REPORT

REVIEW OF THE PERSONALISED SUPPORT LINKED TO HOUSING: SUPPORTIVE LANDLORD SERVICES PROGRAM AREA AS PART OF THE INDEPENDENT LIVING PROGRAM

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List of Recommendations

Recommendation 1 The Mental Health Commission develops a clear definition of the supportive landlord component of the service model, as well as a formalised common ILP framework, in a co-design process with consumers and landlords, for inclusion in new service contracts and to better align with contemporary recovery standards. This should include consideration to the framework proposed by ILP Forum as the ILP model of a supportive landlord.

Recommendation 2 The Mental Health Commission, in collaboration with service providers, revise the ILP guidelines in accordance with the national guidelines for recovery; specify outcomes for service providers, and change administration of the ILP to better become recovery- oriented.

Recommendation 3: Pending the review of Guidelines in Recommendation 2, the Mental Health Commission reviews funding for the 'supportive landlord' and 'community support' components of the ILP, in full consultation with service providers and consumers, to ensure service providers have the capacity to fulfil the guidelines and consumer support needs are met.

Additionally, if shortfalls in community or psychosocial support are identified, the Mental Health Commission explore mechanisms to expand access to this support, for example through growth in the community support stream as identified in the Plan.

Recommendation 4 The Mental Health Commission clarifies whether the ILP is intended to be a transitional model as part of a comprehensive accommodation pathway for mental health consumers, or a home for life. If the former, the other pathway components should be designed and commissioned with some urgency, and incorporate the principle of no reduction in support or loss of housing stability for current ILP consumers. These should include not only pathways towards alternative secure housing but also mechanisms to improve consumers' ability to sustain private housing by increased income through employment. If the ILP is intended to be a home for life, the Mental Health Commission investigates, with the Department of Communities, options for maintaining the current stock allocated to the ILP as permanent housing for consumers who need it.

Recommendation 5 The Mental Health Commission ensures all HSPs in the ILP agree to strong collaborative team-work models that improve ILP consumer outcomes and reach recovery goals. That these models are formalised as contractual obligations by HSPs in relevant documents.

Recommendation 6 The Mental Health Commission improves in integrating mental health and alcohol and other drug service planning, and raises the capacity across the public mental health sector to work in an integrated manner with ILP consumers.

Recommendation 7 The Mental Health Commission initiates a process of collaboration with relevant agencies across all sectors to assess the feasibility of introducing a private rental scheme for ILP tenants.

Recommendation 8 The Mental Health Commission develop an outcomes framework for measurement and reporting, including baseline indicators and methodology which would track the program's effectiveness.

Recommendation 9 The Mental Health Commission establish a robust mechanism to assess chronic shortages in supported accommodation for mental health consumers and identify ways to address them.

Recommendation 10 The Mental Health Commission's plan for service delivery include reforms to the ILP in accordance with recovery-led approaches as outlined in the National Framework for Recovery-oriented Mental Health Services.

Recommendation 11 The Mental Health Commission establish a project that works with relevant stakeholders to leverage the potential benefits of the NDIS for mental health consumers in supported accommodation services, including the ILP, through supporting their NDIS access.

Recommendation 12 The Mental Health Commission establish a project or other mechanism to map and monitor the impact of the NDIS on ILP and other supported accommodation programs.

Section One: Introduction

1. Context and background

1.1. About WAAMH

The Western Australian Association for Mental Health (WAAMH) has been contracted by the Mental Health Commission (MHC) to conduct a review and report on the 'supportive landlord' component of the Independent Living Program (ILP). This report is submitted as a full report of the outcomes of the review, as a key deliverable by 6 September 2019.

WAAMH is the peak body for the community mental health sector in Western Australia and exists to champion mental wellbeing, recovery and citizenship. WAAMH recognises a continuum of supports – built on principles of human rights, recovery, co-production, personalisation and choice, social inclusion and cultural connection – are essential to the promotion, protection and restoration of mental wellbeing. WAAMH promotes, advocates for and further develops this network of supports.

WAAMH's membership comprises community-managed organisations providing mental health services, programs or supports and people and families with lived experience of mental health issues and suicide, with whom WAAMH engages in genuine partnership. WAAMH also engages in a wide network of collaborative relationships at a state and national level, with individuals, organisations and community members who share its values and objectives.

1.2. Strategic context

Globally, communities, experts and governments agree we need to establish a new balance for mental health systems so that problems can be prevented, and people can find and access the support they need before reaching crisis point. International models demonstrate how to organise mental health services that respond to need where and when it is most needed, through increasing self and community-based care, and reducing over-reliance on hospitals and specialist services.[1]

Prevention, early intervention, and community support contribute significantly to people's emotional and social wellbeing and to a financially sustainable health system, saving money and lives.[2] Without investment in treatment and recovery services in the community people can become increasingly unwell, and need to access hospital beds or far more costly emergency departments in order to get support.[3] The *National Review of Mental Health Programmes and Services* cited high rates of emergency department admissions and readmissions to acute psychiatric services as evidence of "failure to provide timely and adequate community-based mental health supports" in Western Australia.[4]

Western Australia has a bipartisan government plan that provides the roadmap to rebalance this – the *Western Australian Mental Health, Alcohol and Other Drugs Services Plan 2015 – 2025* (the MHAOD Plan). This plan includes in its principle a primary focus is on rebalancing

[1] World Health Organization, *The Optimal Mix of Services: WHO Pyramid Framework.* http://www.who.int/mental_health/policy/services/2_Optimal%20Mix%20of%20Services_Infosheet.pdf accessed 19 October 2018
[2] McGorry, P. (2015). Mental health as significant as tax reform, says economist. *PM program*. Sydney, NSW: Australian Broadcasting Corporation.
[3] Alan Fels, 2018. Please don't dismiss the PC inquiry into mental health as 'just another inquiry'. https://theconversation.com/please-dont-dismiss-the-pc-inquiry-into-mental-health-as-just-another- inquiry-104695 Accessed 31 October 2018.
[4] National Mental Health Commission, *The National Review of Programmes and Services*, NMHC 2014.

services between hospital-based and community-based: moving services to the community where clinically appropriate.[5]

The Plan identified community support as a basic building block of an effective and balanced mental health system, and the most under-resourced service type, meeting only 22% of demand. [6] Modelling undertaken for the Plan by state government showed that community support needs to grow from 8% to 19% of the service mix. [7]

Similarly, a recent report by the Auditor General found the Western Australian mental health sector is under significant pressure, often struggling to meet demand because of an inefficient system: *'One of the reasons for this is the mix of services currently available does not match what the state needs.'* [8]

The report supported the MHAOD Plan as a good plan but stated that progress in changing the service mix has been very limited. The audit's conclusion was that:

An efficient and effective State-funded mental health care system should help people to stay in the least intensive care setting required to manage their condition, while providing access to more intensive care when needed. The Better Choices. Better Lives: Western Australian Mental Health, Alcohol and Other Drug Services Plan identified an urgent need to expand community mental health services and rely less on costly hospital beds. It is a soundly devised plan, developed with extensive consultation and strong support from consumers and care providers. However, there has been limited progress in implementing the Plan to rebalance the service mix. This means that the system continues to deliver services inefficiently and ineffectively. The Plan aimed to reduce the proportion of funding for hospital beds from 42% to 29% by 2025. By the end of 2017-18, it had instead risen to 47% of State mental health funding.' [9]

WAAMH anticipates that the Mental Health Commission's acceptance of the report's findings will be an important driver in finding the means to increase supported accommodation services as a critical part of the community support mix.

A key emerging issue that will affect the mix of services and supports available for mental health consumers is the introduction of the National Disability Insurance Scheme (NDIS), from which many people will gain significant benefit. The benefits can be seen, for example, in the number of people living in psychiatric hostels with new access to NDIS supports that will enable improved quality of life and community inclusion. However, the impact of the NDIS on the service landscape is still emerging, and its interaction with accommodation supports in particular remains unknown. There is a need to both proactively support people to access the scheme to leverage its benefits for people and the state mental health system, and to map and address any negative impacts so that the state government commitments to no one being worse off, can be met.

1.3. The importance of housing to recovery

A safe and stable place to call home is recognised as fundamental to good mental wellbeing and to recovery of people who experience mental health challenges. For example, the WA

[5] Government of Western Australia, Mental Health Commission, *The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 for consultation.* Government of Western Australia, 2014, p.5.
[6] *Mental Health, Alcohol and Other Drug Services Plan 2015-2025 for consultation.*
[7] Government of Western Australia, Mental Health Commission, *Better Choices Better Lives. Western Australian Mental Health, Alcohol and Other Drugs Services Plan 2015-2025*. 2015, p.21.
[8] Office of the Auditor General, 2019, *Access to State-Managed Adult Mental Health Services*, Report 4: 2019-20, p.4
[9] Ibid. p.8.

Mental Health Commission's Outcomes Statements include as an important consumer outcome: '*A home and financial security: people have a safe home and a stable and adequate source of income'*. [10]

Government investment in supported accommodation has long reflected the need for a range of support options, with significant investment in community accommodation supports over the past 25 years to develop effective support options and progress deinstitutionalisation. The ILP is one of these programs, alongside other services that offer more in-depth support. More recently in 2011, government introduced the Individualised Community Living Strategy (ICLS) to offer individualised support and funding as a contemporary approach for improving the appropriateness, accessibility, and responsiveness of mental health service delivery in Western Australia.

State mental health reports, reviews and policy also recognise the need to increase access to supported accommodation for people with mental health issues who are unable to live without support. The Stokes Review found there is a significant deficit in community support and related accommodation services, with clinicians in every inpatient service they met describing insufficient community accommodation, including Step-Up Step-Down services and supportive accommodation, as an impediment to discharging a patient. [11]

The MHAOD Plan estimates that by 2025, between 1474 and 1867 Western Australians who have mental health, and/or alcohol or drug issues will also be homeless. Appropriate accommodation supports are expected to comprise a significant proportion of the services needed to meet the modelled fivefold increase in demand for mental health community support by the end of 2025.

To strategically address this issue, the Mental Health Commission has developed the 'Western Australian Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018-2025, Draft' (Accommodation and Support Strategy, draft)'.

This draft noted that modelling is still being undertaken to estimate the demand for accommodation related to community support. The Stokes Review stated that a range of accommodation options are needed within each region of the State. It is imperative thorough needs analysis, informed by consumers, family members, clinicians and service providers in all regions inform service modelling efforts.

Despite these efforts, inadequate housing remains a problematic barrier to recovery for too many mental health consumers, and current services are fragmented with few options that can adapt to people's changing needs over time, or support people to move on, thus freeing up services for others who need them.

A project funded by the Mental Health Commission to be delivered by WAAMH in November 2019, will seek to improve access to mental health accommodation services through the development of a draft referral framework. It is envisaged that this framework will provide a process and guidance for public mental health services and not-for-profit service providers and streamline transition (both in and out of services and between services) for consumers. The project will also assess key issues and priorities relating to consumer and system flow, identify system gaps including those that contribute to failed discharge/exit planning, identify blocks and ways to address these, consult on how existing services might better address accommodation requirements, and recommend other system changes that may be

[10] Government of Western Australia, Mental Health Commission, 2012, 'Mental Health Outcome Statements'.
[11] Government of Western Australia, Department of Health and Mental Health Commission, 2012, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, Professor Bryant Stokes AM.

necessary.

Given the significant unmet demand for supported accommodation, the review of the ILP is a timely opportunity to examine this service model through a contemporary lens, identify and address improvements to the service design, identify possible service pathways into private rental, and identify changes to the systemic environment in which the program is situated.

1.4. Procurement of the ILP

The current procurement environment for community support services is undergoing change. The *Delivering Community Services in Partnership Policy* sets out more consistent standards for commissioning agencies to achieve in Western Australia. Over time, the policy is expected to drive commissioning practice more closely aligned with principles of robust and genuine partnership between government and non-government organisations.

The MHC has developed the *Community Services Procurement Schedule* for the procurement of mental health and alcohol and other drug services to provide greater clarity for service providers about when different types of services will be procured. [1212]

The Schedule maps out the MHC's procurement timelines for its program areas over the life of the Western Australian Mental Health, Alcohol and Other Drugs Services Plan 2018-2025.

