



BHC Ltd and Partners in Recovery

Step Up Step Down Project: Consumer and Carer Consultation Report

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Good thinking

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Summary of Key Findings

This report presents the feedback of mental health consumers and carers on a proposed Step Up/Step Down service. The report forms part of a wider project funded through the North Brisbane Partners in Recovery Innovation Fund investigating the demand, feasibility, potential operating model and design for a Step Up Step Down facility for North Brisbane. The project is being undertaken by project lead, BHC Creating Liveable Communities, in conjunction with collaborating partners, Footprints, Communitify, Open Minds, Metro North Hospital Health Service and Partners in Recovery/Medicare Local.

Feedback was provided by five separate group discussions organised by partner agencies, and involving a mix of consumers and carers as well as some agency staff. Consumer and carer input is intended to supplement input already provided by mental health agencies and professionals in earlier phases of the project, and the findings of the needs analysis and design and feasibility process.

Overall, participants were strongly supportive of the service concept. They felt it would fill a current gap in the service system, and that the level of demand would exceed the capacity of a single facility. The following provides a short summary of consumer and carer responses, which are outlined in full detail in the body of the report.

Entering the Service

- Consumers need to have accurate information about the service in order to make an informed decision about whether it meets their needs.
- Referral should be able to come from a variety of sources including self-referral, community agencies, GPs and hospitals. While ideally those “stepping down” from hospital would be referred by the hospital as part of a planned discharge, consumers were not confident this would happen consistently and saw a need for other avenues of referral.
- At the point of admission each resident would work with a case manager to develop an individualised plan for their time in the facility.

While in the Service

- Participants saw strong value in residents taking an active role in the day to day running of the facility including cooking, cleaning and planning day to day activities. This would help with the transition to independence and re-learning of skills lost due to their period of illness. However, they needed to be supported to do this and in many cases would need to learn or relearn basic life skills.
- They saw a wide scope for group activities helping people to address a wide range of issues. Groups could be planned and chosen by residents ahead of time and they would choose which groups to participate in or avoid.
- Individual case-work would include ongoing clinical treatment, but have a strong focus on preparing to return home or to an independent living situation. This individual work should be done in partnership with community support agencies where the resident already has a relationship, and with carers and the person’s own doctors where appropriate.
- Participation in the service as a whole and in different service elements was seen as necessarily voluntary, but residents needed encouragement to participate, both by creating a need for social interaction and “contracting” for various types of participation as part of a case plan.

- Participants generally agreed with the proposed staffing model with a mix of clinical and non-clinical staff. However, many questioned whether a single staff member overnight would be sufficient for the number of residents.

Leaving the Service

- Participants agreed that wherever possible discharges would be carefully planned, in partnership with other key support services and carers where these are involved.
- There should be reliable follow-up for all residents, ideally beginning the day after discharge and extending for varying periods depending on the person's needs, possibly up to three months.
- The idea of a "warm line" that former residents could ring for help at certain times of the day was generally supported, with evenings cited as the most likely time this would be needed.
- There was a general view that people would be free to leave at any time, but a protocol for informing carers or other key people of an unplanned departure needed to be negotiated at admission in the interests of safety.

Design Feedback

- Participants liked the small scale and home-like feel of the proposed design.
- Most felt that lift access would be needed in a multi-story building, given the level of co-morbidity among people with mental illness.
- They were strongly supportive of individual rooms, with some debate about the level of cooking and food preparation facilities in each room, and whether individual rooms should have their own TVs.
- There was mixed responses in relation to whether separation of male and female residents was necessary.
- They identified a number of uses for the shared spaces including cooking and eating, a "quiet room", arts activity, exercise and group meetings.
- They felt quality outdoor space was important, with facilities ideally including a separate smoking area, gardens, seating and possibly BBQ or outdoor eating. They also thought at least some car parking would be required on site.

1. The Step Up/Step Down Project

This report presents the feedback of mental health consumers and carers on a proposed Step Up/Step Down service. The report forms part of a wider project funded through the North Brisbane Partners in Recovery Innovation Fund investigating the demand, feasibility, potential operating model and design for a Step Up Step Down facility for North Brisbane. The project is being undertaken by project lead, BHC Creating Liveable Communities, in conjunction with collaborating partners, Footprints, Communitify, Open Minds, Metro North Hospital Health Service and Partners in Recovery/Medicare Local.

A Step Up/Step Down service would help people recovering from mental illness by:

- Providing a place where they can “step down” following a stay in hospital, helping them to make more progress in their recovery before they go home
- Providing a place where they can “step up” if they become unwell, avoiding a stay in hospital by addressing the problem early.

The model is based closely on the Prevention and Recovery Care (PARC) Services which operate in a number of locations in Victoria and also in the ACT and elsewhere. Some of the key facets of the model include the following:

- It would be a residential service designed to be a “home-like” as possible, rather than a clinical setting.
- Residents would typically stay for periods of up to four weeks.
- It would be staffed by a mix of clinical and community support staff - many such facilities are jointly managed by the public health services (providing the clinical component) and a community organisation (providing the community support component).
- It would potentially provide a service to people diagnosed with a fairly wide range of mental health conditions including schizophrenia, bi-polar, personality disorders, depression and anxiety.

So far, the project has carried out a number of activities which between them contribute to a detailed proposal for the establishment of the service.

1.1 Needs Analysis

A detailed needs analysis for the project was carried out by Andrea Young Planning Consultants. This needs analysis combined a review of need data from the Metro North Health Region with a detailed examination of the operation of similar services elsewhere in Australia. Some highlights of this research are as follows:

- Step-Up/Step Down (SUSD) services have been demonstrated to be successful in reducing rates of hospital readmission amongst those who use the service. As these services are less costly to operate than acute mental health facilities this represents both a net improvement for consumers and a cost saving for the health system.
- Within the Metro North region there are likely to be in the region of 40,000 people affected by moderate-severe and severe mental illness.

- Current demand for acute inpatient services and community care substantially exceeds supply and service providers consider that they would easily fill more than one SUSD facility from current known consumers.
- The acute inpatient services in the Metro North region have relatively high rates of readmission of discharged patients within 28 days of discharge (23.5% for RBWH in January 2014) and are failing to meet targets for post-discharge follow-up, both indicators SUSD facilities have been demonstrated to improve substantially.

The needs analysis also included a detailed examination of the operation of existing SUSD facilities in Victoria and the ACT, providing details of governance arrangements, staffing, physical layout, services operated and budget. This information provided an important starting point for the development of the Metro North proposal.

