Submission

Inquiry into the Provision of Supported Accommodation for Victorians with a Disability or Mental Illness

November 2008
1. Preamble

MI Fellowship is a major provider of community-based services to Victorians with serious mental illnesses, including schizophrenia, bipolar disorder and other low-prevalence disorders (see Annual Report attached). MI Fellowship provides psychosocial rehabilitation services (including home-based outreach, day programs, residential, Prevention and Recovery Care, respite and community care units), employment, education and advocacy services.

Our services are built around the vision of a society in which mental illness will be understood and accepted.

MI Fellowship has a vital interest in provision of housing support to our participants. Through our psychosocial rehabilitation programs we offer support to people living in their own homes. Home-Based Outreach Support is a vital component in assisting people to stay in their own home, or in establishing and maintaining themselves in accommodation. We also partner with clinical services in providing residential rehabilitation programs to people managing episodes of illness and progressing towards recovery and return to independent living. We are frequently involved in assisting vulnerable people through accommodation transitions, liaising with specialist housing and homelessness services to ensure that they remain housed and supported.

MI Fellowship provides residential rehabilitation for just under 200 participants in the year just passed. Our HBOS service annually supports some 400 Victorians living with a mental illness in independent community housing.

In 2007 MI Fellowship participated in a national survey of people with mental illness and their families (MIFA, 2007a). This survey returned the finding that housing is the Number One issue of concern for this constituency. MI Fellowship has committed to campaigning and advocating on behalf of our members to overcome the multiple sources of housing vulnerability that contribute to their marginalization. We have made a strategic commitment to increase our role in supporting people with mental illness to sustain stable long-term housing.

MI Fellowship recently sponsored a visit by Dr Sam Tsemberis, Director of Pathways to Housing in New York and credited with founding the ‘Housing First’ movement in USA. Pathways to Housing is
a specialist program offering housing and support to homeless people with mental illness. This
program applies a simple and effective program logic to the complex problem of mental illness and
vulnerability to homelessness: provide people with an affordable house first, and then support them
in that home with tailored and flexible support services. The result of this housing and support
package is that the health and social outcomes for the person significantly improve over time, thus
offsetting the additional costs associated with subsidizing private rental accommodation (Pathways
to Housing, 2008).

During 2008, MI Fellowship developed in collaboration with leaders in the Mental Health and
Housing sectors, ten principles for provision of effective housing for people with mental illness.
These are outlined in Appendix 1 and provide the framework for this submission.

This submission addresses questions of adequacy and standards of supported accommodation, in
the light of what we would regard as the characteristics of ‘best practice’ accommodation for people
with mental illness. First we present some case studies from our own practice before outlining
elements of what we would regard as ‘best practice’ supported accommodation for people with
mental illness.

2. Case Studies of supported accommodation for people with mental illness

2.1 Tom
Tom is 56 years old and he has experienced mental illness for most of his adult life as well as some
communication and learning disabilities. After his parents died in 1984, Tom needed to find other
housing and initially was moved into a rented unit in an inner city suburb. At the time he was
working in a factory job and could afford the rent, however his social skills were limited and Tom
became lonely and unhappy.

When soon after this Tom ‘retired’ onto full Disability Support Pension, his income and savings were
insufficient to allow him to remain in the rented unit. It was also acknowledged by the caseworker at
the Day Program Tom attended, that his quality of life was not optimal and that he lacked key skills
for independent daily living such as cooking, shopping, money management and recreation.

Tom’s affairs were placed in the hands of the State Trustees and when a place became available,
he moved to a pension-level Supported Residential Service (SRS) in his old suburb. This facility
caters for people with psychiatric disability and provides a service that is well regarded in the Psychiatric Disability Rehabilitation Services (PDRS) sector. Tom receives his meals, medication, laundry services and is assisted in the upkeep of his private room and shared bathroom. He has friends there. He receives regular support and intervention from the workers at his PDRS to assist him to maintain a reasonable quality of life in his SRS. There is also coordination between Tom’s PDRS and the SRS, in that the PDRS program assists the SRS residents with some recreation activities and transport.

Tom is now stable, secure and happy with the balance between privacy and support in his life. The cost of his supported accommodation ($310 per week) means that Tom has very little disposable income left from his pension, however on balance he feels he has been fortunate to have found this place. Tom’s HBOS workers think that things are working well for him, particularly when they compare his SRS and his living circumstances to some of the other supported accommodation situations of which they are aware.

