Reviewing the Independent Living Program

Discussion Paper for the Future Directions Workshop
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Section I

Introduction and Overview of the Process

“The Independent Living Program in WA is an example of what has been termed Supported Housing. At its core, the supported housing model combines scattered site, socially integrated housing with individually tailored support services.

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 As the client's needs change, the supports and services can be introduced or withdrawn.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 supported housing model also seeks to draw resources from the community.

The key characteristics underpinning Supported Housing

- A Home
- Choice
- Citizen role
- Client control
- Social integration
- Permanent setting
- Individualized supports
- Facilitative environment

The Independent Living Program (ILP) was established in the mid 1990’s. The program is “a joint initiative between the Department of Housing & Works and the Department of Health of Western Australian for the provision of housing and support to enable people with severe and persistent mental illness to live independently in the community.” (Independent Living Program – Providers Operational Guidelines, Draft, December 2005)

The ILP enables people with a psychiatric disability to rent Department of Housing and Works (DHW) properties, via a lease with a supportive landlord agency. The supportive landlord role is funded by the Department of Health (DoH) to provide services that assist in establishing and maintaining people in stable housing. People living in these properties also receive support services from non-government agencies, which are funded by the DOH, and clinical services from public or private mental health providers.

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

(quote from ILP Consumer, September 2006)
SUCCESS OF THE ILP

The ILP commenced in 1995 with the transfer of Eden Hill Cluster Homes from the Department of Health (DoH) to the Department of Housing and Works (DHW) in return for an agreement guaranteeing access for people with psychiatric disability to 24 independent units of accommodation scattered throughout the community. Funding was allocated through the National Mental Health Strategy for NGOs to provide a supportive landlord service and psychosocial support to people entering the housing program.

From these humble origins, the ILP now offers accommodation and support to more than 650 people with mental health problems, with the DHW providing around 60 properties each year through its Community Disability Housing Program. Funding has been increased significantly over the years for both the landlord function and for psychosocial support as part of the Mental Health Strategy. The funding formula that had been introduced by the OMH for the landlord role was generally recognised by the NGO providers as a significant step forward in the continuing development of the ILP.

During the consultations, there was universal support from the Department of Housing and Works, the Mental Health Division, NGO providers, consumers and MHS staff for the ILP and recognition of the benefits that the program had brought to the lives of consumers. The overall attitude of people to the program is perhaps best summed up in the words of two people:

“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)

and

“The Independent Living Program is a brilliant program - for those who are lucky enough to get into it.” (NGO Provider)

There has also been formal recognition of the excellence of a number of ILP non-government organizations as highlighted below:

Hills Community Support Group – WA & National Award Winner

In 2005 the Hills Community Support Group (HCSG) won the National Community Housing Award for Best Achievement in the category ‘Service to Tenants and Communities’. They also won the inaugural WA Community Housing Award for Excellence in the same category.

The program supports 65 adult tenants through the ILP program. It provides a holistic approach to tenants’ needs, combined with excellent mechanisms to receive feedback on its service, a culture of ongoing improvement and a number of practical initiatives. As a result of the Program’s support, of the 65 tenants, 12 are in paid employment, eight are studying courses in the wider community, two are doing voluntary work and one is in work experience.

The changing needs of tenants are addressed, including ageing tenants who can be linked to Home and Community Care Services. An ongoing partnership between Rainbow and the Eastern Metropolitan Community Housing Association (now Foundation Housing), has meant that tenants have more options to transfer between properties as the need arises. Documents have been developed that clearly explain referral processes, as well as eligibility criteria and the roles and responsibilities of both housing and support providers.

The Program’s annual surveys, as well as workshops involving staff, tenants and carers, have encouraged ongoing improvement. HCSG also conducts exit interviews to improve the quality of service.

Other initiatives include the Work Options Project, begun in response to tenants articulating a need for meaningful work. Initially funded by WA Lotteries Commission but now self-sustaining, the Project tenders for contracts in the region to provide maintenance and gardening services. Four crews of three people are supervised and paid award wages for their work.
Apart from securing Moving-In-Grants from Lotterywest, the program has also successfully encouraged the community to support its tenants by donating furniture, linen, crockery and other household items.

Tenants have also been further assisted in integrating into the community by participating in an art exhibition at Mundaring Arts Centre. This drew much community interest and resulted in subsequent commissions and prizes for some artists.

From: Community Housing Coalition of WA, Housing Update, Winter 2005.

Recognition of Best Practice

The peak representative and service body for organisations providing non-government social housing in WA, the Community Housing Coalition, recently identified a number of ILP organisations as examples of ‘best practice’:

- Baptist Care, Geraldton
- City Housing (now Foundation Housing)
- The East Metropolitan Housing Association (now Foundation Housing)
- Fremantle Housing Association (now Access Housing)
- Hills Community Support Group
- The Milligan Foundation (now Access Housing)
- St Bartholemew’s House
- Wesley Housing (now UnitingCare West)

In 2004, St Bartholomew’s House was highly commended by the judges in the Excellence in Corporate Governance category in the first WA Community Housing Award for Excellence. St Bartholomew’s is a supportive landlord provider in the ILP.

The Great Southern Community Housing Association, an ILP supportive landlord provider, received a Certificate of Appreciation from Mr Bob Kucera, then Minister of Disability Services, in recognition of the support options provided by the Association to people with a disability.

From: Best Practice: Community Housing in WA, Community Housing Coalition of WA Great Southern Community Housing Association, Annual Report 2004/2005

While acknowledging the value of the ILP, reviews tend to highlight the problems with a service. Workshop participants are urged, therefore, to keep in mind the successes of the program as they search for ways that it can be improved to better meet the needs of people with persistent mental illness and disability.
REVIEWING THE ILP

The ILP has now been in place for over 10 years. The WA Association for Mental Health (WAAMH) and the Mental Health Division (MHD), Department of Health are jointly leading an evaluation of the ILP, which is being undertaken by the Western Australian Centre for Mental Health Policy Research. An ILP Evaluation Research Steering Committee has been established to oversee and guide the evaluation process and its members are:

- Vanessa Rowe, WA Association for Mental Health (Chairperson)
- David Axworthy, Mental Health Division
- Carly Dolinski, Mental Health Division
- Russell Murphy, Department of Housing and Works
- Michael Livingston, Consumer representative
- Kimberley James, Consumer representative
- Sandra Vidot, Hills Community Support Group
- Mick Geaney, UnitingCare West
- David Baird, Community Housing Coalition of WA
- Geoff Smith, WA Centre for Mental Health Policy Research
- Theresa Williams, WA Centre for Mental Health Policy Research

The Review Process

The overall purpose of the evaluation is to provide options for future policy directions in the ILP. The evaluation has been separated into two phases. The first phase recognises the need for an immediate review of the program which heavily considers the expert opinion of providers and consumers of the current program about issues which need to be addressed in the near future. The second phase has a longer time frame, comprising a research study based on quantitative and qualitative data analysis, to assess the impact of the program against its objectives of reducing hospitalisation and improving the quality of life for consumers and their families.
### ILP Review - Phase 1

| 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 consultations |
| 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 Review 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. |

### ILP Review: Phase 2

A further research study is planned for 2007 to more fully understand the impacts of the ILP program. This study will have more emphasis on gathering and analysing data and could include issues such as the impact of the program on consumers and their families, the impacts on the use of mental health services, particularly inpatient services, the cost effectiveness of the program and future likely demand for places. A further objective would be to understand which consumers have benefited most from the program and conversely, which ones have not and why this may be.
THE CONSULTATION

An extensive consultation was undertaken during August and September 2006, both through face-to-face interviews with individuals and with groups and by teleconference. It was not possible to interview every ILP provider, however, a good representation of organisations across the rural and metropolitan areas were included.

