

PROFESSIONAL SERVICES

**Housing, homelessness and mental health:
towards systems change**



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Acronyms and abbreviations used in this report

ACT	Assertive Community Treatment
ACT	Australian Capital Territory
AHURI	Australian Housing and Urban Research Institute Limited
AIHW	Australian Institute of Health and Welfare
AMHS	Acute Mental Health Services
BCG	Brisbane Common Ground
CCU	Community Care Unit
CCGs	Clinical Commissioning Groups (UK)
COAG	Council of Australian Governments
CHPs	Community Housing Providers
Commission	National Mental Health Commission
DoH	Department of Health
DSS	Department of Social Security
D2D	Day to Day Living in the Community
GP	General Practitioner
HASI	Housing and Accommodation Support Initiative (NSW)
HASP	Housing and Support Program (Queensland)
HF	Housing First
HoNOS	Health of the Nation Outcome Scales
HUD-VASH	US Department of Housing and Urban Development Veterans Affairs Supportive Housing program
ICLI	Individualised Community Living Initiative
JGOS	Joint Guarantee of Service
IPRSS	Individual Psychosocial Rehabilitation and Support Services
LHN	Local Health Network
MOU	Memorandum of Understanding
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
NHFIA	National Housing and Homelessness Agreement
NHS	National Health Service (UK)

NMHSPF	National Mental Health Service Planning Framework
NMHSPF-PST	National Mental Health Service Planning Framework Planning Support Tool
NSW	New South Wales
NT	Northern Territory
PHaMs	Personal Helpers and Mentors
PHN	Primary Health Network
PDRSS	Psychiatric Disability Rehabilitation and Support Service
PiR	Partners in Recovery
QLD	Queensland
SA	South Australia
SHIP	Survey of High Impact Psychosis
SHS	Specialist Homelessness Service
TAS	Tasmania
THT	Transitional Housing Treatment Program
UK	United Kingdom
VIC	Victoria
WA	Western Australia

Glossary

This section defines a series of key terms that are used in this report.

Mental illness and mental ill health

The terms mental health, mental wellbeing and mental illness are used inconsistently in the literature and in common usage, and often the meanings of these terms overlap. In addition, there are many definitions of these terms (e.g. clinical, procedural). For the purposes of this paper we use the terms mental ill health and mental illness as follows.

The Department of Health (DoH) defines **mental illness** as:

...a clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities. Examples include anxiety disorders, depression, bipolar affective disorder, eating disorders, and schizophrenia. (DoH 2017a: 67)

This report uses the term **mental ill health** as an umbrella term that captures the range from people with temporary, periodical and manageable conditions through to people with severe and persistent disability.

Affordable housing

'Affordable housing' is housing offered at a below market price, whether this be rent (e.g. public housing, community housing, private rental housing) or home ownership. Affordable housing is targeted at low to moderate income households and is priced to be affordable to them. Usually this means that housing costs should not exceed 30 per cent of gross household income. Historically, state and territory governments were the primary providers of affordable (usually public) housing. In recent years affordable housing has been produced increasingly in partnership with government, not for profit and private sector organisations (Milligan et al. 2016).

Social housing

Social housing is rental housing that is provided or managed by government or non-government organisations (NGOs). It comprises public and community housing. Social housing aims to assist people who are unable to access sustainable accommodation in the private rental market.

Community housing

Community housing is rental housing that is managed by community based organisations that lease properties from government or have received a capital or recurrent subsidy from government. Community housing is provided to low-to-moderate income and special needs households.

Public housing

Public housing is dwellings that are owned or leased and managed by state and territory housing authorities.

Precarious housing

'Precarious housing' is defined as housing that concurrently exhibits two or more of the characteristics identified below (Mallet et al. 2011):

→ unaffordable (high housing costs relative to income)

- unsuitable (overcrowded and/or poor dwelling condition and/or unsafe and/or poorly located)
- insecure (insecure tenure type and subject to forced moves).

