21 November 2008

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

Dear Committee members and Staff

Re: HACSU Submission – ‘Disability Services’ - Provision of Supported Accommodation for Victorians with a Disability or Mental Illness

Further to our mental health submission provided on the 12 November attached please find the second submission (Disability Services Component) of the Health and Community Services Union in respect to the Inquiry into the ‘Provision of Supported Accommodation for Victorians with a Disability or Mental Illness’.

Thank you for the opportunity to make a contribution and submission to the inquiry.

We remain available to clarify and respond to any issues.

Yours Faithfully

[Signature]

Lloyd Williams
State Secretary
Victorian Parliament Family and Community Development Committee

Inquiry into Supported Accommodation for People with a Disability or Mental Illness

Submission of the
Health and Community Service Union

Disability Services Component
Disability Services Component
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EXECUTIVE SUMMARY

INTRODUCTION

The Health and Community Services Union (HACSU) welcomes the Committee's inquiry into supported accommodation for people with disabilities. HACSU represents the industrial and professional interests of the disability workforce in both Government and Non-Government (CSO) services. The union has a long history of productive involvement and participation in policy development, service improvement and reform in the area of intellectual disability.

Our experience over the last 80 years in the industry has been around the establishment and closure of large institutions and the resulting development and growth of the community residential services sector, the development of specific community based programs and the growth of the non-government (or community services organisation, CSO) sector. Our focus has remained on the provision of a skilled and competent workforce to support the evolving service system.

The primary focus of any service system should be ensuring the delivery of quality outcomes for service users within the allocated budget. The pervasive one-service fits all approach is no longer an option. This being said, it is also not appropriate to create an unregulated approach to disability services receiving direct, or indirect through payment, government funding. To best achieve quality outcomes in supported accommodation, the range of service options needs to increase and reflect the diversity of the support needs of people with a disability.

GOVERNMENT AS PROVIDER

The State Government has a long history in providing services to its citizens who are most vulnerable and in the greatest need. This focus needs to continue and they are core services that government should provide. There is a commonly articulated view that as funder, service provider and regulator of accommodation support services government services has a conflict of interest and that government should absent itself from direct service provision. We believe this argument is fallacious.

There is no empirical evidence of the qualitative benefit to service provision or quality of life for an individual arising from the separation of housing and support provision, and/or their management by different entities. In our view, the debate about the government/non-government service provider is a distraction being advanced by entrepreneurial service providers and lobbyists who simply wish to expand their business – it is not about quality. It is vital to remain embedded within a service system if there is to be influence and control over desired outcomes.
ACCOMMODATION - PROVISION AND SUPPLY

The impact of an individual not being able to access supported accommodation is greater than just that person; it extends to the family and often other service providers. The degree of impact on the family depends to an extent on their relationship with that person and the amount of internal capacity available. Lack of supported accommodation will possibly result in increased stress for the family unit, may result in health issues for members of that family and increase the possible risk of family breakdown.

A fundamental focus for families and carers when needing to make decisions around the support of their child/family member with a disability is one of permanence and certainty. Whilst there is a decline in the support for the community residential unit, there is a loud, clear voice from families; they want a physical placement. The move to individualise funding has not included any notion of the provision of houses or facilities for service provision. This lack of funding will result in the limitation of physical placement offers.

The provision and maintenance of accommodation suitable for the residence of people with many and varying disabilities is costly and requires an ongoing budget for the replenishment of old stock and the purchase of new stock in developing areas. The structures required are often unaffordable to individual families, again making it an appropriate government activity. Funding people to buy-in the support they need to live independently assumes that the services exist or will develop in response to the funding model. This has major planning, quality accountability and protection issues for individuals in receipt of packages.

It is beyond question that there are insufficient supported accommodation places within the State. The most recent data states that unmet demand for accommodation places is around 1370 people, or 30% with demand increasing by about 4 - 5% annually. [Victorian Auditor-General's Report Accommodation for People with a Disability 2008, p2]

HACSU contends that in order to address this service shortfall there should also be new investment in accommodation stock. The Office of the Public Advocate [OPA] echoes this view. The Community Visitors Report 2007 recommends, among other things: 'that the government urgently prepares a strategy to plan and build more disability specific accommodation of the CRU type, to avoid an escalation of the crisis in unmet accommodation needs and eliminate the use of respite beds for emergency accommodation.'

HACSU strongly supports individuals having choice in where and with whom they want to live, the manner in which they receive support and to be able to move if their situation becomes unsustainable. For this to happen there needs to be a large flexible system. Individualised funding that needs to be pooled does not provide a remedy.
TRAINING AND PROFESSIONAL DEVELOPMENT

We contend there are three pillars necessary to underpin the capacity of staff to deliver the protection of people’s rights and enable them to achieve a meaningful life in the community, these are:

- A focus on staff training
- Good staff support
- Open and accountable service governance

Without all three being robust and in place across a service, the capacity to deliver quality service outcomes is compromised and external scrutiny is less effective.

In terms of quality outcomes for service users there is a direct correlation between service adequacy and the adequacy of service management, service governance and, the support and training given to all staff. These are critical factors in determining the quality of service delivery. To ensure quality outcomes it is vital that there is commitment and investment in strategies such as:

- Appropriate training
- Clear but not onerous or conflicting procedures
- Leadership and supervisory development
- Proper human resource management practices
- Security of employment

WORKFORCE

The Disability workforce is facing major attraction, retention and skills growth problems. Without some major industry wide policy/funding and intervention this situation will not improve and we believe that service provision reform and change will stagnate as a result. Sound workforce capacity and skill level underpin any quality and productive service system.

There is no short-term, quick fix to developing and/or repairing workforce problems, particularly when there have been long periods of workforce neglect and cost cutting - such as the 1990’s which effectively saw 10 years of cuts to training and the breaking down of professional career structures.

To do nothing to address these significant shortfalls and pressures would be negligent and HACSU urges the Government to undertake to invest substantially in the key areas of the provision of accommodation options and the training and skilling of an appropriate workforce to meet the complex and changing needs of people with a disability in our community.
MAIN SUBMISSION

INTRODUCTION

The Health and Community Services Union (HACSU) welcomes the Committee’s inquiry into supported accommodation for people with disabilities. HACSU represents the industrial and professional interests of the disability workforce in both Government and Non-Government (CSO) services. The union has a long history of productive involvement and participation in policy development, service improvement and reform in the area of intellectual disability. During the deinstitutionalisation process, HACSU was a strong advocate ensuring accommodation places were not lost.

HACSU’s submission will focus on and address the questions in respect to those people who are potentially the most marginalised within the disability sector – those with an intellectual disability and high support needs.

In this submission we will argue that given the extent of the devastation wrought during the 1990’s and the time this takes to overturn, a sustained government investment is required to:

- Focus on improving service outcomes for people, not service provision at the lowest cost
- Maintain service provision for people with the highest needs as a responsibility of government
- Plan, implement and appropriately fund a growth strategy for accommodation placements in order to address the current waiting list and to meet future service demand
- Plan for the anticipated impact of aging parents/primary carers becoming increasingly unable to provide that primary care needs
- Increase funding for respite care to address the needs of both the current waiting list and future projected demand
- Address the workforce recruitment, retention and professional development needs

We believe government should dismiss any argument that government services have a conflict of interest as funder, provider and regulator, as it is seriously flawed. Government services are more accountable and better scrutinised than NGO's. There needs to be acknowledgement of the historical evidence that the transfer of government run services to the CSO sector does not result in an increase in quality service outcomes for clients [KRS 58 places initiative]
CURRENT POSITION

Victoria leads Australia in the provision of disability services; it has the highest numbers of supported accommodation places in the community, and a greater budget allocation to individual packages than most other Australian states. However, there are other jurisdictions within the OECD that have higher numbers of supported accommodation places per head of population than Victoria, who also have individual planning and funding mechanisms akin to Individual Planning and Support [IP&S], for example there are more supported accommodation places for people with 'learning disability' (i.e. intellectual disability) in Scotland per head of population than there are in Victoria, given their similar size populations.

HISTORY AND SERVICE STRUCTURE

Historically, State Government has responsibility for the provision of services to people with a primary intellectual disability and, in general, this group of citizens are the most vulnerable group in our society and require additional protection. CSO, or non-government providers have evolved from the provision of services for people with primary physical and sensory disabilities traditionally funded through the Federal Government.

The Intellectually Disabled Persons’ Services Act 1986 (IDPSA) was the catalyst for deinstitutionalisation and its first State Plan saw the creation of Community Residential Units (CRUs) which are government funded, staffed group homes located within the community.

Victoria’s institutions have been progressively closing since 1986, and people have moved to new supported accommodation managed by the State. As a result, over 60% of the total of around 1000 CRUs in Victoria are directly managed by the Department of Human Services (DHS) and tend to accommodate the people with highest needs. The latest institutional closure – Kew Cottages - created 470 places and added 93 houses to the CRU stock.

The election of the coalition government in the 1990’s saw a period of severe cost cutting to disability services. This had an enormous negative impact on quality of service that clients received and resulted in a major cultural shift that saw the service focus move from a developmental program focus aimed at increasing client’s independence skills to one of focussed on meeting people’s most basic needs.

The most significant impact of this period was:

- Severe cuts to rosters and staffing levels, removing any capacity for the provision of community based inclusion, individual or group activities and individual development

De-professionalisation of the workforce with a shift from a highly qualified and trained one to a significant number 40% of untrained staff. The creation of the Human Service Workers’
were not required to have, nor were provided with, any training above a two week induction program.

- Significant casualisation of the workforce
- Increase of occupational assault in the workplace
- Loss of supervisory structures with House Supervisors being allocated two CRUs to supervise, reducing their capacity and ability to support staff

These changes resulted in major recruitment and retention problems across the disability services sector, with services shifting to a custodial care focus. The Auditor Generals report in 2000 was highly critical of service provision and as a result the government has worked steadily towards the improvement of services in an attempt to address the identified systemic issues. The government has implemented a range of changes that include:

- Rebuilding career structures
- Providing training
- Ensuring the minimum standards of training
- Replacement and/or upgrade of DHS housing stock in order to improve the quality of accommodation. In many cases this is long overdue.

Less work, however, has been undertaken in the non-government sector that continues to suffer significant workforce, recruitment and retention problems. These services were created and similarly cut during this period. Many CSO's inadvertently contributed to this situation by engaging in competitive tendering for services at the lowest cost through the 1990's. The subsequent impact still requires significant attention to mitigate the ongoing effects.

Q1. WHAT HAVE BEEN YOUR EXPERIENCES WITH SUPPORTED ACCOMMODATION IN VICTORIA WITH REGARD TO AVAILABILITY, SUITABILITY AND ADEQUACY OF CARE FOR PEOPLE WITH A DISABILITY?

Our experience over the last 80 years in the industry has been around the establishment and closure of large institutions and the resulting development and growth of the community residential services sector, the development of specific community based programs and the growth of the non government (or community services organisation, cso) sector.

All of the programs outlined below currently operate in both the government and non-government sector with the government sector tending to focus on those citizens with a higher support needs.
CONGREGATE CARE

Colanda Residential Services, in Colac, and Sandhurst Training Centre, Bendigo are the 2 remaining state run congregate care facilities. Colanda currently accommodates around 140 adults and Sandhurst accommodates around 50 adults. There remains a ‘No New Admissions Policy’ to these services, unless under exceptional circumstances within the parameters of the Disability Services Act 2006.

There is also a smaller non-government facility managed by Wallara Accommodation Services called Cussen House that has operated since 1969 and accommodates 23 people. Wallara has been researching new models of service to meet the changing needs of people residing at Cussen House and this is a major part of their current accommodation redevelopment project.

COMMUNITY RESIDENTIAL UNITS (CRUS) / GROUP HOMES

CRUs are community-based houses that provide accommodation and support for generally between 4-6 clients, in very limited cases 5-8. Some CRU’s are purpose built; others have been purchased and equipped or remodelled according to client need. Staff are rostered to provide ongoing support as determined by client need. Overnight staff support is either via a sleepover or an active night shift. All DHS CRU’s have a dedicated House Supervisor who provides local leadership. NGO’s are more likely to have House Supervisors managing at least two or more CRUs.

Adequacy and Suitability

We need to remember that people with a disability are not an homogenous group of people, they are individuals with diverse support needs. The services provided should reflect this diversity and meet their various needs: one service model does not fit all, particularly those citizens who have high and complex support needs. Contemporary service provision is more sophisticated and complex. There is a broader focus on supporting a person’s individual needs, which relates not only to a persons physical and personal care needs but also to their developmental needs. There is also the requirement to ensure an individual’s inclusion and participation in their wider community.

The standard Community Residential Unit model does not sufficiently meet the needs of all people with a disability and requires some attention to its footprint, design and location to be able to respond to these differing needs. This is not to say that the Community Residential Unit model does not have a place in the service system, rather that the service system needs to expand the range of options.

All community based accommodation options require sufficient resourcing to enable staff to appropriately tailor and deliver services required by the individual and to respond to demand. Again this is even greater for individuals who exhibit behaviours of concern or who have high medical and complex care needs.
The ability to provide individualised support is contingent on staff's capacity to deliver this level of support. In the absence of rostered capable staff, individualised support is unlikely to occur and by implication such service provision is inadequate.

**Availability**

In Victoria there are insufficient supported accommodation places to meet current demand. The most recent data states that unmet demand for supported accommodation places is around 1370 people, or 30% with demand increasing by about 4 – 5% annually. [Victorian Auditor-General's Report Accommodation for People with a Disability 2008, p2]

The demand for and high cost of accommodation has resulted in the government moving to alternative funding models, including individual packages as a service diversion strategy. Since 2003, all new funding has been in the form of individual packages, most of which are not at a level that could support people in greatest need. We believe this strategy fails to address the issue of the increasing demand for accommodation places and has diverted attention away from this issue. In the last five years there has been no funding allocated to increase Community Residential Unit stock which continues to be identified by families as their preferred option.

HACSU contends that in order to address this service shortfall there should be new investment in accommodation stock. The Office of the Public Advocate [OPA] echoes this view. The Community Visitors Report 2007 recommends, among other things: ‘that the government urgently prepares a strategy to plan and build more disability specific accommodation of the CRU type, to avoid an escalation of the crisis in unmet accommodation needs and eliminate the use of respite beds for emergency accommodation.’

**Recommendation**

- HACSU urges the government to review the existing service options and expand the models to beyond the ‘one size fits all’ approach.
- That government fund additional supported accommodation places to address the current, and future, unmet service need.
- HACSU urges the government to invest in such options and fund the necessary support requirements to deliver quality, individualised services.
- That the government ensure appropriate levels of trained, rostered resource within the CSO and DHS sectors.
SPECIFIC COMMUNITY BASED PROGRAMS
RESPITE CARE

There are two models of respite care delivered by both the government and non-government sector. One is ‘facility-based’ i.e. delivered in a 5-6-bedroom house with 24-hour care provision for pre-arranged periods. The other is ‘in home’: this is either in the person’s family home, or via community based activity, thereby giving respite to their primary carers. The services are adult and child specific services and there are significant efforts across sector to coordinate these services to ensure the maximum spread to all families.

Adequacy and Suitability

The lack of specific respite care facilities make it difficult for the recent additionally funded episodes to occur anywhere other than the family home. This is significant as many families request out of home respite, allowing them to remain in the home whilst the child is in care.

Availability

The figures on respite care are reported as a whole, making it difficult to ascertain the level of facility-based respite from other respite episodes, i.e. in home support. Lengths of stay in facility based respite can vary based on need. They can be anything from 1-2 nights to over a year for extended placements. Most services report that they are increasingly unable to provide regular planned respite to families as the beds are used to support people who are homeless awaiting a permanent placement.

Whilst 2004/5 State Budget allocated $8.3 million over 4 years for 1000 additional 'episodes of respite', the current supply of respite care is inadequate to meet unmet service need. Again, there is no discussion about or funding of ‘facilities’ into which respite services can be located. Extended respite placements, being used to respond to crisis as there is is no suitable accommodation place available, continue to place further pressure on an already stretched service.

Recommendation

- That funding for respite places be further enhanced to meet the very significant demand from families for facility based adult respite, an estimate of which would require a doubling of current bed capacity.
OUTREACH

Outreach support is provided to a range of people with a disability, who live independently in an owned/rented accommodation or with their family. However, the lack of suitable housing and broader housing shortage can result in many people being effectively homeless and moving from one Supported Residential Service (SRS) to another. Outreach workers meet a range of needs, provide skills development training and other supports. Service users receive support until they have achieved their agreed outcomes.

In-home support arrangements for people to live in their own homes can be dependent on the level of funding they receive as part of an individualised package. Funding level dictates the level of pay received by the workers employed to provide the care, which in itself can dictate the skill level at which the worker operates and can reflect their qualification level.

Adequacy and Suitability

The outreach model makes good policy sense because it is flexible and supports people in their community. The focus of Outreach is the support and development of an individual's independence and enhancement of their capacity to live more meaningfully within their community. The service can be expanded and adapted to meet the long-term support needs of people and is able to provide support to those who are unable to access support elsewhere. In some instances the focus of service provision is the family and not just the person with a disability.

This is often not a viable option for people with high, medical support needs, because funding available from packages can be insufficient to meet the need for multiple carers to provide the support required. However, outreach can and has been an effective model of service for people with behaviours of concern, as it often allows for the person to live alone and reduces the number of triggers.

Availability

There is very little enhanced or extended outreach provided by government services and there is a great need for this level of support. Most regions have some small outreach program in place.