1.2 Operating Model Development

Alongside this needs analysis process, Sagacity Consulting carried out a process to develop a detailed draft operating model for the proposed service. This operating model covers the aims and objectives of the services, the roles of key partners, and a set of operating details including:

- Eligibility and assessment
- Occupancy and duration of stay
- Service planning
- Care planning
- Medications
- Catering
- Staffing matters
- Governance
- Funding
- Risk management
- Standards and quality systems
- Client complaints and disputes
- Confidentiality and record keeping
- Monitoring and evaluation
- Tenancy and housing issues.

This draft operating model provides a detailed picture of how the service would operate.

1.3 Facility Design and Feasibility

The final component of the project to date is the development of a physical design for the facility and preliminary feasibility assessment, carried out by KO and Co Architecture. This process designed a facility to be built on an existing Queensland Health-owned site in order to ground the project in real life, although there is no firm commitment to this site at this point. The resulting design involves the following key features:

- A three story facility, built on a relatively small but well-located plot of land in the middle suburbs of Brisbane.
- Eleven self-contained studio units for consumers, ten of these on the first and second floors and one at ground level to allow for full disability access.

- An office, interview and activity rooms and a large shared kitchen and dining area on the ground level, as well as some shared facilities on the second and third floors.
- Swipe card security including the ability to limit access to certain floors - for instance one of the residential levels could be designated for men and another for women to provide for safety and privacy, and there could be further separation of one of the floors to manage the likelihood that at times there would be an imbalance of genders.
- An additional ensuite room to allow for staff sleepover, given that the facility is intended to be staffed 24/7.

2. Consultation Process

The current project is intended to fill the remaining gap in the processes outlined above - to provide opportunity for feedback on the proposal by consumers and carers. This allows the project proponents to “reality-test” the proposed model with people who may at times be users of the facility and to get their input into what would make it work for them or others in their position.

Consultations were conducted via a series of group discussions with consumers and carers organised by the participating organisations. Groups varied in size from two to 13. These groups are described briefly in Table 1 below.

Table 1: Consultation Summary

Date	Group	Description
23 April 2015	Metro North Mental Health Services Consumer and Carer Engagement Group	This is an ongoing consumer and carer group facilitated by Metro North Mental Health Services, who allowed us time on their agenda. There were 10 participants from across the region, a mix of consumers and carers.
24 April 2015	Metro North Mental Health Services focus group	This group was brought together specifically for this project by Metro North Mental Health Services to tap a wider group. There were 13 participants, a mix of consumers, carers and service provider reps, with all participating actively.
30 April 2015	Communify Partners in Recovery focus group	This was group specifically brought together by Communify for this project. The threat of wild weather led to some intended participants staying home and only two participated - but discussions were lively and helpful!
1 May 2015	Open Minds Consumer and Carer Advisory Group	This is an ongoing consumer and carer group facilitated by Open Minds who allowed us time on their agenda. There were six participants, a mix of carers and consumers. Open Minds staff were also present but largely listened rather than participating.
6 May 2015	Footprints focus group	This group was brought together by Footprints' Action, Recovery and Citizenship program. Five consumers participated in this discussion, one of whom was also a peer support worker. The staff member who organised the group also participated in this discussion.

The group process asked a series of open-ended questions aimed at gaining feedback on the proposed service as designed in the project so far. The questions were designed to prompt discussion and were not necessarily all put explicitly in each discussion - often

participants answered them without being explicitly asked once the discussion was under way and discussion was allowed to flow freely to encourage input while guiding people to remain “on topic”.

The process also aimed to flesh out some of the parts of the service model that are only described in general terms in the service model - what would consumers be experiencing as they enter the service, while they are there, and after they leave? It also sought feedback on the building design developed in the earlier phases of the project.

The focus groups were facilitated jointly by Jon Eastgate from 99 Consulting and Karen Ognibene from KO and Co Architecture.

2.1 Some overall comments

Consumer and carer responses to the specific questions posed in the consultation are summarised in the following sections. Here we pull together some of their feedback on the concept as a whole.

Virtually all the consumers who participated had been hospitalised for their illness more than once, and the carers had the person they cared for admitted - many had repeated admissions over a period of time and some had spent long periods in hospital. Most saw hospital admission as a last resort - they preferred not to be in hospital if at all possible and would delay admission if they could. For some this was because they perceived a stigma in hospital admission, for others they preferred not to be in the hospital environment or found the process of getting admitted stressful.

Against this background all were strongly supportive of the Step Up/Step Down concept as an alternative to hospitalisation. They felt it was important that it create a home-like environment rather than a clinical one and present a welcoming face to consumers. This would make them more likely to go there as a “step up” before their illness reached a critical point. They also had negative experiences of post-discharge follow-up and welcomed the idea of a service that would do this more thoroughly and carefully. Overall they saw the service as filling an important gap in the current service system.

Participants were also aware of a high level of need in the community and most were clear that ultimately there would need to be more than one service in the region to meet the expected demand.

Participants pointed to a number of existing service models that they had used or were aware of which may provide extra insights or lessons for establishing the Step Up/Step Down service. These included:

- Acmena House at Loganholme
- The Soteria House movement worldwide, although it was noted that there were elements of “anti-psychiatry” in this approach
- Red House, run by Brook Red at Upper Mt Gravatt
- Mantle Housing, operated in partnership with Wesley Mission
- The Rose Hill centre in Michigan USA
- The Haven Melbourne, a partnership project established with the support of Alan Fels, although this is long term housing

- The Jerendene program run by ARAFMI, which provides respite
- The residential services run by the Richmond Fellowship.

While many of these services have different objectives to the Step Up/Step Down project participants felt they could provide lessons either for the physical design of the facility, or for the way the service was managed and the residents supported.

They were aware that one service can't meet everyone's needs and some of the limits they say on this facility included the following.

- It would not replace the need for acute care for some people - those who were critically ill, for instance, or those who were managing a changeover of medication which needed constant medical supervision.
- It would generally not be suitable for people who were on compulsory treatment orders, given it would not be a secure program and the service is oriented around voluntary participation.
- It may not be suitable for those who had an active addiction.

Within these limitations, though, most were highly enthusiastic about the possible creation of this service.

3. Entering the Service

Participants were prompted to respond to a set of general questions about the process of entering the service, as follows:

- What would be useful for potential residents to know before they made a decision to go there?
- What sort of entry and referral process do you think there should be - how is it best for the service to get to know potential residents and their needs?
- How should they plan their time there and set goals?
- Where is the service best located? i.e. proximity to what type of services?
- If people are using this for early intervention to prevent a hospital visit, how should they make contact with the service and get accepted?
- How should we let potential service users know about it - what are the best information channels?
- What would stop you from using the service and how could barriers be overcome?