The MHC is conducting a review in August-September 2019 of some types of community support services to inform its procurement decisions for service agreements expiring in June 2020, with ILP one of the programs affected. The MHC commissioned WAAMH to undertake this review to support the MHC's next steps in the procurement of this program.

[12] Community Service Procurement Schedule https://www.mhc.wa.gov.au/about- us/commissioning/community-services-procurement-schedule/, accessed 5 September 2019.

2. About this report

2.1. Terms of reference

The terms of reference for the review, agreed to by WAAMH and MHC, are:

1. To define and describe the ILP service model and outline the services currently provided by ILP providers, with attention to:
    a. Level of support provided to tenants;
    b. Relationship of tenancy support workers with the tenant's support workers, GP, or case coordinator;
    c. Processes of engaging and supporting ILP tenants to access other mental health and/or alcohol and drug services;
    d. Differences between an ILP tenant and other community housing tenants.
2. To identify the barriers to tenants moving to private rental and other systemic barriers and actions to address these issues;
3. To assess the effectiveness of the ILP service model in the current mental health, alcohol and other drugs landscape;
4. To assess any impact of the NDIS on the model;
5. To complete a report of project findings and identification of ways forward, including a recommendation on a future co-design process with stakeholders to redesign the model.

2.2. Methodology

2.2.1. Consultations and data collection

Consultations with consumers included a short survey administered through Survey Monkey, and five focus groups held in Perth and Albany. A total number of 64 individual consumer responses were received.

WAMMH team worked in partnership with Consumers of Mental Health WA (CoMHWA) to facilitate workshops in Albany because the region was identified as a site of high service provision and visible consumer presence through the Depression Support Network (DSN). Albany hosts a number of supported accommodation programs including the ILP, and recovery support agencies, while DSN presence ensured that there was an active sample of consumers to contribute.

WAAMH contracted a consumer consultant, Trish Owen – a long-term ILP tenant – to assist with collating consumer responses to the ILP review, their views on the effectiveness of the program, their relationships with support providers, experience up to and including the ILP program, and journey through the mental health system. Ms Owen facilitated consumer focus groups in Perth and administered a short survey through Survey Monkey. The consultant was responsible only for facilitating consumer focus groups and collating consumer responses, and providing a short report which summarised the consumer data and organised it in a table aligned with the terms of reference. All consumer data collected by the consultant was reviewed by Jasmina Brankovich.

Consultations with service providers and policy makers were undertaken by Jasmina Brankovich and Colin Penter. These consultations included representatives from key stakeholder groups: community services including community housing organisations, public mental health services providers, and government agencies.

Service consultations included visits to community and public mental health services in regional and metropolitan areas. Individual and group interviews were conducted with representatives from Access Housing, Advance Housing, Foundation Housing, Uniting Care West, Rise Network, St Barts, Pathways South West, Centrecare, and Ruah; the group interviews included both management and recovery/tenancy support staff.

Group interviews and focus groups were held with North Metropolitan Health Service, South Metropolitan Health Service, and WA Country Health Service representatives, including management, nurses, psychiatrists, psychologists, and mental health support staff.

Individual community housing organisations have provided valuable data, including consumer survey results, detailed contacts between tenancy support staff and support services and other data reported to the MHC, and engagement documentation.

The complete list of organisations and number of individuals who participated in the review can be found in Appendix 1. The list of survey questions for consumers, and focus group questions for providers are in Appendices 2 and 3, respectively.

2.2.2. Data management and analysis

Data collation and management was a collaborative project. The timeframe of the review is insufficient to allow sophisticated and objective coding using software such as Nvivo; however, we were able to use manual tagging and coding to sort through the data and draw out major themes. The initial analysis, including following qualitative research protocols, data tagging and categorisation, data summaries, and the first write-up was undertaken manually by Jasmina Brankovich. Data review was undertaken by Colin Penter. Coordination of consultations, administrative and project support was provided by Justine Kamprad. Overall project management was by Chelsea McKinney.

Quantitative data from Survey Monkey tool provided ready-made responses and graphs. The qualitative data set from each different stakeholder group was initially collected in Word and Excel format. Qualitative data was read and reviewed, using common keywords across all sources, and coded accordingly. These codes were reviewed, revised, and combined into recurring themes. The recurrent themes, on which there was consensual opinion across consumers, families, carers, and service providers, were identified as key responses to the terms of reference for this review.

The literature search and review were undertaken to validate the preliminary findings, where possible, and where relevant body of academic and other research addresses the systemic barriers to supported accommodation programs in Australia and overseas similar to those we identified as arising from our consultations.

Peer review of analysis and written drafts was undertaken within the WAAMH team. Each draft was read, edited, and reviewed to conform to the terms of reference. The final report was prepared by Jasmina Brankovich, Colin Penter and Chelsea McKinney.

2.2.3. Scope and limitations of this report

We engaged fully with service providers, and the breadth and depth of consumer engagement was a significant strength of the project.

The key limitations of this report are its scope and the short timeframe provided to complete the review. The timeframe provided to complete the review within 3 months meant that this report presents the results of a preliminary review of the ILP, and it does not constitute a full evaluation.

A full redesign of the ILP would allow time and resources for a more substantial engagement with consumers. There were several variables which determined the extent of consumer engagement in the limited timeframe:

The majority of ILP consumers have little to no access to online technologies. For example, of 274 ILP tenants in Access Housing properties, only 30 have a stated contact email address. While providers agreed to distribute the survey to their tenants, lack of access meant there would be a limited response to the survey.

We liaised closely with the support staff in distributing the Survey Monkey link to consumers in regional areas, but any engagement would have been more successful after a concerted outreach, over a period of time, which could not have been achieved within the agreed timeframe for this review.

It was pointed out that most CHOs and support services conduct their own surveys of consumer satisfaction, and most consumers would have been feeling 'surveyed out', and understandably weary and hesitant about continually re-telling their stories.

The timeframe allowed only for a brief investigation into consumers' lived experience while living in the ILP program, and an exploration of options for redesign of the ILP was beyond the scope of this process.

While WAAMH is confident about the level of engagement in the process despite these limitations, a full redesign of the ILP should allow time and resources for a more robust process, more substantial engagement with consumers, co-design with consumers and providers, and more comprehensive findings.

2.3. Terminology

In this report:

Consumer and ***tenant*** are used interchangeably as people who live in ILP program are both consumers of mental health services and tenants for the purposes of the *Residential Tenancies Act* 1987 (WA).

Community support and ***psychosocial support*** are used interchangeably and refer to the community support stream as outlined and described in the MHAOD Services Plan. They are distinct from the clinical support provided by a public mental health services through a community treatment team.

Public mental health services refers to all services provided by Health Service Providers ("HSPs"), including community treatment services.

Community support services are all non-government services which provide non-clinical, recovery and tenancy support to mental health consumers in supported accommodation.

These include community housing organisations.

The terminology used in this report is informed by the *Recovery-Oriented Language Guide* published by the Mental Health Coordinating Council, second edition, 2018

2.4. Acknowledgements

We would like to acknowledge the support and partnership of Consumers of Mental Health WA (CoMHWA), and lived experience consultant, Trish Owen.

WAAMH would also like to acknowledge the contribution to the content of this report by all lived experience participants who took part in focus groups and the survey.

Section Two: An ILP Consumer's Story

My story by Trish Owen

Wanting to share with the review panel (or however/whoever these MHC reviews get sent to) a lived experience viewpoint of my experience as an end user for the ILP it. This is my life as a case study. I hope to highlight the parts of my story that highlight the immediate need for the lived experience voice to be at the forefront of systemic research/policy/plans/frameworks/governance bodies, not just in mental health and housing but across all systemic structures. My story hopes to show the impact the siloed system has had on my experience. As a living being I have not been able to separate my mental health, housing, domestic violence, parenting, welfare, employment and training into neat little departments. As each story that is beginning to be heard will highlight, the unique experiences of holistic individuals needs to be central and foundational to systemic procedures and processes. If it is not, I suffer, we suffer. Those the system is attempting to support are disadvantaged when our voices are not heard. Consumer lead peaks are rising up, are you listening? AODCCC, CoMHWA, MHM2, TAGWA...

This is my story.

When I was growing up I never learned how to deal with anger and hurt. I was taught that happiness was acceptable and every other emotional state not so. Ugh. It wasn't that these emotions weren't felt, it's just that I was taught no healthy, safe way to express them. So I didn't. I played the good girl role. Following the instructions of my caregivers (mum, nanna, teachers), not out of love but out of fear. Our punitive education (and even religious although I wasn't brought up in a church) system meant, for me that to have me need to love and belonging met I needed to perform and tick all the boxes. This was exhausting. It still can be.

By the age of 14 I found some reprieve in self medicating that emotional and mental pain within by smoking marijuana and drinking alcohol. Not really needing the social lubricant, more just needing to calm my mind down. By 17 I had managed to graduate from high school, bury my nana, piss off my mum and move out of home into a share house with a drug dealing pedophile. My mum and I lived in Homeswest back then, but she had not put me on the list so when she started to earn too much this house was lost and I was in the private rental market, where I would stay for the following 7 years.

After three years in the share houses, still working and or studying as I still had internal people pleasing propelling me from a place of fear. By my 21st birthday I'd had the required amount of mental health admissions with drug induced psychosis to then receive my own label of bipolar affective disorder. I read the literature and seemed to accept that it (the label) knew more about me than I did, so did the psychiatrists and mental health staff. I have journal entries showing evidence of my internal state at this time:

> *"What does it matter what drugs you are on if you're not happy with who you are as a person"*
>
> *"...people use drugs to forget their past or hide from their present reality"*
>
> *"I get the easy parts wrong and the hard ones right"* - regarding life challenges

Pretty insightful for a 21-year-old crazy woman! There was also evidence of me attempting to 'play the good girl' and take medication so that I wouldn't get sent to hospital again.

That's what our system was like in the late 90s early 2000s, drug 'em up, get 'em out. Many people are still paying the consequences of this systemically imposed addiction to medication. Even though I was told that I would be on medication for life, there was a voice within me that knew this was its own insanity. I used drugs and alcohol to medicate my mind and emotional states, I never saw the difference of those drugs being obtained by pharmacy, bottle shop or dealer. Each had the same end result... a calm mind and balanced or manageable emotional states.

In 2003 I had a child with my defacto partner, who also used similar means to me to deal with his mental state. I recall a time, when we lived in Kalgoorlie when we both looked at each other baffled when we had been offered to purchase (on the street) the actual medication I was prescribed. Unaware if the significance then, I am now clear that the systems gaps in helping one manage their emotional and mental state can be filled in ways that may be more detrimental to society and the individuals within that the systemic solutions we are meant to buy in to.

Becoming a mother lead to a breakdown (and proceeding breakthrough) when I found myself in a mother and child unit within a mental hospital. Depression had hit hard. I'm grateful my alcoholism (a mental, physical, emotional and spiritual disease) was misdiagnosed as bipolar back then. There is not enough help for those with similar issues and children. Rehabilitation centres for addicts are a gap within our system. After this breakdown, it wasn't long before my relationship broke down and I found myself in precarious housing. I couldn't afford the private rental after my relationship had broken up. I began staying between my uncles and a friends with my baby girl.

After the hospitalisation with my daughter, I was to be hospitalised one more time. That was in February 2004. In November 2004 I received my ILP property. There are many positive contributions I have been able to make to the world/our society since receiving my property, I think this is pertinent to point out. Since having a safe, affordable place to call home, I have not burdened our system with any more $1500/night(+/-) beds in a hospital ward. I do not want to demean my nor any other persons recovery to a monetary value. The progression of my mental health recovery journey has cost much more than money, both to myself and the system. I do want to make it clear that my recovery may not have started when I moved into my property but I am not sure it could not have started without safe secure and affordable housing.

I came into my property with basic life skills. The Independent Living Program has not provided me independent living skills. I could manage a basic/low budget, communicate with schools/childcare/service providers, I was a functioning, thrifty addict, I got by, although not always well. In 2005 I found myself a church that provided much community support. By 2007 I was studying and went off prescription medication, under the care of my GP. I helped out with children in the church and completed an education degree in 2014. Being in the independent living program didn't give me, for the first 12 years, any extra skills to become more independent or self supported. Those all came from the independent skills I already had. Each person entering ILP would have varying skills. I did therapy and groups to attain some I needed.