**NGO Psychosocial Rehabilitation & Support and Landlord Services**
- Access Housing Association (formerly Milligan)
- Baptist Care Geraldton
- Goldfields Mental Health Action Group
- Hills Community Support Group
- Pathways Bunbury

**NGO Psychosocial Rehabilitation and Support Services**
- Albany Halfway House
- Perth Home Care
- Ruah Community Services
- LAMP Group

**NGO Supportive Landlord Services**
- UnitingCare West
- Access Housing Association
- Esperance Housing Association
- Foundation Housing
- Esperance Aboriginal Housing Association
- Great Southern Community Housing Association
- St Barthslemew’s House

**Mental Health Services (Rural)**
- Great Southern Community Mental Health Service
- South West Area Mental Health Service
- Esperance Mental Health Service
- Kalgoorlie Mental Health Service

**Mental Health Services (Metropolitan)**
- Swan Adult Mental Health Service
- Fremantle Mental Health Service
- North Metropolitan Area Mental Health Service
- Inner City Mental Health Service
- Rockingham Adult Mental Health Service

**Government Agencies and Peak Bodies**
- Mental Health Division, Department of Health
- Community Housing, Department of Housing and Works
- WAAMH

**Interstate Agencies**
- Office of Housing, Department of Human Services, Victoria
- NSW Health
- Department of Human Services, Victoria
- Neami
- Doutta Galla Community Health Service, Victoria

**Consumers**
- Baptist Care Geraldton, Consumer Advisory Group
- Swan Mental Health Service, Consumer Advisory Group
- UnitingCare West, Consumers

**Key Themes from the Consultation**

Four key themes emerged from the consultations:

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

These themes are explored in each of the sections which follow.
What people said….

• Not enough housing to meet demand
• Spot purchase process too slow in current housing market

DISCUSSION

Not Enough Houses

A clear message which emerged during the consultations was that the supply of housing to the ILP has not kept pace with demand. Since its inception in 1995, the allocation of houses to the ILP through the DHW Community Disability Housing Program has been maintained at approximately 60 per year. Clearly, however, there is a growing demand for houses as evidenced by increases in the ILP waiting lists.

In recent times, probably because of cost pressures within the Western Australian housing market, the annual allocation of 60 houses not been fully delivered.

The result is that waiting lists are growing. One agency, for example, reported a current waiting list of 59 for an ILP house. They have been typically allocated approximately 4 to 5 houses a year but are still waiting for 3 houses from last year’s allocation. At this rate people coming onto their list can expect to wait years for a house. The problem is even more acute in certain pockets of the Perth metropolitan area. For example, in one area south of the river, despite an annual allocation on paper of approximately 6 houses, no new houses have come into the program for the past 3 years and their wait list is over 60. The Joondalup area has also reportedly received no housing allocations for some years.

While it is unclear exactly how many houses the ILP should be aiming for, the need to increase access to housing stock is pressing. The question is how to achieve this. Western Australia is not alone in confronting the issue of how to increase access to social housing. The researchers found Victoria and NSW are facing similar challenges The following represent some options to stimulate thinking.

Joint Venture Housing Program: DHW

The DHW Joint Venture Housing Program is targeted towards organisations that have resources to contribute to the development of rental accommodation options for people on low incomes. A typical arrangement is that the organisation provides the land and some capital, whilst the DHW contributes to the construction of the properties. One ILP provider, the Great Southern Housing Association, has recently entered into a joint venture with DHW.

From: DHW website: Joint Venture Housing Program http://www.dhw.wa.gov.au
Disability Housing Trust, Victoria

The Trust was launched in June 2006 with funding of $10 million to provide new homes for 100 people with a disability. It is a non-government charitable trust whose role is to own, manage and maintain properties to accommodate people with disabilities. In building these community assets the Trust will seek donations and resource partnerships from individuals, community, commercial, philanthropic and other sources. The assets owned by the trust will be held in perpetuity for the use of eligible people with disabilities. The homes will include houses, flats and units and be in appropriate locations to assist the tenants to participate fully in community life.

In July and August 2006 the Trust is undertaking an Expression of Interest (EOI) process to allow individuals as well as community, commercial, government, housing, local government and other organisations to put forward proposals to join in partnership with the Trust to leverage the initial $10 million contribution from the Victorian Government. The initial EOI attracted 44 proposals from all regions across Victoria, from individuals, families, community service organisations, community housing organisations and local governments.

As well as developing new housing options, the Trust will also have an advocacy role in reducing barriers to access and create inclusionary environments by promoting housing and disability issues and building positive community and business relationships.

From: Disability Housing Trust website http://www.dht.org.au

Affordable Housing Options, Community Housing Coalition of WA

Housing affordability has been on the political agenda at a state and national level for the last few years. It is on the agenda largely due to the rapid rises in house prices and a reduction, in real terms, in spending on public housing. Some innovative options include:

Shared Ownership/Shared Equity Models
Governments around the world are acknowledging the potential gain of widening the benefits of saving and asset ownership, particularly to those on low incomes, as assets are key to escaping poverty. A report commissioned by the Office of the Deputy Prime Minister in the UK found that 'social housing tenants form a significant proportion of those with little or no assets and also often face most disadvantage in terms of the quality of their housing and the housing choices available to them. For owner-occupiers, housing assets were identified as their main source of wealth.

Equity Investment by Tenant’s Families
A number of different models are being developed to provide housing for people with disabilities. Some of these models have been initiated in response to meeting the needs of parents of young disabled adults seeking to ensure that their children’s housing requirements will be met once they are no longer able to care for them. These models are designed to ‘tap into’ the resources of the community serviced by the housing provider.


KEY QUESTIONS

While the importance of increasing access to more housing for the ILP is recognised, it is a complex issue and not easily dealt with in a half-day workshop. This topic could be addressed through another process jointly lead by DoH and DHW.
Section III

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. The program is not simply about maintenance of tenancy, but assisting people in the process of recovery. Support services are a critical component of the program. 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
- Clinical care and rehabilitation

PROPERTY AND TENANCY MANAGEMENT

What people said ...

- Should the landlord and support functions be carried out by one agency?
- Should the landlord agencies be providing social activities?
- There is considerable variability in the landlord role among agencies and in the services they provide for clients – welfare versus social enterprise philosophy.
- How should the workload benchmark be determined (e.g. one FTE per how many houses)?
- Supportive landlord funding for newly acquired houses is only made available at the beginning of each contract year
- Who should provide sheets/towels/cutlery etc when clients first move into house as this is not covered by Lotterywest?

DISCUSSION

The landlord role is a critical one. One of the key objectives of the program is to provide long-term, secure and affordable housing for people with mental illness who have a history of or are at risk of homelessness or have a history of housing instability. During the consultations, the researchers found that the rate of tenancy failure amongst clients of the program was extremely low at less than 5% per annum. Actual evictions from the program were extremely uncommon.

The program commenced in 1995 with contracts with Ruah for the provision of the psychosocial rehabilitation and support services and Wesley Care for the provision of supportive landlord services. It was considered to be important at the time to keep these two roles separate. A subsequent change in policy has seen a few organizations successfully take on both roles and one rural organization transfer the landlord function to a local housing association. Several providers have merged into two large housing associations, Access Housing in the southern and Foundation Housing in the northern metropolitan areas.

