STANDING COMMITTEE ON HEALTH AND DISABILITY

Appropriate Housing for People Living with a Mental Illness

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Report 4
APPROPRIATE HOUSING FOR PEOPLE LIVING WITH A MENTAL ILLNESS

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Resolution of appointment

On 7 December 2004, the Legislative Assembly for the ACT resolved to establish the Standing Committee on Health and Disability to:

examine matters related to hospitals, community, public and mental health, health promotion and disease prevention, disability matters, drug and substance misuse targeted health programs and community services, including services for older persons and women, housing, poverty, and multicultural and indigenous affairs.¹

Terms of reference

To inquire into, and report on, the current levels of access to safe, secure and affordable housing for people with mental illness, with particular reference to:

- the flexibility of criteria for gaining access to public housing;
- support mechanisms for people who currently live in public housing;
- opportunities to involve non-Government stakeholders in the provision of appropriate housing;
- the feasibility of alternate support-based housing models; and
- any other related matter.

¹ Legislative Assembly for the ACT, Minutes of Proceedings No. 2, 7 December 2004, p. 12
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Foreword

"A house is a home when it shelters the body and comforts the soul". (Phillip Moffitt)

Societies and the Governments that they elect, are faced with a range of challenges which they must deal with.

In recent years, the issue of delivery of services for people living with a mental illness has come front and centre of our society’s attention. This is only right.

This is one particular issue where there is much emotion attached. It is also an area that seems to have never ending challenges attached. But this is only natural. None of us would wish to have a mental illness. Equally, we would prefer not to have to deal with the problems that arise when we have a relative or friend living with a mental illness.

But we do have members of our community who have to face these challenges. And these challenges should not be seen as theirs alone, but a challenge to be faced with courage by the entire community and the Governments that they elect.

This report, on appropriate accommodation, deals with one area that impacts on the lives of those living with a mental illness. But it is an area that has the potential to make these lives so much better, or so much worse.

I hope that this report might aid the Government to deal with these challenges with courage.

Karin MacDonald MLA
Chair
Executive Summary

This matter was adopted by the Committee on 9 March 2005.

The Committee received eighteen submissions and conducted seven days of public hearings between 7 February and 30 August 2006. Details of the hearings and witnesses who appeared are in Appendix A and submissions received are listed in Appendix B to this report. A small number of submissions have not been published because they contain personal details which it would not be appropriate to put in the public domain.

The Committee also inspected, for comparison, accommodation for those living with a mental illness in Victoria and the ACT. A list of those organisations the Committee inspected appears at Appendix C.

The Committee wishes to thank all of those who participated in the Inquiry.

In its submission to this inquiry the Office of the Community Advocate (OCA)² states that:

The delivery of mental health services is based on the notion that most clients will choose to live in the community either on their own or with family as support.³

The OCA in supporting this choice adds an important rider, that the person must be provided with ‘... the necessary care, accommodation and safeguards to meet their mental health and associated needs’.⁴ That view is generally shared by all of those who participated in the Committee’s inquiry.

The provision of accommodation for people with a mental illness cannot be looked at in isolation from the early intervention and support services, both clinical and social, which are available to identify, treat and assist patients and their carers to manage their condition and participate in the community. An

² Note that the Office of the Community Advocate was renamed the Public Advocate of the ACT in March 2006.
³ Submission, Office of the Community Advocate, p. 7
⁴ ibid., p. 10
'accommodation solution' in the absence of proper support is of very limited help to those with a mental health problem.

It is absolutely clear that the demand for public and community housing far exceeds the supply and that this has a significant impact on people who are suffering a mental illness and do not have suitable accommodation. The number of houses, units, etcetera available specifically for people with a mental illness needs to be increased significantly. Equally important, a range of housing options needs to be available which matches the needs of the residents. Inappropriate accommodation can exacerbate mental health problems.

Mental Health services in the ACT have, in the past, generally lagged behind those in other states and territories. Per capita expenditure on mental health ranks seventh out of the eight jurisdictions. The ACT also ranks seventh in terms of 24 hour staffed in-patient residential beds and last in terms of total public inpatient beds.\(^5\)

On the positive side, expenditure on mental health services in the ACT has increased significantly more than the national average for the last decade. Government support for community groups is on the national average and, in terms of clinical staff employed in ambulatory care settings, the ACT rates well above average.\(^6\)

The most optimistic feature of mental health service delivery in the ACT is the recognition by government of the need to devote more resources to the sector and shift the focus of services to:

maintaining good mental health ... and ... shift the emphasis away from treatment towards a well-being model. This shift, will require clinical and welfare services accommodation services and other social and economic services in the community committing to this cultural change.\(^7\)


\(^6\) ibid.

\(^7\) ACT Mental Health Strategy & Action Plan,2003-2008, p. 4
The key features of the ACT Mental Health Strategy are:

- An emphasis on mental health promotion;
- Increased support for prevention and early intervention services coupled with support and training for primary health care providers;
- Improved access to, and coordination of, services;
- A recovery orientation for treatment services and improved linkages with supported accommodation providers, vocational training and rehabilitation; and
- Enhanced governance of the mental health system.

The Committee believes that this policy framework provides a sound basis for the provision of mental health services, including supported accommodation. The Committee was also reassured that the approach of the Director of Mental Health in the ACT (see paragraph 1.28 & 1.29) reflects both the strategy and the aspirations of the community mental health sector.

It is also clear that there is a broad consensus among mental health professionals, community groups involved in providing services to those with a mental illness, advocacy groups, carers and patients that these are correct priorities for the provision of mental health services.

Thus, in the Committee’s view, the question with regard to providing appropriate accommodation for those with a mental illness is not, "what should be done?" as there is broad agreement on that. The real challenge is one of implementation; we know what needs to be done but will the resources be made available in a timely way to implement the changes and provide the services required? This is a question for the community as much as for government.
RECOMMENDATIONS

RECOMMENDATION 1
1.4 The Committee recommends that ACT Health and Treasury investigate strategies that could help to alleviate the financial burden placed on families who are supporting family members with a serious mental health illness.

RECOMMENDATION 2
1.21 The Committee recommends that Housing ACT work closely with ACT Health to develop strategies to enable Housing ACT staff to recognise and refer clients with a mental health illness, at an early stage, before a crisis occurs, wherever possible.

RECOMMENDATION 3
2.34 The Committee recommends that Housing ACT investigate alternative models of community housing, such as that provided by Supported Housing Ltd, Victoria, that can support people with special needs in a variety of housing options.

RECOMMENDATION 4
3.21 The Committee recommends that Housing ACT develop a strategy to ensure that workers in community organisations assisting those with a mental health illness have an awareness and understanding of all Housing ACT policies in relation to mental health issues.

RECOMMENDATION 5
3.45 The Committee recommends that discharge planning from acute care facilities be reviewed by Mental Health ACT to ensure that patients are discharged with a responsible person in the community being advised of the release and accepting responsibility for the patient; provision for accommodation of the patient being made; and the relevant community health centre being advised.

RECOMMENDATION 6
3.46 The Committee recommends that, wherever possible, people with a mental illness are not released from acute care facilities after 3.00pm on Friday afternoons or over the weekend due to the difficulty of arranging
support staff, through community organisations, at such a late stage in the working week.

**RECOMMENDATION 7**

3.54 The Committee recommends that step-up and step-down facilities be included in the ACT's forthcoming Mental Health Services Plan and that they be established as a matter of urgency.

**RECOMMENDATION 8**

3.59 The Committee recommends that all relevant government agencies ensure that details of their full range of services and relevant contacts are available to the community in a readily accessible form.

**RECOMMENDATION 9**

3.66 The Committee recommends that the ACT Human Rights Office clarify the position of individuals such as Housing ACT managers or community housing workers who wish to seek medical help for a person but do not have that person's consent to do so.

**RECOMMENDATION 10**

3.67 The Committee recommends that the government investigate ways to facilitate an amenable living environment for clients with a mental illness and their neighbours, who may be affected during an episode of poor mental health.

**RECOMMENDATION 11**

3.68 The Committee recommends, following clarification from the Human Rights Office, that the Minister for Health and the Minister for Housing work to ensure that the position of Housing ACT staff is clearly outlined in a specific policy addressing this issue and that appropriate training is developed and provided to all relevant housing staff, both in Housing ACT and in the community sector.

**RECOMMENDATION 12**

3.77 The Committee recommends that an audit of all non-government mental health services be conducted, to determine the number of services and types of services provided, to reduce duplication of services and to maximise quality service delivery outcomes to people with mental health issues.
RECOMMENDATION 13
3.86 The Committee recommends that Housing ACT examine the ratio of specialist housing managers to clientele to ensure the right balance is met, and assesses this need on a periodic basis.

RECOMMENDATION 14
3.106 The Committee recommends that Mental Health ACT develop a 'half-way house' either as a single campus or as specific units in the community in which forensic mental health patients can be supported in making the transition from incarceration to living in the community.

RECOMMENDATION 15
3.112 The Committee recommends that the government ensures that there is a range of accommodation models to provide for the diversity of clients with a mental health illness in the ACT.
1 INTRODUCTION

1.1 People living with a mental illness may be divided into three groups: those who manage their condition and their accommodation needs without formal assistance; those who require ongoing institutional care; and those who can live and work in the community with the appropriate support mechanisms.