Many who need such opportunities like a safe, affordable home need much more than what I received when I moved into my home. The necessary links this program required on implementation were not evident to me until 2016 when my housing provider started to run focus groups asking its tenants (end users) what we thought and what we needed. I have participated in these groups and find it an important part of my recovery journey to give back

in this way. I am no longer connected to systemic mental health service providers, nor a specific religious body as I find my support through a 12 step program.

These focus groups are a great opportunity for peer support. They provide opportunities to have my voice heard and have been of huge benefit to me building skills (skills that I use on my work today). The focus groups run by my housing provider have helped gain skills like budgeting, volunteering and general networking.

The connections these groups have on the value to my life is probably hard to measure. Attending these focus groups has meant that I feel seen as a valued tenant. More than a tenant, I am a person. These groups, which we get a food voucher to support our attendance are a great avenue for communities to get together to share their experiences. The 'dress for success' workshop was great to participate in to see other tenants actually gain some hope in building something of their life. I find great value in hope being shared. Receiving a grant to complete a protective behaviours course was a great stepping stone in me starting my own business through NEIS. There are many benefits these groups hold for tenants. Just the vouchers alone have helped me build connection and teamwork with my teenager at home. She uses the vouchers and purchases shopping, its safe than giving her money. Also the continuity in her schooling and being in a decent area for schooling have been something I have probably taken for granted but are a positive result of the ILP. Even though I am no longer linked in to mental health service providers, I still have the same mental and emotional challenges. Having a home that I know is secure is a huge benefit. Earning too much is a bit of a fear. The insecurity of private rental would have disadvantages to my mental and emotional health and I could not handle full time 'normal' work which I would need if I were to buy a property. I feel socioeconomically disadvantaged in that to keep safe and secure housing which is necessary for stable mental and emotional health I need to keep financially below the threshold.

I appreciate the opportunity to share my experiences with you.

Trish Owen

Section Three: Terms of Reference

3.1 The ILP model and scope

3.1.1 Key elements of the ILP model

The ILP began in WA in 1995, as a joint initiative between the Department of Housing and Works and the Department of Health, to assist mental health consumers in living independently in the community.

The ILP was influenced by the Supported Housing model emerging in the US in the 1980s. The most important element of this model was a permanent, secure home in the community, with choice of housing and support based on consumer preference. [13]

The ILP comprises the following three key elements:

- The provision of a social housing home and a supportive landlord service through a Community Housing Organisation (CHO);
- A requirement to access clinical mental health support through a public mental health community services, a General Practitioner (GP) or a private psychiatrist;
- Access to community mental health support (sometimes called psychosocial support) through a non-government mental health service provider.

Figure 1: Key elements of the ILP Program.

The 2016 revised ILP guidelines outline broadly roles and responsibilities of CHOs, clinical mental health services, and community support providers. They also outline the criteria and eligibility for ILP, which stipulate that the prospective tenant must be currently receiving

[13] Smith, G. and Williams, T., *Evaluating the Independent Living Program, Phase 1: Policy Review*, Western Australian Centre for Mental Health Policy Research, 2008.

clinical support provided by either a GP, private psychiatrist or a public mental health service.

The model weighs clinical support as a key to maintaining the tenancy. Prospective tenants must have a diagnosis of 'severe mental illness', and all referrals are sent to the local catchment area MHS, where the assessment team makes the first important decision in accepting or rejecting the referral. The public mental health services are, in some sense, a gateway to the ILP.

The property stock constructed or purchased for the ILP has been funded under the Community Disability Housing Program (CDHP) since 2011. There are nine service providers designated as Community Housing Organisations (CHOs) by the Department of Communities – Housing who manage the property in the ILP across the state. They vary in size from seven beds in Kalgoorlie (Centrecare) to 272 beds (Access Housing) in south metropolitan Perth (for a full list refer to Appendix 1).

With a couple of exceptions (Access Housing and Foundation Housing), most CHOs provide community recovery support as well as the 'supportive landlord services to tenants. The guidelines specify roles and responsibilities of each stakeholder only in the broadest of terms, and lack definition of the 'supportive landlord'. The guidelines also have no stated outcomes for the program, or any other mechanisms by which the effectiveness of the program could be measured. (This is further discussed in Term of Reference 3.) Maintaining an ongoing tenancy is a key goal of the program, but there is no provision to aim for or track a tenant's recovery.

3.1.2 'Supportive landlord' definition

What distinguishes the ILP from other mental health supported housing models such as the Independent Community Living Strategy, is the unique 'supportive landlord' function. This function is tied to the property, not the consumer, but its intention is to ensure that tenants maintain engagement with a clinical mental health service (and other support services) to retain the tenancy. The model, however, assumes that tenants will need this clinical engagement to maintain their wellbeing.

The MHC has adopted the term 'person-centred support linked to housing' to describe the supportive landlord function as the core of the ILP model. Service providers, however, prefer the term 'supportive landlord' because it better describes their role, and because all agree that the support should follow the consumer, not the property, if it were to be truly 'person-centred'.

The scope of the 'supportive landlord' service has only been defined in 2019, as an effort by CHOs to define the model of service, and specific activities and features of the ILP which make it a unique program in the suite of 'supported accommodation' funded by the MHC. However, the CHOs were operating for decades largely without a unifying framework or clear definition of what constitutes the ILP service model since the program began. As one ILP service provider put it: "*ILP is a mish-mash of a program; different providers have different ideas about what it is. We have the ILP Forum which has been trying to resolve this for some time*."

The ILP Forum, which includes all CHOs and HSPs, has agreed to the common Definition Model of the ILP and the 'supportive landlord' function (attached in Appendix 2) in August 2019. The model includes these elements, which distinguish the 'supportive landlord' service from the service provided to general community housing tenants:

- Features of the supportive landlord model:
    - ‘Sensitive letting’: acknowledgement that ILP tenants have multiple unmet needs and letting conditions are suitable to them;
    - Strengths-based tenancy management: supportive tenancy management staff who work with the tenant’s strengths to support the tenancy;
    - Smaller tenancy portfolios relative to general community housing portfolios.

- Activities of the supportive landlord:
    - Advocacy;
    - Referrals;
    - Brokering;
    - Psycho-social support;
    - Crisis care management;
    - Collaborative decision-making;
    - Capacity building.

While the model incorporates person-centred support and practice, it is broad enough to incorporate some differences among CHOs in how they manage the ‘supportive landlord’ role. These differences have evolved from local contexts; for example: some CHOs manage their own waiting lists of clients, while others work with the area public mental health service which compiles referrals and sends recommendations to the selection panel on which CHOs sit.

This Definition Model developed by the ILP Forum provides a comprehensive description of the ‘supportive landlord’ element of the ILP, and clarifies the important differences between ILP and general community housing provision. It also clarifies responsibilities by CHOs and the scope of recovery support they provide.

The 2016 ILP guidelines should be fully revised to reflect the new model, ensure common understanding of the supportive landlord services, and how they complement other supports for ILP tenants.

Recommendation 1

The Mental Health Commission develops a clear definition of the supportive landlord component of the service model, as well as a formalised common ILP framework, in a co-design process with consumers and landlords, for inclusion in new service contracts and to better align with contemporary recovery standards. This should include consideration to the framework proposed by ILP Forum as the ILP model of a supportive landlord.

3.1.3 Level of support provided under the ILP

The success and effectiveness of the ILP is dependent on the interaction between 3 different

types of support (see Figure 1) [14]:

- Provision of a home and a supportive landlord service through a community housing organisation;
- Access to clinical mental health support through public mental health services, a General Practitioner (GP) or a private psychiatrist;
- Access to psychosocial support through a non-government mental health service provider.

Problems, failings or limitations with one or more of these three support types will impact on the capacity of services to meet tenant needs and hinder the effectiveness and quality of support and services that are delivered to tenants.

In 2018/2019, the MHC purchased approximately 8,811 hours of support under the ILP program area. It is WAAMH's understanding that these hours of support are allocated per house 'historically' – meaning that the hours of support needed have been estimated by providers at some point in the history of that property. This is the funding used by CHOs to deliver the 'supportive landlord' services to tenants. The service activities as described by providers in the guidelines, include (but are not limited to) the following:

- Tenancy support workers who connect tenants to services in the area and support the tenant to maintain their engagement with the clinical mental health services;
- Maintenance of tenant property and supportive, regular 'property inspections';
- Management of complaints and disputes, communication challenges and similar, between tenants;
- Advocacy and psychosocial support, and the development of independent living skills through workshops and other activities;
- Crisis case management;
- Brokering and referrals to appropriate services.

A significant issue raised by service providers is the challenge of being able to match the levels of personalised support to varying levels of tenant need throughout their tenancy; for example there are times in the process of recovery when the support requirements are not as high as at the beginning of the tenancy. One tenant said that 'I don't need much now… but like the idea of support being there where circumstances change'. Frequently, tenants report requiring different levels of support at different times of their lives.

Both the service providers and consumers told this review that for some consumers the current levels of support across all three elements of the ILP model - supportive landlord, clinical mental health support and psychosocial support - are insufficient, inadequate or unavailable to support those tenants in their recovery-based journey. Problematic psychosocial or clinical support access exacerbates the challenges faced by Supportive Landlord providers to match and deploy support across their tenants and offer personalised supports to those who need it.

Across the board, all nine service providers report challenges in meeting the needs of ILP tenants. Many ILP tenants identify that they have multiple unmet needs and require varying levels of clinical and recovery supports. Service providers also raise this issue with one stating: 'a key policy question for this program is what does independent mean in a context where most clients have complex needs and require a lot of support?' Providers also stated that they are providing supports they are not funded to provide because of a range of service access challenges.

[14] See 3.1.1

Challenges in accessing support may be because levels of funding are inadequate, as well as other systemic factors that make it difficult to access those supports at the time they are most needed. Some systemic factors identified in the consultations include:

- lack of clarity, in sufficient detail, about who is responsible for which elements of the ILP model;
- inadequate levels of funding for the level of support required;
- wait lists;
- restrictive criteria that exclude some consumers;
- heavy demands on services which mean they are unable to provide support at the time it is most needed;
- clinical discharge out of hospital or to the GP, often described as inappropriate or too early by ILP providers;
- different understanding and views among service providers about what type of support is needed;
- lack of staff or staff with the expertise to provide the type of support needed;
- no specialist provider of those supports being available or is not available at the time they are required; this is often the case in rural areas;
- reliance on relationships between staff of the different services in the absence of other reliable mechanisms for securing support for tenant;
- changes to federally funded programs (Partners in Recovery, Day to Day Living and Personal Helpers and Mentors Service) has removed a means of support previously available to tenants;
- the need to support tenants to access the NDIS placing an additional demand and level of service complexity onto ILP providers and psychosocial support providers.

Our consumer survey shows that of the 25 consumers that completed the question, only 50% report adequate levels of psychosocial support from community services. Consumer data from focus groups also indicates that there are significant shortfalls in the supply of recovery services relative to demand, and tells us that these gaps are largest in regional areas. This finding is echoed in government strategic policy, with the Plan highlighting the need for large increases in community support overall, especially in regional areas.

In practice, some consumers may have the supportive landlord as their only source of community/psychosocial support; this makes the ‘supportive landlord’ function all that more important in supporting the consumer to maintain the tenancy and continue recovery.

Further, the guidelines are insufficiently clear where the ‘supportive landlord’ function ends, and the responsibilities of community support providers begin. The only responsibility of CHOs, according to the guidelines, is to ‘assist consumers to access and maintain suitable accommodation and tenancies that are linked to it’. Revised guidelines should reflect accurate and precise descriptions of roles and responsibilities of each stakeholder in the ILP, as we state in Recommendation 2. This would set accountability mechanisms for the delivery of services and move to outcomes-based service delivery and reporting.

