Long-term Supported Housing for Mental Health Consumers in Tasmania

Advocacy Paper

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Shelter Tasmania

ADVOCACY TASMANIA INC.

Mental Health Council OF TASMANIA

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Purpose

A persistent message the Mental Health Council of Tasmania (MHCT), Advocacy Tasmania and Shelter Tasmania hears at its consultations around the state is that there is a small but significant cohort of people with severe psychosocial disability experiencing recurring homelessness, because of unsatisfactory, insufficient and/or inappropriate housing and support service and poor discharge planning.

These consumers require long-term supported accommodation because they:

- have a psychosocial disability that is likely to be long-term or even, in some cases, permanent; and
- have functional impairment in one or more areas affecting daily living, including self-care, decision-making, and learning.

Through networking, cooperating, coordinating and collaborating we aim to secure long-term supported accommodation for mental health consumers with severe psychosocial disability in Tasmania.

Vision

All mental health consumers in Tasmania are able to "live contributing lives from a secure and safe home and from access to the mental health support they need."[1]

Mission

Working together to secure long-term supported housing which maximises the independence of all people living with a serious mental illness.

We will advocate to:

- Create supportive environments and foster understanding of the issues facing people with mental illness and their carers in Tasmania.
- Protect consumers from homelessness and inappropriate housing and promote long-term supported housing for mental health consumers.
- Achieve enhanced investment in housing and support for mental health consumers.
- Engage more key stakeholders to share responsibility in an integrated system that ensures long-term supported housing for mental health consumers.
- Develop processes to identify existing provision of met and unmet accommodation needs in a local region, to help to establish the case for further resources.

[1] National Mental Health Commission, (2012) *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention*, Sydney: NMHC, p. 121.

Recommendations

1. Generate a well-co-ordinated, clearly targeted, integrated and efficient system for delivering appropriate long-term, supported housing for mental health consumers with severe psychosocial disability.

2. That the Tasmanian Government allocates capital funding for appropriate housing for this cohort.

3. That a project similar to the MHS project about to commence in Andrew Street, New Norfolk be put in place. Initially to cover up to at least 30 consumers in the southern region, then expanded state-wide to meet needs in the north, north-west and north-east of the state.

   Estimated additional cost: Based on the Home in Queanbeyan model:

   i. Capital Costs: $6 million (approx.)

   ii. Recurrent Costs: $300,000 - $400,000 p/a (until the NDIS is fully implemented)

4. That provision for adequate step-down from the Wilfred Lopes Centre is reviewed, and a functioning program be put in place.

5. That a state-wide review of discharge planning practice in mental health facilities is instigated to ensure that:
   - practice is in line with relevant policy and legislation;
   - decisions regarding support needs and readiness for discharge are informed by recent and accurate information;
   - internal factors adversely affecting discharge are identified and addressed; and
   - people are not discharged into homelessness

6. Undertake a comprehensive consultation project with carers, to determine the full scope of the housing and support needs of people with mental illness and their ageing carers.

Background

Overwhelmingly, treatment options for people with serious mental health problems are focused on treating symptoms rather than providing ongoing care. The MHCT recognises that most people with serious, ongoing mental health conditions are in and out of hospital, and need more consistent monitoring and support.

Through its discussions with consumers and carers, clinical and community services and organisations including Advocacy Tasmania, the MHCT and Shelter Tasmania are aware of a small number of people whose level of severity of mental illness and the resulting level of impairment and functional limitation results in them being expelled from existing services. They then either get into trouble with the law and/or become homeless. This is a group of people which requires intensive psychosocial support and supported accommodation for a longer period than is currently offered by most services.

There is a significant body of evidence, both anecdotal and documented, that demonstrates that a considerable number of people with affective disorders, psychoses and schizoid-type disorders cycle between homelessness services, boarding houses, emergency rooms, acute psychiatric care and back into homelessness. There is an obvious shortage of suitable supported accommodation in the community for people with mental illness, particularly long-term and 24/7 supported housing options, and this is preventing the discharge of people from hospital. In addition, people in mental health facilities are largely excluded from the accommodation and support that is provided by the disability sector due to their diagnosis and/or location.

In Tasmania, we estimate upwards of 30 people in the Hobart area alone are without sufficient services.[2] For these people, mental illness is not a short-term condition. With the lack of security, safety and support their mental illness can become very unstable, driving them back into hospital, homelessness or worse.

There is a clear need for an increased supply and range of supported housing options that provide on-site support for at least 16 hours per day (preferably 24). Those services and support for people with psychosocial disability need to be driven by flexible, person-centred and individualised approaches.

