



**OFFICE OF THE  
PUBLIC ADVOCATE**

**Submission to the Inquiry into Supported  
Accommodation for Victorians with a disability  
and/or mental illness**

*Response to Family & Community Development Committee  
Discussion Paper*

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## Glossary of acronyms

ABI	Acquired brain injury
CCU	Community care unit
CSO	Community service organisation
DHS	Department of Human Services
DSR	Disability Support Register
HASI	Housing and Accommodation Support Initiative
HBOS	Home based outreach services
IRRC	Integrated Rehabilitation and Recovery Care
KRS	Kew Residential Services
MACNI	Multiple and Complex Needs Initiative
OPA	Office of the Public Advocate
PARC	Prevention and Recovery Care
PDRSS	Psychiatric disability rehabilitation and support services
SAVVI	Supporting Accommodation for Vulnerable Victorians Initiative
SECU	Secure extended care unit
SRS	Supported residential services
WHO	World Health Organisation

## 1. About the Office of the Public Advocate

The Victorian Public Advocate is appointed by the Governor in Council pursuant to the *Guardianship and Administration Act 1986 (Vic)*. It is a statutory office, independent of government and government services, and can highlight situations in which people with disability are exploited, neglected or abused.

The Office of the Public Advocate (OPA) provides advocacy, guardianship and investigation services to people with a decision-making disability. People with a decision-making disability include people with an intellectual disability, a mental illness, an acquired brain injury, dementia and people who are in a coma or otherwise lack the capacity for cognition or communication.

OPA coordinates the Community Guardianship Program and the Private Guardian Support Program, as well as the Community Visitors Program and the Independent Third Person Program. It also has a role in community education, the provision of advice and information and in undertaking research and policy projects.

The Office of the Public Advocate works with people living in a range of supported accommodation settings. These include:

- People with a cognitive disability – including, but not limited to, people with intellectual disability, people with an acquired brain injury (ABI), people with age-related dementia, and people with a mental illness
- People with cognitive disability experiencing abuse, neglect and exploitation
- People who have high and complex needs – including, but not limited to, physical care needs, behavioural issues associated with disability and diverse support needs resulting from dual disabilities
- People who are isolated, vulnerable and disconnected from their families and communities
- Families of people with cognitive disability – and often where there is conflict about understandings of what the represented person’s wishes are and what is perceived to be in that person’s best interest.

In 2007-08, 590 Community Visitors conducted 5,654 visits to people in mental health facilities, disability accommodation and supported residential services. In the same period, OPA was guardian to 1,200 of the most vulnerable Victorians, a large number of whom are patients in mental health facilities, or reside in disability accommodation and supported residential services.

The work of the Office informs the Public Advocate’s perspective in considering supported accommodation.

## 2. Summary of recommendations

This submission makes the following recommendations:

### HUMAN RIGHTS CONTEXT

1. That the *Victorian Charter of Human Rights & Responsibilities Act 2006* and the United Nations Convention on the Rights of Persons with Disabilities are monitored in the provision of supported accommodation to people with a disability and/or mental illness.
2. That the needs and preferences of people with a disability and/or mental illness are prioritised in determining how supported accommodation is provided.
3. That support is provided to people with a disability and/or mental illness in the least restrictive environment, minimising limitations to liberty and freedom of movement and maximising opportunities for self-determination and/or rehabilitation.

### POLICY CONTEXT

4. That the evidence and findings of the SRS Review, the review of the mental health service system and the review of the *Mental Health Act 1986* are considered in the context of the Inquiry.
5. That the recommendations from the Victorian Auditor-General's Report on Accommodation for People with a Disability are considered in the context of the Inquiry. That is, that DHS
  - a. resource and provide guidance for developing individual support plans
  - b. review the funding model for disability shared supported accommodation
  - c. assess the capacity of staff in shared supported accommodation to deliver support services
  - d. assess resident satisfaction
  - e. expand demand management strategies.

### UNMET NEED AND UNMET DEMAND

#### MENTAL HEALTH

6. That there is an urgent increase in the number of mental health beds in relation to demand, requiring
  - a. an increase in the number of secure extended care unit (SECU) beds
  - b. the expansion of the Prevention and Recovery Care (PARC) model to meet shortfalls in discharge options from acute care across the state and to assist where acute admission is not required.

7. That there is an urgent increase in community-based accommodation and support options, including
  - a. increased funding to the psychiatric disability rehabilitation and support services (PDRSS) sector to build its capacity to provide rehabilitative support in long-term accommodation settings
  - b. new models of housing to address the cycle of homelessness and disengagement from services experienced by many people with a mental illness.

#### SUPPORTED RESIDENTIAL SERVICES

8. That the government invests financially in the SRS sector to enable it to strengthen compliance, ensure residential rights and make improvements to the existing model of pension-level SRS accommodation.
9. That attention be given to developing alternative funded accommodation models for people whose needs are inadequately addressed in the SRS sector, but who have no other options.

#### DISABILITY SERVICES

10. That there is an urgent increase in the number of shared supported accommodation houses available to people with disability.
11. That there is an urgent increase in the number of disability respite beds for people with disability in relation to demand.
12. That DHS initiates a demand management strategy to address the potential need for disability services (including people with ageing parents who will need alternative accommodation when their parents can no longer care for them).

#### SECTOR WIDE

13. That innovative models for funding the provision of accommodation are further explored and developed (for example, collaboration and investment with DHS/other CSOs/housing associations and trusts).
14. That funding and access is provided for an urgent increase in the amount of public housing stock available to people with disability.
15. That there is an urgent need for an increase in the level of support provided to people with a disability and/or mental illness living in the community, including
  - a. an increase in Home Based Outreach Services (HBOS) to provide people with mental illness with an appropriate level of support in the home
  - b. an exploration of the potential for applying the HBOS model with other disability service users
  - c. the expansion of the Multiple and Complex Needs Initiative (MACNI) and the Integrated Rehabilitation and Recovery Care (IRRC) program in order to provide

individualised accommodation with appropriate supports, particularly for residents and patients with complex needs and/or dual disability.

16. That there is an urgent increase in the number of community based accommodation and support options
  - a. that individualised supported community-based accommodation is made available for people with complex needs and behavioural problems who are inappropriately placed in secure extended care facilities
  - b. that funding is provided to enhance the availability of specialist accommodation and high level support for people with Huntington's Disease, autism and acquired brain injuries
  - c. that funding is provided to increase the availability of accommodation for people with dual disability (mental illness and intellectual disabilities) and dual diagnosis (mental illness and substance abuse issues).

#### **QUALITY OF ACCOMMODATION**

17. That all remaining institutions for people with disability are closed and that appropriate supported accommodation is developed as an alternative.
18. That funding is made available to improve the right to privacy and safety for residents in shared supported accommodation.
19. That minimum standards of maintenance are created for all supported accommodation settings to ensure consistency and compliance with health and safety standards.
20. That a definition of 'home-like' environment is incorporated into the SRS regulations and greater guidance is provided (particularly to SRS proprietors) in how to create a home-like environment for residents.

#### **QUALITY OF SUPPORTS**

21. That individualised models of support are expanded in recognition of the diversity of needs and the specific need for self-determination of people with a disability and/or mental illness.
22. That there is an increase in the provision of specialised and flexible support for people with complex and changing needs.
23. That the use of restrictive practices in disability services, including restraint and seclusion, are minimised and eliminated where possible.

24. That a body is established to ensure training and development in relation to guidelines established by the National Mental Health Seclusion and Restraint project for the elimination of seclusion and restraint in mental health settings.
25. That additional support to residents of SRS is made available to ensure adequate case management, planning and support.

#### **STAFF QUALIFICATIONS AND EXPERIENCE**

26. That minimum industry standards for qualifications, experience and training be increased for all staff working in supported accommodation settings in disability and SRS.
27. That staff in supported accommodation settings receive additional training specific to
  - a. assisting in understanding the complexities of working with people with complex and changing needs – particularly those with Huntington’s Disease, dual disability, acquired brain injury, autism spectrum disorder and whose needs are changing with age
  - b. ensuring familiarity with new models of practice and changed practices that relate to new legislative frameworks.
28. That workforce planning strategies be adopted to improve career pathways and staff recruitment and retention.
29. That minimum standards for staff / resident ratios across supported accommodation settings be adopted.
30. That a specific project to improve staffing in SRS be implemented:
  - a. that the government introduces minimum qualification levels for all personal care staff at SRS
  - b. that the requirement for a trained personal care coordinator to be on duty is increased from 38 hours per week to 24 hours per day.

#### **FINANCIAL BURDEN**

31. That the cost of disability be formally recognised in considering the financial burden experienced by residents in supported accommodation.
32. That the government review the fee for pension-level SRS to ensure that all residents have an adequate disposable income for their personal needs and opportunities.

### **LACK OF CROSS-SYSTEM INTEGRATION**

33. That a review of the barriers to cross-sector collaboration be undertaken as matter of urgency and that existing protocol within DHS between disability services and mental health require review to ensure a more effective service delivery for people with a disability and/or mental illness is achieved.
34. That cross-sector case coordination must be implemented to ensure effective and adequate support is provided to people with a disability and/or mental illness residing care.
35. That DHS review inter-regional boundaries and catchments to ensure that these limitations do not prevent people with a disability and/or mental illness from having their needs met and that their needs can be adequately met in their region of origin.
36. That people with disability and /or mental illness are appropriately assessed before discharge to an SRS and that the provision of adequate case management and support must be established before the person is accepted into the SRS.

### **FAMILIES AND CARERS**

37. That families and carers are provided greater support services and information enabling them to access the relevant support to fulfil their caring role.
38. That strategies are implemented to provide people with a disability and/or mental illness who have no family or social networks with opportunities to build social connections.

### **DIVERSE AND OTHER NEEDS**

39. That the diversity of people's needs is recognised through more flexible support and practices for indigenous people with a disability and/or mental illness and those from culturally and linguistically diverse backgrounds.
40. That the perennial issue of lack of available and accessible support and accommodation in rural and regional areas is urgently addressed through greater resourcing and regionalising existing metropolitan services.

### **INDIVIDUAL RIGHTS – SAFETY AND SECURITY**

41. That the exposure of people with a disability and/or mental illness to violence and abuse in supported accommodation settings is minimised through more effective monitoring and reporting of critical incidents, in addition to a commitment to review practices following incidents.

**INDIVIDUAL RIGHTS – TENANCY RIGHTS**

42. That residents in SRS accommodation are afforded the same rights and protections provided to residents under *Residential Tenancies Act 1997*.

### 3. Overview

The Inquiry into supported accommodation for Victorians with a disability and/or mental illness is timely and appropriate. The Office of the Public Advocate welcomes the opportunity to provide input into this important issue. OPA's Policy & Research Unit undertook internal consultations with staff (including advocate guardians, community visitor coordinators and advice service staff) and Community Visitors to ensure the breadth of OPA's experience relating to supported accommodation is reflected in this submission.

Since its inception, OPA has been a strong advocate for support and accommodation that promotes the opportunities of people with a disability and/or mental illness to experience a quality of life, self-determination and social connectedness. The process of de-institutionalisation from the 1980s is one that OPA has strongly promoted and endorsed. Indeed, OPA continues to advocate for the closure of remaining institutions in the disability sector. Similarly, since the Ministerial Review of Special Accommodation Houses in 1986 and for nearly two decades, OPA has been concerned about the suitability of pension-level supported residential services as a permanent form of accommodation for people who often have complex needs that required specialist support.

OPA acknowledges that over the past two decades, reforms to accommodation models and support practices have led to improvements in the options available to people with a disability and/or mental illness. The *Disability Act 2006*, for example, is a development that provides a new legislative framework for promoting the rights of people with disability. While the legislation is in its infancy and there are some discrepancies in its implementation, it has the potential to improve the quality of life and opportunities for people with a disability.

Another recent positive development from OPA's perspective is the Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI). As this submission will emphasise, there are significant issues with the ability of current pension-level SRS to adequately meet the needs of people with a disability and/or mental illness and enhance their quality of life. The funding provided through SAVVI has been an initial step that recognises these challenges, and seeks to provide some resources to improve the viability of SRS and the support needs of residents.

This submission outlines the importance of accommodation and appropriate support to the quality of life and self-determination of people with a disability and/or mental illness and their right to an adequate standard of living and social protection. While the focus of the Inquiry is specifically limited to supported accommodation, the intersection with housing and support more generally cannot be ignored.

As indicated above, the move away from institutions to facility based treatment and rehabilitation and shared supported accommodation settings (such as community residential units) have been positive developments. There remains a significant gap, however, in the adequacy of intensive, specialist support provided to individuals who would previously have been cared for in an institution setting. This is a significant system failure. Furthermore, responses to the increasing

complexity of needs of many people with a disability and/or mental illness have not been effectively integrated into the provision of support, accommodation and planning.

