Evaluating the Independent Living Program

Phase 1: Policy Review
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The opinions expressed in this report are those of the authors and are not necessarily those of the Department of Health.


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1. OVERVIEW

1.1 Background

The Independent Living Program (ILP) is a supported housing program which has been in place for over 10 years. The Western Australian Centre for Mental Health Policy Research is undertaking an evaluation of the ILP, under the auspices of the WA Association for Mental Health and the Mental Health Division of the Department of Health, to provide options for the future direction of the program.

The evaluation has been separated into two phases. As a policy review, Phase 1 focused on program management, operational and service development issues. It was primarily based on findings from the literature, examples of best practice in other jurisdictions and input from extensive consultations with policy makers, service providers, consumers and carers. Phase 2 will be developed as a retrospective, longitudinal study to better understand the characteristics of those who are successful in maintaining their tenancies and to assess the impact of the program on hospital use.

This final report on the Phase 1 policy review should be read in conjunction with the report Reviewing the Independent Living Program: Discussion Paper for the Future Directions Workshop, which outlined the findings from the consultations and illustrated examples of best practice in supported housing programs.

1.2 The Issues

There was widespread support for the Independent Living Program (ILP), with most people recognising the substantial benefits it has brought to the lives of many consumers. It was not surprising to find, however, that after more than a decade of operation, many of the stakeholders wanted to talk about their concerns with the program and how things could possibly be done better.

Putting this into context, the program has grown by an average of 60 houses per year since 1995 so that now there are more than 650 people receiving support through the program. With tenancy failure rates well below 5%, the program has indeed lived up to one of its key objectives, that of providing an affordable, secure home for most participants in the program.

Whether the ILP has reduced hospital re-admissions for residents is not yet known. This and questions about the characteristics of tenants who leave will be addressed in Phase 2 of this evaluation.

The things that people have been most concerned about have been:

- The shortfall between the supply and demand for housing, particularly recently as rising prices have significantly reduced acquisitions;
- The provision of psychosocial support has not kept pace with the supply of housing, leading to questions about who should get access to the program;
- ILP providers reported a very varied experience in terms clinical support from Mental Health Service staff, with most wanting a stronger partnership; and
The lack of consistency in the way that the various ILP services across the State operated, particularly in terms of roles of the partners, assessment and selection of clients, management of waiting lists and management of housing.

Clearly, there are some basic measures that could be put in place to redress these difficulties within the ILP. The question is, however, would such measures be enough or is there a need for a more comprehensive response?

1.3 The Need

It has been estimated that, at any point in time, there are more than 7,000 West Australians aged 18 to 64 who suffer from psychotic illnesses. Based on Victorian data, we expect that around 4,500 of them could be getting significant benefit from participating in rehabilitation and support programs that provide a range of services that foster recovery and social inclusion.

Furthermore, based on the data from the 'low prevalence study', we believe that there are at least 1,100 people with a psychotic illness who are living in, marginal or unsatisfactory accommodation that would get considerable benefit from having access to supported housing as part of their rehabilitation and support program (Jablensky et al, 2000). Anecdotal information on waiting lists for the ILP tends to support this supposition.

Despite almost 15 years of National and State/Territory investment in service development since the launching of the National Mental Health Strategy, there has been growing concern amongst consumers and carers about the provision of mental health care across Australia. This culminated in the release of the reports Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia (Mental Health Council of Australia, 2005) and A National Approach to Mental Health – From Crisis to Community (Senate Select Committee on Mental Health, 2006). In both reports, the central thrust is for the development of community-based services for people with persistent or recurrent mental illnesses and disability.

All the evidence points to the fact that it has been these groups of people who have derived least benefit overall from the vast investment in service development that has been made since 1992. Jablensky and his colleagues found that, although the majority of these people now live in the community, only a minority attain a level of functioning and well-being that is commensurate with good quality of life. They concluded:

“The need for therapeutic, housing, rehabilitative and support measures that are likely to have an impact on the course of their disorders and their social adjustment remains largely unmet. There is at present international consensus that, even in the absence of primary prevention and radical cure, much of the disability and distress associated with the psychotic disorders can be prevented or reduced if the effective interventions and management strategies that exist today are widely available and applied consistently and systematically over the various stages of the illness.” (Jablensky et al, 2000, p. 235)

One of the major impediments to the proper care of people with psychotic illnesses has been the failure by most of the States/Territories to establish comprehensive, effective rehabilitation and support service systems aimed at improving their level of functioning and well-being.
1.4 The Vision

We argue that, while increasing the supply of housing and the level of psychosocial support available for people in the ILP will bring a degree of benefit for those that are fortunate enough to get into the program, it will do little to assist the large group that are not part of, or are unable to get into, the program. What is required is a comprehensive rehabilitation and support system offering a range of services, with services tailored to the needs of each individual. Stable affordable housing is essential but is, in itself, not sufficient to ensure recovery for people with mental illness and disability.

This was brought home forcibly during the review in consultations with ILP tenants who, while very supportive of the program, spoke of their needs for employment, meaningful activity, education and training, friendship/companionship, social inclusion and budgeting assistance, as being largely unmet.

The review puts forward a vision, modelled on the Victorian system, which is generally regarded as the most effective in Australia, of a rehabilitation and support system that operates as a partnership between Mental Health Services and the NGO sector to provide a comprehensive and seamless network of services that promote recovery and social inclusion for people with psychotic illnesses and disability.

As part of this vision, it is envisaged that the public sector ‘clinical care and rehabilitation services’ will operate as discrete area-based services separate from the acute treatment services. Within this model, the ILP would continue to be actively developed as ‘one program’, albeit a very important one, within the broader rehabilitation and support services system. We believe that this model would not only ensure access for all clients, regardless of their housing and accommodation arrangements, to a full range of services, but would also facilitate the development of close partnerships between MHS clinical care staff and psychosocial support providers, something that has been largely underdeveloped to date.

1.5 Priority for Access

We consider that priority for access to the rehabilitation and support services system, including the ILP, should be accorded to people with persistent or recurrent psychotic illnesses, who, as a result of their disability have lost, or are at risk of losing, essential life roles. Particular consideration should be given to providing entry to the program for people at an early stage in their illness where timely access to stable housing may help prevent progressive impairment.

1.6 Future Directions

The recommendations are set out under the major themes that were identified during the consultation phase of the review.

There are three broad objectives that underpin these recommendations. There is a set of recommendations aimed at improving the operational management of the ILP. These recommendations are particularly targeted at:

- Increased specificity in prioritising clients for entry to the program;
- Improved processes for acquiring, allocating, managing and assigning housing;
• Improved systems for developing and managing waiting lists;
• Standardised assessment of support needs;
• Ensuring that all people entering the program get psychosocial support based on their assessed needs;
• Developing and implementing an appropriate model(s) for funding support needs; and
• Implementing a system for improving partnerships between stakeholders.

There are a set of recommendations aimed at growing the capability and capacity of the ILP. These recommendations are particularly aimed at:

• Limiting the role of the landlord and separating it from the psychosocial support provider role;
• Working across the public, non-government and private sectors to double the number of houses in the program over the next 5 to 6 years; and
• Expanding the supply of psychosocial support services provided by the NGO sector to ensure that all people in the program have a level of support that matches their assessed needs.

Finally, there are a set of recommendations directed at building the rehabilitation and support services system. These recommendations, which are in line with the Vision outlined above, are particularly aimed at:

• Expanding the supply of psychosocial rehabilitation and support services provided by the NGO sector to ensure that all people who require rehabilitation and support, regardless of their housing and accommodation arrangements, have access to a level of support that matches their assessed needs;
• Separating the public sector ‘clinical care and rehabilitation services’ from the acute treatment services to enable them to operate as discrete area-based services;
• Developing & implementing standards for psychosocial support services;
• Upgrading training and workforce development in the area of psychosocial rehabilitation and support; and
• Strengthening capacity in the rehabilitation and support sector.

Clearly, it would not be feasible, nor indeed desirable, to introduce this whole package of changes in the short-term. Rather, we envisage that the areas of work outlined above would be progressed simultaneously rather than sequentially as part of a 5 to 6 year program of development and implementation.
2. BACKGROUND

By the 1970s, as the de-institutionalisation of people with mental illness reached its peak, the mental health system had developed a model of residential care, which has been termed the ‘Linear Continuum’ or ‘Transitional’ model. This model was characterised by the provision of a continuum of accommodation settings (e.g. hostels, group homes, cluster homes, individual houses/apartments) that provided different levels of supervision (e.g. continuous staffing, visiting and on-call staff). Under this model consumers were matched to a setting based on their level of functioning and need for supervision. In each setting, the client was expected to gain the skills necessary to progress to a more ‘normal’, less restrictive setting. Typically, decision-making remained with staff members.

In the late 1980’s the ‘Supported Housing’ model emerged as the dominant model in the USA. The principles on which the model is based are:

- **A Home**: the house is a permanent home and not a residential treatment service;
- **Choice**: choice of housing is based upon consumer preference;
- **Clients Control**: control of the environment is moved from the staff to the consumer and they decide the level of support they need at any given time;
- **Citizenship and Social Integration**: houses are normal houses dispersed throughout the community and consumers, as community members, are supported in participating as fully as possible in the life of the community; and
- **Individualised Supports**: support is individualised and flexible, according to the consumers’ needs and wants.

[Ridgeway and Zipple, 1990; Hogan and Carling, 1992]

The most important element of the Supported Housing model is the development of a permanent, secure home in the community; one that reflects, to the greatest extent possible, the individual’s own ideas concerning an appropriate home. The home is then supplemented by the development of skills associated with community living, participation in the life of the community, the provision of a personalized set of support services and, where necessary, medical and therapeutic services based on the needs of the individual. As the client’s needs change, the supports and services can be introduced or withdrawn. The model also seeks to draw resources from the community.

The ILP was, and continues to be, based on the Supported Housing model. It was established in 1995 as a joint initiative between the Department of Housing and Works (DHW) and the Department of Health (DoH) to assist people with severe and persistent mental illness and associated disability to live independently in the community.

The ILP enables people with a psychiatric disability to rent DHW properties, via a lease with a NGO supportive landlord agency. The supportive landlord role is funded by the DoH to provide services that assist in establishing and maintaining people in stable housing. Ideally, people living in these properties should be receiving psychosocial support services from non-government agencies, which are funded by the DoH, and clinical services from public or private mental health providers.
3. THE EVIDENCE

The key questions raised in the ongoing debate about models of housing provision are:

- Which housing model gives the best client outcomes?
- Does the Supported Housing model work for all clients?

The short answer to the first question is that the evidence to date does not provide a definitive answer. A recent analysis of the literature concluded:

“…results indicate that housing with supports in any form is a powerful intervention that improves the housing stability of individuals with mental illnesses……..dramatically demonstrating the effects of housing in maintaining residential stability, decreasing homelessness and decreasing hospitalisation.”