The failure of mental health services to deal effectively with the problems of difficult to place consumers is perhaps best understood in relation to three factors:

1. The community care model was not designed with the needs of people who require long-term high support in mind.

2. The models of community care that have developed since the closure of long stay psychiatric hospitals have tended to focus on rehabilitation as a means of preparing people for more

[2] This number is based on discussions with a range of people working directly with these consumers including from Advocacy Tasmania, Specialist Homelessness Services and the Royal Hobart Hospital.

independent living thereby ignoring the very specific needs of consumers who are hard to place, and often presenting with complex issues.

3. The initial costs of providing high supported accommodation for this relatively small group of consumers appears less cost effective when compared with the numbers of people that can be provided for in less intensive supported accommodation.

Increasingly, it would appear that some form of permanent provision for these consumers is required. This does not mean hospitalisation, but does require intensive, and therefore costly support to be provided.

Gaps in Data

In Tasmania there is insufficient data concerning housing needs of mental health consumers. It is critical to clarify need, and to determine where funds should be best placed.

A British report has noted that "the complexity of providing accommodation for people with mental health issues has become more obvious. It is clear that future planning of these services requires thought to be given to predicting levels of need; how to balance the drive for independent living with the needs of some people for permanent, high level support; and how to ensure value for money and cost effectiveness across service provision."[3]

In particular, in Tasmania, there is an urgent need to know how many mental health consumers have severe, persistent and complex needs that require a high level of support, including ongoing disability support. These consumers may require on-site support and supervision for 16-24 hours per day; a structured living environment; and access to timely and responsive clinical mental health support.

Unless we have a clear idea of who they are, how many of them require secure accommodation with high levels of support and where they are currently living, we cannot begin to put together packages to meet their needs.

In terms of the broader spectrum of accommodation and support needs of people with mental health issues in the community, there is some good work being done in this area. However, gaps remain and it is important to take a comprehensive look at what is required including housing stock, support workers, case managers and set-up costs. We recommend that the Mental Health, Alcohol and Drugs Directorate, in consultation with Shelter Tasmania, Housing Tasmania, community mental health service providers and consumers, explores the range of options needed for housing for mental health consumers at every stage of their journey to:

- Map what housing is required at every level from post-acute supported housing to permanent housing solutions.
- Arrive at an implementation plan with funding attached to be rolled out over the next 5 years.

[3] Dr Lisa O'Malley and Karen Croucher, (2003) *Supported housing services for people with mental health problems: evidence of good practice?* Paper presented to HSA Conference "Housing and Support", University of York 2nd April 2003, p. 20.

Discharge planning

A significant number of those people requiring long-term supported accommodation do not have stable accommodation before their admission to hospital. Whilst others are discharged to stay with family or friends but do not have a long-term housing option. Others do not have support in the community at all and resort to boarding houses or other transitory accommodation before becoming homeless, or in the worst case, being imprisoned for a minor transgression. They are often discharged into Specialist Homelessness Services (crisis accommodation). A recent Australian Institute of Health and Welfare report states that, 'Specialist homeless agency/outreach workers were the most frequently recorded source of referral (12.8%) for clients with a current mental health issue.'[4]

It has been argued by some researchers that the closure of psychiatric hospital beds has led to an increase in mental health problems dealt with in the prison system. According to Macpherson et al:

> It is unclear whether the deinstitutionalisation movement has led to real increases in the numbers of severely mentally ill people in the UK prison system. However, Lamb (1998) is sure that in the USA it has. He presents two arguments to support this view: the large numbers of mentally ill prison residents, and the observation that a high proportion of mentally ill people found in the criminal justice system resemble in most aspects those who used to be in long-term psychiatric institutions. Within the UK system it is clear that prisons are sometimes used to accommodate difficult patients with challenging behaviour who do not readily fit into modern short stay acute NHS facilities, and it also appears that a small number of people with severe mental illness are inappropriately placed in the criminal justice system.[5]

This is also the case in Tasmania, where there are a small number of people with severe mental illness inappropriately placed in the forensic unit, including those who are considered too disruptive to remain in the Psychiatric Intensive Care Unit (PICU).

Deinstitutionalisation has had an impact on people with severe psychosocial disability if only for the reason that community supports have not been provided in sufficient amounts to provide for those who were once in asylums. A 2011 report noted that:

> It is not de-institutionalisation per se; rather the under-investment in community and home based mental health services. Reports from services suggest that is can be challenging for people with severe and persistent mental health issues, who need permanent housing linked to ongoing health and wellbeing support services, to access the right type and intensity of support needed for a successful tenancy. [6]

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[4] Australian Institute of Health and Welfare, (2012) Mental health services in Australia, p. 1, viewed at http://mhsa.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=27917288155

[5] Rob Macpherson, Geoff Shepherd & Tom Edwards (2004) 'Supported accommodation for people with severe mental illness: a review', *Advances in Psychiatr*ic Treatment, vol. 10, viewed at http://apt.rcpsych.org/ 183, the authors cite the work of H R Lamb, (1998) 'Deinstitutionalisation at the beginning of the New Millennium', *Harvard Review of Psychiatry*, 6, 1–9.