1.2 The submission by the ACT Government states that "A large majority of people with a mental disorder manage both their disorder and their accommodation without formal intervention or support services".8

1.3 The needs of that majority should not be forgotten. It should not be assumed that those who manage their condition with the support of family, friends and other private assistance are coping at all times or that they would not benefit from more readily available community-based services to assist with managing the condition and the provision of more respite services for their carers.

RECOMMENDATION 1

1.4 The Committee recommends that ACT Health and Treasury investigate strategies that could help to alleviate the financial burden placed on families who are supporting family members with a serious mental health illness.

1.5 There may also be other areas where government can assist individuals and families to manage their condition, for example with regard to matters such as stamp duty and the tax status of property where a family provides independent accommodation for a child living with a mental illness.

1.6 Future demands on the public sector may emerge as the circumstances of people in this group change, for example as ageing parents can no longer provide the social support necessary to enable a child with a

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8 Submission, ACT Government, July 2005, p. 3
mental health problem to live independently or as an aging adult, who has successfully managed their mental illness, can no longer manage their condition and the effects of physical decline.

1.7 The second group is composed of people whose condition is of such seriousness that they require ongoing institutional care. This report has some comment to make on the provision of acute care services and, more importantly, the movement of patients through those services and back into the community. However, the actual quality of acute care services is outside the Committee’s terms of reference.

1.8 This Committee’s report concentrates on the third group who can, with proper support, live and work in the community but at some stage cannot obtain accommodation through the private market either by purchase or rental. This group requires varying degrees of assistance (both individually and at different periods of time) in managing or treating their condition and, specifically, also requires support in finding and retaining suitable accommodation. For these people finding suitable accommodation and, equally importantly, receiving the support necessary to ensure that they can continue to occupy that accommodation, is crucial to the management of their condition.

1.9 Stability of domestic arrangements is a key element in managing a mental illness. Where a person’s condition is deteriorating and intervention or support is required it should be available as early as possible by providing appropriate and timely support both to those with the illness and to their carers. Where a person with a mental illness requires the support of either the public or community sector for their accommodation needs, then the medium to long term objective of that support should be to get the person into a position where they are able to sustain their tenancy.

1.10 Where a person’s mental illness is of a type or severity beyond their capacity to manage without help and where it makes it difficult for them to maintain accommodation from their own resources, external support of the right sort is necessary. Appropriate accommodation is a part of that support. It is not just a matter of putting a roof over a person's head but of providing the right type of accommodation.
1.11 Inappropriate accommodation may exacerbate a person’s mental health illness by exposing them to social situations that they cannot manage or placing them in environments that militate against the proper management of their condition. If a person with a mental illness needs help in finding and maintaining accommodation it indicates that the person’s condition (and social and financial circumstances) is such that they could have more challenges in facing the issues of day-to-day life.

1.12 Indeed, difficulties with finding or maintaining accommodation may be a symptom or result of mental health illness and dealing with the housing issue without recognising and treating the health issue may not be of great benefit to the person. For example, if a person is having difficulty maintaining steady employment because of mental health difficulties, dealing with the employment question, allowing the person to have a reliable income may ‘solve’ the accommodation problem.

1.13 Thus appropriate accommodation is not enough in itself. It must be seen as part of a range of support services that seek to identify the underlying causes of a person’s problems, that can respond to any emerging decline in a person’s condition or circumstances at an early stage and can support the person in managing their condition in a way that minimises the disruption to the person’s life.

1.14 These three groups do not represent hard and fast categories. Individuals may move from one group to another as their health and other circumstances change. Mental health problems are also found in conjunction with other factors which may exacerbate the problem and make managing it more difficult; for example where mental health problems are combined with substance abuse or with the trauma and discrimination experienced by refugees.

1.15 It should also be remembered that it may not be apparent to the person seeking public accommodation or to Housing ACT or other accommodation providers that a mental health illness is the primary or contributing factor in the applicant’s housing crisis.

1.16 The principal provider of supported accommodation in the ACT is Housing ACT. Mental illness may be a factor in meeting the criteria for allocation of public housing. These criteria are:
- homelessness or imminent risk of homelessness
- exclusion from the private rental market because of poverty, discrimination, medical condition or special needs
- existing Housing ACT tenants facing overcrowded or unsuitable accommodation.

1.17 A mental health illness may not be specifically identified as an issue when a person is seeking access to public housing. While it may well be the cause of a person’s need for housing, the policy of Housing ACT is to avoid prioritizing the underlying causes of homelessness in assessing relative need. The applicant themselves may be unaware of such a problem or, through fear of discrimination or prejudice, may be unwilling to acknowledge a problem publicly.

1.18 It may be that simply putting a roof over a person’s head is not the optimum response. As the ACT Government submission comments:

   Another level of complexity, when assessing applicants in crisis, is the need to focus on whether a housing response is the most appropriate way to meet the presenting needs. Households with accommodation that may not be optimal … and have considerable complexity in their lives may not require an urgent or immediate housing response, rather other supports that increase their resilience or capacity to manage.

1.19 The Committee notes the importance of focusing on early identification and intervention.

1.20 Housing ACT staff, while given some training in recognising clients’ difficulties, are not health professionals and may not be qualified in identifying a mental health illness as an underlying cause of the applicant’s accommodation problems. Housing ACT may only become aware of a tenant’s mental health problems when issues arise with the tenancy - non-payment of rent; disputes with neighbours; and so on.

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9 See paragraph 3.4 below
10 Submission, ACT Government, p. 13
RECOMMENDATION 2

1.21 The Committee recommends that Housing ACT work closely with ACT Health to develop strategies to enable Housing ACT staff to recognise and refer clients with a mental health illness, at an early stage, before a crisis occurs, wherever possible.

1.22 The needs of those with a mental health illness may not be best met by Housing ACT’s ‘ordinary’ stock of housing types. There are sound financial and other reasons for Housing ACT to invest in medium to high density housing types; both the capital cost of acquisition and the ongoing maintenance costs are lower than for lower density housing. However, these may be least suitable for a person with a mental health illness.

1.23 A noisy or disruptive environment, difficulties with neighbours, isolation, even the inability to keep a pet can mitigate against the creation of the ‘point of stability’ that is necessary for a person’s mental condition to be properly managed. At the same time, isolation in a house in the suburbs, particularly if it is remote from shops and services can be equally unsuitable and damaging. Matching the type of accommodation to the needs of the patient is vitally important.

1.24 This issue is recognised through the indirect provision of public housing either through Mental Health ACT or through non-government organisations (NGOs) such as Havelock Housing Association.

1.25 The Mental Health Council of Australia recently published a report entitled *Time for Service* which stated in its introduction that:

    The state of mental health services in Australia has been well documented, including in the Mental Health Council of Australia’s own *Not for Service Report* and most recently by the report of a Senate Committee of Inquiry entitled *From Crisis to Community*. It is commonly agreed that a lack of investment and accountability following deinstitutionalisation has led to a crisis in
public confidence because people cannot access the mental health services they need when they need them.11

1.26 It is clear from the response to this Committee’s Inquiry that the Mental Health Council’s general point applies to the specific area of access to appropriate accommodation for those living with a mental illness. It is also clear that a broad consensus exists within the ‘mental health community’ - clients, carers, health professionals and other service providers - as to what needs to be done.

1.27 The importance of ‘a point of stability’ - usually secure and stable accommodation - in the life of people suffering from a mental illness is well established.12 Further, ‘good, or even neutral relationships with neighbours … [are] very important to lessen [sufferers] fear of discrimination, create a sense of belonging in the community and contribute to their sense of well-being’.13

1.28 In evidence to the Committee the Director of Mental Health for the ACT, Dr Peggy Brown, outlined the types of services that she believed the ACT required and that, she implied, would be included in the forthcoming ACT Mental Health Services Plan. Dr Brown’s ‘wish list’ included, in addition to acute inpatient facilities, step-up and step-down facilities for those requiring sub-acute care or in transition from acute care to community care; a range of rehabilitation facilities, both campus and community-based, catering for both short and longer term patients and a variety of accommodation types in the community ranging from 24 hour staffed treatment facilities to those where ‘the level of support may vary from anything up to daily or on-site for a certain number of hours a day to much less frequent contact’.14

1.29 Dr Brown made clear her support for early intervention and the reduction of the need for acute care:

12 See reports by the Australian Housing and Urban Research Institute (AHURI), quoted in ACT Government submission, p. 6
13 *ibid.*, p. 16
14 Transcript of Evidence, 22 March 2006, p. 191
It is clearly part of our overall goal to work towards having something that can intervene earlier—prior to hospitalisation—where we can put in place a range of supports and interventions that would prevent the need for acute hospitalisation.\textsuperscript{15}

1.30 It would be reasonable to conclude that Dr Brown’s approach addresses many of the current deficiencies in the ACT system identified by witnesses to this Committee and elsewhere.

1.31 The Committee notes, in the following chapter, that the objectives of both the ACT and the National Action Plan for Mental Health strongly emphasise the need for early intervention, more integrated services and a holistic approach to treating mental illness. The broad consensus as to what is required should be reflected in the new Mental Health Services Plan.