2.2 Tony

Unfortunately Tony’s mental illness has not been stable over recent years. Although he lived in a relatively ‘good’ SRS, last year his behaviour became so challenging and disruptive that he was admitted to hospital and his place in the SRS was not retained. His caseworkers (DHS) decided that because of violent and difficult aspects of his behaviour, it was preferable for Tony not to return to his original SRS after discharge from hospital. Accordingly, Tony moved in to the only place available to him at the time, on the other side of town.

Tony is very unhappy and insecure in this SRS facility. He describes it as very substandard: He shares a room with two others, and his things cannot be kept secure from theft and damage. The meals he regards as being of poor quality and cold. He has no confidence or liking for the proprietors, who he feels do not support him. He has no friends, and feels constantly under threat from bullying and fighting behaviours on the part of other residents, which are commonplace. The only opportunity for privacy in this facility is to shut the bathroom door. Tony says that the whole building often feels cold. His sleep is often disrupted by the noise and violence of other residents. He feels regularly bullied by particular individuals but does not believe that there is any form of redress available to him. There are no recreational or other organized activities for residents available through this facility, and weekends seem particularly long until he can get back to see his friends at the PDRS during the week. Tony is always frightened when he is at home, and he feels
deeply sad that he cannot return to his original home. Tony pays $340 per week to live in this facility.

The HBOS workers are advocating on Tony’s behalf to the SRS proprietors on what seems a weekly basis. Very concerned about Tony’s circumstances, they are negotiating with Tony’s clinical case managers to see if he can be returned to his original home.

2.3 Christine
Christine usually lives in a one bedroom flat where she feels very isolated although she does have some brief contact each week with a support worker. Her parents feel that she needs more support than she receives, and possibly she should move into a supported accommodation facility.

Recently Christine became unwell and needed to receive a higher level of assistance for a period, including some inpatient stays in hospital. The accommodation here was very comfortable although Christine’s parents felt that it would have been better had the residents been involved more actively in doing tasks around the facility, and also had there been greater communication between staff and residents.

Although Christine’s parents felt that she was not ready to be discharged, she was obliged to leave her residential rehabilitation facility when her treatment was completed. Christine’s parents searched for some other supported accommodation for her, and she was lucky to find a vacancy at Regina Coeli (a facility providing supported accommodation for women at risk of homelessness) where she stayed for a period before moving back to her one bedroom flat. Christine’s parents have since searched for other forms of supported accommodation or other means of increasing her support at home, but as yet to no avail. They are disappointed that she was not able to stay for a longer period in residential rehabilitation, mistaking this treatment facility for supported housing.

Christine’s parents’ experience convinced them that ‘there is a definite need for more supported accommodation for consumers who fall between hospitalization and living independently’. They felt that the transition for Christine from highly supported residential rehabilitation back into independent living, was too sharp and too fast. Whilst in transition the insecurity she felt undermined the gains she was making in her recovery. Although Christine’s parents believe their daughter may need ‘live-in’ support, Christine has never received high levels of support in-reached into her home so the viability of this alternative has not been explored. Everyone agrees that having greater certainty regarding the availability of support would definitely have helped.
2.4 Josie
Josie was a fairly independent adult who worked and lived on her own. Her depression and anxiety issues however gradually mounted until several years ago she experienced a ‘breakdown’ and lost a great deal of confidence. At this time the only way she could cope was to move back home with her parents, who were surprised that despite her maturity she needed help with many aspects of daily living such as going to Centrelink, shopping, budgeting, completing forms and so on.

Josie became involved with the Home Based Outreach Service, and together with her support worker Josie and her parents applied and were eventually successful in obtaining a one bedroom unit made available by the Housing Choices organization. Josie moved in earlier in 2008.

With support from her HBOS worker of approximately three hours per week, Josie has now regained skills in looking after herself. The Individual Participant Plan devised collaboratively with her, focuses on the areas that most challenge Josie, viz budgeting, shopping and cooking, and visits to Centrelink. Josie is now much more confident, and with support from her HBOS worker she has obtained work at a local supermarket, and has commenced studying again.

3. ‘Best practice’ supported accommodation for people with mental illness

3.1 A Home is more than a roof over one’s head
MI Fellowship believes strongly that service design for people with mental illness, must take place within a conceptual framework that takes a broad definition of the ‘home’. In its ‘Review of evidence on housing and health’, the WHO (2004) identifies a range of social and mental conditions for ‘healthy housing’, including security, privacy, safety and protection from aggression, a ‘holding space’, an ‘envelope in which intimacy will appear and develop’ and the opportunity to be oneself (p.3). In addition to providing a place of shelter, having a home can instil a sense of place or belonging, of control over environment and of ownership (not necessarily financial). A home can also support social and economic participation, and provide an opportunity to develop personal responsibility and independent living skills that can build a greater sense of self-worth and control.