Recommendation

- That Outreach services be extended and also include 'new style' arrangements such as key ring, which will be discussed in section three.
PRIVATE SECTOR SUPPORTED ACCOMMODATION

SUPPORTED RESIDENTIAL SERVICES (SRS'S)/ROOMING HOUSE/BOARDING HOUSE

Adequacy and Suitability

Supported Residential Services (SRS) comprise a major form of private sector supported accommodation for people with a disability. However, the adequacy and suitability of this type of accommodation for people with a disability has been of concern for many years. This is shown by several reviews of SRSs, such as the 2001 report by David Green entitled 'Advice to the Department of Human Services on Supported Residential Services' (hereafter called the Green Report): http://www.health.vic.gov.au/archive/archive2004/greenrept/srs_green_report_final.pdf

Concerns about SRS's have also been raised regularly in the annual reports of the Community Visitors from the Office of the Public Advocate. For example, the 2007 Community Visitors Health Service Annual Report noted that "there are even more young people with a disability or mental illness living in pension-level SRSs than last year", and "Community Visitors are dismayed that congregate care facilities are being accepted as a long term option for young people who need opportunities for development to lead more fulfilling lives." Executive Summary: downloadable at: http://www.publicadvocate.vic.gov.au/Publications/Annual-reports-and-reviews/Community-Visitors-Health-Services-Annual-Report-2007.html

A major issue is that SRS cater for different age groups with a range of disabilities and support needs, including psychiatric disabilities. This broad access means that the residents of an SRS may include frail older residents as well as people in their twenties with complex problems such as intellectual and psychiatric disabilities, and problems with use of alcohol and other drugs. The support needs of different residents may be quite distinct, but not reflected in the basic nature of the care provided. Cost is also a concern. Even the fees charged by 'low-cost' or 'pension-only' SRS generally leave between $5-$20 per week over from a pension for residents to spend on personal items and recreational activities.

Other types of for-profit accommodation are rooming houses and boarding houses, with the latter providing at least one meal on a daily basis. People with a disability use these forms of accommodation, but the level and quality of support is not guaranteed, and the environment can be threatening and dangerous for vulnerable people. For instance, there may be ready access to drugs and alcohol, and exposure to violence. This often results in the person with a mental illness presenting to an Emergency Department, police or other emergency service in a distressed state after fleeing from this environment.
Availability

The continuing problems with SRS over time demonstrate this is not a service model warranting endorsement. Moreover, at the very least, there is little incentive for SRS to encourage the rehabilitation of their residents, and the high cost of even the pension-only SRS means that residents have little money left to engage in activities that could assist their recovery process.

Recommendation

- HACSU does not endorse this model as appropriate given that there been continuing problems with SRSs over time.

NURSING HOMES

Most nursing homes are established to meet the needs of our ageing population. Many are currently used to accommodate a number of younger people with significant care issues, causing stress on an inadequate service system and stress on the young people located in the aged care system.

There is also the current debate around the notion of ageing ‘in place’ and the impact of this for Disability supported accommodation services. Ageing ‘in place’ recognises the importance of the relationships that people develop and the comfort of a familiar environment. Often, additional resources are required to appropriately support the changing care needs of the client and services are not funded to meet this new demand.

Adequacy and Suitability

A number of people with very significant disabilities can find themselves required to live in aged nursing homes due to a lack of available suitable accommodation options. People in this circumstance have often been injured and tend to have high, medical support needs. The government has recognised the inadequacy of this level of service for young people and is trying to address this service gap through the Young People in Nursing Home strategy.

A number of aged care facilities have inferior staffing and management regimes when compared with the CRU model, resulting in people moving from a service with a higher level of support to one with a lesser level of care. Staff in aged care facilities are not often familiar with the individual support needs of a person with an intellectual disability which can often lead to inadequate responses.

Recommendation

- To prevent the current need to use nursing homes, government fund a number of 5-10 bed units to provide a specialist service for people with high medical and age care needs within supported accommodation services.
• That individual funding be allocated to support people residing in disability supported accommodation who can and wish to age ‘in place’.

Q2. WHAT IS YOUR EXPERIENCE OF TRYING TO ACCESS SUPPORTED ACCOMMODATION IN TERMS OF INFORMATION, PLANNING AND DECISION-MAKING?

As an industrial body we do not have direct experience of accessing supported accommodation services, however our member’s have advised us of the following.

Our only comment would be that with the shifting focus to one of allocating individual funding to procure support arrangements, the need for detailed, clear information for families making decisions is of paramount importance. This system is likely to cause further pressure on the existing caseloads of client service workers and will need additional funding to be appropriately supported.

Q3. WHAT OTHER APPROACHES / MODELS SHOULD BE CONSIDERED TO ADDRESS SUPPORTED ACCOMMODATION FUNDING, PLANNING AND DELIVERY?

The primary focus of any service delivery should be to ensure the delivery of quality outcomes for service users within the allocated budget. The pervasive one-service fits all approach is no longer an option.

This being said, it is also not appropriate to create an unregulated approach to disable services receiving government funding either directly or indirectly through payment. To best achieve quality outcomes in supported accommodation, the range of service options needs to increase and reflect the diversity of the support needs of people with a disability.

It could appear that successive governments have moved from the overarching CRU paradigm supplanting it with another: the individualised planning and funding paradigm, through individual ‘packages’ of support. HACSU would rather see a continuum approach to service delivery which would range from intensive, specific restrictive intervention, to structure shared accommodation, to individuals supported in their own homes, to individuals structuring a particular care package that works for them. The paramount focus should be providing one best response to the individual’s need within the funding framework to achieve best possible outcome.

The key to any alternative accommodation model is appropriate staffing and resourcing. We could purchase individual flats for all people currently listed as needing accommodation, this would not solve the problem. People register for SUPPORTED accommodation, with the support aspect being paramount. Services need to be appropriately resourced to be able to deliver individualised, community inclusive support in line with the Disability Services Act 2006.
OTHER MODELS

OUTREACH/INDEPENDENT LIVING OPTIONS

Currently, outreach is provided in quite limited circumstances, restricting options rather than enhancing them. Outreach is the provision of support to people with a disability, which enables them to continue to live in their own homes, either alone or shared. This service premise is expansive and has the capacity to allow for creative supports being developed. The key is to provide the minimum core staffing which creates the base from which responses can ebb and flow.

'Keyring' is one such model of care where a number of people with a disability live in high density housing and receive support modelled on this system. This model allows for flexibility in living arrangement (shared/single), caters to the individual needs (twice daily support up to monthly support) and can also accommodate individuals with some high support needs in some circumstances. This model is a useful component of a service system for some people with disability and needs to be considered.

SPECIFIC AGED CARE SERVICES - TRANSITION

Many of the people currently presenting for support or service are often unknown to the service system and require a greater level of support initially. The lack of transition services, where people could initially live following traumatic family event, can often result in poor decision making. At this time of transition, the types of support and services that a person would require would be different and more intense. This would include dealing with loss, trauma, dealing with change, loss of independence and usually identifying a new range of skills. This was a service offered widely in the 1980's but seems to have disappeared with the shifting focus to individualisation.

OTHER APPROACHES

DIRECT PAYMENTS

Direct payments is currently being put forward as an option to resolve current demands for service and is couched in the language of individualised services and client control. HACSU does not believe that the method of paying for services necessarily resolve the issue of providing appropriate support services tailored to the needs of individuals with a focus on those in the greatest need. Further, it fails to address issues of equity with regard to outcomes and relies on the abilities of others to be well placed in managing and manipulating funding for optimal outcomes.

We believe that the funding model should be cautiously approached and only considered in circumstances where the outcome is greater than currently exists in the existing system. Experience with this approach reveals a number of concerns, mainly about the vulnerability of clients to abuse, workforce quality and consistency and the ability to maintain a trained and competent workforce.
‘POOLING’ PACKAGES

The pooling of packages is not a new approach, although it is sometimes presented as such. Pooling is simply a group of individuals pooling their individual packages together to purchase a collective outcome. This method still presents the problem of physical accommodation, as physical structures are not a component of the funding allocation. This would be an option for people who already have an appropriate house to share. It is the method by which many services were established in the period of competitive tendering in the 1990’s.

This model potentially limits the level of a persons ‘choice’ and the ‘portability’ of their funds as they can become ‘locked in’ to an arrangement. The arrangement relies on the continued relationship of the people living together and requires solid conflict mechanisms to be in place and supported. This option is probably best considered by a smaller group of individuals who may wish to reside together.

HACSU strongly supports individuals having choice in where and with whom they want to live, and to be able to move if their situation becomes unsustainable. For this to happen there needs to be a large flexible system. Individualised funding that needs to be pooled does not provide a remedy. The Singleton Equity model developed in the 1990’s will adequately demonstrate some of the inherent difficulties with this approach. HACSU contends that given the size of its service DHS has a better record of enabling people to move within its systems than does a CSO.

Recommendation:

- That the government increase its direct outreach services and work with the flexibility that the program offers to expand its available options.
- That the government commit to a greater range of physical structures being developed to provide greater choice for people requiring supported accommodation.
- That the government commit to the development of interim accommodation options which provide relief to the true ‘respite’ services and that support the assessment of the individual to achieve the best long term outcome for them.
Q4. WHAT ARE THE IMPLICATIONS FOR INDIVIDUALS WHO NEED BUT CANNOT GET SUPPORTED ACCOMMODATION? IS THE ALTERNATE ACCOMMODATION THAT IS AVAILABLE ADEQUATE AND CARE APPROPRIATE?

The impact of an individual not being able to access supported accommodation is greater than just that person; it extends to the family and often other service providers. The degree of impact on the family depends to an extent on their relationship with that person and the amount of internal capacity available. Lack of supported accommodation will possibly result in increased stress for the family unit, may result in health issues for members of that family and increase the possible risk of family breakdown. This can lead to increased pressures on other services such as medical service, family counselling and ultimately the Department of Human Services.

There have been instances where a family can no longer cope and they have taken the no option but to 'leave' their relative at a respite facility. Although this use of respite is considered crisis accommodation and as a result the person would be placed as a high priority on the Service Needs Register, appropriate placement can take up to, or over, a year. Such use of respite limits the responsiveness of that respite facility to provide respite to other families, thus increasing pressure on those families.

The lack of supported accommodation places in a physical location, with the focus on 'individualised packages' is an increasing worry to ageing parents and/or primary carers as there want to be certain that future support is tangible. Some parents articulate this concern as 'being afraid to die' with the uncertainty that they experience.

Inability to access supported accommodation can have a range of outcomes; none of which provide adequate accommodation or appropriate care and which in some instances are long lasting. A person can end up living within an Supported Residential Service (SRS) and this submission has previously detailed our concerns about this form of accommodation and support. A person can end up homeless, living at risk on the streets or in squats, 'hot bedding' or 'sofa surfing'. Homelessness can in turn lead to alcohol or drug abuse, mental health issues and in the worst-case scenario can result in the person ending up in the criminal justice system. Inevitably, there are financial and service pressures that arise for services that provide support to people in such circumstances.

**Recommendation:**

- That government prioritise developing/expanding services for people with a disability who are living with aging parents.
• That government consider the development of an emergency response team whose focus would be supporting these families most in need and assist with negotiating some short term solutions. This might be supports for the family rather than the person with a disability.

• That the government commit to the development of interim accommodation options which provide relief to the true ‘respite’ services and that support the assessment of the individual to achieve the best long term outcome for them.

Q5. WHAT IS YOUR VIEW ON THE PROVISION OF ACCOMMODATION AND CARE IN PRIVATE, GOVERNMENT AND COMMUNITY SECTOR MANAGED SUPPORTED ACCOMMODATION?

The key finding from all research in the disability field is that: ‘Adequate levels of resourcing, appropriately trained and supported staff… are critical’ (Accommodation models discussion paper. Dr Andrew Burbidge. 2002, and his referenced papers)

The first thing that needs to be stated is there is simply not enough. Irrespective of provider, there are not enough places available and there is not the workforce available to provide the service. In our view, the debate about the government/non-government service provider is a distraction being advanced by entrepreneurial service providers and lobbyists who simply wish to expand their business – it is not about quality.

It is beyond question that there are insufficient supported accommodation places within the State.

The most recent data states that unmet demand for accommodation places is around 1370 people, or 30% with demand increasing by about 4 - 5% annually. [Victorian Auditor-General's Report Accommodation for People with a Disability 2008, p2]

The demand for and high cost of accommodation has resulted in the government moving to alternative funding models, including individual packages as a service diversion strategy.

Since 2003 all new funding has been in the form of individual packages, most of which are not at a level that could support people in greatest need.

We believe this strategy fails to address the issue of the increasing demand for accommodation places and has diverted attention away from this issue. In the last five years there has been no funding allocated to increase Community Residential Unit stock which continues to be identified by families as their preferred option. Particularly where clients have ageing parents.
Funding recipients to buy-in the support they need to live independently assumes that the services exist or will develop in response to the funding model. This has major planning, quality accountability and protection issues for individuals in receipt of packages.

HACSU contends that in order to address this service shortfall there should also be new investment in accommodation stock. The Office of the Public Advocate [OPA] echoes this view. The Community Visitors Report 2007 recommends, among other things: 'that the government urgently prepares a strategy to plan and build more disability specific accommodation of the CRU type, to avoid an escalation of the crisis in unmet accommodation needs and eliminate the use of respite beds for emergency accommodation.'

GOVERNMENT

The State Government has a long history in providing services to its citizens who are most vulnerable and in the greatest need. This focus needs to continue and they are core services that government should provide. There is a commonly articulated view that as funder, service provider and regulator of accommodation support services government services has a conflict of interest and that government should absent itself from direct service provision. We believe this argument is fallacious, driven by remnant 1990's ideology and entrepreneurial providers wanting to 'grow their business'. These are the same providers that claim they lack capacity to deliver existing services. There is no empirical evidence of the qualitative benefit to service provision or quality of life for an individual arising from the separation of housing and support provision, and/or their management by different entities.

It is appropriate that the government maintain a strong presence and investment in the delivery of services to citizens with a focus on quality outcomes. It is vital to remain embedded in a system if there is to be influence and control over such outcomes. Being intimately involved in providing the demands of the Disability Act 2006 enhance the Departments capacity to work with CSO's to achieve the same.

Further there is greater accountability and a higher level of scrutiny for DHS than within the CSO sector. The DHS is subject to Freedom of Information [FOI] legislation, internal scrutiny by the Auditor General and Community Visitors and direct Ministerial oversight. Whilst DHS is not perfect, there is acknowledgment of the fragilities in the system and the progress in remediing these issues is positive. In comparison CSO's are far less accountable; they are neither subject to FOI legislation nor answerable to the Auditor General. The authority of Community Visitors was only recently extended to include this sector, arising from the creation of the Disability Act.

Government is involved in balanced service delivery across a range of services including education and children services. This is in the public interest. It's appropriate that the government maintain a
strong presence and investment in the delivery of services to citizens, with a focus on quality outcomes.

COMMUNITY SERVICES ORGANISATIONS - CSO’S

In comparison, CSO’s are far less accountable; they are neither subject to FOI legislation nor answerable to the Auditor General. The authority of the Community Visitors has only recently been extended to include the sector, arising from the Disability Act (2006)

This is not to say that there is no role for the CSO sector, quite the contrary. The CSO sector plays a strong role in providing an alternative service options and can more swiftly provide alternatives as they are not as constrained by the rigours of government mechanisms. But we need to be careful in not assuming that the CSO sector itself is homogenous.

The period of time, which saw competitive tendering for services in the 1990’s, created a competitive, entrepreneurial culture between the CSO’s and has resulted in interesting growth patterns of organisations. It is questionable whether the amount of CSO’s involved in the provision of services remains viable, with the rigours of the new legislation, workforce development capacity and indeed with a focus on maximising the quality outcomes required. This is a sensitive topic of debate but one that needs some thought and attention.

The CSO sector is diverse, with many organisations beginning as groups of parents coming together to form an organisation to meet the needs of their children. Organisations have grown at disparate rates, often a result of the skills and knowledge of the staff they employed. The growth period of the 1990’s heightened the disparity and has resulted in differing levels of organisational capacity. Some organisations manage as little as 4 supported accommodation services whilst others are multi million dollar enterprises providing a suite of services in most parts of the State.

To then entertain discussions about a sector with no reference to this disparity creates the illusion of capacity beyond achievement. The larger operators in the CSO sector and NDS as their peak body, continue to indicate their ability to manage services currently managed by the Government at a cheaper rate. They do not disclose that this would be at the cost of staff wages and conditions, whist needing to retain the skills of existing staff, particularly in the current workforce retention crisis. At the same time, the CSO sector continues to seek parity with the Government sector around wages and conditions. These arguments are contradictory. This would not provide improved service to the people residing in the supported accommodation services, to the contrary there would be further workforce damage and skill loss.

Recent references by CSO lobbyists to Tasmania contracting out the government supported accommodation services to the CSO sector need to be qualified with the detail. There were only 9 properties involved with the CSO sector being the dominant provider of supported accommodation...
services in Tasmania managing some 139 properties. Existing staff were redeployed into the public service, or took redundancy packages, creating a significant skill loss in the arrangement. By contract, the government in Victoria manages some 600 services, with 2 larger congregate care facilities. It is clearly not possible to compare and apply insight from 2 such differently sized and configured service systems. The opposite hypothesis could be applied that the larger service provider takes over the smaller, resolving a number of the capacity issues.

PRIVATE PROVIDERS

With regard to private providers, we have a strong view that public money should not be expended on services with a focus on shareholder profit. This focus impacts on the capacity of individuals to purchase the greatest level of support or it would be provided at the cost of workers being paid significantly less money. This, in turn, results in the continued challenges of recruiting and retaining a quality, trained workforce. There is also little accountability that can be required of private operators and this could leave individuals quite exposed. We provide the following case study as our most recent experience with a private provider:

Case Study

In mid 2005 in Victoria, a privately run service for eighty people with an Acquired Brain Injury that employed nearly sixty carers, went bankrupt.

Initially it had been set up as one company but the directors created a second company into which the assets were transferred, thus leaving one company holding the assets and the other holding operational responsibility for service provision. Clients continued to pay the initial company with operational responsibility for all services. In initially establishing the facilities, some residents had advanced the company a loan of money to achieve renovations they required for their room.

After bankruptcy of the company responsible for operating services, the Administrators estimated staff were owed over $500,000. This sum included back payment due for under award entitlements and unpaid entitlements included Long Service Leave, annual leave and redundancy entitlements. One client was owed $16,000, a cost incurred for renovations. The second Company’s assets, including the all properties in which people resided, were estimated to be over $3 million in value. This money was not accessible because this company had no responsibility to the operational company upon division.

