is within a health-based therapeutic environment. The existing Long Bay prison hospital would be replaced by an 85-bed hospital to include 40 acute psychiatric assessment beds and a 15-bed expansion zone for non-forensic acute mental health patients in the prison.

Dr CARNE: I have not read the latest copy of that report.

CHAIR: That adds up to 285 beds of which about 250 are for forensic patients?

Dr CARNE: Yes, that is getting close to the figure that New South Wales would need.

The Hon. AMANDA FAZIO: If there is a shortage of psychiatric and mental health nurses and also a shortage of psychiatrists, even if the State Government were to put in a lot more resources to provide services for people with mental health problems, it would be quite difficult to manage those services if you did not have qualified staff. What could be done to attract people into the psychiatric profession?

Dr CARNE: There are different levels of entry. With psychiatrists I am not sure that it is the absolute number of psychiatrists that is the problem. It is the nature of the psychiatric practice that is involved and working in a service that is underfunded and inadequately resourced; it becomes demoralising and extremely difficult to work there. When psychiatrists have a choice between working in a public system and going into private practice, there is a greater likelihood they will choose not to work in the public system and will resign from it and work in private practice.

In my personal experience, firstly there is an absolute shortage of nurses throughout the developed world. Britain is trying to get nurses from Spain and India and we are continually recruiting nurses from elsewhere. There is an absolute problem in training nurses and we need to train more nurses. In addition, retention is another issue. If the service offered was a better quality service, you would retain nursing staff in the services because the job would be more rewarding. I have observed services in which, in order to save funds, positions are not filled resulting in an increased burden on the remaining staff and a higher rate of staff turnover.

One thing that could be remedied is to properly fund the services so that staff are adequately supported by the requisite numbers, which will lower the turnover rate. But there has to be an absolute addition to training nurses. That requires looking at the whole training system and why people do not want to become nurses.

Dr FALK: The numbers of psychiatrists could be addressed by reintroducing visiting medical officers [VMOs] into the system. VMOs have a high level of expertise and there is a high level of goodwill for psychiatrists to work in the system and support it and try to improve it. But the funding is not available. VMO positions have been advertised and when people have applied the system changed its mind and decided that it could pay three junior social workers for one part-time psychiatrist. Funding should be made available. The system needs it.

The Hon. JOHN HATZISTERGOS: How much money?

Dr FALK: I do not know.

The Hon. JOHN HATZISTERGOS: I would like to know how much this will cost.

Mr RAMOS: It is difficult to come up with a number.

The Hon. JOHN HATZISTERGOS: That is what everyone says.

Dr FALK: The psychiatrists are there, they are available and they are willing. A lot of the work could be done by VMOs. The way that the system is now, the only way people can survive in the system and keep their sanity is to spend only part of their time there. That would improve the teaching, the standard of therapy and staff morale. This is an important question.

CHAIR: On that, the submission by the superintendent of the Northern Sydney Area Health Service, one of the few people in the system who has given the Committee a submission in spite of the Minister's warning, stated that there is a need for a consulting psychiatrist to support the mental health teams. In other words, someone they could go back to—that used to exist, but seems to have been cut out. Is that true?

Dr FALK: It is true. There are very few consultants in the system.

Dr CARNE: For four years I was a staff specialist psychiatrist in St Vincent's Hospital in Sydney. As well as being responsible for in-patients and training registrars I was also responsible for community mental health services and a group of nurses and so-called multidisciplinary staff. From that experience I was able to make the observation that one of the reasons for the shortage of nurses and other staff was because posts were kept open. Positions were not filled and, therefore, there was an increased burden on the existing staff and their turnover increased and the system gradually collapsed. What you described does exist.

CHAIR: The Northern Sydney Area Health Service has lost the ability to employee the consultant who supported the mental health nurses.

Dr FALK: That is right. I am a child and family psychiatrist, aside from seeing adults. The system is bereft, there are very few child and family psychiatrists in the system.

CHAIR: We will come to that. What is the VMO support?

Dr FALK: The positions are not available even when there is a designated shortage of people and people are willing to work in the system. Some places may not have filled the positions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I would like to ask a forensic question. I would like to know why Dr Carne resigned before we speak to the people from Corrections Health.