[Rog, 2004]

There is considerable consistency in the characteristics of consumers that are associated with poorer outcomes in the literature on Supported Housing. Those clients who do not fare as well tend to be younger with relatively more impairments and have co-morbid substance abuse. It needs to be recognised, however, that there are significant variations in organisational arrangements, population characteristics and type and range of support services in terms of programs that fall within the rubric of Supported Housing.

One such program, the Pathways to Supported Housing, took homeless people with serious mental illness and substance abuse straight off the streets of New York and placed them in scattered, individual apartments. Support services were provided by a team using a modified assertive community treatment model, which allowed clients to determine the type and intensity of services or refuse them entirely. After 5 years, 88% of the program’s tenants remained housed, 65% were receiving treatment from the program’s psychiatrist and 27% were employed for at least part of the final year of the study. Many of them were no longer abusing drugs. (Tsemberis & Eisenberg, 2000)

The NSW Housing and Support Initiative (HASI), which is one ‘variant’ of the Supported Housing model, is a partnership program between NSW Health, the Department of Housing and the Non-Government sector.

It provides housing that is linked to clinical services and to ‘funded packages’ of psychosocial rehabilitation and support. These funding packages, which have targeted people with mental illness and disability, have ranged from $10,000 per person per annum for people with low support needs to $70,000 per person for people with very high support needs. The $70,000 provides for up to 8 hours of support per day and, although it may seem high, represents only a fraction of the cost of recurrent and/or extended inpatient care.

Evaluation of the program to date has shown high levels of housing stability, reduced use of inpatient services, improved social functioning and high levels of consumer satisfaction. (Social Policy Research Centre, 2006)
The question as to whether the Supported Housing model works for all client needs, therefore, to be qualified in terms of what are the objectives of the program (increase housing stability, reduce inpatient care), who are the clients being targeted by the program (people with low or very high support needs, co-morbid substance abuse) and what support services are being provided (tenancy support, assertive community treatment, funding and support packages). The HASI program, which is undergoing ongoing and extensive evaluation, should provide good evidence of what can be achieved by an intensive, targeted, well-funded program.

There are two important issues that should be considered in this debate. Firstly, that consumers have consistently and overwhelmingly expressed a preference for independent housing with individually tailored support rather than group homes or other congregate models that ‘bundle’ housing and treatment services (Brown et al., 1991; Carling, 1993; Tanzman, 1993; Nelson et al., 2006). Secondly, that key objectives for people with mental illness and disability are ‘recovery’ and ‘social inclusion’, not simply ‘treatment’ and ‘care’.

Social inclusion may be defined in terms of improved rights of access to the social and economic world, new opportunities, recovery of status and meaning and reduced impact of disability. Key issues are availability of a range of opportunities that users can choose to pursue, with support or adjustments where necessary; for example, education, work, joining social, cultural and religious groups, friendships and relationships, raising a family and participating in civic life. Typical and normalised housing, as found in the Supported Housing model, constitutes a housing environment that is more conducive to community integration; although of course, it does not, in and of itself, guarantee it.

The overall message from the literature is that Supported Housing has proved successful, even for people who are severely disabled, those who have been homeless for extended periods of time and/or are disaffiliated from the mental health system. It is a complex intervention with multiple goals, interventions and outcomes. Successful programs have not concentrated exclusively on housing issues, but have been multifaceted interventions. No one model of programming or one method of service delivery has emerged as the most efficacious approach to practice.

Supported Housing has been found to produce an impact beyond simply getting people into housing. It has been found to improve the quality of life, engender stability, reduce the use of costly inpatient services and increase the level of social interaction and functioning people experience. Although it has not to date been found to be more efficacious than other forms of ‘supportive’ housing, it is the model that is most highly preferred by consumers.
4. THE REVIEW

Evaluation of the ILP has been separated into two phases: The objective of the first phase, which relied heavily upon the opinions of providers and consumers for identification of important issues, was to provide options for the future policy directions for the ILP.

The second phase, which has a longer time frame, will take the form of a quantitative analysis of the data. It will assess:

- the impact that the ILP has had on the use of mental health inpatient services;
- which client groups the program has primarily served; and
- the characteristics of clients who have successfully maintained their tenancies and those that have been unable to do so.

4.1 The Review Process

Phase 1 of the research was conducted under the auspices of the Mental Health Division, Department of Health and the WA Association for Mental Health, with additional guidance provided by the ILP Evaluation Research Steering Committee.

The steps that were followed in Phase 1 are outlined below.

| 1. Background Information | • Discussions with the MHD and the DHW on current and emerging program and policy issues for the ILP; • Preliminary identification of key issues with ILP Evaluation Research Steering Committee. |
| 2. Consultations | • Face to face, telephone or group consultations with consumers, service providers and policy makers to ascertain their views on issues in the current ILP; • Telephone interviews with key interstate NGOs and Government Departments with experience in supported housing programs. |
| 3. Literature Search | • Electronic literature search; • Key policy documents identified during consultation. |
| 4. Future Directions Workshop Paper | • Summary of key themes identified during the consultations, major findings from published literature and similar programs in other jurisdictions and key questions to be debated at the Workshop. |
| 5. Future Directions Workshop | • Key stakeholders to debate future directions for the ILP. |
| 6. ILP Review Report | The Report will: • Synthesize the results of evidence and experience from other Australian and international housing support programs; • Outline the results of consultations with key stakeholders on current program issues and future directions; and • Propose options for future policy directions for the program. |
4.2 Progress of the Review

A discussion paper *Reviewing the Independent Living Program: Discussion Paper for the Future Directions Workshop* was prepared based on the key themes that emerged during the stakeholder consultations, major findings from published literature and similar programs in other jurisdictions. Four key themes emerged:

1. Housing;
2. Support (Property & Tenancy Management, Psychosocial Rehabilitation and Support, Clinical Care and Rehabilitation);
3. Managing the Program; and
4. Quality.

A number of questions aimed at exploring themes 2, 3 and 4 in more depth were developed, following which the paper was circulated to inform discussion at the *Future Directions Workshop* in November 2006. The first theme, housing, essentially revolved around the fact that the supply of housing had not kept pace with demand. While the need for increased housing was indisputable and vital, the solutions were felt to be too complex for resolution at a workshop and required a broader Government response. The key questions, which were put to participants at the Workshop, are set out in Appendix 3.

The Workshop was held on Tuesday 28 November 2006 at Lotteries House in West Perth. A presentation was given at the Workshop outlining the features, including the strengths and weaknesses, of the ILP and comparing it with the New South Wales and Victorian supported accommodation programs. Two scenarios were also put to Workshop participants outlining what the ILP may look like in 2012:

**Scenario 1:** *Strengthening the independent living program*

The focus in this scenario was specifically on improving and strengthening the Independent Living Program. The scenario was built around clients and their housing need.

**Scenario 2:** *Building the rehabilitation and support system*

The focus in this scenario was on improving and strengthening the supported housing program, but within the broader psychiatric rehabilitation and support system. The scenario was built around *clients and their overall rehabilitation and support needs*.

The two scenarios were meant, therefore, to represent the two ends of a continuum. They were presented to expand peoples’ thinking about what the WA supported housing program *could* look like in 5 years time. The Workshop Presentation can be found in Appendix 1, the future scenarios in Appendix 2, the Workshop discussion questions in Appendix 3 and the list of workshop participants in Appendix 4.
5. SETTING THE FRAMEWORK FOR THE FUTURE OF THE ILP

The most fundamental questions, which need to be addressed in looking to the future of the ILP, revolve around the objectives together with the philosophy and principles that underpin the program. Put succinctly, what is the program trying to do, for whom and with what expected outcomes?

5.1 Redefining the Objectives

The ILP operational guidelines make it clear that the program is aimed at providing secure and affordable housing for people with severe and persistent mental illness to assist them to live as independently as possible in the community. The program is expected to give priority to people who are homeless, at risk of homelessness or otherwise having difficulty because of their illness in maintaining stable tenancy.

The NSW Housing and Support Accommodation Initiative (HASI) program goes further; namely, the program aims:

“to assist people with mental health problems and disorders requiring accommodation [disability] support to participate in the community, maintain successful tenancies, improve quality of life and most importantly to assist in the recovery from mental illness”.

[NSW Health and NSW DoH, 2005]

In its submission to the Senate Select Committee on Mental Health in May 2005, Vicserv, representing the Psychosocial Disability and Rehabilitation Support Sector in Victoria, wrote:

“The role of the Home Based Outreach (HBO) worker is to support consumers, assisting them to generate independent living skills, community links, and friendship networks and to engage in the recovery process. One of the most significant initiatives which allowed the development of HBO as the single greatest component of Psychosocial Disability and Rehabilitation Support (PDRS) was the Housing and Support Program (HASP).”

What NSW and Victoria have attempted to do, is to set the housing program within the broader framework of psychosocial disability and rehabilitation, underpinned by the philosophy of Recovery, which has been defined as:

“…. a process, sometimes lifelong, through which a consumer achieves independence, self esteem and a meaningful life in the community.”

[Power et al, 2003]

Social inclusion, defined earlier as encompassing improved rights of access to the social and economic world, new opportunities, recovery of status and meaning and reduced impact of disability, is being introduced in the UK as the policy framework within which mental health services are being developed. Recovery and social inclusion need to be seen as the two sides of the same coin; recovery being the individual journey and social inclusion the philosophy, which guides the service response.

The significance of this is that the ILP is not simply a housing program, aimed at ensuring secure tenancy, but a housing and support program, the objective of which is to provide both secure tenancy and psychosocial rehabilitation and support services for people with mental illness and
associated disability to aid their personal recovery and to help facilitate their integration into the community.

As outlined earlier, two scenarios were put to the Workshop held in November 2006. The first focused on improving the ILP essentially by ensuring that all clients entering the program received individually tailored support services and by bringing greater clarity and consistency to the way in which the ILP operated (e.g. roles of the partners, eligibility for access to the program, assessment of client needs, maintenance of the waiting list and management of the housing).

**SCENARIO 1: STRENGTHENING THE INDEPENDENT LIVING PROGRAM**

The second scenario looked at building the Supported Housing program, but as a component, albeit an important one, of a broader Psychiatric Rehabilitation and Support System, similar to the model that had been developed in Victoria.

**SCENARIO 2: BUILDING THE REHABILITATION AND SUPPORT SYSTEM**
There was a range of views expressed by attendees at the Workshop in relation to the scenarios. Amongst those who leaned more towards the first scenario, there was concern that the program may lose something if it moved “too far, too fast” and that any change needed to be measured and steady.

There was a general recognition, however, that the ILP was more than simply a housing program and that psychosocial support, incorporating a range of interventions tailored to individual needs, should be a central component of the program.

Irrespective of any consideration about the rate of development, we are of the view that, over the next five years, WA should be putting in place a Psychiatric Rehabilitation and Support System (PRSS) similar to the Victorian model within which the ILP would continue to be actively developed as a component, albeit a very important one. It is envisaged that the PRSS would be underpinned by the philosophy and principles of Social Integration and Recovery.