All employees were sacked without notice and clients were given 60 days notice of eviction, some of whom had lived in their houses for 9 years. Staff received payment through the Federal GERS scheme and clients were left with money still owing them. The 2 directors retained their assets in the second company and were not held responsible for the debt of their second company.
FOCUS: QUALITY OUTCOMES FOR SERVICE USERS

We contend there are three pillars necessary to underpin the capacity of staff to deliver the protection of people's rights and enable them to achieve a meaningful life in the community, these are:

- A focus on staff training
- Good staff support
- Open and accountable service governance.

Without all three being robust and in place across a service, the capacity to deliver quality service outcomes is compromised and external scrutiny is less effective.

In terms of quality outcomes for service users there is a direct correlation between service adequacy and the capacity of service management, service governance, and the support and training given to all staff. These are critical factors in determining the quality of service delivery. To ensure quality outcomes it is vital that there is commitment and investment in strategies such as:

- Appropriate training
- Clear but not onerous or conflicting procedures
- Leadership and supervisory development
- Proper human resource management practices
- Security of employment

In our experience the DHS has a better record than the CSO’s in addressing these issues. This is not to say that there are not good CSOs where these matters are adequately addressed, but most have less robust accountability and quality frameworks. The CSO sector would contend that they are not funded at a level that would allow for the implementation of these strategies. This would be an example of the issue around organisational capacity discussed in question 3.

We believe that the debate about Government v non-government service providers is a distraction. The key issue is that there are simply not enough access places and not the available workforce to provide these services.

It is vital to remain embedded in a system if there is to be influence and control over such outcomes.

The current balanced distribution of services across the government and CSO sector should be maintained, with regard to of the issue of organisational viability raised in question 3. Future investments would also be equally distributed to ensure the ongoing development of a robust and viable system. The sectors are connected and related, with the actions of one impacting the other.
Just as in many other public services, DHS needs to lead the way, invest in the new approaches that can then flow out to the CSO sector.

**Recommendation**

- That government remain an active manager of disability supported accommodation services
- That government continue to invest new monies equally in the government and CSO sector.
- That government give consideration to implementing a process of ‘true’ review that would see equitable funding to the CSO sector having regard to the salary packaging arrangements.
- That government increase CSO regulation, accountability and transparency of service, following the review recommended in question 3.

**Q6. WHAT ARE THE POSITIVES AND/OR NEGATIVES OF THE CURRENT APPROACH TO THE PROVISION OF SUPPORTED ACCOMMODATION ON FAMILIES AND CARERS?**

Families have consistently sought ongoing safe accommodation for their relatives with profound disabilities. A safe comfortable home with the supports to enable one to have a good quality of life is at the very basis of any hierarchy of needs. In our view, whether this is support delivered by separating housing from it, is less important than the issue of providing ongoing security and quality.

Families want a safe sound, respectful, caring and permanent residential place for their relative and many worry about the sustainability of the service their relative receives. Typically, families worry when services change e.g. deinstitutionalisation, that their relative will have less services or will be left homeless. When families have seen the outcomes, so far, of deinstitutionalisation for their relative, they typically acknowledge the outcomes are much better than they had before.

In Victoria, most redevelopments of congregate care services have been undertaken in consultation with HACSU and have resulted in services being directly managed by government as a direct request of families.

The current system of allocation a ‘place’ rather than a package provides families and carers with the security and comfort of knowing that their family member has a ‘home’. The shifting focus to the provision of ‘packages’ or ‘funding’ does not provide this same level of comfort. Whilst there are some families and carers who do like this new approach, this view would be the exception. Many carers and families love and support their family member but still want them to move out of home.
Q7. WHAT ISSUES NEED TO BE CONSIDERED IN THE ACCESSIBILITY AND PROVISION OF SUPPORTED ACCOMMODATION FOR PEOPLE FROM:

- RURAL AND REGIONAL VICTORIA
- CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS
- INDIGENOUS VICTORIANS

RURAL AND REGIONAL VICTORIA

The impact on people with a disability living in the relatively sparsely populated and/or geographically isolated regions of Victoria illustrates the issues inherent in person centred planning in the absence of place based planning as described by Stimson (Stimson et al. 2003).

Supported accommodation tends to be located in the larger rural towns, although there are some services in quite remote locations. Although there are marginally more supported accommodation places per head of population in regional Victoria than in Metropolitan Melbourne, there remains a very significant unmet need in regional Victoria. This is exacerbated by the tyranny of distance. People who do get access to supported accommodation in regional Victoria are likely to be moved significantly from their community of origin. Over time, the costs to individuals and their relatives of maintaining regular connections with each other over such distances tends to weaken these connections. This is particularly the case for those people whose disability prevents them using technologies commonly available to maintain contact with distant relatives and friends.

The application of individual packages in the absence of low cost housing does not address this critical issue. People living in remote areas, even with a package of funding cannot get the support they need. The individual packages do not include physical structures, so will only maintain the person in their own home, which is not always appropriate. Even if supports were available, when the person’s support needs are high, the funding is inadequate to meet their needs without ‘pooling’. And there remains the constant problem of finding appropriately trained and capable staff to provide the service, an even greater challenge in rural Victoria.

HACSU believes that the answer is ‘place based’ planning and delivery from regional hubs.

"In Victoria, diverting growth funding from the investment in services to individualized funding has had negative implications for people with higher levels of support needs, for people living in areas where access to housing-both in the private and public sector-is more restricted and for people living in remote locations where it is difficult to receive individualized supports” (Ilan Vizel, Individualised
funding in the context of scarce resources and inaccessible housing markets Faculty of Architecture, Building and Planning, University of Melbourne)

CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) BACKGROUNDS

The shortage of accommodation places in Victoria has a disproportionate impact on people from culturally and linguistically diverse backgrounds. A number of factors are likely to lead to this outcome. Among these we put forward the following as significant.

The disability field suffers from a ‘forest of terminology’ (Clement T, Bigby C, Building Inclusive Communities: Facilitating community participation for people with severe intellectual disabilities. Pages 16-20, and various) that is confusing and alienating for everyone and likely to be particularly so for those from CALD backgrounds.

Pathways to access are now even less clear than before the passing of the DSA, and the rhetoric of the State Plan can be very confusing.

Understandings in the wider community and its bureaucracies, of pathways to disability services and supports are fragmented, at best. Consequently people from CALD backgrounds are unlikely to be able to obtain appropriate advice about these in their dealings with their communities and other parts of the bureaucracy and local government.

There is a sense that services are not always culturally sensitive to their needs, particularly when they have a differing vision to the Disability Act 2006.

We are unaware of attempts to attract CALD workers into the service system, it is accident rather than design. We would suggest that the ‘forest of terminology’ actively discourages workers from CALD backgrounds considering a career in the service. We recognise that DHS has funded training for workers from CALD backgrounds to become professionally proficient in written English, but the application of this training was to a very limited target group, and should be extended. This is particularly so when it is said that this group of workers will be one of the future areas to be targeted to deal with recruitment issues.

Government needs to ensure that services are equitably delivered, and guard against a risk inherent in the IP&S framework in the absence of ‘place and population’ based planning, that the more well resourced and articulate families can bring most pressure to bear and get disproportionate access to resources for their relatives.
INDIGENOUS VICTORIANS

'Indigenous people have significantly higher rates of profound and severe core activity limitation than non-Indigenous people...Indigenous people aged over 18 years who had a profound or severe core activity limitation was approximately 2.4 times that of non-Indigenous people in 2002' (Report on Government Services 2008 - Indigenous Compendium - Steering Committee for the Review of Government Service Provision Report, Productivity Commission)

As indicated elsewhere in this paper, the government needs to ensure the service system is balanced and equitable in application, and HACSU is concerned that some of the rhetoric potentially further marginalises the most disabled.

The absence of culturally appropriate disability supports for indigenous people, together with the proportional allocation of funds, is, we contend a stark example of a system unbalanced in its application. Training around the particular support needs or cultural issues is not part of the training that staff receive, thus making the service responses hit and miss.

Workforce attraction and retention seems to have particularly difficult in rural areas, and it is assumed this relates to the potential pool from which disability workers can be drawn. As well, we are unaware of any specific attempts by Government to recruit indigenous workers to disability accommodation services.

Recommendation

- That the Government apply a ‘place based’ planning and population based planning across regional Victoria.

- That the Government ensures that its services are equitably delivered, and guards against a risk inherent in the IP&S framework in the absence of ‘place and population’ based planning, that the more well resourced and articulate families can bring most pressure to bear and get disproportionate access to resources for their relatives.

- That the government invest in recruitment, training and retention strategies to attract workers to regional areas.

- That the government invest in recruitment and retention strategies specifically aimed toward recruiting and maintaining indigenous workers and workers from CALD backgrounds.
Q8. **WHAT OTHER ISSUES DO YOUR THINK NEED TO BE CONSIDERED WHICH HAVE NOT BEEN ADDRESSED BY THE ABOVE QUESTIONS?**

**WORKFORCE - OUR PASSION**

The Disability workforce is facing major attraction, retention and skills growth problems. Without some major and industry wide policy/funding and intervention this situation will not improve and we believe that service provision reform and change will stagnate as a result.

Sound workforce capacity and skill level underpin any quality and productive service system.

There is no short-term, quick fix to developing and/or repairing workforce problems, particularly when there have been long periods of workforce neglect and cost cutting - such as the 1990's which effectively saw 10 years of cuts to training and the breaking down of professional career structures.

Both government and non-government service providers have major attraction, retention and skill level issue facing them. However, problems are particularly chronic in the non-government sector; the government sector has fared better since 2000 with greater leverage of a single workforce, greater capacity of a single management and greater ownership and investment by government as employer.

By contrast, the non-government service providers have not leveraged funding models that provide for capacity building around workforce and skills development, nor have the non-government service providers been collectively pure in passing on Government funding increases to their workforce. There has been a pattern of many, usually smaller, NGO's not passing on wage growth funds to employees; this is exacerbating workforce attraction and retention problems in the sector and expanding wage disparity problems.

The drivers around Disability workforce attraction and retention are varied and interrelated. Wages are poor; there is low recognition and valuing of care work; care work is not seen as part of the productive economy and as a result they don't leverage higher pay. The working arrangements (rosters) are not family friendly, work is structured only around peoples primary care needs which results in work being predominately part-time with a high level of casualisation. The career structures are flat and there are poor career development opportunities.
TRAINING AND SKILLS DEVELOPMENT

Both on and off-the-job training are of fundamental importance within the disability sector. Training and skills development impacts on quality outcomes for service users, work culture, career development and retention.

The research report 'Identifying paths to skill growth or skill recession: Decisions for workforce development in the community services and health industries', commissioned by the Industry Skills Council, argues that broadly speaking employers generally have little incentive to train their employees as it is in their interest to keep their costs down. If they train people they have to pay for that training and then may have to increase employees pay in acknowledgement of that training.

The report argues and identifies the preconditions which lead to skills growth or skills 'atrophy' in organisations, atrophy being different to skills recession - failing to attract people to train. We would argue this is particularly salient to the Disability workforce and in particular within the CSO sector. In our view, the preconditions that lead to skills atrophy exist within the Victorian disability services, i.e.:

- **Funding models** - do not support in-service training (low investment)
- **Ownership and capacity** - Larger organisations have more scope to train than smaller ones and competitive pressures between CSO puts pressure on smaller organisations.
- **Employment structures** - Hours of work and working arrangements in disability services make it difficult to release staff for skills training.
- **Job Design and Perceptions** - value of work, caring roles not seen as part of productive economy - reflected in low skill set expectation and career pathways.
- **Incentives to train** - Restricted career pathways, no funding for promotions or recognition of skills enhancement and work intensification combine to create disincentive to train. Organisations do not give skills growth a sufficiently high enough priority and funding models do not support it.
- **Perceptions of customer need** - Moves to focus on the new Individual funding models is problematic for skills growth. Training is not a factor in the individualised funding approach and there is little work being done to ensure that the funding model doesn't create disincentives to invest in skills. i.e People purchase low skill services, that will impact on quality and increase risk.

In short the combination of these Attraction Retention and Training issues result in the Disability sector not being seen as 'career of choice'.

Response to Victorian Parliamentary Inquiry Into Supported Accommodation for People with a Disability or Mental Illness – Disability Component
HACSU submits that that there is a need to increase funding further with specific ties to training outcomes in the sector. There needs to be a major Disability workforce and training strategy developed, funded and implemented to arrest the current skills and workforce problems. Some of this work has commenced but will fail without significant financial investment to support the initiatives.

Without a deliberate decision to move to a skills growth approach to the provision of Disability supported accommodation services with the required, significant injection of additional funds directed to this activity, the outlook for quality service provision is looking bleak. We already have a significant skilled workforce crisis without additional pressures around retention.

**SUPPLY OF SUPPORTED ACCOMMODATION SERVICES**

A fundamental focus for families and carers when needing to make decisions around the support of their child/family member with a disability is one of permanence and certainty. Whilst there is a decline in the support for the community residential unit, there is a loud and clear voice from families; they want a physical place. The move to individualise funding has not included any notion of the physical provision of houses for service provision. This lack of funding will result in the limitation of physical placement offers.

The provision and maintenance of accommodation suitable for the residence of people with many and varying disabilities is costly and requires an ongoing budget for the replenishment of old stock and the purchase of new stock in developing areas. The structures required are often unaffordable to individual families, again making it an appropriate government activity. Funding people to buy-in the support they need to live independently assumes that the services exist or will develop in response to the funding model. This has major planning, quality accountability and protection issues for individuals in receipt of packages.

As previously mentioned, since 2003 all new funding has been in the form of individual packages, most of which are not at a level that could support people in greatest need. We believe this strategy fails to address the issue of the increasing demand for accommodation places and has diverted attention away from this issue. In the last five years there has been no funding allocated to increase Community Residential Unit stock which continues to be identified by families as their preferred option, particularly where clients have ageing parents.

HACSU contends that in order to address this service shortfall there should also be new investment in accommodation stock. The Office of the Public Advocate [OPA] echoes this view. The Community Visitors Report 2007 recommends, among other things: 'that the government urgently prepares a strategy to plan and build more disability specific accommodation of the CRU type, to avoid an escalation of the crisis in unmet accommodation needs and eliminate the use of respite beds for emergency accommodation.'
Recommendation

- HACSU urges the government to review the existing service options and configurations to expand the models of care beyond a 'one size fits all approach'.

- HACSU urges the government to invest in such options and fund the necessary support requirements to deliver quality, individualised services.

- A major Disability workforce and training strategy developed, funded and implemented to arrest the current skills and workforce problems.
12 November 2008

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

Dear Committee members and Staff

Re:  HACSU Submission – ‘Mental Health’ - Provision of Supported Accommodation for Victorians with a Disability or Mental Illness

Enclosed please find the first submission (Mental Health Component) of the Health and Community Services Union in respect to the Inquiry into the ‘Provision of Supported Accommodation for Victorians with a Disability or Mental Illness’.

Our written submission in respect to the 'Disability Component' will follow by mid next week.

Thank you for the opportunity to make a contribution and submission to the inquiry

Yours Faithfully

[Signature]

Lloyd Williams
State Secretary
Victorian Parliament Family and Community Development Committee

Inquiry into Supported Accommodation for People with a Disability or Mental Illness

Submission of the Health and Community Service Union

Mental Health Component
Victorian Parliament – Family and Community Development Committee
Inquiry into Supported Accommodation for People with a Disability or Mental Illness

Submission of the Health and Community Service Union
Mental Health Component
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EXECUTIVE SUMMARY

Introduction

The Health and Community Services Union (HACSU) represents the industrial and professional interests of Victoria’s Mental Health Workforce. HACSU has a long history of actively participating in mental health policy development and reform.

The Committee’s Inquiry is welcome. In Victoria, supported accommodation for people with a mental illness is under-developed, under-resourced and in need of urgent action to meet existing, let alone future, service needs.

The present range and level of supported accommodation for people with a mental illness is inadequate. There are deficiencies in both the number of beds and also their distribution across the state. The impact is seen in increased numbers of people with mental health problems in the following settings:

- On informal but very real waiting lists for CCUs, SECUs and all types of Residential Rehabilitation beds;
- Waiting in Emergency Departments for admission to acute psychiatric inpatient unit beds;
- Being held in police cells.
- Accessing homeless shelters.
- Living in sub standard accommodation.
- Living on the streets.

The supported accommodation system, including clinical and Psychiatric Disability Support Service (PDRSS) sectors, is an interdependent system where both action and inaction in one sector will always impact on other sectors, or beyond in the broader community.

This Executive Summary outlines key points in HACSU’s response to the questions posed in the Committee’s Discussion Paper, and associated recommendations.

Key Points and HACSU’s Recommendations

The supported accommodation for people with a mental illness being considered by the Committee includes clinical services such as secure extended care (SECU) and community care units (CCUs), as well as non-clinical services provided by the PDRSS sector. In addition, the private sector operates Supported Residential Services.

Each of these services is described in detail later in this submission, with attention paid to problems of availability and demand pressures.

Clinical Accommodation Services

Victoria’s clinical accommodation services are operated and managed by Area Mental Health Services (Public Hospitals). These bed-based services face particular demands as a result of existing bed numbers not keeping pace with population growth, the increase in the prison population, inadequate development of exit pathways (especially in the complementary PDRSS sector) and other factors such as the downward trend in the availability of affordable mainstream housing.
Recommendations:

1. High priority should be given to construction of the extended care clinical facility on the former Heidelberg Repatriation site, to increase the number of SECU beds.

2. The shortfall in CCU beds for the north-east and northern metropolitan areas should be resolved by provision of additional CCU beds to meet increased demand related to population growth in the northern corridor. **HACSU also considers the Goulburn Valley has a need for a CCU and that a CCU be provided as promised in 2006.**

3. An immediate review should be undertaken regarding the adequacy of CCU beds to meet the access needs of consumers in rural and regional areas and outer suburban growth corridors.

4. Additional SECU beds should be built in metropolitan areas to ensure access for consumers from designated rural areas.

