INQUIRY INTO SUPPORTED ACCOMMODATION FOR VICTORIANS WITH A DISABILITY OR MENTAL ILLNESS

Melbourne Citymission (MCM) is a large provider of disability services including Case Management, Shared Supported Accommodation, Outreach, Respite, Day Services and family supports, predominately in the Melbourne metropolitan area. MCM has a specialist Acquired Brain Injury (ABI) Unit that offers services across Victoria. MCM manages eleven Community Residential Units (CRU’s) one of which is a unit for children and young people. MCM also manages a shared care unit for children and young people with behaviours of concern.

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<th>Focus Questions:</th>
<th>Availability:</th>
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<td>1. What have been your experiences with supported accommodation in Victoria with regard to availability, suitability, and adequacy of care for people with a mental illness or disability?</td>
<td>There has never been enough supported accommodation options to meet the demand for the full range of people with disability. If there are vacancies, they are often not suitable for people with complex needs (including those people with behaviours of concern) and therefore this group is not being provided an appropriate service. In fact children in this category (aged 16 years and over) and adults are often not able to access any services – in particular respite (due to OH&amp;S issues) or inclusive recreation. Families may be able to access in-home support but this may not meet the needs of the person and their family. For people who have experienced an ABI there is poor availability of supported accommodation with more options being available through the compensable and private sectors. There is a lack of understanding of the diversity of support needs</td>
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of this group and the need for a range of models. People with ABI often don’t see themselves as having a disability so don’t want congregate care but want individual units or live with family to maintain their role (parents, partners). Options need to be flexible to change with the person’s circumstances. There are no options to support people to be parents, especially in congregate care situations, and there are difficulties with who is responsible for the children. There have been a few (6 – 8) purpose built places for people with ABI, which have worked. Currently there are no rehabilitation models in this area and this is needed.

For people with a dual diagnosis of ABI and mental illness there are no adequate options. There are people who remain in the Royal Talbot Rehabilitation Centre – Behavioural Disorders Unit for many years as there is nowhere else appropriate.

Historically:

The service system grew in the community through deinstitutionalisation and rehousing of the people living in the institutions, thus there were few options for the people who had remained in the community with families. There was some real growth in the 1990s in funding for shared supported accommodation and then limited growth until 2002, but there was and continues to be a dearth of skilled staff and thus has led to many difficulties in growing a high quality service.

In the late 1990s many people requiring a long-term option for supported accommodation were residing in respite services, this is still the case. Families in extremely difficult situations who were already excluded from more community based options were unable to access planned facility based respite. Additionally it is more and more difficult to get people into respite due to the procedural requirements such as completion of the respite agreement and Behaviour Support Plan. This has had a huge impact on family relationships and stability.
Suitability of Care

The people with disability accessing CRU’s are often coming from very difficult situations or breakdown of care arrangements and as a result have reduced choice in with whom or where they may live.

There are major workforce issues across the sector. As CRU’s are outposts, it is difficult to recruit, train and support staff. Staff are often not qualified. If staff are qualified the common base qualification is Certificate IV (Disability) but this does not adequately prepare people for employment in residential services. This course serves as an introductory course but does not provide enough depth in order for workers to grow and positively challenge their work practice. There are also noticeable gaps in learning about practical tasks – for example incident reporting requirements. It is of concern that some educational facilities are now offering Certificate IV (Disability) as a 6 week course.

The quality of care can vary from house to house and service provider to service provider and is in part dependent on the skill sets of the staff and the level of support and supervision. This is especially evident when working with people with complex and/or specialist needs such as people with ABI.

Current funding models allow only for the accommodation and basic needs to be met.

There are many people who have come from institutions who are aging prematurely due to long-term limited health care deficits and a sedentary lifestyle. Thus there are now many people in CRU’s who are aging and wish to “age in place”. This challenges the way current supports are funded and provided, in that most houses are not staffed during the day.

There are a number of examples of people being identified as mismatched, there has been no solution found to this and in one instance in a MCM CRU this has been
the case for 5 years.
Currently, the Disability Leasing Model (DLM) provides some challenges for service providers who are now also landlords. The DLM was introduced with no increase in funding for service providers who are now required to manage repairs and individualised arrangements for rental. This also requires a different skill set.

