Inquiry into the provision and regulation of supported accommodation in Queensland

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SAPA

Supported Accommodation Providers Association (SAPA).

Future Model of Care for Supported Accommodation

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1. Glossary of Key Terms

Supported Accommodation:

In Queensland, level 3 residential services, are known as supported accommodation.

Residential services in Queensland refers to boarding houses, aged rental schemes and supported accommodation.

Two pieces of legislation govern the operation of residential services in Queensland:

Residential Tenancies and Rooming Accommodation Act 2008 (RTRA Act), administered by the Residential Tenancies Authority (RTA)

Residential Services (Accreditation) Act 2002, administered by Regulatory Services – Department of Communities, Housing and Digital Economy.

All accredited residential service providers (including level 2 & 3) must also meet level 1 accreditation standards. A level 3 (personal care) service provider may elect not to be accredited for level 2 (food service).

Operators do not receive government funding. Facilities are funded by the rents charged to residents which are typically linked to a percentage of the residents disability support pensions (similar to aged care).

Clinical governance:

Clinical governance is defined as the system by which the governing body (bodies), managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers/patients/residents.

Co-morbidity:

Other conditions that occur at the same time as mental illness. This is often physical illness or poor health but also includes use of alcohol and other drugs. Both are very common in those with mental illness or mental disorders.

Alcohol and Other Drugs (AOD):

This term most often refers to excess use of alcohol and misuse of illicit or prescribed drugs.

Psychosocial Disability (PSD):

Psychosocial disability is a term used to describe a disability that may arise from a mental health issue.

Not everyone who has a mental health condition will have a psychosocial disability, but for people who do, it can be severe, longstanding and impact on their recovery.

Term	Definition
Hospital and Health Services (HHS):	QLD regional HHS operates health facilities and other services
Warm transfer	The Facility actively communicates with the service to which the individual is connected to provide essential information about their needs before transferring them. Wherever possible, support is maintained for the individual by the Facility until they are received by the service.
Foundational Supports	Foundational supports are a key part of the NDIS Review's vision for a disability support ecosystem in Australia. There are currently a range of disability-specific supports that are available for people with disability, families and carers outside of NDIS individualised budgets. They're designed to cater to individuals with disabilities who might not meet the criteria for NDIS funding, but still need support - however, some foundational supports will also be available to those on the NDIS. Foundational supports would intertwine with existing mainstream services. The two types of proposed foundational supports are: **General**: These services will be available to all people with disability, including advice, capacity building, advocacy, information, peer support, and employment services. **Targeted**: These services will only be available to people who are not eligible for the NDIS. These supports can include: home and community care, aids and equipment, psychosocial supports, early intervention, support for young people in key life transitions, and help with navigating all of these supports.

2. Introduction and Overview

This paper has been prepared to support SAPA's proposed model of care for the future of Supported Accommodation facilities (**Facilities**) in Queensland.

The residents which Supported Accommodation care for are a key group for the Queensland government to include with the Targeted Foundational Supports as proposed by the NDIS Review.

There is currently a large number of residents and potential residents for who are out of scope of within the current model of service. This could change with a limited investment from the Queensland government.

The new model of care is designed to improve the services at Supported Accommodation by offering improved levels of care. It envisages Facilities that are welcoming, low stigma, transitional homes for individuals for those with moderate to high levels of needs.

The improved model of care will further assist vulnerable adults, having available supports as needs emerge, to have access to onsite care, advice and support provided by a multidisciplinary team of professionals.

Facilities are to provide an accessible, responsive service that meets immediate needs and provides expertise in assessment of needs, linkage and support, and care. Facilities should also provide integrated mental health and AOD services.

Whilst, over time, the Facilities may meet a range of special needs, a key imperative will be ensuring the model of care offers a culturally safe response to the needs of Aboriginal and Torres Strait Islander people and those from a multicultural background for whom English is a second language.

The proposed model of care for Supported Accommodation facilities in Queensland provides good value for money. Indicative costing of approximately $35,000 per annum per resident provides for support workers on site 24/7 at a ratio of up to 15:1, plus mental health nurses, case management and senior management oversight.

It is estimated that the total outlay for the 1,463 registered beds across the state would be approximately $50 million per annum. This is expected to be offset by a reduction in the usage of mainstream government services including hospitals, police, ambulance, justice and prisons. As well as other homeless and community organisations.

The sector will also benefit from limited capital grants from the Queensland government to improve the facilities and amenities of Supported Accommodation, such as single rooms, ensuites, air conditioning, and fire systems. This investment would provide good value for money and enhance the quality and standards of the sector.

A cost-benefit analysis of the net reduction on other services is needed to validate the overall cost savings to the state.

2.1. Background:

A lot of people who live in Supported Accommodation are not getting the care they need, because they fall into a gap between policy or funding limitations in the service systems. Many people do not get the supports they need from mainstream government or the NDIS. They often have complex and specific needs that are not met or are under-supported.

In general, supported accommodation providers have been overseeing and prompting resident care in lieu of any other body taking this responsibility. Community care is often disconnected from the wider accommodation and health care system – institutionally, professionally, clinically and culturally. Artificial boundaries between services mean that many people do not receive co-ordinated support for their physical health, mental health and wider social needs, and instead receive fragmented care that treats different aspects of their health and wellbeing in isolation.

People residing in supported accommodation also have cyclical mental health need episodes. In a stable, supported model of care supported accommodation providers are able to identify changes and commence support earlier than those residing in private housing. Providers are also aware of triggers and can anticipate care needs before escalation.

They often have high health needs (including dual / tri morbidities) along with high PSD needs.