[6] Homelessness Australia, (2011) *States of being: Exploring the links between homelessness, mental illness and psychological distress: An evidence based policy paper*, p.8.

The Case for Providing Long-Term Supported Accommodation

Access to a range of longer-term supports and community-based services will increase the early intervention and recovery support options for people with a mental illness who are homeless or poorly and inadequately housed.

1. The high support needs of people are not being met

In its Strategic Plan for 2006-2011 the DHHS reported that 3% of the Tasmanian population has severe mental health disorders, of which 0.6% has high support needs.[7] This means that, by the government's reckoning, approximately 15,000 Tasmanians have severe mental health disorders and that 90 people have high support needs. Which means that a small but significant number of Tasmanians have severe, persistent and complex needs that require a high level of support, including ongoing disability support. It is unclear what the true number of people within this category might be because not all will have sought mental health services, many of them may be homeless and some will have complicating drug and alcohol addictions.

Whatever their actual numbers, this group is typically in need of long-term supported accommodation; on-site support for 16-24 hours per day; a structured living environment; and access to timely and responsive clinical mental health support. Such support does not currently exist, or services exclude this cohort due to high support needs. Public housing is generally inappropriate for this cohort; due to inadequate conditions, overall lack of stock supply and the high needs of the drug, alcohol and mental health issues of many tenants.[8]

The disability sector has a much larger number of long-term and highly supported accommodation options. However, current policy in the disability sector excludes people with psychosocial disability who have a primary diagnosis of mental illness from most of this accommodation.

Many of these people end up either on the streets or in far more expensive settings, such as hospitals and prisons. This impacts on hospital emergency rooms and police, who are already dealing with an increasing number of people with untreated or severe mental illness.

2. The limitations of the NDIS

The Tasmanian *Disability Services Act 2011* which came into effect on 1 January 2012 enshrines a broader human rights view in line with the United Nations Conventions on the Rights of Persons with Disabilities. It defines disability as follows:

> ***disability***, in relation to a person, means a disability of the person which –
> **(a)** is attributable to a cognitive, intellectual, psychiatric, sensory or physical impairment or a combination of those impairments; and
> **(b)** is permanent or likely to be permanent; and

[7] Tasmania, DHHS, (2006) *Mental Health Services Strategic Plan 2006-2011*, p. 2.
[8] Rowland Atkinson and Keith Jacobs, (2008) *Public Housing in Australia: Stigma, Home and Opportunity*, UTAS, Housing and Community Research Unit, p. 17.

(c) results in –
(i) a substantial restriction in the capacity of the person to carry on a profession, business or occupation, or to participate in social or cultural life; and
(ii) the need for continuing significant support services; and
(d) may or may not be of a chronic episodic nature;

Tasmanian mental health and disability legislation and United Nations principles emphasise the right of people with mental illness and psychiatric disability to live in the community and to receive support in the least restrictive environment possible. However, people with a primary diagnosis of mental illness and associated disability do not currently have consistent access to the full range of disability services.

In particular, they do not have access to the majority of supported accommodation that is funded under the DSA. To exclude people with a primary diagnosis of mental illness does not adequately take into account the person's functional impairment and psychosocial disability – the key reason why they need supported accommodation.

In an opinion piece for *The Australian*, chief executive of the Mental Health Council of Australia, Frank Quinlan[9] noted that now was a good time to examine the National Disability Insurance Scheme in the context of psychosocial disability. Psychosocial disability makes lasting impacts on the everyday lives of those affected, reducing their ability to function and participate in society. People with psychosocial disabilities often have complex support needs, including in some cases the need for constant, supervised care.

It is hoped that with the roll-out of the NDIS from 2016 onwards, people with psychosocial disability will be eligible for the support they need. Rule 7.19 (d) of the NDIS Rules points to the possibility of capital dollars for the type of integrated housing and support model that would best service people with severe and prolonged mental illness.

At the AHURI Housing Conference, held in Adelaide in November 2013, Bruce Bohyhady, Director of the National Disability Agency, stated that there is recurrent funding for capital for housing under the scheme—$550 million when the scheme is at full rollout (2017). However, he qualified that there were constraints on the NDIA borrowing funds to invest in housing, and owning housing stock, and therefore the NDIA will need to work in partnership with community housing organisations and other community partners. He also mentioned that whilst housing is a priority for the NDIA, there has been little discussion between the disability and housing sectors to date.

It is critical that housing is provided for this cohort and that this is considered a matter of urgency by the State Government.