Despite these limitations, tenants comment positively on the quality of service, with 86% of respondents satisfied with their ‘supportive landlord’ in answer to the question: ‘are you satisfied with your tenancy support services provided by your landlord?’:

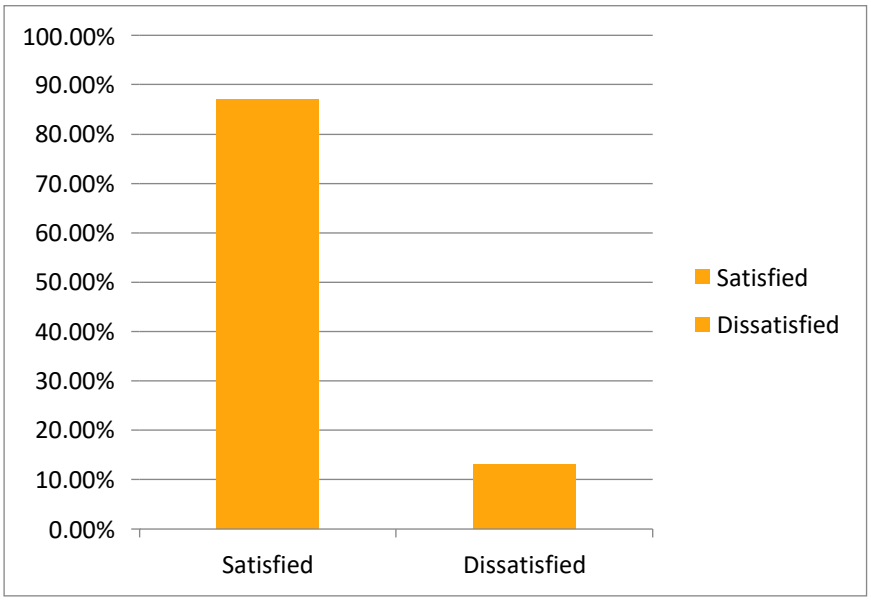


Figure 2

As one consumer noted, the supportive landlord function is what makes the ILP 'more than a roof over my head'.

Recommendation 2

The Mental Health Commission, in collaboration with service providers, revise the ILP guidelines in accordance with the national guidelines for recovery; specify outcomes for service providers, and change administration of the ILP to better become recovery-oriented.

Recommendation 3

Pending the review of Guidelines in Recommendation 2, the Mental Health Commission reviews funding for the 'supportive landlord' and 'community support' components of the ILP, in full consultation with service providers and consumers, to ensure service providers have the capacity to fulfil the guidelines and consumer support needs are met.

Additionally, if shortfalls in community or psychosocial support are identified, the Mental Health Commission explore mechanisms to expand access to this support, for example through growth in the community support stream as identified in the Plan.

3.1.4 Duration of tenure provided under the ILP

Over the long history of the ILP since 1994, there have been two conflicting messages communicated both to tenants and CHOs: the ILP property was initially regarded as a 'home for life', while more recently, there has been an emphasis on seeing the ILP as a 'long-term transitional supported accommodation' program. [15]

[15] McPherson, P., Krotofil, J., and Killaspy, H., 'Mental Health Supported Accommodation Services: a systematic review of mental health and psychosocial outcomes', *BMC Psychiatry,* 18, 2018.

ILP tenants report that they, in general, have a clinical diagnosis of 'severe, persistent mental illness', as required by the ILP eligibility criteria. Vast majority also report histories of co-occurring drug or alcohol issues, physical health issues, prolonged contact with acute and sub-acute mental health services and episodic periods of homelessness, contact with the justice system, and challenging family issues. But all have demonstrated the capacity for recovery, with appropriate levels of support from all services.

For many of those who recover, the key question remains about the ILP house being their 'forever home'. Consumers express concerns over housing security if they are reminded that the ILP house is intended as temporary, albeit long-term, accommodation. Out of 23 consumers who answered the survey question: 'How long would you like to stay in your current ILP home?', 20 responded 'forever/permanently/as long as possible'. The sense of security felt by consumers in their homes is a large element of their recovery process and so the introduction of an element of insecurity implicit in a long-term but temporary housing arrangement undermines the sustainability of a person's recovery.

There is an expectation that tenants who recover would be able to obtain unsupported housing from DoC-H or move into the private rental market. But there are also significant barriers to them doing so, not least in the lack of appropriate dwellings in the public housing stock, and unaffordability of privately leased dwellings, noting that this group of consumers experiences low levels of employment and relies on income support payments. (This is discussed further for Term of Reference 2.) Most CHO staff report that the demand for ILP housing outstrips the supply in the housing stock by far, and lack of appropriate housing that is 'fit for purpose' in the regions is at a critical point.

'Appropriate housing', or 'fit for purpose' housing simply means having a stock of housing that suits different types of needs (most ILP tenants are single and large houses are not appropriate), is close to public amenities and transport, and gives tenants a choice about where and how they live. Further data is needed to inform conclusive outcomes from ILP consumers about what 'appropriate housing' would mean, but this sits outside the scope of this review.

As a result, the average length of ILP tenancy is well over 10 years, among the consumers we have consulted.

For both tenants and the CHOs, the ILP house as 'forever home' is a key policy question which requires clarification at the policy making and cross government level, because it has impact on the 'supportive landlord' definition, and the level and type of services accessed by the tenants during and beyond the tenancy. International literature findings on supported accommodation and psychosocial outcomes, however, are clear that '*the most robust evidence supports the effectiveness of the permanent supported accommodation model in generating improvements in housing retention and stability.*'[15]

There are systemic issues that both drive and result from this key policy question including the impacts on social and community housing demand, the ability for other mental health consumers to access needed supported accommodation services, the ability to discharge people from hospital into appropriate support, and the impact of changes to one program potentially impacting others.

These issues will be explored in more depth in the Flow Project (Supported Accommodation Referral Framework) that the Mental Health Commission has contracted WAAMH to undertake.

Recommendation 4

The Mental Health Commission clarifies whether the ILP is intended to be a transitional model as part of a comprehensive accommodation pathway for people with serious mental health issues, or a home for life. If the former, the other pathway components should be designed and commissioned with some urgency and incorporate the principle of no reduction in support or loss of housing stability for current ILP consumers. These should include not only pathways towards alternative secure housing but also mechanisms to improve people's ability to sustain private housing by increased income through employment. If the ILP is intended to be a home for life, the Mental Health Commission investigates, with the Department of Communities, options for maintaining the current stock allocated to the ILP as the permanent accommodation for consumers who need it.

3.1.5 CHO tenant worker relationships with other services

This section describes roles and responsibilities of service providers, specifically the relationships between tenancy support workers in CHOs, and public mental health services and community support services. Key aspects of the ILP model are described in section 1.1; in this section we examine how the service linkages work, and what impact they have on ILP tenants.

3.1.5.1 Community support provided by NGO

In most cases, as well as being the 'supportive landlord', the CHO is also the main provider of psychosocial support to tenants and assists with maintaining tenant engagement with the public mental health services (including community clinics, GPs, and private psychiatrists). CHOs such as Uniting Care West, Rise, St Barts, Pathways Southwest are also some of the key NGOs providing support services in the sector. While psychosocial support is not explicitly tied to the ILP property, clinical mental health support is a condition of tenant engagement.

This dual role of CHOs is important in the context where support is tied to the property, not the person, and there is a general shortage of support services, as is the case in regional WA. If there is no strong fit or alignment between the supportive landlord and the psychosocial support service, the outcomes for clients may be generally poor, especially if clients also disengage from clinical mental health support. Consumer choice of support services is therefore extremely limited in regional areas. CHOs which do not provide psychosocial support employ tenancy workers who assist tenants to link with appropriate support in the catchment area.

Consumer data suggests that there are no major differences in levels and types of support, whether that support is provided by the CHO or another support organisation. For example, our survey sample included a large number of tenants in Access Housing and Uniting Care West, two of the largest ILP providers, who have respectively different roles: while Access Housing does not provide recovery support services, but relies on other services to support their tenants, Uniting Care West is a dual support provider, providing both supportive landlord and recovery support. But consumer satisfaction is equally balanced and consumers from both agencies report same levels of satisfaction with the support provided,

reflected in 86% positive response overall.

Irrespective of the details of engagement, the relationship between the function of 'supportive landlord' and the psychosocial support function is critically important to successful recovery. However, a comprehensive analysis of the dual function of supportive landlord, was unfeasible in the time granted for this review.

3.1.5.2 Clinical support

Clinical mental health support – provided by a GP, psychiatrist, or area mental health service – is, however, central to the ILP model. As noted above, engagement with clinical support is a condition of applying for ILP. Area public mental health services also manage waiting lists and assess applications for further consideration by the ILP selection panel. In short, clinical mental health service have considerable responsibilities in the ILP.

The ILP guidelines stipulate the roles and responsibilities of clinical mental health services, psychosocial and community support services, and the CHOs, in broad terms. In practice, however, the relationships between the different sectors vary in the quality and level of communication and collaboration, and this has the flow-on effect on tenants. In order to provide a holistic and person-centred recovery-oriented practice, the model would benefit from a tighter collaboration between all services needed by the tenant.

Challenges faced by services in regional areas, where there is a lack of many transitional and crisis care programs, are particularly revealing about the need to broaden the supports along with appropriate funding. One CHO/support provider in a regional area gave us the following response to a question about service collaboration:

> *Link with services? There is none. If a consumer decides to disengage, there are no attempts to bring them back. There is no ongoing care for the majority, either clinical or psychosocial … We are the last person to know if the clients go back to hospital – and only if we notice they are not at home and we call the hospital to check.* (CHO tenancy worker)

The illustrative quotation above, provided by a regional tenancy worker, demonstrates the difficulty providers have of linking and securing support for people where that support is insufficient or completely lacking in the geographical area.

There is a common view among the majority of CHOs that the clinical support services are provided at a level that is insufficient to provide the necessary support relative to ILP tenant need. However, the North Metropolitan Health Service and the CHOs which operate the ILP in this region, provide a workable model of service collaboration, which this is detailed further below.

There is also a shared understanding that area mental health services, in particular, are precariously placed as the first place of referral, and subsequent discharge into the ILP property. Area mental health services are often left with no other options but to discharge clients into the care of a GP, which opens another set of problems impacting on continuous and adequate clinical care for the ILP tenant, as described by another worker:

> *It is impossible to have an exit plan for tenants who do not have contact with the mental health service. GPs who take over the care of clients from the mental health service, are often not trained or educated enough to provide the level of service that is required by ILP tenants.* (CHO tenancy worker).

While we acknowledge that the Commission's contractual arrangements require CHOs to link their tenants with the most appropriate support providers, both clinical and recovery support, this is not effective in practice and is dictated by the resources available to all service providers to meet consumer needs. CHO tenancy workers cannot hold the whole responsibility for consumer engagement with the public mental health services, because of structural limitations of the mental health system. The imbalance is highlighted in regional areas, in particular in those lacking inpatient hospital units (Geraldton, Bunbury, Busselton). (The service gaps will be analysed more closely in the Flow project forthcoming from WAAMH).

Where there is a large gap in the capacity of area mental health services to respond, it can have tragic endings in situations of emergency:

> *There was a client who required urgent help on a Friday, saying that he would commit suicide, and that he could not last. [HSP] never responded to him, and he was found dead from an overdose on the Monday after. We do not know if his death was accidental overdose, but once it happened, then they wanted to get involved and started getting in contact! But it was impossible to reach them earlier. They were just not responding.* (CHO tenancy worker) [16]

Service collaboration in the ILP varies from region to region, and the scope of this review is not sufficient to examine in detail what the more collaborative model would look like. But it is clear that consumers should receive the types and quantity of support that they see necessary for their recovery and that the systemic changes that need to happen to achieve this include improved service collaboration.

3.1.5.3 Case study: How the ILP works in north metropolitan area

The North Metropolitan Health Service (NMHS) is one of 4 Health Service Providers in the state. It works closely with Uniting Care West (UCW), one of the largest ILP providers with 221 properties in the north metropolitan region. Both organisations describe their relationship as strong; their staff communicate regularly, and meet quarterly to discuss how to work better together. They have an MOU which outlines respective responsibilities, and specifies respective tasks and duties.

The NHMS employs a community engagement officer, and identifies staff with responsibility to allocate housing, manage waiting lists, collate referrals and quality check the documentation. There are staff responsible for supported accommodation at each site across the north metropolitan region.