The question has been raised about which is the best model to follow:

- Managing the landlord and psychosocial support roles in separate organizations or managing them, albeit programmatically & structurally separate, within a single organization;
- Moving towards a model in which the landlord role is separated off and the property and tenancy services progressively moved to a small number of community housing associations; or
- Development of a specialist mental health community housing association to take on the landlord role.
The landlord organizations often reacted to this lack of access to psychosocial support services by expanding their own roles in an effort to combat such problems as social isolation and loneliness, neighborhood challenges and financial management. One of the only ways available to landlords for managing this demand on their services was to try to control the entry of clients with higher support needs.

There is also a significant degree of cross-subsidizing of high support need clients by landlord organizations. As one service provider told the researchers, approximately 70% of their clients, once settled, are no different from the general DHW clients. However, there are around 15% who require a moderate level of support, often because of neighborhood issues or attitudes, and another 15% who are very marginal and require a high level of support just to maintain their tenancy.

This raises the question of what the landlord function should actually be. Should the landlord be providing social support programs for their clients, sorting out neighborhood problems or working so intensively with clients to keep them in accommodation?

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**What's happening in Victoria and New South Wales?**

Victoria has been operating a similar supported housing program since the late 1980s. It started out in a very similar way to WA, with housing being provided through a specialist disability housing program within the public housing provider. This program is currently under review and people with psychiatric disability requiring psychosocial support have now been given priority within the general housing program.

The landlord role in Victoria has, until recent years, been carried out by the public housing provider, which is made easier by the fact that it is a Division within the same department as mental health; namely, the Department of Human Services. Interestingly, the Office of Housing also has developed a program to employ its public housing tenants in the maintenance of its properties.

More recently, community housing associations have been developing and they are progressively taking over the landlord role. Mental Health Services do not fund the landlord role.

In 2002, the New South Wales Department of Health introduced a new supported housing program, the Housing and Accommodation Support Initiative (HASI) for people with a mental illness. The New South Wales Department of Housing, one of the key partners in the program, provides the housing and it, together with community housing associations, manage the landlord role. The Department of Housing funds the property and tenancy services, while the Department of Health funds the psychosocial support services.
The landlord role is much clearer in the case of New South Wales and Victoria. The question is whether there would be any loss of benevolence in moving to a similar model in WA. There is considerable variability in supportive landlord roles. In addition to the traditional landlord roles some supportive 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 alternations to the property;
- Manage difficulties and complaints from neighbours; and
- Arrange social activities for tenants.

Any potential loss of service, however, would need to be addressed by incorporating these functions into the psychosocial support. The current funding model for the landlord function is based on the number of units of accommodation under management rather than on the assessed needs of clients. As such, there is no incentive to take on clients with high needs who attract the same rate as low need clients. Furthermore, it acts as a strong disincentive to discharge people from the program when they no longer have any need for the supportive landlord role without first accessing a replacement housing unit. These issues raise a number of questions:

- Should the landlord role be funded and if so by whom?
- What should be the model of funding for the landlord function?

PSYCHOSOCIAL REHABILITATION AND SUPPORT

What people said…

- Funding for support services has not kept pace with the increase in housing
- People with higher support needs miss out on getting into the program because of a lack of support services
- The lack of funding has meant that after hours and weekend support services have not been provided
- Funding for the provision of psychosocial support services is not tied to the ILP

DISCUSSION

The biggest and most common concern expressed by interviewees about the ILP was that the provision of psychosocial support had not kept pace with the supply of housing. This problem had been compounded by the fact that there was no definitive link between funding for psychosocial support services and client entry into the ILP. Interviewees argued that this led to clients with higher support needs missing out on housing allocation.

The landlord organizations generally believed that psychosocial support should be mandatory for people participating in the ILP and that this should be reflected in contracts with psychosocial support service providers or, alternatively, that the support and landlord roles should be combined within each agency.

An important underlying question is what is psychosocial rehabilitation and support? There are a plethora of terms and definitions throughout the literature and policy documents that are used to refer to psychiatric/mental health/psychosocial rehabilitation and to separate this from disability support. Much of this is aimed at making the distinction between what services should be provided by the NGOs and which ones should be provided by public mental health services. As the NGO sector moves towards increased training and specialization of its workforce, this distinction becomes less and less meaningful.
The term psychosocial rehabilitation and support has been adopted by the researchers to reflect both components of rehabilitation, namely:

- Specific interventions that assist people to recover from mental illness by improving role functioning, increasing ability and/or decreasing disability and developing skills and resources that are specific to individual needs - psychosocial rehabilitation; and
- Interventions that are aimed at the maintenance of role functioning, life skills and independence - disability support.

The document entitled Supported Community Living for People with Psychiatric Disability (OMH, July 2003), commented that:

"People living in these [ILP] properties also receive support services from non-government agencies and clinical services ….. The type of support offered varies according to the needs of the person and their carers. It may include disability support, psychosocial support, recreational and social support and respite. 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."

The program has continued to grow each year with additional properties coming on line from DHW, but without the commensurate growth in funding for support services. As a result, some of the landlord agencies are starting to question the suitability of the program for people with greater levels of disability or people with comorbidities. This raises the issue of what sort of clients should be accepted into the ILP program, what sort of supports should be made available and how should the support program be funded?

**What’s happening in Victoria and New South Wales?**

*In Victoria, the Psychiatric Disability Rehabilitation and Support Services (PDRSS) are community-managed specialist, tertiary services within the broad range of mental health services that assist people to achieve their life goals in key areas such as independent living, social relationships, recreation/leisure, education, personal development, vocational activity and housing. They have a different focus to, and are designed to complement, the clinical services in the mental health system.*

PDRSS provide a range of activities, which enable people to access programs in different environments allowing people to participate in the program that best suit their needs, including:

- Psychosocial Rehabilitation Day Programs;
- Home-based Outreach Support;
- Residential Rehabilitation;
- Supported Accommodation;
- Carer Support;
- Planned Respite Services; and
- Mutual Support and Self Help Services.
There are now more than 170 programs throughout Victoria providing rehabilitation and support services to more than 11,000 people.

Eligibility for the PDRSS program is based upon a person having a psychiatric disability as a result of serious mental illness. On entry to the program, all people are allocated a key worker who is responsible for coordinating a comprehensive assessment and the development of an Individual Program Plan that reflects the person's rehabilitation and support needs. The key worker is also responsible for facilitating the person's access to community, clinical and support services.

People referred for the supported housing program are placed on the waiting list, a key worker is appointed and an assessment undertaken. All people referred for supported accommodation are receiving support through PDRSS at entry to the program.

The original funding formula for the provision of psychosocial support in the program was based on 1 FTE per 10 clients funded at the base rate of a social work salary ($50,000 per annum). This was premised upon the expectation that the standard workload would have a mix of high and low support clients. Currently, funding is expressed in hours of support, which equates to 1 FTE per 5 to 10 clients depending on support needs.

As outlined above, New South Wales introduced the Housing and Accommodation Support Initiative (HASI) program in 2002. This program is a supported housing program that is being introduced in a series of stages, targeted at specified groups of people with varying psychosocial rehabilitation and support requirements. HASI Stage 1, for example, sought proposals from not-for-profit NGOs for the provision of high-level accommodation support services for 100 people with complex mental health problems.

The funding packages for the various stages of the program have ranged from $10,000 to $70,000 per client per year based upon the estimated hours of service required. The funding packages for HASI Stage 4, which is targeting people with very high-level needs will be $70,000 per annum, based upon an expectation of each client receiving up to 8 hours of support each day.

