30 October 2008

Committee Secretariat
Family and Community Development Committee
Parliament House
Spring Street
East Melbourne VIC 3002

Dear Sir/Madam,

**NWMH Response to Inquiries into the Provision of Supported Accommodation for Victorians with a Disability or Mental Illness**

Please find attached a response from NorthWestern Mental Health to the Inquiries into the Provision of Supported Accommodation for Victorians with a Disability or Mental Illness. We are pleased to have the opportunity to provide feedback and participate in the discussion about the Supported Accommodation needs of Victorians with a mental illness. We have responded to the integrated questions documented in the Family and Community Development Committee Discussion Paper, which integrates the Terms of Reference of the concurrent Legislative Assembly and Legislative Council Inquiries.

We hope our feedback is helpful in the context of the current inquiry and planning for change. NWMH would welcome any involvement in the process of redeveloping Supported Accommodation options to improve the quality, rights, access and level of support that people living with a mental illness might expect and receive on entering supported accommodation.

Yours sincerely,

Mr. Peter Kelly
Acting Executive Director
NorthWestern Mental Health
Melbourne Health
NorthWestern Mental Health Response
Inquiry into Supported Accommodation for Victorians with a Disability or Mental Illness

Introduction

NorthWestern Mental Health (NWMH) - a division of Melbourne Health - is one of the largest publicly funded providers of mental health services in Australia. It operates in partnership with Northern Health (Northern Hospital, Broadmeadows Health Service, Bundoora Extended Care and Craigieburn Health Service) and Western Health (Sunshine and Western Hospitals). NWMH provides comprehensive hospital-based, community and specialist services to youth, adults and aged people across northern and western metropolitan Melbourne.

NWMH commends the Victorian Parliament for undertaking this inquiry. There are longstanding problems with the standard, range and adequacy of supported accommodation for people (of all ages) with mental illness, and a gross imbalance between supply and demand. The significant reform of mental health services in Victoria over the last twenty years has resulted in most people with mental illness receiving their treatment, rehabilitation and support in the community. It is therefore imperative that high quality, affordable and appropriate accommodation and support options are available. Further, accommodation service providers/staff must be both prepared and equipped to deal with the nature and complexity of persons with mental illness who require supported accommodation. Without adequate and safe accommodation, effective treatment and rehabilitation strategies cannot be implemented (Burdekin et al. 1993; Shepherd et al. 1996; 1997). Thus, it is essential that accommodation be considered a priority when addressing the needs of people with a mental illness.

People with mental illness and related psychosocial disabilities often experience difficulties in accessing affordable, safe and stable housing. Furthermore, illness can disrupt tenancies and jeopardise the consumer’s housing tenure. A significant proportion of homeless people and people living in sub-standard or marginal housing have a mental illness. Housing linked to support plays an important role in recovery from mental illness and assists consumers on low-incomes to live successfully in the community.

In providing this response, NWMH would like to individually address the questions posed in the Family and Community Development Committee Discussion Paper, which integrates the Terms of Reference of the concurrent Legislative Assembly and Legislative Council inquiries. However, from the outset it must be emphasised that there are simply not enough supported accommodation services specifically tailored to meet the needs of people with mental illness. Increasing the range of options and improving the viability and sustainability of existing supported accommodation services must therefore be an urgent priority to ensure the availability of stable and affordable accommodation for these vulnerable and needy members of our community.

An Important Note on Definitions

'Specialist' supported accommodation (including Community Care Units, Secure Extended Care Units, PARCS, residential rehabilitation units)

It is our view that these programs named above and cited in the Inquiry’s Terms of Reference should not be thought of as ‘supported accommodation services’, but rather treatment and rehabilitation programs in bed-based/residential settings. CCU and SECU are operated by clinical mental health services. In the case of Prevention and Recovery Care Services (PARCS), alternatively known as Step Up/Step Down Units, clinical and Psychiatric Disability Rehabilitation Support Services (PDRSS) collaborate in their operation, and Residential Rehabilitation Programs are operated by PDRSS alone. The primary purpose of these programs is to provide time-limited psychiatric treatment, rehabilitation and support aimed at assisting the consumer to recover sufficiently enough to live ‘more independently’ in the community. There are a limited number of these places/beds in each Area Mental Health Service (AMHS) catchment, and throughput is required in order to meet continuing demand.
Very often the lack of suitable community based accommodation and support services means that discharge of consumers who no longer require care in the specialist bed based treatment service is considerably delayed.¹

In some cases the consumer remains in the specialist service (CCU or SECU) not because of clinical need, but because there is no suitable supported accommodation option. This is typically the case for consumers with dual disability (mental illness and intellectual disability), dual diagnosis (mental illness and substance misuse) and those with a significant forensic history. Consumers with complex and multiple needs, enduring disability and chronic risk require specifically tailored accommodation and support services, such as a specialist dual disability community residential unit for both respite and long term accommodation. For a small but often over looked group of consumers currently residing in SECU, the development of secure life long care in a more permanent home like environment is needed to ensure their right to stable and safe supported housing.

To assist a mutual understanding of the current range of available accommodation options and services used by people with a mental illness we have summarised these, their advantages and limitations in TABLE 1 (which is available on the next page).

An extended description/definition list is also available in Appendix Three.

Availability of supported accommodation (Q1)

The availability of supported accommodation (PDRSS housing and support programs, boarding houses, rooming houses and SRS) varies enormously across metropolitan Melbourne. However, in general there is a chronic shortage of affordable accommodation, with support attached, for people with mental illness. This situation would be vastly improved if each catchment area/AMHS had a robust PDRSS managed accommodation and support service/s working in partnership with clinical services to deliver an integrated and comprehensive mental health service. It is very important to note that PDRSS/clinical accommodation partnerships work most effectively when they have access to sufficient permanent and transitional housing properties, particularly single occupancy.

The most effective PDRSS housing programs have very long waiting lists. Availability of housing stock is an ongoing problem; these programs need access to much more housing, including single units. Indeed it is often it is the lack of housing, rather than the availability of support, that is the core problem.

¹ Please refer to Appendix One — Excerpts from ‘Redressing the Homelessness in North West Communities of Melbourne’ P.7/8 which outlines that homeless mentally ill people occupy acute mental health beds 3 times longer than individuals who have secure housing. The cost in December 2007 for Broadmeadows Inpatient Unit (NWAMHiS) was $64,288. The result on an annual basis is $1,011,463. Multiply this by 4 inpatient units the cost = $4,045,852.
### Accommodation Options Available to People with a Mental Illness (Other than living with family members)

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<thead>
<tr>
<th>PERMANENT</th>
<th>TEMPORARY</th>
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<td><strong>Types</strong></td>
<td><strong>Types</strong></td>
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<td><strong>Most support available</strong></td>
<td><strong>Temporary Respite Services</strong></td>
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<tr>
<td>Special Residential Services (SRS) / Hostel / Nursing Homes</td>
<td>PDRSS Residential Rehabilitation Programs</td>
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<td>PDRSS Housing &amp; Support Individual properties with Outreach Support</td>
<td>PDRSS Transitional Housing with Outreach Support</td>
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<td>Department of Housing Stock</td>
<td>Crisis Accommodation Services/ Shelters</td>
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<td>Permanent tenure.</td>
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Table 1. Accommodation Options Available to People with a Mental Illness (other than living with family)
### Segment 1 – Recurring Homelessness
- Application accepted, almost impossible to obtain. Even with Seg1 2-3 years before single property is available.
- Vacancies often in high-density blocks, which are often unsuitable for people with mental illness.

| Transitional Housing - Nomination Rights held by some Housing Support agencies | Medium Term Some single properties, mostly shared. Generally SAAP funded housing outreach worker available. | Many properties 'shared' – this often is not suitable for the vast majority of people with mental illness. Insufficient properties of this VITAL OPTION. Due to a lack of housing stock moving on from transitional housing may necessitate a shift of area away from established supports – a destabilising event. |
| Community Rooming Houses | Stepping stone from Crisis Accom to more permanent accom. Not for profit = affordable & non exploitative. | Waiting Lists. No support or supervision attached. Can be unsafe. Shared facilities incl. bathrooms/kitchen. Tenancy hard to sustain due to resident dynamics/intimidation. |
| Private Unregistered 'Rooming'/Boarding Houses | Often the last resort option due to lack of other alternatives | No regulation of tenancy rights or safety. Constant reports of exploitation, high rents poor facilities, intimidation, exposure to violence |

| Least support available | Private Rental Market | Housing Crisis = landlords advantage. Rent high, those with illness & disability discriminated against or 'squeezed out'. Often unable to provide references; stable income that can |

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Suitability of supported accommodation (Q1)

There are a range of issues in regard to the suitability of supported accommodation for particular groups of people these are outlined below. But firstly it is important to note at the outset that problems with availability and suitability of supported accommodation options mean that it is not uncommon for vulnerable people to rely on emergency/short term accommodation services such as Flagstaff and Ozanam House. Unfortunately discharge from hospital to emergency accommodation, rather than being the last option, is increasingly the only option for a number of mobile, difficult to manage and engage consumers. These environments are not conducive to recovery and stability, and often contribute to the vulnerability and distress of people with mental illness, and a ‘revolving door’ pattern of hospital admissions.

