



Submission to the Parliamentary Inquiry into Homelessness in Victoria

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Abbreviations

ABI	Acquired Brain Injury
AHRC	Australian Human Rights Commission
AHURI	Australian Housing and Urban Research Institute
CCU	Community Care Unit
CRPD	Convention on the Rights of Persons with Disabilities
CMIA	Crimes (Mental Impairment and Unfitness to Be Tried) Act 1997
CSO	Custodial Supervision Order
DHHS	Department of Health and Human Services
DSP	Disability Support Pension
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
OPA	Office of the Public Advocate
RTA	Residential Tenancies Act 1997
SDA	Supported Disability Accommodation
SRS	Supported Residential Services
UN	United Nations
VCAT	Victorian Civil and Administrative Council

Recommendations

Recommendation 1

Corrections Victoria should:

- adopt appropriate protocols to screen for cognitive impairment at entry into prison, which is a contingent factor for successful discharge planning to occur later.
- adopt protocols to identify whether people entering their service are NDIS participants or are potentially eligible to be so, and to facilitate access at the earliest opportunity.
- allow NDIS-eligible prisoners to have access to NDIS planning and supports while in prison.
- Ensure that prisoners who are placed on remand solely because they do not have an address to which they can be bailed, have access to discharge planning while on remand to ensure they are not homeless if they are released after appearing in court.

Recommendation 2

The Victorian Government should ensure that prisoners who remain on remand after sentence expiry because they are homeless are given immediate access to crisis or short-term accommodation with appropriate disability supports and a case worker to support them to find appropriate longer-term accommodation.

Recommendation 3

The Australian and Victorian Governments should:

- address the interface issues between the NDIS and the Victorian prison system to reduce the number of prisoners with cognitive disability becoming homeless upon release because of a lack of appropriate disability supports.
- ensure that prisoners who have had their DSP or Newstart allowance suspended or cancelled because they are in prison are provided with prior release support to have their DSP restored at the earliest opportunity as part of their discharge planning so that at the very least another welfare benefit is secured for them whilst their application is considered.

Recommendation 4

The Victorian Government should establish a specific service to provide a therapeutic programme to address offending behaviours of concern for offenders with an Acquired Brain Injury (ABI) who have been deemed unfit to stand trial and have subsequently received a Custodial Supervision Order under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997.

Recommendation 5

The Victorian Government should develop a Disability Justice Strategy, as proposed in the Australian Human Rights Commission report *Equal before the law* (2014), to reduce the number of people with disability and/or mental illness who are incarcerated due to inadequate support for their needs.

Recommendation 6

The Victorian Government should advocate to the National Disability Insurance Agency (NDIA) that it should consult on, publish, and implement its Maintaining Critical Supports and Immediate Support Response policy and framework as a matter of urgency. This policy and framework should ensure that:

- multiple designated providers of last resort are clearly identified;
- providers of last resort are adequately resourced to enable them to respond immediately in situations of market failure which includes having staff available on short notice;
- the providers and their staff have specialised experience, skill and expertise that are relevant to the specific needs of participants;
- clear procedures exist to guide planners, local area coordinators and support coordinators when the need arises for a provider of last resort to supply any approved support (not just 'critical' supports);
- participant plans have built-in flexibility for situations in which a provider of last resort is required, including the ability to access contingency funding;
- participants are transitioned back to support outside provider of last resort arrangements, as soon as possible;
- providers of last resort mechanisms are established as an ongoing component of the NDIS market (i.e. they continue to exist once the transition to the NDIS is fully completed).

Recommendation 7

The Victorian Government should review the effect of the changes to the Disability Act 2006 and Part 12A of the Residential Tenancies Act (RTA) 1997 on the stability of tenure of residents with cognitive disability who either reside in, or are eligible to reside in, in Supported Disability Accommodation (SDA). The review should be coordinated through the Department of Justice and Community Safety, which has responsibility for the RTA.

Recommendation 8

The Australian Government should provide incentives to encourage more SDA development to meet demand.

Recommendation 9

The Australian Government should:

- Amend the NDIS Act 2013 to guarantee security of tenure for SDA residents and to recognise Community Visitors and their power to visit unannounced all supported accommodation housing people with cognitive disability and mental illness

- Provide clarity around which agency will be responsible for providing a list of eligible SDA dwellings on a regular basis to Community Visitor programs in each state.

Recommendation 10

The Commonwealth and Victorian Governments should commission research into more appropriate accommodation options for people with a disability and mental illness.

This research should:

- fully map at international, national and local level the range of supported accommodation options available
- develop innovative supported accommodation options that move beyond the SDA, congregate care and cluster housing models
- investigate supported housing models such as 'Housing First'.
- develop incentives to better match supply with demand.

Recommendation 11

The National Disability Insurance Agency, in conjunction with Australian, State and Territory Governments, should adjust market levers and policies (including the pricing framework) to ensure the existence of sufficient numbers and diversity of SDA and crisis accommodation providers, and should also ensure that sufficient funds are provided so that SDA provision is able to meet future demand.

Recommendation 12

The National Disability Insurance Agency should establish a central register for participants seeking SDA.

Recommendation 13

The Victorian Government should advocate to the Australian Government that the NDIS Act 2013 should be amended by the Australian Parliament to remove sub-section 29 (1)(b), which states that a person ceases to be a participant in the NDIS when 'the person enters a residential care service on a permanent basis, or starts being provided with community care on a permanent basis, and this first occurs only after the person turns 65 years of age.'

Recommendation 14

The Australian Government should ensure that Australia implements the United Nations recommendation in its report on the review of Australia's obligations under the CRPD that 'persons with disabilities are included as a priority cohort in the implementation of poverty and homelessness reduction programmes, including the National Affordable Housing Agreement and the National Partnership Agreement'.

1. About the Office of the Public Advocate

The Office of the Public Advocate (OPA) is a Victorian statutory office, independent of government and government services that works to safeguard the rights and interests of people with disability.¹ The Public Advocate is appointed by the Governor in Council and is answerable to Parliament.

OPA provides a number of services including the provision of guardianship, advocacy, and investigation services to people with cognitive impairment or mental illness. In 2018-19, OPA was involved in 1,823 guardianship matters (978 which were new), 404 investigations and 258 cases requiring advocacy.² About 49 per cent of OPA's new guardianship clients were over 65 years of age. More than half of OPA guardianship clients under 65 years of age were National Disability Insurance Scheme (NDIS) participants (58 per cent).³

Under the *Guardianship and Administration Act 1986* (Vic), OPA is also required to arrange, coordinate and promote informed public awareness and understanding about substitute decision making laws and any other legislation dealing with or affecting persons with disability.⁴ OPA does this by providing an Advice and Education Service that offers information and advice on a diverse range of topics affecting people with disability. Last financial year, the telephone advice service answered 13,344 calls, 29 per cent of which related to powers of attorney and almost one in ten related to neglect and abuse (nine per cent). OPA also coordinates a Community Education Program where staff address both professional and community audiences across Victoria on a range of topics including the role of OPA, guardianship and administration, enduring powers of attorney, and medical decision making.

