Mind Response to the Victorian Government Parliamentary Inquiry into Supported Accommodation Services for people with a disability or mental illness.

1. Introduction and Context

Mind welcomes the opportunity to contribute to this important inquiry into the supported accommodation services available to people with mental illness and other disabilities. Mind services work extensively with people with serious mental illness, as well as with those who are homeless. The overlap between these two groups is well established, so that many Mind services work with a client group which has experience of mental illness as well as various levels of homelessness.

This submission will therefore focus on these two broad groupings of people, although, it is important to note at the outset that many Mind clients are multiply disadvantaged. They are over-represented amongst those clients with alcohol and other drug problems, poor physical health, poverty, homelessness, intellectual and other disabilities. Overwhelmingly they rely financially on some form of disability pension or other low paid benefit. This means that the accommodation options for Mind clients are often limited to those available to people with little or no income, with serious health and social problems, and with diminished capacity to advocate for their own needs.

In preparing this submission, both staff and consumers of Mind have provided input. Our submission, which is structured around the questions posed in the inquiry discussion paper, includes quotes from members of Mind’s Consumer Reference Group. This is a group comprised of Mind consumers who provide leadership to consumer participation in Mind. The group recently met to discuss the questions in the discussion paper. They understand supported accommodation from the inside, and their views should be of particular interest to the inquiry. Other quotes included in our submission come from service delivery staff working in a range of differing contexts - city and country, youth and adult services, and mental illness and homelessness.

2. 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?

“...I have lived in a supported accommodation program run by Mind Australia. I found this an invaluable part of my recovery. There specialty, support and day program and willingness to work with other services on personal goals was important.”

- Mind CRG Member

The overwhelming consensus amongst staff and consumers of Mind is that there is just not enough appropriate housing for people who experience serious mental illness. This problem is a special instance of the well documented, more general societal problem of lack of affordable housing. The problems for mentally ill people are multiplied, however, since affordability is irrelevant to the vast majority of people with serious mental illness. Mind clients rely on various forms of public housing, and there is simply not enough of these sorts of dwellings available. Each week Mind central office staff receive many calls from mentally ill people, or their advocates, who urgently need safe, secure housing, with appropriate support. The options are depressingly limited.
Once the problem of finding a home is resolved, there is the level of support needed to sustain a person with a serious mental illness in that home. Some people need minimal support, whilst others need intensive support. Outreach models can accommodate to a variety of support needs amongst clients, but there are many fewer options for people with needs that require an intensive residential service. The PDRSS in Victoria has developed a range of Residential Rehabilitation services, for both adults and younger people, that offer a much needed augmentation of the clinically based residential services. These services work to assist people whose lives have been damaged by their encounter with mental illness, to begin their recovery in a setting within the community. The emphasis in these services is on assisting people to re-learn, or in some cases to learn for the first time, the range of living skills that they need to operate effectively in the community.

Because of the current shortage of appropriate rental accommodation in the general community, consumers in Mind’s Residential Rehabilitation programs find it difficult to access suitable accommodation at the end of their stay in the program. This results in people who have been living in our programs moving to unsatisfactory accommodation where they are more likely to be at risk of a relapse in their mental health condition. It also causes bottlenecks in our residential programs while the best accommodation opportunity for each person is sought.

There is, unfortunately, an insufficient supply of every sort of supported accommodation option at present, and an urgent need to increase the housing stock of almost every accommodation type. Mind clients come to our services from the full range of housing possibilities. As well as being referred from clinically based services, such as acute units, CCUs, Forensic, and SECU’s, many have been living in special accommodation services with few supports, (other than a well meaning manager and occasional visits from mental health workers); in cheap and often nasty boarding houses, with no supports at all, in caravan parks, or parks without caravans, or at home, where the burden of care rests entirely on an exhausted under-resourced family.

Unfortunately, the options are mostly the same when clients are leaving Mind services. The elusive option that everyone is seeking is that place a person can call their “home”. For Mind clients this is a place in a local community they have come to know, and can operate effectively within, that has a flexible range of adequate supports. These supports can be intensified in times of greater need, and then withdrawn as the person grows in confidence.