Responses can be usefully grouped under a number of headings.

3.1 Information for Prospective Residents

There was general agreement that potential residents need good information about the service.

At the most basic level, they need to know it exists, and how they can get referred to it. One participant commented that for “step-down” residents it was unwise to rely on the hospital knowing and making the referral - staff are overworked and often turn over quickly, so there is no guarantee that the person who is there when discharge is being planned will know of the service or be sufficiently aware to tell the consumer about it. This person thought the facility may need to make regular personal contact with acute care facilities (they are small in number so this should not be hard) to keep the service near the top of staff minds and ensure there is good information to provide to consumers.

Some specific things different participants identified as needing to know in order to make an informed choice included the following:

- What support and care is offered, so they can assess if this is what they need.
- What the ground rules are, so they can assess if this is for them and if they can live within the boundaries the service asks of them. This would include things like their responsibilities for household tasks, the food/catering arrangements, and openness to visitors
- The physical living and sleeping arrangements. For those with social anxiety, for instance, it is of crucial importance to know how many people are there and how much privacy/personal space they can have and what opportunities there are to withdraw from stressful social situations.
- The mix of illnesses that might be there and some information about what symptoms people might show, to help them to cope with other people’s behaviour.
- The cost.

One of the groups suggested that there could be an introductory interview and tour of the facility to help consumers make up their minds if it was for them, prior to a more detailed

intake process. They also suggested that there needed to be written information because people rarely take everything they are told in at the first contact and it is useful to have something to take away and re-read.

3.2 Criteria for Admission

There was only a small amount of discussion about criteria for admission and participants' responses didn't amount to a comprehensive response to this issue. The things mentioned included the following:

- What would be the attitude to dual diagnosis (mental illness and drug addiction)? It was felt that this shouldn't necessarily preclude people from the service but active drug use would not be acceptable - legally a service can't possibly condone illicit drugs on the premises.
- What attitude would be taken to self-harm? Some discussion suggested that people who were actively self-harming should be excluded. However, one participant who had experienced self-harm as part of her illness questioned this, suggesting that self-harm is not a black and white issue and it would be more appropriate to assess the risks on a case by case basis - was the risk/level of self-harm manageable within the parameters of the service?
- Some participants felt that one of the criteria would be around the impact of the potential new person on existing residents - would their admission create a problem or cause disruption within the facility because of the mix already there? It was acknowledged that this would be difficult to assess and would possibly change over time.

3.3 Referral Process

Participants suggested that there would be different referral processes for stepping up and for stepping down.

For those stepping down, the primary referral point would be from the hospital, with referral to the service one of the discharge options considered. However, the comments about this in 3.1 applied - some participants were not confident that the hospitals would do this consistently. This means there would need to also be a way for the consumer to initiate his or her own referral.

For those considering stepping up, the pathway would be likely to be more varied, and participants considered that there needed to be openness to a wide variety of referral sources. These might include:

- Self-referral - some participants indicated that a consumer often knows their own illness better than anyone else and is in a strong position to know when they need extra help.
- Referral from case managers and community support organisations
- Referral from GPs, counsellors and other health professionals.

Where time-frames were discussed, the main view was that decisions on admission should be made fairly quickly - ideally within 24 hours. This reflected the fact that while this is not an acute treatment service (those with urgent acute illness would still be admitted to hospital) nor crisis accommodation, timeliness is important both for those stepping down

(as they don't want to be stuck in hospital while they wait, and hospital is costly) and for those stepping up (where timely admission could prevent a worsening of their condition so that it becomes acute).

There was also some discussion about how excess demand would be managed. While the idea of a waiting list was discussed in one of the groups, the consensus ended up being that this would not be practical, as by the time the person's name reached the top of the list their condition would have changed. However, it was not clear how else this should be managed - perhaps consistent excess demand would simply be evidence for the need to add further services.

3.4 Intake Processes

There was considerable discussion across all the groups about the process of intake overall.

The idea that dominated much of the discussion on this subject was the notion that each person would have a case plan, and this would be developed at intake and then monitored and implemented across the course of their stay.

In order to develop such a plan, the case manager would need to understand some key things about the resident, including:

- The nature of their illness and its current treatment.
- Their level of functionality and cognition and how this fits with the program on offer at the facility
- Their current living and family arrangements
- Other community supports they have in place
- Their reasons for entering the service and the issues they want to work on while there.

This could potentially be done using a formalised assessment tool - many of these exist - for instance PIR uses one called CANSAS which makes a thorough assessment of a person's physical and mental health as a starting point for case planning. Others suggested that the tool used by the Aged Care Assessment teams or the one used by Youngcare may represent models, although these are designed for clients with different issues.

Participants in one of the groups discussed the fact that as mental health consumers they have to tell and retell their story each time they meet a new service provider. They felt some resources to help reduce this would be really helpful for consumers. Perhaps, for instance, a consumer could be supported to develop a dossier about themselves which they could give to a new service, so the intake person could read it and not have to ask the same things all over again. However, others noted that a person's condition can change over time so the facility would still need to do at least an "as of now" type of assessment. One carer participant thought that the dossier could include information on what the consumer was like before he or she became unwell. This would assist the provider to understand the true temperament of the consumer and perhaps provide guidance as to how to return the consumer to their previous self.

They saw this assessment as being followed by a process of case planning in partnership with the consumer. A case plan was seen as including a wide variety of things, depending

on the person's situation. Some of the elements discussed across the various groups included.

- An arrangement for managing their medication while at the facility - would they self-manage or have it managed by a staff member? What medication was involved?
- A skills acquisition plan - what does the person need to learn to make a successful transition to independence? This was seen as varying widely from person to person, potentially including issues to do with better managing their illness, support to resolve interpersonal issues, support and strategies for managing physical health issues, or perhaps learning basic skills for independence like cooking and cleaning or financial management.
- A transition plan - some participants suggested that in a facility designed for short stays, it was important to being planning for their eventual return home as soon as they arrive - the purpose of the service needs to be kept clearly in view.
- A participation plan for their time in the service - what group and individual activities would they participate in while they are there?

Once again some participants felt a clear procedure and template for this would be useful. Some have found the Wellness and Recovery Action Plan (WRAP) a helpful process to go through, and wondered if perhaps an appropriately adapted version of this could be used in the service. They also felt that this planning shouldn't be isolated from processes they are already engaged in - for instance, if they have a mental health plan, or receive support from a community agency this should be integrated with the plan. For instance, if they already work with a community agency they could be involved in the plan and its implementation to facilitate a smooth transition home. It would also be important in many cases to involve their primary carer (e.g. partner or parent) in the plan, if there is such a person in their life.