OPA's work is supported by more than 700 volunteers across four volunteer programs: The Community Visitors Program, the Community Guardian Program, the Independent Third Person Program and the Corrections Independent Support Officer.

Community Visitors are empowered by law to visit Victorian accommodation facilities for people with disability or mental illness at any time, unannounced. They monitor and report on the adequacy of services provided, in the interests of residents and consumers. They ensure that the human rights of residents or consumers are being upheld and that residents are not subject to abuse, neglect or exploitation.⁵

There are more than 400 Community Visitors who visit across three streams: disability services, supported residential services, and mental health services. Under the *Mental Health Act 2014* (Vic), Community Visitors visit mental health services, including acute and

¹ Guardianship and Administration Act 1986 (Vic) pt 3.

² Office of the Public Advocate (Vic), *Annual Report* (2018-19) Carlton (Vic.): Office of the Public Advocate, 2019, 9.

³ OPA Internal data.

⁴ Guardianship and Administration Act 1986 (Vic) s15(e).

⁵ Office of the Public Advocate (Vic), *Annual Report* (2018-19), 14.

secure extended care units. Community Visitors conducted 5,527 statutory visits across all three streams in 2018-19, 1,670 of which were to 170 mental health units across Victoria.⁶

2. About this submission

The Public Advocate welcomes the opportunity to make a submission to the Parliamentary Inquiry into Homelessness in Victoria (the Inquiry). OPA has research and practice expertise in the Victorian context by virtue of its statutory functions that are relevant to the Inquiry's terms of reference. This submission draws on the experiences of our clients to identify relevant systemic issues concerning homelessness in Victoria.

The evidence used in this submission primarily comes from the stories of OPA clients, which have been de-identified, and pseudonyms used. Information from other OPA publications and submissions is also incorporated, as is relevant legislation and material derived from other organisations' publications where relevant.

2.1 A human rights approach

This submission applies a human rights approach that:

- affirms that all people with disability have the right to enjoy equality of opportunity and to effectively participate in, and be fully included in society
- recognises that the challenges experienced by many people with disability are a result of disabling systems and closed environments, rather than being due to an inherent 'lack' in the individual
- does not deny the reality of impairment or its impact on the individual
- does seek to challenge physical and social environments to accommodate impairment as an expected dimension of human diversity.

The *International Covenant on Economic, Social and Cultural Rights*, to which Australia is a signatory party, is of relevance to housing and the issue of homelessness. In particular, article 11 of the Covenant recognises the right to a decent standard of living, which includes the right to adequate housing and is not merely limited to the requirement of shelter. For instance, the United Nations Committee on Economic, Social and Cultural Rights holds that the following factors are determinative of whether housing can be regarded as adequate: affordability, location, legal security of tenure, availability of services and facilities, habitability, cultural adequacy, and accessibility.

Specific to people with disability, the United Nations *Convention on the Rights of Persons with Disability* (CRPD) recognises the universal right to adequate housing. Articles 14 (the right to liberty and security of person), 19 (the right to live independently and be included in

⁶ Office of the Public Advocate (Vic), *Community Visitors' Annual Report* (2018-19) Carlton (Vic.): Office of the Public Advocate, 2019, 50.

the community), 26 (the right to habilitation and rehabilitation) and 28 (adequate standard of living and social protection) are all relevant.

The United Nations (UN) report on Australia’s review of the CRPD, published on 24 September 2019, speaks to some of the issues raised in this submission. Most relevant is the UN’s recommendation relating to article 28 that “persons with disabilities are included as a priority cohort in the implementation of poverty and reduction programmes.”⁷

OPA calls upon the Victorian government to intervene to fully realise the rights of all people, including people with disability, to be supported to live independently within their communities.

3. Context: The role of statutory guardianship in Victoria

Guardianship is the appointment of a person (‘a guardian’) to make decisions for an adult with a disability (the ‘represented person’) when they are unable to do so.⁸

Under the *Guardianship and Administration Act 1986* (Vic), the Victorian Civil and Administrative Tribunal (VCAT) has the power to appoint a guardian for a person if it is satisfied that the person:

- has a disability⁹
- is unable ‘by reason of the disability to make reasonable judgments’ (about matters relating to their personal circumstances)¹⁰ and
- is ‘in need of’ a guardian.¹¹

When deciding whether to appoint a guardian, VCAT must also consider the wishes of any nearest relatives or other family members of the proposed represented person and the desirability of preserving existing family relationships.¹²

Victoria’s new guardianship legislation, *Guardianship and Administration Act 2019* takes effect from 1 March 2020 and aligns closely with the UN CRPD, by promoting supported decision-making, for example, instead of the current substitute decision-making model of guardianship.

⁷ United Nations, ‘Concluding Observations: UN Report on Australia’s Review of the Convention on the Rights of Persons with Disability (CRPD), 24 September 2019’. New York: United Nations, 2019, 14.

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⁸ Office of the Public Advocate, *Annual Report 2017-18* Office of the Public Advocate 2018, 15.

⁹ Guardianship and Administration Act 1986 (Vic) ss 22(1)(a).

¹⁰ Ibid s 22(1)(b).

¹¹ Ibid ss 22(1)(c).

¹² Ibid ss 22(2)(b)–(c). VCAT is also required to consider the overarching objects in section 4(2) of the *Guardianship and Administration Act 1986* (least restrictive, best interests and the wishes of the proposed represented person are, wherever possible, given effect too).

The Public Advocate is appointed by VCAT as the guardian when there is no other party either able or willing to act (an appointment of last resort).¹³ The Public Advocate is most often appointed as a limited guardian, in that the order of appointment is limited to one or more of the powers and duties that a plenary guardian could be given (being all the powers and duties as if the guardian were a parent of the represented person). In cases where the Public Advocate is appointed guardian for a person over 65 years, the powers most commonly included in the order are those related to accommodation decisions, access to services and health care.

The role of a guardian is to act as a substitute decision maker, acting in the best interests of the represented person, giving effect to their wishes whenever possible in a manner that is least restrictive of their freedom and action.¹⁴ A guardian also acts as an advocate for the represented person.

Because guardianship is a restrictive intervention, a statutory guardian is only involved in a represented person's life for as long as there is a decision to be made and only to the extent of the decision-making authority in the order of appointment. Guardianship orders are usually of limited duration. They are reassessed annually (unless VCAT orders otherwise). Once major decisions are made and implemented and guardianship is no longer needed, the order is usually revoked. For example, if the relevant decision is to place someone in a residential aged care facility, the person has settled well into the facility and there are no other decisions to be made, it is likely that VCAT will revoke the guardianship order. VCAT may also make a self-executing order that expires after a designated period or event, unless an application is made to extend the order (more common for guardianship than administration orders).

A guardian does not have an ongoing case management or ongoing monitoring role, once a decision has been made and successfully implemented.