1.32 As \textit{Time for Service} points out the treatment of a mental illness often takes the opposite approach to the treatment of other conditions:

\begin{quote}
If a woman has a breast lump, [she] is encouraged to get advice as soon as possible … If it’s serious, treatment is provided early to get the best result. In mental health, people are sent away and told to come back only … when the problem is worse if not overwhelming.\textsuperscript{16}
\end{quote}

1.33 This comparison, while perhaps slightly dramatic, does emphasise the importance of early intervention in the treatment of mental health problems. As with early intervention in physical illnesses the outcomes are generally better and the treatment less intrusive and traumatic. Early intervention is also cheaper in the long term - a consideration any government faced with the ever increasing demands on health services should recognise and welcome.

1.34 The Committee was aware of a multitude of organisations and services and heard complaints of poor communication and people’s needs being ignored or ill-served. The Committee also heard evidence that there is a

\textsuperscript{15} ibid., p. 185
\textsuperscript{16} Mental Health Council, \textit{op cit.}, p. 2
level of anxiety among individuals with a mental health problem, their families, friends and carers when they could not get the services they required.

1.35 The Committee believes the number of agencies that may be involved in a person’s care and support is not just a potential source of confusion, but also can contribute to worsening a person’s condition. As a representative of the local indigenous community told the Committee:

I think that sometimes too many services can get involved. With mental health clients you’ve got mental health involved, then you might have drug and alcohol involved and the police get involved. You’ve got all these other services, and that frightens them. It’s kind of scary for them because they don’t understand.  

1.36 The Committee will comment on those issues later in this report. However it should be recognised from the outset that, although there is always scope for improvement in any area of service provision, a degree of uncertainty and less than optimal responses by the health and related systems are inevitable.

1.37 People seeking public housing may not wish to identify a mental health problem as the underlying cause of their difficulties; Housing ACT cannot be expected to operate diagnostic services and may be constrained by privacy considerations or a tenant’s own wishes in seeking to involve mental health services in the management of a tenant.

1.38 The individual’s ability to access services may be constrained by the condition itself or by other factors such as cultural or language barriers.

1.39 People with a mental health illness may come to the attention of mental health services in a variety of ways - through referral from a general practitioner; as a result of a mental health crisis that requires a response from community health, the Crisis Assessment and Treatment Team

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17 Transcript of Evidence, 14 June 2006, p. 222
(CATT) or admission to an acute care facility. A person’s condition may first be expressed in a context and in a manner that does not lead to an immediate diagnosis of a mental health problem.

1.40 The inability to provide assistance in the first instance should not be taken as evidence of system failure but more as a reflection of the inherent complexity of the issue.
2 THE CURRENT POSITION IN THE ACT

Mental Health Services in the ACT

2.1 The Mental Health Strategy & Action Plan 2003-2008\(^1\) is the basis for current mental health policy in the ACT. Applying models derived from research in other communities, the document estimates that:

7% of the ACT population will experience moderate to severe mental health problems, while a further 10% will be at risk of developing mental health problems or require early intervention.\(^2\)

Based on the 2001 Census that represented approximately 52,000 people in the ACT experiencing a mental health problem, while 21'450 could be expected to experience a moderate to severe problem. In terms of actual service provision in the financial year 2005-2006 those estimates translated into 1198 mental health patients receiving in-patient care and 210,014 'community-based occasions of service' provided by Mental Health ACT.\(^3\)

2.2 Mental Health ACT provides a full range of services. Acute care is provided through the Psychiatric Services Unit (PSU) at Canberra Hospital and Ward 2N at Calvary Hospital. In-patient care is also provided at the Brian Hennessey Rehabilitation Centre, which provides both acute and sub-acute care and also has a Secure Extended Care Unit.

2.3 Episodes of in-patient care provided by Mental Health ACT have been declining steadily, however, the number of in-patient bed days has

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\(^2\) ibid., p. 17

\(^3\) ACT Health Annual Report 2005-2006, p. 20. An 'occasion of service' is, in effect, any contact between a patient and a service provider.
been steadily increasing indicating longer stays per patient.\textsuperscript{21} Dr Brown indicated in evidence to the Committee that the PSU’s occupancy rate is currently 98% which is well above what would be considered desirable and does indicate the pressure on the facility.\textsuperscript{22}

2.4 The private mental health unit at Calvary, Hyson Green, provides in-patient and day services while also running a number of programs relevant to mental health problems.

2.5 A number of other services provide accommodation and professional support for people with mental health problems and medium to high support needs, for example Centacare, the Richmond Fellowship, Havelock Housing Association and the Mental Health Foundation. There are providers offering specialised services to particular groups - Barnardos offers care to children and the Queen Elizabeth II Family Centre provides in-patient care to mothers with young children as well as a range of out-patient and day services.

2.6 Mental Health ACT also operates the Crisis Assessment and Treatment Team (CATT) which provides a 24 hour service to respond to people experiencing a serious mental health episode.

2.7 Community-based services are provided through the ACT’s community health centres with Adult Mental Health teams based at the four regional health centres. There are separate Child and Adolescent and Older Persons services. In addition to these specific services a range of other services and programs have a bearing on mental health, for example, the alcohol and other drugs service which offers education, counselling, assessment and referral services.

2.8 Mental Health ACT also has two programs in hand which are directly relevant to many of the deficiencies identified with the ACT’s mental health system. A recurring concern expressed in evidence and discussed in more detail later in this report, was how easy it was for patients to ‘fall through the cracks’ between various parts of the mental health system.

\textsuperscript{21} ACT Health Annual Report, 2005-2006, p. 20
\textsuperscript{22} Transcript of Evidence, 22 March 2006, p. 185
health system. The need for early intervention and better integration of the various health and other services that the person living with a mental illness required was common theme.

2.9 The Collaborative Therapy project which seeks to incorporate 'consumers, carers, clinicians and services working systematically towards the achievement of optimal health outcomes' has, among other outcomes demonstrated ...improved linkages and partnerships across the mental health and primary care sector.'

2.10 Similarly the Better General Health for People with a Mental Illness project seeks:

- to improve outcomes by supporting general practitioners (GPs) and consumers to maintain regular contact and facilitating improved reciprocal support between GPs and specialist mental health staff.23

General practice will be the first point of contact with medical care for many of those suffering from a mental health problem, thus it is essential that GPs are equipped to identify emerging mental health problems, to offer appropriate treatment and to refer patients to specialist help where appropriate.

2.11 The ACT’s mental health system also operates within the agreed objectives of the National Action Plan for Mental Health which promotes:

- early intervention, including measures to enable the community to better recognise the risk factors and early signs of mental illness;
- integrating and improving the system, including social supports and health services; and
- participation in the community employment including access to accommodation.24

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23 ACT Health, Annual Report, 2005 2006, p. 21
24 ibid., p. 22-23
2.12 Mental Health ACT is currently developing a Mental Health Services Plan which will:

- identify current and future mental health needs of the ACT community and, recommend the range and type of services required to meet these needs and address workforce and training requirements.\(^{25}\)

2.13 Some concerns have been raised in the community with regard to the timing of this plan in the context of decisions already taken, funds committed and work being undertaken on the provision of acute care at The Canberra Hospital.

2.14 The representative of the Mental Health Council of Australia made the point most trenchantly:

we sense that some of this infrastructure and capital outlay is all happening now, in advance of a mental health services plan. It looks as though the capital is driving the plan as opposed to the plan driving the capital.\(^{26}\)

2.15 The Director of Mental Health ACT acknowledged some justice in the comment but she stressed that the work being undertaken was required and that it would not 'bias the broader mental health services plan'.\(^{27}\)

2.16 The Committee hopes that it is not an 'either-or' choice between acute care and community care. Acute care and other specialist in-patient units will be required. The existing PSU has been widely criticised and its replacement is welcomed. The other capital projects - a secure forensic care unit, a youth unit and a psychiatric emergency unit - are also necessary.

2.17 The evidence to this Committee has made clear that both professional opinion and community expectations are that the trend to greater investment in early intervention, care in the community - including social support - supported accommodation for those with mental health

\(^{25}\) ACT Health, op cit, p. 21

\(^{26}\) Transcript of Evidence, 9 February 2006, p. 70

\(^{27}\) Transcript of Evidence, 22 March 2006, p. 184
problems and prevention will continue. In the medium term it would be desirable to see the balance of funding between acute care and community care reversed.

2.18 While the Committee hopes that the current program of capital investment will not distort the development of a mental health services plan along the lines outlined by Dr Brown, it must be acknowledged that in an environment of limited funding, financial support for community-based programs will have to compete with the already committed programs.

Public Housing in the ACT

2.19 Housing ACT provides public housing both directly as the landlord and manager of properties and indirectly through the Community Housing Program.

2.20 The services that are provided cover the full range. Housing ACT is responsible for the assessment of eligibility of tenants, for the allocation of properties, supporting and managing tenancies and management and maintenance of properties.

2.21 In evidence to the Committee the Minister for Housing, Mr John Hargreaves, described Housing ACT’s role as one of assisting:

Mental Health ACT and provid[ing] resources to contribute to the holistic approach to supporting people with a mental illness. However, Mental Health ACT is the lead provider and the lead agency that provides support to people with a mental illness. We see ourselves as a junior partner in the range of holistic approaches to address the quality of life of people with mental illness.