Many are distrustful of government due to past trauma or as part of their ongoing PSD. There is a history of transiency and homelessness and require improved stability of accommodation.

They live with low income as many depend on the DSP for their living. They lack the ability to navigate service systems.

People with severe mental health problems often experience poor physical health and less effective care and support for their physical health needs. The United Nations Ottawa Charter for Health (1985) advises that health is multidimensional and all spheres are interrelated. A wholistic model of care is required.

Residents living in Supported Accommodation, with multiple physical and mental health conditions and with benefit from an improved model of care in Supported Accommodation. This model would provide a more integrated approach to care and accommodation.

2.1.1. Sector's Contribution and Challenges:

Gap-Filling Services:

Supported Accommodation fills the critical accommodation and care gap between NDIS and health services. It is recognised as a valuable resource by healthcare institutions and government support providers.

Social and Economic Sustainability:

These facilities offer both economic and social sustainability, servicing the needs of some of our community's most vulnerable individuals. By providing supportive housing solutions, Supported Accommodation mitigates the strain on emergency services, hospitals, and the justice system.

Challenges in Sustainability:

While serving as a vital resource, sustainability has become a growing concern. Supported Accommodation providers face the challenge of maintaining operations without sustainable funding, resulting in an increasing strain on resources and service delivery.

2.1.2. Resource Limitations Impacting Capacity to Provide Quality Care:

Person-Centred Approach Hindered:

Staffing ratios constrained by the lack of funding and workforce limitations pose challenges in maintaining a person-centred approach. This deficiency restricts the level of attention and individual support each resident requires. Lack of an understanding or awareness of each stakeholder's responsibility and limitations creates gaps in care and support. It can also cause inefficiencies in funding as services may duplicate each other or undermine each other's approach or model of care.

Limited Tailored Care Plans:

Insufficient resources often hinder the development and implementation of individualised care plans tailored to residents' diverse needs. This impedes the delivery of personalised care, considering their unique backgrounds and challenges.

No Case Management:

There is currently no systematic and comprehensive case management for residents of Supported Accommodation. Case management falls outside of scope of services offered by the sector. While some individual residents have various forms of case management looking after specific areas of need (such as mental health), but their high caseloads, lack of dedicated time, scope of services and coordination across services is limited. Targeted organisational funding and NDIS funding are proscriptive on what they will and won't provide. Residents often fall between the funded gaps.

Trauma-Informed Care Constraints:

Resource constraints limit the availability of specialised training and expertise required to offer trauma-informed care to residents who may have experienced past trauma or adverse life events. This shortfall limits providers ability to provide best practice supports.

Holistic Care Limitations:

The sector faces challenges in providing holistic care due to limitations in accessing various support services, including acute and community mental health professionals, allied health services, and community resources. This impedes comprehensive care delivery covering all facets of residents' well-being.

2.1.3. Residents' Backgrounds and Needs:

Residents who choose Supported Accommodation come from varied backgrounds and arrive through different pathways: They represent a diverse demographic, which presents unique challenges in meeting their varied needs.

Residents living in Level 3 Residential Services generally have some form of disability[1] and a high level of need. At times a resident's condition may escalate and require more staff time and a necessary timely intervention.

Many residents are living with a combination of an intellectual disability, mental health and physical health illnesses. A limited study recently commissioned by SAPA and undertaken by Micah Projects into the needs of the sector found the following:

Demographics

- Average age is 50 (ranging from 18-72yo)
- 5% indigenous
- 75% male
- 50% resided there >5 years
- 90% are on the Disability Pension

Health

- 100% have Mental Health issues (70% diagnosed with schizophrenia)
- 73% dual / tri morbidity issues
- 91% disclosed a history of chronic health issues
- 85% smokers

NDIS / Other Supports

- ~50% have NDIS (typically personal care, daily living and community access)
- Significant barriers exist to getting access to or appropriate levels of support
- Limited other supports currently available

Other

60% finances managed by Public Trustee

[1] Client needs-Level 3 Supported Accommodation (SAPA report), Micah Projects, 2023

2.1.4. Forms of Disability

Generally speaking, residents may be living with one or more of the following:

- Psychosocial Disability, including: Schizophrenia, Paranoia, Anxiety, Depression, Bi-Polar, low Emotional IQ;
- Intellectual Disability, including: ADHD, Autism, Down Syndrome, Foetal Alcohol Spectrum Disorder, Developmental delay. (Consistently score below 70 to 75 on a standardised IQ test.);
- Cognitive Impairment, including: a person who has trouble remembering, learning new things, concentrating or making decisions that affect their everyday life (which may not affect or be indicated by a person's IQ score);
- Alcohol-Related Brain Injury (ARBI), including: Korsakoffs
- Acquired Brain Injury (ABI)
- Neurological Disease, including: Huntington's Disease, Cerebral Palsy, Epilepsy, Dementia;
- Health Disease, including: Diabetes, Allergies, Cancer, Parkinsons Disease, High and Low Blood Pressure, Dysphagia requiring specialised diets, Dental
- Physical Disability, including: requiring a physical aid to be mobile e.g. Wheelchair, Wheelie Walker
- Sensory Impairment, including: hearing, visual, touch, taste, smell; and
- Addictive Behaviours such as alcohol and other drugs (**AOD**)

2.2. Need for a Targeted Initiative and Investment

The model of supports provided in Supported Accommodation can be improved with a focused initiative and investment from the Queensland government. To cover the gap and to provide the basic care that they need.

People residing in supported accommodation require a safety net and a collaborative process whereby their key stakeholders can communicate and provide a coordinated continuum of care. Client centred care requires all stakeholders to communicate in their care provision in support of the client. Residents feel more secure in their own place of residence and the cares they see every day therefore this is the ideal place for case conferencing. It should be an expectation that the scheduled review meeting take place between key stake holders in consultation with the resident.