CHAIR: That can be left until tomorrow. If any of you wish to add anything to your evidence would you please transmit that to the Committee. The Committee may need to recall you for further questioning on the specialist parts of your submission.

(The witnesses withdrew)

MYREE ANNE HARRIS, Convener, Coalition for Appropriate Supported Accommodation for People with Disabilities in New South Wales, Post Office Box 5, Petersham, on former oath:

CHAIR: Today the Committee has heard from the B. Miles Women's Housing Scheme, the Richmond Fellowship, Shelter New South Wales and the National Association of Practising Psychiatrists. The Committee is addressing homelessness and mental illness. The submission from the Coalition for Appropriate Supported Accommodation for People with Disabilities is an excellent one. The submission is not about mental health only, is it?

Sister HARRIS: No, we concentrated on licensed boarding houses initially. That is where 44 per cent of people have a mental illness, 33 per cent of people have an intellectual disability, 16 per cent of people have brain damage and about 4 per cent have other physical disabilities and so on.

CHAIR: How many of those would have a dual title?

Sister HARRIS: I do not know. I was interested in the 50 per cent of the other kind of dual diagnosis. The drug and alcohol plus mental illness is increasing in that population as well, but there is also the dual diagnosis of mental illness and intellectual disability.

CHAIR: When wearing your other hat you said that these were the most toxic, most dangerous and most violent of people.

Sister HARRIS: They are the ones with the personality disorder and substance abuse. You asked about an acronym, a good one is MISA, for mental illness substance abuse.

CHAIR: Yes, we will call mental illness substance abuse by the acronym MISA. Thank you.

Sister HARRIS: That is used by the Americans.

CHAIR: Is there anything in the document that you would like to draw particular attention to?

Sister HARRIS: The lack of appropriate supported accommodation. I would like to follow through what is happening in the boarding house system. There are some real concerns, huge concerns, happening there. I would like to focus on that.

CHAIR: Yes, especially if you have some recommendations for improvement.

Sister HARRIS: Yes we do. I will go through the statistics. Today I checked with DADHC which informed me that there are 68 boarding houses; really there are 67 because one at Goulburn is about to close. There are 1,211 beds, and that is down from 2,175 in the middle 1990s. Under the reform process, which started about five years ago, the Carr Government allocated $66 million, some of which is recurrent, and 324 high-level needs residents were removed to 24-hour supported accommodation in the community run by non-government organisations. Originally when this intensive assessment was carried out across the State there were 310 highest-level needs people. Funding was there to relocate that group.

The problem was that it took about a year to get under way and in the three years after that many boarding houses were closed. The whole system is very much in a state of flux. Rarely is there any warning of closures, a bit more so now but in the early days there was not. In one instance the residents were informed at breakfast and that the place was closing, they were given a garbage bag and asked to put their things in it, and then the trucks and buses pulled up and they were told where they were going. They were not asked, they were told. That happened at Drummoyne.

There were a number of places like that. In the process of rather dramatic closures many people's mental illness and other disabilities increased in severity, they became high-level needs and they needed more care. Some of those original places had to be reallocated to the people affected by closures. On my estimate there are still around 200 in the system. We cannot get the exact numbers because no-one will give us access to the data. But there are around 200 people with high-level needs still in licensed boarding houses in this State. They are down the Southern Highlands, they are in the west of Sydney, they are in the west of the State and the last time I heard about it about 50 were still in central Sydney. They are still waiting on their relocation packages, and unless there is more funding in this budget and onwards they will not be relocated. They are getting older, sicker and frailer. In the process a number of aged-care

people have been moved out, and that is good. There were 80 and 90-year-old people in this system who should never have remained in boarding houses. But what I am really worried about at the moment is the safety and protection of the people in licensed boarding houses. I do not believe that the system, as it is at the moment—

CHAIR: That is the licensed ones?