Homelessness

Until recently, the most widely accepted definition of 'homelessness' was that developed by Chamberlain and MacKenzie (1992; 2008). This definition is based on cultural expectations of the degree to which housing needs were met within conventional expectations or community standards. In Australia this means having, at a minimum, one room to sleep in, one room to live in, one's own bathroom and kitchen and security of tenure.

This definition describes three types of homelessness:

- primary—rough sleeping
- secondary—temporary accommodation (includes people moving frequently from one form of temporary accommodation to another, including emergency housing, boarding houses or staying with family or friends, e.g. couch surfing)
- tertiary—inappropriate housing (refers to people staying for longer than 13 weeks in rooming houses or equivalent tertiary accommodation).

In 2012 the ABS developed a new definition of homelessness informed by an understanding that homelessness is not 'rooflessness' (ABS 2012). A person is considered homeless under this revised definition if their current living arrangement exhibits one of the following characteristics:

- is in a dwelling that is inadequate
- has no tenure or their initial tenure is short and not extendable
- does not allow them to have control of and access to space for social relations; provide a sense of security, stability, privacy or safety; or provide the ability to control living space.

It is notable that the 2012 ABS definition includes people in severely overcrowded dwellings who are considered not to have control of or access to space for social relations.

Indigenous understandings and definitions of homelessness can differ from those described above and can include 'spiritual homelessness' (the state of being disconnected from one's homeland, separation from family or kinship networks or not being familiar with one's heritage) and 'public place dwelling' or 'itinerancy' (usually used to refer to Indigenous people from remote communities who are 'sleeping rough' in proximity to a major centre) (ABS 2014; AIHW 2014a; Memmott et al. 2003).

Indigenous homelessness is not necessarily defined as a lack of accommodation. It can be defined as losing one's sense of control over or legitimacy in the place where one lives (Memmott et al. 2003) or an inability to access appropriate housing that caters to an individual's particular social and cultural needs (Birdsall-Jones et al. 2010). Some public space dwellers who have chosen to live rough may not see themselves as homeless (Memmott et al. 2003).

Early intervention and prevention

Early intervention and prevention are key concepts in homelessness policy and service delivery, but research, policy and program literatures offer no consistent definition. While the terms are frequently used together, or interchangeably, they are not the same thing.

Prevention and early intervention strategies aim to re-orientate the service system away from crisis management and include offering post-crisis support where necessary. They also aim to ensure successful transitions for people exiting institutional settings such as psychiatric care facilities and prisons.

The national and international evidence base has firmly established that the longer someone is homeless, the more difficult it is to assist them to stabilise their life. The responses and resources required are therefore substantively different for someone who is homeless compared to someone at risk of homelessness.

Prevention strategies operate at the structural level (Chamberlain and Johnson 2003) and occur before a person has become homeless. They aim to:

- address the underlying political, economic and social causes that place people at risk of homelessness (e.g. increasing the supply of affordable housing, improving labour markets)
- identify people who are most at risk of homelessness and build up their protective factors and decrease their risk factors
- focus on people who are at risk but not actually homeless (e.g. sustain tenancies)
- use broad population wide strategies that target the general population and at-risk groups; these interventions are not solely in the domain of Specialist Homelessness Services (SHS), but include mainstream services, such as housing, health, education, employment and family welfare services (Culhane et al. 2011).

Early intervention strategies are targeted at individuals who have recently become homeless and aim to ensure that short periods of homelessness do not become chronic.

Tenancy sustainment programs

Tenancy sustainment programs are prevention and early intervention initiatives aimed at preventing people at risk of eviction from losing their tenancy and becoming homeless. These programs are usually short term. They encompass Private Rental Assistance programs, which operate in all jurisdictions and typically provide financial relief in the form of bond loans and rental grants, subsidies and relief (AIHW 2018; Tually et al. 2016). Private Rental Brokerage Programs are tenant advice schemes that frequently adopt a case management model and provide targeted early intervention and assistance in the form of information, advice and brokerage services designed to build tenancy capacity. They also aim to establish links with the local private rental industry.