The role of a guardian does not equate to that of a family member, a friend, a supporter or an independent advocate. A guardian is a decision maker with legislative authority that is often limited to one or two areas of need and is limited in duration.

While guardianship is a last resort protective but restrictive mechanism, it can also be a rights' enabling mechanism in that it promotes the social wellbeing of the person and gives effect to their wishes whenever possible. It is Australia's position that guardianship, when undertaken with appropriate safeguards, is compliant with the United Nations CRPD (2006). VCAT regularly reviews guardianship orders to determine if they are still required and, if the order is not required it is revoked. The maximum period of review is three years, but the more usual period is twelve months. OPA guardians are also required to consider the Charter of Human Rights and Responsibilities Act 2006 (Vic) in their decision making, and apply the National Standards of Public Guardianship, which have been developed by the Australian Guardianship and Administration Council.

¹³ *Guardianship and Administration Act 1986* (Vic) pt 4.

¹⁴ *Guardianship and Administration Act 1986* (Vic) s 22(2).

4. Structure of this submission

Terms of reference

This submission will address all three terms of reference of the Parliamentary Inquiry:

1. provide an independent analysis of the changing scale and nature of homelessness across Victoria;
2. investigate the many social, economic and policy factors that impact on homelessness; and
3. identify policies and practices from all levels of government that have a bearing on delivering services to the homeless.

Issues addressed

The following issues relating to the terms of reference will be highlighted in this submission:

- The criminal justice system
- Mental health
- Supported Residential Services
- The impact of the NDIS
- Specialist Disability Accommodation

5. Homelessness and people with disability

While much reform has occurred in disability policy and service delivery over the last three decades in Australia, the process of deinstitutionalisation has failed to address adequately the need of many people with disability to access long-term accommodation and support. Despite the adoption of the policy of deinstitutionalisation in the 1990s and the closure of the remaining standalone institutions, OPA and Community Visitors report that without adequate housing supports, some people with long-term disability or mental illness are still not afforded the same opportunity to live and participate fully in the life of their community.

The reality is that, while policy frameworks may have changed, housing services have not kept pace with the needs of people with disabilities or, more generally, with the increasing pace of growth in population. In order to be effective, deinstitutionalisation and individualised funding must go hand in hand with the expansion of affordable, high-quality community-based housing options.

Housing instability affects many OPA clients. Through its Advocate Guardian and Community Visitors Programs, OPA has experience in providing advocacy and support to:

- people with disability who need access to affordable, appropriate and safe accommodation;
- people with disability who are neglected, exploited or abused as a result of living in unsuitable or unsafe accommodation because there are no other options available;
- people with disability who are homeless or at risk of homelessness;
- people who are disadvantaged in the housing market as a result of their low income and complex needs;
- people with disability who are isolated, vulnerable and disconnected from their families and communities;
- families and carers of people with disability, including where there is an issue relating to accommodation.

In the Advocate Guardian program, OPA has been appointed as an advocate or guardian of last resort for people with disability and mental illness who are:

- at risk of homelessness because of their involvement with the criminal justice system;
- on a pathway to becoming homeless because of accommodation system failures that cannot meet their specific needs, which can lead to the person cycling through a number of inappropriate accommodation options;
- homeless.

Community Visitors perform a safeguarding role for people in closed environments and sometimes insecure and dangerous accommodation. Community Visitors similarly advocate for people with disability and mental illness on a pathway to, or at risk of homelessness as a result of their involvement with the criminal justice system and/or because of accommodation market failures.

For example, the Community Visitors Program was informed by the service provider about the situation of 'Joe' in the case story below.

Case story 1

Joe became homeless following the death of his mother and the inability of his father to care for him. Through his NDIS plan, he was able to obtain respite accommodation for a two-week period, however, the move to an unfamiliar environment coupled with emotion and anxiety were factors behind him assaulting other residents and staff within the service. Consequently, the service provider advised they could no longer provide him with support and that he would have to find alternate accommodation. The provider claimed it was not safe for their staff to be involved with this client.

The provider was proactive and assisted Joe to move into an Airbnb and sought an ongoing residential placement. However, they were unsuccessful due to the hurdles described below.

Firstly, the NDIS planner was not responsive to this client's situation, despite being alerted of the change in circumstances as well as the urgency of the situation. Furthermore, the client has cycled through three support coordinators over the course of a year, which has been disruptive to the search.

NDIS market issues were also at play; due to his behaviours of concern and known aggression, this client required sophisticated services in a thin market, and relevant services were refusing to accept him.

Over a period of time spanning more than a year, the client has trialled multiple, albeit temporary, accommodation settings. Assessments by allied health professionals have recommended disability supports required to support this client and that aim to ultimately reduce behaviours of concern. However, without a fixed home in which to deliver these services, it has not been possible to implement the recommendations. In the absence of an address, all other services have also come to a halt.

The provider has remained involved to provide advocacy on a 'pro-bono' basis, although they recognise that this is not their role and should instead be the task of the National Disability Insurance Agency (NDIA) planner and support coordinator.

In this case story— a scenario that OPA clients can commonly be confronted with — an OPA advocate/guardian cannot achieve much more than the parties which are already involved with regards to sourcing accommodation. That is, a guardian will certainly advocate for a represented person but will be met with thin markets and similar reluctance on behalf of service providers.

Until 1 March 2020,¹⁵ guardians are required to make decisions that are in the best interests of a represented person. With regards to accommodation, guardians are usually met with a scarcity of options. In practice, guardians often have no alternative other than to consent to the safest available accommodation option, even when they recognise that the chosen

¹⁵ The *Guardianship and Administration Act 2019* (Vic) will come into effect on 1 March 2020. Under the new Act, guardians are to make decisions based on the represented person's 'will and preferences'.

accommodation may not fully meet the represented person's preference or support needs. This may mean consenting to a young person being discharged from hospital into a residential aged care facility because that is the safer option.

The following overarching themes underlie the key topics that are addressed in this submission.

Gaps in services: There are gaps in services. Some people fall through those gaps when their needs cannot be met by the service system, and they become homeless.

No provider of last resort: In the NDIS market-driven system there are no longer providers of last resort who must take on clients with multiple and complex needs and provide appropriate supported accommodation and other services. This thin market of appropriate service providers, or sometimes the lack of providers, can lead to homelessness.

Guardianship is not a solution: Guardians are substitute decision-makers who can make decisions based on available options. Where there are no options, guardians have no decision to make. Guardians can advocate for their client for better options but cannot force a provider to create options or accept a client. Nor can guardians force a client who is mobile and refuses services to accept services.

Unsafe and insecure housing options: This submission also describes the systemic issues that people with disability face when seeking housing: unavailability of stock (both within and outside the NDIS market), waiting lists and delays, and as a result, compromised safety. While some people with disability may have a roof over their heads, many of these options offer little to no security of tenure, often limited access to private space, may be dangerous environments, and, ultimately, do not promote positive outcomes.

