



Promoting Affordable Housing for all Western Australians



Shelter WA

Submission

To

**The Western Australian Mental Health Commission
(MHC)**

WA - Mental Health Towards 2020: Consultation Paper

September 2010

Shelter WA thanks the Mental Health Commission (MHC) for the opportunity to provide feedback on the *WA - Mental Health Towards 2020: Consultation Paper*. Shelter WA will focus this submission on housing needs for people with mental health issues.

About Shelter WA

Shelter WA is an independent community based Peak organisation that is committed to the principle of safe secure appropriate and affordable housing for all people. Shelter WA has been active in Western Australia since 1979 and advocates on behalf of community groups and housing consumers. Shelter WA focuses on people who have low incomes or who are otherwise disadvantaged in the housing market. This includes people who are homeless or at risk of homelessness.

Shelter's role is to give an informed and effective voice on housing policy issues based on sound research, collaboration, consultation, and representation of vulnerable housing consumers and community based organisations working with housing and related issues. We do this by: holding regular forums, surveys and consultations in response to housing need, policy and practice issues; actively participating in government and community sector committees; and, by informing and educating through the electronic circulation of regular newsletters, reports and fact sheets which are also made available on our website. We promote housing options for people on low incomes, including social housing (public housing and community housing), affordable housing provided through the private sector, and affordable home ownership.

Shelter WA is committed to the presence and extension of choice in the articulation of Government housing policy and therefore to the availability of a range of housing options for low income and special needs housing consumers.

Housing as a Foundation for Mental Wellbeing

Appropriate secure and affordable housing is a foundation for individual wellbeing and the cornerstone of a civilised society. With the de-institutionalisation of mental health services over past decades, people who have been accommodated in psychiatric and special purpose facilities are now being managed in the community. The increased focus on community based support or care options within the mental health system has meant that people with mental illness who are unable to access housing appropriate to their needs are vulnerable in the community and are likely to experience high levels of homelessness. According to the Mental Health Council of Australia:

People with mental illness face a number of barriers in their attempts to achieve and maintain stable housing. These include housing unaffordability, insecure tenure, poor housing conditions, financial difficulties, administrative issues, behavioural and social issues, stigma and discrimination, and a lack of support and treatment. Certain groups will experience additional difficulties due to their increased social isolation. Mental illness can also result from, or be exacerbated by, the experience of homelessness or unstable housing.¹

The public perception of mental illness and the related stigma and discrimination that it ensues must be addressed. Shelter supports the Vision, Actions & Initiatives as outlined in

¹ Mental Health Council of Australia, *Home Truths – Mental Health, Housing and Homelessness in Australia*, 2009, p.7

the MHC consultation paper, however further commitment is essential to reducing the stigma and discrimination that impacts on people with mental health issues and is a barrier to accessing housing in the community. The MHC must be proactive in its planning and assertive in influencing the general public and local government authorities - who often thwart the establishing of mental health facilities in communities.

Key Housing Issues for People with Mental Illness

Shelter WA has identified several key areas of housing for people with mental health issues that must be addressed:

Homelessness

The relationship between mental health and homelessness is well documented. The overrepresentation of people in crisis and emergency accommodation facilities who report a psychiatric diagnosis has remained high. Although less than 5% of WA homeless service clients reported that mental health issues/psychiatric illness was the main reason for seeking assistance in 2008-09², agencies reported they provided up to 53% of their clients with emotional support and up to 11.3% with psychological or psychiatric services. These homeless services also report that they believe a high number of their residents at any one time have undiagnosed and untreated mental health issues. Homeless service providers have consistently reported that the level of unmet demand for community based independent and supported housing and residential respite mental health services is a major factor in the housing instability and risk of homelessness for people with Mental Health problems.

Shelter WA welcomes new funding for homelessness services through the National Partnership Agreement on Homelessness. Under the Agreement, services for people who are homeless or at risk of homelessness will receive much needed funds that will help those agencies provide support to people in need. People with mental illness experiencing homelessness often require a range of services to adequately address their health issues alongside the need for safe, affordable housing. Shelter WA will continue to monitor the implementation of the National Partnership Agreement on Homelessness, including its impact on people with mental illness.

Lack of supply - community based supported accommodation facilities

There is a significant lack of community based supported accommodation facilities for people affected by mental illness. Shelter acknowledges that community supported residential units are a very good model but there are not enough, neither in the WA metropolitan area nor in any regional and remote locations. Planning for the delivery of accommodation needs to be informed by the prevalence of mental illness in the community and the specific data around homelessness and low socio-economic indicators. The MHC population based planning and coordination of services must include adequate independent affordable social and supported housing and residential respite response.

Lack of funding for community based, in-home support services and outreach

There is a lack of community mental health care and an absence of visiting outreach services to ensure people struggling with a mental health problem can access low-level preventative support, and the kind of gentle, non-intrusive monitoring from trusted support

² AIHW April 2010. Government Funded Specialist Homeless Services: SAAP National Data Collection Annual Report 2008-09 Western Australia Supplementary Tables

staff that can identify changes in wellbeing and trigger increased assistance if mental illness escalates to become acute or episodic. Funding to support services for mental health consumers living in the community must be increased to enable the service to respond to the numbers of clients in need, on waiting lists or requesting assessment to be assisted in a timely manner.

Boarders and Lodgers

Well run quality lodging and boarding houses can provide accessible, affordable and flexible accommodation for short-medium periods for individuals who may be unable to access the limited supported psychiatric hostel and group home accommodation or mainstream private, self-contained housing. Yet, the conditions of many lodging houses are substandard and boarders and lodgers are not adequately protected against unscrupulous landlords. The current housing crisis in WA and the lack of affordable and supported accommodation, has found many people with mental illness either without housing or at risk of homelessness. Shelter WA is aware of several privately owned houses in the Town of Vincent that are operating as unregulated and unregistered boarding houses, but which provide no guarantee of adequate standards in ablution facilities, cooking and meal preparation areas, privacy, security of belongings or sole occupancy of a room. For many with mental health issues, accommodation as a boarder or lodger in this form of tenure is the only available option, and comes with no legal protection and inadequate support and care. The MHC must urge government to address the legislative inadequacies and increase supply of affordable housing for people with mental health issues, across the range of dwelling and tenure types.

Respite

Carers of people living with mental illness are at risk of exhaustion, neglect of their own health and wellbeing and social isolation to the same extent as the people they support. Many get no relief and do not enjoy social support, recreational activities, holidays or other benefits of autonomy due to their carer responsibilities. Attractive and supportive, non-intrusive respite options need to be explored for consumers living with or being supported by a carer, particularly older parent carers. This is also a preventative and precautionary strategy that will help carers and families become aware of and become used to receiving the level and types of appropriate supports they may need to care for the person with mental illness.

Greater linkages between housing and health and across service delivery

Greater linkages between services both government and non-government are essential to the provision of effective care for people with mental health issues. A Public Health Agency should not be able to refuse service on the basis of co-existing morbidity, but should be able to elicit a suitable response from an appropriate sister service to work in partnership to address any range or combination of imbalance(s).

Working collaboratively and respectfully with members of a persons' social system also needs to improve, it is often the family, friends or partners who identify changes in wellbeing and frantically try to generate a response from services – too often to no avail and the individual then deteriorates to eventually be forced into an involuntary admission or worse – becomes dangerous to themselves or others in the community. This is counterproductive for all and particularly in the use of government resources in acute hospital admissions that could be prevented, and long recovery and rehabilitation that would be unnecessary if early intervention was provided.

Conclusion

Shelter WA and the WA Association for Mental Health produced a report in 2001, *Housing Needs of People Affected by Mental Health Problem – Perth*; this report addresses the housing needs for people with a mental health problems in WA and offers solutions to these issues and a suggestion as to best practice models. A copy of this report is included in this submission, see Appendix A.