This has a number of implications for both the ILP and for the broader system. Effective recovery from serious mental illness requires a combination of clinical treatment and intensive community-based psychosocial rehabilitation and support services. In Victoria, where this model is most advanced, these services are provided through a partnership between the government and non-government sectors. Planning for the development of these services involving all stakeholders needs to be initiated, incorporating a timetable for funding strategy.

In terms of the ILP, entry to the program would be through referral to the PRSS and follow a full assessment of needs. All people entering Supported Housing would, therefore, have an individual service plan and would be in receipt of psychosocial support.

### 5.2 Setting Priority for Entry

Priority for entry to the ILP, or indeed the broader PRSS, should be accorded to people with persistent or recurrent psychotic illnesses who have lost, or are at risk of losing, essential life roles. Particular consideration should be given to providing entry to the program for people at an early stage in their illness where timely access to stable housing may help prevent progressive impairment.

An Australian study, *People Living with Psychotic Illness* (Jablensky et al, 1998), which sampled people with psychotic illnesses receiving treatment, (62% schizophrenia/Schizo-affective Disorder, 20% Bipolar Disorder and 15% other non-organic psychoses) found that:

- The peak age of onset for psychotic illnesses is in youth (15 – 25) and, while 21% had periods of recovery, in 71% the illness was either chronic or recurrent with only partial recovery between episodes;
- 49% had persistent distressing delusions and 36% persistent hallucinations;
- 80% had deteriorated in function as a result of their illness, with 26% of men and 19% of women showing very severe deterioration of functioning;
- 30% showed severe dysfunction in their ability to care for themselves, 60% in their overall socialising and 58% in their social interactions;
- 72% were unemployed and two thirds of those who were employed had not been in regular full-time employment in the previous year;
63% were single and 21% separated, divorced or widowed;  
30% had a history of alcohol abuse and 24% daily use of cannabis; and  
Around 20% were in a lodge or hospital, 16% in a group home or hostel and 11% in marginal accommodation, including 9% with no fixed address.

The study found that people with psychotic illnesses were very high users of specialised mental health services. Just over half had been admitted to an inpatient unit during the preceding year, with 24% reporting two or more admissions in that year. Half of those admitted had at least one involuntary admission. The mean length of stay was 13 weeks. On the other hand, participation in a rehabilitation program or other program aimed at improving their functioning was low (19%).

A high proportion (44%) had at least one contact with an emergency service during the preceding year, including 20% who had attended a general hospital emergency department. They were also regular and frequent users of welfare services, the three most common being the Commonwealth Department of Social Security (69%), Housing and Works (25%) and the Commonwealth Employment Service (25%).

Based on the prevalence figures from this study (4.7 per 1,000), it has been estimated that in any one-month period, there are close to 7,000 Western Australians aged between 15 and 64 with psychotic illnesses. In 2002, there were over 11,000 people in Victoria with mental illness and disability receiving psychosocial rehabilitation and support from the Psychosocial Disability and Rehabilitation Support Services (PDRSS), which is the NGO sector of the State’s rehabilitation services. This represents around 65% of the estimated 17,000 people with psychotic illnesses at any point in time in that State. This would translate into approximately 4,500 people in the WA context.

In a report on the ‘low prevalence disorder’ study the authors concluded:

“The majority of people with persisting psychotic disorders now live in the community, but only a minority attain a level of functioning and well-being that is commensurate with good quality of life. Many of the services available to them tend to be provided on a crisis-response basis. The need for therapeutic, housing, rehabilitative and support measures that are likely to have an impact on the course of their disorders and their social adjustment remains largely unmet. There is at present international consensus that, even in the absence of primary prevention and radical cure, much of the disability and distress associated with the psychotic disorders can be prevented or reduced if the effective interventions and management strategies that exist today are widely available and applied consistently and systematically over the various stages of the illness.” (Jablensky A, et al, 2000)

**Recommendation 1**

*Develop a Psychiatric Rehabilitation and Support System (PRSS), based on the Victorian model, that operates as a partnership between Mental Health Services and the NGO sector to provide a comprehensive and seamless network of services to foster recovery and social inclusion for people with mental illness and disability.*
Recommendation 2

Strengthen and expand the Independent Living Program (ILP), the WA Supported Housing Program, being cognizant of the fact that it will become one program, albeit a very important one, in the PRSS.

Recommendation 3

Accord priority for access to all components of the PRSS, including the ILP, to people with persistent or recurrent psychotic illnesses who have lost, or are at risk of losing, essential life roles. Particular consideration should be given to providing entry to the program for people at an early stage in their illness where timely access to stable housing may help prevent progressive impairment.
6. HOUSING

As outlined earlier, the supply of housing within the ILP has not kept pace with demand and this has been reflected in the growing waiting list. Currently within the ILP, there are 650 housing units, which have been accruing at about 60 houses per annum over the past 10 years. In recent times, the cost pressures within the WA housing market have seen a significant decline in the housing allocation. NSW and Victoria are facing similar challenges. This raises the questions of just how many houses we should be aiming for to clear the backlog and meet new demand and how can we achieve this.

If we were to look simply at the people who were found to be in marginal or unsatisfactory accommodation in the study by Jablensky et al (2000), WA would need at least 1,100 housing units today. On this basis, we are of the view that we should aim to double the number over the next 5 years to 1,300 housing units. That would require the addition of 130 units per annum to the housing stock. Given that we have been having difficulty in meeting the current housing quota, new strategies will be required.

There is clearly no straightforward way that this can be achieved. It will require a commitment from Government to pursue a broad intersectoral approach across both the public, community housing and private sectors. Options worth considering in this context include:

- Setting up a ‘Disability Housing Trust’: This could be modelled on the Victorian initiative, which was launched last year with an initial commitment of $10 M from the Government.
- Private rental market initiatives: There are many different options that could be considered including:
  - Community Housing Associations entering into lease agreements with private rental investors;
    - Government making grants to private investors for the re-development of apartment blocks in return for guaranteed access to a percentage of units at agreed costs over a fixed period of time (Massachusetts, USA); and
  - Rental subsidies for eligible consumers to enable them to access private rental properties (‘Section 8 Housing’ subsidy system, USA).
- Public Private Partnerships: Private investment could be sought for the construction cost of housing, with the housing rented back to the public sector (UK public sector).
- Joint ventures between Department of Housing and Works (DHW) and the community sector including:
  - Large Community Housing Associations using their equity to partner DHW in developing additional housing stock; and
  - NGOs using equity in property to partner DHW.

There are clearly significant cost implications in the proposed expansion of the ILP, particularly in terms of capital outlay for housing. On the other hand, the recurrent cost savings are likely to be substantial. The Social Policy Research Centre, University of New South Wales, which has been evaluating HASI Stage 1 found that not only had 85% of the clients maintained their tenancy, but also there had been a 90% reduction in the use of hospital bed days and a 50% reduction in substance abuse disorders.
It has been estimated that HASI Stage 1 saved over $7 million in the first year, despite funding packages of $50,000 per client per year for 118 clients with high support needs. A number of studies of Supported Housing have recorded similar significant reductions in the use of psychiatric inpatient services and other public sector services. (Culhane, 2002; Martinez & Burt, 2006; Harkness, 2004).

**Recommendation 4**

_Pursue a broad intersectoral approach across both the public and private sectors, to find ways of doubling the number of housing units in the ILP over the next 5 years._
7. SUPPORT SERVICES

The ILP aims to improve housing stability and community participation for people with mental illness through the provision of community-based housing and coordinated support services. There are three component parts to the support services that are essential to the program:

- Property and tenancy management - the supportive or benevolent landlord role;
- Psychosocial rehabilitation and support; and
- Clinical care and rehabilitation.

7.1 Property and Tenancy Management

One of the key objectives of the ILP is to provide a long-term, secure and affordable home for people who, because of psychiatric disability, have difficulty in maintaining their tenancies or participating in community life. The landlord role is, therefore, a critical one.

Originally, the landlord role and the psychosocial support role were developed separately, but a subsequent change in policy has seen a few organizations successfully take on both roles and by way of contrast, one rural psychosocial support provider transfer the landlord function to a local housing association. Recently, several social housing providers have merged into two large housing associations, Access Housing Association in the southern metropolitan area and Foundation Housing in the north.

Questions were raised at the Workshop about:

- Whether the two roles landlord and psychosocial support should be managed in separate organizations or within a single organization?
- What should the landlord functions actually be?
- Whether the landlord role should be maintained by the human service sector NGOs or moved across to the Community Housing Associations (CHAs)?

Despite the strong ideological position common amongst some adherents of the Supported Housing model promoting the separation of these roles, there is no evidence in the literature on what organisational approach works best. Many workshop participants had no difficulty with the concept of managing both roles, albeit programmatically and structurally separate, within a single organization. Opinions were more mixed in relation to whether the landlord role should be moved across to the CHAs.

Subsequent feedback on the draft final report highlighted the concerns of organisations who perceived they, or their member organisations, would be adversely impacted on by the recommendation to separate the landlord and support roles. Their concerns were mainly on the difficulties of sharing confidential client information and the added complexity of co-ordinating services and communicating across organisations.
The landlord role, which has evolved over time, has been strongly influenced by the lack of access to psychosocial support services for many of the clients of the landlord agencies. This has led to them expanding their own roles in an effort to combat such problems as social isolation and loneliness, neighbourhood challenges and financial management. In addition to their property and tenancy functions, some landlords undertake the following:

- Assist tenants to identify and source household items in addition to those provided by Lotterywest;
- Invest considerable time in the partnership with the local MHS and support provider including participating in regular allocation and management meetings;
- Pay for cleaning of a property in order to maintain the tenancy or pay for alterations to the property;
- Manage difficulties and complaints from neighbours; and
- Arrange social activities for tenants.

The landlord role is much clearer in NSW and Victoria where the public housing authorities and CHAs provide a more limited, traditional landlord role. Neither DHS Victoria nor NSW Health funds the landlord role. Under the NSW HASI program, for example, the ‘Social Housing Provider’ is responsible for:

- Developing acquisition briefs, acquiring stock on the private market and providing replacement properties;
- Outlining the roles, responsibilities and expectations of the CHA to the tenant and ensuring the tenant understands the Residential Tenancy Agreement;
- Informing the tenant about the services available through the CHA;
- Providing sensitive, responsive housing management to the tenant;
- Asset managing any of the properties headleased from the Office of Community Housing; and
- Promptly informing the Support Provider and Area Mental Health staff about matters that affect staff safety, breaches of the lease or any other matters that may affect the sustainability of the premises.

After due consideration of all the arguments put forward about the future direction of landlord services and discussions with experts in the field in the other States, the reviewers recommend that we bring the role of the ‘supportive’ landlord into line with that or the Social Housing Provider in NSW and, further, that this role be taken on by the WA Community Housing Associations. The DoH funding currently going into landlord services should then be transferred into funding NGOs for the provision of psychosocial support services.