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28 See paragraph 1.28 and 1.29
29 A full description of Housing ACT’s current activities and services can be found in the Annual Report of the Department of Housing & Community Services 2005-06 p. 50
30 Transcript of Evidence, 9 February 2006, p. 50
2.22 The Minister went on to characterise Housing ACT’s approach to its tenants with a mental health illness as one of providing sustainable tenancies under which;

people with mental illness are safe and securely housed, with support services provided to enable them to continue their lives in the community in the same way as any other member of the community.\(^{31}\)

2.23 Housing ACT has also recognized the special needs of many of its clients by requiring housing managers to undertake specialist training in dealing with clients with special needs. In addition, it employs five 'client service co-coordinators' who work with clients 'with identified complex needs in order to achieve sustainable and stable tenancies'.\(^{32}\)

2.24 The Minister was at pains to impress on the Committee the limits of Housing’s responsibility:

our relationship is with the tenant; our relationship is not with anybody else in a formal sense, necessarily. ... What we do have is a recognition of our responsibility to make sure that our tenants are sustained. The tenants themselves speak with their own supports. Our housing specialists speak to tenants whenever a difficulty arises. We do early intervention if we find that there’s a problem with income, a problem with disruptive neighbours or that sort of thing. The housing specialist will go in and talk to people in that way.\(^{33}\)

2.25 This is important to bear in mind as it emphasizes the importance of the other services that support a person with a mental health illness, and of coordination between the service providers.

2.26 Housing ACT is responsible for more than 11,000 social and community housing properties. Community housing is a relatively small proportion of that figure with 286 properties. A high proportion

\(^{31}\) Transcript of Evidence, February 2006, p. 50
\(^{32}\) ibid., p. 51
\(^{33}\) ibid., p. 55
of tenants in both types of accommodation receive rental rebates - eighty-five percent in public housing properties and ninety-two percent in community housing.\(^{34}\)

2.27 The ACT has the highest proportion of public housing of any jurisdiction in Australia – nine percent of the total compared with a national average of five percent. Despite this, the waiting lists for housing in the ACT are long and the proportion of public housing tenants receiving the highest levels of rental subsidy is increasing. The private housing market, whether purchase or rental, is becoming progressively less accessible to those on very low incomes or dependent on government benefits.

2.28 Housing ACT works in partnership with a wide range of NGOs and supports a range of accommodation types provided by them. Where a proposal involving housing is put up to the ACT Government, (recent examples include the Keyring approach and the Abbeyfield Society), Housing ACT can support the proposal through direct grants for the acquisition of property or by acting as head lessor.

2.29 Ideally once a public housing tenant is identified as having a mental health illness, that person will be linked to appropriate support and treatment services, and the type of accommodation they are placed in will be suitable to their needs.

2.30 The role of the Richmond Fellowship gives a good insight into the operation of community groups in the mental health area. The Fellowship manages its own properties providing accommodation, support and rehabilitation for tenants. It also provides support and rehabilitation services to people living in Havelock House properties and in a number of Housing ACT properties.

2.31 The Fellowship is contracted to support a minimum of forty-two clients at any one time and averages between forty-two and fifty-nine clients.

All clients have individual support plans and have business and out-of-hours contact with staff.35

2.32 Not all community housing groups are as well equipped to provide comprehensive care and support. The Chief Executive Officer of the Coalition of Community Housing Organisations of the ACT, Ms Faye Brockelsby, outlined a model where the community housing provider restricted themselves to the 'landlord' role and social support came from other sources.

Community housing was traditionally funded to provide housing which was tenancy, management, maintenance, repairs and maintenance and things like that; it was never funded to provide support to people living in those properties.36

2.33 The Committee visited Supported Housing Ltd (SHL) in Kew, Victoria and was impressed with the model of community housing provided to people with a disability, including those with a mental illness. SHL is a registered Victorian Affordable Housing Agency and works in collaboration with individuals, families support agencies and government to provide specialised housing needs. SHL provides the 'bricks and mortar' while the support to tenants is provided through a diverse network of support partners. Housing is not provided to tenants without a case worker or the involvement of a support agency.

RECOMMENDATION 3

2.34 The Committee recommends that Housing ACT investigate alternative models of community housing, such as that provided by Supported Housing Ltd, Victoria, that can support people with special needs in a variety of housing options.

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35 Transcript of Evidence, 7 February 2006, pp. 32-33
36 Transcript of Evidence, 1 March 2006, p. 126
3 DOES THE SYSTEM WORK?

3.1 This chapter looks at specific issues raised with the Committee and identifies areas where Government could improve services.

Availability of accommodation

3.2 In its evidence to the Committee ACT Council of Social Service (ACTCOSS) summarised the housing situation in the ACT:

> The overarching problem ... at the minute that is affecting everyone on low incomes and all disadvantaged people is the lack of affordable housing. ... This means that mental health consumers are finding it much more difficult to manage households and to find suitable accommodation that they can afford. It includes growing public housing waiting lists, SAAP services that are not only full but also have lengthy waiting lists and an increasingly inaccessible private rental market.\(^{37}\)

3.3 It is quite difficult to get a clear idea of how many people with a mental illness are currently tenants of public or community housing. Estimates of the prevalence of mental illness among the homeless run as high as eighty-five percent. So it can be assumed that a significant proportion of public housing tenants also have mental health issues.

3.4 Those who apply through the normal application process will not necessarily be identified as having a mental health illness. Housing ACT in its submission to the Committee commented that:

> The primary tests for priority allocation to public housing are incapacity to obtain shelter and lack of financial resources to maintain any form of shelter contract......Given the breadth of circumstances experienced by applicants for social housing,

\(^{37}\) Transcript of Evidence, 1 March 2006, p. 117
Housing ACT does not prioritise the causes of homelessness in assessing relative need.  

This means that it is the urgency of the need - actual or imminent homelessness or exposure to unacceptable living conditions - rather than the underlying causes of that need that determine a person’s priority in seeking public housing.

3.5 As mentioned in the previous chapter, there is a long waiting list for public and community housing in the ACT. As we know a percentage of the general community is affected by mental health issues, and further that many homeless people suffer with poor mental health, we can assume that a significant number of people with a mental health illness are on Housing ACT's waiting list at any given time.

3.6 The waiting lists for general public housing are combined with a relatively small number of houses specifically reserved for people with a mental illness. There are 213 funded places in supported accommodation, spread across four different categories - medium to long term rehabilitation places; group homes; respite and outreach places.

3.7 The Director of Mental Health Services for the ACT, Dr Brown estimated that four to five hundred accommodation units of various types were required "to meet the social and treatment needs of people with a mental illness in the Territory". Dr Brown’s colleagues concurred with this figure.

3.8 Providing a roof over the head of a homeless person or a person whose current living conditions are otherwise unsupportable, is obviously a first priority. However, people also have preferences for accommodation and the type of accommodation they are provided with can be crucial to their ability to manage a mental health illness:

38 Submission, ACT Government, p. 13
39 ibid., p. 17
40 Transcript of Evidence, 22 March 2006, p. 183
Because people have a mental illness does not mean to say that they do not have preferences in the type of accommodation they want to live in. Often they will choose those places that are quiet and conducive to good mental health, and often those accommodations are not available to them.41

3.9 Thus the type and quality of housing is also a significant issue. What is needed is a range of types of housing and flexibility in their allocation and management. Depending on the nature of the mental health illness and other factors such as the age of the patient, virtually every type of accommodation will be appropriate to one group or another.

3.10 Regrettably there are numerous examples of mental health patients moving through various unsatisfactory situations receiving virtually no professional support and having little opportunity to re-establish themselves in the community. For example, a representative of the ACT Mental Health Carers Network told the Committee of the experience of a member of her own family who had a number of violent psychotic episodes but has not received appropriate support and treatment:

One is not having accommodation that is supported, where he can be kept an eye on, and just treatment. With treatment, with proper care, I believe that he could get back to being a useful member of society, as we judge it, to get off benefits, to get a job. He wants to work ... We are left in an awful situation.42

3.11 There is also a clear distinction between the types of accommodation required and that which is available. In its submission to the Committee, the Office of the Community Advocate (OCA) outlined a number of key issues in regard to mental health rehabilitation, with particular reference to the Brian Hennessey Rehabilitation Centre (BHRC), as there is no other accommodation option in the ACT that offers the same degree of support for those with a mental health illness.

41 Transcript of Evidence, 7 February 2006, p. 25
42 Transcript of Evidence, 1 March 2006, p. 142
3.12 OCA described patients residing in BHRC for many years in the absence of more suitable facilities. This has the dual disadvantage of restricting those patients’ opportunities for independent living in the community and denying the BHRC to other patients. Similarly OCA described patients who require rehabilitation care, spending extended periods in the Psychiatric Services Unit in the absence of other suitable accommodation options.43

Securing tenancies in time of crisis

3.13 A significant issue for tenants who have a mental health illness is that, should they experience a medical crisis that results in a failure to pay rent or otherwise comply with the conditions of a tenancy, they may lose their accommodation.