The report identified that for people with mental health problems to achieve and maintain housing tenure they:

- must feel **secure and safe** in their physical and social environment;
- require **accessibility and proximity** to social, cultural and family networks, carers, shops, support services, medical and alternative treatments and programmes, recreation options, transport, amenities and community services that assist people with mental health problems to maintain tenure;
- must be properly **heard and responded to** if housing is to be maintained;
- require **secure tenure that is sufficiently flexible** to allow people to move between housing and support options and/or location without loss of continuity of care or tenancy; and
- reasonable **choice without disadvantage** has special significance for people who already experience alienation, discrimination and isolation and for whom their home is also their place of rehabilitation and healing.³

The Mental Health Commission must include housing and housing supply as an essential factor in determining its future policy and funding strategic framework. Adequate housing is the foundation of social inclusion, capacity building, employment, education and opportunity, and without it individuals have no personal capacity to address any other factors in their lives. Get housing right and the rest follows. Ignore housing needs and nothing further can progress.

³ Shelter WA and WA Association of Mental Health, *Final Report: Housing Needs of People Affected by Mental Health Problems – Perth*, 2001 p.7



Western Australian Association
for Mental Health
WAAMH

Final Report

Housing Needs of People Affected by Mental Health Problems - Perth

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1: Introduction

with the increased focus on community based support or care options within the mental health system, people with mental illness who are unable to access housing appropriate to their needs are vulnerable in the community and are likely to experience high levels of homelessness

Shelter WA State Election Housing Forum

It is the vision of Shelter WA to see every person accommodated within affordable, appropriate, secure and safe housing that is free from discrimination.

Shelter WA is a community organisation that represents the views of low income housing consumers and community groups on housing issues.

Shelter WA regularly holds community forums on issues related to housing as part of its funding arrangement with the Department of Housing and Works and to facilitate cross-sector discussion, inform and provide direct representation on major housing issues to Shelter WA's policy work. After identifying the housing needs of people with mental health problems as an area of concern, Shelter WA approached the Western Australian Mental Health Association (WAAMH) to cosponsor one such forum.

Shelter WA and WAAMH see the housing requirements of people with mental health problems as a priority issue. WAAMH has estimated a minimum of 3 500 people living with mental illness are homeless or at risk of homelessness in Western Australia.

A discussion paper was prepared by Christina Kadmos as the first stage in the community forum consultation process for the metropolitan region. The Discussion Paper provided a review of research and reports from both the housing and mental health sectors and interviews with WAAMH, people from the Mental Health Consumer Representation Project and workers in the field. Its purpose was to capture key elements of the issue and inform the discussion and agenda of the Mental Health Housing Forum, conducted on Tuesday May 1st, 2001.

31 participants attended the Forum and included representation from: consumers; advocates; support providers; housing providers; government and policy peaks. A full list of attendants is included in Appendix 1.

The Forum agenda incorporated presentations by speakers; small group sessions and feedback to all participants.

The Forum speakers included:

- ▶ Sheryl Carmody: Support Issues Across Tenures
- ▶ Jacquie Carter: Issues from a consumer perspective
- ▶ Janey Glauser: Issues from a non-government housing provider perspective
- ▶ Lance Risbey: Issues from a clinical support perspective

2: Key Findings

2.1: Reform Process

The direction of service provision to people with mental health problems has been toward deinstitutionalisation, with an emphasis on independence and interdependence. Interventions should be the least restrictive possible and promote the maintenance and development of independence. Support services are ideally delivered in the place of residence.

2.2: The Reform Process & Housing

Housing is consistently identified as a priority area where few gains have occurred, shortages are increasing and the situation is critical.

Availability of affordable and secure housing is central to the success of deinstitutionalisation. Evidence of strain within SAAP and services for the homeless, decline in affordable and accessible private housing options, stretched public and community housing and support resources and continued pressure on inpatient beds indicate that housing is an area requiring immediate attention.

Addressing the housing needs of people with mental illness must also include an understanding of the essential role support services play. A coordinated approach requires the incorporation of income support, Disability Services, Community Development, Police and Justice, Immigration, Education, employment and recreation and must occur within a government, non-government, consumer, carer and community partnership.

Interviews and workshops with stakeholders undertaken as part of this report largely supported the direction of reform but all agreed that the rhetoric of whole-of-government approaches, deinstitutionalisation and social health frameworks still has a long way to go before people living with a mental illness will have sufficient access to suitable, affordable housing options sufficiently flexible to respond to their diverse needs.

2.3: Extent of Mental Illness

The 1997 National Survey of Mental Health and Wellbeing of Adults found that 18% of those surveyed experienced some form of mental health disorder in the twelve months prior to the survey. This is consistent with other estimates that 1 in 5 Australians will experience a significant disruption to mental health and wellbeing sometime in their lives with 3-5% of the population experiencing a serious, ongoing illness requiring treatment.

2.4: Some Key Target Groups

Young People

Research conducted by the National Youth Coalition for Housing reinforces the notion that factors that place young people at risk of homelessness also place them at risk of mental illness. For young people, diagnosis of mental illness is often delayed and precipitated by crisis.

Aboriginal and Torres Strait Islander People

Aboriginal and Torres Strait Islander People are over-represented in mental health inpatient units. Whilst 2 % of the population, Aboriginal and Torres Strait Islander people can comprise over 15% of inpatient admissions and are five times more likely to be involuntarily hospitalised.

Direct and indirect discrimination and inadequate understanding the needs of Aboriginal people add to existing barriers to housing security.

Homeless People

It must be acknowledged that not all homeless people have a mental illness and the majority of people with a mental illness are not homeless. However, homeless people are more likely to experience mental health problems than the general population, estimates range from 25% to 75% of homeless people being affected.

People with mental illness are at greater risk of homelessness due to requirements of personal care, social isolation, family breakdown, stigma, discrimination and a breakdown in housing tenure due to hospital admissions.

Women

The HREOC Inquiry (1993) proposed that sociodemographic factors such as poverty, single parenthood, social role of carer and discrimination may place women at a greater risk of mental health problems.

Women with mental health problems as carers of children must be acknowledged in the provision of housing and support services.

Carers and Family

It is important to remember that family and/or carers are supporting many people living with mental illness and that carers require assistance, training and respite.

The place of carer and family must be incorporated more into the planning and design of supported housing options. This may take the form of extra bedrooms in public and community housing or 'rooming in' beds for family in residential support centres.

2.5: Housing Needs

For someone with a mental illness or disorder, appropriate and secure housing is critical for a return to health. However, for many, tenure of housing is jeopardised through a lack of options, flexibility and support.

Research conducted by the Mental Health Reform 2000 Accommodation Reference Group in Perth last year found an estimated 46% of inpatients in public mental health acute units could have been discharged if there had been suitable community alternatives. The same research also found 49% of residents in SAAP services on the day of survey were diagnosed with a mental illness.

In order to achieve and maintain housing tenure, people with mental health problems:

- ▶ must feel **secure and safe** in their physical and social environment;
- ▶ require **accessibility and proximity** to social, cultural and family networks, carers, shops, support services, medical and alternative treatments and programmes, recreation options, transport, amenities and community services that assist people with mental health problems to maintain tenure;
- ▶ must be properly **heard and responded to** if housing is to be maintained;
- ▶ require **secure tenure that is sufficiently flexible** to allow people to move between housing and support options and/or location without loss of continuity of care or tenancy; and
- ▶ reasonable **choice without disadvantage** has special significance for people who already experience alienation, discrimination and isolation and for whom their home is also their place of rehabilitation and healing.

2.6: Existing Options and Issues

Boarders and Lodgers

People in private boarding and lodging arrangements have little legal protection and access to services in the home is problematic. People with mental illness living in these arrangements can be vulnerable and open to exploitation.

Cluster Homes

Cluster housing in small to medium complexes is seen as a viable option for providing independent living whilst reducing social isolation and maintaining stability and well being.

Few cluster homes are presently operating, but feedback from consumers is positive. There appears to be widespread support for an increase in the establishment of cluster housing models.

Crisis Accommodation

A forum held by the WA SAAP Protocols Project on the issue of mental health consumers highlighted the need for improved linkages between SAAP and mental health services. Improved information exchange, increased training and increased access to after hours support has been recommended. The inflexibility of mental health service boundaries was also found to be problematic.