There are structural reasons why this option is so elusive. Clients, who are lucky enough to find a supported housing option that gives them long term tenure with diminishing support as their recovery progresses, stay on in these houses when they no longer need the support. This is as it should be. The structural problem is that there are no replacement properties for other needy clients to move into.

“The Supported accommodation model introduced by DHS in late 1990’s has been a spectacular failure in terms of providing a system that encouraged throughput and freed up supported housing options in the community. All tenants in these programs are signed up as long term tenants and therefore have the right to remain in these properties for their lifetime. We have at least 4 of our 13 nomination properties that have people in them who no longer require support but have established connections to their neighbourhood and community and are unwilling to move on, and we are unable to force them to do so. When this scheme was first introduced, it was my understanding that housing would be more fluidly managed and
properties such as these would be “handed back” to DHS to be managed as public housing tenanted properties and replacements be made available as stock for programs”.

- Mind Rural Home Based Outreach Manager

3. What is your experience of trying to access supported accommodation in terms of information, planning and decision making?

“All regions have different service providers, criteria, assessments and service provision. There is no registry for mental health specific accommodation services, similar to the one SAAP has developed. Planning and decision making can be difficult as clients and staff are not always able to get definite time lines for occupancy”.

- Mind Homelessness Service Manager

There is general agreement amongst Mind staff that the processes for accessing supported accommodation across the service systems is labyrinthine and confusing. Different organisational requirements, catchment areas, and tenancy arrangements all lead to a confusing muddle for anyone trying to navigate the system. The Because Mental Health Matters

The Victorian Government’s reform process has recognized the need for a twenty four hour triage system to quickly assess need for treatment.

We need a psychiatric triage system that has 24/7 capacity to promptly assess people who are unwell and link them into specialist clinical care, and can also proactively help them access primary health or private mental health care if that is what would best meet their needs. (BMHM page 68)

The government’s discussion paper also emphasises that adequate housing is a critical part of the recovery process for the seriously mentally ill. The service system must be able to respond adequately to,

Individuals with enduring psychiatric disability (often complicated by acquired brain injury, physical or intellectual disability) who have very poor functional living skills and require long term supported accommodation augmented with onsite, up to 24/7 ‘slow stream’ psychosocial rehabilitation support. Adequate supported accommodation must be an integral part of the housing and recovery continuum. (BMHM page 93)

We believe that the Victorian Government should consider linking these two exigencies – prompt assessment with supported accommodation assessment. A 24/7 capacity to assist seriously mentally ill people to access available and suitable housing options from a central database could short circuit the frustrating and often futile shopping around for available supported accommodation options. Of course, there is still the problem of lack of available housing – supported or otherwise – to contend with.
4. What other approaches/models should be considered to address supported accommodation funding, planning and delivery?

The current array of supported housing options reflects the diversity of client need. There is a need for many housing options, since client need varies so dramatically - from serious incapacitation through to being able to function with minimal support within the community. The problems lie in the scarcity of key components of the system, and the lack of co-ordination of access to these. Scarcity breeds a sense of system failure – the systems are not coping with the need.

Better co-ordination should involve more partnering between different parts of the accommodation service system, so that clients can benefit from the ready availability of resources they will need as they recover. The differentiation between clinical and PDRSS provided supported accommodation services should be further broken down. There are encouraging examples of how the system can operate, in the recent Integrated Rehabilitation and Recovery Care Projects. These are demonstration programs in which PDRSS outreach staff work into SECU's and CCU's to assist long stay patients in these settings to move into homes in the community, supported by both clinical staff and community workers. PARCs are another example of the possible future for other parts of the service system. There is no reason why PDRSS's should not actively be involved in the support given to patients currently living in CCU's. Nor any reason why clinical staff should not be employed alongside rehabilitation experts in PDRSS residential settings.

"Increase service capacity of a diversity of models - residential rehab; cluster units; home based outreach but with housing stock attached; resources to families to build rooms / granny flats etc. where there is the desire for the person to remain within a supportive family environment."