This submission outlines a range of issues with the service systems that provide supported accommodation to people with a disability and/or mental illness. These include the following:

- **Supply of housing, supported accommodation and mental health beds:** Victoria does not provide adequate levels of accommodation to meet the current and potential needs and demand of people with a disability and/or mental illness. This includes mental health beds, supported accommodation placements and long term housing and support. In addition to the need for increased capacity in the availability of beds and accommodation, there is a need to further explore partnerships between the government and community sector organisations through the development of housing associations and trusts that can develop new and innovative models of housing.
- **Quality of support:** People with a disability and/or mental illness with complex and changing needs do not have access to adequate levels of specialist, individualised support to meet their needs. This, in turn, affects their capacity to achieve the quality of life that fulfils their right to autonomy, self-determination and social connectedness.
- **Quality of staffing:** The quality of supported accommodation in meeting the needs of people with a disability and/or mental illness is dependent on the skills, experience and qualifications of staff in these settings. In some sections of the supported accommodation sector, particularly the supported residential services sector, staff lack the specialist qualifications and experience necessary to work with the client group they support. High levels of staff turnover and casualisation of the workforce also has significant implications for the capacity of supported accommodation providers to effectively meet the needs of people with a disability and/or mental illness.
- **SRS supported accommodation:** Despite the recent SAVVI funding, the provision of support in pension-level SRS remains a significant concern to OPA, and deserves special mention. These privately owned facilities that operate on a for-profit basis provide supported accommodation to the most vulnerable, disadvantaged Victorians, thereby minimising the government's responsibility for this population group. From OPA's perspective, the system of supported accommodation provided within SRS is questionable in view of the often complex needs and vulnerability of the population group and the inability of SRS to provide an adequate level of specialist support. This is despite efforts by the government to regulate the industry.

The failure to provide adequate housing and support for people with a disability and/or mental illness contributes to both increased economic and social costs to the community. More specifically, there are economic costs to the community associated with ill-health, increased use of health services and increased exposure to the criminal justice system. For people with a disability and/or mental illness there are social costs relating to disempowerment, social isolation, lack of autonomy, and restriction of movement.

From OPA's perspective, the supported accommodation system needs to provide people with a disability and/or mental illness the opportunity to be empowered, to be socially connected, to have choice and flexibility in their support and accommodation options, and to feel safe and secure. To achieve this, there needs to be adequate availability of supported accommodation options that are consistent in the standards of facilities and care they provide. Within supported accommodation, there needs to be qualified, experienced and well trained staff to meet the needs of people with a disability and/or mental illness. Supported accommodation models need the capacity to provide flexible, specialist support that is effectively coordinated across service systems. Population based planning to determine the future needs of people with a disability and/or mental illness in regard to supported accommodation is essential.

## 4. Human rights context

The Public Advocate is concerned with the rights of people with a disability and/or mental illness and aims to support them to reach their individual potential and to promote their involvement as active members of our community. The provision of adequate housing and support is central to achieving that potential and involvement in the community.

The right to housing is a recognised international human right. Furthermore, within the United Nations Convention on the Rights of Persons with Disabilities, the right to an adequate standard of living and social protection is set out specifically in Article 28. This Convention has been ratified by the Australian government and sets a new rights framework from which accommodation for people with disability needs to be considered.

### **Article 28**

#### **Adequate standard of living and social protection**

1. States Parties recognize the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions, and shall take appropriate steps to safeguard and promote the realization of this right without discrimination on the basis of disability.
2. States Parties recognize the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability, and shall take appropriate steps to safeguard and promote the realization of this right, including measures:
  - (a) To ensure equal access by persons with disabilities to clean water services, and to ensure access to appropriate and affordable services, devices and other assistance for disability-related needs;
  - (b) To ensure access by persons with disabilities, in particular women and girls with disabilities and older persons with disabilities, to social protection programmes and poverty reduction programmes;
  - (c) To ensure access by persons with disabilities and their families living in situations of poverty to assistance from the State with disability related expenses, including adequate training, counselling, financial assistance and respite care;
  - (d) To ensure access by persons with disabilities to public housing programmes;
  - (e) To ensure equal access by persons with disabilities to retirement benefits and programmes.

A significant intention of these rights is to protect the needs of people with a disability and/or mental illness. Housing fulfills physical needs by providing security and shelter from weather and climate. It fulfills psychological needs by providing a sense of personal space and privacy. It fulfills social needs by providing a gathering area and communal space for family and social networks.

In regard to accommodation and support needs, people with a disability and/or mental illness are no different from anyone else in Victoria in wanting to live in an environment that enables them to be safe, connected to their community and that provides security.

It is critical that the accommodation and support provided to, or accessed by, people with a disability and/or mental illness is of a standard acceptable to the community and that it ensures a reasonable quality of life. The World Health Organisation (WHO) refers to the concept of ‘healthy housing’, which is the ‘provision of functional and adequate physical, social and mental conditions for health, safety, hygiene, comfort and privacy.’<sup>1</sup>

‘Adequate shelter’ is defined as:

‘.. more than a roof over one’s head. It also means adequate privacy; adequate space; physical accessibility; adequate security; security of tenure; structural stability and durability; adequate lighting, heating and ventilation; adequate basic infrastructure, such as water-supply, sanitation and waste-management facilities; suitable environmental quality and health-related factors; and adequate and accessible location with regard to work and basic facilities: all of which should be available at an affordable cost. Adequacy should be determined together with the people concerned, bearing in mind the prospect for gradual development.’<sup>2</sup>

Critically, WHO emphasises that in addition to protection and shelter from the outside, healthy housing provides social connection and a sense of identity. That is, the personalisation of ‘a space of intimacy in a home allows for feelings of being separate and differentiated’.<sup>3</sup> The self-advocacy group for people with an intellectual disability, Reinforce Self Advocacy, stated in a presentation in 2007 that ‘[p]eople should get support so they can do the things they want to do with different people like friends, family, volunteers, [and] other groups’.<sup>4</sup> Often activities for people with disability are tailored to groups rather than to individual preferences, and Reinforce makes the point clearly that people’s individual preferences need to be taken into consideration.

The importance of being empowered to live as independently as possible is critical for people with a disability and/or mental illness. People who participated in research conducted by DHS into the aspirations of people with a disability stated that their independence was central to their quality of life. Participants described independence as ‘being spontaneous’ and ‘having plenty of choices’.<sup>5</sup> For people with a disability and/or mental illness, achieving this independence and sense of empowerment often requires the support of others.

While the UN Convention provides a framework to ensure people’s right to adequate health and personal care, often service providers and the community place less emphasis on enabling people with a disability and/or mental illness to be as independent as possible. Support and care need to

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<sup>1</sup> World Health Organisation 2004, ‘Review of evidence on housing and health: Background document’, Fourth Ministerial Conference on Environment and Health, Budapest, Hungary, p.1.

<sup>2</sup> WHO 2004, ‘Review of evidence on housing and health’, p.1.

<sup>3</sup> WHO 2004, ‘Review of evidence on housing and health’, p.4.

<sup>4</sup> Reinforce Self Advocacy 2007, ‘Housing and support for people with an intellectual disability and complex and changing needs’, in C. Bigby & C. Fyffe, Proceedings of the Second Annual Roundtable on Intellectual Disability Policy, p.8.

<sup>5</sup> Department of Human Services 2000, ‘The Aspirations of People with a Disability within an Inclusive Victorian Community’, DHS, Victorian Government, Melbourne, p.10.

maximise independence and choice, and minimise abuse, neglect and paternalism. Autonomy and choice are critical in determining support and care for people with a disability and/or mental illness, as each individual's needs and preferences are diverse and different.

Poor quality housing can have both direct and indirect consequences for physical and mental health. This is the case for all Victorians, including those with disability and/or mental illness. WHO identifies that unhealthy housing can lead to physical, emotional and psychological issues.<sup>6</sup>

An appropriately designed environment is central to the wellbeing of people in supported accommodation. This includes accommodation that provides residents the right to privacy and their own personal space, that is accessible and that limits health and safety risks to people with a disability and/or mental illness. Residents of supported accommodation have the right to feel safe in supported accommodation. Like any other member of the community, they need to live in places where they do not suffer abuse, neglect or exploitation.

Restrictive practices, such as restraint and seclusion, are used in the context of people with a disability and/or mental illness who exhibit behaviours of concern. OPA strongly believes these practices need to be limited as far as possible. The rights of residents subject to these practices need to be promoted and protected.

In view of the use of restrictive practices in supported accommodation settings, the civil and political rights outlined in the Victorian *Charter of Human Rights & Responsibilities Act 2006* are particularly important to monitor for people with a disability and/or mental illness. The rights contained within the Charter that have greatest relevance include, the right to freedom of movement, the right to liberty and security of person, and the right to humane treatment when deprived of liberty.

As this submission will outline, there are blockages in the supported accommodation system, and there are situations where staff lack experience or the workforce is casualised, or when inadequate supports are provided. In view of these system inadequacies, the potential for violation of rights is heightened.

This submission addresses these issues further in the following sections.

## **Recommendations**

1. That the *Victorian Charter of Human Rights & Responsibilities Act 2006* and the United Nations Convention on the Rights of Persons with Disabilities are monitored in the provision of supported accommodation to people with a disability and/or mental illness.
2. That the needs and preferences of people with a disability and/or mental illness are prioritised in determining how supported accommodation is provided.

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<sup>6</sup> WHO 2004, 'Review of evidence on housing and health'.

3. That support is provided to people with a disability and/or mental illness in the least restrictive environment, minimising limitations to liberty and freedom of movement and maximising opportunities for self-determination and/or rehabilitation.

## 5. Policy context

The current policy environment is important to consider in the context of supported accommodation for people with a disability and/or mental illness. In particular, to what extent has this population group experienced benefit from broad social policy directions and initiatives such as *A Fairer Victoria*. It is questionable, for example, that people living in pension-level SRS are experiencing the level of social inclusion that *A Fairer Victoria* promotes for disadvantaged people.

It is important to acknowledge that there are a range of relevant reviews currently being undertaken by the Victorian Government that will affect people with a disability and/or mental illness. The implications of these reviews need to be taken into consideration by the Family and Community Development Committee in its review of supported accommodation. These reviews include:

- The review of the government regulations for SRS under the *Health Services Act 1988* and the *Health Services (Supported Residential Services) Regulations 2001*
- The review of the mental health service system
- The review of the *Mental Health Act 1986*

DHS is also continuing to review and develop its policies relating to the implementation of the *Disability Act 2006*.

The Office of the Public Advocate has responded to (or is currently responding to) each of the reviews listed. These responses also inform OPA's response to this Inquiry.

The Victorian Auditor-General's Report on Accommodation for People with Disability is also important to consider in the context of this Inquiry.<sup>7</sup> It raised a range of significant issues, and provided recommendations for addressing challenges within disability supported accommodation. The findings centred on the following broad areas:

- The capacity and expertise of service providers – does the workforce have the capacity and expertise to adopt the changes that are being implemented in the disability sector?
- Unmet demand for support – DHS is unable to provide support for all those requesting it and demand is increasing.
- Block funding for shared supported accommodation – funding tied to the service provider rather than the individual reinforces a 'group approach' to service provision rather than a system that services the needs of the individual.

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<sup>7</sup> Victorian Auditor-General Report 2008, 'Accommodation for People with a Disability', Victorian Government Printer, Melbourne.

- Availability of shared supported accommodation – need to upgrade shared supported accommodation houses, some houses operate from an ‘institution’ mindset, no increase in shared supported accommodation bed capacity over past 5 years.
- Individual support plans – there is a risk that support plans will not be prepared on a consistent basis.

### **Recommendations**

4. That the evidence and findings of the SRS Review, the review of the mental health service system and the review of the *Mental Health Act 1986* are considered in the context of the Inquiry.
5. That the recommendations from the Victorian Auditor-General’s Report on Accommodation for People with a Disability are considered in the context of the Inquiry. That is, that DHS
  - a. resource and provide guidance for developing individual support plans
  - b. review the funding model for disability shared supported accommodation
  - c. assess the capacity of staff in shared supported accommodation to deliver support services
  - d. assess resident satisfaction
  - e. expand demand management strategies.

## 6. Key issues

This submission addresses the factors contributing to inadequacies in the provision of supported accommodation to people with a disability and/or mental illness. The consequences of inadequate supported accommodation for Victorians with a disability and/or mental illness (and their families and support networks) are also discussed. In particular, the implications for the individual rights of people living in (or seeking to access to) supported accommodation are given consideration.