Issues which arise from Sharing Accommodation

The majority of supported accommodation options that are available require people to live in shared arrangements. The combination of limited availability of single units and the relatively high rental costs incurred is a key-contributing factor to this situation as is the general government planning policy of increasing high-density housing precincts within the general community. However, for many people, particularly single adults, sharing accommodation with others is not their preference. Shared accommodation for people with mental illness can be highly stressful and detrimental to emotional stability and wellbeing. There is an urgent need for an increase in the availability of single person housing stock and the development of supported accommodation models that ensure tenancy is both affordable and sustainable.

Issues for Older Adults with Mental Illness

Older Adults over 65 years of age are finding it increasingly difficult to maintain their accommodation in Supported Residential Services (SRS) due to the progressively more disturbed environments and their vulnerability to intimidation by more physically able younger adults. Older consumers of mental health services have utilised SRS for many years and often are too ‘able’ to meet Aged Care Assessment for aged care facility criteria but increasingly too frail to survive changing SRS environments. Other consumers might be unable to continue to reside at home but do not meet the financial criteria of non-profit community housing or the physical criteria of Aged Care Assessment for support services.

The recent legislative review of SRS is a timely one as the need for a targeted diversity of SRS accommodating people of differing ages and vulnerabilities is well overdue. (See Appendix Two for the NWMH Response to Victorian Government Review of the Regulation of Supported Residential Services).

Parents with Mental Illness

Parents with mental illness who have dependant children have particular accommodation and support needs and must be assisted to access and sustain stable, long-term housing. We urge that those with mental illness who have dependant children be considered to be a priority group, as we know unstable housing is a contributing factor to life stressors for the whole family, including children. Currently the funding requirements for ‘supported housing and accommodation programs’ dictate that the number of bedrooms must correlate with the number of rental
payments needed for a property (e.g. a 3 bedroom property requires 3 rental payments). This means that a single parent with dependants is excluded from accessing such housing, as their dependant children would not pay rent. There are currently only a few exceptions to this, such as women-specific PDRSS (WISHIN and Prahran Mission’s Mothers Support Program), which allow for single mothers and their children to access housing under the ‘Housing and Support Program’. Given that more than 20% of Australian children have a parent with a mental illness and approximately 10% of those families are single parent families, many of these families will need public housing. There is an urgent need to review Department of Housing guidelines and funding formulas in order to decrease the housing crisis and particularly the discrimination experienced by parents with a mental illness who live with or wish to have access to their children.

Issues for Young People with Mental Illness

ORYGEN Youth Health is a public mental health service for young people aged between 15 and 24 years, covering the catchment of the west and north-west regions of Melbourne. Within this catchment there are currently four refuges and four THM’s that ORYGEN Youth Health consumers can be referred to for housing and/or support. With the competing demands for housing services over the past 12 months the following sequelae have become evident.

1. Difficulty in accessing youth refuge beds due to lack of availability, resulting in consumers either:
   a) remaining in hospital longer;
   b) being discharged from hospital to inappropriate boarding houses;
   c) returning to/living with others who may be abusive or exploitative; or
   d) may “couch surf” with friends/extended family.

2. There have been instances where housing services have closed their books for months due to not being able to allocate workers, or consumers being on waiting lists for 6 to 8 months before supports can be allocated.

3. There are inadequate public housing options for single young people, therefore if a young person is in supported accommodation the exit points are limited which has a ripple on effect for others requiring supported accommodation.

4. In some cases mentally ill patients can be difficult to manage, therefore by default they are discriminated against. Housing agencies, both refuges and SAAP services are not provided with enough funding, support or training to manage difficult behaviours and due to these reasons, as well as needing to protect other clients, they may struggle to accept those with mental health issues.

5. Many families supporting their loved one with a mental illness need respite, however there are very few respite options available that suit the particular needs of young people. Subsequently the Inpatient Unit (IPU) becomes the only or consequent respite, often due to the young persons’ health deteriorating. A “Step-Up Step Down/PARCS” model specifically for young people would support families in order to both prevent hospitalisation and family breakdown.

Adequacy of care in supported accommodation (Q1)

There is a need for a co-ordinated blend of clinical (treatment and symptom management) and tenancies support (activities of daily living, social activities, conflict resolution between house members, house repairs and maintenance) so that stable housing can be ensured for people disabled by mental illness. Although there are elements of tenancy support that are intrinsically part of the work of a clinical mental health team, a significant amount of this work is best undertaken by non-clinical, community based organisations.
The only available supported accommodation option for many people with mental illness is a pension-only SRS. Generally these are people with complex needs, who are not able to live more independently, and who lack other supports. There is a concern that people are often placed in SRS accommodation because they would not be able to manage in a less supported environment, but that the SRS environment does not adequately meet the full range of their needs. It seems that the ‘special or personal care’ provided is limited to a bed, meals, and medication supervision, and little else. It is important to recognise that people living in pension-only SRS are in a vulnerable position because they have little money and often lack family and other supports. It is therefore important that the SRS is able to actively provide or link the residents into a range of other services that will meet the needs of the residents - such as health, mental health, dental, drug and alcohol services, social, recreational and other meaningful activities.

A system whereby specialist SRS were available, catering to the particular needs of a target client group - e.g. younger people with mental illness, older people with mental illness, dual disability, and women only - would lead to more successful care outcomes for residents and could also lead to workers in SRS developing specialised skills in working with the client group.

SRS accommodation services that are known to work well are those that are managed by a government support agency and collaborate with other disability specific services (e.g. local area mental health services) to better meet needs of individual consumers, as well as the overall management of the SRS. The NWMMH Response to the recent review of SRS Legislation in APPENDIX TWO outlines more issues covering availability, suitability and adequacy of care.

Access in terms of information, planning and decision making (Q2)

A number of electronic community accommodation directories exist however they are generally viewed by mental health workers as of limited use given their generality, and are often considerably out of date. A well maintained regionally based electronic supported accommodation directory for people with mental illness would be of assistance to those attempting to help people with mental illness to find appropriate accommodation. To be of real use this would need to be actively maintained perhaps by regional DHS offices.

It is not uncommon for consumers requiring supported accommodation to be on multiple waiting lists. This leads to fragmentation, inefficiency in service delivery, and significantly distorts the real levels of demand. On the other hand, the fact that long waiting lists exist means that many people in need of supported accommodation simply do not bother to register with agencies, which also distorts the real extent of demand.

NWMMH would also like to suggest that when new supported accommodation is being developed, mental health services (both clinical and non-clinical) are engaged early in the development phase to assist with planning and design. This aims to ensure that accommodation is designed to suit the needs of people with mental illness and also that adequate treatment and support services will be available. Subsequent to this, where new support services are involved, they must commence operation at the time of the accommodation opening and residents arriving.

Other approaches to supported accommodation funding, planning and delivery (Q3)

Ideally, a comprehensive range of supported accommodation options for people with mental illness would include:

- A variety of age and need specific ‘pension-only’ SRS type/hostel accommodation for those requiring ongoing provision of meals, cleaning and general practical assistance
- Group housing for those wishing to lived in shared housing
- Long term supported housing options, structured on a small scale cluster of units/houses with significant clinical and tenancy support in
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- Accommodation with lifestyle support only
- Accommodation with availability of increased or decreased levels of clinical support in accordance with changing consumer need
- 24 hour intensively (clinically) supported emergency accommodation for those in need of that level of support
- Age appropriate supported respite accommodation to provide relief for carers of people with mental illness
- Nomination rights to transitional housing properties (for both single and family occupancy) provided to clinical/PDRSS partnerships.

There should be increased partnerships between mental health services and SAAP services. We support the recent pilot that embeds a SAAP experienced worker within a community mental health service (including MHS having dedicated transitional housing property naming rights) and vice versa - having mental health professionals in-reach and collaborating with specialist homeless services. The Mental Health Housing Pathways Program, described below, is a good pilot example of the former, while the Homeless Outreach Psychiatric Service is a good example of the latter. Importantly both are only operating in selected parts of Melbourne. We support the development and expansion of programs such as these, which allow workers across systems to exchange knowledge and work closely together for the benefit of people who are homeless and have a mental illness. Comprehensive rollout of these two complementary models across metropolitan Melbourne would result in a much more integrated and effective approach to service delivery.

We support the maintenance and upgrading of the specialist-housing sector – SAAP – as they have expertise in understanding and accessing housing for people with a mental illness, however their workforce is poorly remunerated and their expertise under-recognised.