SAAP and crisis services can experience conflict between balancing the needs of all groups using a service. With a focus on domestic violence, youth or the homeless, workers can be under-trained and under-resourced in the area of mental health.

ILP

The Independent Living Program, whereby the Department of Housing and Works housing is headleased to community organisations and arrangements are put in place for support provision, is an initiative that has broad approval.

Long waiting lists have been raised as a barrier to accessing the ILP and the success of the programme, results in low turnover, increasing pressure on waiting lists.

Psychiatric hostels

Criticism of this model raised by consumer, advocacy and carer groups includes inadequate support and quasi -institutionalised care that does little to encourage independent living.

Some hostels require residents to vacate the building during set times - further removing any sense of normalisation. In addition, access to many hostels by support workers can be difficult. People residing in unlicensed hostels and lodging houses are even more unprotected.

Private Rental

People with mental health problems are vulnerable to discrimination and housing based poverty in accessing the private rental market. Research indicates that more than 70% of low income renters are in housing cost burden (pay in excess of 30% of income on rent) (cited in Shelter WA, 2000). Increasing rents have resulted in a shortage of affordable private rental in many Perth suburbs.

Discussions with the Mental Health Consumers Representative Project highlighted the need for greater assistance with the ongoing costs associated with private rental and recommends a higher rental subsidy for people on a disability pension.

Also recommended is private landlord support and education to increase links between private landlords and mental health services and reduce discrimination.

People living successfully in private rental still require varying levels of support and assistance to maintain tenancy, especially during times of high need or hospitalisation.

Public Housing

The Department of Housing and Works plays a significant role in the provision of housing to people with mental health problems through general housing, disability housing and the Community Disability Housing Program. Of the 35 000 general DHW tenancies, 17% are in receipt of a Disability Support Pension or Carers pension and 26% are in receipt of an Aged or Veterans Pension (no separate statistics on people with health problems are available from DHW). In addition, 687 units are dedicated to people with disabilities through the Community Disability Housing Programme.

Waiting lists are a significant problem for people accessing public housing. As at 31st October 2000, 876 people with disabilities were waitlisted. Some people have been on waiting lists for public rental for years only to miss 'their turn' through hospitalisation.

Whilst expansion has occurred in some programme areas, overall DHW presence as a proportion of total housing stock has been in decline from 6% in 1991 to 4.7% in 2000.

Many consumers identify problems negotiating their housing requirements in relation to location, safety and modifications - with DHW staff don't always have sufficient understanding of the needs of consumers.

Difficulties arising from lack of community acceptance, neighbour complaints and evictions linked to anti-social behaviour were also raised.

Respite

Respite services are required for both people living at home with family and those living independently. Respite services, both in home and facility based, are particularly important for CALD communities and young people whom are more likely to be cared for in the home. More than 50% of young people with mental illness live with family.

2.7: Issues for Resolution

Across all reports reviewed and individuals interviewed several areas of pressing need in housing people with mental health problems have been consistently identified. These are:

- ▶ Need for increased flexible, affordable and secure housing opportunities.
- ▶ Improved availability, coordination and linkages in regard to support services that assist people to maintain housing.
- ▶ Improved responsiveness to consumer and carer requirements.
- ▶ The need for a whole of government, cross-sectorial, government/non-government approach.

2.8: Outcomes From the Forum

Small groups were formed to discuss and each of the four key issues identified in the discussion paper and to develop recommendations for addressing these. The four key issues were:

- ▶ the Need for increased flexible, affordable and secure housing opportunities;
- ▶ improved availability, coordination and linkages in regard to support services that assist people to maintain housing;
- ▶ improved responsiveness to consumer and carer requirements; and
- ▶ the need for a whole of government, cross-sectorial, government/non-government approach to responding to the needs of people with mental health problems.

An action plan has been established which incorporates the outcomes from the forum. .The action plan includes:

Guiding Principles: Strategies aimed toward addressing the housing needs of people affected by mental problems should:

- ▶ increase the provision of flexible, affordable and secure housing;
- ▶ Improve the availability, coordination and linkages of support services and these should assist people to maintain independent housing;
- ▶ improve responsiveness to consumer and carer requirements; and
- ▶ promote a whole of government, cross-sectorial, government/non-government approach to service provision.

Objective 1: The provision of affordable housing will be increased.

- ▶ Increased funding under the CSHA for the construction of rental housing will be promoted and will include an increased cash commitment from the WA Government.
- ▶ Increased provision of community housing will be promoted, in particular under the CDHP/ILP.

Objective 2: The design and construction of public and community housing will recognise the need of consumers for secure and appropriately located housing.

- ▶ Recognition of consumer's need for physical security and well located housing will be promoted.
- ▶ Clustered housing will be promoted as way of reducing the impact of social isolation.

Objective 3: Flexibility in the provision of support services will be increased.

- ▶ Increased resources to best practice models will be promoted, these include: ILP and ACHA.
- ▶ Broadening of the provision of HACC services to include people with mental health problems will be promoted.

Objective 4: Cross government coordination will be increased.

- ▶ The need for wraparound support with the ability to provide continuity of service provision across locations and tenures will be promoted.
- ▶ The need for gross govt. funding of multi-targeted crisis accommodation services in non-metro areas will be promoted.

Objective 5: The provision of training to generalist workers will be increased.

- ▶ Training on how to work with people with mental health problems will be promoted for generalist workers in: DHW, community housing agencies, SAAP, HACC and other generalist agencies.

3: The Reform Process

Mental Health has been an area of national and state reform since the early 1990's. The National Mental Health Strategy (1992), National Inquiry into the Human Rights of People with Mental Illness (1993), and National Standards for Mental Health Services (1996) was followed by the WA Ministerial Taskforce on Mental Health (1996) and State Mental Health Plan.

The key conceptual shifts have been towards deinstitutionalisation, an emphasis on independence and interdependence; community based care, prevention, social-cultural-medical frameworks, consumer and carer focus. The endorsed aims of the National Mental Health Strategy are to promote health, prevent development of ill health, reduce impact of mental illness and assure consumer rights.

Within this framework, interventions should be the least restrictive, the maintenance and development of independence is to be fostered and support services are ideally delivered in the place of residence, where possible.

The 2nd National Mental Health Plan (1998-2003) re-affirmed strategic direction and focused upon a whole-of-government approach and the expansion of reform to include broader social health issues.

Western Australia has commenced a review of this reform. Mental Health Reform 2000 Plus (MHR2000+) began with a wide ranging consultation conducted by eighteen sub-groups comprising of consumers, carers, mental health service staff, non-government organisations and members of the public.

A discussion paper on the findings has recently been distributed for comment.

One sub-group of the project was the MHS Accommodation Reference Group whose report *Finding a Home - Keeping a Home* is available from the Metropolitan Mental Health Service. The report presents a recent and detailed picture of the Perth context in regards to supportive accommodation and alternatives to hospitalisation and has been sourced throughout the discussion paper.

3.1: Reform and Housing

Whilst many improvements have occurred in the provision of services since reform commenced it is agreed there is room for improvement. Accommodation is consistently seen to be a priority area where few gains have occurred, shortages are increasing and the situation is critical (WAAMH, MHR2000+, NYCH, Walls,)

Central to concepts of reduced institutional care, community based care and interdependence is the availability of affordable and secure housing. As found by the National Inquiry (1993:337):

the policy of deinstitutionalisation cannot succeed unless it is complemented by the appropriate policies on housing - and a commensurate allocation of resources.

Evidence of strain within SAAP and services for the homeless , decreased cheap and accessible private housing options, stretched public and community housing and support resources and continued pressure on inpatient beds indicate that housing is an area requiring immediate attention.

An essential ingredient to successfully responding to housing needs is to address the professional, political and administrative demarcation between health and housing. The housing needs of people with mental ill health is both a health and housing issue, with each framework offering necessary perspective, knowledge and expertise.

Housing requirements exist along a continuum for people with mental health problems. From hospitalisation to intensive residential support to various forms of independent living, people need to be able to move along this continuum without jeopardising security. To arbitrarily draw a line along this experience and call one half a health concern and one half a housing issue may be administratively and professionally easier, but rarely results in the best interests of the client being served. The housing and health needs of people with mental illness cannot be so easily separated.