The work of the Office of the Public Advocate brings it into contact with people in supported accommodation contexts across a range of sectors, including supported residential services (SRS), mental health facilities, disability supported accommodation and other community based accommodation and support. There are similarities and differences across the mental health, disability and SRS sectors in the inadequacies of these supported accommodation systems and the attention to the rights of people within these settings, impact on people with a disability and/or mental illness. These similarities and differences are acknowledged throughout this submission.

The submission highlights specific areas in which OPA has identified inadequacies in the systems that provide supported accommodation. The issues discussed in greater depth are:

- Unmet need and unmet demand – inadequate availability of suitable supported accommodation and housing with support in the community
- Quality of accommodation – inadequacy of design, consistency in standards and upkeep of houses and facilities
- Quality of support – inadequate responses to complex and changing needs (including behaviour support, complex healthcare needs and changing support needs)
- Staff qualifications and experience – inadequate staff qualifications and experience to provide the support required in supported accommodation settings
- Financial burden – inadequate systems that put excessive financial pressure on Victoria's most vulnerable, minimising their disposable income
- Cross-sector integration – inadequate coordination across service systems to ensure adequate support and accommodation
- Families and carers – inadequate systems responses to families and carers
- Diverse needs – inadequate systems responses to people with disability or mental illness and diverse needs
- Individual rights – inadequate protection of tenancy rights, right to privacy and right to safety

## Unmet need and unmet demand

Demand for supported accommodation is not being met in disability services, mental health services and in supported residential services. It is also not adequately meeting the needs of people with disability who do not fit the ‘criteria’ of disability and/or mental illness within human services frameworks, such as people with Huntington’s Disease, autism spectrum disorder and dual disability.

There is a range of issues that are relevant to all areas of supported accommodation, while others are more specific to sectors. This section therefore provides a general overview, which is followed by specific comment on the different sectors.

The lack of available housing to meet the needs of people with a disability and/or mental illness has a range of systemic implications. In short term placements, for example, such as those within the mental health service system, there are bed blockages, a lack of discharge options, and people staying for extended periods in inappropriate mental health units. For those people needing longer term accommodation and support, the inability to access appropriate supported accommodation often leads to the inappropriate use of disability respite accommodation, unsustainable pressure on families and people being accommodated in unsuitable housing.

Notably, unmet demand leads to people with a disability and/or mental illness living in inappropriate accommodation that has negative implications for their health and wellbeing, quality of life and social connectedness. These implications are experienced by people in the disability, mental health and SRS sectors. Consultations undertaken with OPA staff and Community Visitors for this submission revealed that increasing numbers of people are living in caravan parks and rooming houses due to the lack of available and appropriate supported accommodation. These environments are often highly unsuitable for people with a disability and/or mental illness as there are no supports and they are often in isolated areas with minimal access to transport and, therefore, to accessing support.

While there are a range of issues that are relevant to all supported accommodation settings and unmet demand, there are also sector specific issues. These are outlined below.

### **Mental health**

People’s mental health condition can improve or deteriorate as a direct consequence of their housing circumstances.<sup>8</sup> For people with mental illness, there are notable shortcomings in the provision of both temporary and long-term supported accommodation in Victoria. Through its work with people with mental illness, OPA is aware that there are significant issues relating to unmet demand. These issues include bed shortages and blockages, a lack of discharge options and a lack of long-term housing and support options.

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<sup>8</sup> WHO 2004, ‘Review of evidence on housing and health’.

## BED SHORTAGES

The shortage of acute beds remains a key finding of the annual Community Visitor reports that has been reported to Parliament since at least 2003.

For several years, the Community Visitor Annual Report has identified the need for urgent increases in secure extended care beds to help ease the pressure on adult acute beds. A small number of high needs patients remain in acute units for up to eight months awaiting admission to secure extended care units (SECU).<sup>9</sup>

There is a shortage of 24-hour care accommodation (eg. short-term community care units) for patients who require follow-up or permanent care and rehabilitation after discharge, particularly from adult acute inpatient units, sometimes leading to patients being discharged outside their area. For example, Community Visitors reported in 2007 that a patient from Maroondah Hospital was placed in the community care unit in Wodonga as there were no beds available in Dandenong.<sup>10</sup>

Shortages in mental health services are a significant problem for consumers and carers in rural and regional areas. There are shortages in acute beds, some regions do not have access to SECU and others lack appropriate accommodation and support options, resulting in discharge delays. There are risks for patients admitted to general wards because no mental health acute beds are available. Other patients are sent to regions where they can gain access, resulting in isolation from their family and other support networks.

## BED BLOCKAGES

Approximately ninety-nine patients have been identified in acute, community care units (CCU) and SECU through the Office of the Public Advocate's Long Stay Patient Project, who are not able to be discharged until appropriate, alternative clinical or community-based accommodation and support options become available. See Focus Report, p.32.

SECU managers have identified that up to 25% of patients could be supported in a less intensive environment. That is, they are ready for discharge but are unable to relocate due to a lack of appropriate accommodation and support options.<sup>11</sup>

Patients may be inappropriately placed in acute units while waiting for placement in a CCU or SECU. Acute units may be locked because of a lack of high dependency beds.<sup>12</sup> This raises significant human rights issues, notably impinging on the right to freedom of movement and the right to liberty.

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<sup>9</sup> Community Visitors 2007, 'Annual Report 2006-07', Office of the Public Advocate, Victorian Government Printer.

<sup>10</sup> CV 2007, 'Annual Report'.

<sup>11</sup> DHS 2008, 'Because mental health matters: A new focus for mental health and wellbeing in Victoria', Consultation Paper, Victorian Government Publishing Service.

<sup>12</sup> Community Visitors 2008, 'Annual Report 2007-08', Office of the Public Advocate, Victorian Government Printer.

## SHORTAGE OF DISCHARGE OPTIONS

Community Visitors report an acute shortage of appropriate community-based accommodation available on discharge across all regions. Many patients who have reached their optimum level of rehabilitation can remain in the system for periods of two years or more due to the lack of appropriate accommodation and support in the community.<sup>13</sup> Of particular concern is the release of patients from SECU into SRS accommodation where the level of support provided may be inadequate.

Long-stay patients in CCU and SECU settings who require supervised care with supported access to the community and others who cannot cope with shared accommodation due to their mental illness, remain in the system waiting for short-term intensive care and rehabilitation combined with longer-term care options.<sup>14</sup> See Focus Report on page 32.

### CASE STUDY – A CASE FOR MORE DISCHARGE OPTIONS

Robert is a 40 year old male who suffers from a mental illness and has issues with his alcohol and other drug use. Robert had been treated for an acute episode of his mental illness and then discharged on a community treatment order to an SRS where he has remained for the past two years. Robert is living with residents who are frail and elderly. He has no case manager and has no access to any alcohol and drug services. Robert wants to be relocated into independent living, however he has no family or case manager to assist him access to necessary accommodation or support options. Robert spends all day in the SRS and has very limited opportunities to access to community. He continues to wait to access a community care unit and to receive assistance to find alternative accommodation with the appropriate supports.

## LONG-TERM HOUSING AND SUPPORT OPTIONS

Acquiring secure and affordable housing is critical if people with mental health issues are to maintain any level of stability. There are currently serious shortfalls in the system. OPA welcomes initiatives such as the Integrated Rehabilitation and Recovery Care (IRRC) program that targets people who have remained in CCU and SECU for extended periods, but whose discharge requires an intensive period of case management support. Only a small number of clients, however, will be assisted through the last funding round of \$1.26 million.

Victoria's psychiatric disability rehabilitation and support services (PDRSS) model is recognised nationally as providing effective low cost accommodation and support options for people with long

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<sup>13</sup> CV 2007, 'Annual Report'.

<sup>14</sup> CV 2007, 'Annual Report'.

term mental health issues. These services are seen as effective in supporting people to build lives in their communities and helping to maintain wellbeing without costly hospital admissions. The sector is currently significantly under funded in proportion to the value of the service it provides in prevention and recovery (the sector currently only receives around 10% of the mental health budget).

OPA welcomes the expansion of the Prevention and Recovery Care (PARC) program as an alternative to inpatient care. This is a significant development in alternative models of patient care and has strong potential for preventing costly acute re-admissions. Further expansion of this model is required to meet shortfalls in discharge options from acute care across the state. It should be noted, however, that increases in PARC will not reduce the need for SECU.

There is a shortage of non-clinical accommodation and support options that provide a social model of support for people recovering from mental illnesses. In the UK, a model like the Surrey County cluster model that provides a step-down home-based environment with 24 hour outreach support in a home like environment provides a cost effective solution to hospital based clinical care that can be utilised by patients in the early days of recovery.

Current responses to homelessness have preconditions that must be met before homeless people can attain permanent housing (outreach/drop-in → shelter → transitional housing → permanent housing).<sup>15</sup> Housing First is a new approach to housing for people with a mental illness that believe that housing is not something that people with a mental illness should be forced to work their way towards. In the Housing First model there is no requirement for consumers to accept support and treatment.

Victoria has a history of developing effective models for ensuring housing security of tenure for people with mental illnesses. These have not been adequately funded, however, and in many cases not replicated across regions. For example, in the 1990s a model was developed in one region where through collaboration between the Office of Housing and Mental Health facilities, people were able to be discharged into priority public housing. Unfortunately this model is no longer funded.

The Housing and Accommodation Support Initiative (HASI) model of housing adopted in NSW is also worth noting as it provides a level of security of tenure and choice in housing to tenants. There is strong evidence that the model is successful in averting homelessness and reducing the need for hospitalisation. Evaluations of the program demonstrate success with people maintaining their tenancies, increasing their participation in the community, and developing and strengthening social and family networks.<sup>16</sup>

### **Supported Residential Services**

Supported Residential Services were formed in 1973 to meet the needs of people over 60 years with physical disabilities and mental illness. The SRS industry is categorised into two subgroups –

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<sup>15</sup> This feature of community-based housing was described by Sam Tsemberis at the Bruce Woodcock Memorial Lecture in Melbourne this year and applies equally well to Victoria as it does to models of housing provision in the US.

<sup>16</sup> Social Policy Research Centre (SPRC) 2008, 'Newsletter' No 98, University of NSW, Sydney.

the pension-level facilities where 80 per cent of beds are provided for a fee not exceeding the pension plus Commonwealth Rent Assistance, and the above-pension level facilities.

In recent years, there has been a shift from a regulatory approach focusing on the characteristics or needs of the residents to one based on the types of services provided.<sup>17</sup> While SRS facilities have continued to cater to a similar client group, there has been a notable shift towards a more diverse mix of residents, with numbers of younger residents with complex needs increasing. In 2005, DHS estimated that the proportion of the resident population aged less than 60 years had increased from 44% in 2003 to 61% in 2005, while the proportion of residents with a mental illness has increased from 45% to 58% over the same period.<sup>18</sup> This highlights the reduction in housing options for people aged over 60 years who need low-cost supported accommodation.

There are significant differences in quality of accommodation and support between pension-level and above-pension level facilities. These differences have been reported by Community Visitors over several years. Many pension-level facilities struggle with their financial viability and, in turn, struggle to maintain their facilities in a condition that meets occupational health and safety standards. Some also struggle to provide the level of support that is required by residents. These issues are addressed later in this submission.

For some people, however, pension-level SRS facilities provide much needed accommodation and, in the absence of more appropriate alternatives, the housing model can work for them. In view of this, it is critical that there is adequate availability of SRS. At the same time, strong emphasis needs to be made about these services being accountable for providing adequate support and accommodation.

In recent years, several pension-level SRS have closed due to their inability to meet the regulations or maintain viability. As facilities that run on a for-profit basis, maintaining a viable business when accommodating people with high and complex needs is extremely difficult and presents a paradox that the government needs to address.

The injection of funding by DHS in 2006 through the SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) has been a significant measure in addressing the issue of viability for pension-level facilities. In many cases, it has seen positive outcomes for residents. This was reported by the Community Visitors in their 2008 Annual Report.

In the first 10 months of 2008, however, 2 pension-level facilities have closed, resulting in loss of 51 beds in the system. While SAVVI is contributing to increased viability, there are clearly some facilities that are unable to meet the requirements to continue operating. It is important that facilities that are below standard and unfit for people to live in get closed. These closures, however, contribute to the decreasing availability of accommodation options for people with a disability and/or mental illness.

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<sup>17</sup> DHS 2008, 'Review of the Regulation of Supported Residential Services in Victoria: Discussion Paper'.

<sup>18</sup> DHS, 'Review of Regulation of SRS in Victoria', p.8.

## Disability

There is an acute shortage of placements across the overall shared supported accommodation service system in the disability sector. According to the report on accommodation for people with a disability prepared by the Victorian Auditor-General's Office, the Department of Human Services is unable to meet demand for 30% of people seeking shared supported accommodation.<sup>19</sup>

The implications of this shortage of options of supported accommodation are significant for people with disability and their families and support networks. Scarcity of beds in various supported accommodation sectors means that people who need supported accommodation frequently end up in accommodation that does not meet their care needs and/or limits their freedom and life chances.