The Social Policy Research Centre, University of NSW, has been conducting a formal evaluation of HASI Stage 1. Results to date show that not only have 85% of clients successfully maintained their tenancy, but there has been a 90% reduction in the use of hospital bed days and 50% of clients who came to the program with a substance abuse disorder are no longer experiencing substance abuse problems.
As can be seen from the New South Wales experience, supported housing programs can produce extremely good outcomes, even for people with high support needs/comorbidity, providing appropriate levels of support are provided. It has been estimated that HASI Stage 1 saved over $7 million dollars in the first year, despite funding packages of $50,000 per client per year. Based upon the survey of providers, the ILP program in WA is not servicing clients with the highest support needs, but confirmation of this will not be achieved until the quantitative component of this study is completed.

In order for the ILP to deliver maximum benefit to clients and to the mental health system, a number of important changes to the program will need to be implemented including:

- Clearer definition of the client groups to be targeted by the program and of the expected outcomes;
- Introduction of a standardized system of needs assessment and a system of key workers appointed to facilitate the client’s program; and
- Development of a funding model for the provision of psychosocial rehabilitation based upon the level of support services required.

Both the New South Wales and Victorian funding models are based upon estimated hours of service, which is dependent upon the assessed support needs of each client. The New South Wales model is very tightly focused on staged packages of support for specified client groups that are selected by area health services. A combination of the Victorian and New South Wales funding models may be appropriate in WA, with the NSW package of care approach being reserved 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).

While the ILP plays an important role in assisting people on low incomes with a mental illness to live successfully in the community, it needs to be seen within the broader context of the psychosocial rehabilitation and support system. There are many other people with a severe mental illness living in their own homes, in rental accommodation, with parents and families, in marginal or substandard housing or who are homeless who have a high need for access to psychosocial rehabilitation and support. In the Victorian context, the pathway to the supported housing program is through referral to a PDRSS where a comprehensive assessment of the client's needs is carried out. All people entering supported housing, therefore, have the level of psychosocial support identified in that assessment and set down in their Individual Program Plans.

Pathways to Housing, New York City

The Pathways to Housing supported housing program in New York City provides immediate access to independent scatter-site apartments for individuals with psychiatric disabilities and concurrent substance addictions who are homeless and living on the street. Support services are provided by a team that uses a modified assertive community treatment model. Pathways to housing provides opportunities for its tenants to undertake employment within the program and each support service team includes a consumer mentor.

A study of the program found that after 5 years, 88% of the program’s tenants remained housed and 27% of them were employed at least part of the time each year. This program challenges many widely held clinical assumptions about the relationship between the symptoms and the functional ability of the individual. It shows that people with severe psychiatric disabilities and associated addictions are capable of obtaining and maintaining independent housing when provided with the opportunity and necessary supports.
The employment of tenants as mentors within the Pathways to Housing program highlights two important issues; namely, the valuable role that consumers can potentially provide within a supported housing program and the importance of employment for people with a mental illness. Consideration should be given to introducing a similar program into WA. The mentor program that the Commonwealth Department of Family and Children’s Services and Indigenous Affairs (FACSIA) will be funding over the next 5 years offers a real opportunity to progress the ‘consumer mentor’ model. Combined with increased opportunities for ongoing skills development, such a program could provide a real pathway for people with mental illness into a range of jobs within mental health/health services.

CLINICAL CARE AND REHABILITATION

What people said…

- There are limited resources in rehabilitation in the Mental Health Services
- There are problems with staff continuity and with getting clinical support for ILP clients, particularly where there is no designated accommodation coordinator
- There appears to be a lack of visibility of the ILP program amongst many MHS clinic staff and new staff need to be provided with information about the program
- Clients who have been ‘de-activated’ by MHS clinics find it difficult to get back into the MHS system when they require urgent services
- It is difficult to get clinical support from GPs and private psychiatrists
- MHS clinic boundaries are rigidly adhered to and staff won’t follow the client when he/she is accommodated outside the clinic district

DISCUSSION

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.

There were a number of situations that posed particular difficulties for ILP providers:

- Difficulty was frequently experienced in obtaining access to services in an emergency for clients from clinics when clients had been ‘de-activated’ [removed from the list of active patients].
- Getting clinical services from private psychiatrists and GPs could be difficult at time, particularly in urgent situations.
- The practice of transferring client care from one clinic to another when clients were housed outside the treating clinic’s boundaries was distressing for clients and problematic for ILP providers.

One of the major underlying problems in WA is that 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. This tension can also be reflected in the movement of funds from rehabilitation services, particularly during service restructuring. …. The identification of discrete rehabilitation workers minimizes the impact of treatment service demands on the delivery of rehabilitation services.”
Herein lies the one of the major constraints in the provision of clinical support services for clients in the ILP. The ILP program is centred on the community mental health clinics. Waiting lists are developed and held, by and large, by the clinics, houses allocated to clinics 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 clinics having very rudimentary rehabilitation services. As outlined earlier, ILP needs to operate within the framework of the broader psychosocial and rehabilitation service system.

**What's happening in Victoria**

The specialist public mental health system consists of clinical services and psychiatric disability rehabilitation and support services (PDRSS). Clinical mental health services are managed by public hospitals and provide assessment, diagnosis, treatment and clinical case management to people with a serious mental illness. PDRSS are provided by non-government community organisations as outlined earlier in this chapter. Specialist clinical mental health services in Victoria are provided on an area basis, and are often referred to as area mental health services (AMHS).

**Continuing care services**

These are the largest component of adult community based services. These services provide non-urgent assessments, treatment, case management, support and continuing care services to people with a mental illness in the community. The length of time case management services are provided to a person varies according to clinical need. Continuing care services may be involved with people for extended periods of time or may provide more episodic care.

**Mobile support and treatment services (MSTS)**

These services provide intensive long-term support to people with prolonged and severe mental illness and associated high-level disability. They utilise an assertive outreach approach and operate extended hours seven days a week. MSTS’s differ from continuing care services in the frequency and intensity of intervention offered and work more closely with psychiatric disability rehabilitation and support services.

**Community care units**

Community care units provide medium to long-term accommodation, clinical care and rehabilitation services for people with a serious mental illness and psychosocial disability. Located in residential areas, they provide a ‘home like’ environment where people can learn or re-learn everyday skills necessary for successful community living. While it is envisaged that people will move through these units to other community residential options, some consumers require this level of support and supervision for a number of years.

**Secure extended care inpatient services**

These services provide medium to long-term inpatient treatment and rehabilitation for consumers who have unremitting and severe symptoms of mental illness, together with associated significant disturbance, that inhibit their capacity to live in the community. These services are provided on a regional basis, and are gazetted to take involuntary consumers.

**Homeless outreach services**

Homeless outreach psychiatric services (HOPS) provide a specialist clinical and treatment response for people who do not engage readily with mental health services. HOPS work in partnership with homelessness services and use assertive outreach to locate and engage with their clients to create a pathway out of homelessness by providing early and appropriate treatment. HOPS link clients into the mental health service system, including access to long-term housing augmented with outreach support, and improve the coordination and working relationships between mental health and homelessness services.
Victoria probably has one of the best organized and integrated service systems for the management of people with enduring mental illness and associated disability. The public mental health system has developed a close partnership with the Psychiatric Disability Rehabilitation and Support Services (PDRSS), which are operated by the NGO sector. Nevertheless, when the Victorian Auditor General turned the spotlight on hospital re-admission rates earlier this year, he found that:

“More than one in seven mentally ill patients discharged from Victorian psychiatric facilities are back in hospital within 28 days. … Mental health experts say many patients are given inadequate discharge planning and insufficient support outside hospital.” [Age, 14/02/2006]

How does the situation in WA compare? The area with potentially the highest return on investment is in the management of people with enduring or recurrent mental illness. They represent a relatively small and easily identifiable group, but their use of inpatient services is extremely large. Well coordinated and integrated programs like the New South Wales HASI program 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 psychiatric rehabilitation and support services in WA: about whether they should be developed as a discrete service system separate from the acute treatment services, what level should they be organised (e.g. area-based) and what role should the NGO sector have. But, more specifically in relation to ILP:

- 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?