A home-like environment is a necessary precondition for recovery from mental illness. Recovery is now understood to be a personal journey of reclamation of self, in which the person re-
establishes a framework for self-efficacy, recovers relationships and purpose, and achieves a sense of meaning and hope:

'Recovery happens when people with mental illness take an active role in improving their lives, when communities include people with mental illness, and when mental health services can enable people with mental illness and their communities and families to interact with each other' (NZ Mental Health Commission, 2001, cited in UNSW Consortium March 2008).

3.2 Key elements for sustainable housing of people with mental illness

Information about the standards of housing and support services that best meet the needs of people with mental illness, is well documented in the literature.

There is convincing evidence that for people living with a mental illness, a stable and affordable home is an enabler for recovery, reducing risk of relapse, promoting community tenure and security, and increasing quality of life. Absence of housing stability and affordability places mental health at risk; for those already experiencing mental health problems, absence of these conditions can exacerbate illness.

Conditions of independence, privacy, safety, provision to live alone and to make daily decisions, are frequently cited. Hogan and Carling (1992, cited in Chesters et al, 2005), identify the following conditions required for housing of people with psychiatric disability:

- Housing which keeps levels of stress manageable
- Housing that enhances stability, and is not time-limited
- Housing that enhances opportunities for control over the environment.
- Consumer choice - the housing is chosen by the person with the mental illness
- Neighbourhood amenity – the housing is located in areas that offer the prospect of ‘assimilation’ and support for the person with the mental illness
- Proportion of residents with mental illness is ‘limited and consistent with community norms’
- Appearance of housing is consistent with neighbourhood norms.

3.3 Support factors

There is strong evidence that people with mental illness have specific support needs that arise from their illness and that must be addressed if they are to achieve viable ‘community tenure’:
Many people with psychiatric disabilities have significant impairments which, without adequate supports, will place their successful tenure in jeopardy. Such impairments to functioning can include cognitive, positive, negative and disorganized symptoms of psychosis and the subsequent impairment to social skills, sense of self, personal confidence and self-efficacy (MIFA, 2007b).

The realms in which support is needed are agreed to be essentially three:

- **Tenancy management** – flexible support around the administration of a tenure (lease, mortgage) and practical support to maintain and upkeep the property;

- **Clinical support** – medical and clinical services that are accessible in the local community and if need be, direct to the home;

- **Psychosocial support** - assistance with household administration, budgeting, relationship support (e.g. managing conflict with neighbours), accessing and participating in the resources of the local community.

3.4 ‘Best Practice’ supported accommodation associates with recovery

When the housing conditions outlined above are provided for people with mental illness, the evidence demonstrates a link with recovery:

- Baker and Douglas (1990) found that patients who remained in adequate and appropriate housing improved, while those in poor housing remained the same or deteriorated in their level of functioning (cited in Meehan et al, 2007).

- A longitudinal evaluation of the NSW Housing and Accommodation Support Initiative (HASI) found that the factors of stable, affordable, supported tenancy resulted in two significant improvements to people with mental illness. First, in their mental health: Over two thirds of residents experienced improved Global Assessment of Functioning Scores, and hospitalization rates for psychiatric and emergency admissions dropped in frequency and duration. Second, HASI participants showed improvement on measures of community participation, including increased participation in paid and voluntary employment and education, and increased numbers of friendships and social networks:
`For the recurrent annual program cost of less than $58,000 per person, HASI resulted in substantial decreases in hospitalization rates, stabilized tenancies, improved mental and physical health, increased life skills, and social, educational and workforce participation.'
(Muir, 2008, p.5)

Against these benchmarks we can now consider the standards and adequacy of supported housing for people with mental illness as it is currently provided.

4. Critique of models of supported accommodation for people with mental illness

4.1 Analysis of current models of supported accommodation

Supported accommodation models for people with mental illness vary in several important dimensions.

Congregate models which offer residential treatment and psychosocial rehabilitation, are a significant model of treatment that coincidentally provide accommodation for people with mental illness. They include facilities auspiced by DHS (e.g. SECU’s and CCU’s), or involving shared provision by the clinical and PDRS sector (e.g. PARC’s). In these treatment facilities the person with the mental illness may be a paying resident and length of stay is determined by clinical treatment outcomes. When length of stay is long, it is not uncommon for people to forfeit their other accommodation arrangements, thus intensifying their accommodation dependence on the treatment facility. However there is no intention in treatment facilities to provide long term accommodation; the logic of residential treatment is that one stays only as long as required for illness to stabilize and improve.