The failure of supported accommodation to meet a resident's needs can have detrimental affects. For example, three and a half years ago a woman with a mild intellectual disability was admitted to one of the three remaining disability institutions in Victoria in urgent circumstances. She currently remains in a locked setting, despite no longer needing this level of security. Her freedom and her choices are restricted, and she is reported to be losing life skills. Her chances of being moved to alternative and more suitable accommodation are limited because she is not seen as a priority on the waiting list for accommodation. The rationale for this is that she already has accommodation.

The situation of unmet need and unmet demand is exacerbated by the way it is measured and used (or not used) for planning. The current methods used by the Department of Human Services (DHS) for determining and measuring demand are inadequate. At a 2007 roundtable on housing and support for people with intellectual disability and high, complex or changing needs, there was

unanimous agreement that data on service use, unmet and under met needs are exceptionally difficult to piece together and little data are available on the population of people with disabilities who use support services. For example, no common assessment is made of the nature or severity of a person's disability, often basic diagnostic information is no longer collected. Data are also fragmented and different sources are not comparable. Changing definitions and data collection methods have also meant that it is difficult to track trends over time.<sup>20</sup>

The Disability Support Register (DSR) is used by DHS to monitor met and unmet demand. It is used to allocate accommodation, individual support packages and day activities. Successfully getting onto the DSR waiting list is particularly challenging. In many situations, a person in inappropriate accommodation might be considered 'housed' for the purposes of the DSR, regardless of the impacts of the accommodation situation on the quality of life of that person. An additional concern regarding the current DSR is its failure to measure or account for potential need. This prevents adequate planning for meeting the accommodation and support needs of people with intellectual disability into the future.

The outcome of not accurately measuring demand is a distorted perspective on what demand for supported accommodation realistically looks like. This, in turn, has significant implications for

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<sup>19</sup> Victorian Auditor-General Report 2008, 'Accommodation for People with a Disability'.

<sup>20</sup> Bigby, C & Fyffe, C 2007, 'Housing and support for people with intellectual disability and high, complex or changing needs', Proceedings of the Second Annual Roundtable on Intellectual Disability Policy, p.6.

people in need of supported accommodation. Providing adequate levels of supported accommodation and meeting demand requires effective population based planning and related data collection.

The Australian Institute of Health and Welfare (AIHW) uses four categories to describe demand for disability services:

- Met demand – people receiving a service that meets their needs
- Unmet demand – people who have asked for a service and met eligibility criteria but are not receiving the service, or receiving an inadequate or inappropriate service
- Unmet need (often used interchangeably with unmet demand) – people with an expressed need for a service who may not be eligible for that service (but may perhaps be eligible for another type of disability or mainstream service)
- Potential need – people with a severe or profound disability who may in future need, but have not yet expressed a need for, services. This category also includes people with an inferred and predicted need for services.<sup>21</sup>

Current approaches to measuring demand do not consider potential need. This is a significant gap.

To respond to unknown or potential need, more effective population based planning is required. Rather than a reactive approach to demand, a proactive approach is required that would explore and research the population of people with a disability and/or mental illness and make projections based on need rather than demand. This, in turn, would enable more effective forward planning.

Reports from both Community Visitors and staff in the Advocate Guardian program at OPA indicate that families and support networks are resorting to desperate measures to get their child, sibling or niece or nephew into accommodation that can effectively support their needs and maximise their quality of life.

One indicator of the desperation of carers is the use of respite for longer term accommodation. Anecdotal reports reveal that respite services have become a default long-term accommodation option. This is obviously problematic. It reveals significant systemic issues that relate to the shortage of housing options. The use of respite as a long-term strategy for housing, in turn, exacerbates existing systems problems.

This inappropriate use of respite houses results in further system blockages, making respite placements harder to secure. The obvious consequence is a shortage of respite placements. Determining the extent of the issue requires an audit of respite capacity to assess availability.

A further issue is that the role of respite is increasingly compromised if it becomes a default accommodation option. There is no scope for formal planning in long-term placements for people in respite. Furthermore, the respite system does not have the capacity to provide consistent

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<sup>21</sup> Australian Institute of Health & Welfare 2007, 'Current and future demand for specialist disability services', Disability Series, Cat. No. DIS 50, Australian Institute of Health and Welfare, Canberra.

support. Long-term ‘residents’ in respite services are often moved from service to service within regions to accommodate other ‘booked’ respite beds.

**CASE STUDY – A CASE FOR MORE DISABILITY SUPPORTED ACCOMM**

Josie is a single woman in her 50s with a moderate intellectual disability who lived with her mother. Due to unexpected health, Josie’s mother was admitted to nursing care and was no longer able to care for her.

Josie was admitted to emergency respite care and placed on the waiting list for permanent disability supported accommodation. During this time, Josie’s health deteriorated dramatically and she admitted to a hospital sub-acute inpatient unit.

Following the stabilisation of her medical condition, Josie continued to wait for an appropriate place in a community residential unit.

Josie remained in the inpatient unit for 345 days, at a significant cost the community.

The cost of her stay in the inpatient unit was:

\$495 per day x 345 days = \$170,775

The equivalent stay in a CRU would have been:

\$300 per day x 345 days = \$103,500

## **Recommendations**

### MENTAL HEALTH

6. That there is an urgent increase in the number of mental health beds in relation to demand, requiring
  - a. an increase in the number of secure extended care unit (SECU) beds
  - b. the expansion of the Prevention and Recovery Care (PARC) model to meet shortfalls in discharge options from acute care across the state and to assist where acute admission is not required.
  
7. That there is an urgent increase in community-based accommodation and support options, including
  - a. increased funding to the psychiatric disability rehabilitation and support services (PDRSS) sector to build its capacity to provide rehabilitative support in long-term accommodation settings
  - b. new models of housing to address the cycle of homelessness and disengagement from services experienced by many people with a mental illness.

#### SUPPORTED RESIDENTIAL SERVICES

8. That the government invests financially in the SRS sector to enable it to strengthen compliance, ensure residential rights and make improvements to the existing model of pension-level SRS accommodation.
9. That attention be given to developing alternative funded accommodation models for people whose needs are inadequately addressed in the SRS sector, but who have no other options.

#### DISABILITY SERVICES

10. That there is an urgent increase in the number of shared supported accommodation houses available to people with disability.
11. That there is an urgent increase in the number of disability respite beds for people with disability in relation to demand.
12. That DHS initiates a demand management strategy to address the potential need for disability services (including people with ageing parents who will need alternative accommodation when their parents can no longer care for them).

#### SECTOR WIDE

13. That innovative models for funding the provision of accommodation are further explored and developed (for example, collaboration and investment with DHS/other CSOs/housing associations and trusts).
14. That funding and access is provided for an urgent increase in the amount of public housing stock available to people with disability.
15. That there is an urgent need for an increase in the level of support provided to people with a disability and/or mental illness living in the community, including
  - a. an increase in Home Based Outreach Services (HBOS) to provide people with mental illness with an appropriate level of support in the home
  - b. an exploration of the potential for applying the HBOS model with other disability service users
  - c. the expansion of the Multiple and Complex Needs Initiative (MACNI) and the Integrated Rehabilitation and Recovery Care (IRRC) program in order to provide individualised accommodation with appropriate supports, particularly for residents and patients with complex needs and / or dual disability.
16. That there is an urgent increase in the number of community based accommodation and support options
  - a. that individualised supported community-based accommodation is made available for people with complex needs and behavioural problems who are inappropriately placed in secure extended care facilities.

- b. that funding is provided to enhance the availability of specialist accommodation and high level support for people with Huntington's Disease, autism and acquired brain injuries.
- c. that funding is provided to increase the availability of accommodation for people with dual disability (mental illness and intellectual disabilities) and dual diagnosis (mental illness and substance abuse issues).

### **Focus on: Long-stay patients in mental health facilities**

Community Visitors have reported that one of the themes of visitor's reports over many years has been the 'inappropriate long term placement of patients'. Community Visitors undertook a special project to examine the situation placed in mental health facilities and to develop recommendations for the resolution of these problems.

Community Visitors identified 99 long stay patients across the state who had been in acute care units for longer than three months, in community care units (CCU) for longer than two years and in secure extended care units (SECU) for longer than six months.

Over two thirds of these patients were involuntary patients and over half the patients were in locked settings. Their average age was 44. Forty patients had been in mental health units for more than five years including 16 patients who had been in units for ten years plus.

SECU and CCU units are not intended to provide life long accommodation and support yet many people are living for extended periods in mental health units because there is no where else to go. In effect, parts of the mental health system are being used as a holding facility for people with a dual disability and complex needs because of the lack of individualised and specialised support options in the community.

Most long stay patients are not able to be discharged because of a lack of funding for community based accommodation with ongoing 24-hour clinical or non clinical support. Long stay patients are either on waiting lists for suitable accommodation and support or there is no suitable accommodation and support available because they do not meet eligibility criteria for services.

The mix of vulnerable patients and patients with behavioural support needs in locked SECUs makes it an unsafe environment for patients with special needs, including people with intellectual disability, dual disability and / or other health problems, many of whom are living in these units for extended periods of time.

Long stay patients create blockages in the mental health system overall, hindering the capacity of patients in other parts of the system to progress to the next level of care. For example, patients in acute settings are waiting longer than necessary for discharge from acute units because no CCU or SECU beds available and long stay SECU patients are blocking approximately one third of SECU beds across the state.

OPA is concerned about the indefinite detention of long stay patients in mental health facilities due to the lack of less restrictive community based accommodation options and lack of support available. OPA believes this constitutes a breach of the civil and political rights outlined in the Victorian *Charter of Human Rights and Responsibilities Act 2006*. It is not reasonable to limit a person's rights where their circumstances are dictated by a service system failure to meet their needs.

The lack of sufficient funding for community based accommodation and support options needs to be addressed and appropriate accommodation and support discharge options made available for

long stay patients. The types of community based accommodation and support options that require expansion and development include:

- Psychiatric disability rehabilitation and support services
- Accommodation for people with dual disability (e.g. mental illness and intellectual disability) or a dual diagnosis (eg. mental illness and issues with alcohol & other drug use)
- Community residential units (for patients with intellectual disability and secondary mental illness)
- Public housing with sufficient support provided
- Specialist facilities that provide intensive support for people with Huntington's Disease and acquired brain injury who are currently inappropriately placed in acute units and SECU
- Individualised secure community based accommodation that provides appropriate support based on individual needs
- Long term mental health aged care facilities

## Quality of accommodation

Issues relating to adequate design and standards of buildings and physical infrastructure of supported accommodation for people with a disability and/or mental illness have been consistently reported to Parliament by Community Visitors since the establishment of the program. The importance of the right type of accommodation for enabling quality of life is outlined in the following focus report on the de-institutionalisation of Kew Residential Services.

A number of factors are important in the context of the building and physical infrastructure of supported accommodation:

- consistency within and across sectors
- good design – for privacy, to increase resident safety, to ensure accessibility, etc
- maintenance of properties to prevent deterioration, to maintain standards.

People with a disability, people with a mental illness and people who are older and homeless have the right to living standards that provides privacy, clean surroundings, a safe environment and an acceptable level of comfort. Consistent standards are needed to ensure that all people who live in supported accommodation are afforded the same living standards. This is particularly important for those people living in SRS accommodation, who should be entitled to the same standard of living conditions as any other resident of shared supported accommodation.

A key issue raised in our internal consultations on supported accommodation is the inadequacy of design. The design of accommodation frequently does not take into consideration the needs of people who will live in shared supported accommodation. The design of properties is integral to the protection of the rights of people with a disability and/or mental illness. The right to safety for residents is critical, and funding bodies have a duty of care to ensure that residents (particularly female residents) of supported accommodation settings are protected from violence and abuse. The design of supported accommodation facilities plays a central role in preventing violence and abuse. The section below on mental health explores this issue further.

The right to privacy is equally significant and shared supported accommodation needs to be designed to ensure adequate privacy. People with a disability and/or mental illness have the same need for privacy as any other individual in the community. To understand the significance of privacy, the World Health Organisation (WHO) provides valuable insight. WHO suggests that one of the primary functions of housing is to provide a shelter from external threats. This has been the situation since humans first sought shelter in caves. The reality of this shelter can lead to a sense of security.<sup>22</sup>

The need for privacy will differ from one individual to another, and according to culture. A house loses its protective value when troubles from the outside break in and intrude on an individual. Ill-defined boundaries of a house allowing easy unauthorised entry from outside or within can

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<sup>22</sup> WHO 2004, 'Review of evidence on housing and health', p.2.

generate psychological manifestations, such as anxiety, depression, insomnia, paranoid feelings and social dysfunction.