3.14 This situation can arise either, without warning where a person is in public housing but not identified as having a mental health illness (or if so identified is not receiving adequate monitoring or support), or when a person requires medical care as part of a managed treatment program.

3.15 For example, the Chief Executive Officer of the Coalition of Community Housing Organisations of the ACT described a situation where, as a result of a severe mental health illness, a resident has to leave their accommodation for an extended period:

   It is very difficult for someone to leave their house for, say, six months for some treatment or if they are going away for some rehabilitation or whatever they are doing. It is acknowledging that they still need a home and need to continue to pay rent on that home. It needs to be safe and secure. They are leaving their belongings behind for six months.44

3.16 It is to be hoped that where such a problem arises without warning - for example, where failure to pay rent is the first hint of a problem - that a

43 Submission, Office of the Community Advocate, p. 7
44 Transcript of Evidence, 1 March 2006, p. 130
tenant would not be evicted without proper consideration of all aspects of the problem. Loss of accommodation in such circumstances could be devastating for a person’s condition.

3.17 In light of the long waiting list for public housing, the Committee noted the difficulty faced by housing organisations in maintaining a person’s tenancy for an extended period of time when they are away from the residence and unable to pay their rent.

3.18 Residents of community housing who are in hospital may get their rent paid for the period of hospitalisation but if they are absent from their accommodation for other reasons that may not happen. The Mental Health Foundation provided the Committee with an example where a patient:

Initially, ... went to PSU and he eventually ended up in Brian Hennessy House, a rehabilitation place at Calvary. While people are in Brian Hennessy, their rent is not paid. While people are in hospital, their rent is paid. So our community organisation had to pick up his rent and his household bills. We do not get a huge amount of money for that program anyway, so for us it is a huge issue.45

3.19 Housing ACT is aware of the difficulties faced by tenants who need to leave their properties for an extended period of time and covers this through their "Tenant/Resident entering Residential Rehabilitation" policy which is included in the Rental Rebates Policy. This policy assists tenants and other occupants of Housing ACT dwellings who need to enter a live-in rehabilitation program for drugs, alcohol, gambling addictions or mental health illness by exempting the income of the person entering the rehabilitation facility from rental rebate assessment for the duration of the residential stay. The main criteria for the rebate are that; the residential rehabilitation provider is an organisation recognised by the Commissioner for Housing; and the

45 ibid., p. 142
person is required to make a payment towards the cost of the treatment.46

3.20 The Committee notes that the interests of the tenant demand that their problems not be exacerbated by the threat of loss of accommodation. It seems an unfortunate situation that somebody in rehabilitation, with the real prospect of returning to living in the community should be at risk of losing their accommodation, particularly if they are unaware of the options available to them.

RECOMMENDATION 4

3.21 The Committee recommends that Housing ACT develop a strategy to ensure that workers in community organisations assisting those with a mental health illness have an awareness and understanding of all Housing ACT policies in relation to mental health issues.

Early intervention and community support

3.22 This and the following two sections deal with subjects for which there seems to be almost unanimous agreement. Early intervention is a well-established practice in medical care. The advantages of early identification of a health problem enabling treatment to be provided at an early stage and, usually, in a less intrusive manner are well known.

3.23 The principles and advantages of early intervention are equally applicable to mental health as they are to physical health. The extract from the Mental Health Council of Australia’s Time for Service quoted in chapter 147, suggests that patients presenting to GPs or other health professionals with a minor mental health issue may receive the opposite response from that which would be given to a minor but potentially serious physical symptom; they are sent away with instructions to return when the problem is more serious.

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46 Full Housing ACT Rental Rebate Policy available at:  

47 See paragraph 1.25
3.24 It is not possible to determine how prevalent this attitude is. However, the difficulty of accessing services at an early stage has been identified in many reports on mental health services in Australia generally and the ACT specifically. The Mental Health Council's report, *Time for Service* identified difficulty of accessing services and the lack of attention to early intervention as key issues for the ACT.  

3.25 There is also broad agreement that, while mental health professionals in the public sector identify early intervention and prevention services as a priority, the actual placement of effort and resources does not reflect that:

> the bulk of the resources continue to go to the acute end ... We need to start looking more seriously at prevention and early intervention. It creates a disincentive to get well and it means that consumers are still not getting access to services before they get sick or adequate assistance to prevent a relapse. Often, consumers will ring and ask for help—but they are not sick enough. We need to develop a system where people do not have to be so sick that they need crisis help.  

3.26 In a submission to the Mental Health Council's inquiry the ACT Mental Health Consumer and Carer Caucus commented that:

> Both consumers and carers reported that in the ACT it is almost impossible to get intervention or be listened to at an early stage when warning signs are initially beginning to appear.  

3.27 Early intervention is central to the question of accommodation for those with a mental health illness. The overall objective of mental health care must be to enable as high a proportion of people with a mental health illness as is possible to live and work in, and be full members of, the community.

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48 Mental Health Council of Australia, op.cit, (2005), p. 78  
49 Transcript of Evidence, 1 March 2006, p. 117  
50 ibid.
3.28 Early intervention can obviate the need for an 'accommodation' solution by enabling people to retain their existing accommodation. It can also ensure that those who are in public or community housing can be supported in that accommodation by pre-empting or managing a potential health crisis at an early stage thus avoiding the need for acute care and a major disruption of the person’s life.

3.29 Early intervention needs to be backed up by continuing social and professional support as necessary. Again community groups felt that that support was not as accessible as it needed to be. For example Ms Brockelsby commented that:

> It is a little bit harder [compared with physical disability services] when it comes to assisting people with mental health issues. That support is not as clearly documented, from our perspective; it might well be in the mental health area or in the health system. From a housing perspective, trying to get into that system to access health is not as easy to do.\(^{51}\)

3.30 ACTCOSS noted that the current situation paid inadequate attention to support services:

> Neither Housing ACT nor Mental Health ACT directly provide psychosocial support services. This gap must be filled by the community sector. Another problem with the support services is that they are still not joined up, so there are difficulties in communication between those support services—between mental health services and housing managers.\(^{52}\)

3.31 They also described a situation where, even when services were provided, they could easily be 'lost'.

> The approach is still not client focused and the support is often attached to housing, or to the acute need. So, if a person moves on,
or if they become well, that support will fail because it will be left behind with the service.53

3.32 As ACTCOSS’s use of the term ‘psychosocial’ makes clear, support is required both from medical professionals and people trained to provide social support.

It’s the adequate supports that we need to keep them in housing, because so many people lose their housing simply because they have not managed to pay their rent because they were in a psychotic episode. They need someone to go around and say: “Have you had your medication today? What are you doing about food? Have you managed to pay the rent?”54

3.33 In evidence to the Committee Ms Rosie from the ACT Mental Health Community Coalition stressed the need for a system that kept people well in the community, minimising the need for acute beds. A recent development in the United Kingdom that employs support, time and recovery workers to support people with a mental health illness in the community, has been evaluated and found to be very effective.

Basically the employed people are there because of their knowledge and experience in mental illness and the training that they have acquired along the way. They service those needs to maintain people in the community. They give the support. They provide the time. If we had that sort of system [in the ACT], the PSU would be empty.55

3.34 ACT Health’s priorities for Mental Health in 2006-07, as summarised in the Annual Report include:

- Promotion, prevention and early intervention, including measures to enable the community to better recognise the risk factors and early signs of mental illness and find appropriate treatment

53 ibid., p. 118
54 ibid., p. 124
55 Transcript of Evidence, 7 February 2006, p. 27
• Integrating and improving the care system, including social supports and health services;
• Participation in the community and employment, including access to accommodation; and
• Increasing workforce capacity, including measures to build the capacity of the public, private and community sector workforce to deliver services.\textsuperscript{56}

3.35 Clearly this is an area where a broad consensus exists across government and non-government organisations. It would appear that the pace of change is more influenced by the level of resources available than any fundamental disagreement on the directions to be pursued.

### Discharge planning

3.36 A regular criticism of Mental Health ACT is that patients are discharged from acute care facilities without adequate planning to ensure that the person has accommodation and support in the community.

3.37 The discharge of people from PSU, while they are still unwell, was identified as a significant problem by the Richmond Fellowship and other groups. The Fellowship noted that acute care facilities seem to have a policy of sending patients back to the community on Friday afternoons without advising relevant support services. Thus a person who may still be seriously unwell may be without support over a weekend.

\begin{quote}
We often get people discharged on a Friday afternoon back to our group houses who have had a serious suicide attempt. We are not notified. That in itself to me presents a serious gap in the services, because we then rely on other group house residents to either notify us or to support that client over the weekend—because
\end{quote}

\textsuperscript{56} ACT Health, Annual Report 2005-06, p. 22-3
there’s no staffing on the weekend at our houses at present—to make sure this client doesn’t end up back in hospital.\footnote{Transcript of Evidence, 7 February 2006, p. 39}

3.38 Mental Health ACT acknowledged that this is an issue. With an occupancy rate of ninety-eight per cent, it is inevitable that patients will be released from the PSU in a less than optimal condition.