Decisions on intake into the ILP are made by a team which includes the CHO and clinical support providers. It is a critical point for the consumer because important decisions are made about their support plan for the future, which determine the levels of support they receive and their recovery. As one CHO explained: *"We have regularly given presentations to clinicians about what we do, so they have us in mind when relevant consumers come along. … Mental health clinicians [in the NHMS] know who we are, and that makes a difference."* (CHO manager)

The NHMS manages the waitlist for UCW, which means that the public mental health service is a constant mechanism. The strength of the model, as reported by both agencies, is that the clients are matched with the most appropriate house.

[16] These 3 comments were made by tenancy workers in 3 different CHOs in metropolitan and regional areas.

To improve service integration, all CHOs develop memoranda of understanding with community support services and mental health services. This highlights the effort of CHOs to build and maintain positive relationships and clearer understandings of roles and responsibilities.

Thus, it is not an absence of documented processes, more so that relationships between CHO workers and services are affected by external pressures, such as demand and discharge pressures faced by clinical teams, the limitations of primary care for ongoing clinical support, and inadequate funding for both community services and the level of support hours allocated to ILP houses.

In summary, service collaboration in the ILP varies from region to region, with problematic impacts on consumer recovery and the fidelity of the model. The MHC should consider improvements to the integration aspects of the model design and seek buy-in from all relevant providers to support the achievement of improved outcomes for people accessing the ILP, regardless of the region in which they live.

Mechanisms for further exploration might include contractual mechanisms that formalise work practices and obligations to facilitate collaborative teamwork across agencies, the development of minimum standards, and the development of shared reporting requirements, based on the outcome's framework.

Approaches that appear to warrant development include the identification of a dedicated staff member in the clinical team, with the specific role of linking CHOs and community support providers, as is the case with NMHS.

Recommendation 5

The Mental Health Commission works with HSPs to develop strong collaborative team-work models that improve ILP consumer outcomes and reach recovery goals. That these models are formalised as contractual obligations by HSPs and regularly evaluated by the MHC.

3.1.6 Processes of engaging and supporting ILP tenants

Successful implementation of processes to support ILP tenants and engage them with other services depends heavily on several variable factors:

- Individual management style and the relationships developed between staff who are responsible for service delivery influence communication and collaboration between organisations. In smaller towns and regions, in particular, these relationships shape to great extent collaboration with both positive and negative consequences for ILP tenants: where these relationships are strong, outcomes for tenants are better.
- Resources available to employ tenancy workers and other support staff in CHOs and facilitate the connections with other services need to be improved.
- Resources available to clinical support services to liaise and work together with other support services also need to be improved. Where a public mental health service has identified community development staff, the relationship between clinical mental health services and CHOs is strong and enduring, with good outcomes for the tenant.

There is an opportunity for any future workforce planning for capacity building in the primary mental health sector and clinical mental health services:

> *Clinicians generally do not understand the importance of housing for someone's mental health. Some of them do not see how it belongs within the recovery framework or what its role is. There should be serious consideration given to building the workforce which is educated about recovery-based approaches to mental health.* (CHO tenancy worker)

Co-occurring conditions, particularly the use of alcohol and other drugs, and the need to access appropriate services in a substantial proportion of ILP tenants, is an ongoing issue. There is a widespread perception that alcohol and other drugs sector is a 'silo' still separate from mental health services.

> *There is very little service integration and getting each specialist to recognise the importance of cooccurring conditions is difficult. Why is that so when this happens to 80% of our tenants? (CHO tenancy worker)*

In regional areas, absence of rehabilitation and detox facilities, and Step-Up Step-Down services, and transitional programs which assist in management of alcohol and other drug use, is acutely felt across supported accommodation services, including the ILP. While more recently, there has been increased focus and new Step-Up Step-Down services opening in regional areas, our consultation data indicates that this is not occurring at the required level to meet community needs.

Recommendation 6

The Mental Health Commission improves in integrating mental health and alcohol and other drug service planning, and raises the capacity across the public mental health and community sectors to work in an integrated manner with ILP consumers.

3.1.7 Differences between ILP tenants and general tenants

In general, services observe that tenants in community housing are not dissimilar to tenants who are in the ILP: both groups engage with community housing because private rental and home ownership markets have not been accessible to them. CHOs have told this review that most tenants come from disenfranchised backgrounds, and suspect there is high prevalence of undiagnosed and untreated mental health problems in the general community-housing population.

CHOs respond to these challenges by working to establish relationships between different groups of tenants, such as in organising communal activities. The Definition Model clarifies the differences in service provision to general tenants and tenants in the ILP. The key differences are in resources available for any support coordination by CHO, which is higher for ILP because of the 'supportive landlord' funding. But it also means that CHOs absorb more readily any commercial losses incurred by ILP tenants than that is the case for tenants in the general community housing stock.

Generally, CHOs report that general tenants have shorter length of stay, and have more opportunities to leave community housing. However, long waiting lists for community

housing in general demonstrates that there is substantial shortage relative to demand.

3.2 Barriers to private rental accommodation and options to address them

While successful transition to private rental does work for a small number of supported accommodation consumers, there is a strong and consistent view among those consulted that private rental is not currently [17] a viable option for most consumers in supported accommodation.

Supported accommodation providers and clinicians suggest that transition to private rental from the ILP is an option that can and does work for some consumers; however, this has happened in a small number of cases. Each service was able to describe one or two clients who over time had made the transition to private rental, however the numbers are small.

There is a strong view among ILP accommodation providers and clinical staff that private rental is not an option for the majority of ILP clients and that a small number of tenants in supported accommodation have the capacity to access and sustain private rental, without considerable support (including financial, psycho-social, clinical and tenancy support).

However, private rental accommodation is the most common form of accommodation for people with lived experience of mental ill health. [18] As the proportion of affordable public and community housing available to people with mental health issues declines relative to demand, programs and services to support people with mental health issues to access and sustain private rental become more important as a vital element in the suite of supported accommodation support programs and services.

3.2.1 Barriers to private rental

3.2.1.1 High cost and limited availability of low-cost rentals

The high cost of private rental and the amount of their income that people are required to pay is seen as a major barrier byservice providers, clinicians and supported accommodation tenants.

The private rental market has failed to provide affordable housing for people with low income or those receiving government income support. The Anglicare Rental Affordability Study found that private rental is largely unaffordable for people receiving Newstart, the Disability Support Pension or government income support. [19]

The snapshot found that nationally just one property was affordable for a person receiving Youth Allowance and just two properties were affordable for a single person on Newstart. Only 4% of rental properties were affordable for households receiving government income support.

Affordability and associated issue of security of tenure are well-known as major deterrents for most community housing tenants from exiting into private rental housing. [20] A particular problem for mental health consumers is that the decline in affordability is greatest at the

[17] Changes being proposed to the WA Residential Tenancies Act by groups such as the Make Renting Fair Alliance, if accepted by government and incorporated into a revised Act, could have the effect of making private rental a more appropriate tenure for people with mental health issues in supported accommodation.

[18] Brackertz, N, Davison, J & Wilkinson, A (2019) Trajectories: the interplay between mental health and housing pathways A short summary of the evidence, report prepared by AHURI Professional Services for Mind Australia, Australian Housing and Research Institute, Melbourne 2019.

[19] Anglicare Australia, Rental Affordability Snapshot, National Report, April 2019.

[20] Wiesel, I., Pawson, H., Stone, W., Herath, S. and Ncnells, S., *Social Housing Exits: Incidence, motivations and consequences,* AHURI Final report 229, AHURI, Melbourne, 2014.

bottom end of the private rental sector.

In places like Margaret River, Busselton, and Albany the high cost of private rental combined with the shortage of low-cost rental properties are major barriers to tenants transitioning from supported accommodation. In Bunbury, private rents had fallen somewhat but are still expensive for people on low incomes or income support.

In Albany, several mental health consumers described how a lack of affordable private rental meant that they had to move from the town to find rental accommodation in small towns and on farms located considerable distance from Albany. This made it difficult to access mental health services and support and find employment. This also increased people's isolation from family, children, friends and support and increased their costs due to the high price of petrol.

3.2.1.2 The challenge of accessing private rental accommodation

The process of finding and accessing private rental can be challenging and demanding for mental health consumers. Knowing how to find a property and having to deal with property agents and landlords and to provide all the necessary documentation and requirements is stressful and anxiety producing. Many mental health consumers require assistance and support to access and inspect properties and to present themselves to agents and landlords. In one example, a worker from CHO related experience of an ILP tenant who was preparing to move out of the property and was seeking private rental, having already obtained full-time employment and progressed well in recovery. The tenant's needs included support to approach landlords and attend 'home opens' outside of normal business hours and on weekends, which was impossible to meet because of lack of resources.

Understanding their responsibilities and rights as a tenant in a context where tenants have only limited rights and the power lies with landlords and agents is a significant challenge for all tenants, not just mental health consumers.

The financial costs of accessing and establishing a private rental tenancy are also a barrier. Finding the money for a bond and being able to pay rent two weeks in advance places a severe financial burden on people receiving benefits and income support or with limited savings and/or income.

3.2.1.3 Lack of security of tenure and threat of eviction

Another significant barrier for people with mental health issues is the lack of security of private rental. Leases are usually for 6 or 12 months and most tenants have no long-term security and can be evicted 'without cause' or reason. Short, insecure tenancies make life unstable and have serious mental health and wellbeing impacts for many tenants, particularly mental health consumers.

ILP clients expressed concern about their capacity to manage in private rental when they are unwell. They fear that when they are unwell, they are more likely to be evicted. At the moment, there are no mechanisms available for situations when tenants exit supported accommodation, but meet with a challenge in the recovery process or get unwell after leaving their support behind. In many cases, these consumers will return to homelessness, and back to where they were before they entered supported accommodation. We have

heard from several ILP clients who had lived in private rental, described how they were hospitalised when they became unwell and then ended up being evicted from their private rental property.

Service providers and clinicians describe examples of situations where mental health consumers were evicted or faced the likelihood of eviction from private rental as a result of behaviours arising from their mental health condition. In those cases, the behaviour created problems for neighbours, housemates, property agents or landlords that resulted in the threat of eviction or of eviction itself. In addition to the risk of homelessness, eviction can have serious and long-lasting mental health impacts and result in consumers being re-admitted to hospital.

Australian research found that people with disabilities, including psychosocial disabilities, in the private rental sector are almost twice as likely to experience a 'no grounds eviction' compared with other renters. [21]

The inability of WA's tenancy laws to provide security of tenure and to provide tenants with greater protection is a critical problem that affects mental health consumers.

3.2.1.4 Stigma and discrimination

Stigma and discrimination and the lack of understanding and awareness about mental health issues among property agents and landlords also contributes to the vulnerability of mental health consumers in private rental.

A 2008 study by SANE Australia found that 90% of the respondents experiencing high and low levels of mental health issues reported discrimination when seeking private rental. [22]

Mental health consumers often find themselves at the bottom of the application pile. It is not unusual for them to have to submit numerous applications. Real estate agents have a significant say in who accesses private rental by assessing, selecting and recommending prospective tenants to landlords, and mental health consumers are at a significant disadvantage. Consumers and services providers identify that negative attitudes among property agents and landlords act as a barrier to access.

3.2.1.5 Exploitation of tenants

Fear of exploitation by landlords, property agents and housemates is a concern expressed by CHOs, clinicians and ILP clients. One ILP client described experiences with 'slum landlords', and service workers identified numerous examples where consumers were exploited by unscrupulous private landlords who charged exorbitant rents for a single room, or in one case for a single bed in a small room shared with another person.

During the consultations we heard stories of private landlords and other tenants in private rental properties who took advantage of the vulnerability of consumers who found themselves forced to live in marginal housing in the private rental market because no other options existed.

[21] Choice, National Shelter and the National Association of Tenant Organizations (2018) Disrupted: The consumer experience of renting in Australia, Choice, National Shelter and the NATO.
[22] Cited in Brackertz, Wilkinson & Davison 2018.

The fact that these experiences are reasonably common among mental health consumers highlights why many are hesitant and concerned about private rental as a housing option.