Still ‘congregate’ but essentially different to treatment models, supported accommodation for people with mental illness can take the form of rooming houses and pension-level SRS’. These are typically though not always privately owned and operate to generate a profit. In these facilities, clinical and psychosocial rehabilitation support is in-reached by private arrangement between the resident (the person with a mental illness) and his or her treating and rehabilitation services. Here, security of tenure is separate from clinical and psychosocial outcomes, however it is strongly influenced by the ability of the resident to meet payments and their compliance with behavioural expectations (which is in turn heavily influenced by treatment outcomes). In these settings, the resident may be said to have greater independence in relation to the management of their illness,
and security is promoted by the structural separation of treatment outcomes from security of tenure. Conversely however, these residents will typically have far less support and flexibility around the achievement of wellness. Moreover, depending on the quality of the facility, other factors may directly compromise security and quality of life. Coordination of care, where this is available, is an important mitigating factor in that in the absence of a worker’s input, accommodation arrangements can rapidly fail through a diverse range of circumstances, e.g. where the resident neglects to meet tenancy payments or lacks the skills to resolve issues with neighbours.

Between these two poles exist a variety of individual housing and support arrangements that include separate dwellings owned and operated by benevolent auspice organizations, through to situations in which the person with the mental illness is living in a privately owned or rented home or a family dwelling. The unifying factor here is that the person with mental illness is housed in an individual or family household — or even a small shared household — rather than in a congregate household, and support is in-reached to the home.

Within the variety of individual supported accommodation arrangements there are some important distinctions. In many situations the support may be provided by the same organization as owns the dwelling. This can preclude any separation both in personnel and records between tenancy management and clinical or psychosocial support, and lead to conflict between tenancy issues (e.g. rent) and skills development issues (e.g. budgeting). In other situations the housing is auspiced by one organization and the psychosocial and clinical services are in-reached from another organization. For example, the Home Based Outreach (HBOS) service provides extensive support in very small allocations to many people living in individual housing.

Crucial to these situations is the coordination of care in the three realms of clinical, psychosocial and tenancy support. When coordination is strong and support is sufficient these supported accommodation arrangements have been shown to be stable, durable and resulting in very high satisfaction to the resident. A critical determinant of success is the extent of support and flexibility to vary it in keeping with the resident’s needs through time.

Given the principles outlined in (1) above regarding optimal housing and support arrangements for people with mental illness, MI Fellowship Victoria has strong views regarding all these models as they are currently delivered in Victoria. These views are described below.
4.2 Supported accommodation and the principle of housing stability

Given the central importance of housing stability for recovery, there is a risk inherent in the transitional nature of residential treatment settings. Within this limitation there are steps however that can be taken. Primary here is a need to strengthen the continuity of accommodation that people experience as they move through the treatment system.

As their stay in residential treatment extends, many people forfeit their home (e.g. a rented house or a room in an SRS). This means that for them, the treatment facility becomes a de facto ‘home’. This fundamental misunderstanding about their tenure in the treatment facility leads to disappointment and insecurity when the time comes to move; a disappointment that is then compounded by the difficulties frequently experienced in securing accommodation to exit to. Contrary to the goal of rehabilitation, transition through residential treatment facilities can lead to significant stress for the person with a mental illness.

MI Fellowship recognizes as an important priority the development of ‘pathways’ that create greater continuity and planned security for people with mental illness moving through the treatment system. Through our Opening Doors program we endeavour with our partners to achieve pathways from clinical care through residential rehabilitation into supported independent living, thus providing for our participants a sense of continuity and housing stability. Important elements of this model are collaboratively devised ‘care plans’ and clearly articulated pathways that provide the resident with a sense of security, continuity and ongoing achievement of recovery goals. In addition, the range of supports offered in the residential rehabilitation facility means that support can be tailored to individual needs.