A 'Housing First' approach, which has been adopted in the USA, Canada and New Zealand as a key method for housing homeless people with complex needs, may address the problem of housing people with a disability and mental illness in the long-term. The Australian Housing and Urban Research Institute (AHURI) has long advocated for a 'housing first' approach to address homelessness because the provision of housing provides the stability for the person, which then enables other complex issues to be addressed in a holistic way with service providers cooperatively working together to provide the 'wrap around' support needed. The financial savings to the housing and other service systems can be substantial.¹⁶

¹⁶ Australian Housing and Urban Research Institute, 'AHURI Brief: "What is the Housing First model and how does it help those experiencing homelessness?: The benefits of prioritising housing for those experiencing homelessness". Melbourne: AHURI [2018] <https://www.ahuri.edu.au/policy/ahuri-briefs/what-is-the-housing-first-model> accessed 12/1/20. A similar model in Canada focused on people with a mental illness and was successful using the 'Housing First' model. See Eric McNaughton et al. *The At Home/Chez Soi Project: Moving Evidence into Policy: The Story of the At Home/Chez Soi Initiative's Impact on Federal Homelessness Policy in Canada*. Ottawa: mental Health Commission of Canada, 2016. <http://www.mentalhealthcommission.ca>

5.1 Criminal justice system

OPA is concerned that prisons have become institutions for people with cognitive disability or mental illness who have been failed by other service systems that have been unable to meet their complex support needs. In part, this is the case because of the lack of a 'provider of last resort' of appropriate disability accommodation and supports which will take on clients with the most complex needs. In a recent OPA publication, 'The illusion of 'choice and control'—which used actual OPA cases in de-identified form: 'Robert's story' exemplified the type and difficulty of the issues involved in finding appropriate accommodation for someone with complex disability or mental health support needs.¹⁷

The correlation between involvement in the criminal justice system and homelessness is clear. A recent report by the Australian Institute of Health and Welfare shows that this issue is an ongoing problem: one in three persons entering prison report being homeless in the four weeks before prison¹⁸ and over half of the persons being discharged from prison expect to be homeless upon release.¹⁹

There are multiple time points in a trajectory through the justice system where a person's insecure housing status has adverse consequences, or where the justice system can put the person at risk of homelessness. These are described below.

At the time of an arrest, some OPA clients are not granted bail because there is no appropriate supported accommodation that meets their specific needs to be bailed to. As a result, some people are spending more time on remand in custody awaiting their day in court than they would if they had been sentenced to a term of imprisonment. In these cases, people are released from court without the opportunity for any discharge planning at all. Whilst on remand they typically have had no access to discharge planning to arrange accommodation and other supports.

Some prisoners then remain in custody after having served their sentence because they do not have an address to be released to nor do they have the necessary supports. This is especially true for people with high and complex needs. Some OPA clients find themselves caught in a cycle where their release is contingent upon locating supports, yet it is hard to enlist supports from within a custodial setting. On the larger scale, this may contribute to the high proportion of Victorian prisoners on remand (currently estimated to represent about one third of the prison population).

The Victorian Ombudsman recently investigated an individual case where this occurred. The case concerned a woman with the pseudonym 'Rebecca' who was an OPA client. Rebecca was charged with a minor offence and found unfit to plead. There was no specialist treatment facility suitable for her disability needs and she spent 18 months on remand in

¹⁷ Office of the Public Advocate, *The illusion of 'Choice and Control'*. Carlton: Office of the Public Advocate, 2018, 10-11. The broader systemic issues raised are discussed extensively with case examples included at pp.28-45 and also in 'Ryan's story' at pp.64-8.

¹⁸ Australian Institute of Health and Welfare 2019. *The health of Australia's prisoners 2018*. Cat. no. PHE 246. Canberra: AIHW. 22.

¹⁹ *Ibid*, 24.

prison, mostly in 23-hour lockdown, before a suitable placement was found.²⁰ Rebecca was ultimately an NDIS participant but the processes of the NDIS and other agencies for arranging supports for her were lengthy. Whilst issues with the operation of the NDIS remain, including those described in this section of the submission, Rebecca did ultimately benefit from her participation in the scheme, and the operation of the agency has improved since the release of the Ombudsman's report.

Upon a person's release from jail, irrespective of whether they have been on remand or sentenced, social and economic circumstances are likely to result in the person being homeless. Poor pre-release and post-release planning for people with disability who are leaving custody can lead to the acceptance of inappropriate supports, including accommodation, which consequently increases the risk of reoffending. A 2015 Victorian Ombudsman report on the rehabilitation of prisoners found that housing instability is a factor predicting return to prison. Transitional supports for prisoners are effective in reducing this risk, yet few prisoners are afforded comprehensive pre and post release supports. Indeed, the Ombudsman estimates that only 1.7 per cent of Victorian prisoners have access to housing through the two existing state government programs for former prisoners. As a result, the risk of offending again is elevated, especially if no other supports are organised for the individual.

In the recent OPA submission to the Victorian Government's Royal Commission into Mental Health, OPA referred to 'Mark's' story (not his real name). As a result of his multiple disabilities and complex support needs, Mark needed appropriate pre-release planning, including assistance with applications to Centrelink and assistance obtaining housing. Despite his requests for this assistance from the prison, it was not provided, and he was released with nowhere to go. He has since returned to custody, hoping that when he is next released he will be provided with the assistance he needs.²¹ The provision of a 'Housing First' type model referred to in section 5.4 below would have provided the type of support 'Mark' needed to achieve his goal of not reoffending and returning to prison.

This issue of supporting prisoners not to reoffend upon release is an important area for reform and OPA has long advocated for thorough pre-release planning.²² Yet little has happened to address this issue. The Ombudsman makes the following call to action in relation to supports for prisoners:

The state needs a comprehensive approach – across the justice system, education, health and housing – to focus on the causes of crime rather than its consequences. Offenders need to be dealt with in ways that make it less likely they will reoffend –

²⁰ Ombudsman of Victoria, 'Saddest case: 18-month imprisonment of a Victorian woman found unfit to stand trial'.

<https://www.ombudsman.vic.gov.au/News/Media-Releases/imprisonment-of-woman-found-unfit-to-stand-trial> (16/10/18) [accessed 18/12/19].

²¹ Office of the Public Advocate, *Submission to the Royal Commission into Victoria's mental health system*. Carlton (Vic.): Office of the Public Advocate, 2019, 39-40.

²² One example is Office of the Public Advocate, *From Corrections to Community: 'The Need for Transitional Support Services for Offenders with a Cognitive Disability'*. Carlton: Office of the Public Advocate, 2003.

through alternatives to imprisonment where appropriate, or through a prison system with a greater focus on rehabilitation.²³

There is confusion at critical points in the criminal justice system as to when a person can access and receive funding for NDIS supports. It has also been difficult for NDIS funded services to gain entry to custodial settings to support prisoners. It is crucial that the interface issues be resolved in order to fully support people with disability to secure accommodation upon release from a custodial setting.