3.2.1.6 Onerous conditions

The onerous requirements and conditions of private rental, such as paying a large bond up-front, three monthly inspections, difficulties getting maintenance done, changing methods of paying rent, lack of clarity about normal 'wear and tear', responsibility for 'damage', complex contractual arrangements and disagreements over bond disbursement create difficulties for mental health consumers. Disputes over bond distribution are a common occurrence in private rental and a source of considerable stress and anxiety.

Several ILP clients spoke about the challenges they face in meeting these conditions and requirements as a deterrent from considering private rental.

3.2.1.7 Anxiety about regular moves

Because of the insecurity of private rental, service providers described consumers' anxious and concern about having to move away from supports, services, family, friends and known and familiar routines and places due to the insecurity of private rental and the need to make regular moves.

Having to move regularly is also costly as tenants must pay rent on 2 properties, as well as a bond on a new property before they receive the bond back on the first house. They also must pay costs associated with moving to the new house.

3.2.1.8 Lack of support

Another barrier is the lack of tenancy, psychosocial and clinical support available to people who transition to private rental from supported accommodation.

3.2.1.9 Poorer housing conditions

The private rented sector tends to have worse housing conditions than any other sector. Conditions such as excess cold and heat, poor ventilation, water leaks, damp and mould, pest infestation, poor air quality, lack of insulation, poor security, physical risks, exposure to dangerous substances and chemicals, lack of safety devices and poor energy efficiency can directly affect physical health and mental health.

3.2.2 Actions to address barriers

Some actions that would make the private rental sector better able to house people with mental health issues currently housed in the ILP include:

- Reduce cost of private rental through rent stabilisation and rent controls;

- Increase levels of rent assistance and/or provide rental subsidies;
- Develop recovery mental health supported accommodation programs; designed to enable people to enter and sustain private rental tenancies;
- Develop social and ethical landlord responsibilities among property agents, landlords and real estate sector;
- Make the private rental sector more fit- for- purpose; and
- Reform the *Residential Tenancy Act 1987* (WA) accordingly.

While we acknowledge that most of these reforms fall outside the remit and responsibilities of the Mental Health Commission, there are some actions that the Commission could take. One such action is to develop a specific recovery oriented mental health supported accommodation program, designed to transition people from the ILP and other supported accommodation to enter and sustain private rental tenancies.

3.2.2.1 Private rental supported accommodation programs and services

Private rental accommodation is the most common form of accommodation for people with lived experience of mental ill health.[23] However, there are few supported accommodation services or programs specifically designed to assist people with mental health issues who require support to access and sustain a private rental tenancy for the long haul. This is a major gap in mental health supported accommodation.

Across Australia, some private rental support programs and services have been developed and although these do not specifically target mental health consumers, people with mental health issues may benefit from these programs

These programs have demonstrated some success in assisting people with complex needs, including mental health issues, to access and sustain private rental tenancies over time.

3.2.2.2 Australian initiatives

- *Doorway*

An example of a private rental supported accommodation program/service for people with persistent mental health issues is the Doorways program in Victoria.

Doorways is a Victorian government program delivered by Wellways for people with lived experience of persistent mental ill-health who are at risk of or experiencing homelessness.

Doorways aims to support participants to access and choose private rental through the open rental market and provides support to sustain the tenancy through the combination of time limited subsidised rental payments, support to develop living skills and tenancy skills and build natural support networks and clinical support.

Doorway workers are embedded in public sector acute mental health services and provide housing and recovery inputs to care.

[23] Brackertz, Wilkinson & Davison 2018.

The program partners with the Real Estate Institute of Victoria to support both the tenants and agents.

An evaluation of the program found that the model is successful in securing housing for people with mental health issues and delivers additional benefit in client outcomes, alongside reduced use and cost of mental health and other services. [24]

- *NSW Private Rental Brokerage Service*

The NSW Department of Family and Community Services' Private Rental Brokerage Service assists people with complex needs who have support arrangements in place to find and sustain accommodation in the private rental market. People who may be eligible for the service include mental health consumers with physical illness, drug or alcohol issues, a physical or intellectual disability or other needs.

3.2.2.3 WA initiatives

In WA there are no specific private rental supported accommodation programs or services to support people with mental health issues to transition from supported accommodation or public and community housing and to access and sustain private rental accommodation.

However, several private rental supported accommodation services have been developed for people who are homeless or at risk of homelessness and people on the Department of Communities - Housing social housing wait list.

- *WA Assisted Rental Pathways Pilot*

Launched in 2017, the Housing Authority's Assisted Rental Pathways Pilot offers tiered rent subsidies and individually tailored support services for up to four years to help people succeed in the private rental market. The aim of the Pilot is to assist participants to build their skills and personal capacity to become self-sufficient in the private rental market.

Participants are carefully assessed for their suitability and must have a good rental history and minimal debt to be eligible. They receive a tiered rental subsidy and can access individually tailored support services, provided by community service organisations, including Centrecare, Multicultural Services Centre of WA Incorporated, Outcare Incorporated and Salvation Army Australia.

Landlords are guaranteed rent for the duration of the residential tenancy agreement with the tenant. Rental amounts are adjusted annually in accordance with the Australian Bureau of Statistics' Consumer Price Rent Index for Perth. The Housing Authority will also pay landlords up to $5,000 for any out of pocket expenses for property damage after the application of tenancy bond and insurance proceeds.

An evaluation of the pilot has just been completed.

- *National Partnership Agreement Homelessness Private Rental Tenancy Support*

[24] Dunt, Dr, Benoy, AW, Phillipou, A, Collister, LL, Crowther, E, Freidin, J & Castle DJ (2017) 'Evaluation of an Integrated housing and recovery model for people with severe and persistent mental illness illness: The Doorway program', Australian Health Review, 2017, 41, 573-581 http://dx.doi.org/10.1071/AH16055

Services

The Private Rental Tenancy Support Service (PRTSS) is one of several programs funded under the joint Commonwealth/State National Partnership Agreement on Homelessness. Services currently operate in North West metropolitan, South West metropolitan, Metropolitan CALD clients, South West and Great Southern. The PRTSS aims to prevent eviction from private rental tenancies.

Funded services assist eligible families and individuals experiencing difficulties maintaining their tenancy in the private rental market to stabilise and maintain long term accommodation. Funded services provide support to tenants to address debts, unpaid rent and other tenancy issues to ensure these issues don't become too large or eviction processes start. Services liaise with landlords and property agents to facilitate the maintenance of tenancies. Service also have access to a small amount of brokerage funds to use to maintain the tenancy.

A three-year evaluation of the program found that it was successful for those accepted into the program and has assisted families and individuals to deal with immediate and short-term crisis that placed their tenancy at risk. The evaluation found the program has delivered significant housing and non-housing benefit for clients and been able to reduce and prevent homelessness. [25]

- *20 Houses for 20 Lives in Fremantle*

The recently announced 20 Lives 20 Homes Project in Fremantle will attempt to house homeless people in the private rental sector and provide support to assist them to retain their tenancy. The project will be a two-year pilot program.

Private rental properties will be leased and managed by a community housing provider. Tenants will pay a reduced weekly equivalent to 25% of household income, with a rental subsidy paying the additional rent for a time limited period

Outreach and intensive wrap around support, including after-hours support, will be provided to tenants by non-government community service organisations.

These programs share several elements/features:

- Private properties are sourced and managed by an NGO housing provider who acts in the role of a supportive landlord;
- Property owners are offered support to select a tenant and to ensure rent is paid and the property is maintained;
- Property owners have a level of security that rent will be paid;
- Referrals can be made by a variety of sources;
- NGOs may source suitable rental properties and provide various forms of support;
- NGOs provide individually tailored wrap-around support to tenants, including in some cases after hours support;
- NGOs provide ongoing tenancy and psychosocial support to assist the client to maintain their lease;
- NGOs provide support and assistance to link tenants with existing community

[25] Cant, R, Meddin, B & Penter C, National Partnership Agreement Homelessness: Evaluation of WA Programs Final Report, Evaluation report prepared for the Department of Child Protection, March 2013.

services and resources. Brokerage funds are available to address specific needs the tenant may have that will benefit their capacity to sustain their tenancy e.g. to purchase household white goodsor household cleaning products, to participate in a course or training program;

- Tenants only pay 25% of their income as rent and rental subsidies are provided fora defined period. However, one problem with time limited rental subsidies is that once they are withdrawn the sustainability of private rental tenancies becomes precarious. The result can be that people find themselves homeless or readmitted to hospital and/or they need to relocate back to public and community housing or supported accommodation.

Recommendation 7

The Mental Health Commission initiate a process of collaboration with relevant agencies across all sectors to assess the feasibility of introducing a private rental scheme for ILP tenants.

3.3 Effectiveness of the ILP model

In addressing this term of reference, WAAMH has collated major points made in consultations by consumers and community support providers, and mental health services. Specifically, we highlight instances where there was consensus among all groups of stakeholders on what elements of the ILP model worked well, and what areas needed improvement.

There are a number of factors which mean that this review had a limited capacity to measure overall effectiveness of the program. First, the timeframe available to complete this project was insufficient for an in-depth evaluation of the ILP that would allow detailed feedback from consumers and agencies. Second, the ILP has not been evaluated since 2006, and this evaluation did not include consumer feedback, nor did it measure the impact of the ILP on consumer wellbeing and their recovery journey. Since then, the mental health landscape has undergone considerable change. A thorough evaluation of the ILP would be more appropriate to determine the program's overall effectiveness and inform any design changes that arise. Third, the services report to the MHC on outputs, not outcomes. It is not possible to measure effectiveness without the baseline data on outcomes that are agreed by the sector and consumers.

Despite these limitations, the consultation and engagement into the review was very robust, and the views of service providers and consumers were consistently aligned in their support of the program itself and the supportive landlord component of the model. As such, the review provides some evidence to determine findings and recommendations which identify ways to make improvements to the model and the landscape in which it is provided. Should the Mental Health Commission wish to pursue major changes to the service model, a thorough evaluation of the ILP is warranted, but at this point, it is not an urgent requirement.

We were able to identify some outcomes and impacts of the ILP on consumers, and assess them against the MHC's *Mental Health Outcome Statements*, however, but recommend the development of program-specific outcomes aligned with the recovery model.

Recommendation 8

The Mental Health Commission develop an outcomes framework for measurement and reporting, including baseline indicators and methodology which would track the program's effectiveness.

3.3.1 Consumer satisfaction

Consumer narratives and comments collated from focus groups and the survey, speak strongly about the importance of the ILP for recovery and improved quality of life. Ms Owen, the lived experience consultant engaged for the project, has submitted her life story to illustrate the impact of the ILP program on her recovery, in Section Two.

One focus group participant told her story of the impact of the ILP:

I was studying when I had a breakdown as a consequence of long-term, family trauma. I was also anorexic, and was diagnosed with bipolar by a GP. I went mute for a little while … Ruah connection was wonderful, helped me find ILP property and that helped me cut off contact with my family. My 19-year-old son is a university student and works part-time; very positive relationship. Ruah support is so helpful I do not have a need for a psychiatrist. I've learnt lots of skills. I started a newsletter for the other tenants.

The consumer consultations demonstrate that the effect of ILP has been life-changing. Tenants often speak of empowerment and independence they achieved: '*[The ILP] allowed me to achieve a level of Independence that would not have been financially possible*.'

There is consensual agreement among consumers that the 'supportive landlord' function in combination with the adequate supports has been effective in preventing a return to hospitalised care, or minimising the need for a return to hospital. Of 23 consumers who completed the survey question on re-hospitalisation, 11 had not returned to hospital at any point in their tenancy. Twelve consumers did seek re-hospitalisation, but found the support provided by CHO at that time very adequate (one of these responses includes a Hospital in the Home on two occasions for a single consumer). Those who did report a time spent in hospital while in the program, also comment that having a house to return to was a relief, important to their sense of safety, making the recovery quicker.

At least ten consumers reported experiencing a loss of private rental as a consequence of mental health challenges, and regarded the eventual referral and acceptance into the ILP program as preventing them from homelessness.