[9] Frank Quinlan, 'Mental health can't miss out', *The Australian*, October 07, 2013, viewed at http://www.theaustralian.com.au/national-affairs/opinion/mental-health-cant-miss-out/story-e6frgd0x-1226733819328

3. People with psychosocial disability are at greater risk of homelessness

A recent report on healthcare in Tasmania stated that, "It is noteworthy that Tasmania had the highest rates of residential mental health services, patients and care days in 2009-10. The greater reliance on residential care for mental health patients in Tasmania appears to be a result of relatively low provision of supported housing places and high levels of forensic mental health services, but it warrants further examination."[10]

Community living with low intensity support is clearly not an option for those consumers who require greater levels of support and in some cases 24 hour staffed accommodation. Thus we should be cautious in assuming that the current levels of and approach to community living is a viable option for all people with mental health problems, either at the present time or in the future.

Rates for residential mental health services in Tasmania may look more than sufficient based on figures noted above but are characterised by a lack of long-term supported housing. Instead, caravan parks, boarding houses and couch-surfing are too often the only alternative or even worse, sleeping rough or prison. There is a strong body of research which supports the assertion that the prevalence of mental illness among people who are homeless is substantially greater than that found in the general population.[11] It is important to note that Tasmania has the highest proportional rates of people at risk of homelessness in the nation.[12]

4. Well-planned, comprehensive support in the community leads to a better life and less episodes of hospitalisation

In a recent report the Mental Health Coordinating Council noted that:

> Consistently, studies show that people living with mental illness who are provided with well-planned, comprehensive support in the community have a better quality of life, develop an improved level of functioning and social contact, and have fewer relapses.[13]

Participation in society improves mental health, self determination, and general functioning. On a broader social level, it reduces discrimination and stigmatisation, both essential to achieving and maintaining good mental health. It also assists people to stay out of hospital.

De-institutionalisation has strong momentum internationally, and experts are consistent in supporting community-based care complemented by hospital beds for acute care as required.

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[10] The Commission on Delivery of Health Services in Tasmania, (2012) *Working towards a sustainable health system for Tasmania:* Preliminary Report to the Australian Government and Tasmanian Government Health Ministers, p. 13.
[11] Anita Pryor, (2011) *Well and at home, 'It's like a big mental sigh': Pathways out of mental ill health and homelessness*, The Social Action and Research Centre Anglicare Tasmania, p.13
[12] NATSEM, "Geographical Analysis of the Risk of Homelessness" National Centre for Social and Economic Modelling, University of Canberra, June 2013.
[13] Rachel Merton and Jenna Bateman,(2007) *Social inclusion: its importance to mental health*, Mental Health Coordinating Council Inc, p. 2

5. Well-planned, comprehensive support in the community leads to less episodes of imprisonment

It has been widely demonstrated that people with mental illness are more likely to be victims of crime than perpetrators.[14] Nonetheless, people with mental health disorders and cognitive impairment are significantly over-represented in the criminal justice system. In their Report Card for 2013, The National Mental Health Commission found that:

> In 2012, 38% of all people entering our prison system reported having been told they have a mental illness. If these findings were applied to the 29,000 prisoners in Australia, then this would equate to around 11,000 people each year.[15]

Furthermore, the Report Card records the Commission's concern that this situation may be exacerbated by lack of the right support and treatment when it was needed which could have helped the imprisoned mental health consumers "avert a life in prison, a loss of their liberties and human rights, and therefore avoid the punitive and mental health-eroding environment of prison. It would have stopped the subsequent double discrimination from having a criminal history as well having a mental illness, when trying to re-establish a life in the community."[16]

In a media article on the Commission's focus on the criminal justice system, it was noted that National Mental Health Commission chairman Professor Alan Fels stated that "more than one-third of people entering the prison system have a mental illness and that many people have moved from asylums as their accommodation into prisons which are becoming the new asylums.'[17]

A UK study found that "stable accommodation has a key role to play in both reducing reoffending and improving mental health and wellbeing … stable accommodation can bring about a 20% reduction in the reconviction rate of ex-prisoners … recent figures released by the Ministry of Justice (2010) also suggest that stable accommodation can impact on re-offending rates – offenders who had been homeless prior to custody had a one-year reconviction rate of 79% compared with 47% for those who had been in accommodation."[18] While this is not a Tasmanian, nor even an Australian example, it may be supposed, in the absence of any local data, that the situation may be similar here.