There are a number of significant benefits in the CHAs becoming the housing providers:

- It brings clarity to the role of the landlord and prevents the ‘cross-subsidy’ of support services for clients by the landlord;
- It highlights the need for all ILP clients to be provided with tailored psychosocial support services;
- CHAs with large housing stocks will provide greater choice for clients and will be able to rotate stock if clients leave to prevent houses becoming ‘stigmatised’.
Clients who no longer need psychosocial support services will be able to exit the ILP program, but remain in their home as regular tenants of the CHA;

Larger CHAs will have the potential to enter into joint ventures with DHW to expand their housing stock; and

It ensures that DoH funding goes into psychosocial support where it is most needed.

As outlined above, there are a number of NGO landlord agencies that are currently providing a range of support services that go well beyond the functions that will be subsumed within the new role of the housing provider and this will require complementary changes to the psychosocial support provider role to ensure that these functions are not lost.

The move to the CHAs taking over the housing provider role is complex given the mix of current arrangements and an implementation plan will need to be developed in conjunction with the stakeholders. The concerns raised by organisations which currently combine both the landlord and psychosocial support roles also need to be adequately addressed and managed through this transition process. We envisage that the changes will need to be implemented in a series of steps involving:

- All newly acquired housing stock being managed by the CHAs;
- Agreement in principle to the current NGOs gradually transferring from the landlord to the psychosocial support roles, and the development of a transfer plan and timetable; and
- Development of a plan, including costings and timeframe, for increasing the provision of psychosocial support services to a level that ensures that there is adequate support to meet the needs of the priority groups as outlined earlier.

**Recommendation 5**

*Limit the role of the landlord agency to being one of a Social Housing Provider with responsibility for more traditional property and tenancy management functions as is the case in the NSW (HASI) the Victorian (HASP) supported housing programs.*

**Recommendation 6**

*Separate the role of the Social Housing Provider from that of the Psychosocial Support Provider, with the NGO human service sector taking on the latter role. This transition should be undertaken in a staged way in close consultation with the current NGO services providers who will be affected by the change.*

**Recommendation 7**

*Undertake a staged transition of the Social Housing Provider role to the Community Housing Association sector.*

**Recommendation 8**

*Restrict funding from the Department of Health to the provision of Psychosocial Support Services, with the Department of Housing and Works funding the Social Housing Provider services if, in fact, required.*
7.2 Psychosocial Rehabilitation and Support

The research has consistently shown that clinical treatments, including medications, are not enough to ensure recovery of people with psychotic illnesses and associated disabilities and that psychosocial rehabilitation is an important aspect in the mix of services.

It has also been shown that within the broad framework of psychosocial rehabilitation, a range of services need to be available, with the mix tailored to the needs of each individual. For example, if a person wishes to continue formal education or wants to get employed or wants to establish a stable home, then supported education or supported employment or supported housing programs respectively are not only useful but necessary to maximise the possibility of success.

As outlined earlier, the ILP program is not simply a housing program. Stable, affordable housing is important, but not sufficient to ensure recovery, and psychosocial rehabilitation and support needs to be seen as an essential component of the program.

Of course, the need for psychosocial support is not limited to people within the ILP, but should be available as part of the mix of services for all people with psychotic illnesses and associated disability, regardless of whether they live in their own home, with parents, in private rental accommodation, in temporary or transitional accommodation or are homeless.

As outlined in the earlier Discussion Paper, the largest and most common concern expressed by all the stakeholders, including residents of the program, was that the provision of psychosocial support had not kept pace with the supply of housing. This was compounded by the fact that there was no definitive link between funding for psychosocial support services and client entry into the program. These points were reinforced by attendees at the Workshop.

The document entitled Supported Community Living for People with Psychiatric Disability (Office of Mental Health, July 2003) commented that:

“The level of support historically provided through these services is primarily suited to people with low to moderate support requirements. A Survey of providers showed that the majority of ILP residents were receiving 10 or less hours per month.”

It went on to say:

The Independent Living Program will continue to grow .... but with greater emphasis on increasing the levels of disability and social support so that it can properly meet the needs of people with greater levels of disability”

In fact, the ILP has continued to grow each year with additional properties coming on line from DHW, but without the commensurate growth in funding for psychosocial support services. As a result people have been questioning the suitability of the program for people with higher levels of disability an/or co-morbidities.

As can be seen from the NSW HASI program evaluation, supported housing programs can produce extremely good outcomes, even for people with high support needs, including co-morbidities, providing appropriate levels of support in place.

Based upon the Victorian figures, it has been estimated that there are 4,500 people who, because of persistent or recurrent psychotic illnesses and disability, could benefit substantially from receiving psychosocial rehabilitation and support services, including many of the residents within the ILP.
At present, there are no readily available figures on just what percentage of the 650 residents in the ILP are actually getting support services.

In both NSW and Victoria, the NGO sector has been given the primary role of providing psychosocial rehabilitation and support services, but within very different contract and funding models. The NSW model has primarily been built on very tightly focused housing and support packages for specified client groups. These packages, which have ranged from $6,000 for low support to $70,000 for very high support per client per year, have been put out to tender for services to be provided by NGOs. This is illustrated diagrammatically below.

NEW SOUTH WALES HOUSING AND ACCOMMODATION INITIATIVE (HASI)

The Victorian model, on the other hand, is based upon a funding formula of 1 NGO worker for every 5 to 10 clients depending upon the assessed level of support needs of the clients. The Victorian housing program, the Housing and Support Program (HASP), is firmly embedded in the Psychiatric Disability Rehabilitation and Support Service (PDRSS) program. Housing is clearly one of the key areas of need that is assessed for each client in the PDRSS. The sector provides a range of activities, which enable people to access programs in different environments including:

- Psychosocial Rehabilitation Day Programs;
- Home-based Outreach Support;
- Residential Rehabilitation;
- Supported Accommodation (including HASP);
- Carer Support;
- Planned Respite Services; and
- Mutual Support and Self Help Services.

All people entering the housing program in Victoria, by ‘definition’, are in receipt of support services. This is illustrated below.
Given the stage that the ILP is at, with a program that has now been in operation for more than a decade and has over 650 housing units, it would seem most appropriate that WA go generally with the Victorian funding model, although the NSW package of care approach could be used for situations in which mental health services are seeking to target a particular class or group of clients (e.g. young people with complex needs, including dual disability; people considered ready for discharge from supervised accommodation programs; or extended stay inpatients).

It would not be economically feasible, or indeed practicable, to build up the psychosocial rehabilitation and support services immediately to cover 4,500 people and an implementation plan will need to be developed in conjunction with the stakeholders. We envisage that the development will need to be implemented over 5 years in a series of stages:

- **Stage 1:** Build up the support services to ensure that all new clients entering the ILP have appropriate support services in place;
- **Stage 2:** Identify unmet psychosocial support needs amongst current residents of the ILP and amongst clients who are not resident in the ILP;
- **Stage 3:** Implement a program to ensure psychosocial rehabilitation and support services are professionally expanded through the NGO Sector to the estimated 4,500 people who would be likely to gain significant benefit.

As outlined above, it is envisaged that around 4,500 people will be receiving psychosocial rehabilitation and support by the end of year 5 of the development program. With a ratio of 1 staff member to every 10 clients, it is estimated that 450 staff will be required at a cost of approximately $25 million. Higher support need clients would require increased staff ratios.

It is not clear what the level of unmet need is currently amongst ILP residents and therefore it is difficult to comment on the growth required to cover this need, but with an estimated 130 new houses coming on line each year over 5 years, a further 13 staff will be needed annually ($0.72 million).

NSW, to date, has committed $20.3 million in recurrent funding each year to meet the psychosocial support needs of some 754 clients, including 460 places for people with low, 244 with high and 50 with very high, support needs. The potential, however, for reduced recurrent expenditure on inpatient bed days is very high as demonstrated by the HASI 1 evaluation.

**Recommendation 9**

*Determine an appropriate model or combination of models for funding psychosocial rehabilitation and support services, which reflect the varying support needs of client groups.*

**Recommendation 10**

*Expand the level of psychosocial rehabilitation and support being provided through the NGO sector in the following stages:*

- **Ensure that all new clients entering the ILP receive an appropriate level of psychosocial support;**
- **Conduct an audit of unmet need for psychosocial support amongst existing ILP clients and put in place a program for meeting these needs; and,**
• Develop and implement a strategy for the progressive expansion of psychosocial support services provided through the NGO sector to the estimated 4,500 clients who, although not in the ILP, would gain significant benefit from participating in a rehabilitation and support program that fosters recovery.

7.3 Clinical Care and Rehabilitation

The ILP providers reported a very varied experience in terms of the provision of clinical support from MHS staff. There appeared to be a much more collaborative relationship between providers and MHS staff and greater satisfaction with the level of clinical support in areas where there was a designated position of accommodation coordinator. Where this was not the case and this function was simply ‘tacked on’ to the duties of a clinician, there was not that same sense of partnership and ILP providers felt the program was not given the same level of priority by the MHS.

One of the major underlying problems in WA is that, unlike Victoria, there is no comprehensive and integrated system across the State for managing people with persistent or recurrent mental illness and associated disability.

A report by the Office of Mental Health in September 2004 entitled *A Recovery Vision for Rehabilitation: Psychiatric Rehabilitation Policy and Strategic Framework* commented:

“A major issue identified by .... practitioners is the need to balance the funding and provision of treatment and rehabilitation services. For rehabilitation staff working within a combined treatment and rehabilitation service, crisis work can take priority. Staff are often asked to participate in the provision of treatment services (such as emergency rosters and duty cover) at the expense of providing rehabilitation services. ....The identification of discrete rehabilitation workers minimizes the impact of treatment service demands on the delivery of rehabilitation services.”

Another significant constraint in providing clinical support services for clients in the ILP is that the program is centered on community mental health clinics. Waiting lists are developed and held largely by the clinics, houses allocated to local clinical catchment areas and clinical support and rehabilitation provided by clinic staff. Furthermore, the arrangement of clinical and rehabilitation services varies greatly from one clinic to another, with some having very rudimentary rehabilitation services.

The area with potentially the highest return on investment is in the management of people with enduring or recurrent psychotic illnesses. They represent relatively small and easily identifiable groups, but their use of inpatient services is extremely large. Well coordinated and integrated programs have the capacity to significantly reduce inpatient bed use and, in the process, improve the quality of life for clients and their carers.

This raises the broad question about the organization and management of psychosocial rehabilitation and support services in WA. There was considerable support amongst participants at the Workshop for the position put forward in *A Recovery Vision for Rehabilitation*; namely, that: there are significant advantages in rehabilitation services being developed as a discrete service system separate from the acute treatment services. Furthermore, they were of the view that, as highly specialised services, they should be organised on an area health service basis. It was believed that this model would enhance *continuity of care*, which was seen as being particularly important for these groups of clients.
Both Victoria and New South Wales have attempted to distinguish between the services that they believe should be provided by the NGOs and those that should be provided by public mental health services. Clearly, clinical assessment and treatment fall to the latter, but with increasing training and specialisation of the NGO workforce, the distinction between the sectors in relation to many of the other roles and functions in the field of rehabilitation are becoming less meaningful.