Similarly, entering a custodial setting restricts a person's ability to maintain critical safety nets related to stable housing. For instance, prisoners may not be able to continue to make rent payments and maintain a fixed address to which they can be released. Likewise, an NDIS participant who is living in an SDA who has not paid their rent for 14 days could be issued with a breach of duty notice, which could lead to a notice to vacate.²⁴ Public housing, on the other hand, can act as a safeguard, which can serve to cut through many of the obstacles described above.

The situations described above will become even more acute as a result of recent changes to the eligibility provisions for the Disability Support Pension (DSP). Most people with disability who have come into contact with the criminal justice system would be eligible for the DSP. The changes to the eligibility for the DSP from 1 January 2019 for people in prison (including remand) make it more difficult for people with disability to access the DSP once they are released. Under the new provisions, a person's DSP is cancelled after 13 weeks in prison compared to the previous cut-off date of two years in prison. The person would have to re-apply after that period and meet any new eligibility criteria, which may be more onerous than those conditions under which they had previously applied.²⁵

As a result, even if the person had accommodation, the lack of income would mean that the person could not pay their rent and would more than likely lose their housing. The clock starts ticking once a person is placed on remand. In effect, a person released from prison, including those people on remand, not yet found guilty of an offence, could be released from prison with nowhere to live and no income. These changes to the DSP further disadvantage people with cognitive disability and could increase the risk of re-offending, recidivism and homelessness.

Case Story 2

Bruce has been in prison for several months and has lost his eligibility for the DSP. He has a financial administrator who has put his personal belongings in storage for the duration of his imprisonment. Because he has lost his eligibility for the DSP, he is building up a debt he cannot pay and may lose all his personal belongings.

²³ 'Ombudsman of Victoria, 'Saddest case', 3.

²⁴ *Residential Tenancies Act 1997* s. 498ZX 1(a) & 2 (Notice to Vacate) and s. 498ZP (Brach of Duty notices).

²⁵ 'Department of Human Services 'Budget 2018-19: Disability Support Pension — aligning suspension periods for imprisoned recipients. www.humanservices.gov.au May 2019.

There is also a dearth of therapeutic treatment options for offenders with an Acquired Brain Injury (ABI) who have been deemed unfit to stand trial and are subsequently incarcerated under a Custodial Supervision Order (CSO), under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (CMIA). The Public Advocate is currently guardian for two such prisoners. They have both served over three years in custody and the NDIS has taken some time to accept their referrals and put in place limited plans. The biggest obstacle preventing their return to the community is a complete lack of suitable housing that meets their needs.

Whilst there are limited options for other cohorts, there are no specialist facilities for people with an ABI. For example, Thomas Embling Hospital is available for people with a mental illness who are incarcerated under a CSO under the CMIA Act. Thomas Embling Hospital is Victoria's only forensic mental health facility, and it faces the same pressures as other inpatient mental health services across the state, most notably a shortage of beds. However, there is no equivalent service at all for people with an ABI.

Similarly, some people with an intellectual disability receiving compulsory treatment under the provisions of the Disability Act 2006 (Vic.) may receive treatment at a residential treatment facility such as the Disability Forensic Assessment Service. There are no suitable, comparable therapeutic options for people with an ABI.

ARBIAS Inc. is funded to support people with an ABI including accommodation but their capacity to deal with ex-prisoners who have behaviours of concern and complex presentations is limited. The Brain Disorders Unit, part of Austin Health, is unable to take prisoners with very severe behaviours of concern. Previous Victorian Public Advocates have raised the issue of a lack of therapeutic options for people with ABI who have severe behaviours of concern with state governments before but to date no action has been forthcoming.

The likelihood of homelessness further increases when newly released prisoners with disability or mental illness do not meet the threshold for the DSP under the current rules and are placed instead on the much lower Newstart allowance. They may move into a Supported Residential Service (SRS) and are usually unable to stay for very long because they cannot pay their rent. In its recent annual report, the Community Visitors met a resident who was about to be evicted from an SRS because he could not afford the fees for his accommodation on his Newstart allowance. He had been in prison for 17 years, had a serious mental health condition, very poor physical health and only his eye teeth left. He had no family contact or friends on the outside, so relied on his Mind Australia case worker who was assisting him to access a pension and temporary housing.²⁶

The Australian Human Rights Commission's (AHRC) *Equal Before the Law* report (2014) is a significant document for people with disability and all Australians. In conducting its research and consultation, the AHRC heard stories of where the criminal justice system had failed people with disability and mental illness and had compounded disadvantage, in addition to some positive examples of where best practices were occurring.²⁷ The report

²⁶ Office of the Public Advocate, *Community Visitors Annual Report 2018-19*, 76.

²⁷ Graeme Innes, Australian Human Rights Commission, *Towards Disability Justice Strategies* <https://www.humanrights.gov.au/ourwork/disability-rights/publications/equal-law>

proposed possible actions towards the development of a state or territory administered Disability Justice Strategy as a beneficial approach to address some of the inequities faced by people with disability. The AHRC recommended the development of a Disability Justice Strategy to reduce the number of people with disability and/or mental illness who are incarcerated, particularly as there is likely to be inadequate support for their needs in prison. OPA endorses this recommendation.

Recommendation 1

Corrections Victoria should:

- **adopt appropriate protocols to screen for cognitive impairment at entry into prison, which is a contingent factor for successful discharge planning to occur later.**
- **adopt protocols to identify whether people entering their service are NDIS participants or are potentially eligible to be so, and to facilitate access at the earliest opportunity.**
- **allow NDIS-eligible prisoners to have access to NDIS planning and supports while in prison.**
- **Ensure that prisoners who are placed on remand solely because they do not have an address to which they can be bailed, have access to discharge planning while on remand to ensure they are not homeless if they are released after appearing in court.**

Recommendation 2

The Victorian Government should ensure that prisoners who remain on remand after sentence expiry because they are homeless are given immediate access to crisis or short-term accommodation with appropriate disability supports and a case worker to support them to find appropriate longer-term accommodation.

Recommendation 3

The Australian and Victorian Governments should:

- **address the interface issues between the NDIS and the Victorian prison system to reduce the number of prisoners with cognitive disability becoming homeless upon release because of a lack of appropriate disability supports.**
 - ensure that prisoners who have had their DSP or Newstart allowance suspended or cancelled because they are in prison are provided with prior release support to have their DSP restored at the earliest opportunity as part

accessed 4 April 2016.

of their discharge planning so that at the very least another welfare benefit is secured for them whilst their application is considered.

Recommendation 4

The Victorian Government should establish a specific service to provide a therapeutic programme to address offending behaviours of concern for offenders with an Acquired Brain Injury (ABI) who have been deemed unfit to stand trial and have subsequently received a Custodial Supervision Order, under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*.