However, we do know that adequate community care, including supported housing, is ultimately less expensive than the cost of keeping people in prison. A fact sheet produced by the Mental Health Legal Centre in Victoria notes that:

> Imprisonment is far more expensive than community mental health care. In 2003-04 $218 million was spent on Victorian prisons. In the same period there were only 1,194 publicly

[14] National Mental Health Commission, (2013), *A Contributing Life, the 2013 National Report Card on Mental Health and Suicide Prevention*, NMHC, Sydney, p. 79.
[15] Ibid., p. 71.
[16] Ibid.
[17] Sophie Scott (2013), 'People with mental illness being jailed because of inadequate support: Health Commission', ABC News, viewed on 20/01/14 at http://www.abc.net.au/news/2013-11-27/too-many-people-with-mental-illness-being-jailed/5118020
[18] Centre for Mental Health (2011) *A new mandatory power of possession for anti-social behaviour: Consultation response*, p. 2, viewed on 20/01/14 at http://www.centreformentalhealth.org.uk/pdfs/Centre_response_power_of_possession.pdf

> funded community residential facilities providing mental health services. Psychosocial Rehabilitation and Support Services are chronically underfunded yet do invaluable work to address social disadvantage.[19]

In Tasmania, the highly successful Salvation Army Reintegration for Ex-Offenders (REO) program after three years of operation the recidivism rate for clients who entered and completed the pilot programs dropped from 65% to less than 3%.[20]

6. Ageing carers

A VICSERVE report noted that carers can spend over 100 hours a week providing care for people with mental illness. This caring role is hidden and underestimated within the community at large, and within government accounting and assessment. When it comes to providing housing and support options for people with severe and complex mental health issues, this is almost totally the case. Carers are the housing and support providers, providing these in the long and short term and in planned and emergency contexts.

The report states that:

> The extent of the role of carers in these capacities is not well understood, and there are emerging risks and vulnerabilities as some carers age and others face their own housing affordability issues. It is critical to build a comprehensive knowledge of the part carers play in responding to the housing needs of people with mental illness. It is also important to acknowledge that these carers will not be able to provide support indefinitely, especially as they age and need support themselves.[21]

Issues with regard to carers include:

- they may be single with no one else to provide support to them or their loved one
- they may be ill themselves or elderly and becoming frailer and less capable of providing care
- the person with the severe mental illness may be so seriously ill that he/she requires intensive support
- other members of the family, especially children in the household, become frightened and resentful, and feel like most family concerns revolve around the person with the severe mental illness
- marital relationships deteriorate
- no support services are used, or services are not available
- the individual has behavioural difficulties: for example, aggression or extreme antisocial tendencies
- the individual has a dual-diagnosis, for example a substance abuse disorder and mental illness, which makes care and support more onerous

[19] Mental Health Legal Centre, (2009), *Mental Health Issues in Victorian Prisons: Fact sheet for the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, viewed on 290/01/14 at https://www.google.com.au/search?q=Mental+Health+Issues+in+Victorian+Prisons%3A&oq=Mental+Health+Issues+in+Victorian+Prisons%3A&aqs=chrome..69i57j0j69i64.3707j0j8&sourceid=chrome&espv=210&es_sm=93&ie=UTF-8

[20] Salvation Army REO Evaluation data, 2012

[21] Psychiatric Disability Services of Victoria (VICSERV), (2008), *Pathways to Social Inclusion: Housing and Support*, VICSERV, Melbourne, p. 6.

7. Long-term supported housing is consistent with recovery

The authors of this paper wish to make it clear that they do not perceive any conflict between the notion of long-term supported housing and the recovery model. For people with a severe mental illness, housing means affordable and appropriate accommodation, as well as the supports necessary to maintain tenure and to live the best life possible. However there is no overarching and consistent approach to providing housing linked support that meets the changing needs of these consumers, a number of whom will require long-term supported housing.

Long-term supported housing for people with high or complex needs does not mean that they are being shunted aside in 'mini asylums' without any opportunity to lead independent, self-directed lives. It means allowing them the time and support they need on their recovery journey which may take a long time. It is the beginning of recovery for those not currently able to articulate goals or make plans. For people living with severe mental illness, a home is especially important for promoting security, increasing quality of life, and reducing the risk of relapse and hospitalisation. VICSERV's report, *Pathways to Social Inclusion: Housing and Support* cites several studies to support this.[22]

With only a very small number consumers living in supported housing and a much higher proportion trapped in repetitions of different categories of homelessness and the 'revolving door 'of mental health crisis accommodation and criminal justice systems, there is an urgent need for governments and organisations across several sectors to respond to the specific housing and support needs of this marginalised and disadvantaged group.

The Case for Improved Discharge Planning from Mental Health Facilities

An issue that inextricably linked to homelessness and inappropriate housing for people with severe mental illness is inadequate discharge planning. We are concerned that people being discharged from hospital need to have a safe and secure place to go. It is not enough to say that they will not be discharged into homelessness; they must also not be discharged into unstable accommodation.

Appropriate community supports – including clinical support and long-term and highly supported accommodation – are in short supply in the community sector. This can impact on appropriate discharge of people from hospital or from the forensic unit. There is an identified need for step-down accommodation from hospital, as well as the forensic unit, into community managed care to reduce readmission and ensure seamless integration back into the community.