What is essential, however, is establishing clarity of roles and responsibilities in relation to each client. This can be achieved through the development of an individual care plan, developed jointly by the client, the psychosocial rehabilitation and support provider and the clinical team. As part of the NSW HASI program, a number of the joint activities required to coordinate care are set down, including:

- Joint assessments, development of individual care plans and clinical review meetings (MHS, NGO Psychosocial Support Provider and Client);
- Joint training/educational opportunities;
- Consideration of joint programming (i.e. NGO service provision from Area Mental Health sites and AMH service provision from NGO sites);
- Coordinated efforts to gather data on unmet area needs; and
- Coordinated strategic planning to address unmet need.

The HASI program places a great deal of emphasis on strong and effective partnerships between Support Providers, Area Service providers and Accommodation Providers at all levels. This needs to be a key element in the development of the Psychiatric Rehabilitation and Support System (PRSS) in Western Australia.

**Recommendation 11**

*Develop and implement a plan for the establishment of a discrete, specialized ‘clinical care and rehabilitation services program’ within Mental Health Services, separate from the acute care services, which has the following characteristics:*

- Focuses on the clinical care and rehabilitation of people with persistent or recurrent psychotic illnesses and disability;
- Covers inpatient services as well as community-based services;
- Is organized on a health service area basis; and
- Works to deliver a complementary and seamless network of services with NGO psychosocial rehabilitation and support service providers, similar to the model operating in Victoria.*
7.4 Addressing the Special Needs of Rural Services

Because of their relatively small and dispersed populations, rural areas present special problems in providing psychosocial rehabilitation and support services, including supported housing services, for people with psychotic illnesses and disability.

In a regional population of 50,000 people, it could be expected that there would be some 15 such people at any particular time. The actual number, however, is likely to be smaller because of the pattern of drift to the city that is frequently found amongst those with serious mental illness.

A rural supported housing program is likely to be quite small with a part-time staff member providing both the supportive landlord and psychosocial support roles. We still consider that the landlord role should be separated from the psychosocial support role.

Wherever possible the local Community Housing Association (CHA) could be approached to take on the landlord role. This arrangement was implemented in Albany and appears to have worked extremely well.

Where there is no local CHA, DHW should be asked to consider providing the landlord role. In both Victoria and New South Wales, the public departments of housing take on the role as Housing Provider as well as the CHAs. The DoH would then be left to focus on funding psychosocial support services for clients.

As alluded to above, many rural psychosocial support providers are very small. This raises the question of how best to provide and manage this service and to ensure professional support and training for staff. We are of the view that consideration needs to be given to ‘linking’ these small rural service providers into a larger ‘state-wide’ service. This could take a number of forms ranging from statewide services managing rural services to partnership arrangements for the provision of management and staff development and support services.

Neami provides a good example of a large community organisation managing services in rural locations. Neami, which had its origins in Melbourne’s northern suburbs, is now the largest provider of community mental health rehabilitation and support services in Australian with over 900 clients receiving services from 150 staff across 16 different locations, including rural areas, in Victoria, New South Wales and South Australia.

**Recommendation 12**

*Separate the landlord and psychosocial rehabilitation and support roles, with the former being taken on by local Community Housing Associations, or, where there are none available, by the Department of Housing and Works.*

**Recommendation 13**

*Establish a variety of linkage arrangements between smaller rural and larger statewide Psychosocial Support Providers to strengthen management and provide assistance with professional support and training in the smaller organizations.*
8. ACTIVELY MANAGING THE PROGRAM

8.1 Operational Management

Within the ILP there is enormous variation in how the program operates. While the current Independent Living Program – Providers Operational Guidelines outlines broad directions, there are significant gaps such as, for example, clarity about which agency has responsibility for managing the wait list and how clients will be prioritized for housing access. Furthermore, there is no obligation on providers to follow the guidelines.

“It is recognized that not all organisations operating in the ILP operate in the same manner and the operational guidelines are provided as a guide only, for use where it is deemed appropriate to the individual service…Therefore, information is provided solely on the basis that readers will be responsible for making their own assessment of the matters discussed herein…”

[OMH, Draft, December 2005]

There is much to be learned from the NSW Housing and Accommodation Support Initiative (HASI), which has developed detailed operational guidelines on the day-to-day running of the program. Many of these guidelines could be adapted for implementation within the ILP.

There was strong agreement at the Future Directions Workshop and during the individual consultations that the program requires operational guidelines which are specific and systematized, particularly in regards to the following areas.

Recovery Philosophy

The ILP should be based on a recovery philosophy, which aims at achieving social inclusion for each client.

Eligibility

The current ILP eligibility criteria are broad and, with the limited housing available, there is a need for greater specificity about which client groups the program is targeting. If there is greater clarity about the program objectives, such as reducing hospitalisation, this will assist in determining which clients should be gaining access to the program. A standardized approach to assessing eligibility needs to be agreed and then implemented across the program.

Maintaining the Waiting Lists and Prioritizing Access

There are currently a variety of arrangements in place at the local level for the management of ILP waiting lists, ranging from Mental Health Services being in charge of the process to the non-government Psychosocial Support Provider being in control, with a variety of joint management arrangements in between. There is no standardized system for assessing eligibility for the program, nor any for assessing client priority for housing.

Some agencies accept direct referral from General Practitioners and Private Psychiatrists, while others require referral through Mental Health Services.

This lack of precision in the management of waiting lists, when taken together with the practice of assigning housing to local areas on the basis of waiting list numbers, raises concerns about fairness and about whether the people most in need of stable, supported housing are indeed getting priority access to the program.
We consider that the waiting lists, and indeed the ILP itself, could most effectively be managed at an Area Health Service level; or in the case of rural areas, at a regional level. Responsibility for oversight of the program and for management of waiting lists could reside with an ILP Area Coordinating Committee, which would be composed of Accommodation Coordinators from Mental Health Services and representatives from the Social Housing Providers and the Psychosocial Support Providers.

All clients referred to the ILP, including those referred by Private Psychiatrists and General Practitioners, would be given a standardized assessment to determine eligibility and to establish their level of priority for access to housing. The most reliable outcome could be achieved by using a consistent group of assessors such as the Accommodation Coordinators. Specific criteria for establishing priority levels will need to be developed. Access to housing should be determined primarily by client need.

During the assessment process, clients should be given the opportunity to list their area of choice for housing including, if they wish, their second and third preferences. Difficulties can be experienced in obtaining housing in particular geographic areas from time to time and this arrangement would allow people in urgent need of housing to be given another option for consideration.

**Assessing Support Needs, Reviewing & Exiting Clients**

A standardized assessment instrument needs to be used to assess client support needs, with funding linked to assessed need, to enable the appropriate levels of support to be provided. Every client will have an Individual Service Plan and regular assessments will enable support needs to be varied over time.

Processes need to be specified for dealing with disputes and complaints by clients, changes in client status such as hospitalisation and client exits from either support or housing. Where they are not already in place, local ILP Coordination Groups should be established to manage this process.

**Housing Management**

Currently, housing numbers are determined by the DHW and then allocated to local clinic catchment areas based on waiting list figures received from either local MHS Clinics or NGO service providers. This process currently depends on the rigor with which local Mental Health Services or Psychosocial Support Providers pursue the task of identifying potential clients, rather than on any objective measure of need.

If the waiting lists were being managed at an Area Health Service level by a Coordinating Committee, based on a standardized assessment process as outlined above, total waiting list numbers could still be used for the purpose of negotiation between DoH and DHW of the annual acquisitions, but actual allocation of houses across the Health Service Areas would be determined by the priority rating of clients and their housing preferences.

The management of the waiting list and allocation of housing needs to be active, with regular review to give the flexibility to be able to adjust. For example, if housing cannot be acquired in a particular geographic area, consideration may need to be given to shifting the allocation to an area where housing is available. This also provides greater flexibility for DHW in acquiring housing stock. Under such arrangements, clients could be given the choice of taking up the offer of this alternative housing. This provides greater flexibility for clients and increases their opportunity to acquire a house.
8.2 Partnerships and Roles

Expanding partnerships at all levels of the ILP will be a critical part of the continued development and success of the program.

Currently, at the local level, the partnerships vary and there is a lack of clarity about the way in which the partnerships should function, including the roles of each of the players. While there are regular forums convened by the Division of Mental Health and attended by key stakeholders, this is not necessarily the best structure for managing inter-agency policy and program development issues.

The following formal partnership structures are proposed:

- ILP Statewide Advisory Committee;
- ILP Area Co-ordinating Committees.

ILP Statewide Advisory Committee

While the sponsor agencies, namely, the Department of Health, and the Department of Housing and Works, maintain ultimate responsibility for setting policy directions, funding, monitoring performance and overseeing independent evaluations of the program, their decisions can be informed by an ILP Statewide Advisory Committee. The committee could also have responsibility for continuing the ILP Forums which currently operate, to ensure a wider range of stakeholders are brought together to share information and to workshop emerging program and operational issues.

ILP Area Co-ordinating Committees

At the health service area level in metropolitan Perth and at the regional level in the country, ILP Area Co-ordinating Committees would be established which comprise representatives from:

- Mental Health Services;
- NGO Psychosocial Support Services;
- Regional DHW; and
- Community Housing Associations or other NGO ILP housing providers.

While the roles and responsibilities of each of the partners would be specified in the ILP Operational Guidelines, Area Level Service Agreements would be signed by each provider organisation, to reflect the guidelines and to take into account local circumstances.

Core responsibilities of the ILP Area Co-ordinating Committee would be to advise on the flexible purchasing of housing across the area to best match client preferences and the availability of housing stock, manage the area wait list, determine client priority and select clients for housing and monitor the operation of the program.

Local Coordination

At the local Mental Health Service level there will be a continuing need for the service providers to work closely together to develop Individual Service Plans, co-ordinate care approaches and review client progress. Local Service Agreements need to be developed to specify roles and responsibilities, and outline the ways in which the partner agencies will work together to achieve a co-ordinated approach to client care.
Recommendation 14

Strengthen partnership arrangements at the system level by establishing an ILP Statewide Advisory Committee to guide the overall development, management and evaluation of the program.

Recommendation 15

Develop standardized, statewide operational guidelines, under the auspice of the ILP Statewide Advisory Committee, which particularly address:

- The roles of responsibilities of each of the partner organizations;
- Standardized assessment for eligibility and client support;
- Mechanisms for ongoing review and variation in the level of client support, including the development of Individual Support Plans;
- A system for managing client complaints and dispute resolution; and
- Ongoing monitoring of performance and outcomes.