National Mental Health Service Planning Framework

The National Mental Health Service Planning Framework (NMHSPF) is a DoH funded planning support framework, primarily established to deliver the NMHSPF Planning Support Tool (NMHSPF-PST). The NMHSPF-PST allows users to anticipate need and demand for mental health care and the level and mix of mental health services required for a given population. NMHSPF data is not publicly available, however mental health

planning staff within Primary Health Networks (PHNs) and state and territory jurisdictions are among current users of the NMHSPF-PST.

Health of the Nation Outcome Scales (HoNOS)

The Health of the Nation Outcome Scales (HoNOS) is a clinician rated instrument comprising 12 scales measuring behaviour, impairment, symptoms and social functioning for those in the 18–64 years old age group. The HoNOS was developed in the United Kingdom (UK) by the Royal College of Psychiatrists' Research Unit and uses stringent testing for acceptability, usability, sensitivity, reliability and validity. It is widely used by clinical and community mental health service providers in England, Australia and New Zealand as a routine outcome measure.

Community Mental Health Services

Community mental health services deliver psychosocial care for people with lived experience of mental illness through government, not for profit and non-government community mental health organisations, in partnership with people affected by mental illness and public, private and primary health care services. Community mental health services support consumers to manage self-care, and improve social relationships and functioning in daily life, particularly in relation to social connectedness, education, physical health, housing, and employment.

Primary Health Networks (PHNs)

Primary Health Networks (PHNs) are government regional bodies established to deliver efficiency and effectiveness gains in the coordination of medical services for patients, particularly those at risk of poor health outcomes. Part of the remit of PHNs is to manage primary mental health care reform activities and associated flexible funding pools.

Executive summary

This research progresses the priority areas identified by the National Mental Health Commission (Commission) and provides evidence about the systemic issues and policy levers that need to be addressed to provide more and better housing and more and better services for people with lived experience with mental ill health.

A review of the evidence on housing and mental health identified the following key issues:

- there is a lack of affordable, safe and appropriate housing for people with lived experience of mental ill health
- secure tenure allows people to focus on mental health treatment and rehabilitation
- integrated programs addressing housing and mental health are effective but do not meet demand for these services
- discharge from institutions poses significant risks for homelessness and mental health
- housing, homelessness and mental health are interrelated
- the National Disability Insurance Scheme (NDIS) is reshaping the mental health system
- there is a mental health service provision gap under the NDIS
- housing, homelessness and mental health are separate policy systems with little integration, which contributes to poor housing and health outcomes for people with lived experience of mental ill health.

Key findings

There is an opportunity to scale up successful models of consumer and recovery oriented housing for national program delivery

A number of effective models delivering consumer and recovery oriented housing operate in Australia. However, most are pilot programs, are small in scale, localised, or have time limited funding.

The evidence shows that existing programs that integrate housing and mental health supports are effective in generating government cost savings (especially in health), and reduce hospital admissions and length of hospital stay. They also contribute to tenancy stability, improve consumer mental health and wellbeing, social connectedness and lead to modest improvements in involvement in education and work.

The evidence does not point towards one particular program approach that is suitable for all circumstances or consumers (one size fits all); there is a place for a variety of programs accommodating specific needs.

Successful initiatives have in common certain factors and principles that are essential to facilitating good outcomes. Critical success factors include effective mechanisms for coordination at the state and local levels, cross sector collaboration and partnerships, immediate access to housing (social housing or private rental), and integrated person centred support.

The NSW Housing and Accommodation Support Initiative (HASI) and Victoria's Doorway program are two examples of successful initiatives. The success of HASI

shows that high level system integration and the support of interagency collaboration can lead to the establishment and long term sustainment of an effective housing and mental health program in Australia. The Doorway program is highly innovative, as it diverges from the predominant model of providing housing via social housing providers, in favour of the private rental market.

Rather than investing in further demonstration and pilot programs, it is now appropriate to scale up successful programs nationally to meet demand and to extend them to serve new cohorts.