> *Access Housing, has supported myself and my wife. I have schizo-affective disorder and my wife has schizophrenia. Without stable tenancy, we would be homeless. Prior to moving into Access Housing, I moved houses 13 times in 10 years. I had a period of depression for 15 years, when I was unable to get out of bed.*

The security and safety of the ILP program – countering fear of '*being kicked out on the street*' from a private rental – means that 'having a secure house is that one thing that's important when you are feeling vulnerable'. Another workshop participant listed her achievements in the program, which other consumers could relate to: 'ILP = safe, studying,

breaking abuse cycles, home, healing, security, self-care.' People feel safe at their home, and the rent levels in the ILP considerably alleviate their financial concerns. Safety is one critical to MHC Outcome Statements, and the ILP secures this alignment well for those tenants who enter the program.

We asked mental health consumers about suggestions where services could improve, with appropriate funding, in supporting their recovery. Half of all respondents (n=64) to our questions about 'ways forward' for the ILP, cited loneliness and isolation, and insufficient learning activities that develop independent living skills, as gaps in current supports. Service providers noted these same needs and gaps also. While CHOs provide social activities as part of their supportive landlord function, such as monthly get-togethers, newsletters, and festive occasions, there is a need for increase in types and levels of these and additional activities.

The following suggestions relate to improving the capacity of community support services and complete a shift to personalised support (as the supportive landlord funding is attached to the property, not the consumer) to deliver for a range of consumer aspirations:

- Free or affordable activity groups in crafts and arts, but also practical skills such as cooking, budgeting;
- Group discussions for peer support;
- Skills trading service among tenants;
- More social events and allowing pets – both to disrupt feelings of loneliness and isolation;
- Activities in nature – such as walks.

Not all consumers reported needing high levels of support, with some feeling secure that crisis care was always at hand should they need it. The levels and types of support required by consumers are highly individual matters. But at least three of them agreed with the sentiment expressed by one of their fellows in a focus group:

> *Mental health is stretched to its limits. Too many falling between the cracks or forgotten about. Need better facilities and more consumer involvement towards their needs.*

Overall, ILP is much more than a house, but a life-changing opportunity for consumers to achieve recovery on their own terms: '*It has allowed me ... to be whole in myself for the first time in my life, and being in Access Housing lets me do this.'* Consumer satisfaction with the program is high; mental and physical health outcomes improve with the security of a long-term home; consumers develop enriching relationships.

Although the capacity of CHOs to work with consumers in developing skills, abilities and reaching aspirations, should be improved, and mechanisms introduced to ensure support is better aligned with individual needs, the ILP overall is a sound program. It has benefitted a significant number of consumers over the course of its history, but it should be improved in accordance with Recommendation 2 in Section 3, so that its outcomes are personalised and aligned with consumer goals.

3.3.2 Lack of appropriate housing stock

A universal comment made in consultations by service providers was that an acute lack of

general community and public housing stock, accessible to ILP tenants exiting the program, is a major cause of frustration. The inevitable consequences of chronic underfunding of public housing is that it severely limits ILP tenants in their recovery and housing options. There have been clear examples where consumers recover when they are provided with appropriate support and wish to exit the ILP into a wholly independent life in the community, but this is curtailed because the waiting lists are long for the only housing market that is financially accessible to them.

This is an issue of both quantity and quality of available housing stock. Each and every service provider we have spoken to in the course of our consultations had at least one example where the lack of maintenance on a property has caused it to decay to the point of being uninhabitable; or where the vacant properties such as four-bedroom houses were inappropriate for single consumers with no dependents; or where an available property was considered to be in an unsafe location for the next consumer on the waiting list.

The CHOs manage properties on behalf of the Department of Communities – Housing or a regional housing provider such as Community Housing Limited (Geraldton), except where the CHO also owns some properties with the internal capacity to allocate them to the program (such as Advance Housing in Bunbury and Pathways South West in Albany). This means that larger providers have an opportunity to allocate internal stocks to the ILP program and make ILP-identified houses available to the tenants on the waiting list. However, most CHOs do not have that flexibility, and the lack of appropriate housing in the general housing supply in Perth is a major blockage towards meeting the recovery goals of people with multiple unmet needs.

Lack of appropriate housing is an issue that requires a whole of government approach, and sustainable funding to meet the unmet needs of mental health consumers. At the moment, 60,000 houses are needed to meet demand across the state, with 14,000 social housing applicants on the waiting list. [26] This is matter of urgency for mental health consumers in the state, and the key to achieving the goal of exiting consumers who are ready to start living independently in the community.

Recommendation 9

The Mental Health Commission establish a robust mechanism to assess chronic shortages in supported accommodation for mental health consumers and identify ways to address them.

3.3.3 Reforming the ILP on recovery principles

The ILP was introduced in the immediate aftermath of 'deinstitutionalisation' when the language of recovery and recovery-led service provision did not yet make inroads into the thinking in the mental health sector. However, for it to be a program fit for the current landscape, the program and its guidelines should be modernised in accordance with the principles of the National Recovery Framework for mental health services. The changing nature and understandings of recovery, and the requirement that all agencies funded by the MHC conform to National Standards for Mental Health Services, has implications for CHOs, who, as providers of both psychosocial and landlord services to mental health consumers,

[26] shelterwa.org.au/facts

will be required to meet the national accreditation standards.

There are other elements of the ILP which are not recovery-oriented. Currently, access to the ILP is through engagement with the public mental health service in the consumer's 'catchment' area, which acts a gateway to many supported accommodation programs. Further, MHC service agreements state that ILP consumers are to be linked in with a GP, private psychiatrist or public mental health service.

However, it is WAAMH's view that tying the ILP to a requirement to access clinical mental health services is coercive, restrictive, and not in accordance with person centred recovery principles nor the Mental Health Commission's Outcome Statement:

> *Rights, respect, choice and control*
>
> *People are treated with dignity and respect across all aspects of their life and their rights and choices are acknowledged and respected. They have control over their lives and direct their services and supports.*

In order to access supported accommodation programs, consumers should not have to rely on access to public mental health clinical services if they do not have the need for it. Additionally, many mental health consumers experience barriers to accessing public mental health services, which are outlined in the 'Mental Health Supported Accommodation in Western Australia: consumer pathways, access and transition' report (draft). While GPs and private psychiatrists are also options for clinical care, there are many issues about knowledge and capacity of GPs to care for mental health consumers with multiple unmet needs, and the lack of accessible (and affordable) psychiatrists, especially pronounced in the regions, leaves few options to those consumers who do not wish to engage with the public mental health system or experience access barriers to doing so.

Problematic processes, requirements and pathways for accessing supported accommodation services are broader than the ILP, applying to other supported accommodation programs. These barriers have been explored in detail in the 'Mental Health Supported Accommodation in Western Australia: consumer pathways, access and transition' report' (draft).

That report explores options to develop effective consumer pathways to supported accommodation, recommending a new access and navigation service is established, along with strengthening existing access pathways. This would include facilitating an assessment component to ensure consumer needs are identified and match consumers to the most appropriate service.

If implemented, the new access and navigation mechanism, based on a recovery-led approach to service access, would resolve the recovery and consumer choice barrier identified in this report, both allowing consumers to choose and direct their supports whilst concurrently ensuring supported accommodation services remain directed to the target group: people with severe and persistent mental illness.

Recommendation 10

The Mental Health Commission introduces reforms to the ILP model in accordance with recovery-led approaches as outlined in the National Framework for Recovery-oriented Mental Health Services and the MHC Outcomes Statements.

3.4 Impact of the NDIS

The NDIS is a significant social reform that will open up new avenues of sustained support for some people with a psychosocial disability related to a mental health issue.

However, the limitations and access challenges of the NDIS are significant, and well documented. [27]

Due to the delays in the NDIS roll out across Western Australia, its impact on the ILP and supported accommodation services varies considerably by region and location, and the ways in which and the extent to which the NDIS will impact on the service landscape is still emerging.

Consumers and providers report that the NDIS is successfully delivering positive outcomes for some supported accommodation tenants in the ILP. However, where the NDIS has been rolled out, there is also evidence of significant negative impacts for tenants in the ILP.

Significant pressure is placed on CHOs, public mental health services, and community support providers to respond to some emerging and systemic issues posed by the NDIS rollout. This is being done, however, using largely existing resources and is having significant operational impacts on services and their capacity to meet demand whilst retaining service quality standards.

3.4.1 Access and eligibility

Stakeholders in the consultation have reported that the NDIS access determination process is complex and confusing, and there is unclear and conflicting advice given to tenants and support workers:

- The NDIS eligibility criteria does not align with mental health diagnoses or recovery-oriented consumer assessments;
- Consumers require considerable support to apply for the NDIS and it is a time consuming and challenging process, for which the tenancy support services may not have the expertise or resources to assist;
- Significant variations in who is found eligible reported both by Western Australian stakeholders and in documented reports [28] make it difficult to anticipate who will receive a funded plan and who will be declined;
- The time taken to assess access requests is very long - over six months on average;
- Many tenants in supported accommodation require significant advocacy and support from clinical services, CHOs and community support providers to support their NDIS access requests. Providers report that they must leverage any other funding to accommodate these requests, which impacts on service capacity and sustainability; and

[27] Commonwealth of Australia, *Report of the Joint Standing Committee on the National Disability Insurance Scheme: Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*, 2017.
[28] The University of Sydney and Community Mental Health Australia, 'Tracking Transitions of people from PiR, PHaMs and D2DL into the NDIS: Commonwealth Mental Health Programs Monitoring Project, 2019

- Some public mental health services report their resources are seriously impacted by the extensive time required to provide consumers with the documentation required for NDIS access requests, with no additional resources to undertake this work.

Overall, consultation evidence suggests that, where the NDIS assessment process has been completed, the number of supported accommodation consumers found to be eligible are relatively small (with the exception of clients in licensed psychiatric hostels):

- Too many people are being rejected who providers believe should be eligible; sometimes, repeated applications by the same tenants succeed in being approved for the NDIS;
- The depth of knowledge required for NDIS assessors and planners to appropriately assess psychosocial access applications is reportedly inconsistent, resulting in a greater need for consumers to be supported by skilled workers or advocates throughout the access process;
- The mental health model of recovery is fundamentally different to the 'disability model': for example, for mental health consumers, levels and types of support are likely to vary over the lifespan. While the NDIS model does incorporate an understanding of fluctuating support needs, stakeholders report that in practice few provisions are made;
- People with mental health issues and people with co-occurring mental health and AOD issues are being rejected because of eligibility rules. There are reports that people with diagnosed personality disorders are also being rejected because these are not considered a permanent disability.

3.4.2 Problems with NDIS plans and planning processes

Some of the stakeholder reports to WAAMH during the consultation indicate that:

- Public mental health clinicians are concerned that often they are not consulted in the development of a client's plan. Clinicians describe situations where their views and expertise are not sought during the planning process and they are then surprised when the client's package does not include the key support and assistance that they believe is required;
- Plans & packages do not consistently include the levels and type of support and assistance required by the tenants in the ILP to manage their mental health-related issues. For example, some consumers require support and assistance to maintain their tenancy however this is not always included, such as support with cleaning, gardening, maintenance, and basic housekeeping skills;
- Sometimes clients receive less funding and less support than they accessed previously;
- Sometimes packages are not viable because of a lack of support services within easy access, especially in regional areas of the state;
- Low levels of funding in some packages means that the quality of support staff able to be employed is not adequate for some mental health consumers with higher support needs; and
- Local Area Coordinators, plan coordinators and some support workers lack

understanding about mental health issues and psychosocial disability and have not been trained in the recovery-led process.

3.4.3 Changes to federal funding for community mental health supports

The loss of federally funded psychosocial/community mental health support services is having a significant impact for some ILP clients, with Partners in Recovery, Personal Helpers and Mentors program, and Day-to-Day Living previously a significant source of support. Stakeholders report significant concern over their roll-in to the NDIS, particularly what will happen to clients who received services and support previously but who are not eligible for the NDIS.

Some service providers are exiting clients from programs or not taking referrals because of these funding changes. In one example, an ILP tenant with hoarding issues which threatened the tenancy is no longer able to access the program which was assisting him to address the issue. This consumer is likely to lose his accommodation.