- Mind Residential Rehabilitation Manager

The other supported accommodation - which is really largely unsupported accommodation - that deserves immediate attention is that provided by families, and other carers, to people with serious mental illness living in the family home. The fact that it is difficult to get accurate statistics on the size of this group is itself a telling fact. The Australian Bureau of Statistics indicates that 2.5 million Australians over 15 years of age, care for someone at home because of a disability or old age. Carers are typically older Australians, women, and more likely themselves to have a disability. It is not known what percentage of this group is caring for a family member with a mental illness. The Victorian Government's Because Mental Health Matters discussion paper recognizes that many families carry the burden of care for their mentally ill family members. Goal 2.4, in the paper states,

Building stronger, more resilient families where there is risk related to mental health problems or a combined mental health and drug and alcohol problem (BMHM page 56)

The focus in the discussion paper is on strengthened support to families where there is a parent with a mental illness and/or drug addiction. Whilst this is a necessary focus, there are other families – often older Australians - who are the principal carers of family members with serious mental illness. Often these people themselves are ageing, and there is a desperate need in this group for solutions.

"I have recently been approached by an elderly carer who is looking into future options for their son who is 50 and has chronic schizophrenia. He has had little success in finding something is this region that is suitable
and is currently looking at the option of St. Johns which is an aged care facility as there is little else.”

- Mind Rural Service Manager

Assisting these families requires finding options beyond the family home, and the provision of support, both to the family and the person living at home with serious mental illness. Supporting the development of greater resilience will require resourcing these families in a tangible manner – for instance paying them for exercising the caring role. This is one way of both acknowledging the work, and also supporting it, so that it can be done better. Many families in this situation are driven into poverty because of the inability to manage a working life whilst caring for their family member. Enhanced respite options for families that provide flexible responses to family needs – to both carers as well as mentally ill family members – also need to be expanded. And, there is a great need to assist this isolated group into likeminded communities through the development of more effective peer support programs.

There is also a need for accommodation for single people who are not able, either temporarily, or permanently, to live with other people. Very few supported accommodation options offer this facility. Public housing developments rarely offer single bedroom options for mentally ill people. There are always requirements that both bedrooms in two bedroom accommodation are filled – and this can lead to a break down in both tenancies when people who need to live by themselves are forced into living with someone else.

Recent evidence in the US ¹ from the Pathways program in NY, which was recently presented in Melbourne by Sam Tsemberis, found that the sooner people can be placed in long term secure accommodation that they can reliably call home, the better. Waiting for people to be “housing ready”, which usually means getting them to stop drug use, or to better control troublesome symptoms of mental illness, has been demonstrated to be a flawed premise. The evidence indicates that people manage their recovery from mental illness and drug misuse better within the context of their own home.

‘Pathways to Housing’ applies the principles of ‘Housing First’ (‘National Alliance to End Homelessness’, 2006) to provide housing for homeless people with severe mental illness living in New York. These principles include the rapid access to permanent and sustainable housing for the homeless person, after which support is provided for as long as needed, to ensure successful tenancy and promote the economic and social well-being of individuals.²

5. What are the implications for individuals who need but cannot get supported accommodation? Is the alternate accommodation that is available adequate and care appropriate?

“It is not adequate for anyone suffering from a mental disease. I myself have lived in these types of accommodation. I found it is safer to live on the streets. The corporate people that ask these questions have absolutely no idea what these places are like or what the reality of having no other place

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² MIF discussion paper Mental illness and Housing, May 2008
to go to get the help they need. These accommodation places are choc full of society’s rejects where drugs, violence, is rampant and are the only thing the residents care for.”

- Mind CRG member

It is now apparent that homelessness can be a cause of mental illness, as well as making an existing mental illness worse. The above quote from a Mind client says it all. People with serious mental illness are some of the most vulnerable people in the community. They need to live in settings where they can recover, not where their mental illness will be made worse.

“Single adults are the most difficult to house through non mental health services. The issues are: putting people in to shared tenancies, high density and boarding houses, as they impact on health and can result in relapses of illness and or recovery, the start/restart of substance use, and further transience. Any crisis in housing increases the risk of transience and support staff have often been made aware of physical and sexual assaults, criminal activity and offenses committed in boarding/rooming houses.”

- Mind Homelessness Service Manager

Because it seems likely that sub-standard forms of accommodation for the seriously mentally ill will continue to be used, there should be an emphasis on better supports for people living in these. Assertive outreach programs, where qualified outreach workers can locate people floundering in these sorts of housing, can be the start of an improvement in their lives.