Six Recommended Examples of Effective and Suitable Models

1. Mental Health Pathways Housing Program (MHPHP)

One example of a SAAP funded MHPHP Pilot is the Neami Pathways Program operating in the cities of Darebin and Whittlesea. It is run by Neami Ltd (a psychosocial rehabilitation and support service) in close partnership with Northern Area Mental Health Service (AMHS). The program recognises that people entering a psychiatric inpatient unit are often facing issues of homelessness which could be best be addressed early in their admission to facilitate smoother, more timely discharge. It is also recognised that consumers benefit from follow up housing support after discharge, leading to reduced levels of housing instability as well as reduced rates of re-admission to the hospital setting.

For clients of the MHPHP ongoing housing support is provided along with either transitional housing or a period of brokerage funded temporary accommodation at a local motel. The housing support worker works closely with the client's mental health case manager to ensure that all workers involved with the consumer are aware of their goals around housing and what is being done to achieve them.

Three critical elements to Neami's Pathways Program and its success in comparison to other similar MHPHP's are:

1. Access to a number of transitional housing properties,
2. Access to brokerage funding and
3. Close joint management and support of the program between the PDRSS (Neami) and Clinical Services (Northern AMHS).

**Brokerage Funding**

The program has been allocated $20,000 per year for the three years that it is currently funded, for the program to use in a 'brokerage' capacity. Unlike money from the Housing Establishment Fund (HEF), commonly accessed by
people who are homeless, the MHPHP brokerage money can be used flexibly, and can exceed limits set by most housing services per person. Often the brokerage funding is used in a HEF-like way, to pay either rent in arrears or rent in advance. However it can also be used to contribute to a person’s rent for longer, so that they can be safely accommodated for a period of time in which they receive housing support from the MHPHP worker.

Dedicated Transitional Housing Properties
Prior to receiving funding for the MHPHP, Neami Ltd had nomination rights to a number of transitional housing properties managed by North East Housing. After securing the program, Neami allocated three two-bedroom properties as “Pathways Properties” and used these exclusively for MHPHP clients. In addition, the Northern Area Mental Health Service allocated the nomination rights of one of their two TH properties to the MHPHP, so in total the program has the capacity to provide support to seven people living in transitional housing. This housing is critical to being able to offer ongoing support to clients in their local area. The cities of Darebin and Whittlesea have very few crisis housing resources, and as such, inpatients facing discharge into homelessness in the past had to either move out of area to access crisis accommodation, or had to move into private rooming houses – a form of accommodation that is highly unstable and often unsafe.

Joint Management/Support of the Program
The two services involved have been able to build on a strong existing collaborative relationship and view - the worker, transitional housing properties and the acute inpatient consumer group vulnerable to homelessness - as shared resources and primary focus. The Pathways worker is employed by Neami but regarded as an associated staff member of the Acute Inpatient Unit and has strong support mechanisms within the clinical service with the inpatient social work staff and transitional housing portfolio holder. The Pathways worker also attends the area SW monthly meeting. Senior staff from both services oversee the project through a regular steering group meeting.

While this pilot has exceeded targets and expectations even within its first 18 months of operation it has no guarantee of ongoing funding beyond the 3-year pilot timeframe.

2. Intensive Homebased Outreach Program (IHOP)

The Intensive Homebased Outreach Program, based at Macauley a PDRSS situated in the Flemington/North Melbourne area, is a homelessness program that has transitional housing attached. This is a service that targets people who are both homeless and experience mental illness. Consumers are placed in transitional housing with intensive outreach support to work on dealing with the issues that are contributing to homelessness, and develop a plan for long-term housing. Support workers are skilled at working with people with mental illness, and work collaboratively with mental health services. This helps people who have been homeless for a long time to get ready for living in their own accommodation. The housing is managed by THMs (Housing Choices Australia, MetroWest and SASHS Western). The support is funded through the Mental Health Branch. Consumers have moved from this program into their own Office of Housing properties (Early Housing applications), as well as moving to private rental accommodation and returning to live with their families.

3. Wintringham

Wintringham is a not for profit organisation that provides a range of accommodation and support to elderly homeless men and women. Wintringham has three hostels and one nursing home. While people wishing to access these services require a Commonwealth Aged Care Assessment, this is done with the understanding that homeless people tend to experience aging related problems earlier than the non-homeless population and therefore a more flexible approach to age criteria is required. Wintringham also provides community care services. The Wintringham model of targeting services at a particular group of people - the elderly homeless - is an example of good consumer need focussed service provision, because they provide a style of supported accommodation, dignity of residence and quality of life that meets the needs of this often overlooked client group.
4. Janoak SRS – Government funded/PDRSS operated

The only government-funded Supported Residential Service (SRS) for people with a mental illness in Victoria is auspiced by Macauley, a Psychiatric Disability Rehabilitation & Support Service. There are 11 residents, who can stay as long as they want. The service has strong links to the Area Mental Health Service as well as other support services for people with mental illness and disability. This model provides a quality of care and dignity that often private/for profit SRS’s cannot attain, as well as having the advantage of a level of oversight of resident rights by the auspicing organisation and its close clinical partner service. The PDRSS sector is in a good position to develop and run age-specific SRS’s. This development is perceived as a very high priority by NWMH.

5. ‘69 Queens Rd’ – Mixed SRS level-Rooming House Plus Model

The establishment of ‘69 Queens Rd’ required collaboration between CHL, Sacred Heart Mission (SHM) and the Office of Housing (OoH) in order to create a safe community. The 64 tenants are adults of a mixed age profile from 18 years through to 65 and over who require long term affordable housing and are experiencing financial and social disadvantage. About half the tenants will have a range of physical/medical, psychological, social and emotional needs and/or disabilities. Each resident occupies a one-bedroom apartment with ensuite and kitchen of around 45 sq. meters. At the same time there are shared facilities so tenants can decide whether they want to live privately enjoy a more communal group living situation.

The service model is a Rooming House Plus Project (RHPP) and provides a sustainable mix of support to tenants. A feature of this service model is the separation of tenancy management (provided by CHL) from the management of support (provided by Sacred Heart Mission). Both CHL and SHM staff are present 7 days per week, 24 hours per day. CHL provides accommodation, three meals per day, cleaning of apartments and communal areas, laundry, and utility services to the 29 supported tenants. Supported residents are offered this service at a rent, which is 65% of their disability pensions plus the level of Rental Assistance they are entitled to. This means that most of their living needs are met whilst they retain 35% of their pension as disposable income. The 35 general tenants are provided with accommodation, cleaning of the communal areas only, and utilities. These tenants may also arrange for the meals service at an additional fee. These residents have a rent set at 25% of their income up to a maximum level plus the Rent Assistance they are entitled to if on the pension.

While this mix and density of housing does not suit all it provides an important and flexible long-term accommodation option especially for those with declining or changing independent living skills without the need to be dislocated from their home and neighbourhood supports.

6. HomeGround Services

HomeGround is a non-government organisation that receives various sources of DHS (including PDRSS) funding. It has an outreach service that operates within the City of Yarra to provide long-term care management and support to people with complex needs to have a history of or are currently homeless. The service operates on the belief that there are people who are significantly and chronically disabled and who have great difficulty maintaining basic standards of living and health. This group are often also isolated from family, friends and other healthy social relationships and require ongoing support from workers in order to have positive and trusted contact with others. It is these key relationships that that assist people to meet hopes around housing, health, recreation and other aspirations.

Homeground Services acknowledges that people can gain strength from relationships that are ongoing and constant, whether this is with a primary worker who can maintain a therapeutic relationship or an ongoing central

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2 More information about the Mission's work is available on their website (in references).
service provider. Appropriate housing placements sit alongside appropriate ongoing support as a predictor of a person’s success in breaking away from the experience of homelessness.

The Need to Review Transitional & Permanent Housing Guidelines & the Relationship between Mental Health & Drugs Division and the Office of Housing

Access to Transitional Housing properties is a vitally important mechanism through which mental health services and housing services can move consumers from inappropriate unstable accommodation or homelessness into independent living via a period of transitional support and establishment. Given the current lack of housing stock, what was originally conceived as a two to three month transition period has now blown out to two to three years. As a result Transitional Housing is more appropriately regarded at present as medium-term housing.

A major dilemma arises where consumers are supported by workers to establish their independent living, make connections with local community supports to maintain their accommodation and social inclusion in an temporary location without clear expectations re timelines. The requirement of Transitional Housing is that an exit plan is established early and that when an offer of permanent Office of Housing property is made, the consumer, with rare exception, is expected to shift location. In reality this means consumers uprooting themselves, disconnecting once again from supports and having to re-establish themselves in a new community leaving them vulnerable to deterioration in their mental health and social situation. This unnecessary dislocation and re-establishment is purely as a result of the lack of housing.

It appears that the normal rules and procedures in relation to the designation of properties as ‘transitional’ requires review. NWMH would argue that it is timely to explore the potential for transitional properties to be reclassified as permanent, if a case can be made for the consumers need for stability if a transition has not occurred within a six-month period. In parallel, permanent housing that becomes vacant should be reclassified as a transitional property to maintain balance between the two categories. This would require negotiation between the Department of Housing, Mental Health and Drugs Division, SAAP, Commonwealth and State funding allocators.