5. CCUs are a key component of the supported accommodation service system because they provide 24 hour on-site clinical support for clients with complex conditions, including monitoring responses to treatment. This function should be clarified and re-affirmed, and not blurred with that of non-clinical bed-based services.

**Psychiatric Disability and Rehabilitation Support Service (PDRSS)**

This sector complements clinical services by providing recovery focused non-clinical supported accommodation for people with psychiatric disabilities.

PDRS supported accommodation is also under considerable demand pressure, especially residential rehabilitation services. Further, the slowdown in the supply of public housing means people with psychiatric disabilities have diminished access to affordable mainstream housing due to increased competition with other population groups, unless they are pushed into homelessness and obtain priority as a consequence.

**Recommendations:**

1. Prevention and Recovery Care Services (PARCS) should be established for each of the 21 Area Mental Health Services (AMHS) across the State.

2. PDRSS supported accommodation should be expanded, in particular residential rehabilitation services for adults, and home-based outreach support.

3. Additional funding should be made available for public housing, with a targeted quantum for the purchase of housing units for people with psychiatric disabilities.

4. Extend existing PDRSS managed long-term supported accommodation with seven days per week on-site disability support, and clinical in-reach from the local Area Mental Health Service specifically for people with a mental illness who require on-site, non clinical daily support (e.g. meals and medication supervision) due to ongoing persistent psychiatric disabilities.

**Private Sector**

The private sector provides supported accommodation in the form of Supported Residential Services (SRS). Those consumers accommodated in SRSs range in age and type of disability, and can include frail older people alongside younger people with psychiatric disabilities, acquired brain injury or intellectual disability, at times with problematic use of alcohol and other drugs. This raises major concerns about the quality of care. Furthermore, the cost of even pension-level SRSs leaves little over for residents' personal expenses, creating a poverty trap. It is important to note that assisting a resident's rehabilitation and recovery is not part of the remit of an SRS.

HACSU has major concerns with this form of supported accommodation being used for people with psychiatric disabilities, especially where this arises from a lack of more appropriate alternatives.
Recommendation:

1. HACSU considers that the continuing problems with SRSs over time demonstrate this is not a service model warranting endorsement.

The Role of Government

Recommendations:

1. At a broader level, HACSU recommends that government take a lead role in developing and strengthening the overall accommodation support system in the interests of people with a mental illness, and their family carers. This role includes:
   1.1. Planning, developing and funding supported accommodation
   1.2. Setting standards for what is provided, and
   1.3. Monitoring the extent to which these standards are met.

It is critical that these responsibilities are carried by government to ensure transparency, accountability and continuity in terms of service provision. Furthermore, it is a government responsibility to ensure equitable access to supported accommodation across rural and regional Victoria and metropolitan areas, especially outer suburban growth corridors.

Workforce and Related Issues

In this submission, HACSU raises additional issues of concern in relation to the workforce who provide supported accommodation services.

Recommendations:

1. Establishment of a comprehensive workforce strategy to overcome problems of recruiting and retaining a skilled workforce for supported accommodation services.

2. Provision of regular statewide in-service training for staff of clinical bed-based services so that all staff are kept informed about evidence-based practices and service innovations.

3. Additional resourcing to provide mental health advice and support for staff working with clients with intellectual disabilities in Community Residential Units, particularly in managing residents with mental health problems such as anxiety or depression.

4. More strategic use of 'individual support packages' for clients with complex and multiple needs. HACSU considers that a balance must be maintained between establishing services to meet known gaps, and the funding of individual support packages when appropriate services might not be available. Evaluation and review of client outcomes of 'individual support packages' should occur as a matter of urgency.
HACSU Submission to Family and Community Development Committee Inquiry into Supported Accommodation for People with a Mental Illness

MAIN SUBMISSION

Introduction

Being appropriately housed is an essential and basic requirement for good mental health. Without adequate accommodation and the right level of support, people with a mental illness cannot move towards recovery and instead can remain trapped in a cycle of poverty and illness. From a service perspective, this cycle leads to increased demand on high cost bed-based services such as acute psychiatric inpatient beds, and to extended waiting times for mental health clients in Emergency Departments. It contributes to homelessness, and places additional stress on the correctional system.

Victoria has already piloted and established different types of supported accommodation. As a result, there is a solid body of knowledge about what works for whom. What is now required is a readiness to ensure that all areas across the State have access to the full range of accommodation options, so that access to appropriate services is not dependent on where you live.

It is important to emphasise that supported accommodation for people with a mental illness is an interdependent service system. What happens in one part of the system affects other parts, even if those who manage the various components do not always acknowledge this. We already know that when one service component is missing or inadequately resourced, this will have a direct impact on how others function.

A good example of this service interconnectedness is secure and extended care unit (SECU) beds. This is the most secure of the types of supported accommodation being considered by the Committee. The current number of SECU beds is inadequate and the range of post-discharge options for patients is insufficient. As a result of limited SECU beds, patients whose clinical condition warrants admission to a SECU have to remain elsewhere in the service system, often in an acute mental health inpatient unit (a more expensive and less suitable alternative), until a SECU bed becomes available. Access to that acute bed for a person waiting in an Emergency Department for admission is therefore blocked. Furthermore, where there are insufficient post-discharge options for SECU patients, then access to the existing SECU beds will be restricted.

Patients who remain in a clinical bed-based service because the more appropriate option is not available are often unflatteringly referred to as 'bed blockers'. However, the incidence of bed-blockages in itself demonstrates service gaps in the types of supported accommodation which are being considered by the Committee.

HACSU is also concerned about workforce issues, including the availability of staff with the right mix of training, skills and experience for the different types of supported accommodation. In addition, we highlight the importance of access to regular training, and of providing mental health consultation for disability service staff. Lastly, we note an increasing trend to fund 'individual support packages', and are concerned this can erroneously assume that the right services are already in place.
Question 1: The current provision of supported accommodation in Victoria - What is its availability, suitability and adequacy of care for people with a mental illness?

Key differences in the roles of clinical and PDRSS bed-based services

The Discussion Paper's list of supported accommodation for people with a mental illness includes both clinical (operated and managed by, Public Health Area Mental Health Services (AMHS) and Psychiatric Disability and Rehabilitation Support Services (PDRSS) supported accommodation. Whilst their roles are overlapping, these two service categories also have quite different but complementary functions.

Clinical bed-based services focus on treating and managing a client's clinical symptoms, including a small group who for various reasons do not respond to 'standard treatments' or initial psychosocial support. The structure and staffing of these services is also designed to manage behavioural problems such as repeated self-harm, ongoing substance abuse and aggressive behaviour.

In contrast, PDRS bed-based services are not staffed or structured to manage these behaviours, nor to provide active treatment. Instead, their focus is on managing disability. This includes assisting residents with community and social integration, and promoting recovery through helping residents regain capacities lost through illness. Clinical input to clients in PDRS bed-based services is provided by the local Area Mental Health Service (AMHS) on an in-reach basis.

An Overview of AMHS Clinical Bed-Based Accommodation

Secure extended care units (SECUs) and community care units (CCUs) are clinical bed-based services which, like acute inpatient units, are staffed on a 24 hour basis by mental health nurses. Other mental health professionals, such as psychiatrists, psychologists, social workers and occupational therapists, provide assessment and treatment during the day.

Importantly, these services provide containment, and are able to manage people with complex behaviours and persistent psychiatric symptoms. In these clinical settings, various treatment and psychological approaches can be tried and monitored in an environment which is safe for both the individual and the community.

Secure Extended Care Units (SECU)

Suitability and adequacy of care

Secure extended care beds are an essential component of a modern mental health service system. Patients admitted to a SECU exhibit behavioural disturbance which poses significant risk to themselves and the community, and requires extended management in a restricted environment. If sufficient SECU beds are not provided, there is increased pressure on costly and scarce forensic mental health beds. SECU beds are also an important exit option for patients from forensic mental health services. SECU also provide intensive treatment and support for patients whose mental illness has been significantly complicated by other conditions such as intellectual disability, acquired brain injury and misuse of alcohol and other drugs.

In Victoria, there are three dedicated SECUs, all based in the metropolitan area and ranging in capacity from 20 to 26 beds. Each is managed by a public hospital as part of their Area Mental Health Service, and located on the relevant hospital campus. In rural areas, a handful of nominally designated SECU beds exist (32 in total). The Thomas Embling Forensic Hospital also has 40 beds which are designated as SECU.
SECU replaced the locked long-term wards of the former psychiatric institutions before these were closed. They were established from 1995 to 1998. Local PDRSS may be engaged to provide individual or group rehabilitation opportunities for SECU patients either on an in-reach basis, or in the surrounding community, in order to prepare them for movement to a less restrictive environment when their clinical condition improves.

Availability

In 2006, the Victorian Mental Health Branch investigated the capacity and demand pressures on SECU and other clinical and PDRSS bed-based services. The ensuing Report, entitled 'An analysis of the Victorian rehabilitation and recovery care service system for people with severe mental illness and associated disabilities' (henceforth referred to as the Project Report) was published in August 2007 (www.health.vic.gov.au/mentalhealth/atoz.htm). It provides a revealing snapshot of the problems due to under-supply in relation to SECU beds. The Project Report estimated that on average, for each SECU, eight people were waiting for admission, half of whom were in acute inpatient units (Project Report, DHS, 2007, p.22-23). Others outside the mental health system are in prisons and police cells. At the discharge end, the 2006 Boston Consulting Group Report (Improving Mental Health Outcomes in Victoria: The Next Wave of Reform, Melbourne, BCG, p.64) estimated that 20 per cent of SECU patients could be moved to a less intensive service option, if beds were available, such as CCUs and 24 hour staffed PDRSS.

There is a significant under-supply of this type of clinical bed-based service in Victoria. In March 2006, there were 103 SECU beds (Project Report, 2007, p.5 & 52). Effectively the 71 beds in the three metropolitan SECUs are all that is available for the State, because the small number of rural beds designated as SECU (from 3 to 12 beds per area) are often not fully secure, due to the lack of economies of scale. Also, the 40 SECU beds at Thomas Embling Forensic Hospital are fully utilised by the correctional system. The overall shortage of SECU beds is evidenced by the increasing number of patients in acute inpatient units waiting for a SECU bed.

Original estimates of the number of SECU beds required in Victoria were based on institutional populations in 1994, now fourteen years ago, which did not anticipate recent significant population growth and were not evenly distributed. The higher incidence of dual diagnosis, especially amphetamine use, has also contributed to demand for SECU-type beds. Additional pressure arises from increased demand due to the upsurge in the prison population both sentenced and remanded.

In the 2006-2007 budget, $9m was allocated for Stage 1 planning for an extended care clinical facility on the former Heidelberg Repatriation Hospital site. **HACSU considers it is imperative that construction of this facility be given high priority.**

The community will hold the Government accountable if access to secure and supported services is not available for people with mental illness who, rightly or wrongly, are considered to be dangerous and a threat to community safety.

Community Care Units (CCU)

Suitability and adequacy of care

CCUs are another clinical bed-based service. Each of the 21 Area Mental Health Services (AMHS) has access to CCU beds. However, the number of CCU beds and their configuration varies from area to area. For instance, a metropolitan CCU would typically have 20 beds distributed across four or five housing units on the same block. In the country, rural services usually have fewer CCU beds which may be co-located with another type of bed-based service.
The key difference between a CCU and SECU is that SECU provides a secure environment in order to achieve individual and community safety. CCUs are not locked facilities and are usually based in residential areas, with a street address, rather than on a hospital campus. They provide medium to long-term clinical support and rehabilitation in a home-like setting. Typically, CCU residents have ongoing symptoms which require clinical management, such as a variable response to medication. Clinical input and the trialing of ongoing treatment options are central to a CCU's operation.

Like SECU, the two key features of CCUs are their capacity to manage complex behaviours, including concurrent substance abuse, and to apply and closely monitor the response to different psychological, behavioural and pharmacological treatment approaches. As with SECUs, a PDRSS might engage with individual CCU residents to provide additional rehabilitation opportunities in the local community, as part of the process of preparing residents for living in alternative non-clinical accommodation in the future.

CCUs represent an important step-down option for patients well enough to leave either SECU or the forensic mental health inpatient service, for whom there are few available supported accommodation alternatives following discharge. In addition, CCUs provide an exit pathway for patients in acute inpatient units who require extended clinical support to stabilise their symptoms. When these services are not available and patients are discharged to alternatives with insufficient support, their condition tends to deteriorate rapidly. They then end up in services which do provide containment, including Emergency Departments, acute inpatient units, police holding cells and ultimately, prison beds.

Availability

As with SECU, the number of CCU beds is based on outdated estimates from the time of institutional closures in the mid-1990s. Again, the 2006 analysis by the Mental Health Branch reveals the inadequate supply of CCU beds (Project Report, Melbourne, DHS, 2007, p.24).

This analysis estimated that on average, six people were on the waiting list for each CCU bed. About a third were in acute inpatient units, 13 per cent in SECU and a third were being managed by a community-based clinical team. The limited exit pathways for CCU clients were identified as a problem for 'throughput', especially in rural areas (Project Report, Melbourne, DHS, 2007, p.24).

Data shows that the 'Long Stay Patients' (>32 days) in acute inpatient units is running at an average of 16% with the highest at 29% this is almost double the previous year. (Department of Human Services Mental health – Key Performance indicators – Adult (Year to Date) Quarters 1-4, 2007-08)

There are particular pressure points in terms of the distribution of CCU beds. For instance, in the metropolitan area, the North-East AMHS does not have its own CCU. Instead, it has access to the 20-bed CCU in Preston run by the Northern AMHS. However, the catchment area of Northern AMHS includes one of the major growth corridors in Melbourne.

The government has already acknowledged the requirement for additional mental health services due to the population increase in this catchment area. This is shown by the funding allocated in the 2007-08 State Budget for an extra 25 acute psychiatric beds at Northern Hospital. However, no funds were made available to provide more CCU beds, either for an additional CCU in the rapidly developing outer parts of the Northern AMHS catchment area, or for a CCU for the North East AMHS to relieve pressure on the existing Northern CCU. HACSU considers that provision of these beds should be an immediate priority.

Furthermore, a review should be undertaken as a matter of priority, to ascertain access and ensure adequate provision for AMHS of CCU beds in significant growth corridors in both rural and metropolitan areas.
In addition, HACSU is concerned that the recent *Mental Health Matters* Consultation Paper (DHS, 2008) raised the possibility of 'loosening the boundaries' between CCU and PDRSS Residential Rehabilitation Services (RRS). This ignores the essential role undertaken by CCUs in providing a step-down function for patients of SECU, forensic mental health services and to a lesser extent, acute inpatient units. This function is used for patients whose level of clinical need means they could not be safely placed in the more open environment of a PDRSS supported accommodation service.

Currently the Shepparton/Goulburn Valley area has been denied a CCU, making this community one of only three in Victoria that does not have access to its own CCU. Promised by the State Government, in the 2008 State Budget the new 'CCU' has in fact now turned out to be an existing RRS that was merely moved into a new building. Although it is described as a 'unique' and new partnership, it is actually the same as all RRSs, that is, a service managed by a PDRSS with clinical input provided by the local mental health service.

Shepparton/Goulburn Valley should not be forced into a situation of 'either a CCU or a RRS'. As outlined earlier in this document, the two have quite distinct functions. For example, metropolitan areas have both RRSs and a CCU, each service working collaboratively to meet the range of needs in that community. Most rural areas have CCU beds and also a RRS for young people (to date, the number of RRS for adults have been limited to metropolitan areas for historical reasons).

As argued elsewhere in this submission, all communities need access to RRS beds. However, like every community in Victoria, the Goulburn Valley also needs a CCU in order to cater for their high needs clients. Instead, the people of the Shepparton/Goulburn Valley area are being short-changed. They are being denied a fundamental component of the suite of mental health services accepted as a benchmark for all AMHS across the State, and which 86 per cent already have in place.

HACSU considers there is a need to clarify and reaffirm the role and function of CCUs, rather than blurring their distinctive role with that of a RRS. HACSU considers the Goulburn Valley has a need for a CCU and that a CCU should be provided as promised in 2006.

Clinical bed-based services like SECUs and CCUs are a fundamental component of the whole supported accommodation system. These clinical bed-based services provide an essential alternative for clients of PDRSS supported accommodation who become unable to cope with the more open environments of PDRSS, or who simply need extended clinical treatment to settle their symptoms so they can focus on recovery. This critical function has been overlooked by the advocates of 'loosening the boundaries'.

This proposal also ignores the significantly increased demand such a move would place on an already over-stretched number of acute mental health inpatient beds. If CCUs no longer functioned as CCUs, a RRS resident whose mental illness worsened would have to be admitted to an acute inpatient unit. If the local CCU was still operational, the resident could be transferred to the CCU until the person's mental state improved, even if this took some months.

**Prevention and Recovery Care Services (PARCS)**

**Adequacy and Suitability**

Victoria has led Australia in developing this innovative and collaboratively-managed new service type. The local AMHS is responsible for the clinical management of the local PARCS, but a PDRSS runs the day to day operations. The first PARCS in Victoria was opened in Shepparton in 2004. It is managed by Goulburn Valley AMHS in partnership with Mental Illness Fellowship Victoria.

The PARCS undertake a 'step-up' function by providing an alternative to acute inpatient admission for a person who can be managed in the community without intensive hospital care. For a patient leaving acute inpatient care, PARCS offer a 'step down' period of transition and stabilisation before the person returns to their usual living situation. Typically, the local AMHS provides clinical input on a regular basis to their area PARCS. This may take the form of staff from the local Crisis Assessment and Treatment Service (CATS) spending time at the PARCS on a daily basis, or some other arrangement for regular clinical input.

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Response to Victorian Parliamentary Inquiry into Supported Accommodation for People with a Disability or Mental Illness
There is already abundant evidence that PARCS are performing a valuable role in the mental health service system, although a comprehensive evaluation has yet to be undertaken. It is also important to note that PARCS provide (sub) acute care. In order to ensure this key function, it is essential that the PARCS are managed by AMHSs within the suite of acute focussed services which include Emergency Departments, CATS and acute inpatient units. This ongoing strategy of in-reach acute assessment and treatment, and AMHS management keeps the PARCS from becoming a de facto longer-term accommodation option and guarantees client throughput.