Most participants agreed that plans developed at this point would not be set in stone - they would be revised over time as circumstances changed. However, careful planning was seen as essential to a good outcome and as a way of setting clear expectations up front for both the service provider and the consumer.

4. While in Residence

The largest amount of discussion in all the groups revolved around the details of the service itself - what would be happening while people were in residence? What would their days look like? Who would be doing what?

Prompts for this discussion were as follows:

- What sort of activities and supports do you think would help people to get ready to go home?
 - What type of group activities do you think people would find helpful?
 - What type of one-on-one support do you think would be helpful?
 - What balance of activities/free time?
- What sort of contact do you think would be helpful with family/carers/other people residents will be close to when they go home? What about your own doctor and any other support agencies who support you at home?
- How should the household be run?
 - Food purchase, storage, prep?
 - How much collective activity (e.g. cooking and eating together) and how much privacy?
 - What level of separation is required between residents? Each resident will have an individual unit however is it best to separate males and females?
 - Should the units cater for babies or small children if the resident is the primary carer?

Discussions covered a wide range of issues which are summarised under the headings below.

4.1 Management and Decision-Making

Participants in the various groups discussed a number of issues which pertained to the overall management of the facility.

These discussions generally took place within their overall understanding that this was a “homelike” facility rather than a psychiatric hospital. This meant, for instance, that it was not a locked facility and that residents were not compelled to do things against their will, and that residents were free to come and go and make their own choices about participation. However, they also were very aware of the need to manage relationships within the group of people present, especially considering that the resident group would turn over quite rapidly in a short-stay environment and that people would have a variety of illnesses and behaviours which may make relationships difficult.

Most participants believed that residents need to be actively involved in the management of the facility. A primary means for doing this would be through a regular “house meeting” - one group suggested that this could be weekly, another suggested daily. This could discuss practicalities in the house (who was cooking that day, cleaning arrangements, etc), deal with any problems or issues (e.g. issues around personal boundaries, issues which are causing tension or disagreement, etc) and also plan ahead for group activities. This process would serve a dual process - primarily it would provide a

shared means of making decisions, but it would also help people to develop communication and problem-solving skills. Participants saw this as being facilitated by a skilled staff member. It was important at this forum that people be encouraged to be open, but also that it not become destructive and that it focus on positive messages. Some also felt that an alternative mechanism to provide feedback, such as a “ballot box” or feedback form, may help those who struggled to speak up at meetings.

Some other issues that participants commented on were:

- The need to carefully manage the mix of people in the facility - they had a strong awareness that this could be a major source of stress. Management of this would involve a number of strategies, including some care with admissions to avoid creating volatile situations, education for residents about the symptoms of various conditions, skilled management of group situations, and opportunity and physical space to withdraw from stressful situations.
- A clear policy about drug use - most felt that the use of illicit drugs and alcohol should be banned. However, most felt that banning smoking would be impractical and this should be allowed in a designated smoking area.
- They were also concerned about the rules re visiting in one another’s rooms. While all were agreed that residents should have the clear right to refuse visitors, some felt that visits should be banned altogether, or that visits should only be between those of the same gender. The main driver for this was the fear that the situation could be abused - that many people who come into this type of facility are quite vulnerable to exploitation, and that they may not have the self-confidence to say no. A blanket rule would help protect them. However, some participants saw the tension between this approach and the “home-like” ethos - at home, people visit their neighbours.
- There was discussion in one of the groups around a curfew or sign in/sign out process. Most thought a curfew was important for safety, so that someone can be checked on if they do not return.

There was also some discussion about the notion of a maximum 4-week stay. Views differed on this question - some thought 4 weeks was about right, some that it was not long enough. In practice, some thought that many residents, particularly those “stepping up”, may stay for much shorter periods - perhaps only a few days in some cases.

4.2 Tasks for Daily Living

A lot of discussion focused on how to organise the practical tasks of running the facility and the practicalities of daily life. There was general agreement that given this is intended to be a transition to independence, residents should be actively involved in the day to day practicalities. However, there were a wide variety of views on exactly how this should take place.

Some participants commented that mental illness, and particularly extended hospitalisation, can lead to people losing basic life skills. For some, their illness can also affect their willingness to do things others take for granted, like change their clothes, shower or clean their home. Hence, participation in these tasks in the facility was viewed as a way to relearn these skills and be supported to overcome barriers to doing them. In this context it was important that people not be “thrown in the deep end”, but be supported in their tasks. This may be by a staff person, or by another resident if there is someone who is skilled and confident in a particular task.

Rostering

Most participants agreed that there would be some kind of roster for the daily tasks, and that everyone needed to pull their weight. One question which came up in a couple of groups was that of how much compulsion there would be in this roster. Would everyone take a turn in each task, or would people choose and have the option of gravitating to tasks which they enjoyed or at which they felt competent? There were arguments on both sides. On the one hand, some felt that given everyone has to do all the tasks in their own home, it would be good to establish this in the facility. On the other hand, the idea that the place is homelike rather than institutional suggested to some that people should have a degree of choice. It is also possible that this could change over time as the residents turned over - one group may be able to manage a flexible roster, while another may struggle with this and need more structure. This is the type of issue that would be addressed at house meetings.

A related question was how non-compliance would be addressed. In general, most favoured an approach around negotiation and encouragement rather than one based on punishment. Peer review was suggested as means of checking whether the consumer had fulfilled their task adequately.

Participants were mostly agreed that responsibility for people's own rooms would be their own, while there could be shared responsibility for the common areas, although some felt that common areas should be professionally cleaned. Most were also clear that individual rooms would be professionally cleaned in between residents.

Meals

Meals were the subject which occupied the most discussion under the day to day tasks. We started out many of these discussions with the practice in one of the facilities of the evening meal being the responsibility of a different resident each night, with this person working with a staff member to plan the menu, shop for ingredients and cook the meal. Some participants loved this idea but others were less sure. This discussion led to some interesting questions which different groups resolved in different ways.

A basic question was that of how much people would eat together or apart. The most common view was that one meal a day should be a shared meal (perhaps the evening meal) with the others being more individual. However, some participants questioned whether there should be any shared meals at all. There were two main reasons for this. One is that people often have very different food preferences and dietary requirements (e.g. food allergies). How would one shared meal cater for all these? Would a resident with limited cooking skills be expected to cater for a variety of special diets? The other was about social space - some people like to mix a lot, others find mixing difficult. The question was whether they should be essentially forced into one another's company each dinner time, or whether there could be some flexibility about this. Another suggestion was that people could have their meals in smaller groups rather than all together - this would remove the need to cater for the whole group (a fairly daunting task for anyone who is not a confident cook) and also avoid unnecessary clashes between people who may not be compatible. Some also wondered if residents could agree to have one meal with others but vary which meal this was.