Sister HARRIS: Licensed boarding houses for people with disabilities, licensed under the Department of Ageing, Disability and Home Care, I do not believe there is the will or the ability on the part of government or on the part of the system to care for these people adequately, even to provide for their physical safety. I am talking about the most basic thing, physical safety, safety from abuse, physical and sexual abuse. Why I am so adamant about that is that, under freedom of information, I managed to get documents on the boarding houses I was very worried about. There is a third one as well that I have heard more about lately. It took me six months to get this information, and I only got it in the end through the Ombudsman informing me that I could ask for an internal review and that they had to respond to that within 14 days. I got the information on the last of those 14 days. My cheques were returned with the comment: You do not want to press ahead with the internal review, do you? We did not bank your cheques. We have sent them back to you. I do not think they want an internal review. I guess that was the message.

CHAIR: You got your FOI?

Sister HARRIS: I got the information and it is tolerable. It is absolutely frightening. Let us take one instance in the Inner West of Sydney, a boarding house that has been of concern to the Central Sydney Boarding House Team for many years, I know many of the people on that team and I have worked with them. They are very concerned for the safety of the people, let alone their care. Care is non-existent and their safety is precarious. One of the people on the staff at that place has been charged for years and years and years—my documents go back five years—with physical assault of the residents. The allegations are on page 2, page 4 and then page 6. It goes straight through the whole document: He hit me. He kicked me. He pushed me down the stairs. He bashed me. A neighbour complaining of screams from 6.00 p.m. to 6.00 a.m. on Saturday. People walking around with black eye: I found her at 4.30 in the morning with black eyes. I do not know how she got black eyes. That went on all the time.

In that case licensing said that that person was not to remain on the staff, but they cannot enforce that. In the note it said, "Visited the premises. So and so was at the kitchen bench doing paperwork." He was told not to be on the premises, not to have any contact with residents. They cannot enforce that. He is now happily back on staff. Nothing has been done. They can do nothing to stop that. The other instance was a very graphic report of sexual assault of a resident, again by a staff member, a different staff member. That was never followed up adequately by the police. The person who reported it was said to be an unreliable witness. She gives a very detailed, very graphic report in interviews with care of workers and so on. It is all in print. That person who was charged was suspended for a while, then the owner wanted him back on staff. A request was put to DADHC, surely he could be reassigned. We had better do a criminal check first.

He was found to have a drink-driving conviction. That is not too bad. They interviewed him and found out that he knew about people with disabilities. He did not know the Youth and Community Services Act very well, and he did not have a First Aid certificate. But a document said yes, it has been approved. He can be re-employed as a staff member. At the bottom of the document it says "Minister approves." Someone has written at the bottom "surely, we could at least ask that the get a First Aid certificate." If it were not so absolutely horrible it would be absolutely absurdly funny. This is what it is like. It just goes on and on and on like this. The person was put back on staff, even though this very graphic allegation of sexual assault was there. Nothing had been proved either way, but he is back on staff. I am not sure whether he is still there. The other person who was charged with constant physical abuse of people is still there.

In the case of the other place, which is in the country, in the Central West, in a way that is even more frightening because it is so physically isolated. The owner of that place runs a closed system. He will not allow anyone, so far as I can determine from the reports and from other people who have given the evidence, to speak one to one to the residents without a staff person being present. Even when they followed it up in another town where the people go to a day centre, the people in the day centre said that they had to have written permission from the owner before anyone could speak to a resident. You are aware that under the reforms there is an Active Linking Program?

CHAIR: Yes.

Sister HARRIS: The Lithgow Neighbourhood Centre was given the contract. They have refused since late last September to go into those premises or to conduct activities because they consider it unsafe for themselves and all of the residents to go in there. They can see that the premises are unsafe for the residents. They were not allowed access to the names of the residents. The people are called by nicknames. They were blotted out, but I could read them through one of them. Hairy-legs and peanuts are the kinds of nicknames the residents go under. They do not know their names, they were not given a date of birth. When people go on excursions with medications they are given a jar, just a glass jar with a bit of paper in it with the person's name on it. There was no indication of the medication or the dosage, or what it was for. There was no warning of any different behaviours. They could be totally unprepared for anything.