Recommendation 5

The Victorian Government should develop a Disability Justice Strategy, as proposed in the Australian Human Rights Commission report *Equal before the law*, to reduce the number of people with disability and/or mental illness who are incarcerated due to inadequate support for their needs.²⁸

5.2 Mental health

Community Visitors and OPA continue to identify a serious deficiency in the availability of less restrictive, home-like, community-based accommodation options for people with chronic mental illness. This leads to people with ongoing mental health support needs remaining in inpatient settings, cycling through short-term accommodation, or potentially becoming homeless. All these scenarios can impede an individual's recovery.

For example, a mental health patient was to be discharged from an acute service into homelessness, with a warm coat and sleeping bag purchased by the service. The service tried to find accommodation for him but there were limited options and he refused all offers. The Community Visitors Program contacted the Office of the Chief Psychiatrist which liaised with the service. The service consequently provided the person with three nights' accommodation, and a community mental health service agreed to assist with medication.

Some services refuse to discharge to homelessness, resulting in bed blockages and, sometimes, acute-level care for people who no longer need it. OPA's long stay patient project involves the collection and analysis of data by Community Visitors to identify consumers who are in mental health units for extended periods of time. Community Visitors request long stay patient data from staff for publication in their annual report.

'Long stay patients' are defined as consumers spending more than three months in an adult acute unit or more than two years in a Community Care Unit (CCU), Secure Extended Care Unit or other units such as Thomas Embling Hospital and Mary Guthrie House.

²⁸ Office of the Public Advocate, *Submission to Senate Community Affairs Reference Committee: indefinite detention of people with cognitive and psychiatric impairment in Australia* Carlton, Vic. Office of the Public Advocate, 2016, 13.

Since 2007, Community Visitors have identified a remarkable number of consumers who are 'long stay patients'. Many involuntary consumers spend protracted periods of time in these restricted settings on the sole basis that there is nowhere else for them to go.

At the last data collection point in 2018-2019, 27 per cent of these consumers were unable to be discharged because of a lack of suitable accommodation. Community Visitors identified 92 long stay consumers across 21 Victorian mental health facilities, an increase from 2015-2016 when 65 long stay consumers were identified. It is the highest recorded figure since 2010.

The duration of stay of these 92 long stay consumers varied from three months to 24 years for three consumers in a CCU. Multiple barriers prevented discharge from mental health units. In some cases, the person may be too unwell to move on from the service and in these cases, it can be appropriate for them to continue to receive care. In addition, only one-third of consumers aged under 65 years of age had an NDIS plan. Having an NDIS plan, if the patient is eligible, may speed up the process of discharge. However, the most consistently cited factor preventing discharge for long stay consumers was a shortage of accommodation that could ensure a transition into a less restrictive setting and provide the required level of care. In other words, some long stay consumers are residing in overly restrictive environments for lack of alternative step-down accommodation options.²⁹

The capacity of the mental health system to meet its human rights obligations in line with the Victorian Charter of Human Rights and Responsibilities and the UN CRPD is severely compromised by these shortages in community-based accommodation. OPA contends that it is not reasonable to limit a person's rights where their circumstances are dictated by the failure of the service system to provide less restrictive options.

5.3 Supported Residential Services (SRS)

SRS are privately operated residences that provide accommodation and support for individuals who need help with everyday activities. Each SRS differs in services, residents, and fees. SRS can accommodate up to 80 residents, many who live in shared rooms. In pension-only SRS, residents pay approximately 90 to 95 per cent of their disability pension and rent assistance in fees.

SRS residents have varying levels of support needs. The overwhelming majority (91 per cent) have at least one disability. That figure rises to 96 per cent in pension-level SRS, with 60 per cent of them having a mental illness.³⁰ In OPA's experience, the SRS sector is often asked to fill the gap left in the absence of community-based accommodation for people with disability or mental illness. There are a large number of people with mental health issues who would likely be homeless if not living in these facilities. Community Visitors are concerned that there is a misperception in the mental health sector that clinical staff are employed in SRS or that SRS are step-down mental health facilities. SRS can only provide minimal levels of supports to enable people to live in the community. While they meet the needs of some residents, they are not usually suitable for individuals with more complex

²⁹ Office of the Public Advocate, *Community Visitors Annual Report 2018-19*, 9, 54-55.

³⁰ Department of Health and Human Services (Vic), *Supported Residential Services Census 2013*. Melbourne: Department of Health, 2013.

presentations of disability and/or mental illness, particularly as they have such low staff to resident ratios of one to 30, In some ways, SRS replicate many of the features of institutions. Community Visitors meet pension-level SRS residents who require support beyond that which can be reasonably provided by the facility. In some cases, proprietors lack the skills and resources to support people with mental health conditions, thereby increasing their risk of homelessness.

The increased reliance on SRS as a result of the dearth of supported accommodation for this cohort is not an appropriate or effective systemic response. The prevalence of mental illness in combination with drug and alcohol use creates incompatibilities between residents and can often heighten tensions within an SRS, meaning that for many, SRS are unsafe.

Since 2013, Community Visitors have reported 453 issues related to abuse, violence, and neglect within SRS. Aggression occurs between SRS residents, as well as between SRS residents and staff and, according to Community Visitors data, the number of incidents related to resident safety has steadily increased in the past five years. Community Visitors also report a high number of sexual assaults, with more than 50 per cent of pension-level SRS having incidences of one or more sexual assaults.

Sometimes police are called, and in many instances, violent episodes lead to resident evictions, adding pressure on residents to find alternate accommodation and placing them in a precarious situation that may result in homelessness. To this point, the DHHS 2018 SRS census data show that the most commonly cited reason for the issue of a notice to vacate is 'a resident endangering the safety of other persons.'³¹ In many instances, violent episodes led to resident evictions, pressure on people to move to another SRS or even homelessness.

Despite a high need for supported accommodation, some SRS operate with empty beds. In the 2018 SRS Census, proprietors cite the following reasons for empty beds: lack of suitable residents, residents moving to higher care, and residents not being able to afford to stay.

Simultaneously, OPA and Community Visitors are aware that newer pressures are threatening the financial viability of SRS. There has been a significant loss of beds in recent years: since 2013 when the sector counted 5,400 beds, Community Visitors have identified fourteen SRS closures, bringing the number of beds in the sector down to 4,399 (i.e. a 20 percent decrease). The roll out of the NDIS is one contributing factor.

While SRS are often an accommodation of last resort and are not appropriate for some people, they nonetheless fill an important gap in the absence of better accommodation options. Community Visitors and OPA have ongoing concerns about bed losses in the sector when no additional accommodation options are being funded to fill the gap.

5.4 NDIS

The NDIS will ultimately support 460,000 Australians with disability, including through the provision of Supported Disability Accommodation (SDA). However, the vast majority of NDIS

³¹ Department of Health and Human Services (Vic), *Supported Residential Services Census 2018*. Melbourne: DHHS, 2019.

participants will not be eligible for SDA funding. Only approximately six per cent of all NDIS participants will receive funding for SDA. This group is comprised of those people with disability who require specialist housing solutions, including to assist with the delivery of supports that cater for an extreme functional impairment or very high support needs. Many other NDIS participants will receive other supports to enable them to live in the accommodation setting of their choice (but outside of the NDIS market).