Discussion about other meals being individual led to a further set of questions about the storage and preparation of food for these meals. Some participants liked the idea of being able to prepare and eat meals in one's own room, and most agreed that if residents were to have their own food, this needed to be stored individually (perhaps bar fridges in each room) as their experience of shared living facilities was that individual food in shared fridges or pantry tended to be stolen and this was a major cause of conflict. Preparation was a more controversial subject. Some liked the idea of having cooking facilities in each room and being able to prepare food for themselves. Others were concerned about this from a safety point of view - people burning food or burning themselves - and social point of view, with people needing to be encouraged to mix and the use of communal kitchen facilities providing a "natural" way for this to take place. Some argued for a middle position - for instance that individual units could have fridges and microwaves but not cook-tops, or just fridges.

Some participants also raised the need to be very aware of health and safety issues around cooking. Many mental illnesses, or the medication used to treat them, can impair people's hand-eye coordination and make them more prone to accident, so management of tasks need to take account of this.

Some participants suggested a "restaurant" approach for visitors, where the visitor could be treated to a meal prepared by the resident.

Skills Development

Along with the allocation of tasks, most participants agreed that the process of getting the jobs done needed to be allied with a deliberate process of skills development and acquisition. There were a number of ways people suggested this could be done.

- There could be cooking lessons tailored to people's level of knowledge.
- Possibly when people cook for the whole group someone who is a confident could be paired with someone who is less so - this way the one who is less confident can learn while the one who is more so will gain confidence from teaching someone else.
- Residents would also need to be able to learn the skill of cooking for one if they live alone, as well as cooking for the whole group. This could be done with one on one lessons.
- Perhaps one resident could be assigned a task and another as an inspector to give feedback on how it was done - however, needs to be done sensitively and in a positive way.
- Some people would also need support with more personal tasks like personal hygiene and managing a home - this may be better addressed on an individual basis rather than as a group.

Hostel Residents

A final issue that arose in two of the workshops was the question of how this skill development would be experienced by residents in hostels. Some were concerned that the quality of the facility itself would make it difficult for them to return to a hostel where they share a room and have most tasks done for them (e.g. cooking and cleaning). For some, successful participation in these tasks in the Step Up/Step Down facility could be a sign that their long term plan needs to be to move from the hostel to somewhere more independent. However, there are significant barriers to this, not least the cost and

availability of rental housing and long waiting lists for social housing. There were also some skills that took on more urgency for hostel residents - for instance, social skills and the ability to get on with people are crucial for people who live in these kind of communal facilities. We didn't have the opportunity in the course of these discussions to explore these issues in detail but they would warrant further consideration in the course of service planning.

4.3 Group Activities

In general, it was clear to all participants that some activities would need to be done individually, while many others would lend themselves to group activities. Between the groups, they suggested quite a list of potential group activities, including:

- wellness training
- nutrition and cooking
- exercise - e.g. morning walks, yoga sessions, gentle exercise to get people over inactivity, some gym equipment in one of the rooms - there could be facilities and also classes or programs
- mindfulness/meditation
- expression - art, music, forms of emotional expression
- employment-related activities
- shopping on a budget
- bike riding
- first aid
- navigational skills
- developing tools to help you survive at home - one participant talked about developing a personal "toolbox" for when they are feeling stressed or unwell - this is a box full of cards containing things that have made them feel well in the past - you can pull something out of the box and do it
- group therapy - one participant commented that group work had been a real breakthrough because it let them know they were not alone, that other people experienced this stuff as well
- peer support programs - one participant commented that talking to peers was often more effective than talking to clinical staff for them because the peer was familiar with the situation
- wise choices anti-drug program
- working on Wellness Recovery Action Plans (WRAP) - you could use group times to share experiences of what helps
- relaxation techniques
- gardening/outside time
- social skills
- self-awareness programs
- basic living skills e.g. shopping, ordering a meal at a restaurant
- quit smoking programs
- fun activities - e.g. dances, karaoke etc (varying depending on what people enjoy)
- health education - there was particular discussion of management of diabetes and cardio-vascular disease as medication can increase the risk of these illnesses.

With such a wide range of ideas, naturally not all these activities would take place at any one time. Activities could be planned by the group at regular house meetings and tailored to meet the needs/preferences of a particular group of people.

4.4 Individual Programs and Activities

Along with these group activities, all participants were agreed that there would be a component of individual work. As discussed in Section 3.4, participants agreed that each resident would have an individualised plan with its own goals and processes. This individualised plan could include details of what groups the person would like to participate in (it was generally assumed that groups were no compulsory, but attendance would be based on individual needs). However, there would also be individualised activities.

Participants saw it as important to work with people and treat them with respect - they should be active partners in designing their own programs. People need to know what choices are available to them, what pathway they are on and what the next step is. Some felt it would be good to be able to have an advocate of their choice able to take part in discussions and key decisions - there is a need for transparency and for people to have as much control over their own decisions as possible.

Clinical Care

Naturally people saw that their clinical treatment would continue while in the facility, including their medication and any counselling or other therapeutic activity appropriate to their illness. Given that they are preparing to return home, many felt that where possible it would be good for their own doctor or other professionals to be involved in this, to promote continuity. However it is essential that in an environment like this medication in particular is well-managed, otherwise it is difficult for people to benefit from other aspects of the program.

Some participants also pointed out that physical and mental health can be closely connected, and the facility could provide a good opportunity for a thorough health assessment and treatment of physical health conditions, including the development of an overall health plan if needed.

Peer Support

Many participants had been actively engaged in peer support programs and spoke very highly of this experience. Based on this, they advocated strongly for a component for peer support in the overall service mix, both from one another via groups and from more highly trained peer supporters who were further down the recovery path.

Getting Ready to Go Home

The aspect of the service most discussed in all the groups was the process of preparing to go home. One participant suggested that people with mental illness “are always recovering but many will never fully recover”, so it was important to plan on the basis that further episodes of ill health are likely.