A discussion on the housing needs of people with mental illness must also include an understanding of the essential role support services play such as personal care, recreation, employment, social and advocacy services. Within a totality of person framework, a coordinated approach requires the incorporation of income support, disability services, family and children services, police and justice, immigration, education, employment and recreation and must occur within a government, non-government, consumer, carer and community partnership.

Participants and people interviewed before the Forum largely supported the direction of reform and could see the beginning of change. However, all agreed that the rhetoric of whole-of-government approaches, deinstitutionalisation and social health frameworks still has a long way to go before people living with a mental illness will have sufficient access to suitable, affordable housing options that are broad and flexible enough to respond to diverse and changing needs.

4: The People

4.1: Overview

The 1997 National Survey of Mental Health and Wellbeing of Adults (SMHWB) found that 18% of those surveyed experienced some form of mental health disorder in the twelve months prior to the survey. This is consistent with other estimates that 1 in 5 Australians will experience a significant disruption to mental health and wellbeing sometime in their lives with 3-5% of the population experiencing a serious, ongoing illness requiring treatment (HREOC 1993, WAAMH 2001). For some, the experience of mental illness will be transitory and limited, for others it will be a significant health factor throughout their lives.

Mental illness in our society still holds stigma and many people with mental health problems experience discrimination and social isolation as a result. The HREOC inquiry found people with mental illness to be among the most vulnerable and disadvantaged groups in Australian society.

Mental health is a complex issue affected by a range of health and social factors. The relationships between age, gender, culture, life experiences, social and economic factors and the incidence of mental illness are still subject to debate and research. What is clear is the effect that such factors have on the experience of health and illness, recovery and access to treatment, services and support.

The SMHWB survey identified a number of variables in prevalence rates. Care must be given to interpretation here. Whilst these findings *describe* the survey group, they are not presented as *causal* factors:

- ▶ **Gender:** overall, men and women had similar prevalence rates. However, from 35 years of age, women were more likely to have a mental disorder than men. Women had higher rates of anxiety and affective disorder (12% compared to 7.1% and 7.4% compared to 4.2% respectively). Men were more likely to have substance use disorders.
- ▶ **Age:** the prevalence of mental illness declined generally with age. Young people aged 18-24 years had the highest rate at 27%. This declined to 6.1% in those aged 65 years and over. Young men had a high level of substance use disorders at approximately 1 in 5 for 18-24 years.
- ▶ **Living Arrangements:** prevalence rates were highest in people living alone and decreased as the number of people living in a household increased. Rates were highest among those separated or divorced (24% of men and 27% of women) and those who had never married had higher rates than those who were married (18% compared to 12%).
- ▶ **Unemployed** people and those working part-time were more likely to have a mental illness than those in fulltime employment.

- ▶ **Physical health:** the prevalence of physical health conditions such as respiratory, heart, blood pressure problems and disease were higher in reporting for women than men and increased overall with age (21% aged 25-34 compared to 77% aged 65 and over)

4.2: Groups with Special Needs

People with a mental illness are a diverse population, with varying and particular considerations. In addition to the descriptive variables outlined by the SMHWB, a number of studies have identified groups with special needs:

Young People

Prevalence of mental health disorders is highest amongst young people (SMHWB). A research project conducted by the National Youth Coalition for Housing (NYCH 1999) reinforces the notion that factors that place young people at risk of homelessness also place them at risk of mental illness. The project surveyed youth specific SAAP services and found that more than 50% of young people using SAAP services had some form of mental illness with depression being the most frequently reported. Comorbidity (more than one disorder) linked to substance use, self harm, depression, affects of abuse, behaviour issues and identity issues were common.

For young people, diagnosis of mental illness is often delayed and precipitated by crisis (Hodges 1999:7). This is particularly the case if the young person is homeless. Lack of adequate support to young people and their families can lead to family breakdown and the young person leaving home or being hospitalised. There are few accommodation options, young people are often reluctant or unable to access services and many housing services find the needs of young people as requiring specialist attention (NYCH 1999).

An assessment of housing options for mental health consumers in the Joondalup catchment region found high demand on crisis/respite inpatient services from young people 16-24 years (Walls 2000:15)

Aboriginal and Torres Strait Islander People

Aboriginal and Torres Strait Islander People are over represented in mental health inpatient units. Whilst 2-3 % of the population, Aboriginal and Torres Strait Islander people can comprise over 15% of inpatient admissions and are five times more likely to be involuntarily hospitalised (MHR2000+ Accom Reference Group 2001:17).

Aboriginal people confront discrimination in accessing and maintaining housing, experiencing high rates of homelessness, evictions and threatened evictions in both private and public accommodation. Aboriginal people are often excluded from private rental or pay high rents for sub-standard properties.

The National Inquiry into the Human Rights of People with Mental Illness (HREOC 1993: 695), described the distinction and interrelationship between the experience of severe mental distress experienced by Indigenous Australians (and clearly linked to the social context of post-colonialisation) and those with diagnosed psychiatric disorders.

The Mental Health Reform 2000 Plus Discussion Paper puts forward that:

Mental health practitioners should be aware of the cross-cultural differences, institutional racism and Indigenous mental health and acknowledge the historical context and ongoing transgenerational trauma for Aboriginal people. (2000:19)

Direct and indirect discrimination and inadequate understanding of Aboriginal needs add to existing housing security barriers.

Culturally and Linguistically Diverse People

The migration experience can increase social isolation in relation to mental health, especially amongst the elderly and women (HREOC 1993). Access to mainstream services can be difficult and reliance on family systems high.

Refugees face a high risk of mental health problems, especially those that have experienced torture and trauma. For people entering without a valid visa - detention, lengthy processing and multiple barriers to family reunion increase the strain on mental health.

Homeless People

It must be acknowledged that not all homeless people have a mental illness and the majority of people with a mental illness are not homeless. However, homeless people are more likely to experience mental health problems than the general population. WAAMH estimates that between 25-80% of homeless people have a mental illness. A study in Sydney found that 75% of the homeless had at least one mental disorder, comorbidity was common and 50% had at least 1 chronic physical health condition (Hodder et al).

There is increased acknowledgment of the link between homelessness and mental illness. People with mental illness are at greater risk of homelessness due to requirements of personal care, social isolation, family breakdown, stigma, discrimination and a breakdown in housing tenure due to hospital admissions. Decreasing cheap private housing stock increases this risk.

For those without a home, income support can be jeopardised and prolonged stays in hospital settings, crisis accommodation, hostels, 'couch surfing' and sleeping on the streets are the few options available. For homeless people with mental illness facing criminal charges in relation to violence, the lack of address impacts on sentencing options and can increase likelihood of remand in custody or custodial sentences.

Women

The HREOC Inquiry (1993) proposed that sociodemographic factors such as poverty, single parenthood, social role of carer and discrimination may place women at a greater risk of mental health problems. The inquiry focused attention on four main areas in relation to women:

- ▶ the influence of sex role stereotypes on definition, diagnosis and treatment
- ▶ post-natal depression
- ▶ the relationship between mental health and violence against women
- ▶ shelter and crisis accommodation

Women, for whom mental illness and abuse are linked, speak of the difficulties in having their needs in relation to housing requirements properly heard. Often led to feel they should be grateful for housing at all, issues around what it means to have a safe space are not often appreciated and responded to.

SAAP services, with expertise in women and abuse, are limited in their experience and ability to respond to the complex needs of women with mental illness (HREOC 1993, SAAP Protocols Project 1999).

Women as carers of people with mental health problems require acknowledgment and support in their role.

Women with mental health problems as carers of children must be acknowledged in the provision of housing and support services.

Carers and Family

It is important to remember that family and/or carers are supporting many people living with mental illness. Carers require assistance, training and respite.

It has been suggested across the literature review that the place of carer and family must begin to be incorporated more into the planning and design of supported accommodation options. This may take the form of extra bedrooms in public and community housing or 'rooming in' beds for family in residential support centres as recommended by the Indigenous submission in the MHR200+ discussion paper.