Mind currently operates two hostels for people with enduring mental illness. These have been established for many years, and were previously operated by Mental Health Auxiliaries Victoria. They provide full board and accommodation to both men and women in separate properties. There is outreach support provided to these residents from a program operated by another PDRSS service. Some residents in these services have lived there for 35 years, and call this place their home. These hostels are “in the community”, and whilst being unfashionable when compared to other, more modern, supported accommodation, they provide a stable, safe living option, with access to friendship groups, and professional support. They are a part of the continuum of accommodation options, and provide a model for how other rooming houses could be structured to respond better to the needs of people with serious mental illness.

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

The broad thrust of this submission is that a wide range of supported accommodation options is needed to respond to the different levels of disability experienced by people with serious mental illness. The main problems in the system lie, not so much with the models themselves, but with the acute shortage of housing within each model, and the poor co-ordination between the models. It is difficult for both mental health practitioners as well as for their clients to navigate their way through the various options.
The service system should be structured around, and be responsive to clients’ needs rather than the other way around. Helping clients find their way to a place they can call home, and supporting them there, to the extent they need support, until they no longer need it, is what the system should be about. The current insistence that transitional support is tied to a particular property, means that just as people are able to live sustainably in their local community, they are thrown into turmoil again, because of the need to move to another property.

“The NGO sector, working at the ‘front line’ often is in the best position to develop appropriate options for accommodation and support. But it needs resources to be able to invest / build a variety of supported accommodation models which can meet different client cohorts’ needs. For example, when an adult residential support accommodation model is used, resources need to be replaced as used - rather than short to medium stay accommodation, where the person is required to move on after 1-2 years.”

- Mind Youth Residential Manager

The ceaseless “transitionalism” that is characteristic of the entire system is itself bad for people’s mental health. Mind has discovered that it is at times of transition that many people are most placed at risk. Serious Incident Reviews conducted following DHS Category 1 incidents in Mind services, has provided the clear message that many serious critical incidents occur in the context of a significant transition. This can be a transition involving a change of medication or key worker, but it can also involve a change in living arrangements – typically moving from one transitional accommodation setting to another.

“I just want to reiterate that there are different levels of support with supported accommodations. This should be looked at closely when moving an individual on from high level to low level support i.e. from myself a residential rehab to a supported accommodation unit.”

- Mind CRG Member

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

“In the public system there is no choice as to where to go. There is no option to plan a response when a crisis arises. The family has no role in the decision making as this is done by the inpatient unit and the mental health case manager.”

- Mind Carer Consultant

As mentioned elsewhere in this submission, families bear a disproportionate, unacknowledged, and poorly resourced burden of care for people with serious mental illness. The irony of this statement is
that all of this changes when a person enters a clinical or PDRSS provided supported accommodation service. Then, families and other carers have to fight to gain a place where their voice can be heard. It is well known that outcomes for people with serious mental illness are better with good engagement of the family in the treatment and support, yet there still seem to be barriers to this involvement in the mental health service system.

Mind has recently employed a Carer Consultant to assist the organisation become more inclusive of families and carers in the work we do. There is no government funding for this position, and, as far as we know, Mind is the only PDRSS service to have appointed a carer consultant. Clinical mental health services employ carer consultants, but their role is principally associated with working with families in a peer support role, not with helping the organisation with the system change necessary for the system to work inclusively of families.

"As a carer, I feel that my role is...

Terrifying, traumatic, overwhelming, confusing, stressful, isolating, lonely, undervalued, under resourced, not understood, unsupported, unheard, invisible, frustrating, depressing, emotionally draining, physically exhausting.

The contribution I make in society is to provide all that is lacking in the public and private mental health systems as they respond to my family member’s mental health needs. Sometimes, this contribution is everything.

This role and contribution should be recognized through a change in culture and practice for our mental health system.

Research shows that “The participation of families in mental health care is of central importance for its success” (Froggatt et. al; 2007, ‘Families as Partners in Mental Health Care’). When carers and family members are included as partners in the care of people with mental illness, the outcome is often better for the person with mental illness (reduced incidence of relapse, better overall recovery), the family/carer (reduced stress, increased skills and resourcefulness), and the service provider alike (a useful resource with unique experience, increased information, decreased rates of relapse).