Some of these preparations are covered in the types of daily living skills discussed in Section 4.2. Other aspects of this preparation include the following:

- Establishing (or re-establishing) support systems. This includes effective referral to a community mental health agency which can provide ongoing support post-return. Depending on the person, it may also mean re-integration with family and for this purpose it would be useful in many cases to involve family members and carers in planning for discharge.
- Contingency Planning, involving the development of strategies to deal with future illness and knowing what to do or who to contact if things go wrong. This is likely to be different for each person, depending on their illness and the support systems available to them.
- Re-orientation to their community. Participants commented that often people with mental illness become isolated and with some conditions they may not leave their house for weeks or even months. Hence they may need to regain confidence to navigate their neighbourhood and overcome their anxiety about this. It may also involve connecting up with other organisations or activities in their community - community centres, sports clubs, religious organisations and so on, depending on their personal interests and preferences.
- Employment issues - for those who are in work, they may need to reconnect with their employers sooner rather than later, to discuss rehabilitation or return-to-work strategies. In some cases, it may be appropriate for them to return to work while still in the facility or at least to attend work to sort out future arrangements.
- For some it may be helpful to develop a daily plan - for some the task of getting through each day can seem overwhelming and having a plan for each day can be enough to get them out of bed and moving.

Many participants felt it was important for people to leave the facility with good information about things like support services, health options, numbers to ring in a crisis and so on. It would be helpful for the service to have access to a good database which they can use to provide tailored information for each person that relates to the community they are returning to and their needs and interests.

4.5 Staffing Questions

The outline of the service above has clear implications for staffing of which participants were well aware. In general, they were very supportive of the notion that there would be a mixed staff group, with clinical and non-clinical staff working together. Participants saw the mix of staff as including:

- Psychiatrists and mental health nurses who would look after clinical aspects such as medication and associated medical needs.
- Counsellors/psychologists to work with residents one on one and to do some forms of group work.
- Community support staff to develop community strategies and build links for people in preparation for their return home.
- Peer support workers to add the lived experience dimension to people's support.
- A range of contractors who could deliver specific group programs and training as needed.
- Ancillary staff such as cleaners and a cook to assist with preparation of the main meal of the day.

Participants were also in agreement that the facility needed to be staffed 24/7. One item that was hotly debated was the level of staffing overnight. Some felt that one staff

member for the night shift would be enough. However, others felt that this would present significant risks. What would happen, they asked, if one person needed intensive support and then others also needed help at the same time? What would happen in the event of a violent incident or an incident of serious self-harm? Many pointed to the situation of other residential services where overnight staffing ratios were more like one staff for three residents. For this reason, many felt that at the very least there needed to be someone else on call and available at short notice, while others felt there needed to be two staff on site overnight. Some wondered whether it would be appropriate to have a “caretaker” role filled by a peer support person alongside a professional person rostered on.

The view was also widely expressed that all the services to each resident need not be provided from within the facility. In particular, if a resident has an established ongoing relationship with a community support agency, it would provide the best continuity for that agency to be actively involved in their support while in the facility and provide the follow-up. The same went for those who had an ongoing relationship with their own GP, psychiatrist or counsellor.

4.6 Visitors

In general, participants were clear that it would be important for residents to have contact with carers, family and other people who are important to them in their home environment. The main differences between participants were around how much, and how it was to take place.

In one of the groups, participants argued that there should be pretty much “open slather”. On this view, family members would be able to visit at any time, including children and partners staying overnight. Units would be treated like people’s own homes and they would have control over who visited and when.

However, most took a more conservative view on this question. In general, they felt that visitors should be limited to the communal areas of the facility, and within certain hours - perhaps during the day or in the afternoon. A number of reasons were given for this restriction:

- With eleven residents, open slather on visitors had the potential to create a chaotic and overcrowded environment which would impede people’s recovery.
- This is particularly the case since many people experience a level of social anxiety as part of their illness, so constant coming and going of people can be extremely stressful.
- In relation to children, some expressed the view that a facility with a rotating population of eleven unrelated adults may not be a safe environment for children - at least it would be impossible to guarantee their safety, and it would be better to keep them to public areas and for shorter periods.
- There was also concern that people have come to the facility because they are unwell and need space to focus on their own health.

The possible exception to this that many were prepared to concede was the situation of a parent who had sole caring responsibility for an infant child. In some cases they felt it may be desirable or even unavoidable for the parent to bring this child with them, and they thought that perhaps one unit could be fitted out so as to be able to accommodate an

infant. However, most felt the occasions where this would be necessary would be comparatively rare.

A related question was that of pets. Some commented that pets/companion animals can be very important to people and their presence would help recovery. Others argued against this on the basis that some people have allergies to or fears of animals and their presence would be hard to manage. One participant described the process at Red House, where when a potential resident wants to bring their pet with them, the facility assesses the individual pet for suitability - they reserve the right to refuse but will accept pets they regard as appropriate for the environment. Some also discussed the idea of a “house pet” which would live at the facility, as is currently the practice in many aged care facilities.

Some participants also commented that for some people there were visitors who could be described as “toxic” and whose visits would be unhelpful to the person’s recovery. It may be useful to include planning about visitors in the resident’s overall case plan so the person can be supported to make contact with those people they want to see and refuse those they don’t, and to make good decisions about this.

4.7 Participation/Non-participation

A final item which attracted discussion was the question of how participation should be encouraged, and how much participation in programs and activities would be expected of residents.

The answer to this question most participants arrived at in the end was based on the overall understanding that each resident would have an individual plan. They suggested that people in general, whether they have a mental illness or not, have different levels of sociability, so in the normal course of people you expect different levels of interaction in social situations. People’s needs would also differ and this would mean that they would participate in different activities - they would participate in things that met their needs, and not in things that didn’t. This would be a matter for negotiation with case managers and would change over time through negotiation.

Some suggested that residents could contract on entry to participate in a certain number of group and individual activities, and then control how and when they did this for themselves with staff and peer support. Others discussed the idea of a kind of “motel menu” of activity options from which residents could tick the ones they would participate in.

The question then becomes one of what would happen if they didn’t follow through on things they had agreed to do. There were a variety of responses.

- In general, participants held to the principle that the facility is not coercive, so no-one would be forced to participate in activities.
- In part, there was seen to be an onus on management to make programs attractive and worthwhile so that people want to take part. If residents persistently absent themselves, the facility needs to ask if it is doing something wrong.
- Some talked about the possibility of a “buddy system” so that residents look out for each other and encourage each other’s participation.
- Staff would also have responsibility to follow up non-participation and either renegotiate their agreements with the resident, or encourage their follow-through.

- Many people suffer from social anxiety or particular things may trigger their own symptoms and this may lead to them withdrawing from processes part way through - this needs to be understood and respected.
- Some saw a need to generate the necessity for people to interact. This was the reason why many participants thought that there should be no food preparation facilities in individual rooms so everyone would need to make their meals in the common kitchen. Some went further and suggested a “lock-out” from individual rooms during the day, although this was not a majority view.

Despite all this, there was wide agreement that everyone needed to participate in activities to some extent, otherwise there was no point in their being in the facility and they may as well just go straight home.