**Availability and Expectations:**
Australian society expects that adult children will move out of home from late teens to late twenties, therefore there is an expectation that people who have a disability will also move out of the family home around that time and that the care and parenting role will change. However, the service sector encourages adults with a disability to remain at home for as long as possible (often into their 50s). This often means that a co-dependency builds between ageing parent and middle aged person with a disability inhibiting thinking about and planning for the future. It may also mean loss of opportunity to build independence skills while the person is relatively young.

Families can become anxious if their family member is in the SSA Exiting Program as the model of support is more flexible and unpredictable. Some parents have the expectation that once a person moves into a CRU it is their home for life. This might not be the case for a number of reasons including – changing skill level, health or aging needs, compatibility.

**Physical Suitability:**
The physical layout of the accommodation is very important and can impact significantly on the success or otherwise of this option. Typically the model of 5 people sharing a house is the option available. This option provides challenges for
people with behaviours of concern, matching and compatibility, in that it is difficult to provide roomy but private living spaces outside of the bedrooms. Purpose built houses are far more suitable than most refurbished houses as they have very separate living areas and individual bedrooms.

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<th>2. What is your experience of trying to access supported accommodation in terms of information, planning and decision making?</th>
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| **Information:**
| Limited information is given to family members about the process and their options. There is a perception that some people with ABI are still being denied access to the DSR. There appears to be a lack of commitment to take on the needs of this group as appropriate options are limited. There is a disjointed system regarding accommodation vacancies for people with ABI across private, Disability Services funded and Community Housing options and a disconnect between this housing and provision of support. Through the MyFutureMyChoice initiative, there was a positive drive to locate young people living in nursing homes. However, identification of these young people was made difficult due to inadequate information exchange processes between Commonwealth and State governments. |
| **Planning:**
| There appears to be a lack of service planning on a regional basis using demographics and trends. There is a lack of planning for the sector as there is no mechanism through the DSR for anything other than immediate or foreseeable need within a 12 month timeframe. There is limited ability to capture information from the individualised plans to aid service planning. The waiting list time for SSA can be lengthy even if nominated as having an urgent need. Over the last ten years, a few services have been set up to work with aging |
parents/carers to plan for the future accommodation needs of their family members. There is no option at the end of this planning. Some families are wanting the security of knowing that their child is on a waiting list or that their future need has been noted. Many families express their frustration at the inability to plan for a future where their son or daughter is able to move out of home in a planned way.

**Decision Making:**
Parents/families/person can participate in what goes on to the DSR but past that point there is no real input. In the present system there is too much pressure to meet the needs of people with a high profile, which can sometimes lead to poor decision-making and therefore outcomes. There are competing interests playing out in the planning and decision making process. The case manager needs to stress the urgency of the individual’s situation but not over-play the behaviours of concern. Although the residential service is under pressure to fill vacancies the matching process can be complex and time consuming to support a successful outcome. Informed choice and person centred planning is an essential feature of an individualised approach, however a lack of options diminishes this choice and disempowers the individual with a disability or their significant others, who is not given the opportunity of self determination in relation to their accommodation and support choice.

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<th>3. What other approaches/models should be considered to address supported accommodation funding, planning and delivery?</th>
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<td><strong>Continuum Of Support</strong></td>
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<td>A continuum of support is needed to enable personalised responses and choice. Such a continuum may include:</td>
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<td>• Independent Accommodation Network (people can look for other people to</td>
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share with
• Lead tenant/ Co-tenancy
• Key ring
• Neighbour Ring
• Trial/transition models
• Ageing in place
• Shared care
• Slow To Recover
• Support within a Motel setting

Researching positive models
There are a number of positive models currently available that could be examined to understand why and what works and can be replicated. These include:
• Fleet Court
• Pellat St
• Wintringham
• Clyde St

Education and Information is needed for:
• Services, family members, people with a disability regarding what is available and what is possible

Importance of purpose building
Design considerations include:
• Universal Housing principles
• Location – near transport, community facilities, shops and work options
• Physical design to accommodate needs of the people
• Involvement of people who are going to live in the accommodation at the outset
- Having own space
- Motel style
- 1 or 2 bedroom units
- Tailor accommodation layout to allow time away from others, adequate personal space and appropriate least restrictive supervision; site in an appropriate location

Needs of older carers and their family member with a disability and family support models
Supporting older carers and their family member with a disability to plan for the future may require a significant time investment. As suggested in Question 1, the service sector encourages adults with a disability to remain at home for as long as possible (often into their 50s). This often means that a co-dependency builds between ageing parent and middle-aged person with a disability, inhibiting thinking about and planning for the future. It may also mean loss of opportunity to build independence skills while the person is relatively young. Specialist older carer case management programs such as Options for Older Persons (Nillumbik Community Health Service) can provide valuable long term support to such families.