The current lack of a consistent, coordinated and collaborative approach between Mental Health and Drugs Division and the Office of Housing at the State and Regional levels and fragmentation of service systems and funding models across Commonwealth and State, contribute to the difficulty of responsively adapting these complex systems as changing social and economic circumstances occur.

Implications for those who cannot get supported accommodation – adequacy of alternatives (Q4) and Views on private, government and community sector managed supported accommodation (Q5)

The lack of housing options within the community has led to the disturbing development of private entrepreneurs filling the gap with unregistered, informal “boarding/rooming houses”. These individuals describe themselves as “accommodation services” and sub lease rooms in rental properties. In Melbourne, especially in the North and West area, there are a number of “providers” of private boarding/rooming house accommodation that have been operating for a number of years periodically changing names. They promote themselves directly but with only a phone contact point and no identified office. These should not be confused with Community (Not-for-Profit) Rooming Houses (See APPENDIX THREE).

An article in The Age by Oakes and Silkstone (2006) describes a “complex network of up to 150 boarding houses run by a shadowy group of Melbourne businessmen” (Please see the full article in APPENDIX FOUR). The article goes on to state that at least two of the four men believed to run the business have criminal convictions including fraud
and operating illegal brothels. Resident’s of these properties pay up to $170 per week for a room in the sublet property, a cost which is often covered, at least for a couple of weeks, by the government’s Housing Establishment Fund.

In the experience of many NWMH workers, people living in these properties are routinely denied their legal rights under the Residential Tenancies Act 1997 or are not afforded the protection of tenancy law if the property in which they live does not include more than 5 residents. They have been subject to such transgressions as illegal evictions, poor or no property maintenance, illegal rent increases or furniture deposits, no chance to sign a lease and having to live in rooms not originally deemed as bedrooms, such as living rooms and run down outer buildings.

Workers also report that their consumers have experienced assault, intimidation and stand over tactics by rent collectors, co-tenants, and frequently having money and belongings stolen from their rooms, which more often than not have no security.

With the lack of affordable housing, both supported and unsupported in Melbourne, an increasing number of people are forced into these types of private boarding houses. These people are generally among the most disempowered and marginal people in Melbourne, including people experiencing mental illness, substance dependence issues, chronic unemployment and ongoing homelessness.

NWMH believes that the private boarding/rooming house providers take advantage of this fact in two major ways. First of all, they are profiting enormously from the lack of supported accommodation and homelessness services and receive millions of dollars per year through the government’s Housing Establishment Fund. Secondly, they are taking advantage of their residents’ marginal status to avoid any obligations as landlords by restricting their operations to those not covered under the Residential Tenancies Act 1997 or local council by-laws. They appear to rely on the fact that when residents are evicted without notice for example, or forced to leave following an assault, that the person is more preoccupied with their distress and where they will sleep that night, than with asserting their rights under the Act.

These operators have been growing in number for some years, and their presence is far reaching. With the chronic shortage of affordable independent living, rental properties and supported accommodation, consumers and staff supporting them often have no alternative but to utilise this most unsatisfactory accommodation option.

**Positives and negatives for families & carers of current approach to supported accommodation (Q6)**

As an organisation committed to the needs of consumer and carers, we would be remiss not to acknowledge that housing and in particular housing insecurity is a leading cause of concern and/or distress consumers and carers. This is illustrated by the Mental Illness Fellowship National Survey, which showed that 66% of consumers and carers rates housing as their leading issue (MIF, 2008).

It is the understanding of NWMH clinicians, that in general the expectations of families do not match the availability, range and standard of supported accommodation options. Carers/families are concerned about location and physical quality of the housing, financial cost, and security of tenure of the options being considered for their family member. Furthermore, the availability of ongoing clinical treatment and support, practical assistance, monitoring and supervision of wellbeing and involvement in social, recreational, educational and/or vocational activities are also very important concerns for families. When a person with mental illness is able to access good quality accommodation with appropriate and flexible levels of support most families/carers are both extremely relieved and satisfied. As emphasised previously, much more affordable housing stock, with the availability of well coordinated and integrated support service, distributed equitably across all geographical areas would be a most welcome improvement for consumers, their families and the mental health service system in general.
We would also like to recommend that the inquiry should actively consult with The Carers Network Victoria, which is the peak body representing families caring for persons with mental illness.

Other issues (Q8)

Development of Step-Up Step-Down Units and PARC Services

Earlier in this response under the heading 'An important note on definitions' we described Community Care Units, Secure Extended Care Units, PARCS, and residential rehabilitation units as more appropriately being regarded as treatment and rehabilitation programs in bed-based/residential settings rather than 'supported accommodation'.

Prior to the DHS commitment to Prevention and Recovery Care Services (PARCS) a step-down unit precursor was established within the Inner West Area Mental Health Service originally funded under the acute health HARP initiative. This service, Arion, jointly run by clinical services and the local PDSSS, has proven to be an important initiative in preventing blockage of acute psychiatric unit beds through availability of a period of subacute care prior to discharge to independent living or the securing of appropriate housing. It both increases throughput and prevents homelessness of consumers by supporting their ability to maintain accommodation through the course of their illness. (Step-Down Function). This facility also provides limited occasional access for consumers of the Mobile Support and Treatment Team and Continuing Care Teams to access short-term respite with the aim of maintaining their normal accommodation and avoiding an inpatient stay during a period of deteriorating mental state (Step-Up Function).

The Arion Model fulfills two key functions: One stream of higher throughput where the consumer’s stay is limited to four weeks, and a slow stream allowing some consumers to stay up to six months. As future PARCS will be expected to implement a maximum stay of 28 days, given the housing crisis and lack of housing stock cited throughout this response, there is concern that the PARCS will not be a viable treatment and support option for those consumers who do not have an established accommodation arrangement. Arguably there is a need for more flexibility regarding length of stay in order to adequately respond to individual circumstances, local need and changing social and economic phenomena.

Concluding Summary

NWMH welcomes the renewed discussion that this inquiry will generate. This document describes a range of views and feedback regarding issues in supported accommodation for people with a mental illness. NWMH is keen to participate in the review and in the subsequent implementation of changes to achieve improved outcomes for people with mental illness and their families.
NorthWestern Mental Health Response
Inquiry into Supported Accommodation for Victorians with a Disability or Mental Illness

References


www.sacredheartmission.org/

Mental health policy reform and its problems in the UK: deja vu.

APPENDIX ONE

Excerpts from “Redressing the Homelessness in the North West Communities of Melbourne”
AUGUST 2008
Ministerial Briefing Paper

Why is NorthWestern Mental Health acting on homelessness?

NorthWestern Mental Health (NWMH) is well aware of the short and long-term impact of homelessness on the mentally ill and the impact of mental illness on the homeless. Homelessness has become a priority issue for us as we can not stand idle knowing that our internal audit processes reveal that up to 85% of our adults consumers are homeless or at chronic risk of homelessness. The episodic nature of mental illness jeopardises the housing security of many consumers as illustrated by the number of consumers who lose their homes once admitted to our acute inpatient units (Zhang, 2006).

The displacement of consumers from their inner suburban community to the outer, cheaper suburbs of Melbourne has been occurring for a number of years. However, with increasing private rental prices and an ever-growing public housing waiting list, homelessness in these outer suburbs has augmented dramatically. Whilst the impact on the health care system is considerable, it is a tragedy for the individual consumer who in addition to the stigma of mental illness will experience the social exclusion generated by homelessness. “When people experience episodic mental illness, their ability to live independently and maintain housing can fluctuate. They risk falling behind in rent or mortgage payments because of employment difficulties, higher medical costs, hospital admissions and social isolation.” (Commonwealth Government, 2008).

The implications for the health systems are extensive with increasingly acute inpatient unit staff and case managers reporting extreme difficulty in placing consumers in accommodation that is affordable and able to meet their support needs. The lack of crisis accommodation results in expensive acute inpatient beds being occupied by consumers whose mental health needs have been addressed but have no where to live. This perpetuates a cycle of frequent readmissions. Moreover, the co-morbidity of mental health issues with the other health effects of homelessness which include poor dental health, eye problems, podiatry issues, infectious diseases, sexually transmitted diseases, pneumonia, lack of preventative and routine health care, and inappropriate use of medication serve to ensure that homeless people are also greater users of hospital emergency services.

North and West Metro Melbourne – the hard facts

- In 2006 the population was 961,855 people (2006). Applying the findings of a local study on Homelessness in Melbourne, there were 4510 homeless of which 85% experience a mental illness (Council to Homeless Persons, 2005). Therefore 3834 experience either the perpetuating or maintaining factor of mental illness.
As the population is expected to grow to 1,045,406 in 2011, 5954 individuals will be homeless with 506 of them experiencing a mental illness.

- The Commonwealth’s green paper, 2008 states that 10% of all homeless persons are children. If this is applied to the above figures then it is reasonable to expect that somewhere between 384 and 506 children are homeless.