The intention behind the NDIS is to enable people with disability to choose the type of housing and support they require to enhance their quality of life. Despite the promise of choice and control, OPA is concerned that the NDIS and the introduction of SDA funding does not signal the end of congregate living arrangements for people with disability. Such living arrangements have been shown to lead to poorer outcomes for people with disability. To this point, the UN report on Australia's Review of the CRPD raised concerns that the SDA framework "facilitates and encourages the establishment of residential institutions and will result in persons with disabilities having to live in particular living arrangements to access NDIS supports."³²

This is made explicit in the secondary legislation that sets the parameters of the NDIA's decisions around SDA approval, the *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016* (SDA rules). The SDA rules foster the arrangement that NDIS participants who require 24/7 support live in shared arrangements.³³ OPA fears that cluster living arrangements will continue to prevail in the new environment and, in some cases, will operate with fewer safeguards.

Whilst there are examples of very good group homes, and it is essential that high-quality group homes are available to ensure that people with a disability are able to realise their right of choice and control over where they live, the group home model does not work for everyone. OPA and Community Visitors have reported on violence and abuse in these settings over many decades. OPA's recent report *I'm too scared to come out of my room* considers five key factors that affect the prevention of, and adequate response to, violence in congregate care settings and makes 38 recommendations for reform.³⁴

Many OPA clients are eligible for SDA, having previously resided in state-owned group homes. The transition to the NDIS has marketized the provision of residential disability supports and has, to date, placed some NDIS participants at higher risk of homelessness.

There are several contributing factors to this situation. First, it is widely accepted that the SDA market is currently unable to meet demand and while some market development strategies have been proposed, it will take years for supply to reach required levels.

Second, where previously disability residential services were funded, managed, and in many cases operated by the Victorian Government, the NDIS introduces a privatised approach to

³² United Nations, 'Concluding observations', 11.

³³ *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016* s.4.7 (b) provides 'if the participant requires constant person to person supports and cannot be left alone for periods of time, the most appropriate support model may be shared onsite support'.

³⁴ Office of the Public Advocate. *'I'm too scared to come out of my room': Preventing and responding to violence and abuse between co-residents in group homes*. (Carlton (Vic.): Office of the Public Advocate, 2019).

service provision. That is, while funding is provided by the Government through individualised plans, SDA and all NDIS services are provided by non-government organisations and are therefore not immune to market stressors. Perhaps most significant in relation to homelessness is the reality that, in a free market, there is no provider of last resort. A provider can choose to leave the market at any time and under the NDIS rules, has very little obligation to support an SDA resident to find alternative accommodation. This could create a crisis for a tenant, as OPA has seen occur and there is no available crisis response. Indeed, the stimulation of the SDA market has proven challenging and thin markets in this area have caused many participants who have SDA funding in their plan to remain in, or to choose to enter, alternate housing arrangements that are inadequate for their circumstances. This situation points to a lack of adequate safeguards.

Third, the process of approval for SDA funding and subsequently sourcing a provider can be further delayed by bureaucratic hurdles and delays.

Case Story 3

When June, a woman with both an intellectual disability and mental illness spent time in a mental health facility, her SDA provider indicated to the hospital that June could not return to her SDA because of her challenging behaviours. These behaviours were most likely caused because she had been relocated from her previous SDA without appropriate transition supports being put in place. Furthermore, there were problems regarding June's transition to the NDIS and poor support coordination and service planning at June's original SDA. In effect, because of all these moves, June lost her "grandfathered" eligibility for SDA, which has now dropped out of her NDIS plan. The loss of SDA eligibility by default rather than assessment is a key concern. Her private guardian is seeking to stabilise June's health and medication, has engaged another NDIS support provider, sought a review of June's plan to include SDA, and arranged behavioural support assessments and future accommodation planning for June. There appears scope for a complaint to the NDIS Commissioner for Quality and Safeguards in relation to her treatment by her SDA provider. The private guardian has also been unable to find respite accommodation that were able to take her. June remains in the mental health facility, where she can remain for some time until more appropriate accommodation can be found. The facility agreed to this placement, even though there is pressure on beds in the facility. The hospital agreed because it was aware that there was nowhere else for June to go until an NDIS plan with appropriate SDA is put in place. If the facility had not agreed to this long-term placement for June, she would be homeless.

Prior to the introduction of the NDIS, relocation mechanisms were available to the DHHS when a crisis occurred. Those mechanisms are no longer available. As SDA is managed by a multiplicity of providers, and the DHHS no longer plays a funding or regulatory role, there is no way to 'oblige' a provider to take on a client in need. The NDIA has not yet found a system wide resolution to issues like these ones. Instead, respite services are too often used for crisis situations. For example, in one area, thirty families who were using a respite service had their booking cancelled for up to nine weeks when the house was used for one high risk client who posed a serious safety risk to other residents and staff. Regular users of the respite service were redirected to an alternative service, which normally caters for children only. Children's respite services were cancelled two days a week to accommodate adult clients during this time. One family considered applying for full-time care as they were

struggling to cope without access to regular respite. Behavioural assessments needed to be conducted to explore more suitable permanent housing options for this high-risk client, which would take several months. Subsequently, the client was detained within a justice facility following a serious incident so the respite service could resume.³⁵

OPA repeats with minor revisions recommendation 8 from *The Illusion of Choice and Control* below.

Recommendation 6

The Victorian Government should advocate to the National Disability Insurance Agency (NDIA) that it should consult on, publish, and implement its Maintaining Critical Supports and Immediate Support Response policy and framework as a matter of urgency. This policy and framework should ensure that:

- **multiple designated providers of last resort are clearly identified;**
- **providers of last resort are adequately resourced to enable them to respond immediately in situations of market failure which includes having staff available on short notice;**
- **the providers and their staff have specialised experience, skill and expertise that are relevant to the specific needs of participants;**
- **clear procedures exist to guide planners, local area coordinators and support coordinators when the need arises for a provider of last resort to supply any approved support (not just ‘critical’ supports);**
- **participant plans have built-in flexibility for situations in which a provider of last resort is required, including the ability to access contingency funding;**
- **as soon as possible, participants are transitioned back to support outside provider of last resort arrangements;**
- **providers of last resort mechanisms are established as an ongoing component of the NDIS market (i.e. they continue to exist once the transition to the NDIS is fully completed).**

Case Story 4

OPA was appointed as guardian for Liam who was receiving hospital care. When he was ready to be discharged, his parents relinquished Liam’s care because his behaviours of concern had significantly escalated during his hospital stay. However, for this same reason, no NDIS respite service was willing to take him on as a client. NDIS planning meetings and plan reviews were organised by the hospital staff, but it took nearly six months to find safe and suitable

³⁵ Community Visitors, *Annual report 2017-18*, 49.

accommodation to which Liam could be discharged. During this time, he did not require hospital level care and was unnecessarily occupying a hospital bed.