Recommendation 16

Strengthen partnership arrangements at the area level by establishing an Area ILP Coordinating Committee in NMAHS, SMAHS and relevant regional areas, comprising representatives from Mental Health Services, NGO Psychosocial Support Providers, Social Housing Providers and DHW regional offices, to ensure:

- The establishment of an Area Level Service Agreement between the partner organizations which specifies roles, responsibilities and working arrangements;
- The implementation of the Statewide ILP Operational Guidelines with particular focus on:
  - Developing and managing the wait list at an area level;
  - Assigning houses on the basis of assessed client need; and
  - Actively reviewing the acquisition of housing stock across the area and re-allocating across the area if appropriate.

Recommendation 17

At the local Mental Health level, develop Local Service Agreements which outline the roles and responsibilities of the partner agencies and their working relationships.
9. QUALITY

9.1 Monitoring Performance and Outcomes

To date the continuous improvement, performance monitoring and evaluation of the outcomes of the ILP have received limited attention. Once there is clarity about the expected outcomes from the program, the key performance indicators need to be identified and data collected routinely which will enable the success of the program to be continually monitored and reviewed.

The issue of outcomes however, is much broader than the ILP. Measuring consumer outcomes for those receiving psychosocial rehabilitation and support services is an important part of ensuring quality.

As part of its PDRSS quality initiatives, Victoria is introducing a program which encourages NGOs to measure consumer outcomes. Consumers who have an Individual Program Plan would be offered the opportunity to participate. Processes for data collection are being developed, including ways of incorporating this data into standard quarterly reporting.

An approach such as this should be considered by Western Australia and developed in partnership with the NGO Psychosocial Support Providers.

9.2 Service Standards and Accreditation

Currently the Western Australian non-government mental health sector is implementing general service standards, with considerable input and support from WAAMH. There are, however, no service standards which specifically focus on psychosocial rehabilitation and support services.

This is in contrast to Victoria where specific standards for the non-government Psychiatric Disability Rehabilitation and Support Services (PDRSS) have been introduced. These are broadly based on the national service standards but are specifically tailored to the PDRSS and recognise the specialist nature of services provided in this sector. The following provide some examples of the Victorian PDRSS standards:

- Integration (integration within the health system, integration with other sectors);
- Service Development (organisational structure, planning, funding staff training and development, information systems, service evaluation, outcome measurement, research and quality improvement);
- Delivery of Support including:
  - Principles guiding the delivery of support;
  - Accessibility, access, assessment and review;
  - Rehabilitation and support;
  - Community living (independent living, leisure, recreation, education, training, work and employment, family, relationships, social & cultural system);
  - Residential or home-based rehabilitation and support;
  - Psychosocial rehabilitation and support;
  - Planning for leaving the PDRSS; and
  - Leaving and re-entering the PDRSS.
Victoria has also introduced an accreditation process for PDRSS non-government organisations. As with the PDRSS service standards, there is much to learn from the level of support provided by the Department of Human Services to the non-government organizations to assist them with the phased introduction of accreditation. This process of staged accreditation was introduced in 2004 with two streams developed which recognised the different needs of organisations depending on their size.

*Stream A*: Grants to support small PDRSS services to engage in quality planning activities to develop their capacity to engage in formal accreditation processes in the future.

*Stream B*: Grants to assist large stand-alone PDRSS services to achieve formal accreditation including:

- Annual service self-assessment against the complete set of Standards using a self-audit manual;
- The development of a quality improvement report and plan to address any gaps identified in the standards arising from the self-assessment process;
- Annual liaison with the regional office of the Department of Human Services to assist with developmental issues; and
- External formal audit every 3 years, incorporating the data from the annual self-assessment.


While there was considerable support at the Future Directions Workshop for the concept of specific standards for psychosocial rehabilitation and support services, there was concern about the capacity of smaller non-government organisations to comply with formal accreditation processes. This concern has been managed within the Victorian system by providing considerable capacity building combined with gradual implementation.

There has been some debate about whether formal accreditation is necessary or whether standards monitoring would suffice. This is an issue which could be further considered by the Mental Health Division in consultation with WAAMH and the relevant NGO Psychosocial Rehabilitation and Support providers.

**Recommendation 18**

*As part of a quality assurance process, implement outcomes measure specifically for the ILP and more broadly for the NGO Psychosocial Rehabilitation and Support sector.*

**Recommendation 19**

*Develop a phased approach to implementing specific service standards for the NGO psychosocial rehabilitation and support sector, with the Mental Health Division and WAAMH to give further consideration as to whether formal accreditation or some other mechanism is more appropriate to ensure compliance with the specific service standards.*
9.3 Training and Workforce Development

The training and workforce development needs of people working in the ILP should be viewed within the context of a broader rehabilitation workforce, which encompasses the public mental health services, the non-government and the private sectors.

There is currently no clearly articulated policy which specifies the roles of each of these sectors in providing a comprehensive rehabilitation service, nor is there clarity about:

- The type of workforce required and the range of skills necessary to undertake the various roles;
- The basic level of training and qualifications;
- Access to supervision within the workplace;
- Continuing professional development; and
- Opportunities for career progression.

A rehabilitation workforce development plan, which addresses these issues, is urgently needed.

A key component in implementing such a plan is that training programs are actually available for the current and future workforce to participate in. It is not apparent who should have a lead responsibility for engaging existing training providers to ensure that the future workforce is equipped with the skills to work in rehabilitation services and to ensure that the current workforce has access to ongoing professional development.

One proposal to address this is that a new entity, the Centre of Excellence in Mental Health Psychosocial Rehabilitation and Recovery, be established. The Centre could take on the role of working with current training providers to assist them meet the needs of the rehabilitation and support workforce. The concept of the Centre will be discussed in further detail in the next chapter.

The role of WAAMH as a training provider, particularly for the non-government sector, should be strongly supported. WAAMH also has a particular strength in bringing the voice of consumers and carers into training programs for the mental health workforce.

The availability of funding for rehabilitation staff in the non-government agencies to attend continuing education and professional development courses has been a barrier to increasing the skills of the workforce. Consideration should be given to the approach taken in Victoria where the Department of Human Services provides the non-government sector with funding to enable positions to be backfilled when staff attend VICSERV specialist training modules.

As you would expect, access to further training and professional development remains more difficult for those working in rural area and requires special attention as a part of the rehabilitation workforce development plan.

Repeatedly through the consultation process, there was concern raised about the disparity in wages paid to workers in the non-government sector as compared with the public mental health system. It is not surprising that this was considered by many in the non-government agencies to be a significant concern as it has been raised many times over the years. The matter needs to be addressed.
Recommendation 20

Develop a psychiatric rehabilitation and support workforce development plan, focusing on the needs of the public and non-government mental health sectors, which identifies:

- The range of skills, job roles, levels of training and qualifications and availability of training considered necessary for the current and future workforce requirements;

- Access to adequate levels of ongoing supervision in the workplace and continuing professional development; and

- Career progression.
10. STRENGTHENING CAPACITY IN REHABILITATION SERVICES

There is a strong need to develop stronger partnerships between education, research and rehabilitation providers in order to enhance teaching, research and evidence-based practice in rehabilitation services. This will provide a firm base on which to build rehabilitation services into the future. As a supported housing program within a rehabilitation service, the ILP would benefit from such a partnership. The capacity to build the partnerships between education, research and rehabilitation services providers would be strengthened by:

- establishing a Centre of Excellence which will grow the capacity of the entire rehabilitation sector including public, non-government and private services; and
- enhancing the role of WAAMH.

10.1 Centre of Excellence

In July 2006 a proposal was put forward to the Mental Health Network to establish a Centre of Excellence in Mental Health Psychosocial Rehabilitation and Recovery. It was developed and presented to the Mental Health Clinical Network by Sheryl Carmody, Executive Manager, Ruah Community Services and Errol Cocks, Professor, School of Occupational Therapy, Curtin University.

Many of the issues identified in this review could be taken up and advanced by such a Centre of Excellence.

The Centre could, through harnessing the energy, expertise and experience of key partners, provide a focus for developing the rehabilitation sector in Western Australia. The need to provide a vehicle for progressing rehabilitation services is evidenced by the limited strategic activity which has occurred since the launch of the policy framework “A Recovery Vision for Rehabilitation” in September 2004.

The aim of the Centre would be to enhance evidence-based best practice rehabilitation and recovery services for people with psychiatric disability and their families. The Centre would bring together research and training, service delivery and policy expertise to support the development of policy, services and practice.

PROPOSED FUNCTIONS
CENTRE OF EXCELLENCE MENTAL HEALTH PSYCHOSOCIAL REHABILITATION
Each of these elements in interconnected and supports the other:

- Research and development activities develop the base of good practice;
- Education and training disseminates and applies the evidence base;
- Exemplary evidence-based services are developed and delivered; and
- Overall capacity is built through providing technical expertise at all levels from practice, service development and evaluation, to policy and planning.

The Centre would consist of a core level of resources and infrastructure, together with a network of collaborators from the universities, non-government service sector, public mental health services, consumer and carer organisations and mental health policy bodies to both engage in the work and provide a focus and direction for the sector. An Advisory Board, with representation from key stakeholders, could guide the efforts of the Centre including setting strategic priorities.

This approach to structuring the Centre would encourage strategic partnerships to form around specific projects and foster collaborative work between researchers, service providers, policy makers and consumers and carers. It would also facilitate the flow of information and expertise between these partners.
10.2 Building the Role of WAAMH

A strong and vital non-government sector is essential in the delivery of the rehabilitation and recovery services. WAAMH has a key role to play as the peak body for rehabilitation and recovery services in the non-government sector.

Currently WAAMH is developing their strategic plan for 2007-2009. While it is still in draft form, the broad directions are to strengthen the capacity of the non-government sector in providing services, increase community awareness of mental illness and develop the organizational capacity of WAAMH.

We support enhanced resourcing for WAAMH to enable them to strengthen their role in advocacy, policy development, training and capacity building among community service providers in this key service sector.