- 41.1% (14,548 people) of Victoria’s demand for public housing (35,394) sits in the NWMH catchment. As an example:
  - North West Area Mental Health Service (NWAMHS), has 2972 Broadmeadows waiting for public housing; not including 1618 homeless people (excludes Caravan PK)
  - Private rental supply has declined by 26% in three months (Sept-Dec 07) in NWAMHS catchment, while the cost of rent has increased by 32.2% in past two years
  - Moreland-Hume Housing Network 1121 people for housing support in their first month of operations of which 53 were assessed. There are 415 places Crisis, Transitional & Supported Accommodation (NW): 122 Hume (59.5% growth HL) 293 Moreland Jan 08, all of which are full.

Cost to our community

- Applying the number of homelessness in the NWMH catchment 5954, the cost to the service systems is calculated to be $17,213,000 (Sacred Heart Mission, 2007).

- Homeless mentally ill people occupy acute mental health beds 3 times longer than individuals who have secure housing. The cost in December 2007 for Broadmeadows Inpatient Unit (NWAMHS) was $84,288. The result on an annual basis is $1,011,463. Multiple this by 4 inpatient units the cost = $34,045,852
APPENDIX TWO

NorthWestern Mental Health

Response to the Victorian Government Review of the
Regulation of Supported Residential Services in Victoria

AUGUST 2008

This response has been developed by NorthWestern Mental Health. It includes initial general comments, a summary of proposals for changes to the legislation, and a response to some of the 20 questions proposed in the Review. Many of these responses provide background and context to the proposals.

NorthWestern Mental Health is one of the largest publicly funded providers of mental health services in Australia. It operates in partnership with Northern Health (Northern Hospital, Broadmeadows Health Service, Bundoora Extended Care and Craigieburn Health Service) and Western Health (Sunshine and Western Hospitals). NWMH provides comprehensive hospital-based, community and specialist services to youth, adults and aged people across northern and western Melbourne.

This response has been developed for NWMH by social workers across the organisation, who are ideally positioned to comment on the various issues related to the SRS sector and the questions posed in the SRS review.

Whilst we have a general interest in the SRS sector as a whole, for the purposes of this response our particular focus is on those persons with serious mental illness, complex psychosocial disabilities, limited financial means and minimal social support, for whom pension-only SRS is the only option for community living. In general, these persons comprise the population described in the review document – “…the pension-level sector was younger (over 40 per cent aged less than 60 years) and male (nearly 60 per cent of residents were male), with 45 per cent experiencing a psychiatric disability. Across this sector, 30 per cent reported having no contact with family or friends.” (P.8)

The significant reform of mental health services in Victoria over the last 15 years has resulted in most persons with mental illness receiving their treatment, rehabilitation and support in the community. It is therefore imperative that high quality, affordable and appropriate accommodation options are available, and that accommodation services providers/staff are both prepared and equipped to deal with the nature and complexity of persons with mental illness who require accommodation in SRS. In the absence of accommodation services specifically tailored to meet the needs of this client group, improving the viability and sustainability of the pension-level SRS sector must be an urgent priority to ensure the continued availability of stable and affordable accommodation for these vulnerable and needy members of our community. NWMH endorses The Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) initiative, as a strategy to bring increased attention and resource allocation to the supported accommodation needs of persons with mental illness.

A consequent issue we wish to highlight in response to the consultation paper is that as the Pension-only SRS population is generally vulnerable, they have a limited capacity to advocate for themselves; therefore in this process of review they may be largely silent. Carers and families often have a limited involvement and may also be largely unheard in this process. NWMH as well as other clinical mental health services may advocate on their behalf. NWMH feels that this point needs to be taken into consideration in the process of consultation and the weight given to the responses from specific groups.
GENERAL COMMENTS

- There are very few housing options for people who are on a pension and who do not have the ability to live independently, within a broader context of a housing affordability crisis.
- It is of considerable concern that the number of pension-only SRS is decreasing in relation to other types of SRS.
- It is important to acknowledge that pension-only and non-pension-only SRS’s are different sectors, and this needs to be reflected in legislative changes.
- There is a perceived potential conflict of interest in DHS dealing with complaints about SRS. The lack of appropriate accommodation options complicates the complaint process and response, for example DHS is seen in the broad health and welfare sector to be compromised in addressing complaints if it means a decrease in housing stock and options. We will elaborate on this issue in the body of the document.
- The geographical distribution of pension-only SRS is of concern. As they are private services, there is no overall planning about where they should be located. SRS are often far away from other supports or require people to have to move away from familiar locations to be able to access them.
- It seems that pension-only SRS are providing a service to a very vulnerable group of people, for whom poverty, social isolation, family disconnection, mental health, drug and alcohol, brain injury etc are often relevant. It is important that these people be provided with good quality accommodation and support that meets their complex needs. The current staffing ratios are universally acknowledged as grossly inadequate given the increasing acuity and complexity of resident populations.
- There are significant problems of access and discrimination in the SRS sector. People with complex needs - for example mental illness, drug and alcohol issues dual disability, chronic and disabling physical health conditions, acquired brain injury and challenging behaviour - find it difficult to access SRS because the services are privately run and are not necessarily able to meet the needs of these clients. Factors contributing to discrimination include fear and negative attitudes of proprietors of facilities, and staff not being adequately trained to deal with the issues presented by these clients. The corporatisation of the SRS sector is likely to make it harder for clients with complex needs to access SRS accommodation.

SUMMARY OF PROPOSALS:

- Deal with pension-only SRS as its own sector separate from other SRS.
- Legislate for and fund specialised pension-only SRS that are age and need specific, which are regulated to meet the specialised needs of the client group. We recommend that serious consideration be given to developing a model comprising a combination of the features offered in an SRS and those offered in a group home for young people.
- Given the significant vulnerabilities of SRS residents with complex mental health issues they should be no less entitled to conditions mandated in the Disability Sector (eg Yooralla, Scope, Villa Maria) that require each individual to have their own bedroom. This would provide a number of benefits in normalising their quality of life and minimising the often over stimulating and anxiety provoking environment of a shared room. This would reduce the impact of shared residency on their mental health, prevent relapses, increase interpersonal safety and mediate behavioural-relational difficulties.
- When reviewing SRS establishments community visitors and DHS monitoring staff should be required to consult with residents’ external care providers, for example, mental health services.
• Consideration should be given to using an ombudsman so that the complaints process is separated from DHS. More housing options are essential if the complaints process is to be effective and equitable. Again this point is described further in the body of this response.

• Increase the levels of staffing and staff ratios.

• Increase the requirements for all staff to be trained in relation to a range of practices and remunerated to reflect this. It is hoped that this would lead to an improvement in recruitment and would enhance the quality of care provided.

• Develop an option for pension-only SRS to be designated as able to offer short-term respite/transitional places, supported by external community agencies eg mental health, which would add support but also monitor care. Concurrently this would assist with increasing quality of care, service improvement and developing partnership with other agencies. It would also provide a housing option for people experiencing an episode of mental illness, or recovering from an episode, who would then be able to work toward longer term more independent housing options while staying at the SRS. Appropriate DHS funding would be required to resource this development.

• If there were more government funded SRS modelled on supported accommodation services such as Janoak SRS (auspiced by a Macauley PDRS for people with SMI), Winteringham (older homeless people), Bethlehem Community and Regina Coeli (women with alcohol related and psychiatric disabilities) - people’s rights would be better protected and their specific needs met more appropriately. This would decrease inappropriate placements and decrease homelessness.

• Address current lack of compliance with regulations.

• There should be legislation providing for a level of security of tenure for SRS residents, that is for example commensurate with the security of tenure that people living in Rooming Houses have. This should include a breaching process before people can be evicted and the involvement of VCAT, with a right of appeal.

SPECIFIC RESPONSES TO REVIEW QUESTIONS

1 & 2. Are there other ways residents could be effectively protected? Please explain.

There is a concern that the current minimum standards for SRS are not being met, and NWMH staff are not confident that current levels of monitoring by the Department of Human Services is sufficient. There is an anecdotal view that the shrinking of the pension-level SRS sector means that residents have fewer choices, and that quality of accommodation and care is diminishing as a result.

NWMH case managers have raised concerns with their managers upon visiting their clients at respective SRS accommodation. Their concerns are best summarised as follows:

• Levels of heating in buildings (too low in winter and too high in summer)
• SRS staff treatment of clients – one staff member related a story in which a client with Huntington’s disease was treated impatiently and ‘told off’ by staff for having difficulty with mobility
• Mistreatment of residents by other residents – and when this was reported to SRS staff, staff denying that there was a problem and refusing to deal with the situation
• SRS staff persistently requesting CATT intervention for a resident with a psychiatric illness who was actually in distress related to a urinary tract infection.

One case manager reported calling DHS and attempting to make a complaint about an SRS, and then feeling as though she was being strongly discouraged to do so by the DHS worker. Other case
managers reported being reluctant to make complaints because of fear that their client would lose
their accommodation and end up in an even worse accommodation situation.