**Availability**

Not every area mental health service has a PARCS. Only five fully-fledged PARCS are operational in Victoria. In two other AMHS, a partial form of PARCS is in place: Barwon, with six beds co-located with the Geelong CCU, and eight 'Rehabilitation PARC' type beds in Flemington in the inner west metropolitan area.

In the 2008-09 State Budget, government funding was committed to establish a further seven PARCS. These are to be in the northern, mid west, south west, outer east, North West and Middle South metropolitan areas, and the Mornington Peninsula. However, these developments will take time. As yet, there is no government commitment to provide the remaining seven AMHS with PARCS beds.

**HACSU considers that the Government should give urgent priority to the provision of a PARCS for each of the 21 AMHS across the state.** In addition, a watching brief should be kept on the need for a PARCS in the catchment area for the acute unit at Casey Hospital, which is located in a significant growth corridor.

**Psychiatric Disability and Rehabilitation Support Services (PDRSS) Supported Accommodation**

**Adequacy and Suitability**

Victoria’s PDRSS sector provides a range of supported accommodation, and represents the next step on the accommodation and support continuum beyond the SECU and CCU clinical bed-based services. PDRSS are designed for people with psychiatric disabilities who do not need containment, or whose treatment is stabilised to the degree that they no longer require 24 hour clinical monitoring.

The first category of PDRSS supported accommodation comprises separate residential rehabilitation services (RRS) for adults and for young adults. These services have on-site psychiatric disability support staff. Staffing arrangements vary and may include overnight cover. Length of stay for residents is usually from one to two years. In a few adult facilities, ongoing tenure is available and residents can stay as long as they need.

Overall, these RRS fulfil a valuable function for people whose levels of psychiatric disabilities determine they require a period of adjustment to living in the community. In 1998/97, an additional 16 RRS for young adults were established. As a result, the number of RRS for young people increased more than ninefold from two to 18 services across the state, resulting in better access to age-appropriate services. However, this development did not occur for adult RRS, leaving their numbers static. This is a particular problem in rural areas, where there are no adult RRS, other than Shepparton. The lack of development also means that some metropolitan areas have only one adult RRS, whereas others have more. Furthermore, for the majority of adult and all youth RRS, stays are time limited, and exit options to affordable supported housing are minimal.

The second category of PDRSS is home-based outreach support. PDRSS home-based outreach support is provided to people with psychiatric disabilities who require extra daily living support to maintain community tenure, and who live in public or private housing. This includes those whose housing was allocated through Victoria’s Housing and Support program (HASP). Under this program, the Office of Housing provides the property and the Mental Health Branch funds PDRSS agencies to deliver the support. This program has been successful in providing stable low-cost housing and support for many consumers. Home-based outreach support also assists those in private housing, whether owned or rented.
Apart from PDRSS supported accommodation which directly targets people with psychiatric disabilities, non-government agencies also provide supported accommodation to people with a range of disabilities, including psychiatric disability. For example, the government-funded Rooming House Plus program in Albert Park has 64 bed-sit type units for people on low incomes with a history of homelessness or housing risk, some of whom have psychiatric and other disabilities. Residents comprise a mix of those with low and high support needs, with 29 units designated for people, whose level of disability means they require daily support, including provision of meals. This program got underway in 2005, but an evaluation of its effectiveness is not as yet publicly available.

Availability

PDRSS supported accommodation is unevenly distributed across the State. The expansion of RRS for young adults in 1996/97 was unusual in that it was based on a planned statewide rollout of this service type. As a result, most areas across Victoria now have this service in place. In contrast, provision of RRS for adults still largely reflects historical developments. The result is that all but one of the rural areas of the state still lack access to adult RRS, and they are unevenly distributed across metropolitan Melbourne.

The 2006 analysis by the Mental Health Branch identified an average of four people waiting for an adult RRS vacancy, with 29 per cent in acute inpatient units, 17 percent in homeless outreach services and 14 per cent in CCUs (Project Report, Melbourne, DHS, 2007, p.26). It was estimated that on average, five young people were waiting for a youth RRS bed, with half being managed by adult community-based mental health teams, a third by Child and Adolescent Mental Health Services, and the rest by GPs (Project Report, Melbourne, DHS, 2007, p.26).

In addition, the allocation of housing through the Housing and Support Program has slowed in recent years, reflecting the cutback in funding for public housing by the former federal government. The number of public housing places is limited and allocation is tightly targeted. This means that people with psychiatric disabilities remain indefinitely on waiting lists, unless they are homeless or at high risk of becoming homeless. And whilst home-based outreach support now includes a more intensive form of this service type, recipients still need to be housed. Demand has outstripped supply in regard to the Housing and Support Program. Furthermore, tight targeting has unintentionally created a perverse incentive to become homeless in order to have a chance at accessing housing.

HACSU supports the expansion of PDRSS supported accommodation as it is an essential component of the mental health service system, broadening the range of exit pathways for clients leaving clinical bed-based services. Additional funding should also be sought for public housing, with a targeted quantum for the purchase of housing units for people with psychiatric disabilities.

Private Sector Supported Accommodation

Adequacy and Suitability

Supported Residential Services (SRS) comprise a major form of private sector supported accommodation for people with psychiatric disabilities. However, the adequacy and suitability of this type of accommodation for people with disabilities has been of concern for many years. This is shown by several reviews of SRSs, such as the 2001 report by David Green entitled 'Advice to the Department of Human Services on Supported Residential Services' (hereafter called the Green Report: http://www.health.vic.gov.au/archive/archive2004/greenrept/srs_green_report_final.pdf

According to the Green Report, 'Up to 60 per cent of all residents in pension only SRSs now have a psychiatric disability or multiple disabilities including a psychiatric disability (2001, p.13)' with concern that 'Some large SRS are now providing residential care for such a diverse population that the facility can be unsuitable for certain categories of residents and may be counter to the care and rehabilitation needs of those residents (2001, p.37).
Concerns about SRSs have also been raised regularly in the annual reports of the Community Visitors from the Office of the Public Advocate. For example, the 2007 Community Visitors Health Service Annual Report noted that 'there are even more young people with a disability or mental illness living in pension-level SRSs than last year', and 'Community Visitors are dismayed that congregate care facilities are being accepted as a long term option for young people who need opportunities for development to lead more fulfilling lives (Executive Summary: downloadable at http://www.publicadvocate.vic.gov.au/Publications/Annual-reports-and-reviews/Community-Visitors-Health-Services-Annual-Report-2007.html).

A major issue is that SRS cater for different age groups with a range of disabilities and support needs, including psychiatric disabilities. This broad access means that the residents of an SRS may include frail older residents as well as people in their twenties with complex problems such as intellectual and psychiatric disabilities, and problems with use of alcohol and other drugs. The support needs of different residents may be quite distinct, but not reflected in the basic nature of the care provided. Cost is also a concern. Even the fees charged by 'low-cost' or 'pension-only' SRS generally leave between $5-$20 per week over from a pension for residents to spend on personal items and recreational activities.

Other types of for-profit accommodation are boarding houses and semi-independent living arrangements, with the latter providing at least one meal on a daily basis. People with a mental illness use these forms of accommodation, but the level and quality of support is not guaranteed, and the environment can be threatening and dangerous for vulnerable people. For instance, there may be ready access to drugs and alcohol, and exposure to violence. This often results in the person with a mental illness presenting to an Emergency Department, police or other emergency service in a distressed state after fleeing from this environment.

Availability

The continuing problems with SRS over time demonstrate this is not a service model warranting endorsement. Moreover, at the very least, there is little incentive for SRS to encourage the rehabilitation of their residents, and the high cost of even the pension-only SRS means that residents have little money left to engage in activities which could assist their recovery process.

Question 2: Information, planning and decision making in relation to supported accommodation

As can be seen, there are deficiencies in how different types of supported accommodation have evolved over time in Victoria. Development has been inconsistent and planning haphazard. As a consequence, on a statewide basis, there is an inadequate supply of supported accommodation. Furthermore, some areas lack access to the full range of types of supported accommodation, whether these are clinical bed-based services or those provided by the PDRSS sector.

Whilst government has minimal involvement in actually providing this accommodation, clearly it has a key role to play in planning, developing and funding supported accommodation. As well as monitoring patterns of service use and evidence of service gaps, planning should also include identifying and tracking population trends in different areas of the state. In addition to planning, development and funding of supported accommodation, there is also an important role for government in setting standards for what is provided, and monitoring the extent to which these standards are met.
Question 3: Other approaches or models to address supported accommodation funding, planning and delivery

It is also important to note that there is a significant gap in supported accommodation for a particular client group. The group comprises people whose mental illness may be relatively stable, but whose level of psychiatric disability means that they require daily on-site living support on a long-term basis. Typically, these are clients who have reached a 'plateau' in terms of rehabilitation, even though they may show small gains over an extended period of time.

Existing service types do not readily meet the need of these clients for continuing disability support, available on-site seven days per week. The structure and routine provided by this relatively small amount of additional support can make the difference between a person needing a CCU-type bed and managing in the community. This type of service would include regular medication supervision/support, the lack of which is a major contributor to relapse and subsequent acute hospital admission. Because such a service is unavailable, a number of clients remain in CCUs and SECUs, limiting access for others. The 2006 Boston Consulting Group Report estimated that 30 per cent of long-stay CCU clients could move to a long-term non-clinical facility with 24 hours disability staffing, if this sort of service were available (Improving Mental Health Outcomes in Victoria: The Next Wave of Reform, Melbourne, BCG, p.64).

The service gap could be overcome by a type of supported accommodation which used some of the features of the 'Rooming House Plus' model, but was designed for people with psychiatric disabilities rather than a broader group, and had a maximum capacity of 10 to 12 places to minimise the risk of re-institutionalisation. The service would comprise PDRSS-managed long-term supported accommodation with seven days per week on-site disability support, and clinical in-reach from the local Mobile Support and Treatment team.

HACSU considers this type of supported accommodation should be given serious consideration in future service development.

Question 4: What are the implications for individuals who need but cannot get supported accommodation? Is alternate accommodation adequate and care appropriate?

When people with a mental illness need but cannot get the right form of supported accommodation, the implications are serious for the individual, their families and other carers, and for services. Like relationships, accommodation is a basic human need, and a person with a mental illness is particularly vulnerable if this need is not met.

The person may be forced to use inappropriate accommodation such as rooming and boarding houses, with a lack of support, high cost and serious risk of exploitation or injury. Obviously, this is likely to exacerbate their mental illness, and increases 'upstream' demand on high cost acute services as well as spilling over into correctional, police and other systems.

Others may not be able to find accommodation, however inappropriate, and end up living in squats and on the street. This is evident in higher rates of homelessness amongst people with a mental illness, more homeless people with mental health problems, and an increased number of those using homeless shelters who have mental health problems.
When a patient in an acute inpatient unit is ready for discharge, if the right type of supported accommodation cannot be found, then the patient's stay may be extended unnecessarily. This can also occur in SECUs and CCUs. 'Bed blockage' is the term used for this phenomenon, and is now a feature of Victoria's mental health service system. It means a length of stay is prolonged due to a lack of alternative options, which is a clear indication of service gaps. 'Bed blockage' is also costly. Lastly, it contributes to the pressure on Emergency Departments by hindering ready access to psychiatric inpatient admission for people experiencing an episode of acute mental illness.

**Question 5: Provision of accommodation and care in private, government and community sector managed support accommodation**

Most supported accommodation for people with a mental illness is provided either by specialist mental health services, which in Victoria are managed by public hospitals, or by the PDRSS sector or other community-managed organisations. Supported residential services (SRS) are the main private providers of supported accommodation for people with psychiatric disabilities, and for those with a range of other disabilities. Other forms of private accommodation such as boarding and lodgings houses do not include support.

In the mental health sector, the current distribution of responsibilities for supported accommodation has evolved over time. It began with the move away from institutions and reflects contemporary understanding of how best to meet the rights and needs of people with a mental illness.

Clinical bed-based services focus on treating a person's mental illness, whereas PDRS bed-based services seek to overcome the associated disabilities. Thus whilst their roles overlap, these two types of bed-based service have distinctive and complementary functions.

HACSU considers that it is the responsibility of government to plan and provide sufficient funding to ensure the appropriate range of both clinical and PDRS bed-based services are available. An associated responsibility is to set standards for service provision and monitor their achievement. It is critical that these responsibilities are carried by government to ensure transparency, accountability and continuity in terms of service provision. Furthermore, it is a government responsibility to ensure equitable access to supported accommodation across rural and regional Victoria. This also applies to metropolitan areas, especially outer suburban growth corridors.

**The frequency of government reviews indicates continued concerns with private sector provision of supported accommodation through supported residential services (SRS).** This includes the level and quality of support provided to residents, who are vulnerable and easily exploited. Further, there is the inappropriate mixing of people of different ages with a range of disabilities, the high cost for residents on limited incomes, and questions about the viability of this sector over time.

**Question 6: The impact of the current approach to provision of supported accommodation on families and carers.**

Families and carers give high priority to the adequate provision of supported accommodation. This area gets top billing whenever families are asked about gaps in services.

Current inadequacies in the supply and range of supported accommodation mean that families often feel they have no choice but to continue accommodating a relative with a mental illness. They may see this as a stop-gap measure, for instance, to avoid the alternative of the institutional poverty of private supported accommodation such as an SRS. However, it typically leads to an increased burden of care for families, with resulting high levels of stress and poor health. And with long waiting lists, there is no certainty about when a place in appropriate supported accommodation might become available.
HACSU considers this situation is highly unsatisfactory. We urge government action to redress gaps in supported accommodation to relieve this unacceptable imposition on families.

Question 7: What issues need to be considered in the accessibility and appropriateness of supported accommodation for people from rural and regional Victoria, culturally and linguistically diverse backgrounds, and Indigenous Victorians?

People from rural and regional Victoria

Provision of an adequate range of supported accommodation in country Victoria requires innovative solutions to meet the challenges of dispersed populations, distance and difficulty in recruiting appropriately skilled staff. Furthermore, economies of scale would make it unrealistic to provide a fully equipped SECU. Nonetheless, metropolitan SECUs could have designated beds for rural regions.

Other service types such as CCUs, PARCS and adult RRS can and should be provided for all rural AMHS. Furthermore, additional public housing and more funding for PDRSS home-based outreach support would increase the availability of suitable supported housing, and the ability of people with psychiatric disabilities to manage in the community.

People from culturally and linguistically diverse backgrounds

Research on CALD communities consistently finds under-utilisation of mainstream mental health services due to cultural and language barriers. This is a continuing issue for established CALD communities, as well as for more recent arrivals, especially refugees.

For existing clinical and PDRS bed-based services, the priority should be on funding language and cultural interpreters to provide in-reach to people from CALD communities who are clients of the service. This would also enable cultural knowledge to be communicated to service staff. The employment of bilingual workers should be encouraged, whilst acknowledging that it may not be possible to cover all language groups.

A further consideration is provision of gender-specific services for Muslim women, to address cultural and religious sensitivities. This would be particularly appropriate for areas where there are a high proportion of Muslim communities, such as the North Western suburbs.

Indigenous Victorians

Community-managed Aboriginal organisations are culturally best placed to assist Indigenous Victorians requiring supported accommodation due to mental illness and associated disabilities. This could include in-reach support to Aboriginal SECU patients and CCU clients, and home-based outreach support to Aboriginal people living in the community. Priority should be given to building the capacity of community-controlled Aboriginal organisations which already have a track record in delivering mental health services.
Question 8: What other issues do you think need to be considered which have not been addressed by the above questions?

Workforce

The problems in recruiting and retaining an adequately skilled workforce are already well-known. This applies in particular to the staffing of clinical bed-based services. Mental health nurses comprise the core staffing component of these services, yet the nursing workforce is ageing and not being sufficiently replenished with new recruits. HACSU considers that government must commit to a major workforce strategy if this situation is not to deteriorate further.

Workforce problems are also relevant to the PDRSS sector, where inadequate salary rates and career structures make it difficult to attract and keep skilled and experienced workers.

Training Programs

The inadequate provision of in-service training is exacerbating existing workforce problems. There is an urgent need to ensure all clinical bed-based staff have ready access to regular training programs related to their work. These programs should enable all staff to be kept informed about evidence-based practices and service innovations. HACSU considers it is imperative that this training is undertaken on a state wide basis so that staff across Victoria have consistent access to ‘best practice’ knowledge and skills.

Cross-Program Consultation

Mental health and alcohol and other drug services are now working more collaboratively, in recognition of the increased number of clients with a mental illness and problematic use of alcohol and other drugs. Similar collaboration is also warranted between mental health and disability services. St Vincent’s Health provides a dual disability service to assist in assessing and treating clients with intellectual disability and a mental illness. However, this service is in high demand and focuses largely on dual disability clients with psychotic disorders. It needs to be further resourced to provide advice and support for staff of Community Residential Units, particularly in managing more common but often disabling mental health problems such as anxiety or depression.

