Inquiry to Appropriate Housing for People living with Mental illness.

I apologize for not typing this as my printer is not working.

- Housing staff are too rigid, do not take into account letters from psychiatrists, phychologists, G.P's. Welfare Workers & advocate SOP / MOU. between mental health first signed in 1999 & updated at least 2 x. People are human whether they have a mental illness &/or a physical illness.

I was given temporially a flat in [redacted] flats. I accepted it on that condition but dispute the above wanting the welfare worker/advocate seeing them with me.

Windows smashed, / by a bullet, broken into, being attacked & continuing lead & criminal behaviour. I finally was given priority 2. (under homeless) 2 years ago. Only by the persistence of the above & the continuing lead behaviour of some of the tenents.

The only people we see are the police. but at least they do try & calm the troubled waters. No politicians. We have seen M. Moore, B. Wood & this minister wait until this submission & housing were going through their lists. (which resulted in a phone call asking if I still wanted to be on the list to move. nothing about priority.

As you are aware human rights are to have safe, secure, housing. Also mental health is affected by not having that.

Especially when you have been so traumatised to have to live in

a place where you have been broken into by drunk who reckon that you are in their flat. if you go out you never now if your things will be there or that you will have access to be dropped off at your place because the police will be next door & you want be allowed in. Housing staff & the govt who ever it is should be made accountable & that there should be standards. & places should be kept in good repair & if they get to a stage where 20+ years on they arent they should be bulldozed.

people should have access to a laundry not have to go to the laundomat. Especially middle aged women who have been married. I am a widow, bought up children have both a mental illness & physical illness.

What is wrong with building 2 bedroom ~~flats~~ single story similar to aged. (Mentally ill. have grandchildren or they need a carer at times.

There needs to be a variety of housing. 1 in 5 people have a mentally ill. They are all kinds of needs. MHF Richmond Fellowship etc have supported housing usually for single people who have never married. or need some sort of support.

While support should be available; just because you have to live in public housing & have a mental illness & you have to see a certain NGO.

Also housing should employ a consumer consultant but one of the criteria should be that they live in housing flats.

The mentally ill shouldnt be treated as 4th class citizens. There are mental health

typical illness. Should you have to see a agency.
Neither govt or N.G.O.
Also A.C.T Housing should ~~to~~ employ.
consumer & consultants, but one of the criteria
should be that they live or have lived
in housing trust flats.

Also ≠ housing mangers & ~~account~~ transfer.
people are trained & have people skills
the fire is balmed for alot of things.
" " this has been going on before the
fire.
Mental ill & disabled are human beings
are voters.
here are mental health standards, disability
standards.
All housing should be kept up to a
standard if they get to 20 + & obnoxious
not then they should be bull dozed. not
just forgotten whilst their tenents health deteories.

[redacted]

We should encourage
people to live & ~~recovery~~ income
with a mental illness & not have
to be looked after unless that is
needed.

Mentally ill should be offered a sanctuary

DORIS KORDES argues that community-based treatment doesn't always offer a better model of care

SOME of us successfully manage our mental illness while living a full life in the community. But the community may also contribute to our mental decline. At times, our homes may be detrimental to our well-being. For some, there will be a time when we need a place of sanctuary from home and community, a place that actively seeks to promote our health and well-being.

In the past, we have turned to institutional solutions to access such support. The asylum care era is over, and we now turn to the general hospitals, to the psychiatric units, when mental health problems spiral out of control. But is the public psychiatric unit a setting that is conducive to our well-being and recovery? Based on interviews I have conducted with over 40 people in Canberra, the answer is, overwhelmingly, no.

A pharmaceutical response with a view to the stabilisation of a person's symptoms is the public psychiatric unit's main treatment method. However, non-medical treatments, namely environment and relationship, have been documented as also having a positive effect on well-being and recovery. An examination of the care practices of the Retreat, in York, England, and Kenmore Hospital near Goulburn are instructive.

The Retreat was established in 1796 by a group of Quakers. It is a historically significant institution because of its association with new ways of treating insanity.

While new ideas of insanity and methods of treatment were beginning to spread throughout England and Europe towards the end of the 18th century, this knowledge and practice were explicitly developed and promoted by the Quakers at the Retreat in a form referred to as moral treatment.