In the course of this review consultation, a community visitor has expressed the opinion that SRS
accommodation should be for frail elderly people only, and that people with mental health issues
should not be offered this type of accommodation. This raised concerns about the level of
qualification of community visitors to monitor SRS, especially in relation to their understanding of the
needs of people with mental illness, and their ability to advocate for this vulnerable group of people.

NWMH staff also had serious concerns about SRS staff and community visitor qualifications, and their
level of understanding of the various issues that SRS residents have, especially mental health and
complex physical health conditions. It was also thought that employment conditions for SRS staff such
as pay and staff-resident ratios would be such that highly qualified workers would not be attracted to
this industry.

NWMH recommends that the day-to-day manager responsible for the running of the SRS should be
required to gain registration as well as owner of the SRS. If on-site management is required to meet
certain standards of service delivery, it is more likely that residents will achieve optimal service from
all staff members operating under that manager.

Until we can be confident that current standards are properly enforced, it is difficult to gauge
whether these minimum standards as legislated are sufficient protection for residents.

4. Are there any problems with the current definition of SRS? If yes what are they?

Current SRS definition
Premises where accommodation and special or personal care are provided or offered for persons
(other than members of the family of the proprietor of the premises) for fee or reward...' with 'special
or personal care' spanning a range of activities related to assistance with daily living'.

When attempting to place clients in SRS accommodation, a significant amount of research is required
of the worker to determine whether the style of SRS meets the support needs of the client. This is due
to the extreme variation in the type of services and support, as well as conditions offered to
residents.

The definition of SRS is clearly too broad, lending to confusion for workers and residents and resultant
lack of standards to meet resident specific support needs.
We propose a clear distinction be made between pension-only and non-pension SRS as, in practice,
these are obviously separate sectors and legislation should reflect this.

We further suggest that SRS be categorised according to client needs or disabilities so that
accommodation services can then be targeted to specifically meet support needs. For example, an
SRS that specifically houses youth with mental health issues.
We believe this would lead to more successful care outcomes for residents and could also lead to
workers in SRS developing specialised skills in working with the client group.

Additionally, supported accommodation services that we have observed to be currently working well
are those that are managed by a government support agency and collaborate with other disability
specific services (e.g. local area mental health services) to better meet needs of individual clients as
well as the overall management of the SRS.

5. Are there any accommodation options that should be excluded from SRS
regulation? Why?
Accommodation facilities that are regulated as SRS but should be excluded are those that provide poor standards of care and conditions and appear to be managed for the purpose of profit rather than supporting the needs of residents.

In our experience, there are several facilities that offer very similar shelter to rooming houses with basic meals and staffing and are regulated as SRS. It is our impression that some facilities have obtained classification as SRS so they can make higher profit through charging residents money for standards that are no greater than an average rooming house.

We would question the intentions and character of some proprietors and believe that there should be some legislative requirements for screening individuals throughout the application process. In addition to this, every facility should be visited to ensure regulatory standards are met.

6. Do you think that current arrangements for providing information to residents work? If you believe there are gaps, how might these be addressed?

Residents need to receive a residential statement but many would need to be “talked” through it – there needs to be an obligation to present verbally and provide interpreters if necessary- the information also needs to be given to carers and families as appropriate.

7. Do you think that current arrangements for residents to provide feedback or make complaints work? If you believe there are gaps, how might these be addressed?

A number of NWMH case managers reported that they felt they would have put in complaints about the living conditions of their clients at SRS but they did not do so either out of fear that their client would lose their accommodation, or because they did not know the complaints procedure.

Overall, NWMH case managers did not feel that the complaints system was effective. Possible reasons for this include:

- The overwhelming shortage of pension-level SRS means that clients have very little choice about where they live
- The lack of both market competition and enforcement of government regulations makes it possible for SRS proprietors to provide lower quality service and accommodation
- The current system of DHS being responsible for investigating complaints into accommodation presents a conflict of interest, given the level of dependency by DHS on SRS proprietors to keep their services operating. Where there is a lack of alternate accommodation, there may be a resultant lack of motivation to take and investigate complaints.

Recommendations for this include:

- Greater resourcing for the Pension-level SRS sector, to ensure an increased supply of SRS accommodation to meet the needs of people requiring support with daily living
- The establishment of an avenue to make complaints that is, as far as possible, independent of the Department of Human Services, as noted already potentially an industry ombudsman.

9. Do you think that the current arrangements for protecting residents' finances work? If you believe there are gaps, how might these be addressed?

There is concern that residents who do not have a financial administrator, and who have poor financial management skills, are vulnerable to financial abuse by proprietors of SRS. There should be more accountability when it comes to looking after resident’s money by staff at SRS. Administration Orders work for those consumers operating under them. Where orders are not in place, there should be mandatory audits of consumer finances for the use of their funds. Further the cost of bed retention in the event of a relapse requiring hospitalisation needs to be addressed.
10. Do you think that current SRS laws regarding standards of accommodation work? If you believe there are gaps, how might these be addressed?

The laws about standards seem not to be working, as the quality of accommodation can be very poor. For example, some environments are not heated and/or are unsafe for residents. The monitoring and enforcement of SRS standards needs urgent prioritisation. Further, there need to be more options for accommodation, so that people can choose environments that suit them, rather than having to take the only place that is available.

The building poverty of pension-only SRS’s can have a marked impact on visitors/others. This is bound to have an impact on how the residents see themselves and how others regard them as members of the community - i.e. not worthy of an attractive place to live and therefore further stigmatised. A significant number of SRS are located in aging buildings, previously large family homes that are now converted without large modifications into accommodation for many singles. Living/recreational and dining areas are not necessarily size appropriate for the number of residents. Maintenance is often an ongoing issue as buildings are given ‘bandaid’ treatment.

Gaps also extend to proprietor/landlords not seemingly being compelled to spend money on maintenance/decorating or landscaping beyond what meets health and safety standards. The concept of ‘homelike’ environment as per the Health Services Act is too easy to be interpreted as being one of a very basic standard.

The nature of private sector management of SRS’s (and the disabled resident group) seems unfortunately to mean that there is little pride taken in the appearance of these establishments. This is unlike the great majority of aged/other disability specific facilities, which are managed through church or other public services where the sense of public duty to provide comfortable, safe, and pleasant environments is stronger.

An idea to help raise the quality of life and public profile of the SRS sector is to examine the opportunities within TAFE training courses to support those undertaking apprenticeships in landscape/building and design to address these issues in a practical and sustainable way that engages and includes residents. It needs to be considered that a significant number of SRS residents spend large portions of their day at the facility and need environments that they can engage with in multiple and stimulating ways.

11. Do you think the current laws relating to SRS regarding occupancy effectively balance the rights of individual residents with those of other residents, staff and proprietors? If you believe there are gaps, how might these be addressed?

Within the “laws” SRS have the ability to evict consumers with little dialogue with clinical services-there needs to be some mandated level of communication between SRS/clinical services to ensure collaboration and forward planning prior to the event. For a person living in private rental, under law, a landlord must give 120 days notice if they want the tenant to leave for no particular reason. If the landlord is selling the property, or wants to occupy the property themselves, then they must provide 60 days notice. The same laws apply to residents of roaming houses.

The reason given for residents of SRS having little security of tenure is that due to problematic behaviours, it may at times be necessary for the safety of other residents and staff, for a resident to be required to leave on very short notice. Rooming house residents, who often display difficult behaviours, which pose dangers to staff and other residents, have rights when it comes to being evicted for these behaviours. They receive two breach notices, which bring with them the chance to remedy the behaviour, followed by a notice to vacate of not less than 14 days if they fail to remedy the breach. Finally, the landlord must apply to VCAT for a possession notice to actually have the person evicted.
Given that a person living in an SRS is likely to either have a significant disability or to be a frail elderly person, it is highly inequitable that they should be expected to find themselves alternative accommodation in less than half the time of a private renter.

Residents of SRS must have equitable security of tenure. The SRS is their home, and in most cases residents have nowhere else to go. Therefore, it is highly inappropriate for an owner to decide, alone and with no minimum guidelines, whether residents can stay or go. This is an unacceptable amount of power for the owner to have.

SRS residents must have recourse to have their situation heard at VCAT, and there must be legislation, which states the minimum amount of notice that must be given to vacate, and which sets out the requirement for breaches to be given for behaviour, which is unacceptable.
12. Are the current standards for 'special or personal care' still suitable as a minimum for all SRS? Why?

Residents of pension-only SRS seem to generally be people with complex needs, who are not able to live more independently, and who lack other supports. There is a concern that people are often placed in SRS accommodation because they would not be able to manage in a less supported environment, but that the SRS environment does not adequately meet the full range of their needs. It seems that the 'special or personal care' provided is bed, meals, and medication supervision, and little else. It is important to recognise that people living in pension-only SRS are in a vulnerable position because they have little money and often lack family and other supports. It is important that the SRS be able to actively provide or link the residents in to a range of other services that will meet the needs of the residents, such as health, mental health, drug and alcohol, social and recreational and meaningful activity.