Discharge should be shaped by the assessment of mental status, risk and achievement of those goals. Having said that, I cannot deny that the pressure on our inpatient unit is enormous. Currently PSU has an occupancy rate of around ninety-eight per cent, which is higher than you would aim to run any hospital facility. There is pressure on our beds.\footnote{Transcript of Evidence, 22 March 2006, pp. 184 - 185}

3.39 It is also important to note Dr Brown’s qualification of what Mental Health ACT can achieve:

I guess we work more on the concept of recovery rather than wellness per se, and recovery does not necessarily mean the absence of symptoms. It is more an ability to manage one’s own illness, albeit there may well be ongoing symptoms. … the resources are limited, and the demand is quite large. So there is a need for throughput through the system, without doubt.\footnote{ibid., p. 192}

3.40 As Dr Brown put it in evidence to the Committee:

A well-functioning mental health service would, I think, at the point of working towards discharge develop in collaboration with their client what you might call plans, relapse prevention plans and crisis plans.

3.41 There are clearly problems with this part of the mental health care system. It is simply unsatisfactory that patients are released into the community without a proper discharge plan that ensures the community health service is aware that they have been released and of the continuing treatment they may require and that their
accommodation provider knows that they will be returning to their accommodation.

3.42 Mental Health ACT clearly recognises these problems and also knows how to address it. It appears to be largely a question of resources, facilities and staffing. Staff of acute care facilities are under pressure to move patients through and they may be personally stressed at periods of high demand and thus fail to ensure that necessary provision is made for patients being released.

3.43 The acute care facilities are running at ninety-eight per cent occupancy which means that they have in practice, no margin to cope with emergencies other than by moving an existing patient out.

3.44 There also appear to be communication difficulties between the acute care and accommodation services:

which can be very alarming when we come in on Monday morning and someone who was seriously unwell the week before is back at home—has been back in our place for two days and we didn’t know. They could have gone straight home, gone up into their bedroom and killed themselves—nobody would know. So the lack of communication is one of the biggest issues.60

RECOMMENDATION 5

3.45 The Committee recommends that discharge planning from acute care facilities be reviewed by Mental Health ACT to ensure that patients are discharged with a responsible person in the community being advised of the release and accepting responsibility for the patient; provision for accommodation of the patient being made; and the relevant community health centre being advised.

RECOMMENDATION 6

3.46 The Committee recommends that, wherever possible, people with a mental illness are not released from acute care facilities after

60 Transcript of Evidence, 7 February 2006, p. 39
3.00pm on Friday afternoons or over the weekend due to the difficulty of arranging support staff, through community organisations, at such a late stage in the working week.

3.47 The question of effective discharge planning leads naturally to a second major issue to which virtually all parties to the inquiry referred - the need for ‘step-up’ and ‘step-down’ facilities in the ACT.

**Step-up and step-down facilities**

3.48 Step-up step down care is about the balance between clinical and non-clinical care for people with a mental illness. Support is provided to people living in the community with a mental illness and additional support is provided following discharge from a period of acute hospitalisation. However, the prime focus of this model of care is about assisting people to develop and/or redevelop their skills in as normalised an environment as possible and in a way that assists people to integrate with and reconnect with their community. The level of support should be provided in accordance with the needs of the person, as and when required. "At the moment the delivery of services for mental health in the ACT is much more focused on the acute end of service, rather than on the recovery focused end". Delivering more interventions at an early stage has the potential to relieve pressure on the acute care system.

3.49 The need for step-up and step-down facilities in the ACT is the subject of unanimous support in evidence to this Committee. Community groups referred to it in virtually every submission. Dr Brown recognised it as a priority in her outline of the services she would like to see Mental Health ACT provide. The Committee itself visited such a facility in Mont Albert Victoria, Linwood House.

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62 Transcript of Evidence, 7 February 2006, p. 25
63 See paragraph 1.28 above
"The supports that people need to maintain their accommodation are the [same] supports that they need to maintain good health." Step-up step-down facilities provide both an alternative and a complement to acute care. A step-up facility offers a person the opportunity to respond to a deterioration in their condition in a way that may avoid the need for acute care:

you can choose under your own steam to say, “I’m becoming unwell. I need a safe, supportive environment.” That hopefully, with the documentation, will avoid an acute episode of illness. ... we are talking about people ... actually recognising it within themselves and being responsible for their own wellness. This is a matter of turning mental health service provision on its head and people with mental illness recognising that there is actually somewhere to go to become well.

This also offers medical professionals and carers with an alternative option to acute care.

Similarly a step-down facility addresses the problem discussed in the previous section; the discharge of people from acute care when they are still unwell without adequate provision being made for their care.

Rather than just being discharged from the PSU when still seriously ill, there is somewhere to go where you are maintained and encouraged into that wellness before you can go home.

Richmond Fellowship identified the same problem:

The same when they go to hospital: on discharge there is nothing out there. What used to be provided by Brian Hennessy is no longer available because they focus on rehabilitation. So people who come out of hospital and cannot return to their home really

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64 Transcript of Evidence, 7 February 2006, p. 25
65 ibid., p. 26
66 ibid.
have difficulty in managing, and often relatives then become responsible for maintaining them.67

3.53 Because of the unanimity of opinion in support of the creation of such facilities, the Committee does not intend to dwell on the need for them at great length.

RECOMMENDATION 7

3.54 The Committee recommends that step-up and step-down facilities be included in the ACT’s forthcoming Mental Health Services Plan and that they be established as a matter of urgency.

Communication between service providers

3.55 The complexity of the area and the number of agencies involved inevitably lead to problems of communications between the various participants. The Committee heard details of the various Memoranda of Understanding (MOUs) between the various service providers, both public and community-based and acknowledges the efforts being made to improve coordination of services.

3.56 A number of submissions referred to the damage that the (now abandoned) purchaser-provider model of service delivery did to this sector.

Purchaser-provider, of course, put services in competition with each other and broke down a lot of that cooperation, and that cultural change in rebuilding those collaborative networks is something that’s an ongoing process.68

3.57 More typically, the problem is that community groups lack the time and resources to become fully familiar with the range of services and service providers. For example, one community group commented that:

67 Transcript of Evidence, 7 February 2006, p. 39
68 Transcript of Evidence, 1 March 2006, p. 120
you have to have somebody that you are able to consult with within housing to be able to maintain that link and that is very difficult when you are just going in on a customer service level and you are just getting whoever happens to be on the desk or whoever answers the phone.69

3.58 Given that Housing ACT does in fact have trained housing managers and specialist managers, it seems probable that this group may simply have failed to find its way through the system.

RECOMMENDATION 8

3.59 The Committee recommends that all relevant government agencies ensure that details of their full range of services and relevant contacts are available to the community in a readily accessible form.

3.60 The Committee was also advised that Housing ACT has regular meetings with community groups - at least once every six weeks. There are also a large number of advocacy groups and the like in this area which try to coordinate activities and approaches.

3.61 Many community groups acknowledged this problem in their evidence to the Committee but at the same time saw limited opportunities to overcome it. These groups are under considerable pressure - finances are tight and demands on their services are increasing. Thus the prospect of more meetings to coordinate services or finding the time and resources to send staff on training courses to familiarise them with the range of services and service providers operating in the area is simply daunting.

3.62 A further issue that was referred to specifically with regard to seeking support for a person who is exhibiting symptoms of mental illness while in public housing was the impact of privacy laws. It was suggested that, where a person did not agree to someone seeking help on their behalf or acknowledge that they needed help, housing

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69 Transcript of Evidence, 7 February 2006, p. 20
managers or community groups were restricted by privacy laws from seeking help on the person’s behalf. The Human Rights Act (ACT 2004, does, at section 12 identify a right to privacy. If such restrictions do apply the opportunities for early intervention are diminished.

3.63 The ACT Government’s submission commented that:

the interplay of the various pieces of legislation… do not support interventions unless the individual presents as a safety risk to themselves or the broader community; when this is in the context of housing support, the individual has often undertaken a course of action that places their tenancy at risk or actually terminates [it].

3.64 The submission goes on to advise that appropriate protocols be put in place in advance of such a situation arising. While this would be desirable, it is not always practical. Balancing the expressed wishes of the individual (or, indeed, their refusal to acknowledge that a problem exists) with what might be considered best in their long term interest, is extremely difficult.

3.65 The Committee understands that in such circumstances the Public Advocate is the appropriate person to act on the person’s behalf. However, given the uncertainty that exists, the Committee makes the following recommendations.

RECOMMENDATION 9

3.66 The Committee recommends that the ACT Human Rights Office clarify the position of individuals such as Housing ACT managers or community housing workers who wish to seek medical help for a person but do not have that person’s consent to do so.

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70 The Privacy Act 1988 (Cwlth); the Mental Health (Treatment & Care) Act 1994 and the Residential Tenancies Act 1997.
71 Submission, ACT Government, p. 23
RECOMMENDATION 10

3.67 The Committee recommends that the government investigate ways to facilitate an amenable living environment for clients with a mental illness and their neighbours, who may be affected during an episode of poor mental health.

RECOMMENDATION 11

3.68 The Committee recommends, following clarification from the Human Rights Office, that the Minister for Health and the Minister for Housing work to ensure that the position of Housing ACT staff is clearly outlined in a specific policy addressing this issue and that appropriate training is developed and provided to all relevant housing staff, both in Housing ACT and in the community sector.