Again, they could not speak one to one with the people. There is a Residents Committee that reports back to the owner about everything that happens and, apparently, enforces discipline. There were comments about their deciding on punishment for the other residents. There is also one allegation of physical harm done to a resident by the Residents Committee. There was a report by someone in the community who spoke about a woman running naked down the main street of the town in the middle of winter, and having to be taken back to the boarding house in a distressed state. One of the things that really upset me right towards the end of the documentation was that the names were blotted out and there were initials. I could work out that it was an RN. Since so and so is an RN, and I presume that is the owner because I think he is, this person does all the physical health checks on the residents. He does the breast cancer checks and the prostate cancer checks and administers Depo Provera to prevent unwanted pregnancies. I just found myself going cold. That means that the residents do not have access to a general practitioner. They are totally at the mercy of this one person, and there were lots of allegations like—

CHAIR: How do they get licensed?

Sister HARRIS: This is the big question. There are allegations that the boss hits me, et cetera. They are at the mercy of this person. He will not allow anyone else in. The licence is under the Department of Ageing, Disability and Home Care. I know that the one in the Inner West has a very old licence because it has eight people in a room and that is not allowed under new conditions. But they cannot change that and they cannot force him to have fewer than eight people in a room at the moment because he has an old licence. In fact, the department is so helpless that it can no longer even interview staff members if the owner does not want them to. They can do absolutely nothing. The owner of the one in the country has refused since 1996 to have criminal checks done on his staff and he still refuses. They can do nothing about it.

The Hon. AMANDA FAZIO: The country boarding house that you are talking about, how long has it been licensed that you know of?

Sister HARRIS: I assume it is around 20 years. It is an old one. It has been going a long time.

The Hon. AMANDA FAZIO: Are both these and the other one, because you said there is a third one that you are concerned about—

Sister HARRIS: Yes, that is also in the Inner West.

The Hon. AMANDA FAZIO: I have not been involved in this area for about 15 years, but is it still the case that most of those people would have signed their social security, Centrelink payments, or whatever it is, over to the management?

Sister HARRIS: That used to be common in the 1990s in places that I was involved in trying to help the people. I know that licensing in the mid-90s merely tried to change things, we tried to make sure that people were under the protective service that they had bank accounts and that the owner did not have them. It was very common for owners to have a whole sheaf of signed withdrawal forms and hold the bank books, Medicare cards and pension cards. The people had nothing. They had no freedom. I do not know. There is a new policy in place. There is a policy of appeasement going on at the moment. Four or five people have said to me, health people and people in the departments, that they have heard the statement made that Faye Lo Po' has stated that boarding houses are to be kept open at all costs. I am not sure what that means. What kind of costs is she talking about? If that cost is the physical and sexual abuse

of residents then that cost is far too high and the Government is accountable. That really frightens me. What seems to be happening at the moment is that there is a whole new policy. There are no standards prescribed for boarding houses, by the way. We have no legislative review. The legislation is totally weak and ineffective. In effect licensing, even if it wanted to try to set the standards and conditions, cannot do it. The legislation will not hold those things up in court. They would lose prosecutions.

CHAIR: If this is in a licensed area and you say that there are 68 or 67 of them left, what is in the unlicensed sector?

Sister HARRIS: Nobody knows what is going on in the unlicensed, but the horrible thing about the licence system is that these are all people with disabilities. In the unlicensed you are not supposed to have more than two people who have a disability without supervision and support.

CHAIR: But you would not know.

Sister HARRIS: We do not know. They have tried to investigate some, but the current climate is such that they would not want to find new ones because they are not able to adequately monitor the present ones.

The Hon. AMANDA FAZIO: Could I just check with you about the clients? You said that they all have disabilities, so they would all have some sort of mental health problem?

Sister HARRIS: No, not all of them. No, 44 per cent have mental health problems. That was the last statistics I heard of. That was in the mid-90s that I heard that. The other figure was 33 per cent with intellectual disability. Then you have things like alcohol-related brain damage and other forms of brain damage and physical disabilities. But the things that are quite horrifying at the moment are that there are no standards prescribed or enforced. Licensed boarding houses operate under conditions of licence. They are called conditions, but there is no will to prosecute any breach of conditions at the moment. Residents have no legislative protection at all. There are no requirements for records of finances, no enforcement of regulations for provision of medication, no obligation to keep medical files or records, no enforcement of police checks. Plus, as I said, licensing officers can no longer interview staff unless the owner lets them.