The psychological manifestations that can affect an individual who lacks privacy in their home are no less real or intense for people with a disability and/or mental illness. Indeed, for people with pre-existing psychological conditions, stressful housing situations can aggravate their illness.<sup>23</sup>

Property design is also critical to enabling adequate accessibility. ‘Adequate accessibility’ refers to the intersection between a person’s or group’s functional capacity and the environmental demands, that is, the person-environment fit. The design of the property must take into consideration the needs of the person or people living within that home and their ability to use the space. Good design can minimise the need for additional supports.

Through its Annual Reports, the Community Visitors Program has consistently reported that facilities that lack private spaces, that some are cold, old and in need of maintenance and that many have shared bedrooms. In view of these issues, not all supported accommodation can be assessed as meeting an acceptable standard.

In addition to these broad issues, there are also specific issues that relate to supported accommodation in disability services, mental health services and supported residential services.

### **Mental health**

Until recently, there has been minimal attention to ensuring environments in which women admitted to adult acute inpatient units can feel safe from sexual exploitation. Recently, DHS undertook a project to explore the issue of gender sensitivity and safety in acute units. The findings from this report highlighted significant gaps in, and variable implementation of, a policy relating to gender sensitivity and safety in these units.

The review revealed that many women admitted to mental health facilities are at risk of sexual harassment and assault from other patients and staff. Many of these women have experienced abuse, trauma, and violence, both within mental health services and at other times during their lives. Inpatient care has frequently triggered feelings of powerlessness and re-traumatisation.<sup>24</sup>

To address these issues, the design and layout of inpatient units is significant. The types of factors that have been found to be important include female-only recreation spaces, the ability to lock bedroom doors (but to be overridden by staff if necessary), placing same-sex patients to conjoined bedrooms and having separate wings for male and female patients. These physical design features can only be successful if supported by internal policies and procedures that enhance the safety of women consumers. DHS recently provided \$20,000 per facility to improve spaces for women in their care. The benefit of this funding is currently unknown as there has not yet been an evaluation.

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<sup>23</sup> WHO 2004, ‘Review of evidence on housing and health’, pp.3-4.

<sup>24</sup> Department of Human Services 2008 ‘The gender sensitivity and safety in adult acute inpatient units project: Final report’, Mental Health and Drugs Division, Victorian Government, Melbourne.

In addition to issues of design, maintenance of facilities in the mental health sector requires attention. Community Visitors have noted issues relating to poor maintenance impacting on the quality of life of people in some health settings. For example, in the 2008 Annual Report, the Community Visitors highlighted that one facility had no heating for a number of days in the winter months, with maintenance being delayed for a considerable period. The implications were significant for the physical wellbeing of the residents.

### **Supported Residential Services**

For many residents in SRS, the accommodation is long-term. This highlights the significance of these services providing a home-like environment. Anecdotal reports from Community Visitors and advocate guardian staff at OPA, however, indicate that many SRS (both pension-level and above-pension level), have a tendency to be institution-like in their atmosphere. This indicates a need for greater guidance in the SRS regulations on what constitutes a home-like environment.

Notably, there are significant inconsistencies in the quality of accommodation across pension-level and above pension-level SRS. For many residents of pension-level SRS there are major issues relating to poor accommodation standards and inadequate maintenance. Issues raised by the Community Visitors in their Annual Reports are also highlighted in the recent DHS Discussion Paper on the Review of the Regulations of SRS. The Report notes that ‘complaints have been received about poor building fabric, inadequate maintenance or disrepair of premises, poor quality of furniture and inadequate standards of cleanliness’.<sup>25</sup> These poor standards and maintenance issues present significant health and safety risks to residents.

In many pension-level SRS facilities, residents share bedrooms and do not have privacy. In view of the complexity of needs of many of the residents, this can pose significant risks to the physical and mental health and the safety of residents. The issue of privacy is a significant one, and is a recurring theme from Community Visitors, including in its most recent annual report. Community Visitors have reported on a range of situations where SRS residents are denied basic rights to privacy that many of us take for granted. For example, there are still several facilities where up to three people share a room, therefore affording individual residents little privacy. At one SRS, a resident requested that the proprietor put a lock on his door as he reported items had been stolen from his room.<sup>26</sup>

### **Disability Services**

For disability supported accommodation, issues of property design, privacy and maintenance are equally significant.

Concerns raised by Community Visitors about the conditions of disability supported accommodation have also been emphasised in the recent report by the Victorian Auditor-General. Following an audit on DHS owned accommodation for people with a disability, the report noted that DHS has identified significant issues relating to condition, functional space, and health and

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<sup>25</sup> DHS 2008, ‘Review of Regulation of SRS in Victoria’, p.18.

<sup>26</sup> CV 2008, ‘Annual Report’.

safety. The estimated cost of making the necessary improvements to 443 houses to meet required standards is \$225 million.<sup>27</sup> The report further states that DHS has identified that approximately 200 of its houses did not meet current building and health and safety standards. DHS has allocated funds towards addressing these issues.

The significance of design of supported accommodation for people with a disability cannot be underestimated. In a report by Fyffe, McCubbery and Laurie in 2004, they noted that good design can be cost effective in improving quality of life for people with a disability. They also suggest that good design can lead to positive effects on preventative health and minimising long term health costs.<sup>28</sup>

Lack of consideration relating to design has resulted in many shared supported accommodation settings having shared bedrooms for residents. The implications resulting from lack of privacy have been outlined above.

### **Recommendations:**

17. That all remaining institutions for people with disability are closed and that appropriate supported accommodation is developed as an alternative.
18. That funding is made available to improve the right to privacy and safety for residents in shared supported accommodation.
19. That minimum standards of maintenance are created for all supported accommodation settings to ensure consistency and compliance with health and safety standards.
20. That a definition of 'home-like' environment is incorporated into the SRS regulations and greater guidance is provided (particularly to SRS proprietors) in how to create a home-like environment for residents.

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<sup>27</sup> Victorian Auditor-General's Report, 'Accommodation for people with a disability', p.41.

<sup>28</sup> Fyffe C, McCubbery J & Laurie D 2004, 'Research Report: Experiences of inappropriate accommodation support for people with a disability', Disability Advisory Council, Victorian Government, Department of Human Services, Melbourne.

## ***Focus Report – Community Visitors and Kew Residential Services<sup>29</sup>***

In their 2008 Annual Report, the Community Visitors reported that on 20 April 2008, the final residents (numbering 90) moved into their new homes that were purposely built for them on part of the original Kew Residential Services (KRS) site.

In 2001, the Premier of Victoria, Steve Bracks, announced his intention to redevelop the KRS site. Work on the redevelopment started in 2006.

This was effectively the closure of what had been the largest institution in Victoria for people with an intellectual disability. Community Visitors acknowledged the efforts of those who helped the State Government give the people of KRS the opportunity they deserved to receive a much-improved quality of life.

The greatly improved environment in which they live, just like other Victorians, has now been achieved. Community Visitors reported that they have seen many amazing changes in former residents who moved to houses in the earlier stages of the redevelopment – merely from the result of living in improved and smaller environments.

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<sup>29</sup> CV 2008, ‘Annual Report’.

## Quality of supports

Appropriate and adequate levels of support are critical to meeting the needs of people with a disability and/or mental illness and in contributing to their quality of life. OPA is of the view that many supported accommodation settings do not provide an adequate level of specialist support. The level of support in settings for people with a disability and/or mental illness differs according to the length of the placement and the individual needs of the person.

There is a range of supports, varying in intensity, that Victorians with a disability and/or mental illness might need in a supported accommodation setting. These can include:

- support for activities of daily living – mobility, health, self-care and communication
- support for activities of independent living
  - interpersonal interactions and relationships
  - learning, applying knowledge and general tasks and demands
  - domestic life
- support for activities of work education and community living – that is, education, community and economic life and work.<sup>30</sup>

The failure to provide appropriate and adequate supports across a range of settings has significant implications for people with a disability and/or mental illness. For example, inappropriate support can result in distress for people with a disability and/or mental illness and can sometimes contribute to behaviours of concern. In turn, some supported accommodation staff will use of restrictive interventions as a response to behaviours of concern. OPA has a strong view that these practices need to be minimised and that appropriate supports and practices need to be in place to prevent escalating behaviours of concern.

Many people with a disability and/or mental illness have complex needs. These needs are not static. Support is often required for complex healthcare needs and changing intensity of support needs. The complexity and changing nature of the needs of people with a disability and/or mental illness can present significant challenges for staff in supported accommodation services. For staff to provide the level of flexibility and specialist support to meet the changing and diverse needs of people with a disability and/or mental illness, they need to be appropriately trained and qualified. To enable staff to provide quality of support, services need to promote flexible practices and specialist support.

Some people with a disability and/or mental illness exhibit associated behaviours that can be challenging or concerning. This behaviour can include physical aggression, verbal aggression, inappropriate social behaviour, inappropriate sexual behaviour, wandering or absconding, repetitive behaviours, and lack of inhibition.

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<sup>30</sup> Australian Institute of Health & Welfare 2008, 'Disability support services, 2006-07: National data on services provided under the Commonwealth State/Territory Disability Agreement', Australian Institute of Health & Welfare, Canberra.

OPA frequently works with people who are considered ‘too hard’, and is particularly concerned by the way the system fails them. Because these individuals often cannot meet the inflexible rules and conditions of some facilities, they are moved on or evicted, and they frequently cycle through the service system, often resulting in homelessness or living in inappropriate accommodation.

This experience is supported by recent research by Fyffe, McCubbery & Laurie, who state that there are certain groups of people with a disability and/or mental illness more likely to experience inappropriate housing and support. They suggest that these are:

- people of any age with high level personal, medical or behavioural support needs
- people whose support needs are changing over their lifetime
- people in settings in which housing and support are provided as an inflexible package without tenure agreements, and including (but not only) congregate living situations
- people living in their own or family home where there is no coordination of the amount and types of support provided
- people with limited personal resources (including friends, family and finances) to supplement the formal provision of housing and support
- children and young people whose families are unable to provide daily care
- people from whom support has been withdrawn or for whom support was not available in their own home setting and who have moved to a congregate care setting.<sup>31</sup>

Efforts have been made by the current state government to introduce programs that provide the level of intensity and specialist support required by people with behaviours that are found challenging. These include:

- Multiple and Complex Needs Initiative (MACNI)
  - MACNI is a time-limited specialist intervention for those 16 years and older who are identified as having multiple and complex needs including those with combinations of mental illness, substance abuse issues, intellectual disability, acquired brain injury and forensic issues. Often these individuals pose a risk to themselves and to the community.
  - The objectives of the Initiative are to develop a more effective and coordinated approach to supporting this group, so that they can achieve stability in health, housing, social connection and safety, as well as being linked back into comprehensive ongoing support. Participation in a MACNI service response is voluntary.
  - MACNI has a strict entry criteria, which limits the program to a small cohort of people, targeting only up to 50 individuals per year.

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<sup>31</sup> Fyffe et al 2004, ‘Experiences of inappropriate accommodation for people with a disability’, p.2.

- Specialist service responses to people with Huntington’s Disease (such as Arthur Preston Residential Service) and people with acquired brain injury (such as Wintringham)
  - These services can only assist limited numbers of people.
  - In some situations, these services cannot meet the needs of people with behaviours of concern due to their duty of care to other residents and the need to protect their safety.
- The mental health Integrated Rehabilitation and Recovery Care (IRRC) program
  - The IRRC program targets people who have remained in CCU and SECU for extended periods, but whose discharge requires an intensive period of case management support.
  - Only a small number of clients, however, will be assisted through the last funding round of \$1.26 million.

Other responses include more intrusive interventions, such as:

- Restrictive interventions such as seclusion and restraint
  - These interventions are mandated in certain circumstances by the *Mental Health Act 1986* or through behavioural support plans under the *Disability Act 2006*
  - They are more extreme measures that can impinge on the civil rights of people, such as chemical restraint, mechanical restraint, and seclusion.
- Eviction
- Police intervention
- Placement in forensic mental health unit at the discretion of the Chief Psychiatrist
- Prison and involvement with the criminal justice system
  - Anecdotally, staff in the advocate guardian program and Community Visitors have indicated their views that there are more people with a disability and/or mental illness in the prisons due to the inadequacies of specialist interventions and the service system support infrastructure.

OPA is strongly of the view that more adequate support and intervention need to be developed and provided to minimise the need for the intrusive and extreme interventions outlined above.

In view of the diversity and complexity of some people’s needs, it is important that supports are provided with a focus on the individual and their specific needs. In adopting an approach focused on the individual, it is critical that there is cross-sector coordination. This is particularly important for people with a disability and/or mental illness in the context of dual disability and other disabilities that require interventions from multiple sectors. The issue of cross-sector collaboration is discussed in a later section of this submission.