We are however seriously hampered by the limited housing options available to people exiting treatment and rehabilitation. It is absolutely vital that the stock of social housing be increased in order that a supply of accessible ‘exit points’ be maintained to accommodate people moving out of the clinical treatment system. As well as construction of new housing that is integrated into local community landscapes, we need creative approaches to acquisition such as the spot purchase of dwellings. We also advocate for innovative approaches to securing private rental accommodation, for example where the lease is taken out by a housing provider and sub-let at an affordable rental to the person with a mental illness. This kind of arrangement may require subsidy to make up the gap between market rent and pension plus rent assistance.
As an additional aide to achievement of continuity of care throughout treatment, we endorse the concept of ‘brokers’ for coordination of care and housing, being located at key transition points. For example, the Mental Health Pathways program aims to reduce the risk of homelessness for people with a mental illness leaving clinical mental health services, by providing early identification and pre- and post-discharge case management and ongoing support. We favour an increase in positions with this same coordination and facilitation role, being located at other transition points in the treatment continuum to ensure that people with mental illness moving through the system are assisted into appropriate forms of supported housing.

4.3 Support services and coordination of care for people living independently

The availability of independent housing in a community of their choice, is a vital factor in promoting recovery of people with mental illness. The provision of appropriate coordinated care into independently leased or owned housing, should be regarded as a major plank of any supported housing strategy. Given the evidence that ongoing, coordinated three-way support (tenancy, clinical and psychosocial) is vital to sustainable independent housing, we submit that additional resources need to be allocated to achieving this support.

The current funding levels of HBOS permit about 3 hours per week to be spent with residents in their own homes, dealing with budgeting, relationships, housekeeping, and clinical care coordination issues as well as pursuing activities to achieve closer integration of the resident into his/her community. This works for many, but we need additional hours. There has not been sufficient growth in the HBOS program in recent years to support the demands now felt in the community for this form of individualized, in-reached service. We would contend on the basis of evaluations of e.g. the HASI model (Muir, 2008), that home-based psychosocial rehabilitation support is the vital ingredient that can make the difference between long term, quality, independent living, and unstable, poor quality, cyclical stays in inpatient care and various forms of transitional accommodation. The allocations of individual HBOS support per household should be increased to take more account of variable needs. We look forward to the Government’s delivery of a policy of graduated packages of HBOS for households in varying levels of need, as foreshadowed in the mental health reform strategy document ‘Because Mental Health Matters’.

In relation to the auspicing of coordinated support, MI Fellowship is of the view that a separation between housing or tenancy support, and psychosocial support, is preferable for the consumer. We regard arrangements where the housing provider is also the psychosocial support provider, as holding a ‘conflict of interest’ that is not conducive to best practice in either domain. We have
observed situations where clarity and decisiveness in relation to the resident's needs in one of these two fields, has been compromised by the provider's responsibility for the other; accordingly we strongly advocate for the fostering of a sector in which providers specialize in either one or the other activity.

Our preferred mechanism for the delivery of in-home support is the Home Based Outreach service (HBOS). We have provided this service for many years and are convinced that its scope to offer individualized, cost-effective support to people with mental illness living independently or in congregate care, is second to none. We would very much like to see a public policy in relation to supported accommodation, whereby the HBOS is primary vehicle for extending and increasing the support options for people with mental illness.

4.3 Supported accommodation and the principle of 'home-like environment'
MI Fellowship regards the creation of a 'home-like' environment as vitally important in any facility for people with mental illness, not just from the perspective of the resident's comfort but also because this environment is most conducive to rehabilitation outcomes. Highly structured rules and procedures and clinical environments, deny individuality and infringe liberty in ways that are utterly inconsistent with the goal of recovery. We advocate for all settings that offer accommodation (whether providing treatment or just housing), to be designed according to the priority of creating a pleasant, homelike environment and a flexible, non-intrusive and empowering culture of care.

Despite the intention to create a 'homelike environment', many accommodation facilities do not achieve this. People with mental illness are particularly vulnerable and we would contend that it is fundamentally difficult for people who feel disempowered, uncomfortable, threatened, or insecure, to maintain and increase their independence and skills for daily living. It is a paradox that at the same time as people are being engaged in treatment which has as its goal the strengthening of their capacity to live independently, their living circumstances put them at heightened risk of skill loss.

Government initiatives in the SAVVI program to strengthen the links between pension-level SRS and non-government organizations are one way of encouraging culture shift and support to enable SRS' to improve the quality of life they offer to residents. Likewise, treatment facilities that have a residential component (e.g. SECU's and CCU's) can be assisted to reduce their clinical culture through involvement of community-based PDRS providers with non-clinical psychosocial rehabilitation staff.
4.4 Supported accommodation and the principles of individual privacy, choice and autonomy

We are concerned that the preponderance of congregate care in supported housing for people with mental illness, reflects provider requirements of economy and convenience, more than the interests of the consumer. Recovery outcomes are best fostered through supported accommodation approaches that maximize personal choice for the person with mental illness.