The legislation is weak and basically useless. DADHC lacks the legal security to enforce the current conditions. The Residential Carers Association, which is the organisation of the boarding house owners, is testing the limits of the existing legislation. The basic human rights of boarding house residents are at the whim of the owner. I do not want to give the impression that they are all bad. There are a few good places where the owners really are concerned for the rights of residents and really care for the rights of residents. Some of them are good, but the problem is where the owners do not respect the human rights of the residents no-one can do anything about it. There is a new policy of appeasement. The idea is to integrate boarding house owners into a co-ordinated service provision. That is what they are saying. They are talking about the boarding house owners as primary carers. In the case of the two places I have talked about, what happens if the primary carer is also the primary abuser?

CHAIR: Have you discussed these matters with Minister Lo Po'?

Ms HARRIS: I have never had access to the Minister. I write to the Minister at least once every two months about different boarding house issues, but I have never had the privilege or pleasure of meeting the Minister.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you provide us with those documents you are speaking of?

Ms HARRIS: I can give you the freedom of information ones, certainly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And the documents about the boarding house in Central West or Orange?

Ms HARRIS: Yes, I can give you the two sets. All the names are blacked out, of course. I was not interested in names. I was interested in the interaction between the department and the boarding house itself.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably you can tell us which boarding houses you have written about.

Ms HARRIS: I have written about those boarding houses and I have written about others. There is another one in the Inner West where they are really worried because the owner is erratic. One of the other boarding house owners commented that he is back on his lithium. So he himself has bipolar disorder. He is erratic, unpredictable, flies into rages and has grandiose plans and ambitions. People are at his mercy also. That is the third place that everyone is worried about.

The Hon. AMANDA FAZIO: You said that you are concerned about the proposal being put in place to incorporate these sorts of boarding houses into some form of community care.

Ms HARRIS: Continuum of care.

The Hon. AMANDA FAZIO: Is that for people with an intellectual disability or people with mental health problems?

Ms HARRIS: It is for people in the boarding houses. They are people with mental illness, with intellectual disability, with brain damage.

The Hon. AMANDA FAZIO: These types of boarding houses would become part of the acceptable supported accommodation system?

Ms HARRIS: If the Minister is frightened that there will not be any more funding for boarding house reform, therefore we have to keep these places open at all costs and make the owners happy. We have to call them primary carers and tell them that we will include them in this service provision. That is fine. What happens if I am a resident and I have been assaulted by the owner, my health worker comes in to meet with me and the boarding house owner is called in to be part of the conference? That is all we are suggesting. What chance have I got of telling anyone what is going on when I cannot even speak privately to someone and I know I will be bashed up, basically, afterwards if I say anything.

CHAIR: On page 5 of your submission there is a quote from the Premier. The bottom line states:

> Labor is determined that exploitation and abuse will stop.

Ms HARRIS: That is a very nice sentiment. I would be concerned that not everyone is getting the message, if that is the case.

CHAIR: I am absolutely certain that if the Minister knew about this she would be horrified.

Ms HARRIS: I do not know what is going on. We did have some concerns. I have just found out recently that some of this stuff was not getting as far as the Minister and that the advisers were keeping it from the Minister. We hope that the message is getting through now. DADHC is getting a clear policy message that it is to integrate the boarding house owners into the service provision system so that they are part of the care and service provision of these people. We are not protecting these people from those who could be potential abusers of them. How do we get to the Minister? How do we make it clear that the care and safety of these people has to come before anything else?

The Hon. AMANDA FAZIO: As you are aware, we are looking at the mental health area. The Hon. Dr Arthur Chesterfield-Evans and I are members of the social issues committee which is inquiring into accommodation issues for people with disabilities, including people with intellectual disabilities. We can raise some of these issues in the context of the social issues inquiry. In relation to our inquiry into mental health, putting aside all problems of communicating your concerns to the Minister and her staff, what would be the ideal situation for the residents of these licensed boarding houses? What would you like to see done for them?

Ms HARRIS: The first thing that has to happen is a legislative review. I am on the boarding house reference group. We have been asking for the review for years. One almost started last year. They had hired someone and Harry Herbert and I were told we could be interviewed. We rang up and said we wanted to meet with the person and tell him what needs to be done. As soon as we rang back we were

told there has been a delay. The next thing we were told it has been postponed. I do not know who or what is impeding a legislative review.