Recent policy developments have started to see moves towards focusing on the needs of the individual rather than how the individual can ‘fit’ into the service model. The challenge has been in proving the level of coordination necessary and the funding to effectively resource such models.

Other issues that demonstrate the systems challenge in providing appropriate support include:

- People who require supported accommodation are being placed in facilities do not match their needs. For example, young people in nursing homes and people with complex needs in low care facilities.
- General hospital emergency departments frequently see people with supported accommodation needs who are receiving insufficient support. Many health crises could be prevented by adequate monitoring and care in a supported accommodation placement. Often people are discharged with no support plan and repeatedly present at emergency departments.
- People in their forties with alcohol related brain injuries and people with borderline mental health issues can find it particularly difficult to find and maintain a place in supported accommodation.
- People with behaviours of concern also find it difficult to maintain their placements and OPA recognises the link between homelessness and/or inadequate levels of support and contact with the criminal justice system.

In regard to quality of supports in existing supported accommodation settings, there are also sector specific issues that are outlined below.

### **Mental health**

There is a range of interventions for supporting people with a mental illness that involve different levels of intensity and length of support.

Notably, people with a mental illness often require changing levels of intensity in their support as mental health conditions can stabilise and deteriorate. Flexibility in the context of people with a mental illness requires that the system has the capacity to intervene early when a person indicates that they require more intense support. The system also needs the capacity to provide transition from high intensity to reduced support. OPA would welcome the expansion of initiatives such as the Prevention and Recovery Care (PARC) program as an alternative to inpatient care.

The Community Visitors have consistently reported that locked environments and the use of restraint and seclusion impact on the wellbeing of people with mental illness. While acknowledging examples of quality improvement in hospitals where the use of seclusion and restraint declining, OPA continues to raise issues about the level of restriction placed on clients in bed based clinical settings.<sup>32</sup> For example, following a patient’s complaint about mistreatment in seclusion, Community Visitors reported concerns about the use of the hospital’s security staff to

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<sup>32</sup> CV 2007, ‘Annual Report’.

help manage a patient in seclusion at hospital. OPA supports the view that the practice of restraint and seclusion can result in an experience of trauma for patients.<sup>33</sup>

OPA continues to support the reduction of and elimination of the use restraint and seclusion in accordance with the National Safety Priorities for mental health services. The National Mental Health Seclusion and Restraint Project's forum held in Melbourne in May 2008 identified the need for mental health facilities to adopt contemporary approaches to managing patient behaviour triggered by psychotic episodes.<sup>34</sup>

In addition, following the release of people from mental health facilities, they often require community based accommodation with 24 hour clinical and non-clinical support. Sometimes this will be public housing with support provided by a home-based outreach service and other times it will be PDRSS accommodation with support attached. Currently, this type of support is limited in its availability.

### **Supported Residential Services**

Due to the low level of support and care that is generally provided in pension-level SRS and the levels of complexity of people being placed in this form of accommodation, the support needs of SRS residents are frequently not met. This has significant implications for the quality of life of residents and for the realisation of their autonomy and social connections.

A significant issue regarding the provision of appropriate support relates to the lack of coordination of placements into SRS. The result is frequent inappropriate placements (such as people being released from mental health facilities into SRS with inadequate support). Residents in SRS would benefit from a model of coordination similar to the vacancy coordination process used in the disability sector as part of the Disability Support Register.

A major concern for OPA is the frequent inability of staff in pension-level SRS to provide the level of specialist support that is required by residents due to their lack of knowledge and expertise. Residents in SRS are people with a broad range of disabilities, ages and backgrounds, with diverse support needs. Despite these diverse and often complex needs, support plans for residents of SRS are frequently inadequate and demonstrate a lack of awareness of resident needs.

There are notable differences between the quality of residential statements and care plans in pension-level and above pension SRS. Residential statements in pension-level facilities frequently do not contain the level of information that is necessary to outline what residents can expect for their accommodation payment. Similarly, in pension-level SRS care plans often do not contain adequate information about the individual resident's needs. OPA is of the view that the scope, quality and content of care plans are variable. This issue has been consistently raised by Community Visitors since the early 1990s.

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<sup>33</sup> CV 2007, 'Annual Report'.

<sup>34</sup> National Mental Health Seclusion and Restraint Project National Forum 2008

<http://www.nmhsrp.gov.au/c/mh>

To ensure residents receive the adequate support and care they are entitled to, enforcement of the regulations relating to standards of care in pension-level SRS is critical. Care plans need to cover the broad range of health and special or personal care relating to, for example, their health status, medication, dietary needs, interests, and mobility needs. Staff in SRS frequently struggle to manage the support needs of residents.

With the individual needs of residents in pension-level SRS becoming increasingly complex, the need for a review of the future role of the SRS sector in providing support and care is further highlighted.

The residents of pension-level SRS are increasingly diverse. Young people with complex needs are frequently living side-by-side with frail, older residents. This situation is not ideal for either the older residents or the younger ones, due to their different interests and energy levels. Older residents can feel unsafe around the physicality and/or the sometimes challenging behaviours of younger residents, while younger residents can become bored and frustrated.

Staff capacity to intervene effectively when residents exhibit behaviours of concern is critical. Often, however, staff in pension-level SRS are not equipped to manage such behaviours. According to Community Visitors, residents and staff have been subject to physical and verbal abuse. Many residents have no choice but to stay on due to lack of alternate accommodation. Furthermore, the situation appears to be escalating. In 2007, the Community Visitor Annual Report reported an increase in the number of serious incidents in SRS – including threats with knives, assaults and deaths – coinciding with poor staff ratios and inappropriate placement of people with behaviours of concern.

The life chances of residents in supported accommodation are frequently constrained on a variety of fronts: poor links between supported accommodation and the general community; lack of activities in the facility to alleviate boredom; insufficient staff support and access to specialists (eg. speech therapists, occupational therapists, physiotherapists) to maintain and improve health. OPA has also been made aware, through the Community Visitor program and the advocate guardians that the health of some residents has suffered as a result of poor nutrition and poor attention to their health needs.

Social isolation, lack of activities and lack of mental stimulation for residents can result in de-skilling, further limiting their capacity to lead a full life and participate in the general community. Insufficient staff support and opportunities to participate in the community reduce residents' opportunities for develop new life skills.

## **Disability**

The introduction of the *Disability Act 2006* and the pending introduction of the Quality Framework for Disability Services, provide new foundations for strengthening the quality of support provided in the disability sector. The establishment of the Office of the Senior Practitioner and the Disability Services Commissioner are particularly positive developments for protecting the rights and working towards improved quality of supports and opportunities for people with a disability.

Both Community Visitors and staff in the advocate guardian program have observed variations in how the legislation is being implemented. While the legislation is in its infancy, some degree of discrepancy is to be expected. These discrepancies, however, have the potential to impact on the quality of supports and opportunities for people with a disability.

There are two particular areas that OPA has identified variations:— individualised support plans and behaviour support plans in the context of restrictive interventions.

In their 2008 Annual Report, Community Visitors commended the introduction of individualised support planning with a person-centred approach, behaviour support plans and active support strategies. They noted that there were a number of excellent examples of individual support plans. They also commented on the variations emerging in the development, implementation and monitoring of plans, with potential implications for the independence of residents. They encouraged DHS to ensure ongoing training of staff in disability services as a strategy for minimising these disparities.

Even when a strong individual support plan is developed, there can be issues with implementation that relate to funding and intense competition for limited resources. Furthermore, regions are quite autonomous in setting their priorities and this can lead to variations across regions. It is critical for case managers and support people to be involved in application processes that are open, transparent and accessible.

OPA acknowledges that variations in practice relating to the recording of restrictive interventions through behaviour support plans relates partly to the new provisions being in the early phases of implementation. The Community Visitors have noted, however, that the use of restrictive interventions ‘can reflect staff attitudes rather than the principles of person-centred planning and active support practice’.<sup>35</sup> Strategies for minimising the use of restrictive interventions are critical. OPA supports the work of the Senior Practitioner in striving for a team based approach to behaviour support planning, with the teams comprising inter-disciplinary professionals and significant others (family members or friends) of the person with behaviours of concern.<sup>36</sup>

For people with a disability, the challenge in providing flexible support is particularly highlighted by the system’s inability to readily respond to the changing needs of those who are ageing or have complex health care needs. The changing and developing nature of the sector requires not only a higher level of understanding and training but also a broader knowledge of different types of disability. The service system remains ill equipped to deal with people with complex and changing presentations.

The vacancy coordination process within the DSR is also failing to meet the needs of people with a disability and/or mental illness and their placements into supported accommodation. OPA is aware of instances where young people are living with significantly older people, or people with

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<sup>35</sup> CV 2008, ‘Annual Report’, p.41.

<sup>36</sup> Office of the Senior Practitioner 2008, ‘Senior Practitioner Report: Report and recommendations on restrictive interventions and behaviour support plans from from 1 July to 30 September 2007’, Department of Human Services, Victorian Government, Melbourne.

dramatically different needs. OPA believes it is important that a coordination process exists, but that the current process needs to be reviewed.

**CASE STUDY – A CASE FOR MORE SPECIALIST SUPPORT PROVISION**

James is in his 40s and has multiple disabilities, including an intellectual disability and a mental illness. For the early part of his life, he lived in institutional care. Soon after 2000, he was admitted into a secure extended care unit. Since this time he has moved between SECU and community care units.

Following his most recent admission to SECU, he stabilised and was assessed as suitable for a community residential unit placement and was put on the DSR waiting list.

Due to the long wait, however, his behaviour deteriorated and he became aggressive towards staff and other patients. Staff resorted to restraint to respond to his behaviour. James is now restrained on most days, which has a significant impact on his quality of life.

The most positive outcome for James would be to move into a CRU with specialist support for his disabilities. The challenge for the system is in providing the level of specialist support James needs to prevent his readmission to the mental health system.

### **Recommendations**

21. That individualised models of support are expanded in recognition of the diversity of needs and the specific need for self-determination of people with a disability and/or mental illness.
22. That there is an increase in the provision of specialised and flexible support for people with complex and changing needs.
23. That the use of restrictive practices in disability services, including restraint and seclusion, are minimised and eliminated where possible.
24. That a body is established to ensure training and development in relation to guidelines established by the National Mental Health Seclusion and Restraint project for the elimination of seclusion and restraint in mental health settings.
25. That additional support to residents of SRS is made available to ensure adequate case management, planning and support.

## **Focus on: People with Huntington's Disease**

A key example of the inadequacy of support for complex clients is demonstrated by the experience of people with Huntington's Disease (a genetic neurodegenerative disease with cognitive, behavioural, emotional, mental health and physical manifestations which ultimately result in dementia and complete loss of mobility in the late stages of the disease).

Huntington's disease has a long trajectory and the progressive deterioration in abilities require a specialised level of care and support. It is important in the early stages of the disease for the person to establish links to assessment, treatment, support and planning. As symptoms increase over time, maintaining the connection to services and a level of coordination of care are important. The availability of accommodation in proximity to support and treatments will aid this.

Individuals with Huntington's disease have a complexity of service provision needs which necessitate the availability of a wide range of services and individually tailored programs across sectors. Input is required from a number of health professionals and support workers including psychiatrists, social workers, genetic counsellors, neurologists, dieticians, speech therapists, physiotherapists, occupational therapists, housing, financial and caregiver support workers. A multidisciplinary team approach is agreed on as the most effective approach to care.<sup>37</sup>

Family capacity to provide sustained support is often depleted due to the lengthy duration of the disease and the intergenerational impact on family life, education and employment. Not all patients can remain at home for the duration of the disease due to both their own health and capacity and that of their carer. Family breakdown, carer stress, cognitive, physical or psychiatric symptoms all necessitate the provision of non home based accommodation at various stages of the disease.

The combined cost of medications, equipment, transport and home modifications can act as barriers for a family where the caregiver and breadwinner have had to give up work in the middle of their working lives, leading to income loss at a stage where there may be financial strains due to the cost of raising a family. The lack of suitable placement options can be a major cause of stress for families.<sup>38</sup>

At the stage where behaviour becomes difficult to manage, families may find it increasingly difficult to care for their loved one at home. Ironically for families, the exhibition of aggression is one reason managers of care settings give for refusing to accommodate people with Huntington's Disease. Most SRS, hostels and supported accommodation settings are not set up to manage behavioural difficulties as well as provide supervision and support in relation to falls risk, feeding and communication needs.