In our considerable experience as a provider of residential rehabilitation, we have explored congregate care in some depth. Our conclusion is that the only group that consistently derives therapeutic benefit from congregate care is young people aged 16-25. For all other groups, optimal living arrangements equate with private and separate living – bedroom, lounge, kitchen and bathroom facilities for each household.

We advocate for separation of facilities for residents in treatment and accommodation. We are aware of some of our participants who live e.g. in pension-level SRS’, having no physically separate and private space in their homes: shared bedrooms, shared bathroom and lounge facilities, and very little security for personal items. The lack of access to privacy imposes a very heavy psychological cost on people who are already psychologically vulnerable.

4.5 Quality, comfort and amenity of supported housing

We submit that the overall quality of housing and support available to some people in the supported accommodation system, is unacceptably low.

Case Study 2 above illustrates the poor living conditions still endured by some people with mental illness in pension-level SRS. Whilst in part the difficulty here reflects lack of coordination of care on the part of support providers, the more substantive problem is the poor quality of the facility itself and the lack of a culture of care and accountability. Contrast this with the favourable, secure and accountable arrangements that are in place for residents of the facility profiled in Case Study 1.

We applaud the measures recently adopted by the Victorian Government to augment the viability and accountability of private SRS’. Both the Supported Accommodation for Vulnerable Victorians Initiative (SAVVI) and the changes to the Health Services Act 1988 (e.g. imposing rules on proprietors’ handling of residents’ money, developing residential statements and care plans for every resident) - show an appropriate recognition of the need to work with the current framework of SRS services. For all its faults, the loss of this sector of housing for vulnerable people with
psychiatric disability would have worst effect on those who have few if any other housing options. However we question the extent of the impacts that have been achieved by these changes when situations such as that outlined in Case Study 2 remain. It seems strange that the Department of Human Services has authority to license and regulate these facilities under the Health Services Act 1988, yet substandard and compromised care persist. Increasing not just the resourcing but also the enforcement of regulations, would seem important measures and ones to be taken immediately.

5. Conclusion

This submission has taken a broad view of what constitutes ‘supported accommodation’ for people with mental illness, reflecting the real diversity of this sector.

Taking as its standpoint a set of criteria for ‘best practice’ supported housing for people with mental illness, the submission observes that the current framework of service models includes many compromising features. Nevertheless there are steps that can be taken to strengthen this existing framework towards what would be regarded as ‘best practice’ features. These steps include:

- Measures to achieve continuity of care and security of tenure despite the transience that is built into residential treatment models. Crucial to this is investment to increase the supply of social housing;

- Recognition of the strong potential of the HBOS to deliver care coordination and psychosocial rehabilitation support to people with mental illness living independently in the community, thereby increasing the access of vulnerable Victorians to the benefits of ‘supported accommodation’.

- Measures to foster a non-clinical, pleasant and home-like ambience and to reduce the ‘clinical’ culture of some residential treatment settings;

- Efforts to ensure that even within the limitations of a congregate care environment, residents’ individual privacy and autonomy can be enhanced through provision of private quarters;

- Stronger enforcement of the regulations governing SRS’, to protect and enhance the living conditions of vulnerable people who reside in these.
Ultimately, our preferred model for the accommodation of people with mental illness is independent housing in the community. We prefer the model of people with mental illness recovering in a home that they have chosen, that provides stability, security, affordability and into which are provided flexible and coordinated support services. Whilst the severity and entrenched nature of some people's mental illness will require ongoing recourse to congregate and secure settings for a small segment of the population, we would contend that many more people than currently enjoy independence, should be supported to live outside of congregate treatment programs.

Rather than the person with the mental illness cycling through treatment and rehabilitation settings of varying intensity, we favour the concept of 'recovery in place'. In this model, the person with mental illness stays put and coordinated services as required are provided into the home. The best framework for this model would be one in which providers of the three pillars of care – clinical, tenancy and psychosocial rehabilitation – are all separate auspices with one responsible for overall coordination. This model would obviate some of the capital and recurrent costs associated with operation of residential treatment settings, although equally it would require the construction of much more social housing than is currently available, and greater investment in home-based outreach services. Most importantly, it would offer the person with mental illness the right conditions for recovery, rather than as often occurs currently, an environment fundamentally aversive to recovery.
References


Mental Illness Fellowship of Australia Inc (MIFA)(2007b), Housing and people with a mental illness in Australia, March 2007.