[22] Psychiatric Disability Services of Victoria (VICSERV) (2008) *Pathways to Social Inclusion: Housing and Support*, p. 14

In 2004, Anglicare's research into the experiences of people with serious mental illness in Tasmania urgently recommended the development of effective discharge planning protocols specifically relevant to people experiencing socio-economic disadvantage.[23]

Recommendations from this report include that discharge accommodation planning commence at intake; that in instances where a patient is being discharged to another person's home, an assessment is made of that person's capacity to provide care/accommodation; adequate transport arrangements are in place before discharge; and that at intake, Centrelink social workers and housing support workers are engaged to provide follow-up support upon discharge.

Eight years later effective discharge planning is still a pressing issue with most of the recommendations from the Anglicare report yet to be addressed. The Mental Health Commission of Australia's first report card refers to discharge planning in its Recommendation 9 and calls for the following action:

> Discharge planning must consider whether someone has a safe and stable place to live. Data must also be collected on housing status at point of discharge and reported on three months later, linked to the person's discharge plan.[24]

There is evidence to suggest that community alternatives to long term stays in acute settings produces positive outcomes for consumers, and there are sound economic reasons why developing appropriate care for long stay patients in the community should be a priority. Indeed, the shortage of long stay accommodation in community settings, coupled with the closing of hospital beds, will likely mean that people remain longer in hospital, effectively blocking acute readmission beds.

That stable and secure housing linked with support services for people with a mental illness provides a solid base from which recovery can begin is evident from a range of innovative social housing models that currently exist in Tasmania as well as interstate, one example of which is the Queensland Housing and Support Program (HASP) (see Appendix A).

With regard to discharge from forensic units, a Homelessness Australia report notes that:

> …there are links between homelessness and institutionalisation and that people are often discharged from correctional facilities into either tenuous, insecure accommodation or homelessness. We are aware that there are a number of good housing exits programs in place that assist people exiting prison to access transitional and stable accommodation. A couple of providers have informed us that it is often prisoners with mental illness whose accommodation quickly breaks down 'on the outside' and who are need of greater support pre and post-release.[25]

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[23] Prue Cameron and Jo Flanagan, (2004) *Thin ice: living with serious mental illness and poverty in Tasmania*, Hobart: The Social Action and Research Centre, Anglicare Tasmania.

24 National Mental Health Commission, (2012) *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention*, Sydney: NMHC, p.13.

[25] Homelessness Australia (2011) *States of being: Exploring the links between homelessness, mental illness and psychological distress. An evidence based policy paper*, p. 14.

There is a need for a state-wide review of discharge planning practice in mental health facilities to ensure that:

- practice is in line with relevant policy and legislation;
- decisions regarding support needs and readiness for discharge are informed by recent and accurate information; and
- internal factors adversely affecting discharge are identified and addressed.

Two Example Responses

There are many examples of how other states and territories respond to the housing and support needs of people with severe psychosocial disability. We draw attention to two in particular: HOME in Queanbeyan and HASI in NSW.

HOME[26] is a community initiative providing a loving place for 19 men and women with chronic mental illness who struggle to live independently. It provides 24 hour care for and long-term accommodation where residents can be assured of company, a clean bed to sleep in and regular health check-ups. It can house 19 people at any one time. In the report *Home-In-Queanbeyan: Putting the Case,* Leanne Craze *et al,* note that:

> Based on Professor Carr's authoritative study, even if one out of every 10 clients of Home in Queanbeyan is able to participate meaningfully or engage in meaningful activity, there will be reduced costs to government and to society as a whole.[27]

HOME sought funding and in kind support from the corporate, community and government sectors of Capital Costs - $3.3 million for capital costs and $300,000 - $400,000 p/a for recurrent costs.

The NSW Housing and Accommodation Support Initiative (HASI) is an effective model of supported accommodation and agency partnership for people with severe mental illness and associated disability. A formal and comprehensive 2-year longitudinal evaluation of the Housing and Accommodation Support Initiative (HASI), was undertaken in 2012 and found that consumer outcomes were positive with fewer mental health hospital admissions and shorter length of stay, clinically significant change in K10, HoNOS and LSP16 scores, stable tenancies, independence in daily living, social participation, community activities and involvement in education and voluntary or paid work. While there was no single measure of quality of life, most consumers believed that HASI contributed to improving their quality of life compared to before joining the program.[28]

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[26] HOME in Queanbeyan, accessed at the website: http://homeinqueanbeyan.org/whyhome.html

[27] V Carr, A Neil, S Halpin, & S Holmes (2002), Costs of Psychosis in Urban Australia, *National Survey of Mental Health & Wellbeing Bulletin 2*, Commonwealth Department of Health & Ageing, Canberra, p.34, cited in Leanne Craze, Glenn Jarvis, Anne Pratt, (2006) *Home-In-Queanbeyan: Putting the Case*, p. 19.