Are there too many non–government organisations?

3.69 A related issue that was mentioned was whether the proliferation of community organisations supporting specific groups within society or acting as advocates for specific conditions, is having an adverse effect on service provision. Coordinating the services a person with a mental health illness might require to function as a full member of the community is often difficult. It would be unfortunate if the range of services available added to that difficulty and created confusion.

3.70 People experiencing either a mental health illness or a related accommodation problem are perhaps the least well equipped group to deal with the challenges of finding the appropriate service provider to help them. Often the people who are looking after them are ill-equipped to work out the system, due to their age, lack of time, or other reasons.

3.71 The list of organisations receiving Government funding provided to the Committee at its hearing of 30 August 2006 shows a number of organisations receiving funding for very similar activities. There may be sound reasons for some of this - organisations may specialise in a particular aspect of a generally described function - but, taken with the
reports of problems with coordination, it is evidence that this is an area that may need reform.

3.72 A witness to the inquiry suggested that:

What the ACT needs to do is rethink the number of agencies it has got. We have got too many agencies operating in this town. … There are too many players in each individual’s life. … you need to eliminate some of the personal agendas, historical agendas, that exist. 72

3.73 Mr Day was recounting his experience in South Australia running an organisation whose function was to coordinate the provision of a wide range of services to people living in the community who suffered episodic conditions and required services and support. The object of the program was to minimise the need for repeated assessment of a client’s needs and ensure that, having made contact with one service, the appropriate service was provided, even if a different agency was the actual provider, without the constant need for referrals to other agencies.

3.74 Richmond Fellowship made a similar point with regard to the proliferation of groups:

We do have a large number of small project-based organisations in the ACT. We are a small community and we have many, many organisations and, while we need the choice, we tend to set up an organisation rather than make it a project of a larger organisation. It is very difficult to actually collate it all …73

3.75 In raising this issue there is no question of challenging the intentions, or contribution, of individuals or organisations. However, it does appear that the non-government sector has grown in a fairly ad hoc way. It might be of benefit to all parties - clients, non-government organisations and government - to have an independent audit of the sector, to assess whether services could be improved by amalgamating

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72 Transcript of Evidence, 7 February 2006, p. 5
73 ibid., p. 30
or otherwise rationalising the number of community organisations funded by government in the ACT.

3.76 However, the Committee believes there could be significant gains to the community if organisations, where possible, developed partnerships to maximise resources.

**RECOMMENDATION 12**

3.77 The Committee recommends that an audit of all non-government mental health services be conducted, to determine the number of services and types of services provided, to reduce duplication of services and to maximise quality service delivery outcomes to people with mental health issues.

3.78 Having said that the Committee recognises that the number of different groups involved reflects the complexity of the area and the reality that individual needs and circumstances are highly specific. In addition, attachment to a particular issue or group is an important factor in attracting people to work, either for low salaries or as volunteers, in the community sector. The proliferation of agencies may be a product of this and any attempt to reduce the number may prove counter-productive by discouraging people from working in the sector.

**Training**

3.79 A recurring comment from community groups is on the need for more training both for their staff and for Housing ACT staff who are dealing with those with a mental health illness. A further training requirement is for those in the non-government sector on the structure of the ACT system and where responsibility for particular services lies.

3.80 Housing ACT staff do, in fact receive extensive training in dealing with clients. Housing managers, who are responsible for management of tenancies, do receive specific training including in the provision of social support.

3.81 However as the Housing ACT submission notes:
Housing ACT is a generalist provider of social housing, [thus] it is not possible to provide the level of learning and development that would permit Housing Managers to be specialist providers to clients with the full range of needs and vulnerabilities.74

3.82 Housing ACT also employs five Specialist Housing Managers whose role is to assist tenants with ‘identified complex needs who are not currently receiving the level of support that they require … to achieve sustainable and stable tenancies.’ These specialist managers work by assisting clients to access the appropriate specialist support they need.

3.83 In addition to these staff training activities, Housing ACT runs a number of programs to support tenants having difficulties. In view of this the Committee does not believe that criticism of Housing ACT is warranted. There will, of course, be hiccups. Staff turnover in any large bureaucracy may leave tenants and their carers dealing with unfamiliar faces and they may find that disturbing.

3.84 Tenants may expect Housing ACT to provide services that has neither the responsibility nor capacity to provide and interpret the divisions of responsibilities between agencies as unnecessarily frustrating and obstructive. First contact with relatively junior staff who have not been trained in the specific skills of handling applicants who are under stress or exhibiting the early stages of a mental disorder may be unsatisfactory.

3.85 With regard to the training of staff in the community sector, while there is general agreement of the need for it, the issue seems to resolve itself in to the inevitable question of resources. This has two aspects - funds are needed to provide the training program and staff time is needed to enable them to participate in training.

74 Submission, ACT Government, p. 15
RECOMMENDATION 13

3.86 The Committee recommends that Housing ACT examine the ratio of specialist housing managers to clientele to ensure the right balance is met, and assesses this need on a periodic basis.

Issues specific to the indigenous community

3.87 The problems facing the indigenous community are similar to those experienced by the general community but exacerbated by the particular circumstances of the Aboriginal community in Australia. Witnesses to the Committee identified issues with Aboriginal identity, the residual impact of the stolen generations, community attitudes to mental illness, abuse, neglect and dual diagnosis as specific factors contributing to mental health problems within the community.75

3.88 As with many other witnesses Ms Tongs stressed that:

The big issue around appropriate housing for people living with mental illness is the lack of understanding of mental illness, particularly drug-induced psychosis. There’s real discrimination, I believe, against people who have a drug-induced mental illness because, as soon as you mention that it is drug-induced, people don’t want to go there.76

3.89 A contributory problem is that of denial:

A lot of people admit that they’ve got a drug problem, but they won’t accept that they’ve got a mental illness. So, often, if they’ve stop taking the drugs and then they need to be medicated by the psychiatrist, they won’t take their medication. It’s either that they’re on everything or they’re off everything. So they think that they don’t have a problem. That’s why people then become really unwell again. As soon as they start to feel okay, if they are on the

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75 Transcript of Evidence, 14 June 2006, pp. 219-224
76 Transcript of Evidence, 14 June 2006, p. 219
medication, they’ll go off it and then we’re back to square one again.\textsuperscript{77}

3.90 Without a proper understanding of the specific nature of a person’s condition the provision of accommodation, while important was unlikely to achieve anything.

Not having access to appropriate housing is a big issue, it’s a big problem, and it needs to be supported accommodation. People need to be supported.\textsuperscript{78}

3.91 Both witnesses described common situations where people could not manage either their mental health illness or the ordinary demands of day-to-day living without continuous support; break down in one area leading almost inevitably to break down in the other.

I think that maybe housing need to look at setting up a model where there are nurses or mental health workers or something on site 24 hours a day, whether it is in a flat complex or within a group of little houses, just to contain them in stability.\textsuperscript{79}

3.92 The clear requirement is for more resources available for community care. Existing services are stretched to the limit and cannot keep up with the demands made on them. This means more suitable housing specifically for people with a mental health illness coupled with support programs that combine clinical support and treatment with social support that gives patients the skills necessary to live in the community.

\section*{Dual diagnosis}

3.93 Dual diagnosis in this context refers to the coexistence of a mental illness with other health issues. Most commonly it refers to mental illness and substance abuse, but can also refer to physical illnesses and problems associated with ageing.

\textsuperscript{77} Transcript of Evidence, 14 June 2006, p. 223
\textsuperscript{78} ibid., p. 222
\textsuperscript{79} ibid., p. 220
The existence of a dual diagnosis exacerbates the difficulties of managing a person's mental health illness. In the case of substance abuse the two may be directly related as the person tries to "treat" the mental health illness by self-medicating with alcohol, tobacco and/or illegal drugs.

Where the substance abuse provides a perception of temporary relief from the symptoms of the mental health illness the person may cease to try to manage that problem, simply become too disorganised to do so or to accept support in doing so.

In the worst cases the substance abuse may contribute to psychotic behaviour, presenting difficulties for medical authorities and making it impossible to accommodate the person in ordinary community housing. The Committee received a number of examples of this situation, particularly among young people. Unfortunately people in this group are excluded from accommodation and may end up on the street.

This situation does not represent a failure by the accommodation provider. Patients exhibiting violent or other high risk behaviours need special care which most community housing is not able to provide. At the same time, such patients are extremely disturbing for other residents of supported housing, thus their exclusion may be the only response available.

As with many of the other issues identified in this inquiry, the response to the difficulties of managing dual diagnosis is basically one of providing adequate resources to ensure that the level of community care and the appropriate accommodation options are available.

Dual disability patients are those with an intellectual disability and a mental illness. They are generally the responsibility of Disability ACT. Similar issues of appropriate accommodation, facilities which can handle those with high support needs or who exhibit anti-social behaviours, and training for staff to manage both the intellectual disability and the mental illness, arise.
There is a Dual Disability Service within Disability ACT and an Intensive Support and Treatment Service is being developed. The OCA believes that a specialised 'step-up' facility is needed for people in this group who have 'high and complex needs'.