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<sup>37</sup> Aoun S Kristjanson L, Oldham L 2006 'The challenges and unmet needs of people with neurodegenerative conditions and their carers' *Journal for Community Nurses*, vol.11, no.1, pp.17-20; Kristjanson L, Aoun S & Yates P 2006, 'Are supportive services meeting the needs of Australians with Neurodegenerative conditions and their families?' *Journal of Palliative Care*, vol.22, no.3, pp.151-58; Nance M 2007, 'Comprehensive care in Huntington's Disease: A physician's perspective', *Brain Research Bulletin*, vol.72, no.2-3, pp.179-81; Skirton, H 2005, 'Huntington's Disease: A nursing perspective', *MedSurg Nursing*, vol.14, no.3, pp.167-73.

<sup>38</sup> Department of Human Services 2003, 'Review of Arthur Preson Residential Services', Disability Services Division, Victorian Government, Melbourne.

People with Huntington's Disease respond best to an appropriately structured and supportive environment. In care settings that confront, restrict and punish, the person often responds by getting more resistant and unmanageable. OPA works with many people who have spent years of their lives in the middle stages of the disease, moving between acute mental health units and SRS because no specialised appropriately structured and supportive accommodation is available.

There is a need for a facility that can provide intensive support for people in the late stages of the disease when specialised high level care is needed. OPA would support consideration of a similar model to SECUs in the mental health system for people with Huntington's Disease.

CASE STUDY – CASE FOR A SPECIALISED SECURE FACILITY FOR HUNTINGTON'S DISEASE

David is a 39 year old man with Huntington's Disease diagnosed ten years ago. Being unable to sustain his accommodation, he ended up homeless from where he was referred to an aged care hostel. Due to risks associated with his impulsive behaviour and his persistent absconding from the hostel, he was later referred to an acute mental health ward. The deterioration associated with his Huntington's Disease combined with his aggression and the lack of insight he has into personal safety make him vulnerable to exploitation and injury so discharge to an insecure environment is not a possibility. David was ultimately placed in an aged care mental health facility as the acute unit identified that he was inappropriately placed in an acute setting.

## Staff qualifications and experience

Internal consultations with Community Visitors and staff in the advocate guardian program revealed significant concerns with the variations amongst staff qualifications, experience and levels of staffing across the range of supported accommodation settings. There are notable implications for the quality of support for people with a disability and/or mental illness in view of this inconsistency.

Working with people with a disability and/or mental illness involves significant responsibility and requires specialist expertise. Importantly, employees have a duty of care to those they support. As outlined, many people accessing supported accommodation have a dual disability, require prescribed medication, skilled support and interventions, health and personal care, and regular monitoring.

Parts of the supported accommodation sector are understaffed, due to difficulties in retaining staff and the resulting high turnover. In other parts of the sector, staff skills are limited in meeting the needs of the people they are supporting. Over a number of years, the Community Visitors have identified common themes regarding staffing, including low staff numbers, the replacement of a permanent workforce with workers on temporary contracts and inadequate training, supervision and support of staff.

Furthermore, staff qualifications and experience vary across the mental health, disability and aged care service systems that provide supported accommodation. The lack of consistency in staff qualifications and experience is a matter of concern to OPA. It points to the different levels of professional expertise that people with a disability have access to depending on where they fall in the system (as already discussed, where a person with disability and/or mental illness lives is frequently not their choice).

### **Mental health**

The mental health sector is staffed by a diverse workforce across clinical settings and in the PDRSS services. Medical, nursing and allied health staff comprise the workforce mix in the mental health sector.

The most significant issue identified by OPA staff in the advocate guardian program and Community Visitors relating to the mental health workforce is the high level of staff turnover and staff shortages.

The need for workforce planning to address issues of staff recruitment and retention and appropriate career pathways has been identified by the 2008 Mental Health Reform Strategy.<sup>39</sup> OPA strongly supports a focus on workforce planning.

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<sup>39</sup> DHS 2008, 'Because mental health matters'.

## Supported Residential Services

Significant staffing issues exist in pension-level SRS, with major implications for the quality of supports and quality of life of the residents in these settings. For a number of years, Community Visitors have reported on the increasingly complex needs of SRS residents, particularly in the pension-level sector. In 2007-08, Community Visitors again observed that many staff struggle to provide appropriate support for residents given their needs. Minimal qualification levels are inadequate. Currently, only one member of staff in each SRS is required to hold a Certificate III in Community Services (or equivalent). As a result, Community Visitors are aware of instances where a staff member with no formal training or qualifications has been left to manage residents for whom medical crises and complex behaviours occur regularly. This is in direct contrast with government-managed disability facilities providing shared supported accommodation for people with a disability, where over 95 per cent of staff are qualified or undertaking Certificate IV training.

There is a strong case for raising the level of minimum qualifications of the personal care coordinator in SRS pension-level facilities to at least a Certificate IV.

Although SRS proprietors are responsible for ensuring that adequate support staff are required, Community Visitors have also observed that minimum staffing ratios are inadequate given the complex needs of the residents. Significant disparities in the staff / resident ratio between SRS and comparable aged care facilities have been raised consistently by Community Visitors since the mid-1990s. One staff member to 30 residents is not adequate. Similarly, the requirement that one staff member be available overnight is not appropriate in the context of residents who often have high and complex health care needs that require attendance.

In its Discussion Paper on the Review of the SRS Regulations, DHS noted a significant systemic problem and an ultimate paradox for the government. It states:

This review will explore whether current staff skills and competencies are sufficient, or whether alternative approaches are required across part or all of the industry.

This is particularly critical given the diversity of the sector and its residents, and the potential for any blanket increase in staffing levels or qualifications to result in loss of beds from the sector. This could happen due to difficulties in sourcing additional staff (given the current skills shortage), potential loss of existing staff (who, if required to increase their qualifications, may choose to leave the industry), or increases in staff and training costs, resulting in loss of financial viability.<sup>40</sup>

Issues relating to staff recruitment and retention and the need for industry planning have been raised in other health and community service sectors, for example in the disability sector, the alcohol and other drug sector and the family violence sector. It is recognised in these sectors that there is a need to ensure that staff have the skills, qualifications and experience required to provide the quality of service that service-users are entitled to. The government identified the need to strengthen the workforce in these sectors.

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<sup>40</sup> DHS, 'Review of Regulation of SRS in Victoria', p.23.

Residents of SRS are equally as vulnerable and in need of quality service provision as those clients of the abovementioned sectors (indeed, they may often overlap). Residents of SRS sector are no less deserving of quality services. OPA is of the opinion that the government has an obligation to ensure that SRS residents receive quality of service. The government cannot entirely handball its obligations and duty of care for this group of vulnerable Victorians to the private SRS sector. The *Victorian Guide to Regulation* is quite clear in its statement that there is a justification (and community expectation) for government intervention in the pursuit of social justice and equity objectives.

This issue relating to staffing qualifications, therefore, raises a significant systemic problem. It again highlights the need for a review of the role of the pension-level SRS sector in the provision of support to a highly vulnerable and disadvantaged population group. If the viability of pension-level SRS means that staffing cannot be improved, thereby resulting in inadequate service responses to residents, the government needs to reconsider its own role in providing support that works to reduce disadvantage in the context of its social policy commitment outlined in *A Fairer Victoria*.

Furthermore, in instances where the proprietor is not involved in the day to day operation of the SRS, the person who has responsibility for the management of the SRS should be subject to an assessment of their fitness for undertaking the duties and obligations of managing an SRS. Ideally, a list of criteria should be developed in consultation with all relevant stakeholders. Facilities should preferably be purpose built to meet the needs of SRS residents.

## **Disability**

There is no industry-wide minimum requirement for qualifications, training or experience of the staff employed in services in the disability sector.

The Victorian Auditor-General notes a disparity across DHS run services and community service organisations (CSO) services on two levels. DHS has established standard selection criteria for staff in government-run services. There is no similar standard in CSOs. Secondly, in 2007, 94% of staff in DHS services had a Certificate IV qualification. In many CSOs, on the other hand, there was no minimum qualification required for new staff employed.

Community Visitors have noted in their 2008 Annual Report that the continuity of care of residents is affected by the increasing employment of short-term, casual and agency staff. Issues of recruitment and retention are also affecting the ability of services in the disability sector to maintain consistent standards of care and to ensure a knowledgeable and skilled workforce.

The need for ongoing training in the context of significant changes to practices in the disability sector presents new challenges. Staff in the disability sector are more frequently presented with clients they haven't previously worked with, including those with an acquired brain injury, with a dual disability or who are ageing and have complex, age-related healthcare needs. Community

Visitors reported some variations in which staff are being training to incorporate new methods into their practices.<sup>41</sup>

### **Recommendations**

26. That minimum industry standards for qualifications, experience and training be increased for all staff working in supported accommodation settings in disability and SRS.
27. That staff in supported accommodation settings receive additional training specific to
  - a. assisting in understanding the complexities of working with people with complex and changing needs – particularly those with Huntington’s Disease, dual disability, acquired brain injury, autism spectrum disorder and whose needs are changing with age.
  - b. ensuring familiarity with new models of practice and changed practices that relate to new legislative frameworks.
28. That workforce planning strategies be adopted to improve career pathways and staff recruitment and retention.
29. That minimum standards for staff / resident ratios across supported accommodation settings be adopted.
30. That a specific project to improve staffing in SRS be implemented:
  - a. that the government introduces minimum qualification levels for all personal care staff at SRS
  - b. that the requirement for a trained personal care coordinator to be on duty is increased from 38 hours per week to 24 hours per day.

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<sup>41</sup> CV 2008, ‘Annual Report’.

## Financial burden

Residents in supported accommodation are frequently required to pay board or lodgings that does not leave them with the disposable income to purchase personal necessities and opportunities. This is a particular issue for residents in SRS accommodation.

It is recognised nationally and internationally that people with a disability incur many extra but ordinary costs due to their disability and that the cost of living for people with a disability is generally higher than for the rest of the community – such as higher medical costs, and paying for mobility and communication aids, transport and help with attendant care. These costs are not fully covered by Medicare, the PBS and other public subsidies. Some costs are integrated into accommodation payments in some supported accommodation settings. Yet after paying for accommodation, many residents of SRS accommodation are left with almost no disposable income.

The Human Rights and Equal Opportunity (HREOC) National Inquiry into Employment and Disability *Issues Paper 1: Employment and Disability – The Statistics* found there is extensive evidence that people with a disability in Australia are experiencing serious financial disadvantage.

The overall levels of income earned by people with disabilities are also lower than those without disabilities. In 2003, the median gross personal income per week of people of working age with a disability was \$255, compared to \$501 for those without a disability.<sup>42</sup>

Recent Organisation for Economic Cooperation and Development (OECD) research found that Australia has the lowest average personal income for people with a disability, at 44 per cent of the income of people without a disability.<sup>43</sup>

Saunders, for the Social Policy Research Centre (SPRC) states that:

Having a ... disability is associated with a substantial increase in the incidence of financial hardship, a higher probability of experiencing severe financial stress and [often] result[s] in having to sell or pawn things, or seeking help from others. Disability also leads to less social participation, while those with a disability are more likely to report not having access to external financial support if it is needed.<sup>44</sup>

Further research conducted by Saunders in 2006 examined the relationship between disability, living standards and poverty, and demonstrated that ‘where there is someone in the household with a disability, poverty rates are higher and hardship is more prevalent’.<sup>45</sup> The results showed a one-third (32.9 per cent) reduction in overall median income and that the poverty rate for households with a disability were 1.6 percentage points above other households with a corresponding 21.6 per cent higher risk of poverty.<sup>46</sup>

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<sup>42</sup> Australian Bureau of Statistics (ABS) 2003, *Persons aged 15-64 years living in households*, p. 3

<sup>43</sup> OECD 2003, *Transforming Disability into Ability, Policies to Promote Work and Income Security for Disabled People*, p.29.

<sup>44</sup> Saunders P 2005, ‘Disability, Poverty and Living Standards: Reviewing Australian Evidence and Policies’, SPRC Discussion Paper, no.145, pp.9-11.

<sup>45</sup> Saunders P 2006, ‘The Costs of Disability and the Incidence of Poverty’, SPRC Discussion Paper no.147.

<sup>46</sup> Saunders 2006, ‘The Costs of Disability’.

This research also showed that both incidence and severity of hardship increased with disability and confirmed the adverse effects associated with disability identified in the income comparisons.