While WAPHA's guidance [29] indicates that new consumers (those who have not previously accessed the federal mental health programs) can access a new service called Psychosocial Support, there appears to be a lack of clarity amongst stakeholders about the existence of this program as a support option, as well as what the new programs commissioned by WAPHA will offer, and who can access them. This lack of program visibility and stakeholder clarity is likely to be partly reflective of the fast-changing environment in which these services are being commissioned and implemented.

Additionally, the new psychosocial support services funded through WAPHA will operate with significantly loss of funding compared to previous programs. The impact is anticipated to be more deeply felt in regional areas, where other support options are fewer. The continuing lack of clarity about the level of ongoing funding for these programs after 30 September 2019 is a considerable source of anxiety for both consumers, family members and service providers.

3.4.4 Broader NDIS and disability housing reforms

The housing landscape in the NDIS is also undergoing rapid reform. The impact of these reforms on the ILP and the broader mental health supported accommodation space is still emerging.

Several initiatives have potential to identify and leverage benefits to mental health consumers that require either supported accommodation, or support linked to their accommodation. Briefly, these include:

- Initiatives that support people living in psychiatric hostels to access the NDIS;
- MHC work to refine the ICLS, in the context of the NDIS;
- Efforts to understand and respond to the social and public housing and NDIS interface;
- A Carers WA project in partnership with Foundation Housing, funded by the Department of Communities to identify housing barriers for people with disability, identify opportunities for reform and advocate for systemic change

[29] National Psychosocial Support Measure. WA Primary Health Alliance. https://www.wapha.org.au/service-providers/programs/national-psychosocial-support-measure/ Accessed 4 September 2019

- Services for people in supported accommodation (Supported Independent Living, SIL) through the NDIS and the potential for development of shared living options (amidst concern at whether these will be contemporary in nature);
- Potential changes to the NDIS for people with psychosocial disability, based on the findings of the of Mental Health Australia which may include strengthening referral pathways and coordination of care between the NDIS and potential points of access including housing services, and the provision of integrated support to maintain stable and secure housing and to live autonomously. [30]

Given one of the major findings of this report is that many ILP consumers are unable to access sufficient psychosocial support, there may be potential for the MHC to develop specific access support pathways to the NDIS, to complement the limited supports available under the ILP.

Recommendation 11

The MHC establish a project that works with relevant stakeholders to leverage the potential benefits of the NDIS for people with mental health issues in supported accommodation services, including the ILP, through supporting their NDIS access.

Recommendation 12

The MHC establish a project or other mechanism to map and monitor the impact of the NDIS on ILP and other supported accommodation programs.

[30] Mental Health Australia, 2018, 'Optimising Support for Psychosocial Disability'.

Appendix 1: List of consultations

ILP Provider	Region	Beds	Participants	Consultation
Rise Network	Wheatbelt (Northam) and East Metropolitan	70	3	Interview with support workers
Access Housing Association Inc	South Metro	272	1	Discussion / interview with Alison Paterson
Foundation Housing Association Incorporated	North Metro	29	5	Group meeting with key staff
St Bartholomew's House Inc	Bentley	73	5 2	Group Meeting with SA staff Group Meeting with ILP staff only
Unitingcare West	North Metro	221	2 Written data:	Group Meeting with staff UCW tenant satisfaction survey
Pathways South West Incorporated	Bunbury	29	5	Site visits and Interviews
Advance Housing Ltd	Albany	36	3	Site visits and Interviews
Centrecare Inc	Goldfields	7	2	Phone interview
Ruah	Geraldton	23	2	Site visits and Interviews
Industry wide consultation				
ILP Forum	Metro Wide		13	Ruah, Rise, Foundation Housing, Access Housing, Uniting Care West and NMMHS
		Total	**43**	

Consumers Consultation	Region	Participants	Notes
Focus group 1 (CoMHWA and WAAMH)	Albany	3	
Focus group 2 (CoMHWA and WAAMH)	Albany	6	1 consumer is a waitlisted client
Consumer survey 1 (Trish and WAAMH)	State-wide	25	(closed 31.8.2019)
Consumer survey 2 (CoMHWA)	State-wide	5	(closed 31.8.2019)
Focus group 1 (TO)	Metro	6	
Focus group 2 (TO)	Metro	10	
Focus Group 3 (CoMHWA)	Metro	5	
Lived experience advocate		1	
Consumer consultation via mail gathered by LE advocate	All	3	
Total		**64**	

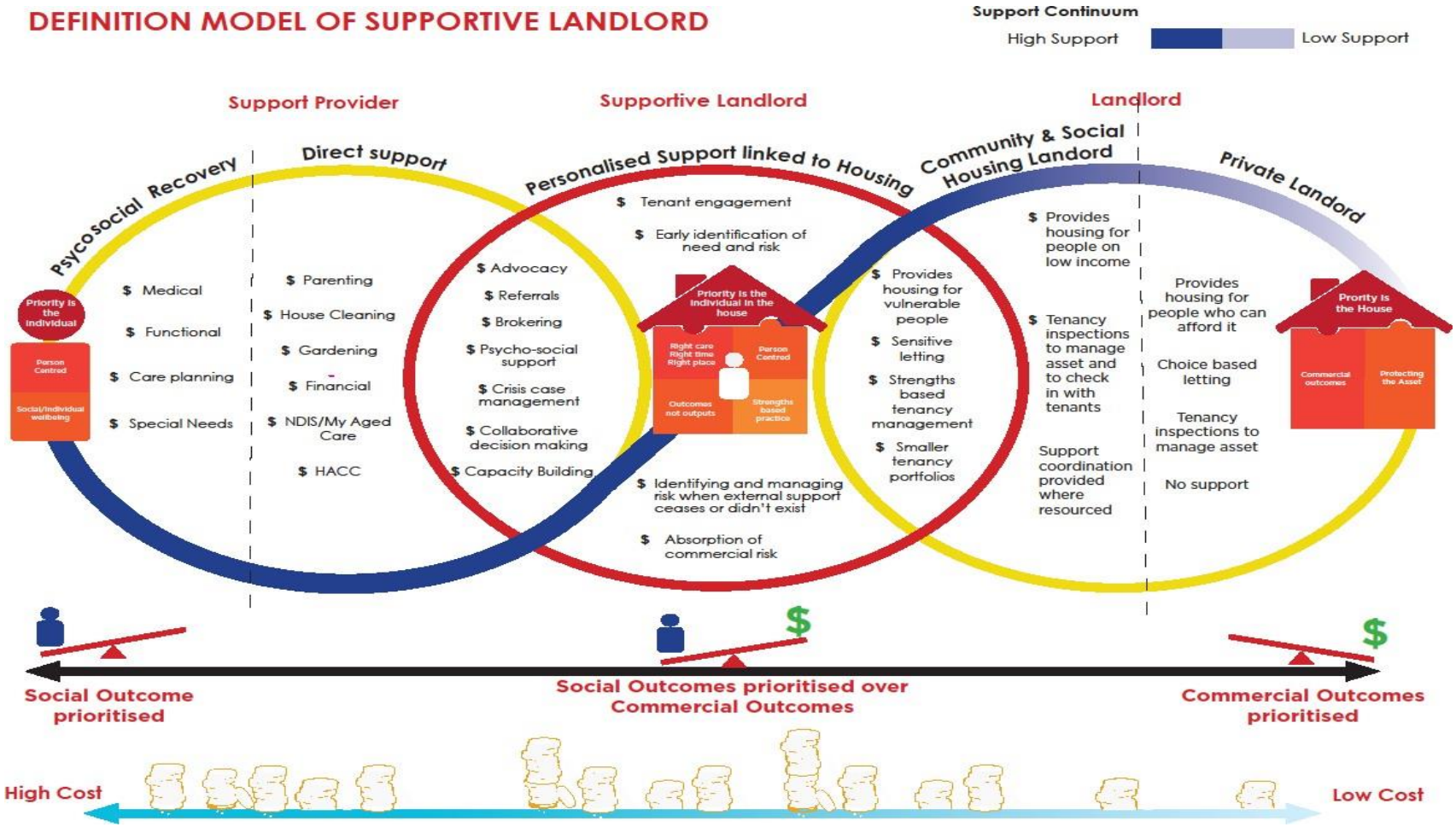
Public mental health services	Location	Participants	Notes
South Metropolitan Health Service	Alma St, Fremantle Hospital	11	This focus group included staff from other locations via telecom.
North Metropolitan Health Service	Osborne Park Hospital	7	
WACHS Geraldton	Geraldton Hospital	2	
WACHS Albany	Albany Hospital	5	

WACHS Bunbury	Bunbury Hospital	4	
WACHS Busselton	Busselton Hospital	9	This focus group included staff from other locations via telecom.
Total 39			

Written Submissions and Reports		Number	Notes
Written Report	CoMHWA	1	
Written Report	MHM2	1	
Written Report	ILP lived experience advocate on tenant consultations	1	
Written Report / Proposed Framework	ILP Forum	1	
Written submission	Access Housing	1	
Total 5			

Other agencies		Number	Notes
Department of Communities - Housing	Policy and Contracting branches	7	Secured ongoing commitment to meet in view of the reviews.
Shelter WA		2	Ongoing partnership with Shelter WA
Mental Health Commission	Policy and Contracting branches	6	
Total 15			

Appendix 2: Definition Model of Supportive Landlord (Graphic)



Appendix 3: Review questions

ILP review questions for services

The questions below are designed as a guide only. Each service will operate in a specific context, and each will have more or less relevant areas they would like to highlight in this review. We are open to listening to all feedback on the ILP.

1. Program assessment:
    a. What does 'supportive landlord' aspect of the program mean in practice? What is the definition and the parameter of the program?
    b. How useful and effective are the current operational guidelines (revised in 2016)?
    c. Quality of stakeholder relationships with clinical mental health services – how would you rate it? What are things that work well? What areas need improvement?
    d. How would you describe the relationship with the Mental Health Commission?
    e. How would you rate the suitability of the ILP to the current mental health policy landscape?

2. Operational aspects:
    a. Current policies and processes related to tenant support under the program: are they clear? Understood? Successfully communicated to tenants?
    b. Housing maintenance: level of need vs. level of funding? What are key issues? Are tenants informed and 'kept in the loop' while their claims are reconciled?
    c. Prioritising clients for entry or transfer in the program
    d. Processes for acquiring, allocating, managing and assigning housing.
    e. Developing and managing waiting lists
    f. Assessment of support needs
    g. Arranging supportive and social activities for tenants

3. Stakeholder relationships:
    a. Liaison with NGOs when required to meet the tenant needs, and in regular allocation of management meetings? Some examples and key issues.
    b. Clarity of respective roles of housing providers compared to psychosocial and clinical support services.

4. Addressing any special needs of rural and regional services

Appendix 4: ILP Residents Electronic Survey - Questions

Using the Survey Monkey platform

This survey is for residents in the supported accommodation program known as the Independent Living Program or Supportive Landlord program. If you are not sure whether or not this is your program, you can ask your support worker or tenancy officer.

I agree to direct quotes from me being used, after any identifying detail has been removed.

{Tick option}

Yes

No

Have you accessed any other supported accommodation programs in the past, before being accepted in the ILP program?

Yes

If yes, which program was it?

{Tick one or multiple options}

Unsure/Cannot remember

ICLS

CSRU

Short stay/crisis

Step up Step down

Psychiatric hostel

Other – please specify

No

If no, where were you living before

{Tick option}

Was homeless (sleeping rough)

Couch surfing

With family

Other (please specify)

How long was the wait for the ILP program?

{Tick option}

0-3 months

3-6 months

12 months

More than 12 months

Unsure

Have you received support from your mental health service to enter the ILP program?

{Tick option}

Yes

No

Have you been readmitted to hospital since starting with the ILP?

{Tick option}

No

Yes

If yes how many times? {text box, validation: numerical entry only}

Were you satisfied with support to enter ILP property?

{Tick option}

Yes

No

Are you satisfied with the support from your housing provider – the landlord – about maintaining your tenancy?

{Tick option}

Yes

No

Please give any comments you would like to make about the support received from the mental health service and the landlord.

{space for comment}

How long would you like to stay in your current ILP home?

{space for comment}

Do you have support from a community mental health service?

{Tick option}

Yes

No