Recommendation 21

Strengthen capacity in the rehabilitation and support services sector by:

- Establishing a Centre of Excellence in Psychosocial Rehabilitation and Recovery which would bring together research and training, service delivery and policy expertise to support the development of policy, services and practice; and

- Enhancing the resourcing of WAAMH to enable it to develop its role in advocacy, policy development, training and capacity building in the non-government sector.
## ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>CHA</td>
<td>Community Housing Association</td>
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<tr>
<td>DHS</td>
<td>Department of Human Services</td>
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<td>DHW</td>
<td>Department of Housing and Works</td>
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<td>DoH</td>
<td>Department of Health</td>
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<td>HASI</td>
<td>Housing and Support Initiative</td>
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<td>HASP</td>
<td>Housing and Support Program</td>
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<td>HBO</td>
<td>Home Based Outreach</td>
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<td>ILP</td>
<td>Independent Living Program</td>
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<td>MHD</td>
<td>Mental Health Division</td>
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<td>MHDHT</td>
<td>Mental Health Disability Housing Trust</td>
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<td>MHS</td>
<td>Mental Health Services</td>
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<td>NGO</td>
<td>Non-government Organisation</td>
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<td>NMAHS</td>
<td>North Metropolitan Area Health Service</td>
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<td>NSW</td>
<td>New South Wales</td>
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<td>PDRS</td>
<td>Psychosocial Disability and Rehabilitation Support</td>
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<td>PDRSS</td>
<td>Psychosocial Disability and Rehabilitation Support Services</td>
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<td>PRSS</td>
<td>Psychiatric Rehabilitation and Support System</td>
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<td>SMAHS</td>
<td>South Metropolitan Area Health Services</td>
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<td>USA</td>
<td>United States of America</td>
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<td>VIC</td>
<td>Victoria</td>
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<td>WAAMH</td>
<td>Western Australian Association for Mental Health</td>
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APPENDIX 1: WORKSHOP PRESENTATION

Western Australian Centre for Mental Health Policy Research

**ILP Review Process**

**Phase 1: Policy Options**

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<th>1. Background Information</th>
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<td>2. Consultations</td>
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<td>3. Literature Search</td>
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<td>4. Future Directions Workshop Paper</td>
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<td>5. Future Directions Workshop</td>
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<td>6. ILP Review Report</td>
<td>The Review Report will:</td>
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<td>• Synthesize the results of evidence and experience from other Australian and International housing support programs;</td>
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<td>• Outline the results of consultations with key stakeholders on current program issues and future directions; and</td>
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<td>• Proposed options for future policy directions for the program.</td>
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**Phase 2: Outcomes**

- Impact on consumers and their families
- Use of mental health services, particularly inpatient services
- Cost effectiveness of the program
- Future demand for places.
Key Themes from the Consultation

Four key themes emerged from the consultations:

1. Housing
2. Support
3. Managing the Program
4. Quality

SUCCESS OF THE ILP

“It guided me back into society, made me feel human again and to do that I had to have a roof over my head”

(ILP Consumer, September 2006)

“The program has had a really big impact on his life, but I wish that we had been able to get him into the program 20 years ago … it would have prevented a lot of secondary problems.”

(MHS staff member)

“The Independent Living Program is a brilliant program – for those who are lucky enough to get into it.”

(NGO Provider)

What is Supported Housing?

At its core, the supported housing model combines scattered site, socially integrated housing with individually tailored support services.

The key characteristics underpinning Supported Housing

- A Home
- Choice
- Citizen role
- Client Control
- Social integration
- Permanent setting
- Individualized supports
- Facilitative environment
The ILP in Context

Western Australian ILP

**Features**
- Longstanding, successful program with over 650 housing units
- Allocation of 60 housing units per year through CDHP
- Strongly defined as a housing program with focus on supportive landlord role by NGOs and CHAs
- Funding formula for landlord function
- Mix of arrangements in terms of provision of landlord and psychosocial support functions
- Problems for landlord agencies in getting psychosocial support for their residents
- Allocation of houses on basis of waiting lists
- Mix of arrangements in terms of way the ILP guidelines operate in practice

**Strengths**
- Widespread support for the program
- Steady annual growth in housing
- Supportive landlord and funding formula for this role
- Quality of services recognized

**Weaknesses**
- No linkage between psychosocial support needs and funding
- No consistency in the operation of program
- System of housing allocation is potentially inequitable
- Poorly defined/developed psychiatric rehabilitation and support system
- No systematised training, workforce development and quality standards
NSW Housing and Accommodation Initiative (HASI)

**Features**
- Commenced in 2002 as partnership between Housing, Health & NGOs
- Strong program focus on housing and psychosocial support
- Staged development
- Centralised housing allocation with properties management by Housing & CHAs
- Targeting specific client groups with funding packages based on support needs [$10K to $70K/client/year]
- Contracted with small number of larger NGOs for psychosocial support
- Organised on a regional basis
- Individual Service Plan for each client
- Selection of clients for entry by panel

**Strengths**
- Strong partnerships at all levels
- Strong focus on client and level of disability
- Psychosocial support linked to housing
- Funding packages based on client support needs
- Clear operational procedures
- Built in evaluation

**Weaknesses**
- Poorly defined/developed psychiatric rehabilitation and support system
- No systematised training, workforce development and quality standards

Victorian Supported Housing Program

**Features**
- Commenced in 1992 as partnership between Health, Housing and the PDRSS [NGO] sector
- Landlord function provided by Housing and CHAs
- Strong focus on psychosocial rehabilitation and support service system
- Access to supported housing is through PDRSS referral
- Key worker appointed for each PDRSS referral and Individual Program Plan developed
- Clients move into supported housing with support through PDRSS provider
- Support services funded on basis of 1 FTE for 1:5 and 1:10 clients

**Strengths**
- Strong, well defined, comprehensive and integrated psychiatric rehabilitation and support system of which the supported housing program is an important component [11,000 in PDRSS in 2002]
- Systematised training, workforce development and quality standards
- Linkage between housing and support services
- Clear roles for service providers set out in IPP

**Weaknesses**
- Does not have clear client prioritisation system or targeting
- Operational guidelines lack specificity
- Funding for support is not based on client support needs
SCENARIO 1: 2012
STRENGTHENING THE INDEPENDENT LIVING PROGRAM

Focus: Improving and strengthening the ILP. Program is built around clients and their housing needs

- 890 housing units and increasing at 60 houses per year
- ILP Executive Committee manages allocation of houses
- Comprehensive needs assessment and placed on area WL
- Client selection for housing carried out by panel
- Landlord function divided between CHAs and NGO Housing Providers
- NGOs Housing Providers also providing rehab & support for tenants
- CHA tenant rehab & support tendered out to NGO support agencies
- Department of Health no longer funds landlord services
- Key worker appointed to coordinate Individual Program Plan and facilitate access to services

SCENARIO 1: CONTINUED

- Funding for psychosocial support provide on basis of 1 FTE per 5 to 10 clients
- All clients receiving support services upon access to ILP
- Accommodation Coordinators appointed to all MHS
- Partnerships strengthened at all levels
- All new MHS staff given ILP orientation course
- ILP specific competency-based training programs developed
- NGO Quality Standards in place
- KPIs reported annually
SCENARIO 1: STRENGTHENING THE INDEPENDENT LIVING PROGRAM

SCENARIO 2: 2012 BUILDING THE REHABILITATION & SUPPORT SYSTEM

Focus: Improving and strengthening the supported housing program, but within the broader psychiatric rehabilitation and support system. Program is built around clients and their rehabilitation and support needs

- 3,500 people receiving psychiatric rehabilitation and support services
- 1,200 of them in supported housing
- Property management by CHAs
- MH Disability Housing Trust established
- Tenancy support by psychosocial support agencies
- Entry to housing through psychosocial rehab and support
- NGO managed rehabilitation & support services sector
- MHS reorganised its own rehabilitation services on area basis
- Close partnership between NGO and MHS sectors
SCENARIO 2: CONTINUED

- Key worker appointed to coordinate Individual Program Plan and facilitate access to services
- Comprehensive needs assessment and placed on area WL
- Client selection for housing carried out by panel
- Funding for psychosocial support provide on basis of 1 FTE per 5 to 10 clients
- Packages of care funding for selected client groups
- Allocation of houses by Supported Housing Executive Committee
- WAAMH funds as peak for NGO Rehab and support sector
- Comprehensive training program
- Specific standards developed for sector and accreditation program in place
- Outcomes established and ongoing monitoring and evaluation program

SCENARIO 2: 2012
BUILDING THE REHABILITATION & SUPPORT SYSTEM
APPENDIX 2: WORKSHOP SCENARIOS

THE INDEPENDENT LIVING PROGRAM: WHAT MIGHT IT LOOK LIKE IN 2012?

Imagine it’s now 2012. What does the Independent Living Program look like 5 years on? We are giving you 2 possible scenarios – and I emphasize the word possible. The idea is that when you come to debate the issues and questions raised in the discussion document, there are no right or wrong answers. Your answers will depend on just how you would like to see the program developing in the future – and of course, in the role that you see for your organization.

To consider just one of the many issues raised in the discussion document, should the landlord and support functions be managed by separate organisations or within a single organisation? There is a strong body of literature that argues for the separation of these functions. But does it really matter? When we asked groups of clients, they did not see it as a problem. Furthermore, combining the functions may be one way of overcoming the difficulty that landlord services have been encountering in getting support for their clients.

There may, however, be advantages in separating these functions. The pooling of housing within larger Community Housing Associations opens up the possibility of joint venture developments, provides a mechanism for overcoming the stigma that can be attached to mental health housing and potentially gives greater flexibility and choice for clients.

The two scenarios should be seen more as the two ends of a continuum. They have been presented, therefore, to give people a range of ideas about what the WA supported housing program could look like in 5 years time, which in turn will shape people’s responses to the questions raised by the consultation.

SCENARIO 1: STRENGTHENING THE INDEPENDENT LIVING PROGRAM

The focus in this scenario has been specifically on improving and strengthening the Independent Living Program. The program is built around clients and their housing need. It’s January 2012 and we are just doing a stocktake of the Independent Living Program. We now have 890 units of housing and over the last 3 years, the Department of Housing and Works has managed to get back to its earlier target allocation of 60 houses per year. In 2006 and 07, the demand for housing in WA had remained high making it impossible for H&W to reach its annual target.

The allocation of housing is no longer based on waiting list numbers but is carried out by the Independent Living Program Executive Committee, which is a Statewide body made up of representatives from the key stakeholder groups. The allocation process is now actively managed throughout the year.

This gives greater flexibility in the housing procurement and allocation process. When houses are unavailable in one area, the allocation can be transferred to another.

On referral to the ILP, each client is given a comprehensive, standardized needs assessment before placement on the Area Mental Health waiting list. Priority on the waiting list is determined by a points system and client selection for housing as it become available is made by a panel, which includes MHS and Psychosocial Support agency staff and the Housing Provider where this
is considered appropriate. Client choice is seen as a hallmark of the program, but those with an urgent need may be given the choice of next available property.

The landlord function is still divided between Community Housing Associations and specialist mental health housing providers, although the latter are now also proving psychosocial rehabilitation and support services for their tenants. Psychosocial rehabilitation and support services for those clients living in housing managed by the Community Housing Associations are being contracted out to NGO support provider agencies. The psychosocial rehabilitation and support agencies are now dealing with neighbourhood problems, furnishing, provision of social activities, etc and the Department of Health no longer funds landlord services.

On entry to the ILP, each client is allocated a Key Worker from the NGO support agency who has responsibility for coordinating the development of an Individual Program Plan that reflects the client’s rehabilitation and support needs. The key worker is also responsible for facilitating the client’s access to clinical and community services. Funding for psychosocial rehabilitation and support services is modelled on the Victorian system of 1:10 or 1:5 FTE to clients depending on client support needs. All clients now are receiving psychosocial rehabilitation and support services on entry to the ILP program although this may be reduced or withdrawn over time as support needs change.

Accommodation Coordinators have been appointed for all MHS and this has brought about a substantial improvement in the coordination of clinical and support services. All new MHS staff are now given an orientation to the ILP and this has led to an improvement in clinical response. Partnerships have been strengthened at all levels of the program. Regional stakeholders, including H&W, Regional MHS, Housing Providers and Support Providers, meet regularly to exchange information, discuss program management issues and monitor the program.