**KEY QUESTIONS**

**Property and Tenancy Management**

1. 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?

2. What should the landlord function actually be?
   - Should the landlord be providing social support programs for their clients, sorting out neighborhood 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**

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

**Clinical Care and Rehabilitation**

1. 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?
2. How can the relationship between the ILP services and MHS be enhanced?
Section IV

Actively Managing the Program

What people said...

- Need to ‘programmatize’ the ILP. This means a clear statement of ILP objectives, target group, criteria for entry, priority for housing allocation, exiting the program and evaluation
- What priority should MHS clients get versus referrals from GPs, private psychiatrists?
- No clarity on policy of accepting people with drug and alcohol issues
- Lack of clarity on roles of the partners and how they should work together at all levels in the program, including working to a recovery model
- Program management at local level needed, including jointly developed shared care/management plans/protocols
- Administering the ILP is a significant demand on the time of MHS, particularly in rural areas
- Administrative and reporting requirements for the MHD too onerous
- Housing allocation based on wait list numbers not necessarily demand and sending waiting lists to the MHD once a year too infrequent
- No active program management so if housing cannot be purchased in one area the funding can be shifted to purchase elsewhere
- Need suitable housing - well designed, near services, not clustered
- Want access to some houses in small country towns so clients don’t have to move to regional centres
- Houses can become labelled as “mental health” so need capacity to swap houses
- How can tenants own part or all of their house?

DISCUSSION

The guidelines for the way in which the ILP should operate are contained within the document Independent Living Program – Providers Operational Guidelines [OMH, Draft, December 2005]. The Preface to this document states:

“It is recognized that not all organizations 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 ....”

The most striking feature evident during the consultation was the lack of consistency in the way that the various services across the State operated within these guidelines in terms of assessment and selection of clients, management of waiting lists and the roles of the various partner organizations. It gave the impression of a program that had grown organically over the years, with each service evolving in its own distinctive way. There was a strong desire expressed by many of those consulted during the review for greater consistency and clarity in the way that the ILP operated, particularly in terms of:

- The objectives of the ILP and the philosophy and principles that underpin it;
- The roles of the partners and the way in which they should work together;
- Eligibility for access to the program;
- Assessment of client needs;
- Maintenance of the waiting list and selection of clients for entry into the program;
- Working relationship of the partners with clients;
- Reviewing clients and managing their exit from the program; and
- Managing the housing.
Program Objectives

What is the program trying to do, for whom and with what expected outcomes? These questions are central to any evaluation of the program. It is clear from the documentation 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.

When the program was originally established, it was intended that it would target people with persistent mental illness and associated disability who had difficulty in maintaining themselves in the community and that this would be manifest in repeated hospitalizations ['revolving door']. Should the program target people who are high users of inpatient services and one of its objectives be to decrease the frequency and/or length of hospital admissions? Should the program also be looking at increasing the number of people taking up open employment, other forms of work, participating in leisure and social activities and increasing levels of contact with families? These objectives need to be articulated clearly in the documentation.

Client Selection

There was a perception amongst a number of the landlord agencies that the level of acuity of the clients being referred to the ILP had been increasing progressively and, as a result, they were seeking clarification about which groups may be suitable and which unsuitable for access to the program. It was reported that some of the agencies were becoming a lot more selective about who they took into their programs.

This raises the question about who manages the program and how it is managed. Who should be selecting the clients for the program, maintaining the waiting list and prioritizing client entry into housing? In the operational guidelines, it states that:

“The role of the Mental Health Service is to ensure that suitable clients for ILP housing are referred to the Housing Provider .... [and that] the role of the Housing Provider is to ensure that a fair and equitable process of allocation is entered into when vacant properties become available ....... [and to ensure that] where applicable, liaison occurs with the relevant MHS workers.”

In practice, arrangements across the State vary considerably, ranging from MHS identifying the clients and controlling the waiting list, through to the ILP partners participating together in the process, and finally to NGO providers maintaining the waiting list and controlling entry into housing. There are a number of significant benefits in establishing a shared approach to these processes including:

- Fairness and transparency;
- Better matching of client with services;
- Better integration of services; and
- Improved interagency cooperation and support.

There is a potential problem with individual MHS services or NGOs managing the assessment, waiting list and selection processes. There are areas (e.g. Joondalup) where it is very difficult for DHW to obtain housing and, although clients may apply to transfer catchment areas, priority is often given to local clients. This raises the question of how and at what level, local, regional or metropolitan, waiting lists should be managed to ensure fairness and equity for all clients. Management of the waiting list at a regional or system level would allow clients with the greatest need to be offered priority access, regardless of where they lived. High priority clients could then be given the option of sticking with their original preference or moving into the next available house.
Who gets priority in terms of access to housing? This is an important question. The eligibility criteria are clearly interpreted differently by the various agencies. In terms of which clients may be unsuitable for the ILP, high support needs and comorbidity alone cannot be seen as reasons for excluding people from the program. The NSW HASI program and the New York Pathways to Housing program demonstrate clearly what can be achieved with the right type and level of support services. A UK study looking at the differences between the characteristics of people in extended stay hospital care and supported housing found that the major distinguishing feature was aggressive behaviour towards others.

Should we give priority to the homeless, especially those with children? Should we target young people showing high or increasing rates of hospital usage in the early stages of their illness, before they develop secondary problems? Should we be targeting those people who are currently extended stay patients in hospital?

In considering these questions, it is worth considering the HASI model introduced in NSW.

At its core, HASI is similar to the ILP in that it is a partnership between NSW Health, the Department of Housing and the non-government sector which provides housing linked to clinical and psychosocial rehabilitation services across a range of levels of psychiatric disability. However, HASI is a clearly articulated program, which identifies objectives and outcomes together with:

- Clearly identified and targeted key groups of clients who are a priority for supported housing;
- A funding model which matches packages of funding to individual clients to support their level of assessed need;
- Operational guidelines which are specific and systematized; and
- Evaluation built into the program from the beginning to determine what works, what doesn't and for whom.

**Working with Clients**

In the NSW HASI program, client support is seen as a joint responsibility by the partner agencies and the roles and responsibilities of each of the partners is set out in an Individual Service Plan. A requirement for client entry into the HASI program requires that the partners, including the client, enter into an agreement allowing disclosure of relevant information between the parties. By contrast with this, the researchers came across one organization that expressed concerns about participating in joint assessment or selection processes because of the need to maintain patient confidentiality.

On entry to the Victorian PDRSS program, clients are allocated a key worker from an NGO service who is responsible for coordinating a comprehensive 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 facilitating the person’s access to community, clinical and support services.