**Forensic mental health patients**

Forensic mental health patients are those in the criminal justice system.

The Committee does not wish to comment on the issues relating to the actual imprisonment of people with a mental illness, beyond commenting that many of this group end up in the criminal justice system because they have been failed by the mental health system at an earlier stage. Once in the system, proper medical care and rehabilitation is vital if this group is to have any chance of rejoining the community at the completion of their sentence.

The use of the Belconnen Remand Centre and Brian Hennessy Rehabilitation Centre for the long-term detention of such people is inappropriate. They cannot offer the appropriate combination of care, security and rehabilitation required. However forensic mental health patients often end up being detained in these facilities for lengthy periods or are refused bail for offences that, objectively, do not warrant detention, in the absence of any alternative system of care.

The Committee notes that the current capital works program includes the construction of a secure forensic unit and a youth unit which will address this issue.

The more important issue for this Committee is the provision of services to forensic mental health patients on their release from incarceration. Upon release, in the absence of appropriate care and accommodation, the risk of re-offending is greatly increased. The Office of the Community Advocate recommended the model of Forensicare in

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80 Submission, Office of the Community Advocate, p. 9
Victoria which provides supported accommodation for up to eighteen months.81

RECOMMENDATION 14

3.106 The Committee recommends that Mental Health ACT develop a 'half-way house' either as a single campus or as specific units in the community in which forensic mental health patients can be supported in making the transition from incarceration to living in the community.

Alternative housing models

3.107 The Committee's terms of reference include mention of 'opportunities to involve non-Government stakeholders' and 'the feasibility of alternate support-based housing models'. The Committee has indicated above that it favours a significant increase in supported accommodation specifically for those with a mental illness.

3.108 With regard to the question of non-government stakeholders, the ACT already has a number of non-government community and not for profit groups providing a range of accommodation and levels of support for people suffering from a mental illness. Typically these groups lease property from the ACT Government but the nature of the service provided reflects the philosophy or objectives of the particular group. The Havelock House/Richmond Fellowship model, separating the accommodation and support services is typical.

3.109 There are other examples of different ownership structures including cooperatives in which tenants may invest in the property and 'buy' a place in a community housing scheme or combine a capital contribution and rental.

3.110 The Committee does not see the primary need as being to search out additional models of supported accommodation or to give its support to any particular approach. The Mental Health Council of Australia has

81 Submission, Office of the Community Advocate, p. 6
recently published a report, *Smart Services: Innovative Models of Mental Health Care in Australia & Overseas (October 2006)*. This report provides a detailed analysis of many services.

3.111 The diversity of the needs and circumstances of people with mental illness means that no one model is ideal. There are many types of supported accommodation operating in the areas of mental health, disability and aged care. The real issue is to ensure that adequate funding is put into the area to enable the full range of services to be offered.

**RECOMMENDATION 15**

3.112 **The Committee recommends that the government ensures that there is a range of accommodation models to provide for the diversity of clients with a mental health illness in the ACT.**

**Conclusion**

3.113 The Committee examined this complex issue over many months and in that time funding has gone into some areas referred to by this report. The issue of appropriate accommodation for people living with mental illness will always provide governments with challenges by the very nature of the issue. The Committee hopes that this inquiry and report will assist the Government to address the issues raised with courage, for the future good mental health of the community.

Karin MacDonald MLA

Chair

31 May 2007
APPENDIX A: Witnesses at public hearings

7 February 2006

Handyhelp ACT
- Mr Ken Day - Executive Officer

ACT Human Rights Office
- Dr Rowena Daw - Human Rights Legal Adviser

Department of Employee and Workplace Relations (Work - Ways)
- Mrs Lisa MacPherson - Executive Director
- Mr Ian Brorson – Disability Employment

Mental Health Community Coalition ACT
- Ms Linda Rosie - Executive Director

Richmond Fellowship of ACT Inc.
- Ms Heide Seaman - Assistant CEO

Canberra Community Housing Young People
- Ms Suzanne M. Maclean - CEO
- Ms Sonja Osfield - Specialist Counsellor
9 February 2006

Housing ACT
- Ms Maureen Sheehan – Director

Mental Health ACT
- Dr Peggy Brown - Acting General Manager and Chief Psychiatrist

Disability ACT
- Ms Lois Ford - Executive Director

Mental Health Council of Australia
- Mr Sebastian Rosenberg - Deputy Chief Executive Officer

Mental Illness Fellowship of ACT
- Mr Ian Morison – President
- Ms Bernadette Redwood - Executive Officer

ACT Shelter
- Ms Kerry Tucker - Representative/Advocate (people on low income)

ACT Government
- Mr John Hargreaves MLA - Minister for Disability, Housing and Community Services

1 March 2006

GROW (mental health organisation and registered charity)
- Ms Patricia Pullen - Support Worker
- Mr Geoff Holt - Chairman of GROW Branch Management Team New South Wales and ACT
- Mr Frank Watson – Past Organiser of GROW groups/stakeholder

Carers ACT
- Mr Malcolm J. Gibson- Representative.
- Ms Veronica J. Barbeler - Individual Carer
Lifeline Canberra
- Ms Marie Bennett - Executive Director
- Ms Fiona May - Policy Officer

ACTCOSS
- Ms Ara Cresswell – Director
- Mr Llewellyn Reynders - Policy Officer

Coalition of Community Housing Organisations ACT
- Ms Fay Brockelsby - Chief Executive Officer

Public Advocate of ACT
- Ms Anita Phillips - Public Advocate
- Mr Victor H. Martin - Acting Deputy Public Advocate

Mental Health Foundation
- Ms Mary Gays - Executive Officer
- Ms Judy Bentley – (member of Mental Health Carers Network and Mental Health Community Coalition) acting as Support Person.
- Ms Jenny White – (member of Carers ACT Plus ACT Carers Network) Support Person

15 March 2006

Tenants Union of ACT
- Ms Deborah Pippin - Executive Officer

Volunteering ACT
- Ms Leila Cormick - Program Manager Connections Volunteers
- Ms Kerry Oddy - Customer Service Manager

Community Members

Mr James H. Snow
Ms Amanda J. Snow
Ms Patricia M. Daniels
ACT Disability, Aged and Carer Advocacy Service
- Ms Andrea Simons - Manager
- Mr Michael Woodhead - Advocate for people with a psychiatric disability

22 March 2006
ACT Health
- Dr Peggy Brown - Director of Mental Health and Chief Psychiatrist
- Ms Karen Lenihan - Director of Alcohol and Drug Program
- Ms Linda Tromph - Manager of Mental Health Policy Unit
- Ms Amanda Urbanc - Director of Rehabilitation and Older Persons Mental Health Services

St Vincent De Paul Society Social Justice Committee
- Mr Nick Stuparich – President of Canberra-Goulburn Archdiocese
- Mr Bob Wilson - Chief Executive Officer of Canberra Goldman Archdiocese

14 June 2006
Welfare Rights and Legal Centre
- Mr Geoffrey Dalton - Case Worker

Havelock House Association Inc
- Ms Sonja Desmond - General Manager
- Ms Nicola Gordon - Chief Executive Officer

Winnunga Nimmityjah Aboriginal Health Service
- Ms Julie Tongs - Chief Executive Officer

Dyiramal Yigay Young Aboriginal and Torres Strait Islander Refuge
- Ms Kasey Boyd – Coordinator
30 August 2006

ACT Government

- Ms Katy Gallagher - Minister for Health, Minister for Disability and Community Services and Minister for Women
- Dr Peggy Brown - Director of Mental Health and Chief Psychiatrist
- Mr Stephen Druitt - Acting manager mental health policy unit
- Mr Ian Thompson - Executive Director, Policy Division
- Ms Amanda Urbanc - Director of Rehabilitation and Older Persons Mental Health Services
APPENDIX B: Submissions

1. Confidential
2. Ms Veronica Barbeler
3. Carers ACT
4. Canberra Schizophrenia Fellowship
5. Confidential
6. Havelock Housing Association
7. Mental Health Foundation
8. Name and address withheld
9. Youth Coalition of the ACT
10. ACT Shelter
11. Mental Health Community Coalition of Community Housing Organisations of the ACT Inc
12. ACT Council of Social Service (ACTCOSS)
13. ACT Human Rights Office
14. ACT Government Submission
16. Minister for Health and Human Services, Tasmania
17. Minister for Health, Queensland
18. Minister for Family and Community Services, Northern Territory
19. Minister for Health, Victoria
20. Minister for Health, Western Australia
21. Minister for Mental Health and Substance Abuse, South Australia
22. Confidential
23. GROW
24. Office of the Community Advocate
APPENDIX C: Committee Visits

ACT Visits

6 December 2005
Richmond Fellowship
“The Lodge”/Ainslie Village

7 December 2005
Hyson Green
Ward 2N
Brian Hennessy Rehabilitation Centre

Melbourne Visits

10 October 2005
Department of Human Services
Appleby Crescent – Residential Rehabilitation
Linwood Prevention and Recovery Care Service and Upton House – (part of Eastern Health Adult Mental Health)
Waiora Community Mental Health Service

11 October 2005
Department of Human Services
Salvation Adult Services
HomeGround Services
Supported Housing - Kew
Australian Housing and Urban Research Institute