Dual diagnosis (Comorbidity)

In attempts to provide the ideal model of secure housing and required support, the needs of people with more than one major concurrent health problem require special attention.

In some cases, the existence of one disorder can predispose the effected person to another eg social phobia may lead to depression.

According to the National SMHGB study, comorbidity patterns differ from men and women. Women surveyed were more likely to have anxiety and affective disorders in combination and men were more likely to have substance use disorders (1997:11).

Young men with acquired brain injury and mental illness has been identified as a high need group (WAAMH, MHR200+) and an increase in the prevalence of homeless women with acquired brain injury (linked to drug use) requiring services has been reported by workers in Sydney (Power 1999:13).

As service delivery is often compartmentalised into 'mental health', 'physical disability', ' drug and alcohol' etc, people whose living experience transcends these boundaries have difficulty obtaining services that can wholistically respond. Often falling between constructed criteria and receiving no support, or receiving disjointed, possibly contradictory support from different service sectors that act largely in isolation.

The Elderly

As people grow older, the mental illness they experience can be complicated by the effect that age can have on health and opportunities.

MHR 2000+ identifies the provision of long term care and care awaiting placement as issues requiring attention.

Victorian research by the Department of Human Services found "single elderly pensioners and single parent households had the greatest difficulty finding affordable private rental dwelling" (Fiedler 1999:14). Older residents are spending 45%-75% of income on rent.

With an aging population, the mental health issues of the elderly will grow in significance and magnitude

5: Peoples Housing Needs

For many consumers the fluctuating nature of mental illness means that services need to be provided in a flexible way, with the capacity to respond quickly and effectively to changes in support needs

Mental Health Reform 2000 Plus

For someone with a mental illness or disorder, appropriate and secure housing is critical for a return to health. However, for many, tenure of housing is jeopardised through a lack of options, flexibility and support.

People with a mental illness have a broad range of housing needs. As a diverse population, housing choices are varied and can change with circumstance and periods of high and/or crisis need.

Many people live independently in public and community housing or private rental or ownership, some live with family or community, some in options. Support services, if used and available, are accessed either externally or within the home.

Others are homeless and residing in crisis accommodation services, hostels and transient options because housing is scarce, inflexible and difficult to access. Some are boarders and lodgers. A number are housed within formal and informal institutional structures (hospitals, prisons, hostels, youth residential services).

Snapshot research conducted by the Mental Health Reform 2000 Accommodation Reference Group in Perth last year found an estimated 46% of inpatients in public mental health acute units could have been discharged if there were suitable community alternatives. The group's research also found 48.7% of residents in SAAP services on the day of survey were diagnosed with a mental illness.

Lack of suitable and flexible housing and support has been well documented to be a causal factor in the 'revolving door' experience of crisis leading to loss of tenancy leading to institutionalisation, to homelessness, to crisis accommodation to increased housing instability to decreased health and increased vulnerability.

5.1: Requirements for Accessing and Maintaining Housing Tenure

In order to access and maintain housing tenure of choice, people with mental health problems require:

Safety

Safety is a paramount issue. People with mental illness must feel secure and safe in their physical and social environment. This is particularly the case for people with a history of abuse. Factors that may affect safety include location, proximity of neighbours, security, lighting, colour, physical layout and property condition.

Location

Where desired, consumers are accommodated in the proximity of their social and cultural supports
National Standards MHS 11.4.B.9

Accessibility and proximity to:

- ▶ Social;
- ▶ cultural and family networks;
- ▶ carers;
- ▶ shops;
- ▶ support services;
- ▶ medical and alternative treatments and programmes;
- ▶ recreation options;
- ▶ transport; and
- ▶ amenities and community services.

assist people with mental health problems to maintain tenure.

Many people with mental illness experience high levels of social isolation and increased costs of living, which can be both exacerbated or ameliorated through accessibility and location.

To Be Heard

The needs of people with mental illness must be properly identified, monitored and responded to, if housing is to be maintained. As consumers of housing services, they are the experts of their own requirements. The need for accommodation providers to hear and respond to the voice of consumers is expressed in *National Standards MHS 11.4.B.7-11.4.B.13*. (Appendix 2)

Affordable, Flexibility, and Security

People with mental illness need access to affordable housing and to be able to reasonably move between housing and support options and or location without loss of continuity of care or tenancy. Being able to move between options in times of crisis, respite or changed circumstances without risking homelessness or institutionalisation. This can include respite services for people living with family, respite time for people living alone, residential facilities, semi-supported 'step down' services.

Choice

In establishing that people with mental illness share the same diversity as the community as a whole, housing options are required across all forms of tenure. Whilst cluster and communal housing may well be the preference of some people, it may not be the choice of others. Whilst public housing should be accessible, some people will have reasons to prefer private rental.

The right to reasonable choice without disadvantage is important to empowerment for everyone but has special significance for people who already experience alienation, discrimination and isolation and for whom their home is

also their place of rehabilitation and healing. Availability of options and ability to choice and move between options form part of the *National Standards MHS (11.4.B.8)*

5.2: Support Services

The direction of policy is to secure accommodation and provide support services to people within their homes as well as offering external services.

National Standards for Mental Health Services (11.4.B.15) states that "the MHS provides treatment and support to consumers regardless of their type of accommodation".

Support can include:

- ▶ personal care
- ▶ maintenance support - cooking, cleaning, transport, gardens, living skills
- ▶ social and peer support - networks, recreation
- ▶ psychosocial interventions - developmental needs, skill development, family support, education and employment
- ▶ therapeutic support - may include alternative and traditional choices
- ▶ advocacy services
- ▶ case management

5.3: Emerging models

Emerging models of support provision across tenures include:

- ▶ innovative peer support such as resourced neighbourhood support networks.
- ▶ Assistance with Care and Housing for the Aged (ACHA) program connects housing and community care for low income frail older people who are homeless in insecure housing. The Federal Government funds organisations to provide paid workers and/or volunteers to link clients to appropriate mainstream housing and/or care services. In Western Australia services are offered by Anglicare, City of Belmont, South West Outreach in Fremantle, and Kimberley Aged Care in Halls Creek.
- ▶ Home and Community Care (HACC) services - designed to provide in home support to the aged and people with a disability and thus reduce the risk of institutionalisation, are often not available to people with a psychiatric disability.

6: Existing Housing Options and Related Issues

Housing options explored in this paper focus on post institutionalisation, so do not cover inpatient beds, acute care units, prisons or detention centres. WAAMH has developed a framework for the range and levels of support required with accommodation options (Appendix 3)

6.1: Aged Care Hostels

The MHR 2000+ recommends aged care hostel care with specialised support and training to staff. Evidence given to the ARG suggest large numbers of elderly people with mental health problems are living in psychiatric hostels with dementia and physical frailty compounding mental illness.

6.2: Boarders and Lodgers

People in private boarding and lodging arrangements have little legal protection and access to services in the home are problematic. People with mental illness living in these arrangements can be vulnerable and open to exploitation.

6.3: Cluster Homes

Cluster housing in small to medium complexes is seen to be a viable option for providing independent living whilst reducing social isolation and maintaining stability and well being (MHR 2000+, Walls 2000, WAAMH). Cluster homes can include provision for caretaker support or neighbourhood consumer support.

Few cluster homes are presently operating, but feedback from consumers seems positive. There appears to be wide spread support for an increase in the establishment of cluster housing models.

6.4: Crisis Accommodation

Increasing numbers of people with a mental illness are accessing services for the homeless.

A forum held by the WA SAAP Protocols Project on the issue of mental health consumers highlighted the need for improved linkages between SAAP and mental health services. Improved information exchange, increased training and increased access to after hours support has been recommended. The inflexibility of mental health service boundaries was also found to be problematic.

SAAP and crisis services can experience conflict between balancing the needs of all groups using a service. With a focus on domestic violence, youth or the homeless, workers can be under trained and under resourced in the area of mental health (HREOC 1993, NYCH 1999). People with mental illness can be discriminated against (blacklists) or may display behaviours unacceptable to communal living.