My own experience has shown me that when strong and trusting relationships developed between my family member, the mental health professionals involved in her care, and myself, a far better outcome was achieved than any of us could have hoped for in caring for or treating her independently. Sadly though, this has not been the experience of the
majority of carers I have come in contact with. Many, particularly those
involved with the adult mental health sector, describe being shut out,
ignored, disempowered and disrespected by the mental health system within
which their loved one is treated.”

- Mind Carer Consultant (Submission to Commonwealth
Government Parliamentary Inquiry into Carers’ Needs)

8. What issues need to be considered in the accessibility and provision of supported
accommodation for people from Rural and regional Victoria?

“It is well documented that rural communities are faced with limited access
and choice; this encompasses a ‘whole of life’ context, not only health and
welfare service provision. An individual’s sense of community and
belonging cannot be upheld if they are required to leave their community
to obtain the assistance they require; this further accentuating a sense of
hopelessness and isolation. Access is therefore, more often than not based
on what is available, not what is most appropriate, meaningful or in fact
helpful.

Despite the move from institutional models of care, there remain
individuals, who for long periods require intensive, consistent and expert
support and service. In this region, there have been many attempts to
persuade the youth specific residential rehabilitation and recovery program
to take on adult consumers due to the lack of other more suitable options.
Clinical services provide time limited service through the Hider Street CCU,
however beds within this unit are difficult to come by and there are only 5
of them. Adult intensive support is an obvious service gap in the region
which also has not been in receipt of funding to develop such facilities as a
PARC service.

More creative options are required to address the limitations in service
range and flexibility. An example could be the development of a
multifunction program that housed a range of options for clients. Given
adequately trained staff with appropriate expertise it is not unrealistic to
imagine the integration of a ‘step down’ facility co-locating with a longer
term recovery and rehabilitation program, with access to community
housing options and outreach service provision. Clients would have the
opportunity to work toward independent community living, receive
consistent well planned service appropriate to demonstrated need, and
move through a continuum of care based on need, rather than service
availability. Development of this approach would need to be cognisant of
the potential to create a mini institution e.g. cluster housing rather than 'under one roof' sites.

Average length of stay for acute psychiatric service provision in this area is approx 8 days. People are discharged, however they may still exhibit signs and symptoms of their illness, and still be quite unwell. I believe there is not an adequate system, model or process to assess people to therefore ascertain their specific needs at specific times in their treatment. A comprehensive 'whole of life' assessment is required to ensure people are linked to the most appropriate level, type and intensity of service provision. Then, of course, we need the services in place to provide it.”

- Mind Rural Residential Rehabilitation Manager

9. What other issues do you think need to be considered which have not been addressed by the above questions?

As mentioned above, Mind operates Residential Rehabilitation programs that augment existing clinical residential services. These programs work to assist people with serious mental illness to develop the capacity to move into the community, equipped with the resources, both psychological as well as practical, that will enable them to live well in that community. Mind residential programs do not offer permanent accommodation, and the people who live in them are provided with support to move to other, more independent housing after two or three years in the program.

The tenancy status of our clients in these services has been an issue that Mind has been attempting to clarify for some time. We have received advice that the “best fit” for our clients in these programs is under the Rooming House provisions of the Residential Tenancy Act (Vic). The problem for Mind is that this “best fit” is not a very good fit.

Problems can arise, for instance, when staff attempt to exercise their duty of care to ensure client safety – entering rooms when permission cannot be obtained, and more generally in the smooth operation of the program – requiring clients to attend particular program activities, and even when it is time for a client to graduate from the program. There are also potential problems when a client needs to be quickly exited from the program because of persistent drug use, violence, or some other serious breach of the program’s rules. The application of the Rooming House provisions of the act means that a person who is due to move to other accommodation can delay their exit from the program. This may limit the capacity of the program to provide a service to as many people as possible.

The RTA exempts certain groups from the provision of the act, but serious mental illness is not one of the exempted categories. Likewise, there is a category of ‘health or residential service’ in the act, but the definitional weight is given to people with physical disabilities rather than serious mental illness.

Mind encourages the inquiry to consider more broadly the tenancy status of people who reside in both Clinical and PDRSS residential rehabilitation services. We think that a change to the act that involves
an explicit mentions of the status of these sorts of facilitates, and their relation to the broader provisions of the act would be good for both the clients and operation of these services.