Funding models including unit costs, innovation funding, national insurance
- Flexible individualised funding to support accommodation and day activity requirements for people.
- Development of a national insurance scheme for acquired disability
- Innovation funding to develop models of support
- Exploration of models which use family trusts and/or family involvement in sustaining care.

Pooling individualised funds
The following models successfully achieve sustainable innovative services through
the pooling of funds:
- Nightlife
- Pellat St
- Key Ring
- Sharing supports through personal choice and private arrangements

**Diversity of Approaches or frameworks**
All of the following are required to meet the span of needs:
- Rehabilitation
- Developmental
- Socio-medical

**Infrastructure including staff/training**
- Appropriate and adequate training for staff
- Working with tertiary education sector regarding alignment of courses to work, including placements in residential settings
- Working with secondary schools to present a career choice
- Increased traineeship options

| 4. What are the implications for individuals who need but cannot get supported accommodation? Is the alternate accommodation that is available adequate and care appropriate? | There is no provision for immediate and urgent funded response to homelessness and supported accommodation needs prior to registration on the Disability Services Register. Alternative responses for individuals who cannot get supported accommodation may include:
- Residential Aged Care facilities
Care in Residential Aged Care facilities has been inadequate at times, which has led to secondary conditions such as pressure sores and contractures. Residential Aged Care facilities are not funded to provide the level of care and additional supports |
required for younger people including community access, social outings, and aids & equipment. There is often a lack of understanding and inadequate training in supporting this population, for example, the use of a rehabilitation model of care and sustaining good dental health. These facilities are not family friendly. It is difficult for young children to visit their parents whilst complying with the needs of the other residents.

- Supported Residential Services (SRS)
SRS accommodation does not provide the level of personal care or behaviour assistance that many people with a disability require. Staffing ratios are inadequate for the number of residents and often the SRS accommodate large numbers of people. Further, many vulnerable people meet and mix with others who may be involved in substance use and abuse or criminal activity. Anecdotally, there are numerous instances of assaults, property damage and theft. SRS staff often have very limited understanding of, and ability to appropriately support, people who display behaviours of concern. Consequently, residing in these settings may be damaging for a person’s self image and community connectedness.
All SRS require significant contributions from residents, which then leaves minimal funds for personal spending.
Some private SRS have specialised in working with particular groups of people for example people with ABI. This has been more successful because there has been a semi-formal partnership with the ABI sector and therefore additional supports (case management, secondary consultation and social/recreation funding).

- Facility based respite:
There has been growth in respite funding but in community models rather than
Facility based. Blockage of respite houses with people who are homeless reduces access and may create more difficult environments, due to compatibility issues. Residential Aged Care facilities are often the only respite option for people with ABI. In order to access the Residential Aged Care facility for respite a person requires an ACAS assessment. Access to such assessments is often a long and difficult process for a younger person.

- In-home support and community access
  Increasing such support is often not sufficient or the most appropriate option and many families breakdown. Currently funding from a number of sources may be required to ensure that the person and their family have adequate support.

- Correctional facilities
  Research suggests that 60 – 70 % of inmates (in both adult and youth facilities) have an ABI – therefore this is becoming another accommodation service for this group without having a specialist rehabilitative focus.

- Other alternatives
  Caravan parks, hotels and supported holidays - which do not provide the stability, services or support required (especially with regard to consistent management of behaviours of concern).

5. What is your view on the provision of accommodation and care in private, government and community sector managed supported accommodation?

| All can be appropriate. The system can be overregulated (OH&S) to the detriment of the person and doesn’t always prevent abuse or inappropriate care. The provider needs to be of an appropriate size to be able to cover the needs and deliver a quality service – ie the provider needs to be of a sustainable size. Overall, there is not enough of any type of accommodation option, but choice of |
providers and models should be supported.

- **Government**
  It is sometimes assumed that government managed supported accommodation will be better quality as they are funded at a higher level but this not always the case. Whilst there is a need for critical mass, some regional services are now very large which may be to the detriment of the service delivered. Currently the CRU model predominates.