[28] J Bruce, S McDermott, I Ramia, J Bullen, and K R Fisher, (2012), *Evaluation of the Housing and Accommodation Support Initiative (HASI) Final Report,* for NSW Health and Housing NSW, Social Policy Research Centre, Sydney, p. 9.

More details on HOME and HASI, and other examples of models of long-term supported accommodation, are provided in Appendix A of this paper.

Conclusion

There is currently not the capacity to provide sufficient, and timely, support due to lack of suitable and sufficient accommodation options. It is important to emphasise that:

- There is a critical shortage of suitable supported accommodation in the community for people with mental illness – particularly long-term and 24/7 supported housing options. This may be a major reason why people remain in mental health facilities longer than necessary.
- There is a clear need for an increased supply and range of supported housing options that provide on-site support for 16 to 24 hours per day, and for services and support for people with psychosocial disability to be driven by flexible, person-centred and individualised approaches.
- Models like the NSW Housing and Accommodation Support Initiative (HASI) or Queensland's HASP are effective examples of supported accommodation and agency partnership for people with severe mental illness and associated disability in those states.
- The disability sector has a much larger number of long-term and highly supported accommodation options. However, current policy in the disability sector excludes people with psychosocial disability who have a primary diagnosis of mental illness from most of this accommodation.

Appendix A.
Models of Long-term Supported Housing

1. The Andrew Street, New Norfolk development

The Future Steps project involves a partnership with Housing and Micare and consists of 5 units (1 a staff base) in the New Norfolk area, which link prospective clients with Micare to provide support. Initially this project will be staffed by Millbrook staff that will provide an overnight support presence.

The units involve a master tenancy held by MHS, and include power, water and the like, as these expenses have been identified to be the biggest stumbling block in regard to community placements. Evening meals will be prepared by staff (as required) with support to prepare breakfast and lunch as well as on an individual basis as required. Also provided will be supports with shopping or other living skills supports as required.

Consultant (psychiatrist) cover will be provided from Millbrook Rise Court with links to local GPs for medical staff. This is an exciting opportunity and provides a tangible pathway out of the hospital setting for some of our long term clients who require ongoing intensive support. This is a good model for those with severe psychosocial disability who require long-term supported accommodation. It could provide the model for further similar units in the south and also throughout the state based on a comprehensive review of numbers requiring this level of housing provision.

2. The 'Housing First' model

This is the model used by supportive housing organisations such as Common Ground which has yielded some very encouraging results for people with lengthy histories of homelessness who are living with severe and persistent mental illness.

Housing first advocates correctly point out that poverty and socio-economic disadvantage combined with mental illness are the key reason for the high incidence of mental illness amongst people who have experienced recurrent homelessness. They maintain that the 'myth of deinstitutionalisation' ignores the very real experience of significant hardships, poverty and social exclusion amongst people with severe and persistent mental illness and have pointed out that affordable housing with ongoing support services is a more cost-effective and socially inclusive solution to the problem of chronic homelessness amongst this group than institutions.

Common Ground Tasmania (CGT) was established in 2008 to work in cooperation with State, Federal, Local government and the private sector to deliver supportive housing services to homeless people and more affordable housing for those in significant need. At this stage, despite vacancies, there seems to be no place within the Tasmanian Common Ground model for people with psychosocial disability requiring a high level of support. It may be that this is set to change, however many are currently excluded due to an inability to live independently. This model could be modified if the criteria is changed to include a targeted, sufficiently supported intake of this cohort.

However, whilst it makes sense to use Common Ground to begin to address the housing needs of this cohort, it must be noted that the need may be greater than the current Common Ground sites can provide.

3. Community and Cooperative Housing

Housing Tasmania has launched *Better Housing Futures* which significantly increases the amount of community housing in Tasmania. The provision of place-based tenancies in community managed social housing would work well for people with long-term severe mental illness if appropriate housing units were to be available for this cohort.

One good example of a cooperative model that might work is Laetare Court at Moonah. This is a disability co-operative community comprising 12 independent living units, plus a community house and respite/transitional unit. This model could provide the kind of support need to keep people with psychosocial disability safely and securely connected to community.

Further to this, community housing providers are well-placed to work closely with neighbourhood houses to help support people in this cohort. Neighbourhood houses are an important vehicle for social inclusion at the grass roots level of communities and the staff members often deal with consumers that manifest particularly difficult and challenging problems. However, this requires much more input and support from mental health services than is currently provided. With dedicated long-term housing and support in the community, the staff of the local neighbourhood house should be include in the support plan for these consumers and helped to provide services to them.