That's why they need in reach supports that can provide the care and services they need in their homes.

People who live in supported accommodation need a safety net and a collaborative process where their key stakeholders can talk and provide coordinated care across the board. Client centred care means that all stakeholders communicate in their care delivery in support of the client. Residents feel safer in their own homes and with the carers they see every day, so this is the best place for case conferencing. It should be an expectation that the scheduled review meeting happens between key stakeholders in consultation with the resident.

2.2.1. Supported Accommodation's Critical Role in Existing Service Systems

As outlined in our submission to the inquiry, *Supported Accommodation Providers Association (SAPA). Submission to the Inquiry into the Provision & Regulation of Supported Accommodation Services in Queensland, 11/12/2023*. Supported Accommodation serves as a pivotal link between the National Disability Insurance Scheme (NDIS), health services, and broader community support networks. The sector plays a fundamental role in providing safe and supportive housing options for individuals facing unique challenges, such as acquired brain injuries, mental health issues, and intellectual disabilities.

Increasing Complexity of Clients

However, facilities are being referred residents with levels of complexity not seen previously in these spaces. Facilities are providing various supports in order to keep residents safe.

Many of these residents have:

- No NDIS support
- Insufficient NDIS support (i.e. not covering after hours or weekends)

Our residents require access to support on a 24-hour continuous basis, their needs do not cease after business hours or nights or weekends.

Those residents with NDIS supports have limited hours of support. This does not allow for support when they need it after hours or on weekends. It fails to consider that people with mental illness have cyclical escalations.

Supported Accommodation staff are there to monitor and mentor these residents and assist in de-escalation strategies when required. The staff have a good relationship and understanding of their residents as they work with them 24/7. Residential staff are well placed to note changes and coordinate with health and allied health professionals.

The complexity of residents is higher than in many funded services, but there is a lack of funding and needs often go unmet.

Supported Accommodation has been inappropriately described as a quasi-hospital for discharge.

Due to the complexity of behaviour and lack of supports, there is typically limited appetite from NDIS / NGOs to take on clients transitioning out of clinical settings because of:

- Complicated and challenging behaviours
- Insufficient funding to be viable for them

As a result, many prospective residents have little options available to them for accommodation.

Age Related Challenges:

With residents ranging from 18 to 72 years old, providing age-appropriate and tailored support becomes complex. Younger residents may have distinct needs requiring specialised care and engagement strategies compared to older residents.

Cultural Challenges:

Catering to diverse cultural backgrounds, including Indigenous residents, necessitates culturally sensitive care that respects and integrates cultural values and practices into support services.

2.2.2. Choices:

Active Choice

Many individuals actively select Supported Accommodation as their long-term home, fostering a sense of stability and community within these facilities. For numerous residents, Supported Accommodation has become a cherished and enduring living environment.

Transitional Support

Some residents view Supported Accommodation as a temporary haven, particularly after experiencing crises or health episodes. These individuals might seek short-term assistance and support while reestablishing stability in their lives.

Limited Choice due to Complexity

A minority face limitation in their housing choices due to complex health needs and legal guardianship. Often placed in Supported Accommodation by legal guardians, these residents require specialised care and support.

2.3. Targeted Foundational Supports

The residents of Supported Accommodation belong to a specific group that are covered by the Targeted Foundational Supports as defined by the NDIS review.

Foundational supports for all people with disability | NDIS Review

Supported Accommodation in Queensland represents a pivotal component of the residential rental sector, offering a vital sanctuary for individuals facing diverse challenges within our community. These facilities serve as essential resources for vulnerable individuals seeking a safe and stable living environment, providing tailored support and care.

The resident cohort is a key target group for Foundational Supports Targeted[2], *those with a disability across Australia, including people with chronic health conditions, to access domestic and personal assistance in their home and community. To ensure service quality and equitable coverage, this investment should be supported by an agreed nationally consistent framework and a benchmark for minimum support standards and coverage.*[3]

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[2] Foundational disability supports for every Australian with disability, NDIS Review, 2023
[3] NDIS Review 2023, Action 1.9

There needs to be supports that offer people with disability a foundation to live a good life, included in the community, regardless of whether they are in the NDIS or not. Foundational supports are essential to a linked disability support ecosystem that ensures people with disability, inside and outside the NDIS, can access the right support at the right time and place.

Psychosocial support programs outside the NDIS are inadequate and fragmented. Many people are unable to access the supports they need, negatively affecting their quality of life and employment opportunities. In 2020, the Productivity Commission estimated that around 154,000 of the 290,000 people with severe and persistent mental illness were unable to access psychosocial supports[4]

The costs of providing a psychosocial assessment for an application to NDIS is prohibitive on a disability pension.

2.4. The case for developing integrated approaches to mental health

One of the key challenges facing the mental health system in Queensland is how to provide effective and appropriate supports for people with complex and multiple needs, such as those with co-occurring mental and physical health conditions. These people often experience poor outcomes across various domains of their lives, such as health, social inclusion, education, employment, housing and justice. They also face significant barriers to accessing services that are responsive to their needs and preferences, and that can work together in a coordinated and holistic way.

There is extensive evidence to support integrated approaches to mental health. This includes:

1. Improved patient outcomes
2. Reduced system pressure; and
3. Reduced overall financial costs

Detailed explanation of this falls outside the scope of this submission but we encourage the committee to understand this further when determining their recommendations[5]

[4] Productivity Commission, Mental Health inquiry report volume 3, Productivity Commission website, 2020, p. 844, 862

[5] Mental health and new models of care - lessons from the vanguards, The Kings Fund, May 2017

3. Core Services to be Provided

To provide the elements of the service model, there are a number of services which all Supported Accommodation facilities would be reasonably expected to provide 'onsite', using funding made available to them and through the most efficient mechanism of service delivery that meets the local need.