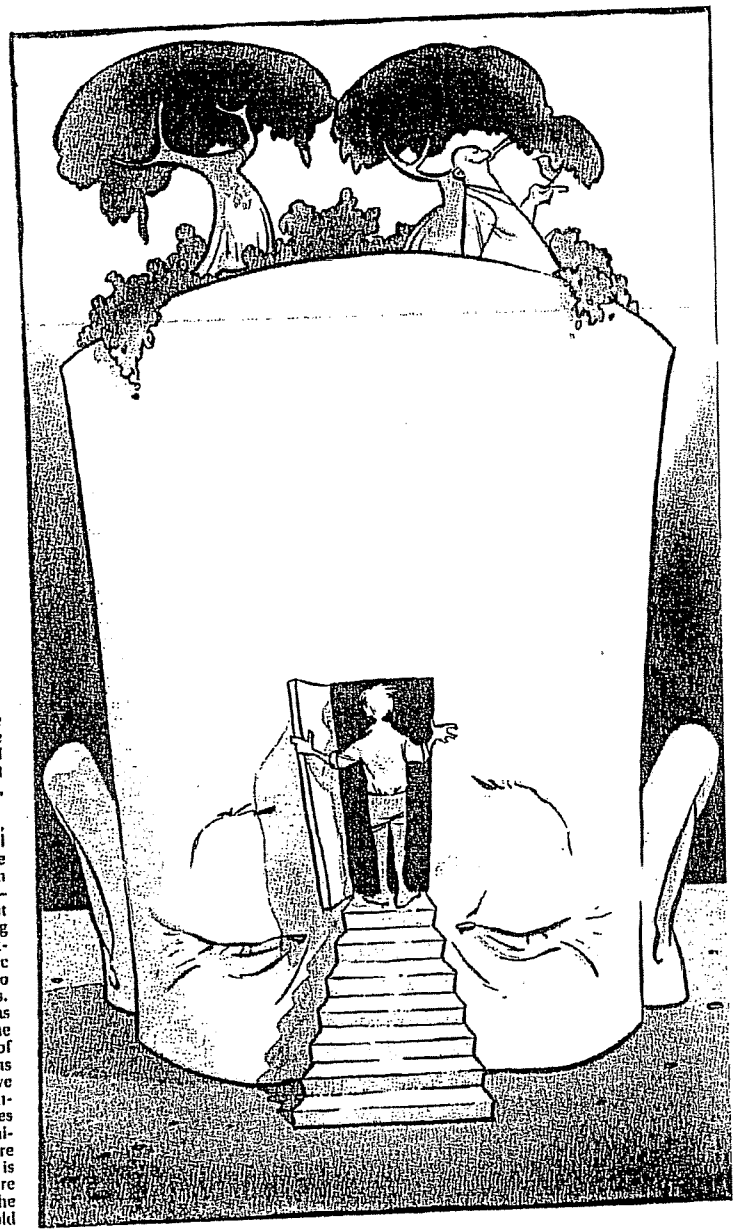
Moral treatment includes mild and humane care practices, of treating the patient with kindness and respect. Environment and relationship are emphasised. As are the appropriate to their class and gender. The Quaker community regularly visited the Retreat and was engaged in both social and spiritual activities with its residents. Retreat patients could, as part of their recovery, undertake outings into the community.

The Retreat, under guidance of Quakers, continues to provide care for mentally unwell people. Last year I spent a day there. The Retreat currently provides short and long-term care for about 150 voluntary in-patients — elderly persons, persons undergoing treatment for alcohol and drug addictions, eating disorders, self-harming behaviours, post-traumatic stress disorders, severe and chronic mental health problems. The Retreat also provides a wide range of out-patient services.

Environment continues to be emphasised as a key therapeutic tool. Complementing the pharmaceutical treatment is an array of psycho-, physio- and occupational therapies as well as art, music, drama, and alternative therapies such as hand massage and aromatherapy. This list is not inclusive of all services provided by the Retreat. Unlike many psychiatric facilities, destructiveness and violence are not issues of concern at the Retreat. This is partly attributable to the fact that clients are there voluntarily. It is also attributable to the respect accorded to them by staff: I was told that clients are treated as trustworthy persons, and that they tend to live up to that belief.

In 2002 and 2003 I undertook fieldwork at Kenmore Hospital. Canberra patients, those who required detention and involuntary treatment, were sent to Kenmore until, with self-government in 1989, we began to establish our own mental health laws and lock-up facilities.

Kenmore admitted its first patient in 1895. It was designed by the NSW Government Architect in close collaboration with the NSW Inspector General for the Insane. A knowledge of insanity was incorporated within its architecture and landscape.



Legal reforms replaced the stigmatising terminology of lunacy and insanity with the term mental illness. Additional regulations regarding patient lengths of stay were built into the Mental Health Act of 1958.

In addition, the number of voluntary patients seeking admission to psychiatric hospitals in the 1960s rose sharply. For the first time, voluntary admissions outnumbered the admissions of involuntary patients. At the commencement of this decade, psychiatric hospitals were run-down establishments. Living conditions were sub-standard and

In addition to group programs, nurses al became more involved with providi individualised care for each patient. It was n unusual for nurses to form friendships wi patients, to invite patients into their home and to take them on outings on their roster days off. Of the 20 consumers I interviewed, had been hospitalised at Kenmore as well as Canberra. Four of these six consumers believe that the care they had received at Kenmore w conducive to their recovery.

What have we overlooked in the move fro asylum to community-based treatment? P