Should the ILP be accepting referrals from General Practitioners and private psychiatrists and what level of priority should they be given? Clearly all Western Australians can expect that they will be given fair and equitable access to public health services, regardless of whether they are receiving their medical care from a private medical practitioner or one engaged in public mental health practice. However, this highlights the need for a standardized form of needs assessment to enable decisions to be made about relative priority before clients are accepted into the program. The role that the private medical practitioner will have in the client’s individual service plan, particularly in relation to urgent assessment and treatment requirements, also needs to be a clearly articulated.

The issue of transferring client’s care when they move outside a Community MH Clinic’s catchment area has been raised in the previous section on Support Services. In the consultations held with ILP clients, this was identified as a problem that needed to be addressed. Clearly, it could be a problem if clients moved from one end of the metropolitan area to the other or from the city to country. But is it necessary when people move into an adjacent suburb? Transferring their care from one practitioner to another can be a major source of stress for clients that can affect their level of functioning for many months.
NSW Housing and Support Initiative (HASI)

Targeted Program:

- Very High Support, 50 places, $70,000 per place, up to 8 hours support per day, no new housing required
- High Support, 244 places, $50,000 per place, 4-5 hours support per day, new housing
- Low/Outreach, 460 places, $10,000 per place, up to 5 hours per week, no new housing

Philosophy: Explicitly stated

Recovery based. Working holistically, with a person's strengths, tailored to individual, development and ongoing review of individual care plans.

Entering and Exiting HASI

There are clear eligibility criteria and the Register of Applications (wait list) is maintained by the local accommodation support provider. A Client Selection Panel is convened locally in each HASI area, coordinated by the relevant accommodation support provider and comprising at a minimum the local mental health service, the support provider and if relevant the housing provider. A standardized Relative Need Assessment generates a numerical score and determines priority. If a client is no longer eligible for support under HASI, they remain in their housing as a community or public housing tenant.

Working with Clients

It is an entry requirement that clients allow disclosure of relevant information between the HASI parties. Individual Service Plans (not the same as Mental Health Care Plans) with clearly defined components are developed between all parties and signed by local HASI providers as well as the client.

Ongoing Monitoring and Evaluation

Does the program work and which clients get the best outcomes? An initial 2-year evaluation by the University of NSW which is funded by NSW Health and the Department of Housing is being conducted. An ongoing minimum data set is being determined to enable longer-term, ongoing evaluation.

Partnership approach

As previously stated, the ILP is a joint initiative between the Department of Housing and Works and the Department of Health. Those two agencies are the key stakeholders in the program together with the Housing Providers, Mental Health Services and the Disability Support Providers. The Mental Health Division (previously Office of Mental Health) convenes a three-monthly ILP meeting for stakeholders to share information and to address matters of concern. The Division also works actively with staff in the Community Disability Housing Program on an ongoing basis. The question is whether these mechanisms have been sufficient to allow for the planned development of new services, the reshaping of existing policies and services and the active management and coordination of the program.

Clearly, the best results for the ILP could be achieved through an active partnership at all levels. The benefits that could be accrued from stakeholders working together at the local service level have already been raised earlier in this section. The NSW HASI program is undoubtedly the best example of this, with structured and robust partnerships at all levels from the system policy level through to the local service delivery level. There is considerable clarity about the roles and responsibilities of each of the partners at all levels of the program and the way in which they will each work together is clearly spelt out and agreed to.
HASI Partnership Approach

HASI has a three-tier management and coordination structure involving:
• Sponsor Agencies
• Partner Agencies
• Local HASI Providers

The Sponsor Agencies are NSW Health and the Department of Housing, who are responsible for allocating the staffing or funding necessary to provide the support services to HASI clients, monitoring the initiative, and overseeing independent evaluations of the program.

HASI is supported by a number of Partner Agencies, namely:
• Office of Community Housing within Department of Housing
• Centre for Mental Health, within NSW Health
• Relevant Area Health Services, in particular the mental health teams
• Community housing providers, funded by the Department of Housing through the Office of Community Housing
• Non-government organisations as accommodation support service providers, funded by the Centre for Mental Health.

HASI is overseen by the HASI Advisory Committee which contains representatives from Sponsor and Partner Agencies, as well key peak organisations. Its roles are to oversee the implementation of the initiative, provide direction, support and feedback to the initiative and support the independent evaluations. The HASI Advisory Committee will operate a series of quarterly forums with a smaller Executive Committee that meets as required. The focus of the HASI Forums is to bring together a wide range of stakeholders that provide services under HASI to share information and workshop issues that will inform the implementation of HASI.

In each location there are three local partners who are responsible for implementing the initiative and directly providing services to HASI clients. These local HASI providers are:
• Local Area Health Service, and specifically its mental health team
• Housing provider, in most cases a local community housing provider or public housing client service team
• Accommodation support provider.

At the local level, Service Level Agreements are signed between the three partner agencies. All partners will participate in Local Coordination Group Meetings and Client Selection Panels. The accommodation support provider initiates and convenes these meetings.

Managing the Housing

The consultations raised a number of issues about the way in which the housing side of the ILP is organised and managed.

Currently houses are allocated once a year. Name de-identified information about clients on each ILP waiting list is sent to the MHD. As responsibility for maintaining the wait lists varies between areas, the information will be sent by either the local MHS or a non-government ILP provider. The MHD then applies a formula to determine the number of houses to be allocated to each area. Approximately 60 houses are anticipated as being available each year, with 75% being allocated to the Perth metropolitan area and 25% to the rural area. The recommended number of units of accommodation is then forwarded to the Department of Housing and Works, who in turn, notifies each housing provider of their annual allocation. A number of concerns about this process were expressed during the consultations.
Housing allocations for each area are primarily determined by the number of clients on their waiting list. Each ILP provider has their own way of determining eligibility for entry to the wait list. Some organisations are more proactive in promoting the program, hence their waiting lists are longer. Overall there is no standardized approach across the system to assess need and determine eligibility for entry to the wait list, beyond the broad criteria outlined in the draft operational guidelines. It was considered that allocating housing once a year was too infrequent. These issues raise concerns about the equity of access to housing and the question as to what is the most appropriate method for determining housing allocations.

A further concern was the need for increased flexibility in managing the housing allocations. When DHW are finding it difficult to purchase houses in a particular area, there is no mechanism in place for DoH and DHW to actively manage this issue across the system. For example, if it is not likely that houses will be available in a certain area, there is currently no capacity to shift the allocation to another area where houses can be built or purchased. Nor is it clear what happens to any unspent funds if houses cannot be purchased and whether they could be used to support other housing options for clients, such as subsidizing rental in the private housing market.

Further issues were raised about increasing DHW flexibility in applying some of their general policies to the ILP by recognizing the special needs of this client group. For example, DHW could allow the purchase of houses in small country towns so consumers do not have to shift to regional centres. In Kwinana, where the DHW policy is to reduce its housing stock, there should remain some opportunities to house clients who have family or other strong connections to the area.

Houses within the ILP can become labelled as ‘mental health’ houses. There is, at present, no policy to address this issue. The DHW Community Disability Housing Guidelines provide opportunities to transfer tenants but there are no specific policies to shift housing between ILP and ‘general’ housing stock when a tenancy ends to avoid the issue of stigma. Larger housing providers will have more flexibility to manage this within their own housing portfolio, however, those with only ILP houses will require other strategies, which could include transfers through the DHW housing stock.

The importance of well-designed houses which are located near transport and community services was consistently emphasised by both consumers and service providers. Many clients are on limited incomes and rely on public transport. Client access to a range of services including work, education and training, social and leisure, is important for their participation in psychosocial rehabilitation and recovery programs. It was also noted by many during the consultations that it is important not to cluster housing for people with psychiatric disabilities, but rather to disperse these houses through the community.