In addition, there are a number of important services and supports upon which the effectiveness of the model depends, which Supported Accommodation facilities are expected to either offer onsite or offer through seamless referral pathways and partnerships with other agencies.

Core services to be provided 'onsite', using funds available to the facilities, to address the key three onsite elements of the service model, must include the following:

3.1. "Onsite" Services

The model of care will seek to address key service gaps in Supported Accommodation by:

- Providing a home where all are acknowledged, feel safe and welcomed
- Providing highly visible, accessible and trained on-site staffing for all residents, particularly those experiencing distress
- Providing on the spot support, care and advice without needing existing NDIS or other support or funding.
- An assessment tool that can be utilised by all key stakeholders. This should include a portal where the information on an individual's care provision can be updated and available to all key stakeholders
- Client centred collaborative care and interagency interaction

3.1.1. 24/7 Support Work

- Funded supports on site 24/7 at a ratio of up to 15:1
    - Immediate support work to support transition into and out of facilities
    - Immediate support work to reduce distress in times of crisis or the episodic nature of their PSD at all times 24/7
    - Supports to assist residents living with various disability and chronic health needs
- Other services
    - MH Nurse on staff
    - Integrated with other core services, see below
- Suitable trained senior management
    - Onsite during business hours
    - Available on call after hours and during weekends
- Provide consistent support teams which build trust and ongoing relationships in order to provide the best possible care alongside the residents.
- Ongoing daily support work scope to include
    - Assistance with medication

  - Assistance with daily living tasks
  - Group programs as a means of building social cohesion and supports
  - Skill and capacity building to assist residents to develop and maintain the skills to transition to more independent forms of accommodation
  - Initial information provision, comfort and, if necessary, management of symptoms, including, where possible, those related to alcohol and drug use.
- Provisions of accommodation and supports that bridges the gap between clinical health settings & independent community living
  - Immediate funded supports to all residents (no criteria) to remove barriers to and facilitate discharge
- Supports in line with best practice frameworks, including:
  - Person-Centred Care: Emphasise individual needs, preferences, and autonomy
  - Holistic Approach: Consider physical, mental, emotional, and social well-being
  - Cultural Sensitivity and Diversity: Address the diverse needs and backgrounds of residents
  - Recovery Oriented: Recovery is owned and led by the individual, who are supported in their recovery journey to live a meaningful life
  - Trauma Informed: Care teams need to have a complete picture of a patient's life situation using the 5 core principles

3.1.2. Case Management

- Person centred care plans are to be developed in line with best practice frameworks that include hospital and police diversion tools
- There should be a connection to services that assist with referral to the NDIS, including providing an in-house biopsychosocial assessment and a central point to coordinate external assessments
- An initial review is to be included to ensure that people are referred to the services they need or might benefit from, including:
  - Community mental health programs
  - Problems related to AOD use
  - Social and community support services
  - Other group-based activities
  - Cultural/Spiritual supports
  - Other social factors or adversity which might impact on their wellbeing.
- There needs to be coordinating and arranging of stakeholders to better integrate health, allied health and other stakeholders care provision to promote early interventions, improved resident outcomes and smooth transitions between services, including patient-controlled admissions
- It is important to develop appropriate pathways, for those who are desirous, to transition into other forms of suitable accommodation.
- Information is required for individuals, families, friends and carers on locally available mental health, AOD and suicide prevention services, and related social support services;
- Support and advice should be available for families, friends and carers to assist them in their role, and acknowledge their social and emotional support needs; and
- Service navigation should be in place especially in hospital clinical care, supporting clear and seamless pathways and providing a point of contact and follow-up.
- Provision should be made of an in-house assessment, including information and support to access services and it should be shared with key stakeholders

- Assistance should be available for managing stressors associated with high levels of distress, including financial problems, civil and criminal legal issues, family support and social isolation
- Connection to specialised domestic violence supports is to be provided in a timely and sensitive manner
- Connection to peer-led services such as peer networks, support groups, or phone lines is an important part of an empowerment process.

3.1.3. Improved Accommodation and Facility Services

Environment in which we live are to be conducive to health and social wellbeing. Funding needs to be available to meet modern day living arrangements and to provide a homelike setting that meets a basic human need requirement for personal growth and empowerment. People residing in a communal setting require a quiet resting place, privacy when required, space to wander and grounds that provide a contrast to living within doors. Environmental considerations are to be made as to their particular physical and mental health needs.

- Funded improvements to accommodation facilities and amenities (where possible)
    - Increased rates
        - Single rooms
        - Ensuites
    - Improved breakout and community spaces
    - Airconditioning
- Streamline and eliminate overlapping and duplicate regulatory systems
- Providers must provide safe, clean and affordable accommodation services in line with the prevailing regulatory requirements, including the provision of:
    - Bedrooms
    - Bathrooms and shower facilities
    - Communal areas
    - Dining facilities
    - Outdoor and other recreational areas
    - Communal laundry
    - Front of house services and areas
        - House management
        - Administration and finance
    - Back of house services and areas (as appropriate for the service provision in each facility)
        - Cleaning
        - Meals
        - Laundry
        - Staff accommodation and breakout areas

3.2. Other Core Services

Facilities will also ensure that the following core services, which are essential to the integrity of the model, are available to people who reside in the facility, either on an 'onsite', 'in-reach' or referral basis. Separate funding is required where existing services are unavailable.