5. Leaving the Service

The final set of operational issues discussed was those around leaving the service.

Participants were prompted to respond to this issue with the following questions:

- What sort of support would help people to make a smooth transition back home and avoid further illness?
- One idea discussed is setting up a “warm line” (a bit like a hotline but not so hot!) that former residents can call in the evening if they need someone to talk to - would this help and what would make it work?

Responses can be conveniently grouped around the following headings.

5.1 Planned Discharge

As discussed in Section 4.4 above, participants understood that a central purpose of the Step Up/Step Down facility was to help people prepare for their return home. It followed from this that the return home itself should be carefully managed wherever possible. They saw that while residents are there, the service should work hand in hand with the person’s community support agency (assuming they have one) and carers to ensure continuity. If this isn’t possible they should at least operate under the same plan rather than have the two work against each other - there should be good communication and handover.

They also saw a need to work carefully with the resident on a discharge plan - this is supposed to be done in hospital prior to discharge but in practice many participants spoke of personal experiences where this hadn’t happened, with discharge being unplanned and often at very short notice.

A number of participants talked about what would be done in preparation for leaving.

- The person would be wanting to achieve the care goals set at the start of their stay.
- Home visits if appropriate, and discussions with carers and significant others about their return to ensure their closest supports also have strategies in place to deal with further illness.
- Possibly re-integration with work/education if this is appropriate for the person.
- The development of ways to remind them of the skills and strategies they learned while in the service.

5.2 Follow up and support in the community

Participants saw follow-up after discharge as crucial to successful return home. Some mentioned that this is supposed to happen currently after discharge from hospital but that often it doesn’t (data cited in the needs analysis for this project confirms that Queensland Health Services struggle to meet their goals in this area of service).

This follow up could be carried out by the person’s established support agency if they have one, but if they don’t it would be best done by the facility, by someone with whom they already have a relationship. Most felt initial contact should be within the first week, and some felt that Day 2 after discharge would be ideal. It is crucial that this follow-up be reliable. It could be done by phone or in person, with in person being preferable in most

cases. In one group participants mentioned the example of Centacare's transitional supported housing, where the organisation carries out regular follow-up for an eight week period after discharge to assist the consumer to adjust to full independence. Others mentioned a period of three months, while suggesting that the need for follow-up would vary from person to person.

Some key elements of this follow up were outlined as follows.

- People need to be supported to re-engage with daily tasks at home, undo the effects of institutionalisation and translate what they start at the facility into their home life.
- Perhaps residents could also arrange their own follow-up with each other - e.g get together for coffee or a meal after discharge.
- Possibly also a social networking presence - facebook page/intranet chat room?
- It should have continuity with the program in the Step-Up/Step Down service, to continue to follow up on the issues dealt with during their time there.
- One participant also suggested a discharge card given to both consumers and their carers with key information and numbers to call.
- It could also include a daily "check in" call as a low level option.

5.3 Unplanned Departures

Participants recognised that in reality not all discharges would happen in this planned way. Some people would simply decide the program was not for them and leave. The question is, how would this be managed? From the groups that discussed this, there were a few key points.

- It was agreed that people are free to leave if they want, the program is voluntary.
- If people leave without telling anyone, how would the service find out they were gone? It was thought if people had committed to various activities during the day, the responsible person for these would notice if they weren't there and follow up. There was discussion around whether a sign in/sign out process would be suitable so the service could keep track of who was and wasn't in the building.
- The main concern about unplanned or un-notified departures was about people's safety - what if they have left because their illness has worsened and they are at risk? It was thought that part of the admission procedure could be to plan for this contingency - e.g. who should be informed if the person goes missing? This might require consent up front to contact a carer or family member.

5.4 The "Warm Line"

Part of the service model outlined in Section 1 above is the idea that the service would also include a "warm line" for former residents. This is a phone line they could call in at certain times of the day if they need someone to talk to or extra support.

Participants were generally supportive of this idea. They discussed some of the help line services they have used. Many have called Lifeline in times of crisis. However, their experience is that it is difficult to call and talk to someone they don't know, and also that

this service is very cautious about suicide risk so a call where they discuss depression and suicidal ideation will often result in a follow-up police visit which they find embarrassing and sometimes distressing. Some also mentioned Brook Red's Warm Line service which they thought may provide a model.

Some participants said they didn't think they would use such a service. However, others felt they would be more likely to call a line where they would get to talk to someone who knew them than to call an anonymous help-line. There would be the advantage of not having to begin at the beginning and tell their whole story one more time, and the hope that the person they talk to would know them and have a more personal idea of what might help them - perhaps be able to remind them of strategies they had developed while in the facility, or their own contingency plans. This would work if the person had ready access to their case records to remind them.

They felt that out of hours was the most important time for such a line to operate - perhaps in the evenings. This is when regular support services are often unavailable and is often a more stressful time for people. Some participants also observed that some consumers struggle with phone communication or don't have ready access to phones, and wondered whether there could also be a "drop-in" or face to face option. They mentioned that the line could deal with issues of varying intensity, from a full blown panic attack to needing a quick reminder about nutritional advice.

6. Design Input

To a large extent the physical design of the facility would be expected to reflect the way the service is intended to run. This means the issues and ideas identified on the previous sections have strong relevance to the physical design.

At the end of each session participants were shown the plans that have been developed for the facility and invited to comment specifically on key aspects of this design. Their feedback is summarised below.

Overall their response to the plans was very positive. They liked the fact that it was a small facility, that it was intended to have a “home-like” atmosphere rather than a clinical one, and that each resident would have their own space rather than shared rooms.

Participants also mentioned difficulties with similar projects getting planning approval due to neighbour resistance. One participant (a carer) talked about working with a group of parents a number of years ago to build a community care facility to fill what they perceived as a gap for this kind of residential facility, and the project being abandoned because of obstructions in the planning system.

As discussed earlier, responses to design were consistent with the overall view that this should be a home-like facility rather than clinical one.

6.1 Disability Access

The issue of disability access was discussed at some length. The proposed design for the facility discussed with participants included three stories with stair access between floors and a ground floor unit designed for full wheelchair accessibility. This design was represented as a compromise - the idea would be to have the whole facility on one level, but this would be difficult to achieve in any established urban area because it would be impossible to find a large enough site and this amount of land would be too costly.

Most participants felt that while this design may meet planning requirements it would not be suitable for purpose, and that a lift would be required in a multi-floor facility. There were a number of reasons for this.