Use of Individual Support Packages

Government funding is increasingly favouring the use of ‘individual support packages’ to respond to clients with complex and multiple needs. Typically such a package involves a set amount of funding to be used by an agency to provide or purchase a range of services for particular clients. However, reliance on the use of packages can wrongly assume that the right services are already in place or will be developed in response to demand. Yet the number of packages being tendered may be too few in number to enable sufficient service capacity to be developed. HACSU considers that a balance must be maintained between establishing services to meet known gaps and the use of individual support packages.
## Attachment 1:- SECU, CCU, RRS & HASP Beds - as at March 2006

(from 'An analysis of the Victorian Rehabilitation and recovery care service system for people with severe mental illness and associated disability: Project Report', Melbourne, DHS, 2007, p.5 & Appendix 1, p.52)

<table>
<thead>
<tr>
<th>Service type</th>
<th>Number of beds</th>
<th>Note</th>
<th>LOS/tenure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure Extended Care</td>
<td>103</td>
<td>Metro 71 Rural 32</td>
<td>According to clinical need &amp; exit options</td>
<td>Rural numbers range from 3 to 12 SECU beds.</td>
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<tr>
<td>ABI secure beds</td>
<td>23</td>
<td>Royal Talbot site</td>
<td>Indefinite</td>
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<tr>
<td>Forensic SECU</td>
<td>40</td>
<td>At Thomas Embling</td>
<td>According to clinical need &amp; exit options</td>
<td></td>
</tr>
<tr>
<td>Community Care Units</td>
<td>308</td>
<td></td>
<td>Mostly up to 2 yrs or more, some less</td>
<td></td>
</tr>
<tr>
<td>PDRSS Residential Rehab Services (RRS) - young people</td>
<td>164</td>
<td>30 beds with 24hr support</td>
<td>Usually 6mths to 2 yrs</td>
<td>Total of 19 with 16 new services rolled out statewide 1996/97</td>
</tr>
<tr>
<td>PDRSS Residential Rehab Services (RRS) - adults</td>
<td>96</td>
<td>51 beds with 24hr support</td>
<td>Facility-specific - some 6mths to 2yrs, others indefinite eg. Vic Lodge</td>
<td>None in rural areas Also - not all existing ones are recorded in report eg. Kinkora, Yandina not on list</td>
</tr>
<tr>
<td>PDRSS Supported Accommodation - Housing &amp; Support Program (HASP)</td>
<td>135</td>
<td>PDRSS provides off-site support</td>
<td>Indefinite - secure tenure</td>
<td></td>
</tr>
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</table>
Attachment 2: - Prevention and Recovery Care Services PARCS (Step Up/Step Down Facilities) in Victorian Adult Mental Health Services

Five PARCS are already in place - Goulburn Valley (Shepparton), Central East (Box Hill), Inner South East (South Yarra), Dandenong (Springvale), & Gippsland (Bairnsdale). In addition, Barwon AMHS also run some PARC beds at the Belmont CCU.

Arion, which is located in Flemington (IWAMHS), was set up originally with HARP funding as a step-down facility and now also has a step-up function. However, it is considered to be a hybrid 'Rehabilitation PARC' rather than a PARC as such and apparently would not be included in any evaluation of PARCS. An MST staff member provides regular clinical input, and LOS can be for up to 6 months.

Seven more PARCS were promised in the budget announcement of November 2006 ($20m commitment to 70 PARC beds) - Northern (Preston), Mid & South West (Deer Park), Outer East (Ringwood), Peninsula (Frankston), North West (Broadmeadows) & Middle South (Clayton).

May 2008 budget announcement - overall commitment of $39.1m - 'delivering the 2006 commitment to development of 70 new PARCS beds in Victoria’. This includes $28.7m over 4 years for Deer Park (20 beds), Broadmeadows (10) and Preston (10), and $10.4m for to build & staff 30 new beds in three new PARCS at Ringwood, Clayton & Frankston.

<table>
<thead>
<tr>
<th>Adult MHS</th>
<th>PRDSS</th>
<th>Location</th>
<th>Metropolitan or Rural</th>
<th>In place or committed</th>
<th>Announced or re-announced</th>
<th>Number of beds</th>
<th>Co-location?</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td>1 Goulburn Valley</td>
<td>MIFV</td>
<td>Shepparton</td>
<td>Rural</td>
<td>In place</td>
<td></td>
<td>10</td>
<td>With RRS</td>
<td>Co located with an RRS on the old Ambermere site.</td>
</tr>
<tr>
<td>2 Central East</td>
<td>ARAFEMI</td>
<td>Box Hill</td>
<td>Metropolitan</td>
<td>In place</td>
<td></td>
<td>10</td>
<td>Stand alone</td>
<td></td>
</tr>
<tr>
<td>3 Inner South East - Alfred</td>
<td>MIFV</td>
<td>South Yarra</td>
<td>Metropolitan</td>
<td>In place</td>
<td></td>
<td>10</td>
<td>Stand alone</td>
<td>?Linked to other MIFV beds</td>
</tr>
<tr>
<td>4 Outer Sth East D'hong</td>
<td>ERMHA</td>
<td>Springvale</td>
<td>Metropolitan</td>
<td>In place</td>
<td></td>
<td>10</td>
<td>Stand alone?</td>
<td>Note: 2.4 EFT CAT staff allocation rostered on-site</td>
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<tr>
<td>5 Gippsland LRH</td>
<td>SNAP</td>
<td>Bairnsdale</td>
<td>Rural</td>
<td>In place</td>
<td></td>
<td>10</td>
<td>With CCU</td>
<td></td>
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<tr>
<td>6 Barwon</td>
<td>Pathways</td>
<td>Geelong</td>
<td>Metropolitan</td>
<td>In place</td>
<td></td>
<td>6</td>
<td>With Belmont CCU</td>
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<tr>
<td>7 Inner West RMH</td>
<td>Doutta Galla CHS</td>
<td>Flemington</td>
<td>Metropolitan</td>
<td>In place</td>
<td></td>
<td>8</td>
<td>Stand alone</td>
<td>Hybrid 'Rehab PARC' (HARP devt) - up to 6 mths LOS. MST staff member, uses Personal Care workers.</td>
</tr>
<tr>
<td>Adult MHS</td>
<td>PRDSS</td>
<td>Location</td>
<td>Metropolitan or Rural</td>
<td>In place or committed</td>
<td>Announced or re-announced</td>
<td>Number of beds</td>
<td>Co-location?</td>
<td>Comment</td>
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<td>6</td>
<td>Bendigo MIND Richmond Fellowship</td>
<td>Bendigo</td>
<td>Rural</td>
<td>In place</td>
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<td>10</td>
<td>Stand Alone</td>
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<td></td>
<td>Mid West Sunshine</td>
<td>Deer Park</td>
<td>Metropolitan</td>
<td>Committed Commenced</td>
<td>Nov 2006</td>
<td>10 of 20</td>
<td>Former nursing home</td>
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<td>South West Werribee</td>
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<td>10 of 20</td>
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<td>Outer East Maroondah</td>
<td>Ringwood</td>
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<td>Committed</td>
<td>2006 then May 2008 (08-09 budget)</td>
<td>10</td>
<td>Stand alone</td>
<td>Not Commenced</td>
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<td></td>
<td>Peninsula</td>
<td>Frankston</td>
<td>Metropolitan</td>
<td>Committed</td>
<td>2006 then May 2008 (08-09 budget)</td>
<td>10</td>
<td></td>
<td>Not Commenced</td>
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<tr>
<td></td>
<td>North West</td>
<td>Broadmeadows</td>
<td>Metropolitan</td>
<td>Committed</td>
<td>Nov 2006 then May 2008 (08-09 budget)</td>
<td>10</td>
<td>To be co-located with CCU</td>
<td>Not Commenced</td>
</tr>
<tr>
<td></td>
<td>Middle South Monash</td>
<td>?Clayton</td>
<td>Metropolitan</td>
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<td>2006 then May 2008 (08-09 budget)</td>
<td></td>
<td></td>
<td>Not Commenced</td>
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<tr>
<td></td>
<td>Northern</td>
<td>Preston</td>
<td>Metropolitan</td>
<td>Committed</td>
<td>Nov 2006</td>
<td>10</td>
<td>With CCU</td>
<td>Not Commenced</td>
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<td></td>
<td>North East Hume</td>
<td>Wangaratta</td>
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<td>Grampians</td>
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<td>Northern Mallee</td>
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<td>South West Healthcare</td>
<td>Warrnambool</td>
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<td>North East</td>
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<td></td>
<td>No Commitment</td>
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Victorian Parliament Family and Community Development Committee

Inquiry into Supported Accommodation for People with a Disability or Mental Illness

Submission of the Health and Community Service Union

Mental Health Component

November 2008
Submission of the Health and Community Service Union
Mental Health Component
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EXECUTIVE SUMMARY

Introduction

The Health and Community Services Union (HACSU) represents the industrial and professional interests of Victoria’s Mental Health Workforce. HACSU has a long history of actively participating in mental health policy development and reform.

The Committee’s Inquiry is welcome. In Victoria, supported accommodation for people with a mental illness is under-developed, under-resourced and in need of urgent action to meet existing, let alone future, service needs.

The present range and level of supported accommodation for people with a mental illness is inadequate. There are deficiencies in both the number of beds and also their distribution across the state. The impact is seen in increased numbers of people with mental health problems in the following settings:

- On informal but very real waiting lists for CCUs, SECUs and all types of Residential Rehabilitation beds;
- Waiting in Emergency Departments for admission to acute psychiatric inpatient unit beds;
- Being held in police cells.
- Accessing homeless shelters.
- Living in sub standard accommodation.
- Living on the streets.

The supported accommodation system, including clinical and Psychiatric Disability Support Service (PDRSS) sectors, is an interdependent system where both action and inaction in one sector will always impact on other sectors, or beyond in the broader community.

This Executive Summary outlines key points in HACSU’s response to the questions posed in the Committee’s Discussion Paper, and associated recommendations.

Key Points and HACSU’s Recommendations

The supported accommodation for people with a mental illness being considered by the Committee includes clinical services such as secure extended care (SECU) and community care units (CCUs), as well as non-clinical services provided by the PDRSS sector. In addition, the private sector operates Supported Residential Services.

Each of these services is described in detail later in this submission, with attention paid to problems of availability and demand pressures.

Clinical Accommodation Services

Victoria’s clinical accommodation services are operated and managed by Area Mental Health Services (Public Hospitals). These bed-based services face particular demands as a result of existing bed numbers not keeping pace with population growth, the increase in the prison population, inadequate development of exit pathways (especially in the complementary PDRSS sector) and other factors such as the downward trend in the availability of affordable mainstream housing.
Recommendations:

1. High priority should be given to construction of the extended care clinical facility on the former Heidelberg Repatriation site, to increase the number of SECU beds.

2. The shortfall in CCU beds for the north-east and northern metropolitan areas should be resolved by provision of additional CCU beds to meet increased demand related to population growth in the northern corridor. HACSU also considers the Goulburn Valley has a need for a CCU and that a CCU be provided as promised in 2006.

3. An immediate review should be undertaken regarding the adequacy of CCU beds to meet the access needs of consumers in rural and regional areas and outer suburban growth corridors.

4. Additional SECU beds should be built in metropolitan areas to ensure access for consumers from designated rural areas.

5. CCUs are a key component of the supported accommodation service system because they provide 24 hour on-site clinical support for clients with complex conditions, including monitoring responses to treatment. This function should be clarified and re-affirmed, and not blurred with that of non-clinical bed-based services.

Psychiatric Disability and Rehabilitation Support Service (PDRSS)

This sector complements clinical services by providing recovery focused non-clinical supported accommodation for people with psychiatric disabilities.

PDRS supported accommodation is also under considerable demand pressure, especially residential rehabilitation services. Further, the slowdown in the supply of public housing means people with psychiatric disabilities have diminished access to affordable mainstream housing due to increased competition with other population groups, unless they are pushed into homelessness and obtain priority as a consequence.

Recommendations:

1. Prevention and Recovery Care Services (PARCS) should be established for each of the 21 Area Mental Health Services (AMHS) across the State.

2. PDRSS supported accommodation should be expanded, in particular residential rehabilitation services for adults, and home-based outreach support.

3. Additional funding should be made available for public housing, with a targeted quantum for the purchase of housing units for people with psychiatric disabilities.

4. Extend existing PDRSS managed long-term supported accommodation with seven days per week on-site disability support, and clinical in-reach from the local Area Mental Health Service specifically for people with a mental illness who require on-site, non-clinical daily support (e.g. meals and medication supervision) due to ongoing persistent psychiatric disabilities.

Private Sector

The private sector provides supported accommodation in the form of Supported Residential Services (SRS). Those consumers accommodated in SRSs range in age and type of disability, and can include frail older people alongside younger people with psychiatric disabilities, acquired brain injury or intellectual disability, at times with problematic use of alcohol and other drugs. This raises major concerns about the quality of care. Furthermore, the cost of even pension-level SRSs leaves little over for residents’ personal expenses, creating a poverty trap. It is important to note that assisting a resident’s rehabilitation and recovery is not part of the remit of an SRS.

HACSU has major concerns with this form of supported accommodation being used for people with psychiatric disabilities, especially where this arises from a lack of more appropriate alternatives.
Recommendation:

1. HACSU considers that the continuing problems with SRSs over time demonstrate this is not a service model warranting endorsement.

The Role of Government

Recommendations:

1. At a broader level, HACSU recommends that government take a lead role in developing and strengthening the overall accommodation support system in the interests of people with a mental illness, and their family carers. This role includes:
   1.1. Planning, developing and funding supported accommodation
   1.2. Setting standards for what is provided, and
   1.3. Monitoring the extent to which these standards are met.

It is critical that these responsibilities are carried by government to ensure transparency, accountability and continuity in terms of service provision. Furthermore, it is a government responsibility to ensure equitable access to supported accommodation across rural and regional Victoria and metropolitan areas, especially outer suburban growth corridors.

Workforce and Related Issues

In this submission, HACSU raises additional issues of concern in relation to the workforce who provide supported accommodation services.

Recommendations:

1. Establishment of a comprehensive workforce strategy to overcome problems of recruiting and retaining a skilled workforce for supported accommodation services.
2. Provision of regular statewide in-service training for staff of clinical bed-based services so that all staff are kept informed about evidence-based practices and service innovations.
3. Additional resourcing to provide mental health advice and support for staff working with clients with intellectual disabilities in Community Residential Units, particularly in managing residents with mental health problems such as anxiety or depression.
4. More strategic use of 'individual support packages' for clients with complex and multiple needs. HACSU considers that a balance must be maintained between establishing services to meet known gaps, and the funding of individual support packages when appropriate services might not be available. Evaluation and review of client outcomes of 'individual support packages' should occur as a matter of urgency.
HACSU Submission to Family and Community Development Committee Inquiry into Supported Accommodation for People with a Mental Illness

MAIN SUBMISSION

Introduction

Being appropriately housed is an essential and basic requirement for good mental health. Without adequate accommodation and the right level of support, people with a mental illness cannot move towards recovery and instead can remain trapped in a cycle of poverty and illness. From a service perspective, this cycle leads to increased demand on high cost bed-based services such as acute psychiatric inpatient beds, and to extended waiting times for mental health clients in Emergency Departments. It contributes to homelessness, and places additional stress on the correctional system.

Victoria has already piloted and established different types of supported accommodation. As a result, there is a solid body of knowledge about what works for whom. What is now required is a readiness to ensure that all areas across the State have access to the full range of accommodation options, so that access to appropriate services is not dependent on where you live.

It is important to emphasise that supported accommodation for people with a mental illness is an interdependent service system. What happens in one part of the system affects other parts, even if those who manage the various components do not always acknowledge this. We already know that when one service component is missing or inadequately resourced, this will have a direct impact on how others function.

A good example of this service interconnectedness is secure and extended care unit (SECU) beds. This is the most secure of the types of supported accommodation being considered by the Committee. The current number of SECU beds is inadequate and the range of post-discharge options for patients is insufficient. As a result of limited SECU beds, patients whose clinical condition warrants admission to a SECU have to remain elsewhere in the service system, often in an acute mental health inpatient unit (a more expensive and less suitable alternative), until a SECU bed becomes available. Access to that acute bed for a person waiting in an Emergency Department for admission is therefore blocked. Furthermore, where there are insufficient post-discharge options for SECU patients, then access to the existing SECU beds will be restricted.

Patients who remain in a clinical bed-based service because the more appropriate option is not available are often unflatteringly referred to as 'bed blockers'. However, the incidence of bed-blockages in itself demonstrates service gaps in the types of supported accommodation which are being considered by the Committee.

HACSU is also concerned about workforce issues, including the availability of staff with the right mix of training, skills and experience for the different types of supported accommodation. In addition, we highlight the importance of access to regular training, and of providing mental health consultation for disability service staff. Lastly, we note an increasing trend to fund 'individual support packages', and are concerned this can erroneously assume that the right services are already in place.
Question 1: The current provision of supported accommodation in Victoria - What is its availability, suitability and adequacy of care for people with a mental illness?

Key differences in the roles of clinical and PDRSS bed-based services

The Discussion Paper's list of supported accommodation for people with a mental illness includes both clinical (operated and managed by, Public Health Area Mental Health Services (AMHS) and Psychiatric Disability and Rehabilitation Support Services (PDRSS)) supported accommodation. Whilst their roles are overlapping, these two service categories also have quite different but complementary functions.

Clinical bed-based services focus on treating and managing a client's clinical symptoms, including a small group who for various reasons do not respond to 'standard treatments' or initial psychosocial support. The structure and staffing of these services is also designed to manage behavioural problems such as repeated self harm, ongoing substance abuse and aggressive behaviour.

In contrast, PDRS bed-based services are not staffed or structured to manage these behaviours, nor to provide active treatment. Instead, their focus is on managing disability. This includes assisting residents with community and social integration, and promoting recovery through helping residents regain capacities lost through illness. Clinical input to clients in PDRS bed-based services is provided by the local Area Mental Health Service (AMHS) on an in-reach basis.

An Overview of AMHS Clinical Bed-Based Accommodation

Secure extended care units (SECUs) and community care units (CCUs) are clinical bed-based services which, like acute inpatient units, are staffed on a 24 hour basis by mental health nurses. Other mental health professionals, such as psychiatrists, psychologists, social workers and occupational therapists, provide assessment and treatment during the day.

Importantly, these services provide containment, and are able to manage people with complex behaviours and persistent psychiatric symptoms. In these clinical settings, various treatment and psychological approaches can be tried and monitored in an environment which is safe for both the individual and the community.

Secure Extended Care Units (SECU)

Suitability and adequacy of care

Secure extended care beds are an essential component of a modern mental health service system. Patients admitted to a SECU exhibit behavioural disturbance which poses significant risk to themselves and the community, and requires extended management in a restricted environment. If sufficient SECU beds are not provided, there is increased pressure on costly and scarce forensic mental health beds. SECU beds are also an important exit option for patients from forensic mental health services. SECU also provide intensive treatment and support for patients whose mental illness has been significantly complicated by other conditions such as intellectual disability, acquired brain injury and misuse of alcohol and other drugs.