- Coordinating primary care and other Medicare Benefits Schedule (MBS) funded providers such as
  - GPs
  - Psychiatrists
  - Occupational therapists
  - Other allied health
  - Dentists
- Group and offsite activities
- Integrated vocational support services

3.2.1. Streamline and eliminate overlapping and duplicate regulatory systems

- Remove duplication between overlapping regulatory frameworks
- Should fall under existing oversight – NDIS commission / OPG etc
- Ensure that policy areas relevant to supported accommodation sector take responsibility for collaborating and communicating with each other to provide a seamless policy framework of support for this sector.

3.3. Education for stakeholder groups

Stakeholder education is essential for the roll out of the new model of care for Supported Accommodation to be successful.

Educating stakeholders, including residents, their families, healthcare providers, government agencies, and the broader community, is crucial in ensuring the successful implementation and sustainability of the model.

Stakeholder education can help to raise awareness and understanding of the model, its objectives, and the services it provides. This can facilitate better collaboration and coordination among stakeholders, leading to improved outcomes for residents. Education can also help to address any misconceptions or concerns that stakeholders may have about the model, promoting greater buy-in and support.

4. Value for Money

4.1. Core Services

The proposed model of care for Supported Accommodation facilities in Queensland provides good value for money.

Indicative costing of approximately $35,000 per annum per resident provides for support workers on site 24/7 at a ratio of 1:15, plus mental health nurses, case management and senior management oversight.

It is estimated that the total outlay for the 1,463 registered beds across the state would be approximately $50 million per annum.

This is expected to be offset by a reduction in the usage of mainstream government services including hospitals, police, ambulance, justice and prisons. As well as other homeless and community organisations. A cost-benefit analysis of the net reduction on other services is needed to validate the overall cost savings to the state.

In comparison, housing the residents in comparative NDIS Supported Independent Living (SIL) would cost an estimated $185,000 per resident per annum ($270m for the sector) before any case management, mental health nursing or primary health care is included.

Core Services Cost Per Annum

Role	Per Bed	Industry[6]
24/7 Support Work[7]	19,965	29,208,380
MH Nursing[8]	3,000	4,389,000
Senior Management[9]	2,000	4,681,600
Case Management[10]	3,200	2,926,000
Overhead[11]	5,633	8,240,996
Total Cost	**33,798**	**49,445,976**

[6] 1,463 registered level 3 Supported Accommodation beds in Queensland
[7] 112hr support worker week, includes inactive overnights for workers on SCHADS award Level 2.1 + on costs at a ratio of 1:15 during the day and 1:30 at night, weekends and public holidays
[8] Mental Health Nurse at a total organisational cost of $150,000 pa at a ratio of 1:50 clients
[9] Senior staff a total organisational cost of $120,000 p.a. at a ratio of 1:8 FTE hours
[10] Case Manager at a total organisational cost of $100,000 p.a. at a ratio of 1:50 clients
[11] Operational overhead at 20% of gross wages

4.2. Capital Upgrades[12]

In order to provide the Improved Accommodation and Facility Services, as outlined above, the sector requires a modest grant to invest into the sector.

SAPA is advocating for the Queensland government to invest into the facilities provided by the sector to improve the quality and standards provided for our residents.

A modest investment into the space provides good value for money, with the potential for a significant uplift in the quality of the amenities. With an investment of $10,000 per bed, it is forecast that Supported Accommodation providers can improve the look and feel of facilities which may have gone without capital investment for an extended period.

A $25,000 per bed investment has the capacity to significantly change the amenities provided with the improvement of fire systems, bathroom modernisations, improved common areas, new flooring, revitalised outdoor areas and the addition of air conditioning.

The sector is also supportive to moves towards more private ensuites for residents, which would require a discrete additional funding.

These costs are very modest compared to the recent government supported housing purchases at more $289,000 per bed before any on costs and required retro fitting.

Capital Upgrade costs

Item	Details	Per Bed	Industry
1	Repaint, New furniture, Kitchen upgrades, Landscaping	10,000	14,640,000
2	Item 1 + Fire upgrades, Bathroom improvements, Common areas, flooring, outdoor areas, air conditioning	25,000	36,600,000
3	Items 1 + 2 + Ensuites	34,153	50,000,000

[12] These costs are indicative only

5. What Services are out of Scope

To ensure that Facilities can provide a safe setting for all residents and staff, demand management and to ensure capacity of staff to care for the resident cohort, facilities will focus on transitional accommodation; however, will still provide a home for those residents who desire to live in a communal setting.

Facilities are not funded to provide:

- Services for people who cannot be managed safely within a congregate living environment (who pose a danger to others due to their behaviours);
- Intake of residents without sufficient history and information for providers to make an informed risk-based choice to offer a provide a place
- Emergency / short stay services, including referrals from police or ambulance, this is particularly acute during weekend and after hours when less resources are available
- Medical or clinical care
- Care for those in high levels of distress, psychosis or a suicidal crisis
- Direct financial support
- Services targeting children and young people which could be provided more appropriately by other specialised children or youth mental health services
- AOD rehab or “dry out” facilities
- Individual resident community access
- Disability support services provided through the NDIS
- Other services which are provided by other agencies in the area (see referrals below).

Protocols for transfers of residents in high levels of distress will need to be refined in partnership with local HHS and emergency departments.

5.1. What happens to those unable to be accommodated

There are a number of reasons why a potential resident may not be suitable to reside in Supported Accommodation. This may be due to the risks that they pose to themselves or others.

It is important for there to be a clear and well-defined protocol in place to ensure that any resident who is unsuitable for the Facilities to receive the care and support they need.