- There's a lot of co-morbidity among people with mental illness - people have injuries or disabilities which make mobility an issue, and the medications used to treat mental illness often lead to weight gain and a high risk of diabetes. This means that stairs can be a problem for many people even if they are not wheelchair bound.
- The current design would also require carrying reasonably large loads up and down stairs at times - luggage on arrival, and also washing as the current design has the laundry on the top floor. This would add to the degree of difficulty with stairs-only access.
- Some were also concerned that having the accessible unit on the ground floor would lead to that person being socially isolated - other residents would be able to socialise on their residential floors but a person in a wheelchair would be shut out of these social networks.

If there was lift access, some felt that there would then be no need for a unit on the ground floor and the entire floor could be communal space. Others felt that maybe a ground floor unit could be retained and be used as a way for residents to ease into the facility, staying in the ground floor unit while they got used to the facility before moving upstairs. They then felt that ideally each unit would be wheelchair accessible.

6.2 Individual Rooms/Units

Participants were pleasantly surprised at the size and design of the individual units. Some who lived in hostels commented that it would be hard to return home after living in such an environment! They liked the privacy involved, and security of being able to lock their door against other residents.

One issue that attracted a good deal of discussion was the mix of cooking and food preparation facilities in the rooms. The design shows each room with a full kitchenette. Some welcomed this and liked the idea that residents could cook full meals for themselves if they chose to. Others had reservations about this for a number of reasons.

- Safety - having cooking facilities in the room created extra fire risks, and risks of burning smells impacting on everyone in the facility.
- Sociability - as discussed in at various points in Section 4, it was seen as important the residents interact with one another, and that meal preparation in a common kitchen was one way of ensuring this.
- Cost - some felt that the cost of installing cooking facilities, fridges and microwaves, and providing and replacing cooking utensils in each unit, would be a waste of scarce resources.

Based on these reservations, participants expressed a number of points of view on what should be in each unit. Most supported the placing of a small fridge and cupboard in which residents could keep their own food. Most would be likely to bring their own favourite foods or comfort foods in addition to the communal meals, and people's experience of shared living was that food kept in a communal fridge or pantry was generally treated as common property. Most also supported having a kettle and microwave to enable tea and coffee preparation and simple food, although some thought these would be best limited to the common areas.

While they were happy with shared laundry facilities, most felt there should be drying facilities in each room, perhaps on the balcony. This was for the same reason as their concerns about food storage - their experience suggested that clothes hung on common washing lines would be likely to go missing.

There was some discussion about TVs in rooms. Some liked this idea, and felt that a TV in the shared lounge would be a recipe for conflict over programming. Others felt that once again this would provide a temptation for people to "hide" in their rooms, and that there needed to be more incentive for people to leave their rooms.

They suggested that each room could have a simple way for residents to personalise the space with their own pictures or decorations - perhaps a pin board or magnet board, rather than allowing people to mess up the walls by using blu-tac.

There was some discussion about accessible showers. Given the prevalence of mobility issues, some suggested that rails could be fitted in the showers. However, this raised the concern about ligature points and participants agreed that this was a problem and “ligature free” design was important. One solution would be to install removable hand-rails, which could be fitted or removed easily depending on the needs of each resident.

As outlined in the discussion on visitors in Section 4.6, there was some discussion about setting up at least one unit to be suitable for a parent with an infant child, and there was also discussion about the installation of trundle beds for overnight visitors - whether people felt this was appropriate depended largely on their view about how visitors should be managed overall.

Balconies were not discussed in detail in all sessions, however when discussed, participants felt it was nice to have the option of private external space as well as internal space.

6.3 Shared Spaces

Participants also responded positively to the amount of shared space and the way it was laid out. Some specific comments included:

- There was a need for communications access - phone and internet access - in shared spaces. Some wondered about the availability of wireless access so that residents could bring their own lap-tops if possible.
- They generally were happy about the availability of a spacious, well fitted out shared kitchen, and shared dining areas. However, some wondered if would be better to have “break-out” dining areas rather than a single big table, so people had a choice other than all eating together.
- They wondered if one of the spaces could be designated as a “meditation room” or “withdrawing room” - a quiet space where people could withdraw from social situations and practice meditation or mindfulness. One of the ground floor rooms which has limited natural light could be appropriate for this.
- They also talked about the need for spaces for varying activities - arts and crafts (it would be ideal if materials could be left out rather than having to be put away mid-project).
- A room outfitted with exercise and gym equipment which could be used for individual or group exercise.

6.4 Access and Security

Participants commented on the access and security arrangements. One issue which attracted a lot of discussion was the secure separation of men and women. Some considered this unnecessary in an environment where each resident had their own lockable room to ensure safety and privacy. However many, including most of the women participants, saw the separation as essential. A number of participants highlighted the fact that many women who experience mental illness have also experienced domestic violence or assault during their lives and that a strong degree of gender separation was essential for them to feel safe. They felt that if they were in a vulnerable state in the early stages of recovery, they would be at risk of sexual exploitation if there was too much opportunity for this.

With this in mind, most supported the secure separation of male and female residents on different floors. They also liked the idea that at least one floor could be partly closed off,

so that if there was a gender imbalance in the facility at any time the secure separation could still be maintained.

In general they approved of the idea of swipe card/electronic access control, and understood that this would allow for different levels of access depending on security clearance. They felt it was important for staff to have access to all areas including individual rooms, although the expectation that staff would only enter an individual room uninvited in an emergency situation. They also thought it would be worthwhile to install emergency buttons in each room.

In regard to security of the facility as a whole, they felt that there could be a “lock down” after a certain time in the evening, after which only staff and residents would be able to enter or leave. During daylight hours they felt the facility could be more open, with access monitored via the fact that there was a single main entrance overseen by staff.

6.5 Outdoor Areas

Participants felt that a quality outdoor area was important even if this was relatively small. This area could potentially involve a number of elements.

- A separate smoking area - tobacco was the one recreational drug participants felt it would be inappropriate to try to ban from the premises, and smokers needed somewhere to go where they wouldn't breathe smoke on others.
- A place to sit and relax.
- A garden space where people could garden (perhaps grow vegetables or herbs for use in the kitchen).
- Possibly a BBQ area or outdoor eating area.

There was also discussion about car parking. The design we discussed shows only a single emergency parking bay and an accessible parking bay because the site doesn't allow for more parking than this. There was lively discussion about whether residents would have cars and if so where they would park them, as well as the issue of “official” vehicles and staff and visitor parking. One participant noted that if a resident had a car on site, they might feel pressured by other residents to drive them somewhere, thus the lack of carparking would discourage people bringing their cars. The answer to this question depended partly on the ease and availability of on-street parking, or of off-street parking nearby. However, it was mostly agreed that some parking would be needed onsite.