For people who are homeless as a result of mental health or require time out, a short-term, communal housing service not specifically geared to their needs, may at times be the only choice but it is not necessarily the best or safest choice.

The MHR 2000+ Accommodation Reference Group (ARG) recommends priority establishment of crisis/interim services for people with mental illness in the Armadale and Joondalup catchment areas. Services for young people, women and women with children have also been highlighted as an area of urgent need.

6.5: Group Homes

Some agencies, such as the Richmond Fellowship, provide group housing where consumers are housed in a share housing arrangement with either an on site non-clinical support person or mobile support worker.

This arrangement works well for people not wishing to live alone or those people requiring more support. National Standards for Mental Health Services look at safeguards to protecting the rights and privacy of supported accommodation such as group homes.

Housing providers can find this option difficult to operationalise due to the requirement for intensive support and issues around resident compatibility and provision of joint bills (Walls 2000:31).

6.6: Home Ownership

Home ownership assistance is provided through the DHW Access Home Loan Scheme for People with Disabilities - with DHW providing up to 50% shared equity.

Barriers to both public and private home ownership include the cost of deposit and expenses and increased property values in areas located near transport and services.

6.7: ILP/CDHP

The Independent Living Program (ILP), whereby public housing is headleased to community organisations and arrangements are put in place for support provision, is an initiative that has broad based approval. However, the programme's success has brought with it high levels of demand for limited numbers of properties. As a consequence, waiting lists have increased consistently and are a major barrier to accessing the ILP. According to the ARG report, 357 people were on ILP waiting lists as of August 1999 (p24).

Dealing with community prejudice and reducing social isolation are factors, which can effect the successful tenancy of ILP tenants. The Department of Housing and Works' 1 in 9 policy which limits DHW's presence to a limit of 11% of housing stock in any suburb, can influence the ability of agencies within the programme to increase stock presence and possibly reduce isolation.

Successful partnerships between DHW, the headleasing agency and mental health support services are essential to programme outcomes.

6.8: Public Housing

The Department of Housing and Works (DHW) plays a significant role in the provision of housing to people with mental health problems through general housing, disability housing and the Independent Living Programme. Of the 35 000 general DHW tenancies, 17% are in receipt of a Disability Support Pension or Carers pension and 26% are in receipt of an Aged or Veterans Pension. In addition, 687 units are dedicated to people with disabilities through the Community Disability Housing Programme.

Waiting lists are a significant problem for people accessing public housing. As at 31st October 2000, 876 people with disabilities were waitlisted. The exact number of people with mental illness on the general waitlist is not known (in 1998/99, 14,326 applicants were on the DHW general waitlist). Some people have been on waiting lists for public rental for years only to miss 'their turn' through hospitalisation (Walls 2000).

Whilst expansion has occurred in some programme areas, overall DHW presence as a proportion of total housing stock has been in decline from 6% in 1991 to 4.7% in 2000 (Shelter WA 2001).

Interviews with consumers in the Mental Health Consumers Representation Project discussed the problems that many people have in negotiating housing requirements in relation to location, safety and modifications - with DHW staff who have an inconsistent understanding on the needs of consumers. Difficulties arising from lack of community acceptance, neighbour complaints and evictions linked to anti-social behaviour were also raised.

In the DHW submission to the MHR 2000+ Accommodation Reference Group, the main issues confronting the Department in accommodating people with disabilities (not specifically people with mental health problems) include:

- ▶ Accommodating people who may be a severe risk to themselves or others. The DHW reserves the right to refuse housing for people perceived to be the responsibility of the Health Department or Disability Services Commission.
- ▶ Providing housing in high demand areas where costs are higher eg inner city and matching stock to housing needs eg single unit accommodation.
- ▶ Limited financial and property capacity to meet increasing demand along with competing priorities and requests.
- ▶ Many DHW tenants have little or no accommodation disability support, creating property and tenancy management issues.
- ▶ Access of DHW staff to after hours assistance.

- ▶ Community opposition to the housing of special needs groups has impeded housing provision and special projects.

To further the role of the Department of Housing and Works in providing housing, partnerships and joint ventures are seen as imperative as is increased funding for the maintenance and expansion of public housing stock.

6.9: Private Rental

People with mental health problems are vulnerable to discrimination and housing based poverty in accessing the private rental market. Research indicates that more than 70% of low income renters are in housing cost burden (pay in excess of 30% of income on rent) (cited in Shelter WA, 2000). Increasing rents have resulted in a shortage of affordable private rental in many inner city and coastal suburbs.

Lack of privacy protection results in the development of 'bad tenant' databases, discriminating against tenants considered difficult. Tenancy law still allows eviction after 60 days notice without due cause.

Discussions with the Mental Health Consumers Representative Project highlighted the need for greater assistance with the in-going costs associated with private rental and recommends a higher rental subsidy for people on a disability pension in acknowledgment of high costs associated with disability.

The MMHS Accommodation Reference Group (2001:29) recommends a private landlord - ILP scheme where agencies are funded to lease property from private landlords for a fixed medium-long term period and are set-up under an ILP model. Also recommended is private landlord support and education to increase links between private landlords and mental health services and prevent discrimination.

People living successfully in private rental still require levels of support and assistance to maintain tenancy, especially during times of high need or hospitalisation.

6.10: Psychiatric Hostels

Licensed psychiatric hostels are usually for profit organisations providing basic accommodation and some support to people with a mental illness. In February Stage II of the reforms to the licensing of healthcare and residential services has begun developing standards and measurements for psychiatric hostels. Particular focus is on the provision of personal care services.

Psychiatric hostels range from 35 to 225 bed facilities. Criticism of inadequate support and quasi -institutionalised care that does little to develop independent living skills have been raised by consumer, advocacy and carer groups.

Some hostels require residents to vacate the building during set times - further removing any sense of normalisation. The HREOC report found access to many hostels by support workers can be difficult. People residing in unlicensed hostels and lodging houses are even more unprotected.

Paternalism, deskilling, lack of privacy and inappropriate groupings eg young people and elderly, were raised as issues by the Mental Health Consumers Representative Project.

As most hostels are private businesses, availability and location are highly effected by market changes.

6.11: Respite Services

Respite services are required for both people living at home with family and those living independently. Respite services, both in home and facility based, are particularly important for CALD communities and young people whom are more likely to be cared for in the home. More than 50% of young people with mental illness live with family (as cited in MHR 2000+).

There is general agreement that facility based respite should be provided separately from crisis accommodation.

The MHR 2000 + Accommodation Reference Group further recommends that funds be made available for respite workers to provide some outreach after consumers have returned to their home for continuity and consolidation. ARG consultations indicate "this service would be particularly beneficial to consumers and carers from culturally and linguistically diverse backgrounds who may have limited contact with mental health services" (p33).

6.12: Benchmarks

The Accommodation Reference Group of MHR 2000+, established service benchmarks for supported accommodation and residential treatment services through an international literature search (no local benchmarks were found in the literature search for this report). According to the findings, Perth requires the following:

Service	Benchmark per 100 000 adults	Total units required for Perth Metro
24 hr highly staffed residential rehabilitation beds	8-10	80 - 100 beds
24 hr staffed accommodation	10	100 beds
Self contained cluster units	20-30	200-300 units
Secure headleased properties	50-100	500-1000 properties
Intensive Case Managers 1:10 consumers	5	50 case managers
Day hospital/living skills places	30-40	300-400 places

Highest Priorities identified by the ARG were:

- ▶ 24 hour clinically staffed residential facilities for treatment (short-term) and rehabilitation (medium to long term)
- ▶ Disability support for SAAP services
- ▶ Increased provision of ILP properties and development of cluster homes/apartments
- ▶ Increases in the range, level and flexibility of disability support

A summary of ARG recommendations is attached in Appendix 1.

7: Issues Addressed at the Housing Needs of People Affected by Mental Health Problems Forum

Consistent across all reports reviewed and individuals interviewed has been the following main areas of pressing need in housing people with mental health problems:

- ▶ Need for increased flexible, affordable and secure housing opportunities.
- ▶ Improved availability, coordination and linkages in regard to support services that assist people to maintain housing.
- ▶ Improved responsiveness to consumer and carer requirements.
- ▶ A whole of government, cross-sectorial, government/non-government approach is required.