Home ownership or part ownership was also raised as an issue. While DHW has programs such as Keystart, it doesn't appear that ILP clients are accessing this option. The reasons for this require further consideration.

**KEY QUESTIONS**

1. What should be the key objectives and outcomes of the ILP?
2. 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?
3. How and by whom should clients be selected and prioritized for access into the program?
4. 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?
5. How should referrals from GPs and private psychiatrists and cross boundary movements of clients be managed?
6. What sort of partnership structures between the stakeholders would best assist in the planning, management and coordination of the ILP in Western Australia?
7. How should housing be allocated (based on the waiting lists, a rural/metropolitan split, or some other means)?
8. How can more flexibility be built into housing program to enable allocations to be shifted to where houses can be purchased?
9. How can the stigma associated with ILP housing be overcome?
10. What needs to happen to increase ILP clients’ access to home ownership?
Section IV

Quality

What people said...

- Improved standards/accreditation processes for NGOs
- Ongoing supervision of NGO staff is required in addition to training
- Need training for staff in all partner organisations in ILP (mental health services, landlord agencies, support agencies and DHW staff)
- Induction programs on ILP for all new staff
- Lack of funds for training
- Access to training and supervision is difficult for rural providers
- Low wages in non-government sector make it hard to attract and keep staff with qualifications and experience

DISCUSSION

Training and Workforce Development

During the consultations the need for training and workforce development was a recurring theme. While many of the comments specifically related to the training needs of the NGO psychosocial and rehabilitation support services, there were also training issues for the government mental health services and the community housing sector.

In the policy framework document entitled A Recovery Vision for Rehabilitation (OMH, 2004) it was noted:

A significant issue is the need for increased specialisation and training of some people who provide mental health rehabilitation services in Western Australia…….The development of appropriate training needs to occur at several levels. Firstly, there is the need to ensure that contemporary philosophy is included in undergraduate and postgraduate training of the full range of mental health professions. Secondly, programs need to be developed to ensure that support workers, who may not have tertiary qualifications, are also provided with opportunities to develop knowledge, skills and attitudes that are consistent with contemporary rehabilitation philosophy.

Recovery oriented skills and attitudes are also required by mental health workers throughout the sector. This need has been recognised in the National Practice Standards for the Mental Health Workforce.

The qualifications and experience of the non-government workforce varies greatly, however, there is linked data which is readily available on the ILP workforce or indeed, the broader psychosocial and rehabilitation workforce. The best information readily at hand is from a recent survey of the non-government mental health workforce quoted this year in a WAAMH briefing document for the Mental Health Network Management and Implementation Committee. It should be noted that these survey results are for the entire NGO mental health workforce, not specifically the psychosocial rehabilitation and support component.

<table>
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<th>Education Level</th>
<th>Staff Numbers</th>
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<td>142</td>
<td>27%</td>
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<td>TAFE</td>
<td>239</td>
<td>46%</td>
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While the non-government agencies recognize the importance of training and developing their workforce, they are doing their best with limited access to appropriate training programs, limited funding and no clarity from the Department of Health about the level of skill required to undertake the contracted services. Furthermore, there are limited mechanisms in place to inform the further education and training sector of the requirements of the psychosocial rehabilitation and support workers in both the government and non-government services. These issues are magnified for rural service providers. They face the additional difficulties of accessing training because of the distance they have to travel to city based training programs. They have the burden of the extra costs, both time and money, associated with this travel.

What was clear from the consultations was that the workforce has a significant number of part time workers, some of whom have limited or no formal qualifications, with few opportunities for professional supervision. Funding levels play a part in contributing to this situation, as does the availability of appropriate training specifically targeted to the psychosocial rehabilitation and support services. The salaries in the non-government sector are generally less than is paid for comparable work in the government system and this makes it difficult to attract and retain qualified, experienced staff.

TAFE currently runs a Certificate IV in Mental Health Work (Non-clinical) which provides “practical skills and knowledge to provide support and service to enhance the quality of life, maximise community participation and meet the needs of individuals accessing mental health services” (TAFE Central Course Description, 2006). It is not clear whether the existing courses at TAFE meet the specific needs of the psychosocial rehabilitation and support services. Nor is there a partnership in place whereby the Mental Health Division, the Department of Education and Training and the peak NGO bodies liaise on current and future workforce training and development needs. The issue of ensuring the relevance of undergraduate and postgraduate university courses in the areas of psychosocial rehabilitation also requires further exploration.

In Victoria the psychosocial rehabilitation and support non-government sector has its own peak body, VICSERV, which plays a key role in relation to training and workforce development. Whether WAAMH could undertake this role in relation to workforce training and development can be raised during the workshop. The following examples illustrate how training and workforce development is being addressed in other jurisdictions.

**VICSERV**

VICSERV is the peak body for psychiatric disability rehabilitation support services in Victoria. It began providing training for the sector in 1994 to fill an identified gap in appropriate training programs. The Department of Human Services provided the funding to establish the training program, continues to fund the ongoing program and funds service organisations to backfill positions when staff attend training. The Department recognised the need to increase the professionalism and capacity of the NGO workforce to work in partnerships.

VICSERV surveys have found staff in the sector are well educated with 60% have university qualifications and most of the remainder having a Certificate IV or Diploma in Community Services or Mental Health.

VICSERV does not provide TAFE type courses, but provides orientation programs followed by additional training in relevant areas. They regard Certificate IV or Diploma level qualifications as a pre employment level qualification and shape their courses accordingly. VICSERV partners with a range of registered training organisations. It also provides training for workers who do not work in mental health but have mental health clients.

From: Options Paper, Training and Other Workforce Development for the Mental Health Sector, Mental Health Co-ordinating Council, 2005
Network of Alcohol and Drug Agencies NSW (NADA)

NADA is the peak body for about 100 drug and alcohol NGOs. When workforce development was identified as a high priority, NADA was funded for a workforce development position. They decided not to deliver training but to strengthen their relationship with existing training bodies, particularly TAFE and the Centre for Community Welfare Training to ensure that they deliver industry relevant training. They have worked with TAFE to produce extra resources where needed, improve the recognition of prior learning for the workforce and deliver more work based training. They provide funds to allow NGOs to ‘backfill’ positions when staff attend training. They also encourage NGOs to send two workers to training simultaneously to increase knowledge transfer to the agency and change culture.

NADA supports workforce development activities by
- working directly with Boards on governance issues;
- working with the National Centre for Education and Training on Addiction to advance best practice in supervision; and
- supplying support to NGOs to implement clinical supervision.

Ongoing funding from NSW Health has been critical to the success of the program.


WA Certificate IV Social Housing

March 2006 saw the first round of graduates from the Certificate IV Social Housing program. This is the result of an innovative partnership between the Community Housing Coalition of WA and the WA Centre for Leadership and Community Development.

It is the first qualification in Australia that is delivering industry-based training in Social Housing. The Department of Education and Training and the Department of Housing and Works agreed to jointly fund the development of the curriculum.

Key innovations of the course are that existing workers are assessed in the workplace to identify their skills and areas where they may need additional training. Once assessed, students undertake work activities and projects in order to gain their qualification. This provides a real benefit to the organisation, as the projects are always relevant and training is delivered flexibly, including in the workplace.


A common observation by each of the partner organisations in the ILP was that partners required broad knowledge of and training in each others area of specialisation. For example:

- mental health workers should know about the housing issues and legislative requirements of the Tenancies Act; and
- housing workers need to know about mental health and specifically about how to address issues of safety and managing client behaviour.