OPA is involved in several similar examples where delays in the administration of the NDIS result in people with disability remaining in custody or in hospital, or cycling through respite, motel, and family settings, all of which arguably contribute to a deterioration of their physical, mental, and behavioural wellbeing.

Fourth, NDIS participants with complex needs and behaviours of concern are not experiencing choice and control over services as intended. This is because in a free market, choice and control is equally applicable to both participants and providers. In other words, SDA (and other) providers can refuse to provide services to participants. OPA has been involved in numerous similar cases, which require increased advocacy efforts by advocate guardians on behalf of participants. OPA maintains its recommendation for a provider of last resort for this cohort.

Finally, OPA has serious concerns about the transition of safeguards related to tenure in disability residential services. In the transition to the NDIS, many of the safeguards that were previously provided through the Disability Act are now diffused between the NDIS Act and the Residential Tenancies Act. The regulatory landscape is more complicated than ever, and oversight, including that of the Community Visitors, has lessened. It remains to be seen what impact these changes will have on safeguards for security of tenure in residential disability services in the longer-term and whether this contributes to more people with disability becoming homeless.

Recommendation 7

The Victorian Government should review the effect of the changes to the Disability Act 2006 and Part 12A of the Residential Tenancies Act (RTA) 1997 on the stability of tenure of residents with cognitive disability who either reside in, or are eligible to reside in, in Supported Disability Accommodation (SDA). The review should be coordinated through the Department of Justice and Community Safety, which has responsibility for the RTA.

Recommendation 8

The Australian Government should provide incentives to encourage more SDA development to meet demand. Recommendation 9

The Australian Government should:

- Amend the NDIS Act 2013 to guarantee security of tenure for SDA residents to recognise Community Visitors and their power to visit unannounced all supported accommodation housing people with cognitive disability and mental illness
- Provide clarity around who will be responsible for providing Community Visitor programs in each state with list of eligible SDA dwellings on a regular basis.

The NDIS, and more specifically SDA reforms, should continue to be regarded as a positive development for people with disability. However, if the promise of choice and control cannot be fully realised, NDIS participants will continue to live in inappropriate, unstable, and sometimes unsafe settings that increase the risk of becoming homeless.

Recommendation 10

The Commonwealth and Victorian Governments should commission research into more appropriate accommodation options for people with a disability and mental illness.

This research should:

- **fully map at international, national and local level the range of supported accommodation options available;**
- **develop innovative supported accommodation options that move beyond the SDA, congregate care and cluster housing models including supported housing models such as ‘Housing First’;**
- **develop incentives to better match supply with demand.**

OPA repeats recommendations 11 and 12 from its report ‘I’m too scared to come out of my room’: Violence in Group Homes (2019), below.

Recommendation 11

The National Disability Insurance Agency, in conjunction with Australian, State and Territory Governments, should adjust market levers and policies (including the pricing framework) to ensure the existence of sufficient numbers and diversity of SDA and crisis accommodation providers, and should also ensure that sufficient funds are provided so that SDA provision is able to meet future demand.

Recommendation 12

The National Disability Insurance Agency should establish a central register for participants seeking SDA.

The dearth of housing options for people with a disability aged over 65 can also lead to the loss of funded services through the NDIS for people in that age group.

People seeking to access the scheme must be under 65 years old. However, once in the scheme, participants are generally able to continue receiving much needed supports after the age of 65. Section 29 of the NDIS Act, however, provides that a person automatically ceases to be a participant if they are in receipt of aged care services in certain circumstances. The operation of this provision, particularly in the context of thin markets, can lead to unfair outcomes for people who have no choice but to accept aged care services once they are older than 65.

This case story below illustrates the 'illusion of choice and control' in a rural area where a lack of accommodation options does not provide a 'choice' for a woman who was forced to move into a residential aged care facility because of a lack of alternate housing options and, as a result, denied access to her previous NDIS funding because of her age.

Case Story 5

The Public Advocate was appointed as a guardian with powers to make decisions relating to accommodation for Issy, a 66-year-old woman. At the time of appointment, Issy was receiving NDIS funding to access community activities. She was living in a SRS in country Victoria, but that service was closing, thus prompting the need to source alternative accommodation to avoid homelessness.

A lack of suitable and available disability accommodation options in that area led the guardian to consent to Issy moving into a residential aged care facility, close to the community centre she frequented. In the first instance, Issy occupied a respite bed and later her placement was made permanent as she informed the guardian that she was happy there. Following this, a scheduled NDIS planning meeting was cancelled by the NDIA who informed OPA that Issy had lost her NDIS eligibility by reason of section 29 of the NDIS Act, which stipulates that a person ceases to be a participant when "the person enters a residential care service on a permanent basis, or starts being provided with community care on a permanent basis, and this first occurs only after the person turns 65 years of age."

OPA was advised that a new access request could not be made and, furthermore, that a decision made under section 29 is not a 'reviewable decision' as defined under the NDIS Act.

By losing NDIS funding, Issy faces a significant decrease in the supports that are provided to her. The aged care system does not provide disability supports to the same extent that were available to her under the scheme. While the guardian has requested a plan review in the hopes of applying for Supported Independent Living and/or Specialist Disability Accommodation (SDA) funding, this will not change the fact that there is a scarce supply of suitable options in that region.

Thin markets in supported disability accommodation, and in the housing market more broadly, limited Issy's options by no fault of her own. Had she been only a few years younger she could have entered residential aged care and continued to benefit from the NDIS into old age. Her story illustrates how section 29, when implemented, can result in age-based discrimination; it is, as prescribed in the Act, only those who enter residential aged care after the cut off age who lose NDIS funding.

OPA recommends that this provision be removed altogether from the NDIS Act.

Recommendation 13

The NDIS Act 2013 should be amended by the Australian Parliament to remove subsection 29 (1)(b), which states that a person ceases to be a participant in the NDIS when 'the person enters a residential care service on a permanent basis, or starts

being provided with community care on a permanent basis, and this first occurs only after the person turns 65 years of age.'

6. Conclusion

This submission concludes that the response to the issue of homelessness for people with disability and mental illness requires a concerted cooperative approach across governments rather than siloed efforts. If Australia is to meet its obligations under the UN CRPD, more supported, secure accommodation is needed for people with disability and mental illness.

As a starting point, OPA stresses the importance of Australia implementing the UN's recommendation that "persons with disabilities are included as a priority cohort in the implementation of poverty and homelessness reduction programmes, including the National Affordable Housing Agreement and the National Partnership Agreement on Homelessness."³⁶

Recommendation 14

The Australian Government should ensure that Australia implements the United Nations recommendation in its report on the review of Australia's obligations under the CRPD that "persons with disabilities are included as a priority cohort in the implementation of poverty and homelessness reduction programmes, including the National Affordable Housing Agreement and the National Partnership Agreement on Homelessness".

³⁶ United Nations, 'Concluding observations', 14.