- **Private**
  Some private accommodation options are not delivering appropriate care and support and have non-transparent processes regarding governance and regulations. These services are reluctant to participate in external oversight and in many cases the monitoring systems may be inadequate.

- **Community Sector**
  Most community managed accommodation services could benefit from growth for greater economies of scale, but this may be to the detriment of innovation and personalisation.

6. What are the positives and/or negatives of the current approach to provision of supported accommodation have on families and carers?

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<td>Family members can be involved in future options, such as a circle of support. Older carers have been able to see their children develop when they thought they wouldn’t. Families now see positive things in the family member 2 – 3 years after being accommodated. If families are supported and included then they can often rebuild relationships with relinquished members. When families have been involved in the development phase and governance, then they are more likely to remain</td>
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engaged and involved in their family member’s life.

- **Negatives**
  
  Lack of out of home options for children places a strain on the family and often leads to breakdown.
  
  Few supported accommodation options support the maintenance of family relationships and roles. There needs to be a family friendly, safe environment for children.
  
  It is a difficult decision to relinquish the family member, which becomes even more difficult if there is no immediate accommodation option available for the person.
  
  Families often experience exhaustion, guilt, mental health issues, relationship breakdown, domestic violence and financial stress (due to low or no participation in the workforce).
  
  Siblings are often affected negatively, for example, reduced school attendance, low self-esteem, poor academic performance, behaviour issues with peers and parents.
  
  Sometimes there are competing needs of family members who wish to remain supportive whilst the resident wishes to become more independent.
  
  Children in family options programs have paid carers (ie foster parents). If that level of support could be put into the birth family home there may be a more positive outcome.
  
  In desperation families of children under 18 years may be forced into the child protection system. Others face the choice of not picking up their son or daughter from respite, school or hospital.

| 7. What issues need to be considered in the accessibility and provision of supported | - Rural & Regional Victoria
Relocation of many people may occur due to availability of services in Melbourne for example, OoH, Drug & Alcohol services, Rehabilitation Services, Correctional |
accommodation for people from:
- Rural and regional Victoria
- Culturally and linguistically diverse backgrounds
- Indigenous Victorians?

Services, Mental Health Services and available housing which may lead to loss of community connection and family involvement. People with high need often relocate to North & West Metropolitan Region, as there is a concentration of specialist services due to the Region’s institutional history.

There may be great distances to access day services/accommodation services – or distances between these services in rural areas. There is the potential to have greater work force issues (availability, flexibility, privacy and choice).

People may move to Melbourne for specialist services and then there is often a difficult decision as to whether to return or not, once these are no longer required. Respect is needed for local culture when developing new services.

Consider a road show idea of a team of people going through the regions on a regular basis sharing their specialist knowledge and techniques, this should be in conjunction with secondary consultation, use of IT (video conferencing).

- Culturally & Linguistically Diverse Backgrounds

There is a case for both ethno-specific services and generic services. Assumptions should not be made – families do not always want services or staff from their culture.

Being sensitive to CALD is deeper than the surface issues (ie language and food), and not just addressing the taboos, it is more complex than that it requires understanding of the person’s experience of being parental care.

There are additional costs associated with providing information and support in appropriate formats for example translation services and interpreters.

Need to have an understanding and be able to cater for the culture’s nuances – values, gender of staff, expectations of what their children do, how does the culture of fostering independence sit with their culture. Gender preference in staffing is
not always available. A family liaison position is needed in some services. Services need to establish links with key community members to assist with planning and development of appropriate models of service delivery.

- Indigenous Victorians

There is a case for both indigenous-specific services and generic services. Services need to establish links with key community members to assist with planning and development of appropriate models of service delivery. Generally speaking, the time taken to connect and develop relationships with community is vital to the provision of successful supports.

| 8. What other issues do you think need to be considered which have not been addressed by the above questions? | Current methods of allocating resources for regions may not been the most appropriate to address disadvantage. There is a need for ongoing commitments from the budget process to develop new options not just refurbishments or moving people out of institutions. There needs to be a range of responses from fully supported accommodation to independent living. More work needs to be done on addressing work force issues and making this a “good” job with career paths. Traineeships and work based training need to be expanded so that people can learn as they go with a guaranteed income. A National Disability Insurance scheme is sorely needed. |