CHAIR: Have you seen the draft legislation?

Ms HARRIS: No.

CHAIR: It has been seen by Shelter New South Wales.

Ms HARRIS: We will try and get hold of it. They have not done a review. There has to be a legislative review which provides enough strength so that the abuse that is happening in licensed boarding houses can be controlled and stopped. That is the first thing. The first thing is to look after the people. You make sure that no more abuse is happening. CASA has always felt that licensed boarding houses are not the appropriate environment for people with disabilities anyway. If you have low level needs and choose to be in a place like that, you can make the choice because you are strong, healthy and independent enough, you know your rights and you can stand up for them, that is fine. That is the population that used to be in boarding houses, perhaps. We believe that anyone who has a disability who does not want to be in a boarding house should not be there and those people should be relocated into a range of models of supported housing in the community.

There have been some good outcomes to some of the closures. In the Blue Mountains recently, for instance, a big boarding house was closed. The Department of Housing worked with a group of about five residents who have a low level needs and found department premises, a big house with five bedrooms and a nice garden. They were able to rent the property and the people live there happily with drop-in support from Home and Community Care. That is one of the success stories. There are now four groups of residents from boarding houses who have been kept together. That is good that they were not scattered. They have been kept together in rented accommodation with a non-government agency looking after them. Supposedly, we have been told, they are being assessed for their housing and support needs. That is good. They have been kept together in Blackheath, for instance, and that is going to be happening in Goulburn. It happened at Enmore and to a group at Stanmore who were in an old boarding house at Campsie that closed. Although they are now being kept together, there is no funding to take that a step further.

CHAIR: Where are they being kept together?

Ms HARRIS: In rented houses. In the case of the group from the boarding house at Stanmore that closed, they have moved to Campsie. A boarding house called Kindlewood had closed and the people moved out, most of them into aged care. The department rented the facility, a house, and they are kept there together.

CHAIR: Who is running that house?

Ms HARRIS: A non-government group. Sometimes it is the House with No Steps, sometimes it is Home Care.

CHAIR: Are there many boarding houses operated by non-government organisations?

Ms HARRIS: No, not of that kind. In the reform process, the relocation, non-government groups tender for contracts. Richmond Fellowship is one group, for instance, and there are a number of others. They buy or rent houses and then provide care. These four groups of residents, and there are 14, 16 or 20 in each of them, has to be relocated but there is no money. We need money to put them in the community. In relation to the models, there are three main groups. There is the group that needs 24-hour supported care. Then there is a group that would need only a lower amount. Some groups might need seven hours a day, some only seven hours a few times a week. Some may need only drop-in care.

The Hon. AMANDA FAZIO: Sister Harris, some of these residents have been living in boarding houses where their needs have been catered for—albeit badly, perhaps—in terms of laundry and meals. Do they need a fair degree of social education before they can live independently or do the non-government organisations who run their new accommodation services provide those supports for them?

Ms HARRIS: It has to be ascertained at each level. In the case of the small group at Blackheath, they were able to do their own services. Someone drops in a few times a week and checks on them. They

have been running their own system. They are looking after themselves. There are not a lot of them. The problem is a lot of people in this system were in institutions for 20 years and have now been in boarding houses for 20 years. They are very institutionalised. Some of the Active Link Initiatives [ALI] programs are useful in helping people to gain living skills, so that they can move further towards independence. A lot of them are old, that is the problem.

CHAIR: When they turn 65 they have access to aged care arrangements.

Ms HARRIS: Yes, to the aged care. That has been an improvement too. Hopefully they go into good ones, but at least they have that.

CHAIR: We have to conclude now. We will most likely want to hear from you again. If you would submit those documents, we will table them and release them publicly. Your uncorrected evidence will be put on the web. You will send you a transcript of your evidence and we ask you to correct it and send it back to us. Then we will put the corrected version on the web. If you want to add to your evidence—you may not have fully answered our questions to your satisfaction—would you communicate that information to us? If we have further questions, may we contact you?

Ms HARRIS: Yes.

CHAIR: Thank you very much for your appearance.

(The Committee adjourned at 5.15 p.m.)