7.1: *Speakers*

Sheryl Carmody: Support Issues Across Tenures

Cheryl spoke about the benefits of the flexible delivery of support services to people with mental health problems, infrastructure problems facing support providers and the importance of community development.

Need for infrastructure: economies of scale were identified as being important to service providers establishing programs and working toward long-term viability.

Separation of support and accommodation: separation of support from accommodation is the most flexible way to deliver services. There are two primary models of service delivery to people with mental health problems. These are:

- ▶ The welfare or institutional model, which increases dependency and reliance on a single agency for the provision of whole life services.
- ▶ The empowerment model, which includes the separation of support and accommodation and focuses on empowerment, increasing opportunities and greater independence.

In-reach: The in-reach model of service delivery is very flexible and has the ability to provide support services across housing tenures and household types.

Importance of community development: community development approaches have led to the establishment of some of the most successful and enduring agencies in WA, these include City Housing (PICHA) and Fremantle Housing Association, which have both been providing community rental housing since the mid 80's.

Jacque Carter: Issues from a consumer perspective

Jacque spoke from a consumer perspective about the need for increased access to safe, secure and affordable housing, the need for increased access to the flexible provision of support services in the community and the need for training to be provided to DHW staff on communicating with people with mental health problems.

Problems with the Medical Model: the medical model of provision is not working for consumers and is dominated by psychiatry.

Imposition of Care Model: the out-workings of symptoms of mental illness can reduce some consumers' ability to articulate their needs to others and models of care are often imposed.

Differences between Private and Public Systems: the Public System focuses on medication, while the privates system spends time with the consumer.

Medication is not the answer

Importance of safe, secure and affordable housing: access to safe, secure, affordable and appropriate housing is critical to wellbeing. The absence of secure and appropriate housing significantly contributes to psychosis.

Economic Benefits of Affordable Housing: recent research has shown that for every dollar not spent on housing, two are spent on increased health care.

Fight to live independently: Consumers require care to be delivered in the community to assist in the maintenance of independent living.

DHW Staff Require Training: DHW Accommodation Managers primarily see themselves landlords, but the reality is that they do get involved in helping but are not trained to do so.

Exit Points: Expenditure under community housing funding programs needs to be directed toward exit point housing. "Having choice is what stops you feeling unwell".

Janey Glauser: Issues from a non-government housing provider perspective

Janie spoke about the Fremantle Housing Association's model of housing provision to people with mental health problems and about issues of concern to FHA.

- ▶ FHA formed during the late 80's in response to the impact of the Americas cup on affordable housing in Fremantle and the consequent increase in homelessness.
- ▶ FHA provides 73 properties funded under the Department of Housing and Works' Community Disability Housing Program.

- ▶ FHA utilises the separation of support model. They house people who are diagnosed with a severe and enduring mental illness, who are able to live in the community with visiting support.

Issues of concern included:

Long waiting list: the housing provided is long-term and there are limited vacancies.

The program doesn't suit everyone: behaviour of some tenants can impact on the neighbourhood; some tenants can find living on their own in the community socially isolating; and tenants can face community prejudice.

DHW 1 in 9 Policy: this policy works against clustered housing and makes it difficult to purchase well located housing. The interpretation of this policy has contributed to many consumers feelings of isolation.

Support Guarantee: FHA requires guarantees that both clinical and disability support will be provided and these guarantees cannot always be provided.

Lance Risbey: Issues from a clinical support perspective

Lance spoke about the provision of clinical support to people suffering from trauma and identified some key issues.

Key issues:

- ▶ continuity of care is critical to the continued wellbeing of people with mental health problems and this should be available regardless of location.
- ▶ People with mental illness benefit greatly from have the freedom to choose their care provider.
- ▶ Private practitioners give clients time.
- ▶ There is a Shortage of clinical support providers. There needs to be three times the number of public clinical support providers and twice the number of private providers.

7.2: Questions to the Panel

Fast Tracking: There was a short period when there was a fast track to Wesley Housing but not anymore.

Reluctance to Ask for Support: people with mental health problems who have stayed in hostels are often afraid to ask for support for fear of being readmitted to a hostel.

Ways forward: Generalist workers need to be equipped with more skills. This could be achieved through access to National Competency Training.

Access to Home and Community Care Services: HACC services refuse to get involved with people with mental health problems. There is a need for HACC services to be clearly defined.

8: Forum Workshops

Forum participants were asked to participate in 1 of 4 workshops. Each was given the task of discussing and developing strategies to address the issues of concern identified in the discussion paper. The workshops and key issues included:

Workshop 1: Need for increased flexible, affordable and secure housing opportunities.

Workshop 2: Improved availability, coordination and linkages in regard to support services that assist people to maintain housing.

Workshop 3: Improved responsiveness to consumer and carer requirements.

Workshop 4: A whole of government, cross-sectorial, government/non-government approach is required.

8.1: Workshop 1: Need for increased flexible, affordable and secure housing opportunities.

Security of tenure and appropriate support

Potential loss of ILP Stock

Exit:

- ▶ post supported housing
- ▶ stock

How to build on ILP gains

Personal relationship with support worker is significant in consumer progress

Move to mainstream:

- ▶ support network
- ▶ capacity to heal

Anti-social behaviour:

- ▶ Community education – dispelling the myths of immediate neighbours
- ▶ Consistent property management -Increases consumer security

DESIGN

Model coherency – match services to people

Start with individual need – develop design and appropriate support

Isolation – lack of choice

Privacy/autonomy with social connection

Cluster with communal courtyard

Security of tenure – permanency l'atche

Variety of cluster designs i.e. consumer need + in-home support

Cluster as step in transition to greater independence

Heterogenous clusters – acceptance/understanding of mental health issues

Pilot project – group homes

8.2: Workshop 2: Improved availability, coordination and linkages in regard to support services that assist people to maintain housing.

Supports are often partial, not holistic. Gaps exist.

Varying ability of case workers to link with all supports necessary in high needs families.

Confidentiality issues can limit/constrain the ability of helping agencies to provide support.

Community housing providers (staff) require training in home visits/communication for tenants with mental health issues.

Barriers to information flow between mental health service providers undermine “duty of care” for workers and clients/tenants.

Lack of discharge planning and clients existing SAAP/CAP housing, lose supports: revolving door.

Education – demystifying strategies required for:

- ▶ private landlords
- ▶ public at large

Service Gaps:

work/alternatives to work

follow up

lack of crisis accommodation

linking into mainstream services

supports for carers

supports for family members

Communication

Communication required between government and non government agencies

Regional connections required for effective lobbying

Reduced isolation of clients by enhancing social networks, community connections, social integration.

8.3: Workshop 3: Improved responsiveness to consumer and carer requirements.

Will change happen?

Yes – if the sub-committee in Cabinet (State) (Social Justice Unit) does its job!

Please note: every \$1 housing saves costs Health \$2 (Finding a Home – Keeping a Home)

Can DHW be more than a landlord?:

- ▶ Communication skills
- ▶ Staff training must include consumer and carer input
- ▶ Specialist accommodation managers

Promotion/prevention (Geraldton mental Health Forum)

Medium-term housing for crisis?

8.4: Workshop 4: A whole of government, cross-sectorial, government/non-government approach is required.

Need to equip generalist workers with more skills: HACC, SAAP etc...

Use of National Competency Standards

Clinicians in Community Mental Health Services not aware of contractual requirement to provide: supervision and case management (NMHS)

Generalists de-powered: assessment language

Need for training of DHW staff

Inner-city homelessness:

- ▶ Need for integrated government contacts
- ▶ Case management services
- ▶ Funded from a number of sources

Review of HACC coming up:

Need to feed into review

Need for rap around services

Lack of access to services

Need for cross government funding of crisis accommodation – especially non-metro

Training strategy – increased funding for agencies to participate in training

9: Action Plan

Guiding Principles: Strategies aimed toward addressing housing needs of people affected by mental problems should:

- ⇒ increase the provision of flexible, affordable and secure housing;
- ⇒ Improve the availability, coordination and linkages of support services and these should assist people to maintain independent housing;
- ⇒ improve responsiveness to consumer and carer requirements; and
- ⇒ promote a whole of government, cross-sectorial, government/non-government approach to service provision.