4. Housing Connect "Level Three"

Level Three Specialist Support Services (of Type 2 Housing Connect services) provide ongoing support to clients who continue to remain at risk of homelessness and require longer term intervention. Clients accessing this support are no longer in crisis but require longer-term support to prevent reoccurrence of homelessness or return to housing crisis. Clients who are referred to level 3 (Type 2) services:

- Present with limited social or family supports;
- Have minimal available resources;
- Present with multiple and complex needs;
- Have a history of failed tenancies; and
- Demonstrate minimal life skills required to maintain independent living.

The description above fits those mental health consumers described throughout this document as having long-term accommodation and support needs. This level of support is highly desirable, but it still requires that people be housed.

5. Hobart Hamlet (based on the Haven Foundation in Chapel Street South Yarra)

Hobart Hamlet is a newly Incorporated Association made up of a group of parents and volunteers working to establish a client based model of long term supported accommodation combined with appropriate services to enable better outcomes for people living with mental illness. Each member has an adult son or

daughter who has a serious mental illness. Each member has spent years battling the maze of mental health services in Hobart. Because of the unique situation of people suffering serious mental illness, mostly schizophrenia; our Tasmanian system of disconnected services and lack of appropriate supported long term accommodation, has failed in this regard.

Hobart Hamlet grew out of a group of proactive and passionate parents striving to establish suitable accommodation for our adult sons and daughters and others in need. Our research indicates that there is a huge gap between needs and available services for people who are seriously ill but still have the potential to lead a 'contributing life'.

This project is designed to assist approximately 14 residents aged over 21. The residents will have been assessed as having the potential to lead a contributing life and potential for independence. There will be 14 one-bedroom, self-contained units, each with its own cooking and laundry facilities. These will provide independent, long term accommodation for people with serious persistent mental illness. The building will be deliberately designed to allow for a degree of community interaction and social inclusion. The facility would include several indoor and outdoor communal spaces.

Selection criteria for residing at the units would include:

- clinical assessment of serious, persistent mental illness.
- Low income earners
- medical compliance (residents may not be on illicit drugs or act in some kind of uncontrolled manner. They will, however, be at the more severe end of the mental illness spectrum).
- they must be at financial disadvantage as indicated by their eligibility for disability support pension.
- Being at the risk of homelessness.
- Seriously affected by a severe and persistent mental illness and have an associated level of disability that cannot be met by alternative housing and support options.
- and for most of them there must be family and carer support.

6. HASI

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. Mental Illness Fellowship Victoria notes that:

For the recurrent annual program cost of less than $58,000 per person, HASI resulted in substantial decreases in hospitalisation rates, stabilised tenancies, improved mental and physical health, increased life skills, and social, educational and workforce participation.[29]

7. HASP

Queensland's Housing and Support Program (HASP), was established in 2006 to support individuals with psychiatric disability leaving acute and extended treatment mental health facilities. The 2010 evaluation report[30] shows that:

- There has been overwhelming support for HASP, with both clients and staff appreciating the holistic approach of the program, noting that collaboration between the agencies involved was integral to its success.
- The average time in inpatient care decreased significantly.
- Overall, the recurrent cost of keeping the 'average' client in HASP for 12 months is less expensive than keeping the same client in a Community Care Unit (CCU) and significantly less expensive than keeping the same client in an acute inpatient unit.

Programs such as HASP are not substitutes for the services of an acute inpatient unit, however, they provide the high level of support needed for consumers with psychosocial disability and greater initial support needs to make the transition into community housing options.

8. HOME, Queanbeyan

HOME provides 24 hour care for people with chronic mental illness who are without appropriate shelter, care, love and support. HOME sees itself at the beginning of a cultural shift in which communities lead the way in taking responsibility for citizens who are extremely vulnerable, isolated, and often homeless.

HOME delivers a purpose built; long term 'Home-in Queanbeyan', with 24 hour pastoral care and support. It aims to:

- Provide emotional and practical support to the residents of HOME so that they might develop a sense of belonging; are able to participate in meaningful activities; become valued members of the community; and are encouraged to build new relationships and networks.
- Generate broad community awareness about the plight of people with mental illness and encourage the involvement and support of local people, churches, community agencies, business and government.
- Help those with a mental illness and in need of supported accommodation to enjoy and maintain a place they can call home: a place to feel secure, and surrounded by community care.
- Work in collaboration with other existing and new programs to provide counselling, personal helpers and mentors, support workers and employment and training assistance and advocacy.

[29] Mental Illness Fellowship Victoria, *Submission to the Inquiry into the Provision of Supported Accommodation for Victorians with a Disability or Mental Illness*, 2008, p.8.

[30] Dr Tom Meehan, Kathy Madson, Nicole Shepherd, Dr Dan Siskind, *Final Evaluation Report of the Queensland Government's Housing and Support Program*, Wacol Qld: Department of Psychiatry (UQ) and Service Evaluation and Research Unit The Park, Centre for Mental Health, November 2010.