This may involve referral to other specialised services or facilities that are better equipped to handle their complex needs. It is crucial that these individuals do not fall through the cracks and that their needs are addressed in a timely and appropriate manner

6. The role of the Facilities in Providing Care to People with Moderate to High Levels of Mental Health and Other Forms of Need

The Facilities' role in relation to accommodating and supporting people with moderate to severe levels of mental illness and other forms of need should focus on providing person centred care which aims to support the individual.

Facilities may include a short to medium term service offering for people with moderate to high levels of need, where there are no available services appropriate to their needs to which they can be referred, or whilst they are waiting to be connected to longer term care (such as sufficient NDIS Home and Living supports).

The Facilities will offer a longer-term home, to those desirous, for people with low to moderate levels of need.

However, if Facilities are to continue to be accessible, and have capacity to deliver sufficient supports to all residents, they will need internal protocols to assist in demand management. The Facilities are expected to have a limited role for those with enduring high levels of need.

An appropriate role for Facilities for supporting people with moderate to high levels of mental health need should include:

- Provision of accommodation and care for people with moderate to severe mental illness and other forms of need;
- A biopsychosocial assessment of their mental health and other needs including co-occurring substance use or physical health issues which may influence their needs;
- Provision of short to medium term care.
- Warm transfer to more specialised services and longer-term psychosocial support where individuals require ongoing, long-term care;
- The provision of continuing case management to individuals who are experiencing moderate to severe levels of psychological distress, to ensure they are not left without services; and
- Connecting family and/or other carers with services that can support them in their roles.

Centres should not replace the role of Queensland Health's community mental health services in providing services to people with acute needs.

In some circumstances, individuals may be referred who are the clients of existing services, including community mental health services or the NDIS.

The evaluation of the trial of Facilities and the ongoing monitoring of the role they play in this area will be useful to inform adjustment of the model of service to appropriately meet the needs of this cohort in a way which does not duplicate the role of other services, yet which helps to address the gap in services for people with more complex needs.

7. Referrals & Pathways

Smooth referral pathways for additional services or to transition out of the Facilities will be essential to the effective operation of the model.

This must include capacity for warm transfers, particularly for people who are at risk of experiencing high levels of distress and who require long term care. Through warm transfers, the Facility actively communicates with the service to which the individual is referred to provide essential information about their needs before transferring them. Support is maintained for the individual by the Facility whilst they are waiting for additional services or for a transition plan to be put into place.

Services to be provided on referral, where it is not possible to provide these services in-house or through using the Facility as a platform, may include:

- Disability support services, including support through future Foundational Supports or through the National Disability Insurance Scheme
- Other forms of community accommodation, including social / affordable housing, NIDS Specialised Disability Accommodation (**SDA**) or Supported Independent Living
- GP management of ongoing physical health issues
- Private MBS funded psychiatry or psychological services
- Funded non-government organisations such as Headspace services
- Other services commissioned by PHNs, including psychological services, Aboriginal mental health services, or services targeting the needs of hard-to-reach groups
- Services providing mental health or broader support services for Veterans
- Warm transfers to acute and emergency care, and public and private hospitals
- Public and private specialist mental health services
- Services meeting particular needs such as perinatal depression, eating disorders, or early psychosis
- Specialised support networks and or physical health support services
- Social support services, including housing, employment, child and family support and income support;
- Community legal assistance services or forensic mental health support services;
- Specialised Alcohol and Other Drug services (where ongoing support is needed as opposed to integrated support for co-occurring mental health and substance use conditions at the Facility);
- Peer support groups, and peer led safe spaces.

7.1. Successful Warm Transfers

Provided below are summaries of 2 recent Warm Transfers undertaken by Supported Accommodation facilities. When done correctly, in conjunction with stakeholders, the residents needs are best catered for.

With greater resources and improved models of care there is anticipated to be increased early identification and improved ability to coordinate with treating teams.

7.1.1. PS: Early recognition of decline and coordination with treating teams

PS presented with delusional dialogue which was quickly identified by onsite staff. The Facility coordinate with Queensland Health's local Mental Health, Acute Care Team to have PS assessed. PS was hospitalised the same day which resulted in his medication being changed and he was quickly discharged back to the Facility where he was stabilised and is living successfully with oversight from the Facility and the treating team. The early recognition of his decline and rapid coordination with the ACT allowed for a minimal treatment and quick discharge.

Queensland Health Acute Care team assessed PS. Was quickly hospitalised and medication changed and was discharged back into our care, stabilised and managing successfully.

7.1.2. DK: Early Identification of Psychosis and Treatment in Home

DK presented with increased aggression and suicidal ideation. DK indicated that he didn't want to be admitted To hospital due to prior bad experiences. The Facility was able to coordinate with DK's treating team to have him assessed in his home environment by a physiologist. The medical team was able to stabilise DK with changes to his treatments without the need for admission. The ongoing coordination between the Facility and his treating team has led to DK remaining out of hospital for an extended period of time whilst living his best life in the community.

8. Partnerships and Protocols

Close partnerships will be formed with the services described above as appropriate to enable an integrated approach to individuals who may require transfer from one service to the other. In particular, clear protocols will be developed for the interface between the Facility, the PHN and the HHS and its emergency departments to enable a seamless transfer of patients when needed. It is anticipated that some people who are referred to the Facility may have existing care arrangements with HHS mental health services.

As part of this it is expected that protocols developed with local services will provide clarity on what sort of presentations are likely to require emergency department attendance, and which individuals experiencing mild forms of distress can be appropriately supported within the Facility.

As many individuals residing at the Facility may already be clients of other services, including public and private specialist mental health services, protocols for communicating with and if appropriate providing shared care with these services will also be important. Each Facility will also need to have good systems with other local providers for referral and coordination of care. It will be important that services are not duplicated and that information is shared among providers (with consent) to minimise the need for repeated explanation by consumers and carers.