In Victoria, there are three dedicated SECUs, all based in the metropolitan area and ranging in capacity from 20 to 26 beds. Each is managed by a public hospital as part of their Area Mental Health Service, and located on the relevant hospital campus. In rural areas, a handful of nominally designated SECU beds exist (32 in total). The Thomas Embling Forensic Hospital also has 40 beds which are designated as SECU.
SECU replaced the locked long-term wards of the former psychiatric institutions before these were closed. They were established from 1995 to 1998. Local PDRSS may be engaged to provide individual or group rehabilitation opportunities for SECU patients either on an in-reach basis, or in the surrounding community, in order to prepare them for movement to a less restrictive environment when their clinical condition improves.

Availability

In 2006, the Victorian Mental Health Branch investigated the capacity and demand pressures on SECU and other clinical and PDRSS bed-based services. The ensuing Report, entitled 'An analysis of the Victorian rehabilitation and recovery care service system for people with severe mental illness and associated disabilities' (henceforth referred to as the Project Report) was published in August 2007 (www.health.vic.gov.au/mentalhealth/atoz.htm). It provides a revealing snapshot of the problems due to under-supply in relation to SECU beds. The Project Report estimated that on average, for each SECU, eight people were waiting for admission, half of whom were in acute inpatient units (Project Report, DHS, 2007, p.22-23). Others outside the mental health system are in prisons and police cells. At the discharge end, the 2006 Boston Consulting Group Report (Improving Mental Health Outcomes in Victoria: The Next Wave of Reform, Melbourne, BCG, p.64) estimated that 20 per cent of SECU patients could be moved to a less intensive service option, if beds were available, such as CCUs and 24 hour staffed PDRSS.

There is a significant under-supply of this type of clinical bed-based service in Victoria. In March 2006, there were 103 SECU beds (Project Report, 2007, p.5 & 52). Effectively the 71 beds in the three metropolitan SECU are all that is available for the State, because the small number of rural beds designated as SECU (from 3 to 12 beds per area) are often not fully secure, due to the lack of economies of scale. Also, the 40 SECU beds at Thomas Embling Forensic Hospital are fully utilised by the correctional system. The overall shortage of SECU beds is evidenced by the increasing number of patients in acute inpatient units waiting for a SECU bed.

Original estimates of the number of SECU beds required in Victoria were based on institutional populations in 1994, now fourteen years ago, which did not anticipate recent significant population growth and were not evenly distributed. The higher incidence of dual diagnosis, especially amphetamine use, has also contributed to demand for SECU-type beds. Additional pressure arises from increased demand due to the upsurge in the prison population both sentenced and remanded.

In the 2006-2007 budget, $9m was allocated for Stage 1 planning for an extended care clinical facility on the former Heidelberg Repatriation Hospital site. HACSU considers it is imperative that construction of this facility be given high priority.

The community will hold the Government accountable if access to secure and supported services is not available for people with mental illness who, rightly or wrongly, are considered to be dangerous and a threat to community safety.

Community Care Units (CCU)

Suitability and adequacy of care

CCUs are another clinical bed-based service. Each of the 21 Area Mental Health Services (AMHS) has access to CCU beds. However, the number of CCU beds and their configuration varies from area to area. For instance, a metropolitan CCU would typically have 20 beds distributed across four or five housing units on the same block. In the country, rural services usually have fewer CCU beds which may be co-located with another type of bed-based service.
The key difference between a CCU and SECU is that SECU provides a secure environment in order to achieve individual and community safety. CCUs are not locked facilities and are usually based in residential areas, with a street address, rather than on a hospital campus. They provide medium to long-term clinical support and rehabilitation in a home-like setting. Typically, CCU residents have ongoing symptoms which require clinical management, such as a variable response to medication. Clinical input and the trialing of ongoing treatment options are central to a CCU’s operation.

Like SECU, the two key features of CCUs are their capacity to manage complex behaviours, including concurrent substance abuse, and to apply and closely monitor the response to different psychological, behavioural and pharmacological treatment approaches. As with SECUs, a PDRSS might engage with individual CCU residents to provide additional rehabilitation opportunities in the local community, as part of the process of preparing residents for living in alternative non-clinical accommodation in the future.

CCUs represent an important step-down option for patients well enough to leave either SECU or the forensic mental health inpatient service, for whom there are few available supported accommodation alternatives following discharge. In addition, CCUs provide an exit pathway for patients in acute inpatient units who require extended clinical support to stabilise their symptoms. When these services are not available and patients are discharged to alternatives with insufficient support, their condition tends to deteriorate rapidly. They then end up in services which do provide containment, including Emergency Departments, acute inpatient units, police holding cells and ultimately, prison beds.

**Availability**

As with SECU, the number of CCU beds is based on outdated estimates from the time of institutional closures in the mid-1990s. Again, the 2006 analysis by the Mental Health Branch reveals the inadequate supply of CCU beds ([Project Report, Melbourne, DHS, 2007, p.24](#)).

**This analysis estimated that on average, six people were on the waiting list for each CCU bed.**

About a third were in acute inpatient units, 13 per cent in SECUs and a third were being managed by a community-based clinical team. The limited exit pathways for CCU clients were identified as a problem for ‘throughput’, especially in rural areas ([Project Report, Melbourne, DHS, 2007, p.24](#)).

Data shows that the ‘Long Stay Patients’ (>32 days) in acute inpatient units is running at an average of 16% with the highest at 29% this is almost double the previous year. ([Department of Human Services Mental health – Key Performance Indicators – Adult (Year to Date) Quarters 1-4, 2007-08](#))

There are particular pressure points in terms of the distribution of CCU beds. For instance, in the metropolitan area, the North-East AMHS does not have its own CCU. Instead, it has access to the 20-bed CCU in Preston run by the Northern AMHS. However, the catchment area of Northern AMHS includes one of the major growth corridors in Melbourne.

The government has already acknowledged the requirement for additional mental health services due to the population increase in this catchment area. This is shown by the funding allocated in the 2007-08 State Budget for an extra 25 acute psychiatric beds at Northern Hospital. However, no funds were made available to provide more CCU beds, either for an additional CCU in the rapidly developing outer parts of the Northern AMHS catchment area, or for a CCU for the North East AMHS to relieve pressure on the existing Northern CCU. **HACSU considers that provision of these beds should be an immediate priority.**

Furthermore, a review should be undertaken as a matter of priority, to ascertain access and ensure adequate provision for AMHS of CCU beds in significant growth corridors in both rural and metropolitan areas.

[Response to Victorian Parliamentary Inquiry into Supported Accommodation for People with a Disability or Mental Illness](#)
In addition, HACSU is concerned that the recent Mental Health Matters Consultation Paper (DHS, 2008) raised the possibility of 'loosening the boundaries' between CCU and PDRSS Residential Rehabilitation Services (RRS). This ignores the essential role undertaken by CCUs in providing a step-down function for patients of SECU, forensic mental health services and to a lesser extent, acute inpatient units. This function is used for patients whose level of clinical need means they could not be safely placed in the more open environment of a PDRSS supported accommodation service.

Currently the Shepparton/Goulburn Valley area has been denied a CCU, making this community one of only three in Victoria that does not have access to its own CCU. Promised by the State Government, in the 2006 State Budget the new ‘CCU’ has in fact now turned out to be an existing RRS that was merely moved into a new building. Although it is described as a ‘unique’ and new partnership’, it is actually the same as all RRSs, that is, a service managed by a PDRSS with clinical input provided by the local mental health service.

Shepparton/Goulburn Valley should not be forced into a situation of ‘either a CCU or a RRS’. As outlined earlier in this document, the two have quite distinct functions. For example, metropolitan areas have both RRSs and a CCU, each service working collaboratively to meet the range of needs in that community. Most rural areas have CCU beds and also a RRS for young people (to date, the number of RRS for adults have been limited to metropolitan areas for historical reasons).

As argued elsewhere in this submission, all communities need access to RRS beds. However, like every community in Victoria, the Goulburn Valley also needs a CCU in order to cater for their high needs clients. Instead, the people of the Shepparton/Goulburn Valley area are being short-changed. They are being denied a fundamental component of the suite of mental health services accepted as a benchmark for all AMHS across the State, and which 86 per cent already have in place.

HACSU considers there is a need to clarify and reaffirm the role and function of CCUs, rather than blurring their distinctive role with that of a RRS. HACSU considers the Goulburn Valley has a need for a CCU and that a CCU should be provided as promised in 2006.

Clinical bed-based services like SECU and CCUs are a fundamental component of the whole supported accommodation system. These clinical bed-based services provide an essential alternative for clients of PDRSS supported accommodation who become unable to cope with the more open environments of PDRSS, or who simply need extended clinical treatment to settle their symptoms so they can focus on recovery. This critical function has been overlooked by the advocates of 'loosening the boundaries'.

This proposal also ignores the significantly increased demand such a move would place on an already over-stretched number of acute mental health inpatient beds. If CCUs no longer functioned as CCUs, a RRS resident whose mental illness worsened would have to be admitted to an acute inpatient unit. If the local CCU was still operational, the resident could be transferred to the CCU until the person's mental state improved, even if this took some months.

Prevention and Recovery Care Services (PARCS)
Adequacy and Suitability

Victoria has led Australia in developing this innovative and collaboratively-managed new service type. The local AMHS is responsible for the clinical management of the local PARCS, but a PDRSS runs the day to day operations. The first PARCS in Victoria was opened in Shepparton in 2004. It is managed by Goulburn Valley AMHS in partnership with Mental Illness Fellowship Victoria.

The PARCS undertake a 'step-up' function by providing an alternative to acute inpatient admission for a person who can be managed in the community without intensive hospital care. For a patient leaving acute inpatient care, PARCS offer a 'step down' period of transition and stabilisation before the person returns to their usual living situation. Typically, the local AMHS provides clinical input on a regular basis to their area PARCS. This may take the form of staff from the local Crisis Assessment and Treatment Service (CATS) spending time at the PARCS on a daily basis, or some other arrangement for regular clinical input.
There is already abundant evidence that PARCS are performing a valuable role in the mental health service system, although a comprehensive evaluation has yet to be undertaken. It is also important to note that PARCS provide (sub) acute care. In order to ensure this key function, it is essential that the PARCS are managed by AMHSs within the suite of acute focused services which include Emergency Departments, CATS and acute inpatient units. This ongoing strategy of in-reach acute assessment and treatment, and AMHS management keeps the PARCS from becoming a de facto longer-term accommodation option and guarantees client throughput.

**Availability**

Not every area mental health service has a PARCS. Only five fully-fledged PARCS are operational in Victoria. In two other AMHS, a partial form of PARCS is in place: Barwon, with six beds co-located with the Geelong CCU, and eight 'Rehabilitation PARC' type beds in Flemington in the inner west metropolitan area.

In the 2008-09 State Budget, government funding was committed to establish a further seven PARCS. These are to be in the northern, mid west, south west, outer east, North West and Middle South metropolitan areas, and the Mornington Peninsula. However, these developments will take time. As yet, there is no government commitment to provide the remaining seven AMHS with PARCS beds.

**HACSU considers that the Government should give urgent priority to the provision of a PARCS for each of the 21 AMHS across the state.** In addition, a watching brief should be kept on the need for a PARCS in the catchment area for the acute unit at Casey Hospital, which is located in a significant growth corridor.

**Psychiatric Disability and Rehabilitation Support Services (PDRSS) Supported Accommodation**

**Adequacy and Suitability**

Victoria's PDRSS sector provides a range of supported accommodation, and represents the next step on the accommodation and support continuum beyond the SECU and CCU clinical bed-based services. PDRSS are designed for people with psychiatric disabilities who do not need containment, or whose treatment is stabilised to the degree that they no longer require 24 hour clinical monitoring.

The first category of PDRSS supported accommodation comprises separate residential rehabilitation services (RRS) for adults and for young adults. These services have on-site psychiatric disability support staff. Staffing arrangements vary and may include overnight cover. Length of stay for residents is usually from one to two years. In a few adult facilities, ongoing tenure is available and residents can stay as long as they need.

Overall, these RRS fulfil a valuable function for people whose levels of psychiatric disabilities determine they require a period of adjustment to living in the community. In 1996/97, an additional 16 RRS for young adults were established. As a result, the number of RRS for young people increased more than ninefold from two to 18 services across the state, resulting in better access to age-appropriate services. However, this development did not occur for adult RRS, leaving their numbers static. This is a particular problem in rural areas, where there are no adult RRS, other than Shepparton. The lack of development also means that some metropolitan areas have only one adult RRS, whereas others have more. Furthermore, for the majority of adult and all youth RRS, stays are time limited, and exit options to affordable supported housing are minimal.

The second category of PDRSS is home-based outreach support. PDRSS home-based outreach support is provided to people with psychiatric disabilities who require extra daily living support to maintain community tenure, and who live in public or private housing. This includes those whose housing was allocated through Victoria's Housing and Support program (HASP). Under this program, the Office of Housing provides the property and the Mental Health Branch funds PDRSS agencies to deliver the support. This program has been successful in providing stable low-cost housing and support for many consumers. Home-based outreach support also assists those in private housing, whether owned or rented.
Apart from PDRSS supported accommodation which directly targets people with psychiatric disabilities, non-government agencies also provide supported accommodation to people with a range of disabilities, including psychiatric disability. For example, the government-funded Rooming House Plus program in Albert Park has 64 bed-sit type units for people on low incomes with a history of homelessness or housing risk, some of whom have psychiatric and other disabilities. Residents comprise a mix of those with low and high support needs, with 29 units designated for people, whose level of disability means they require daily support, including provision of meals. This program got underway in 2005, but an evaluation of its effectiveness is not as yet publicly available.

Availability

PDRSS supported accommodation is unevenly distributed across the State. The expansion of RRS for young adults in 1996/97 was unusual in that it was based on a planned statewide rollout of this service type. As a result, most areas across Victoria now have this service in place. In contrast, provision of RRS for adults still largely reflects historical developments. The result is that all but one of the rural areas of the state still lack access to adult RRS, and they are unevenly distributed across metropolitan Melbourne.

The 2006 analysis by the Mental Health Branch identified an average of four people waiting for an adult RRS vacancy, with 29 per cent in acute inpatient units, 17 percent in homeless outreach services and 14 per cent in CCUs (Project Report, Melbourne, DHS, 2007, p.26). It was estimated that on average, five young people were waiting for a youth RRS bed, with half being managed by adult community-based mental health teams, a third by Child and Adolescent Mental Health Services, and the rest by GPs (Project Report, Melbourne, DHS, 2007, p.26).

In addition, the allocation of housing through the Housing and Support Program has slowed in recent years, reflecting the cutback in funding for public housing by the former federal government. The number of public housing places is limited and allocation is tightly targeted. This means that people with psychiatric disabilities remain indefinitely on waiting lists, unless they are homeless or at high risk of becoming homeless. And whilst home-based outreach support now includes a more intensive form of this service type, recipients still need to be housed. Demand has outstripped supply in regard to the Housing and Support Program. Furthermore, tight targeting has unintentionally created a perverse incentive to become homeless in order to have a chance at accessing housing.

HACSU supports the expansion of PDRSS supported accommodation as it is an essential component of the mental health service system, broadening the range of exit pathways for clients leaving clinical bed-based services. Additional funding should also be sought for public housing, with a targeted quantum for the purchase of housing units for people with psychiatric disabilities.

Private Sector Supported Accommodation

Adequacy and Suitability

Supported Residential Services (SRS) comprise a major form of private sector supported accommodation for people with psychiatric disabilities. However, the adequacy and suitability of this type of accommodation for people with disabilities has been of concern for many years. This is shown by several reviews of SRSs, such as the 2001 report by David Green entitled 'Advice to the Department of Human Services on Supported Residential Services' (hereafter called the Green Report: http://www.health.vic.gov.au/archive/archive2004/greennrpt/srs_green_report_final.pdf

According to the Green Report, 'Up to 60 per cent of all residents in pension only SRSs now have a psychiatric disability or multiple disabilities including a psychiatric disability (2001, p.13)' with concern that 'Some large SRS are now providing residential care for such a diverse population that the facility can be unsuitable for certain categories of residents and may be counter to the care and rehabilitation needs of those residents (2001, p.37)'.

Response to Victorian Parliamentary Inquiry into Supported Accommodation for People with a Disability or Mental Illness
Concerns about SRSs have also been raised regularly in the annual reports of the Community Visitors from the Office of the Public Advocate. For example, the 2007 Community Visitors Health Service Annual Report noted that 'there are even more young people with a disability or mental illness living in pension-level SRSs than last year', and 'Community Visitors are dismayed that congregate care facilities are being accepted as a long term option for young people who need opportunities for development to lead more fulfilling lives' (Executive Summary: downloadable at http://www.publicadvocate.vic.gov.au/Publications/Annual-reports-and-reviews/Community-Visitors-Health-Services-Annual-Report-2007.html).

A major issue is that SRS cater for different age groups with a range of disabilities and support needs, including psychiatric disabilities. This broad access means that the residents of an SRS may include frail older residents as well as people in their twenties with complex problems such as intellectual and psychiatric disabilities, and problems with use of alcohol and other drugs. The support needs of different residents may be quite distinct, but not reflected in the basic nature of the care provided. Cost is also a concern. Even the fees charged by 'low-cost' or 'pension-only' SRS generally leave between $5-$20 per week over from a pension for residents to spend on personal items and recreational activities.

Other types of for-profit accommodation are rooming houses and boarding houses, with the latter providing at least one meal a daily basis. People with a mental illness use these forms of accommodation, but the level and quality of support is not guaranteed, and the environment can be threatening and dangerous for vulnerable people. For instance, there may be ready access to drugs and alcohol, and exposure to violence. This often results in the person with a mental illness presenting to an Emergency Department, police or other emergency service in a distressed state after fleeing from this environment.