The training needs of the sector have been recognised and an ILP specific competency-based program has been develop in partnership with TAFE. Rural areas have been a special challenge, but greater use of telepsychiatry technology has enabled country workers to access training. A mentoring program has also been introduced to support the rural workforce.

The NGO Quality Standards developed by the Division of Mental Health in consultation with the sector are now firmly in place. Specific outcomes for the program have been established and Key Performance Indicators are now being reported on annually.
**SCENARIO 2: BUILDING THE REHABILITATION AND SUPPORT SYSTEM**

The focus in this scenario has been specifically on improving and strengthening the supported housing program, but within the broader psychiatric rehabilitation and support system. The program is built around clients and their rehabilitation and support needs.

It’s January 2012 and we are just doing a stocktake of the Independent Living Program. We now have 3,500 people receiving Psychiatric Rehabilitation and Support Services, 1,200 of which are in supported housing. The remaining clients have a wide variety of housing arrangements including private rental, parental home, own home, transitional accommodation, emergency accommodation and some are homeless.

Of the 1,200 housing units, 890 were provided through the Community Housing Disability Program and the rest through a variety of initiatives including joint ventures with H & W, private rental programs, etc. These initiatives were developed following the transfer of the property management role to the Community Housing Associations and the establishment of the Mental Health Disability Housing Trust [MHDHT].

Following on from the Victorian Government initiative in 2006, the MHDHT was an initiative of the WA Government and was kick-started in 2007 with $20 million from Government and $10 million from the Lotteries Commission. It has also attracted private and corporate contributions.

The psychosocial rehabilitation and support agencies are now dealing with neighbourhood problems, furnishing, provision of social activities, etc and the Department of Health no longer funds property management services.

Entry to housing is the same as for any other psychiatric rehabilitation and support need. The Department of Health has over the past 5 years, funded the development of a vibrant community-managed [NGO] rehabilitation and support services sector similar to the Psychiatric Disability Rehabilitation and Support Services in Victoria [PDRSS].

The Department has also reorganized its own MHS, with rehabilitation services being developed as a discrete area-based service system separate from the acute treatment services. Rehabilitation and support services now function as a **seamless network** of services between MHS and PDRSS sectors.

This has had a very significant effect on the support and care of people with persistent mental illness and disability, which has been reflected in a 25% fall in readmissions to hospital and a 34% reduction in bed-days.

On referral for rehabilitation and support, each client is allocated a Key Worker from the PDRSS who has responsibility for coordinating a comprehensive, standardized needs assessment and the development of an Individual Program Plan that reflects the client’s rehabilitation and support needs. The key worker is also responsible for assessing each client’s level of need for supported housing and the degree of urgency.
Clients with a requirement for supported housing are placed on the Area Mental Health waiting list. Priority on the waiting list is determined by a points system and client selection for housing as it becomes available is made by a panel, which includes MHS and PDRSS staff and the Housing Provider where appropriate. Client choice is seen as a hallmark of the program, but those with an urgent need may be given the choice of next available property.

Funding for psychosocial rehabilitation and support services has been primarily modelled on the Victorian system of 1:10 or 1:5 FTE to clients depending on client support needs. All clients now are receiving psychosocial rehabilitation and support services on entry to the supported housing program although this may be reduced or withdrawn over time as support needs change.

Over the past few years, however, the Department has trialled the NSW system of packages of care funding approach for 4 groups of clients: 40 people who had been continuously hospitalized for more than 12 months; 60 young people with early episode psychotic illness who are showing signs of becoming revolving door clients; 30 people from the transitional housing program; and 60 people with severe mental illness and substance abuse disorders. This funding model has the advantage of matching funding to the client’s assessed needs. The retention rate in the trial had been 89% over 3 years and 50% of people with substance abuse no longer had a drug problem.

As in Scenario 1, the allocation of housing is no longer based on waiting list numbers but is carried out by an Supported Housing Executive Committee, which is a Statewide body made up of representatives from the key stakeholder groups. The allocation process is now actively managed throughout the year. Active partnerships have been developed at all levels between the stakeholders.

WAAMH has been funded to take on the role of representing the PDRSS sector in much the same way as Vicserv. Unlike Vicserv, however, it is not providing training directly to the sector but has developed a strong relationship with the tertiary training sector and has an ongoing input into the design and development of industry relevant training. They have also been funded to allow NGOs to backfill positions when staff attend training.

WA has developed its own Standards for PDRSS in consultation with the sector and these standards have gradually been put in place.

PDRSS Accreditation for the NGO sector in WA was introduced in a staged approach commencing in 2008 with support from the DoH, particularly for smaller organisations to help them develop their capacity.

Clear outcomes have been established and appropriate data is being collected to allow for ongoing monitoring and evaluation of the program. The results are being reported back annually to the sector.
APPENDIX 3: KEY WORKSHOP QUESTIONS

Session One
Support Services

Property and Tenancy Management

- How should the landlord role be organized?
  - Should it be kept separate from the psychosocial support or should they be combined in one organization?
  - Should the property and tenancy services be moved progressively to a small number of community housing associations?
  - Should a specialist mental health community housing association be developed to take on the landlord role?

- What should the landlord function actually be?
  - Should the landlord be providing social support programs for their clients, sorting out neighbourhood problems or working intensively with clients to keep them in accommodation?
  - Should the landlord role be funded and, if so, by whom?
  - What might the model of funding for the landlord function look like?

Psychosocial Rehabilitation and Support

- How can we ensure that people entering the ILP get access to support services?
- What might the model of funding for psychosocial rehabilitation and support services look like?

Clinical Care and Rehabilitation

- Should ILP be organized around the community clinic catchment areas or is this too limiting and should it be developed as an area-based program?
- How can the relationship between the ILP services and MHS be enhanced?

Session Two
Actively Managing the Program

- What should be the key objectives and outcomes of the ILP?
- Which clients should be given priority access to the ILP? Are there any potential benefits to be gained by targeting specific groups as is done in NSW and, if so, which groups?
- How and by whom should clients be selected and prioritized for access into the program?
- How should waiting lists be managed to ensure that all clients have fair and equitable access to housing based upon the level and urgency of their needs?
- How should referrals from GPs and private psychiatrists and cross boundary movements of clients be managed?
• What sort of partnership structures between the stakeholders would best assist in the planning, management and coordination of the ILP in Western Australia?
• How should housing be allocated (based on the waiting lists, a rural/metropolitan split, or some other means)?
• How can more flexibility be built into the housing program to enable allocations to be shifted to where houses can be purchased?
• How can the stigma associated with ILP housing be overcome?
• What needs to happen to increase ILP clients’ access to home ownership?

Session Three
Quality

Training and Workforce Development
• What are the training needs of the psychosocial rehabilitation and support workforce, both government and non-government, and what is the best approach to ensuring that these needs are identified and met?
• How can partnerships with training providers (e.g. TAFE and universities) be strengthened to better meet the training, ongoing development and supervision needs of the psychosocial rehabilitation and support workers, government and non-government? Do we need an organisation like VICSERV or NADA to support this function? Should WAAMH consider taking on this role?
• How can we improve access to training for the rural psychosocial rehabilitation and support services workforce?

Service Standards & Accreditation
• Should Western Australia develop and implement specific standards for the psychosocial rehabilitation and support NGO sector? What are the benefits and risks of going down that path? What supports and processes would need to be put in place to ensure successful implementation?
• Should NGO’s which provide psychosocial rehabilitation and support be accredited and if so, what are the benefits and risks? Should accreditation be developed for the wider NGO mental health service sector or should it relate specifically to the psychosocial rehabilitation and support services? What would need to be put in place to implement this?

Research & Evidence Based Practice
• How can we ensure there is on going monitoring and evaluation of the ILP and how can this be developed?
• What structures could be put in place to support best practice and research in psychosocial rehabilitation?
APPENDIX 4: WORKSHOP ATTENDEES

ILP Workshop - 28 November 2006

<table>
<thead>
<tr>
<th>Contact</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>1 Brooke Butler</td>
<td>Mental Health Division</td>
</tr>
<tr>
<td>2 Denise O’Dowd</td>
<td>Community Housing Coalition</td>
</tr>
<tr>
<td>3 Ian Lake</td>
<td>Baptist Care Geraldton</td>
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<tr>
<td>4 Michelle Ferrara</td>
<td>UnitingCare West Tenant</td>
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<tr>
<td>5 Paul Rutherford</td>
<td>Department of Housing and Works</td>
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<tr>
<td>6 Peta Connor</td>
<td>UnitingCare West</td>
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<tr>
<td>7 Phil McWilliams</td>
<td>Rockingham Adult Mental Health Service</td>
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<tr>
<td>8 Des Bray</td>
<td>Great Southern Community Housing</td>
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<td>9 Duyen My Trinh</td>
<td>Mirrabooka Mental Health Service</td>
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<tr>
<td>10 Glynis Jordan</td>
<td>Perth Inner City Mental Health Service</td>
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<td>11 Joanne Wraith</td>
<td>North Metropolitan Mental Health Service</td>
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<td>12 Kimberley James</td>
<td>Consumer Representative</td>
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<td>13 Sheryl Carmody</td>
<td>Ruah Community Services</td>
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<td>14 Wynne James</td>
<td>Mental Health Division</td>
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<td>15 Joseph Foo</td>
<td>UnitingCare West</td>
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<tr>
<td>16 Kate Radosevich</td>
<td>Goldfields Mental Health Action Group</td>
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<tr>
<td>17 Kurt Egan</td>
<td>Alma Street, Mental Health Service</td>
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<td>18 Louise Cefalo</td>
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<td>19 Pamela Hubert</td>
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<td>20 Sandra Vidot</td>
<td>Hills Community Support</td>
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<td>21 Vicki Caudwell</td>
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<td>22 Adele Stewart</td>
<td>Uniting Wesley Mission</td>
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<td>23 Charmaine Shack</td>
<td>Ruah Fremantle</td>
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<td>24 Mark Henson</td>
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<td>25 Mary Carbone</td>
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<td>26 Michael Sitas</td>
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<td>27 Peter Hill</td>
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<td>28 Clare Bestow</td>
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<td>29 Graeme Donovan</td>
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<td>30 Judith Durnin</td>
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<td>31 Richard Menasse</td>
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<td>32 Sandra Campbell</td>
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<td>33 Sarah Sherington</td>
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<td>36 Carly Dolinski</td>
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<td>50 Stephen Zykowski</td>
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<td>51 Hollie Bowker</td>
<td>Rockingham Early Intervention Centre</td>
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<td>52 Vincenzo La Mela</td>
<td>Avro Mental Health Clinic</td>
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<td>53 Penny Beaton</td>
<td>Hills Community Support Group</td>
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<tr>
<td>54 Sarah Dixon</td>
<td>Bentley Hospital</td>
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