In general, wherever possible, efforts to co-locate services at the Facility should be pursued to support a ‘one stop shop’ approach. This is most likely to avoid fragmentation and retelling of stories.

9. Workforce – A Multidisciplinary Team Approach

To deliver the core functions of the Facility, it is expected that Facilities will establish multi-disciplinary teams, supported by appropriate clinical governance – both within the Facility and where there are shared care arrangements.

Services provided will need to be recovery focused, trauma informed and person-centred. The core workforce may be supplemented by practitioners providing services funded through MBS items.

A multidisciplinary team approach allows the opportunity for support workers and/or staff with dual expertise across mental health and AOD, or with expertise in particular cultural expertise, to utilise their particular skill sets while also functioning as an integrated team with shared team support.

However, not everyone residing at the Facility will require multidisciplinary care. Individuals experiencing high levels of distress, or complex needs will most benefit from having access to a small team whilst they are in the care of the Facility.

On the other hand, many individuals at their baseline will prefer to receive, and may only need support from one professional. Similarly, it would not be efficient to expect Facilities to establish an extended multidisciplinary care team in-house, to meet the needs of all clients.

Facilities should seek to establish partnerships with NDIS providers, GPs, emergency department staff and other external professionals, including MBS funded private service providers, to enhance a multi-disciplinary team approach to meeting needs, without duplicating available services.

Possible Multidisciplinary Team Members

Core Function	Possible multidisciplinary team members
Providing care and support for individuals	• Support Workers / Peer Support Workers • Addiction specialists • Occupational Therapists or other Allied Health Professionals with mental health competency • Mental Health Nurses • AOD Professionals • Aboriginal Health Workers • Transcultural Health Workers • Vocational Support Workers
Case Management & Navigation	• Senior Support Workers with mental health competency • Mental Health Nurses • Occupational therapists • Allied Health Professionals • Nurse navigators
Assessments (noting a single professional would be likely to undertake an individual assessment, but may seek support and advice from other team members)	• Senior Support Workers with mental health competency • Mental Health Nurses • Social workers, Occupational Therapists or other Allied Health Professionals with mental health competency • Aboriginal Health Workers • AOD Professionals • GPs / psychologists

Providing an option for intervention and support to reduce the need for emergency department attendance	• Support Workers / Peer Support Workers • Addiction specialists • GPs • Occupational Therapists or other Allied Health Professionals with mental health competency • Mental Health Nurses • AOD Professionals • Aboriginal Health Workers • Transcultural Health Workers • Vocational Support Workers

Given the role of the Facility in support to reduce the need for emergency department attendance, staff will need to be available who have received specialised training and who are experienced in supporting people at risk of suicide or who are experiencing significant levels of distress. In addition, all staff who provide “front of house” functions and support initial intake of people should be trained in ways to help support individuals experiencing distress.

Staff are expected to regularly experience challenging behaviours. Besides skills in managing these situations they require skilling in self-care and access to employee assistance resources.

It is anticipated that the Facility manager will have extensive operational expertise. Staff should have appropriate support or supervision arrangements in place.

10. Flexibilities

In general, Facilities will be required to provide a reliable model of service and offer a minimum central suite of services as outlined earlier in this document. However, flexibilities should be allowed to address regional variation including the following:

- Addressing particular cultural needs of the region, such as the needs of Aboriginal and Torres Strait Islander people, and the needs of people from diverse communities within the region including LGBTI people
- Potential to adapt or share workforce in areas of reduced availability, for example sharing scarce professionals
- Some Facilities may wish to offer an opportunity for external entities to provide services using the Facility as a service platform, to offer more of an in-house service offering and make best use of resources
- Flexible approaches to providing access to all Core Services over extended opening hours may be utilised to make the best use of limited workforce.
- Planning with professional training programs to utilise and where required, offer supervision to students and junior professionals in training, including those preparing for support worker roles.
- Offer an opportunity for allied health and mental health professionals to have a vocational placement in the facility.

Facilities are to be encouraged to explore partnerships with other agencies for the development of innovative service options to complement the Facility's core functions.

11. Safety and Quality

A comprehensive safety and quality framework will be required as part of the implementation of the Facilities. This should include the following:

- Streaming the multiple regulatory and legislative frameworks which currently oversee the sector under a single existing body or mechanism
- Implementing appropriate confidentiality and privacy arrangements in accordance with relevant legislation, whilst ensuring appropriate information sharing is in place between services involved in a care pathway to support quality care
- Clinical governance to ensure that staff are appropriately credentialled, well supported and trained to provide care to vulnerable people at risk of experiencing crisis. Protocols must be in place to guide review of the care provided and for responding to critical incidents and complaints
- There should be clear lines of accountability within the Facility
- Protocols to ensure the safety of staff and clients in the event that an individual presents a risk to themselves or others
- Protocols with other relevant organisations, for example PHNs and their services, to ensure that offering alternative services to those offered in acute settings does not result in a delay in providing urgent services or otherwise risk the safety and wellbeing of individuals
- After hours arrangements that include provisions to ensure staff and clients are not at risk and are equipped to discretely manage the care of individuals who are intoxicated or exhibiting anti-social behaviour associated with drug use (e.g. arrangements in place with police, minimum after hours staffing levels);
- Consideration of 'Safe, secure and affordable'? The need for an inquiry into supported accommodation in Queensland August 2023, The Public Advocate
- Consideration of the Final Report, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability 2023
- Consideration of Working together to deliver the NDIS, NDIS Review, 2023
- Cultural safety considerations to ensure that Aboriginal and Torres Strait Islander people receive quality responses and equality of care.