14. Do you think the current approach to care planning works? If you believe there are gaps, how might these be addressed?

The current approach to care planning appears to focus on a narrow definition of care to include residents basic primary needs only. We believe that this current definition and associated practices are highly neglectful for residents who require placement in a supported environment. The definition of care should extend to a more holistic definition that includes specific support needs and health and welfare requirements. Care plans are often not easy to access and reported to be rarely used by the SRS in an ongoing way.

Care requirements could be more holistically identified and incorporated into care plans if done in collaboration with resident, carers and other support services. A clearly mandated communication process between all participants needs to be established. Care plans should be updated regularly, serve a clear function which is useful to the resident and the SRS staff, incorporate processes of accountability in relation to holistic care, accessible to residents, carers and supports, and offer an empowering process for the resident. They should not simply be a legislative requirement.

15. Are the staffing requirements suitable as a minimum for all SRS? Why?

Current regulations “must ensure that during the day, there is at least one special or personal care staff member... for every 30 or fraction of 30 residents”.

From experience in supporting clients in SRS facilities, it appears that a heavily contributing factor to the below standard level of care provided to residents, is inadequate staffing. Many staff lack the specialised skills required to meet the support needs of the residents and with so few staff, only basic needs can be attended to. Clients who require SRS accommodation usually have complex care needs requiring specialised interventions and intensive support that require much higher staffing levels than those currently provided.

If SRS were disability or needs specific, staff could become specialised in attending to specific support needs. Staff should have more training, which needs to be funded. More holistic care, that is not just meeting basic primary needs, requires significantly increased staff ratios. In addition, staff in SRS require better wage and employment conditions in order to recruit and retain higher quality staff.

16. Could the department improve the way it assesses the suitability of SRS proprietors? If yes, how?

As there are so few accommodation options for people on pensions who are not able to live independently, it seems that the department is dependent on current proprietors of SRS continuing to run their services. There needs to be more accommodation options for this vulnerable group of
people, so residents have choices about where they go and the department is able to raise the
standards regarding suitability of proprietors. SRS proprietors should be rigorously and regularly
assessed for their suitability.

17. **Where proprietors are not involved in the day-to-day operation of the SRS, should
the person who has day-to-day responsibility for running the SRS also be assessed?**

The person involved in the day-to-day operation of the SRS should be assessed as to their suitability,
and there should be regulations in place to ensure the suitability of all people working at SRS.

18. **Could the department improve the way it assesses the suitability of premises for
registration? If yes, how?**

The term ‘homelike’ to describe the appearance of facilities needs to be extended to an expectation
that facilities ‘blend in with the other housing in the environment and meet the general public’s
expectations of an attractive place to live’.

It is unfortunate that the pressure to increase much needed affordable housing means that corners
are likely to be cut and a lesser standard seems to be accepted for and by this group and their carers.

While the Community Visitors Program (Health Services) could be considered to provide additional
input to the assessment of premises, recommendations made by them to be would need to be
followed up by DHS as part of the prerequisites for registration.

20. **Are there other issues that you believe should be considered as part of this
review? Are there any additional comments you would like to make about regulation
of SRS?**

**Housing shortage**

In the last few years there has been an extremely concerning dearth of accommodation for
consumers with psychiatric issues. This situation is leading to a growing phenomenon of exploitative
private entrepreneurs setting up unregistered ‘rooming houses’ where tenancy rights are never
observed. In this current climate tenants are forced into high cost, overcrowded, sub standard
accommodation placing them at risk - physically, emotionally and financially.

This broader housing situation, and the general lack of all types of accommodation options for people
on low incomes has a direct impact on SRS residents, as does the fact that the number of pension-
level SRS is quickly diminishing. This lack of other options means that all the power is in the hands of
the owners of the SRS, and very little power is in the hands of the residents. This power imbalance is
compounded by the fact that residents have virtually no security of tenure.

The failure of the complaints system - that is, reluctance for complaints to be made, and reluctance
for complaints to be taken – seems to have a connection to the shortage of SRS accommodation and
other accommodation for this client group.

The government – both state and federal – must put resources into housing, and work to create
more low income housing options – including pension-level SRS. In this way, people on low incomes
will have more choice, and some of the power will be given back to the consumer, and not rest
entirely with the provider.

**Cost of SRS**

NWMMH staff believe that the cost of pension-level SRS is too high. In many cases the resident is left
with only a token amount of money after paying rent/board costs. This has a direct impact on the
resident’s quality of life and diminishes their ability to participate within the community. Also, the
cost of a shared room compared with the cost of a private room means that many people are forced
to share when this is clearly not their preference, and at times, is likely to lead to a breakdown in their accommodation.

We recommend that the government encourages the operation of not-for-profit SRS, and also that a maximum cost (perhaps in terms of percentage of the resident's income as is the case in aged hostel accommodation) is enshrined in the legislation. The resident should also be provided with clear information that states what they are getting for their money.

Specialised SRS accommodation
Often younger people with serious psychiatric illness/disability or other disabilities live side by side in SRS with frail elderly people. These groups have very different needs. NWMH staff seriously question whether it is appropriate or fair that these groups of people be forced to live together. Much like the issue of "young people in nursing homes" this needs attention.

We recommend that there are SRS that are specifically aimed at certain groups of people, such as those with a psychiatric disability (according to age) or those who are frail elderly. This way, staff may be chosen more appropriately based on their experience and may be better able to meet the needs of the resident target group. Also, the physical layout of the building may be more specifically suited to the target group, as well as things like recreation opportunities, partnerships with community and health services etc.

CONCLUSION

The consumers of NWMH who are residents or potential future residents of SRS are a marginalised group who need advocacy and the unfortunate current situation in SRS marginalises them further – through inappropriate environments, decreasing places in pension-only SRS overall and limited power within SRS where they may loose their accommodation at anytime with little notice, reasoning nor avenue of appeal and review. Hence we advocate for increase in systematic development of specialist pension-only SRS across Victoria.

We would like to thank DHS for the opportunity to provide feedback within on this important review process and would be happy to be involved in further discussions, consultation and planning at any point.
APPENDIX THREE

Description/Definitions of Supported Accommodation Options

Supported Accommodation

Supported accommodation is a long term housing solution for many people with ongoing psychiatric disability. Support is provided through Psychiatric Disability Rehabilitation Support Services (PDRSS) and tenancy management usually through a housing association. It involves providing a consumer with accommodation, either in a single occupancy or shared house. The consumer is then supported by their “key worker” to both sustain their tenancy and to work on their own personal goals of recovery from mental illness. If and when the consumer no longer requires or wants support, their tenancy is not affected; they may continue to live there for as long as they choose.

This model recognises that many consumers' mental illness is episodic. Therefore, though they may not require ongoing support for extended periods of time, they benefit from the fact that the support is there if they need it. It is felt that because of the relationship that exists between the support service and the tenancy management service; there is greater understanding of issues of mental illness. Without this understanding, many tenancies may break down when a person becomes unwell leading to problems with homelessness that can be very difficult to resolve.

Residential Rehabilitation Support Programs

Residential rehabilitation is another model operated by some PDRSS’s. This is quite distinct from Supported Accommodation in that it is not a long-term accommodation option. The accommodation provided is temporary and a way of having the consumer located at or near services so that they can go through a process of rehabilitation and work on social skills, activities of daily living etc.

Residential Rehabilitation is time limited, and a consumer’s exit from the service is based as much on the fact that their time is up, as their goals around rehabilitation have been met. As well as this, a consumer’s tenancy is reliant on the fact that they are continually willing to engage in the support that is offered. Often, if people are deemed to not be engaging, they are asked to leave. While efforts have often been made to address a person’s housing needs after they leave the service, it is the experience of NWMH that people are sometimes discharged to much less suitable unsupported accommodation such as rooming houses.

Transitional Housing

Transitional Housing is a type of supported accommodation that is available to people experiencing homelessness. It is funded through the Supported Accommodation Assistance Program. Many people living in transitional housing are also clients of an area mental health service. The support is not specific to people with a mental illness, and support workers will have differing degrees of knowledge of mental health systems and mental illness, as well as differing relationships with area mental health services. Transitional Housing is temporary, with the main aim to be that a person goes on to stable, long term accommodation. This is often into public housing via a Segment One (Recurring Homelessness) application the average wait time for this at present is in the 1-3 year range purely through lack of housing stock. Much transitional housing is shared and residents often have multiple issues such as mental illness and substance abuse. While an important option to prevent recurring homelessness – one downfall is the need to move often into areas away from the support networks built up over the 1-2 year stay undermining stability of housing and well being.