Objective	Strategy	Outcome	Responsibility
The provision of affordable housing will be increased.	<p>Increased funding under the CSHA for the construction of rental housing will be promoted and will include an increased cash commitment from the WA Government.</p> <p>Increased provision of community housing will be promoted, in particular under the CDHP/ILP</p>	<p>Increased cash commitment under the CSHA from:</p> <ul style="list-style-type: none"> ▶ the WA Government; and ▶ the Federal Government <p>Increased housing stock under the CDHP is funded by the DHW.</p> <p>Increased ILP support capacity funded by DoH</p>	<p>Shelter WA</p> <p>Shelter WA</p> <p>WAAMH</p>
The design and construction of public and community housing will recognise the need of consumers for secure and appropriately located housing.	<p>Recognition of consumer's need for physical security and well located housing will be promoted.</p> <p>Clustered housing will be promoted as way of reducing the impact of social isolation.</p>	<p>Consultation with consumers & occupational therapists incorporated into DHW design and construction policies.</p> <p>Policy allowing the development and construction of cluster housing adopted by the DHW.</p>	<p>Shelter WA and WAAMH</p> <p>Shelter WA and WAAMH</p>

Objective	Strategy	Outcome	Responsibility
Flexibility in the provision of support services will be increased.	<p>Increased resources to best practice models will be promoted, these include:</p> <ul style="list-style-type: none"> ▶ ILP and ▶ ACHA <p>Broadening of the provision of HACC services to include people with mental health problems will be promoted.</p>	<p>Increased support capacity funded by:</p> <ul style="list-style-type: none"> ▶ The Dept. of Health; & ▶ The Federal Government. <p>HACC Guidelines broadened to include the provision of services people with mental health problems.</p>	<p>Shelter & WAAMH</p> <p>WAAMH</p>
Cross government coordination will be increased.	<p>The need for wraparound support with the ability to provide continuity of service provision across locations and tenures will be promoted.</p> <p>The need for gross govt. funding of multi-targeted crisis accommodation services in non-metro areas will be promoted.</p>	<p>Wraparound support & case management services established.</p> <p>Integrated cross govt. contracts established</p> <p>Case management services funded from a range of funding sources including: Health; DCD; DSC, & FCS</p> <p>Cross govt. funded, multi-targeted emergency accommodation services established in non-metropolitan areas</p>	<p>Shelter WA and WAAMH</p> <p>Shelter WA and WAAMH</p>
The provision of training to generalist workers will be increased.	Training on how to work with people with mental health problems will be promoted for generalist workers in: DHW, community housing agencies, SAAP, HACC and other generalist agencies.	<p>Training program established</p> <p>Training program delivered to generalist workers</p>	Shelter WA and WAAMH

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Appendix 1: Forum Attendance List

Name	Organisation
Jeannine Purdy	Tenants Advice Service
Sheryl Carmody	RUAH Inreach
Margaret Cook	Consumer Representative
Francine McCarthy	South Guildford Centre - Swan Health Service
Ian Hafekost	Office of Housing Policy
Carolyn Ngan	South West mental Health Service
Lee Roberts	Hills Community Support Group
Naomi White	Milligan Foundation
Janey Glauser	Fremantle Housing Association
Anne White	West Australian Association for Mental Health
Camille Inifer	Community Housing Coalition of Western Australia
Catherine Stevenson	Council of Official Visitors
Chris Heslin	Swan Adult Mental Health Centre
Evan Hillman	Fremantle Youth Service
Philip O'keeffe	Psychiatric Emergency Team
Serylee Girling	Psychiatric Emergency Team
Rabecca Colins	Hills Community Support Group
Barbara Rose	AVRO Consumer
Trang NGO	Perth Independent - Curtin Uni
Carol Cheney	Mental Health Division
Sue Matchett	Baptist Care
Vicki Cauldwell	Mental Health Division
Julia Fraser	Avro Clinic
Kelvyn Owen	Albany Halfway House Association
Brendon Clarke	Aboriginal Community Support Service
Marie Noble	Wesley Housing
Patricia Mc Caffry	JCMH
Bronwyn Kitching	Anglicare - Housing Advocacy Support Service
Sandra Vidot	Hills Community Support Group
Carolyn Armstrong	Scarborough Psychiatric Support Service
Bob Chown	South City Housing
Liz Kerry	Anglicare - Coolbellup
Janet Pine	
Evana Hyman	Jarra Road Centre
Jenny Cramer	Curtin Indigenous Research Centre
Tim Davis	Shelter WA
Paul Pendergast	Shelter WA

Appendix 2: Feedback From Forum Participants

Expectations of the Forum	Were Expectations Met
How better partnerships can be gained between accommodation and support	Yes
Looking at alternative housing from DHW stock	No
Increased knowledge of ways to assist homeless/ill people	Good networking and acceptance of common goals
A greater understanding of housing and mental health issues	Yes
Resources, raising awareness of these issues & informing debate	Yes
Techniques to assist tenants with mental health issues	No-perhaps addressed at a more structural level
Strategies for improving access to housing for Indigenous mental health clients	Yes
Information - status quo on housing issues	Yes
Resolve some common strategies on directions for housing for people with mental illness	Yes
Learn more about issue of mental health & housing	Yes
Understand the main issues & gaps in housing provision	Yes
Recommendations on how can improve the housing of people with mental disabilities	Yes
Strategies to improve housing options	Yes
Issues relevant to the Independent Living Program (ILP)	Yes
Discussion/debate on mental health & housing issues	Generally - feedback from the group sessions provided broad information to feed into future dialogue & strategy development processes
Strategies development on above & homelessness issues	
Opportunity to participate in discussions/workshop process	
An understanding of the mandate of mental health services in the community	Yes
Clarity about how access to housing & services is affected by mental health	Yes
Commitment to fundamental principle of affordable and appropriate housing for ALL	Yes
Some possible realistic solutions to the housing needs identified	Marginally
Increased awareness of accommodation issues	(?) Home & Community Care - but needs to be more than cost shifting!
Increased awareness of accommodation options	Identification of social isolation as an issues - gap in "services"
A sense of belonging - there are others who think like me	
Cross boundary interest & co-ordination	
If other community housing providers have similar issues with managing ILP tenancies	There seems to be broad acknowledgement of sector issues/problems: resolving these is what takes time, hard work etc...
If so, how do they?	
How can South City improve it service?	

What did you like about the Forum	What didn't you like
Feedback & questions were welcomed Workshops	Could have been more time for questions after speakers
Informality	No
Different perspectives given as there is a high level of ignorance of the range of services	No
Good - discussion range of perspectives	
The opening presentations	No
Networking Different needs/status quo	
Willingness of people to speak up Information provided from different view points	
Speeches	Starting late & finishing late
Group sessions & feedback worked well Good balance of consumer; housing; and clinical presentations	Lack of Ministry/Govt. presence: does this mean they were not interested or committed to working together on this issue?
Ability to input	No
Consumer rep presentation was excellent	The psychiatrist's presentation had little or no relevance to the forum on housing
Meeting people from the sector	The agenda of separation of support/accommodation
Small group discussion	The psychiatrist mentioned accommodation twice
	Inconclusiveness
Clarity on the shared issues People have good understanding of the problems - this is the easy part	Not enough focus on strategies for resolving issues

Suggestions on improving the forum	General comments
More time for the psychiatrist	No
No	Enthusiasm was high
Would have like more consumer perspectives	
More time for the psychiatrist	More Forums
Being ready to start on time	
Starting on time finishing on time	Speeches were very interesting
More time to wind up and address options for solutions	
No	Acknowledge ACHA
A greater range of options/discussion points	
	More direction/business plan with lobbying
DHW representatives invited/present	Food & venue organisation: very good It is probably premature to expect bureaucrats to do anything to resolve these issues. And not all issues are govt. funding issues. At the end of the day reducing stigma of MH is a people's movement