12. Managing conflicts of interest

In establishing the framework for the model of care, consideration should be given to managing the potential for conflicts of interest.

The nature of Supported Accommodation lends itself to a model where the Core Supported are best provided by the Facility because a single team is best to provide coordinated care, communication, scale, and efficiencies.

Having a single team provide care ensures that all team members are aware of the residents' needs and can work together to provide the best possible care. This improves communication and coordination among team members, leading to better outcomes for residents. Additionally, having a single team provide care allows for economies of scale and improved efficiencies in service delivery.

To manage conflicts of interest, such as the potential for 'client capture,' and complaints a well-funded and functional external visitor, regulation and complaint mechanisms must be put in place.

This should be built into existing systems such as the Community Visitor Program run by the Office of the Public Guardian[13] or the NDIS Quality and Safeguards Commission.

This ensures that residents have access to an independent body to voice their concerns, for advocacy services that that any conflicts or complaints are addressed in a timely and appropriate manner.

[13] https://www.publicguardian.qld.gov.au/about-us/community-visitor-program

13. Pathways to Access Supported Accommodation

Pathways to residing in a Facility will be different, depending on the location and circumstances of the individual at the point of referral.

Pathways should be in place to ensure family / self-referrers as well as professional referrers including HHS, mental health services, corrective services and others have a process of referring into Facilities.

A possible, broad pathway to care is outlined below

Patient pathways within the Centre

<table>
<tr><td>Initial Contact</td><td colspan="2">By phone, on-line, walk-in, or referral from other service (e.g. GP, HHS mental health, hospital)</td></tr>
<tr><td></td><td>Family or Self-Referral</td><td>HHS, Mental Health or other professional referral</td></tr>
<tr><td>Referral Form</td><td>Completion of referral form</td><td>Completion of referral form and detailed background information including diagnosis, treatments, behaviours, triggers to enable continuity of care.</td></tr>
<tr><td>Initial Assessment & follow up Questions</td><td colspan="2">Additional information sought as required and appropriate to the referrer’s circumstances</td></tr>
<tr><td>Preliminary Decision</td><td colspan="2">• Assessment undertaken to identify level of need and/or referrals required, using Initial Assessment and Referral decision tool, or similar. Initial support provided.
• AOD use and physical health assessed. GP advised patient is receiving services.</td></tr>
<tr><td>Meet-and-Greet</td><td colspan="2">• Potential resident invited to a meet-and-greet on site
• Meeting with management and socialised with other residents (as appropriate).
• Orientation and introduction to residents’ rules and protocols</td></tr>
<tr><td>Offer of Bed</td><td colspan="2">• Resident offered a bed and asked to trial living in the Facility. A buddy in place if required.</td></tr>
<tr><td>Trial</td><td colspan="2">• Resident moves in on initial trial.
• Support work and case management begins
• GP, pharmacy, treating teams and stakeholder groups advised resident is receiving services.</td></tr>
<tr><td>Accepted as Resident</td><td colspan="2">• After initial trial period and resident settles into Facility, non-clinical assessments undertaken and referrals to other services commenced</td></tr>
</table>

14. Immediate Implementation

The workforce, management and organisational structures are already in place to support a quick roll out. Specific roles and skills can be sought to supplement these teams as required.

The residents of the Facilities have existing relationships with these teams which will reduce stressors to residents which is triggered by a change in supports or accommodation. Using the existing infrastructure is in keeping with best practice of recovery oriented, trauma informed care.

The existing network of Supported Accommodation facilities across the state can be used to roll out the new model of care.

Information and resource materials can be made publicly available through SAPA’s website.

14.1. Medium Term Development

In the medium term, workforce depth, training and development and continue to be supported and strengthened.

Phased Capital Improvements can be introduced to upgrade the facilities and with the right incentives, encourage the development of new purpose-built facilities.

15. Evaluating the Service Model

In broad terms, the following outcomes for residents are expected from each Facility:

- Reduced total cost to the Queensland government from service users
- Residents will receive immediate care when in distress, which will reduce their level of mental and emotional distress
- Individuals experiencing psychological distress or in crisis will receive the care they need in the Facility, resulting in a reduction in the number of non-urgent presentations to local hospital emergency departments. Including a reduction in involuntary treatment.
- Facilitating earlier discharge from hospitals to free up hospital beds
- Reduced medication levels
- Through ongoing support work and early intervention, reduced call outs of emergency services, including police and ambulance
- Access to the particular mental health and related services they are assessed as needed
- Improved access to suitable NDIS, or other Foundational Supports, as appropriate to the individual residents' circumstances
- For those residents who are desirous, successful transition to more independent forms of community accommodation
- Positive employment outcomes
- Reduced homelessness from residents
- Positive feedback from consumers.
- Person centred, recovery-oriented goals for individual residents

Key outcomes of a successful model

Integrated community-based mental health services could include reductions in service delivery costs, hospital admissions and medication levels, and improved social integration. However, the evidence is not entirely clear cut, as full program evaluations with measurable evidence are not readily available.

Key principles to successful integrated community-based mental health care services appear to be collaborative, multidisciplinary teams, a holistic approach to care that takes into consideration the social determinants of mental health, the inclusion of peer workers, an emphasis on improving care pathways and navigation of care, providing extended hours of service availability including crisis phone lines, and individual therapy programs and specialised interventions for diverse groups.

An evaluation framework should be developed to support monitoring and review of the effectiveness of the model of care in achieving these outcomes, and to inform future improvements to the initiative.

Facilities should collect outcomes data to inform an iterative, ongoing evaluation of effectiveness to ensure the needs of the residents are being met.