Availability

The continuing problems with SRS over time demonstrate this is not a service model warranting endorsement. Moreover, at the very least, there is little incentive for SRS to encourage the rehabilitation of their residents, and the high cost of even the pension-only SRS means that residents have little money left to engage in activities which could assist their recovery process.

Question 2: Information, planning and decision making in relation to supported accommodation

As can be seen, there are deficiencies in how different types of supported accommodation have evolved over time in Victoria. Development has been inconsistent and planning haphazard. As a consequence, on a statewide basis, there is an inadequate supply of supported accommodation. Furthermore, some areas lack access to the full range of types of supported accommodation, whether these are clinical bed-based services or those provided by the PDRSS sector.

Whilst government has minimal involvement in actually providing this accommodation, clearly it has a key role to play in planning, developing and funding supported accommodation. As well as monitoring patterns of service use and evidence of service gaps, planning should also include identifying and tracking population trends in different areas of the state. In addition to planning, development and funding of supported accommodation, there is also an important role for government in setting standards for what is provided, and monitoring the extent to which these standards are met.
Question 3: Other approaches or models to address supported accommodation funding, planning and delivery

It is also important to note that there is a significant gap in supported accommodation for a particular client group. The group comprises people whose mental illness may be relatively stable, but whose level of psychiatric disability means that they require daily on-site living support on a long-term basis. Typically, these are clients who have reached a 'plateau' in terms of rehabilitation, even though they may show small gains over an extended period of time.

Existing service types do not readily meet the need of these clients for continuing disability support, available on-site seven days per week. The structure and routine provided by this relatively small amount of additional support can make the difference between a person needing a CCU-type bed and managing in the community. This type of service would include regular medication supervision/support, the lack of which is a major contributor to relapse and subsequent acute hospital admission. Because such a service is unavailable, a number of clients remain in CCUs and SECUss, limiting access for others. The 2006 Boston Consulting Group Report estimated that 30 per cent of long-stay CCU clients could move to a long-term non-clinical facility with 24 hours disability staffing, if this sort of service were available (Improving Mental Health Outcomes in Victoria: The Next Wave of Reform, Melbourne, BCG, p.64).

The service gap could be overcome by a type of supported accommodation which used some of the features of the 'Rooming House Plus' model, but was designed for people with psychiatric disabilities rather than a broader group, and had a maximum capacity of 10 to 12 places to minimise the risk of re-institutionalisation. The service would comprise PDRSS-managed long-term supported accommodation with seven days per week on-site disability support, and clinical in-reach from the local Mobile Support and Treatment team.

HACSU considers this type of supported accommodation should be given serious consideration in future service development.

Question 4: What are the implications for individuals who need but cannot get supported accommodation? Is alternate accommodation adequate and care appropriate?

When people with a mental illness need but cannot get the right form of supported accommodation, the implications are serious for the individual, their families and other carers, and for services. Like relationships, accommodation is a basic human need, and a person with a mental illness is particularly vulnerable if this need is not met.

The person may be forced to use inappropriate accommodation such as rooming and boarding houses, with a lack of support, high cost and serious risk of exploitation or injury. Obviously, this is likely to exacerbate their mental illness, and increases ‘upstream’ demand on high cost acute services as well as spilling over into correctional, police and other systems.

Others may not be able to find accommodation, however inappropriate, and end up living in squats and on the street. This is evident in higher rates of homelessness amongst people with a mental illness, more homeless people with mental health problems, and an increased number of those using homeless shelters who have mental health problems.
When a patient in an acute inpatient unit is ready for discharge, if the right type of supported accommodation cannot be found, then the patient’s stay may be extended unnecessarily. This can also occur in SECU and CCUs. 'Bed blockage' is the term used for this phenomenon, and is now a feature of Victoria’s mental health service system. It means a length of stay is prolonged due to a lack of alternative options, which is a clear indication of service gaps. 'Bed blockage' is also costly. Lastly, it contributes to the pressure on Emergency Departments by hindering ready access to psychiatric inpatient admission for people experiencing an episode of acute mental illness.

Question 5: Provision of accommodation and care in private, government and community sector managed support accommodation

Most supported accommodation for people with a mental illness is provided either by specialist mental health services, which in Victoria are managed by public hospitals, or by the PDRSS sector or other community-managed organisations. Supported residential services (SRS) are the main private providers of supported accommodation for people with psychiatric disabilities, and for those with a range of other disabilities. Other forms of private accommodation such as rooming and boarding houses do not include support.

In the mental health sector, the current distribution of responsibilities for supported accommodation has evolved over time. It began with the move away from institutions and reflects contemporary understanding of how best to meet the rights and needs of people with a mental illness.

Clinical bed-based services focus on treating a person’s mental illness, whereas PDRS bed-based services seek to overcome the associated disabilities. Thus whilst their roles overlap, these two types of bed-based service have distinctive and complementary functions.

HACSU considers that it is the responsibility of government to plan and provide sufficient funding to ensure the appropriate range of both clinical and PDRS bed-based services are available. An associated responsibility is to set standards for service provision and monitor their achievement. It is critical that these responsibilities are carried by government to ensure transparency, accountability and continuity in terms of service provision. Furthermore, it is a government responsibility to ensure equitable access to supported accommodation across rural and regional Victoria. This also applies to metropolitan areas, especially outer suburban growth corridors.

The frequency of government reviews indicates continued concerns with private sector provision of supported accommodation through supported residential services (SRS). This includes the level and quality of support provided to residents, who are vulnerable and easily exploited. Further, there is the inappropriate mixing of people of different ages with a range of disabilities, the high cost for residents on limited incomes, and questions about the viability of this sector over time.

Question 6: The impact of the current approach to provision of supported accommodation on families and carers.

Families and carers give high priority to the adequate provision of supported accommodation. This area gets top billing whenever families are asked about gaps in services.

Current inadequacies in the supply and range of supported accommodation mean that families often feel they have no choice but to continue accommodating a relative with a mental illness. They may see this as a stop-gap measure, for instance, to avoid the alternative of the institutional poverty of private supported accommodation such as an SRS. However, it typically leads to an increased burden of care for families, with resulting high levels of stress and poor health. And with long waiting lists, there is no certainty about when a place in appropriate supported accommodation might become available.
HACSU considers this situation is highly unsatisfactory. We urge government action to redress gaps in supported accommodation to relieve this unacceptable imposition on families.

Question 7: What issues need to be considered in the accessibility and appropriateness of supported accommodation for people from rural and regional Victoria, culturally and linguistically diverse backgrounds, and Indigenous Victorians?

People from rural and regional Victoria

Provision of an adequate range of supported accommodation in country Victoria requires innovative solutions to meet the challenges of dispersed populations, distance and difficulty in recruiting appropriately skilled staff. Furthermore, economies of scale would make it unrealistic to provide a fully equipped SECU. Nonetheless, metropolitan SECUs could have designated beds for rural regions.

Other service types such as CCUs, PARCS and adult RRS can and should be provided for all rural AMHS. Furthermore, additional public housing and more funding for PDRSS home-based outreach support would increase the availability of suitable supported housing, and the ability of people with psychiatric disabilities to manage in the community.

People from culturally and linguistically diverse backgrounds

Research on CALD communities consistently finds under-utilisation of mainstream mental health services due to cultural and language barriers. This is a continuing issue for established CALD communities, as well as for more recent arrivals, especially refugees.

For existing clinical and PDRS bed-based services, the priority should be on funding language and cultural interpreters to provide in-reach to people from CALD communities who are clients of the service. This would also enable cultural knowledge to be communicated to service staff. The employment of bilingual workers should be encouraged, whilst acknowledging that it may not be possible to cover all language groups.

A further consideration is provision of gender-specific services for Muslim women, to address cultural and religious sensitivities. This would be particularly appropriate for areas where there are a high proportion of Muslim communities, such as the North Western suburbs.

Indigenous Victorians

Community-managed Aboriginal organisations are culturally best placed to assist Indigenous Victorians requiring supported accommodation due to mental illness and associated disabilities. This could include in reach support to Aboriginal SECU patients and CCU clients, and home-based outreach support to Aboriginal people living in the community. Priority should be given to building the capacity of community-controlled Aboriginal organisations which already have a track record in delivering mental health services.
Question 8: What other issues do you think need to be considered which have not been addressed by the above questions?

Workforce
The problems in recruiting and retaining an adequately skilled workforce are already well-known. This applies in particular to the staffing of clinical bed-based services. Mental health nurses comprise the core staffing component of these services, yet the nursing workforce is ageing and not being sufficiently replenished with new recruits. HACSU considers that government must commit to a major workforce strategy if this situation is not to deteriorate further.

Workforce problems are also relevant to the PDRSS sector, where inadequate salary rates and career structures make it difficult to attract and keep skilled and experienced workers.

Training Programs
The inadequate provision of in-service training is exacerbating existing workforce problems. There is an urgent need to ensure all clinical bed-based staff have ready access to regular training programs related to their work. These programs should enable all staff to be kept informed about evidence-based practices and service innovations. HACSU considers it is imperative that this training is undertaken on a state wide basis so that staff across Victoria have consistent access to ‘best practice’ knowledge and skills.

Cross-Program Consultation
Mental health and alcohol and other drug services are now working more collaboratively, in recognition of the increased number of clients with a mental illness and problematic use of alcohol and other drugs. Similar collaboration is also warranted between mental health and disability services. St Vincent's Health provides a dual disability service to assist in assessing and treating clients with intellectual disability and a mental illness. However, this service is in high demand and focuses largely on dual disability clients with psychotic disorders. It needs to be further resourced to provide advice and support for staff of Community Residential Units, particularly in managing more common but often disabling mental health problems such as anxiety or depression.

Use of Individual Support Packages
Government funding is increasingly favouring the use of ‘individual support packages’ to respond to clients with complex and multiple needs. Typically such a package involves a set amount of funding to be used by an agency to provide or purchase a range of services for particular clients. However, reliance on the use of packages can wrongly assume that the right services are already in place or will be developed in response to demand. Yet the number of packages being tendered may be too few in number to enable sufficient service capacity to be developed. HACSU considers that a balance must be maintained between establishing services to meet known gaps and the use of individual support packages.
<table>
<thead>
<tr>
<th>Service type</th>
<th>Number of beds</th>
<th>Note</th>
<th>LOS/tenure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure Extended Care</td>
<td>103</td>
<td>Metro 71</td>
<td>According to clinical need &amp; exit options</td>
<td>Rural numbers range from 3 to 12 SECU beds.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rural 32 (App 1, p.52)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABI secure beds</td>
<td>23</td>
<td>Royal Talbot site</td>
<td>Indefinite</td>
<td></td>
</tr>
<tr>
<td>Forensic SECU</td>
<td>40</td>
<td>At Thomas Embling</td>
<td>According to clinical need &amp; exit options</td>
<td></td>
</tr>
<tr>
<td>Community Care Units</td>
<td>308</td>
<td>Mostly up to 2 yrs or more, some less</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDRSS Residential Rehab Services (RRS) - young people</td>
<td>164</td>
<td>30 beds with 24hr support</td>
<td>Usually 6mths to 2 yrs</td>
<td>Total of 19 with 16 new services rolled out statewide 1996/97</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDRSS Residential Rehab Services (RRS) - adults</td>
<td>96</td>
<td>51 beds with 24hr support</td>
<td>Facility-specific - some 6mths to 2yrs, others indefinite eg. Vic Lodge</td>
<td>None in rural areas Also - not all existing ones are recorded in report eg. Kinkora, Yandina not on list</td>
</tr>
<tr>
<td>PDRSS Supported Accommodation - Housing &amp; Support Program (HASP)</td>
<td>135</td>
<td>PDRSS provides off-site support</td>
<td>Indefinite - secure tenure</td>
<td></td>
</tr>
</tbody>
</table>
Five PARCS are already in place - Goulburn Valley (Shepparton), Central East (Box Hill), Inner South East (South Yarra), Dandenong (Springvale), & Gippsland (Bairnsdale). In addition, Barwon AMHS also run some PARC beds at the Belmont CCU.

Arion, which is located in Flemington (IWAMHS), was set up originally with HARP funding as a step-down facility and now also has a step-up function. However, it is considered to be a hybrid 'Rehabilitation PARC' rather than a PARC as such and apparently would not be included in any evaluation of PARCS. An MST staff member provides regular clinical input, and LOS can be for up to 6 months.

Seven more PARCS were promised in the budget announcement of November 2006 ($20m commitment to 70 PARC beds) - Northern (Preston), Mid & South West (Deer Park), Outer East (Ringwood), Peninsula (Frankston), North West (Broadmeadows) & Middle South (Clayton).

May 2008 budget announcement - overall commitment of $39.1m - 'delivering the 2006 commitment to development of 70 new PARCS beds in Victoria'. This includes $28.7m over 4 years for Deer Park (20 beds), Broadmeadows (10) and Preston (10), and $10.4m for to build & staff 30 new beds in three new PARCS at Ringwood, Clayton & Frankston.

<table>
<thead>
<tr>
<th>Adult MHS</th>
<th>PRDSS</th>
<th>Location</th>
<th>Metropolitan or Rural</th>
<th>In place or committed</th>
<th>Announced or re-announced</th>
<th>Number of beds</th>
<th>Co-location?</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Goulburn Valley</td>
<td>MIFV</td>
<td>Shepparton</td>
<td>Rural</td>
<td>In place</td>
<td></td>
<td>10</td>
<td>With RRS</td>
<td>Co located with an RRS on the old Ambermere site.</td>
</tr>
<tr>
<td>2 Central East</td>
<td>ARAFEMI</td>
<td>Box Hill</td>
<td>Metropolitan</td>
<td>In place</td>
<td></td>
<td>10</td>
<td>Stand alone</td>
<td></td>
</tr>
<tr>
<td>3 Inner South East - Alfred</td>
<td>MIFV</td>
<td>South Yarra</td>
<td>Metropolitan</td>
<td>In place</td>
<td></td>
<td>10</td>
<td>Stand alone</td>
<td>?Linked to other MIFV beds</td>
</tr>
<tr>
<td>4 Outer Sth East D'nong</td>
<td>ERMHA</td>
<td>Springvale</td>
<td>Metropolitan</td>
<td>In place</td>
<td></td>
<td>10</td>
<td>Stand alone?</td>
<td>Note: 2.4 EFT CAT staff allocation rostered on-site</td>
</tr>
<tr>
<td>5 Gippsland LRH</td>
<td>SNAP</td>
<td>Bairnsdale</td>
<td>Rural</td>
<td>In place</td>
<td></td>
<td>10</td>
<td>With CCU</td>
<td></td>
</tr>
<tr>
<td>6 Barwon RMH</td>
<td>Pathways</td>
<td>Geelong</td>
<td>Metropolitan</td>
<td>In place</td>
<td></td>
<td>6</td>
<td>With Belmont CCU</td>
<td></td>
</tr>
<tr>
<td>7 Inner West Doutta Galla CHS</td>
<td>Flemington</td>
<td>Metropolitan</td>
<td>In place</td>
<td></td>
<td>8</td>
<td>Stand alone</td>
<td>Hybrid 'Rehab PARC' (HARP devt) - up to 6 mths LOS. MST staff member, uses Personal Care workers.</td>
<td></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Adult MHS</th>
<th>PRDSS</th>
<th>Location</th>
<th>Metropolitan or Rural</th>
<th>In place or committed</th>
<th>Announced or re-announced</th>
<th>Number of beds</th>
<th>Co-location?</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Bendigo MIND Richmond Fellowship</td>
<td>Bendigo</td>
<td>Rural</td>
<td>In place</td>
<td></td>
<td>10</td>
<td>Stand Alone</td>
<td></td>
</tr>
<tr>
<td>Mid West Sunshine</td>
<td>Deer Park</td>
<td>Metropolitan</td>
<td>Committed Commenced</td>
<td>Nov 2006</td>
<td>10 of 20</td>
<td>Former nursing home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South West Wembbee</td>
<td>Deer Park</td>
<td>Metropolitan</td>
<td>Committed Commenced</td>
<td>Nov 2006</td>
<td>10 of 20</td>
<td>Former nursing home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outer East Maroondah</td>
<td>Ringwood</td>
<td>Metropolitan</td>
<td>Committed</td>
<td>2006 then May 2008 (08-09 budget)</td>
<td>10</td>
<td>Stand alone</td>
<td>Not Commenced</td>
<td></td>
</tr>
<tr>
<td>Peninsula</td>
<td>Frankston</td>
<td>Metropolitan</td>
<td>Committed</td>
<td>2006 then May 2008 (08-09 budget)</td>
<td>10</td>
<td></td>
<td>Not Commenced</td>
<td></td>
</tr>
<tr>
<td>North West</td>
<td>Broadmeadows</td>
<td>Metropolitan</td>
<td>Committed</td>
<td>Nov 2006 then May 2008 (08-09 budget)</td>
<td>10</td>
<td>To be co-located with CCU</td>
<td>Not Commenced</td>
<td></td>
</tr>
<tr>
<td>Middle South Monash</td>
<td>?Clayton</td>
<td>Metropolitan</td>
<td>Committed</td>
<td>2006 then May 2008 (08-09 budget)</td>
<td>10</td>
<td></td>
<td>Not Commenced</td>
<td></td>
</tr>
<tr>
<td>Northern</td>
<td>Preston</td>
<td>Metropolitan</td>
<td>Committed</td>
<td>Nov 2006</td>
<td>10</td>
<td>With CCU</td>
<td>Not Commenced</td>
<td></td>
</tr>
<tr>
<td>North East Hume</td>
<td>Wangaratta</td>
<td>Rural</td>
<td></td>
<td>No Commitment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grampians</td>
<td>Ballarat</td>
<td></td>
<td></td>
<td>No Commitment</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Northern Mallee</td>
<td>Mildura</td>
<td></td>
<td></td>
<td>No Commitment</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>South West Healthcare</td>
<td>Warrnambool</td>
<td></td>
<td></td>
<td>No Commitment</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>North East</td>
<td>Austin Health</td>
<td></td>
<td></td>
<td>No Commitment</td>
<td></td>
<td></td>
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