Community Rooming Houses

These are an option for people experiencing homelessness. They provide a room, with shared facilities (toilet, bathroom, kitchen, laundry). Those that are managed by community groups are not-for-profit, and therefore tend to be affordable. There is normally a waiting list to get into the Rooming Houses. The accommodation tends to be very basic, often noisy, and sparsely furnished. There tends to be a reasonably high turnover of residents because the accommodation is not very comfortable.
There can often be conflict between residents. The good thing about this accommodation is that the provider does not exploit the residents, and it does suit some people, but there is no support provided to residents and it is only a small step up from crisis accommodation.

**Crisis Accommodation**

There are three crisis accommodation services for homeless people in the inner suburbs of Melbourne. Two of these services are for single men only, and one service accommodates women and families as well as single men. Residents are only allowed to stay for up to three months. They are sometimes required to share a room and bathroom. Meals are provided, as is a housing support worker who works with the resident on addressing the issues that are contributing to homelessness. There is outreach support and transitional housing programs associated with the crisis accommodation services, which provide an alternative for some of the homeless people accessing these services.

There are a group of people who have mental illness who tend to spend a lot of time in crisis accommodation, returning there when other accommodation fails, or moving between crisis accommodation and the streets. Mental health and support services try to engage with these clients over time, which can be successful, but there are often limited accommodation options for these people. They require accommodation that is secure and comfortable, close to transport and amenities, and support to manage in accommodation and increase their stability. They may require high levels of support, which is often hard to achieve in current service models.
APPENDIX FOUR

Inside Melbourne’s Seedy Boarding House World
Dan Oakes and Dan Silkstone
The Age, October 14, 2006

As police pored over the fire-blackened ruins of a Brunswick boarding house earlier this month, its exhausted residents huddled together on the kerb.

The group, including a seven-year-old child, were worried where they would sleep that night. But they were also in shock. Two of their fellow residents, Christopher Alan Giorgi, 24, and New Zealander Leigh Sarah Sinclair, 25, had been burned to death in the blaze that engulfed the boarding house — a collection of second-floor rooms in a run-down old building on Sydney Road.

One tenant, Nathan Rao, when asked who managed the six-room boarding house in a decades-old building, said he thought it was a company called Dignity Homes.

The name evokes the image of a haven for those in need of care. But the reality of the complex network of up to 150 boarding houses run by a shadowy group of Melbourne businessmen, is anything but. The Age has uncovered a world where children live cheek-by-jowl with violent drug users, Government money is funneled into the pockets of proprietors, including convicted sex offenders, and real estate agents turn a blind eye as they do business with the managers of sub-standard dwellings.

Behind the homes are a web of companies owned by a rolcall of recurring names: Dillon Fernandez, Mark Vernuccio, Arthur Oshan and George Maatouk. Oshan and Maatouk, along with two other men associated with the group, John Pisani and Joe Tomarchio, are convicted criminals.

Maatouk told The Age this week that there were four companies — Dignity Homes, Edge Housing, Northern Suburbs Accommodation and Northern Share Accommodation — each owned by one of the four key players, Oshan, Maatouk, Mr Fernandez and Mr Vernuccio.

Maatouk, who has convictions for fraud and forgery, said he knew his associates only through the industry, and the companies co-operated only loosely. But The Age believes they are entwined and their connections are deliberately opaque.

It is estimated that the men together manage up to 150 properties across Melbourne, which they either own or lease from real estate agencies.

Their clients are the vulnerable and the desperate, including recently released prisoners, the mentally ill and those with alcohol and drug problems, who are referred to the group by welfare agencies unable to cope with the overflow of homeless people.

Conditions in the homes are bleak, but rents are high. A five-bedroom home that might cost Dignity Homes $320 a week to rent, for example, will be sub-let on a cost-per-room basis at a substantial mark-up. Tenants are also routinely hit with illegal $150 furniture deposits.

At the Sydney Road property, tenants paid anywhere between $130 and $170 for a room in a boarding house that contained only one smoke detector and no fire extinguishers.

When The Age first inquired about the four companies, it heard tales of degradation and intimidation. Residents and welfare agencies reported confusion about who was responsible for which property.

"These are nasty people," said one man, who like many others interviewed for this report, did not wish to be identified. One former Edge Housing tenant talked of an endless parade of housemates, many of them drug addicts, as well as violence, theft and nightly screaming matches.

"It was the crappiest place I've lived in this country," he said.

Another tenant said that when he asked his property manager about the lack of bins, it was suggested that tenants buried their rubbish in the back garden. He said the house, in North Fitzroy, had no smoke detectors or fire extinguishers. A family living next door to one
Northern Suburbs Accommodation house said they suffered six months of abuse and intimidation by tenants, including rubbish thrown over their fence, and backyard bonfires fuelled by methylated spirits during a total fire ban.

_The Age_ this week toured one of the properties and found rubbish piled high, electrical wiring that was damaged and exposed, and heard tales of a blocked toilet and a single smoke detector that didn't work.

THE company that owns Dignity Homes, Commercial Integrity, lists its business as "operating boarding houses" but under Victorian law, it does no such thing. If the number of tenants is kept at five or fewer, there is no need to register the establishments as boarding houses and they are not subject to yearly council inspections or industry safety regulations.

Maatouk told _The Age_ that he and the other men running the four boarding home companies were providing a service to those who had nowhere else to go. "We're not 100 per cent right in how we run our business, but if we weren't there to start off with, these people wouldn't have anywhere to go," he said. "We don't always get it right, we try, but why are these people coming to us?" he said.

Rising rents, the reduction in public housing, the increased flow of people from institutions into the community and the gentrification of the inner city have all increased pressure on those who struggle to find a bed. "The demand is just growing; we can't keep up," Maatouk said. But vulnerable tenants make juicy prey for people looking to make a quick buck. Here is how it works. Tenants are referred to the group by welfare agencies such as St Vincent de Paul and Homeground. These organisations run homeless shelters but can only house a third of those who approach them.

The State Government addresses this problem through its Housing Establishment Fund. Millions of dollars are provided so that homeless agencies can buy emergency accommodation for those they would otherwise turn away. Sometimes it is in cheap motels or caravan parks. Often it is in places run by the likes of Dignity Homes.

Housing Establishment Fund money pays for the first week or two, then the group's income switches to Commonwealth funding as they force tenants to sign up to a direct debit scheme in which rent is automatically deducted from CentreLink benefits. Maatouk said that it was in the interests of tenants to agree to direct debit so they did not fall behind on their rent.

Most agencies spoken to by _The Age_ regularly referred people in need to Dignity Homes or Northern Suburbs Accommodation despite serious reservations. "It's heartbreaking," said one worker. "Dignity, Northern Suburbs, Edge Housing, they use a lot of names but they've been very questionable for some time," said another. "There's been a lot of problems with arguments and aggression in their properties and nobody is overseeing that."

SO WHO are these men, paid by the State Government to provide beds for our most vulnerable? Earlier this year, Northern Share Accommodation owner Oshan and his friends Pisani and Tomarchio pleaded guilty in the County Court to a string of charges relating to the operation of three illegal brothels.

It was alleged that the men lured women, including an under-age girl, to work as prostitutes and sexually assaulted prospective brothel employees.

The three men, who met while working at McDonald's, lived the high life in the 1990s, driving $120,000 black BMWs while telling their wives they worked as cleaners. They advertised in local papers for "topless work". When women, most barely 18, answered the ads, they were taken to a strange location, pressured into working as prostitutes and told to perform sexual "trial massages" on two of the men.

The court heard one victim, still 17, was taken to an inner-city apartment where, over several hours, she had sex with up to seven men, including Oshan. She was paid $160. The prosecution alleged the brothels turned over more than $5 million in just two years.

Oshan's lawyer told Judge Joe Gullaci his client had turned over a new leaf and devoted himself to helping the poor. "Not only does he help in providing housing for people in need ... He assists them in getting their life back together," said Steven Shireffs, SC.

The evidence reveals that Oshan's co-accused, Tomarchio and Pisani, are also linked to the boarding house group. Pisani had a reference supplied to the court by his "employer", Dignity Homes' owner Mark Vernuccio.
In court, Maatouk gave evidence about Oshan’s benevolence, claiming to be a homeless person on whom Oshan bestowed kindness. He said he worked for him, doing odd jobs for $200 a week.

But Maatouk admitted to The Age that he was the owner of Northern Suburbs Accommodation and managed 51 properties. Financial records show that he is also a former "operator" of Dignity Homes and a current director of Proper Cleaning, another business linked to the boarding houses.

Welfare agencies told The Age there needed to be greater regulation so that dodgy operators could be weeded out but feared that revelations about the extent of boarding-house squalor would force the closure of the few options they have.

"We should have some sort of level that we are not prepared to send people into," St Vincent de Paul's Nettle Horton said.

"The community at large has no idea of the sort of conditions that we are sending people into."

Nathan, the man who was confused about who managed the Sydney Road boarding house that burned, has no confusion regarding where he lives now.

"I've got nowhere," he said. "I went to Kmart and bought a tent for $20. I'm going to pitch it in somebody's backyard."