It was also noted that new staff coming into the MHS needed to be given an ILP orientation program.
Service Standards & Accreditation

During the consultation a number of people expressed significant support for the ongoing work of WAAMH in assisting agencies to implement the Service Standards. These standards were developed through the Office of Mental Health with major input from WAAMH and the non-government mental health agencies and published in 2003-2004 in the *Service Standards for Non-Government Providers of Community Mental Health Services*. The 8 standards comprise:

- Rights and Responsibilities
- Safety
- Privacy and Confidentiality
- Consumer Participation
- Carer Participation
- Organisational Governance and Management
- Accessible Inclusive Service Provision; and
- Delivery of Services.

Managing to meet these standards is likely to be more challenging for smaller organisations. Innovative strategies need to be developed to address this. Victoria has a well developed approach to standards and accreditation in the non-government sector. What is most notable is that Victoria has developed specific standards for the psychiatric disability rehabilitation and support sector. They have recognized the particular issues which these type of services need to address and this is reflected in the standards.

**Victorian Standards for Psychiatric Disability Rehabilitation and Support Services (PDRSS)**

Victoria has a strong tradition of psychiatric disability rehabilitation and support service provided by the NGO sector. The Standards for Psychiatric Disability Rehabilitation and Support Services were adapted from the national standards for mental health services in recognition of the specialist nature of the PDRSS sector. The standards are:

- Rights
- Safety
- Participant, community and carer involvement
- Promoting community acceptance
- Privacy and confidentiality
- Prevention and promotion of mental health, cultural and gender awareness
- Integration (service 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)
- Documentation
- 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 & employment, family, relationships, social & cultural system)
  - residential or home-based rehabilitation and support
  - psychosocial rehabilitation and support
  - planning for leaving the PDRSS
  - leaving and re-entering the PDRSS

The question of accreditation for Western Australian NGO agencies which provide psychosocial rehabilitation and support services requires further consideration. As with service standards, the Victorian Department of Human Services has a well developed approach to accreditation which is specific to the non-government psychosocial rehabilitation and support sector.

**PDRSS Accreditation for the Non Government sector in Victoria**

In 2004 the Victorian Department of Human Services introduced a staged approach to accreditation for the PDRSS sector. Two streams were developed:

- **Stream A: Capacity Building** (a quality grant to support small PDRSS to engage in quality planning activities that will develop their capacity to engage in a formal accreditation processes in the future)
- **Stream B: Accreditation Process** (a quality grant to assist large stand alone PDRSS to achieve formal accreditation).

The following is the model for PDRSS sector accreditation for Stream B services:

- Annual service self-assessment against the complete set of Standards using a self-audit manual;
- The development of a quality improvement report and plan that addresses any gaps identified to the standards arising from the self-assessment process, and submission of this to the Department;
- Annual liaison with the regional office on the report and plan to assist with the liaison and support role of the agency liaison officers and assist with the identification of organisation, sector and other developmental issues; and
- External formal audit every 3 years, incorporating the data from the annual self-assessments (including external, peer and consumer auditor, and incorporating the service's self-assessment plans).

Currently the Department of Human Services has funded the Australian Institute for Primary Care to recommend a process that will facilitate the accreditation of PDRSS against the Standards for the PDRSS.


**NEAMI: An Accreditation Example from Victoria**

By way of example, Neami, a PDRSS service provider in Victoria, South Australia and NSW, has completed all the requirements for accreditation with the Quality Improvement Council of Australia. Neami is accredited against the Australian Health and Community Service Standards: Health and Community Service Core Module and the Victorian Psychiatric Disability Standards. The process of accreditation is a 3 year cycle with the first component being the formal accreditation and then a series of plans for 2 years of continuous improvement activities. NEAMI view the accreditation process as another means of ensuring continuous improvement throughout the organisation.

From: [www.neami.org.au](http://www.neami.org.au)

This raises the question as to whether WA should consider developing specific service standards for non-government agencies working in the psychosocial rehabilitation and support sector. What benefits would this bring and what steps would be necessary to facilitate this process?

A further question relates to the issue of accreditation. Currently there is no requirement by the Mental Health Division for non-government agencies to seek accreditation. As with the issue of service standards, consideration needs to be given as to what benefits this would bring. Should accreditation be pursued more generally for all non-government mental health agencies or are the needs of the psychosocial rehabilitation sector so particular that accreditation should be considered specifically for this sector?
Research & Evidence Based Practice

The report A Recovery Vision for Rehabilitation: Psychiatric Rehabilitation Policy and Strategic Framework (OMH, 2004) makes the following observation about research and evidence based practice:

“……further collaboration between education, research and rehabilitation providers will provide a range of benefits to further the development of rehabilitation services in this state. These benefits include the enhancement of teaching and research, and the gathering together of research expertise to expand the evidence base.

Following this report, a proposal has subsequently been developed as a partnership approach with the university sector to establish a Centre of Excellence in Mental Health Psychosocial Rehabilitation and Recovery.

A Proposal to Establish a WA Centre of Excellence in Mental Health Psychosocial Rehabilitation and Recovery

In July 2006 a proposal was put to the Mental Health Network Management and Implementation Committee to establish a Centre of Excellence in Mental Health Psychosocial Rehabilitation and Recovery. This proposal was developed by Sheryl Carmody, Chair of the Office of Mental Health Committee for ‘A Recovery Vision for Rehabilitation’ and Errol Cocks, Professor School of Occupational Therapy Curtin University.

The Centre would have the following benefits:

• Act as a source of international evidence-based best practice;
• Partner in, carry out &/or draw on local research;
• Provide service program model development;
• Promote workforce development in both the public and non-government sectors; and
• Support the non-government mental health sector in carrying out their community role.


The issue of continuous improvement, monitoring performance and evaluating the outcome of the ILP has received limited attention to date. There is little known about the impacts of the ILP for consumers and the mental health system. Clarity about the specific intended outcomes of the program is required, together with identified key performance indicators. It will then be clear what data needs to be collected in order to measure the success of the program.

Consideration should be given to building an ongoing system of evaluation into the ILP as a routine part of the cycle of quality improvement and performance monitoring.

KEY QUESTIONS

Training and Workforce Development

1. 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?

2. How can partnerships with training providers (eg. 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?

3. How can we improve access to training for the rural psychosocial rehabilitation and support services workforce?
Service Standards & Accreditation

1. 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?

2. 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

1. How can we ensure there is on going monitoring and evaluation of the ILP and how can this be developed?

2. What structures could be put in place to support best practice and research in psychosocial rehabilitation?
Key Publications

General

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Housing

Department of Housing and Works, Community Disability Housing Program Guidelines, April 2006

Department of Housing and Works, Strategic Housing Policy for People with Disabilities, April 2004

Disability Housing Ltd, Inventing a New Disability Housing Company on the Run, 2006

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Office of Mental Health, Operational Guidelines, For Independent Living Program (ILP) Housing and Mental Health Services Providers, A Guide for Housing People with a Serious and Persistent Mental Illness, Draft, December 2005

Metropolitan Mental Health Service, Finding a Home ~ Keeping a Home: Supporting the Journey Towards a Secure Base, January 2001

NSW

NSW Health, Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders, November 2002

NSW Health, Framework for Rehabilitation for Mental Health, Mental Health Implementation Group, November 2002

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Workforce Development

Fisher Jane, Freeman Heidi, Options Paper – Training and Other Workforce Development for the Mental Health NGO Sector, Mental Health Coordinating Council, 2005