Saunders, in estimating the costs of disability, cites several pieces of research which demonstrate that where someone in the household has a moderate restriction the cost is equivalent to between 30 and 37 per cent of income, while the costs of a severe or profound restriction vary between 40 and 49 per cent of income.<sup>47</sup>

Once account has been taken of the costs of disability, the differential in poverty rates between those with and without a disability increases substantially, with the poverty rate among those with a disability exceeding that of those without a disability by more than six-fold.<sup>48</sup>

The indicators of hardship or financial stress identified in the *ABS Household Expenditure Survey 1998–99* and used in the *SPRC Costs of Disability and the Incidence of Poverty* discussion paper are:

1. In the past year the person could not afford:
  - a week's holiday away from home each year
  - a night out once a fortnight
  - to have friends/family over for a meal once a month
  - a special meal once a week
  - brand new clothes (usually buy second-hand)
  - a leisure or hobby activities
2. Due to the shortage of money the person:
  - could not pay gas, electricity of telephone on time
  - could not pay car registration or insurance on time
  - pawned or sold something
  - went without meals
  - was unable to heat own home
  - sought assistance from a welfare or community agency
  - sought financial help from friends or family

While some of the costs associated with support needs are absorbed into payments for accommodation for people living in supported accommodation settings, it is important to note that for these people the cost of living is high and that there is often minimal disposable income after accommodation payments have been made. As noted above, this is a particularly significant issue in SRS accommodation.

### **Supported Residential Services**

The issue of the financial burden caused by lodgings is a significant problem in SRS and can lead to safety issues and increased vulnerability.

As already emphasised, the residents of SRS are a particularly vulnerable and high-risk group. OPA has significant concerns about the safety and security of residents, particularly female residents, in SRS who are vulnerable to violence and sexual exploitation. For example, Community Visitors are aware that payment for lodgings often results in residents not having money for necessities. The Community Visitors Program at OPA has reported that women in these circumstances have exchanged sexual 'favours' for what they perceive as basic necessities,

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<sup>47</sup> Saunders 2006, 'The costs of disability'.

<sup>48</sup> Saunders 2006, 'The costs of disability'.

such as cigarettes and money. In pension-level SRS, the gender mix is predominantly male, which heightens the risk for many women.<sup>49</sup>

Many residents in pension-level SRS are unable to make real choices about their lives due to their lack of disposable income. As discussed, there is extensive evidence that people with a disability in Australia experience serious financial disadvantage, and Community Visitors are aware of residents in a pension-level SRS paying up to 95 per cent of their income in accommodation fees.

### ***Recommendations***

31. That the cost of disability be formally recognised in considering the financial burden experienced by residents in supported accommodation.
32. That the government review the fee for pension-level SRS to ensure that all residents have an adequate disposable income for their personal needs and opportunities.

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<sup>49</sup> CV 2008, 'Annual Report'.

## Lack of cross system integration

A key issue in supported accommodation is the lack of cross-sector collaboration and integration of support to people who require multiple supports. People who live in supported accommodation settings are often engaged with more than one service system – including mental health, aged care, disability, alcohol and other drugs and other community based services. To ensure this support is tailored to the individual, effective coordination of these supports is needed across service systems.

Currently, however, the service systems that respond to the needs of people with a disability and/or mental illness often do not effectively embrace strategies for case coordination across service systems. For example, people with a disability and/or mental illness who have a dual disability might receive support from the disability sector yet receive inadequate mental health support, and vice versa. This is despite an existing protocol across the disability and mental health sectors. OPA is of the view that the protocol requires review. A significant concern is that people with a dual disability do not receive the level of specialist support they need to prevent repeated readmissions to clinical based care. Similarly, people with a disability (such as an acquired brain injury – ABI – or intellectual disability) who have issues with their alcohol and other drug use often require a coordinated response that the existing service system struggles to provide. In some instances this relates to shortage of specialist service responses (such as case coordination for people with ABI and alcohol and other drug issues, or access to the Multiple and Complex Needs Initiative – MACNI). In other situations, it relates to a service system gap (such as intellectual disability and alcohol and other drug use).

There is a range of issues that result from the lack of integration across sectors. These include:

- Consequences of inter-regional boundaries / catchments – people who leave one region will often be ineligible for support in another region (particularly in mental health).
- Limitations in support for people with dual disability – people living in community residential units (CRU) with a mental illness are often unable to adequately access community based mental health services or case management services due conflict between mental health and disability service providers.
- Inadequate aged care support for people with disability – older people with an intellectual disability are frequently moved into aged care accommodation prematurely due to the lack of adequate transitional accommodation options and often there is a lack of access or cooperation between disability services and the generic services system for people living in CRU.
- Lack of effective service coordination – support for people across the sectors is often inadequate due to lack of cooperation and collaboration in approaching service delivery and case coordination across service providers.
- Inadequate pathways – there is limited monitoring of people who are referred to SRS from mental health and disability services. Many residents are inappropriately placed with inadequate support or no active case management provided.

## **Recommendations**

33. That a review of the barriers to cross-sector collaboration be undertaken as matter of urgency and that existing protocol within DHS between disability services and mental health require review to ensure a more effective service delivery for people with a disability and/or mental illness is achieved.
34. That cross-sector case coordination must be implemented to ensure effective and adequate support is provided to people with a disability and/or mental illness residing care.
35. That DHS review inter-regional boundaries and catchments to ensure that these limitations do not prevent people with a disability and/or mental illness from having their needs met and that their needs can be adequately met in their region of origin.
36. That people with disability and /or mental illness are appropriately assessed before discharge to an SRS and that the provision of adequate case management and support must be established before the person is accepted into the SRS.

## Families and carers

Inadequacies of the current system of supported accommodation provision have substantial negative effects on families and carers of people with support needs. Health problems, related to anxiety, and financial stresses that come from surviving on a low income are common.

Stress and anxiety levels are very high among carers. Research undertaken by Deakin University, Carers Australia and Australian Unity on levels of personal wellbeing among Australian carers found that carers have the lowest collective wellbeing of any group yet discovered, including people who are unemployed and living alone.<sup>50</sup> They also found that of their carer sample (3,766 persons), more than a third were found to be severely or extremely severely depressed. Wellbeing was reported to decrease as the number of hours spent caring increased.

Carers' worries are compounded by:

- limited access to respite beds
- lack of support services (emotional, financial and respite) for carers
- poor understanding of what supports are available and how to access them
- concern for loved ones placed in inappropriate care settings with poorly trained staff, and
- fear of what will happen to the person with disability and/or mental illness they care for when they are unable to provide care.

Financial pressures on carers are also significant. The 2003 Survey of Disability, Ageing and Carers found that households with carers in them were overrepresented in the bottom two quintiles (bottom 40%) of household incomes. More than half of primary carers indicated that their principal source of income was a government allowance.<sup>51</sup>

The current system does not support and enable carers and families to undertake their caring role in a sustainable way. Instead, families are often stretched to breaking point with their health and wellbeing negatively affected.

The focus of the Inquiry on families is extremely important. OPA works extensively with the families of people who come into contact with the Office and is aware of the significant pressures on carers of people with a disability and/or mental illness.

There is also a need to give consideration to people who are in vulnerable circumstances in supported accommodation (particularly SRS) and who have no family or social networks that provide additional support.

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<sup>50</sup> Cummins, RA & Hughes, J 2007, 'The wellbeing of Australians – Carer health and wellbeing: Summary Report', Australian Unity Wellbeing Index: Survey 17.1, Deakin University, Melbourne.

<sup>51</sup> Australian Bureau of Statistics 2004, 'Disability, Ageing and Carers 2003', Cat. No. 4430.0, www.abs.gov.au, Accessed on 13 November 2008.

OPA works with many people with a disability and/or mental illness who experience such social isolation and lack of family support. These people are often also disconnected from their community. This has significant implications for their quality of life and their ability to participate actively in their communities.

### ***Recommendations***

37. That families and carers are provided greater support services and information enabling them to access the relevant support to fulfil their caring role.
38. That strategies are implemented to provide people with a disability and/or mental illness who have no family or social networks with opportunities to build social connections.

## Diverse and other needs

Consultations with Community Visitors and staff in the advocate guardian program revealed concerns that supported accommodation services do not have the capacity to effectively recognise diversity. This includes diversity in culture, religion and sexuality. Indigenous communities often choose to assume the caring role for those with disability and/or mental illness. To enable them to do this to the level they seek, the system needs to provide more flexible and appropriate specialist support, particularly to carers.

For people with a disability and/or mental illness in rural and remote areas, there are significant issues relating to the lack of accessible and appropriate facilities. Some of these issues have been touched on in earlier sections, particularly relating to mental health facilities. Also concerning is that in some regions, institutional care is the only accommodation option available due to no appropriate alternative supported accommodation for people with a disability.

Transport and community access, particularly for young people, is a significant issue in rural areas. This is exacerbated by the shortage of outreach options.

There are ongoing and significant shortages in respite options in rural and remote areas.

### **Recommendations:**

39. That the diversity of people's needs is recognised through more flexible support and practices for indigenous people with a disability and/or mental illness and those from culturally and linguistically diverse backgrounds.
40. That the perennial issue of lack of available and accessible support and accommodation in rural and regional areas is urgently addressed through greater resourcing and regionalising existing metropolitan services.

## Individual rights

The right to an adequate standard of living and to housing was outlined at the beginning of this submission. It is critical that people with a disability and/or mental illness are protected by rights that enable them to have quality of life, of which their home and living circumstances are central. Within the context of housing in Victoria, people with a disability and/or mental illness require tenancy rights, the right to safety, non-discrimination and equal opportunity. The protection of rights of people who are subject to restraint and seclusion and locked facilities need to be monitored and safeguarded.

- **Safety & security**

The Public Advocate has significant concerns about the safety and security of residents, particularly female residents, of many supported accommodation settings.

As mentioned, women with disability and/or mental illness are particularly vulnerable and in some accommodation settings this vulnerability is heightened. For example, in SRS payment for lodgings often results in residents not having money for basic necessities. The Community Visitor Program at OPA has reported that women in these circumstances have exchanged sexual ‘favours’ for what they perceive as basic necessities, such as cigarettes.<sup>52</sup> In pension-level SRS, the gender mix is predominantly male, which therefore heightens the risk for women.

Similarly, as discussed, in mental health services women have reported feeling particularly at risk of sexual exploitation when they are unwell. The response of staff to incidents of sexual assault and abuse varies considerably, further impacting on the vulnerability of women in these settings. Anecdotal reports from Community Visitors and advocate guardians indicate that the risk of violence in supported accommodation is a concern. Drug use in mental health services and other supported accommodation has also been raised as a contributing factor. Again, the response of staff to violence incidents varies considerably.

For people with an intellectual disability and people with profound and multiple disabilities, there are concerns about safety in supported accommodation. In particular, personal safety and safety from abuse of rights.

### **Recommendation**

41. That the exposure of people with a disability and/or mental illness to violence and abuse in supported accommodation settings is minimised through more effective monitoring and reporting of critical incidents, in addition to a commitment to review practices following incidents.

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<sup>52</sup> CV 2008, ‘Annual Report’.

## ▪ Tenancy Rights

People with a disability and/or mental illness living in shared supported accommodation (including community residential units and supported residential services) are not covered by the provisions of the *Residential Tenancies Act*. This means that they do not enjoy the same rights and protections as other tenants or people who rent rooms.

It is the view of OPA that people with disabilities who pay rent as part of a fee for care should enjoy residential tenancy rights equal at law to other members of the community who pay rent.

In SRS, anecdotal evidence exists in relation to the practice of evictions and persons with disabilities being unable to recover their property from, or be compensated for, such action. In addition, the rights of quiet enjoyment and access may be compromised for those in supported residential services. Residents' willingness to advocate for themselves is limited by their lack of tenancy rights. Residents have told Community Visitors that they are reticent to complain about living conditions or overly restrictive rules (like turning the television off at 8.30pm every night) because the proprietor can ask them to leave at any time.

Residents are often reluctant to speak up about issues of concern for fear of reprisal, such as being removed from their current place of residence. Hence, due to their vulnerability, many residents do not use complaint mechanisms. This is a significant issue. Furthermore, adequate access to information about complaint processes is variable and needs to be more consistent. SRS residents are currently exempt from the *Residential Tenancies Act 1997* and have very few of the same residential rights as residents in comparable accommodation sectors. Community Visitors have raised this issue consistently since 1991.

OPA has advocated to Ministers in recent years for the acknowledgement of tenancy rights for SRS residents along the lines of tenancy rights for rooming house residents.

### CASE STUDY – INTIMIDATION<sup>53</sup>

Community Visitors reported of allegations of intimidation of residents by an SRS proprietor. OPA received several reports that residents lived in fear of the proprietor. For example, it was reported that residents have their pocket money or cigarettes withheld by the proprietor if residents have voiced concerns about any aspect of their care to Community Visitors. In one situation, a caller reported that a resident was observed begging in the street for cigarettes because a staff member had confiscated their cigarettes.

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<sup>53</sup>

CV 2008, 'Annual Report'.

**Recommendation**

42. That residents in SRS accommodation are afforded the same rights and protections provided to residents under *Residential Tenancies Act 1997*.