Successful programs could be promulgated at a national level through national frameworks and formal interagency agreements, together with clear guarantees given by parties around outcomes. Policy and stakeholder coordination at the local and state levels could be achieved via formal agreements, Memoranda of Understanding (MOUs), cross sector collaboration, and local coordination.

Reform frameworks around mental health already have good potential to integrate housing related support and housing provision at a national level using an integrated, person centred approach.

A lack of appropriate, affordable and sustainable housing is an impediment to scaling up successful programs nationally. However, coordination with the private rental sector can facilitate access to an immediate and greater supply of established homes, potentially enabling program providers to readily scale up in response to increased program demand.

Barriers to scaling up successful programs nationally include the lack of a national framework, a lack of commitment to innovative funding models, a lack of formalised agreements for collaboration between housing and mental health providers at the local level, and constraints on organisational capacity in the housing sector around mental illness and mental health provision. Continual reorganisation and reform in both, the mental health and housing sectors has interrupted personal links and advocacy networks.

Stabilising existing tenancies is a key mechanism for early intervention and prevention

Early intervention and prevention can reduce housing insecurity and improve prospects for mental health recovery and wellbeing. Numerous early intervention strategies could be implemented quickly and cost effectively to provide more secure housing and better mental health outcomes for people with lived experience of mental ill health. This includes greater use of existing tenancy sustainment services and capacity building in the housing sector (tenancy managers, real estate agents, social housing providers) to recognise and effectively and appropriately respond to the early warning signs of a mental health crisis.

There is a need to reshape state and federal policies to more effectively address housing insecurity for people with lived experience of mental illness

Better policy integration between housing, homelessness and mental health has the potential to contribute to better housing and health outcomes for people with lived experience of mental ill health and deliver cross-government cost savings. Successful policy integration will depend on overcoming competing policy agendas, competing accountability measures and separate competing funding streams.

Effecting policy and system change will require effective advocacy underpinned by a unified and well-articulated voice across sectors, private sector engagement and public support for the issues.

At the policy level, a lack of policy integration between housing, homelessness and mental health and government silos impede the development of national, cross sectoral and integrated policy solutions for housing and mental health that are underpinned by cross sector accountability mechanisms. A lack of pooled funding across portfolios is an impediment.

Policy integration will need to take place across all levels of government and across government structures. Within sector solutions for affordable housing (housing sector) or separate supported housing (mental health sector) are unlikely to address systemic issues.

Overcoming government segmentation will require new models for policy making, financing and service integration. It will be important to involve central agencies, particularly the Treasury, in discussions about funding housing and mental health services, given the role of central agencies in allocating portfolio responsibilities and the Treasury in allocating resources across government. Central agencies may also be expected to take a broader view of government priorities and a longer term view of whole of government savings, including the projection of future savings resulting from investment in the present.

The UK joint commissioning of services model is a model of service integration that could be adapted for Australia as a means to overcome issues associated with government silos and lack of pooled funding.

Prevent failed discharge planning and exits into homelessness

Hospital and mental health institution discharge processes can have a significant impact on consumers' prospects for improved mental health and wellbeing. Transitions between institutions, or in and out of institutions, are points of risk where people can fall through the cracks and be discharged into homelessness. This can be due to inadequate discharge planning and procedures, hospitals undertaking discharge assessments in time pressured environments and therefore not identifying risk factors, a lack of coordination across sectors, and because there are limited options for exit into appropriate and secure housing.

While some hospitals have good discharge policies and procedures, many do not. Some good transitional housing programs exist, such as the Queensland Transitional Housing Team, which effectively improves housing stability for tenuously housed patients with lived experience of mental ill health.

Policy development options

There are numerous options by which to affect systemic levers and policy to achieve the goals of more and better housing and more and better services for people with lived experience of mental ill health. This would be via two streams of action. The first set of options relates to progressing an agenda to refine what needs to be done to address the identified issues. The second set of options identifies ways in which to progress advocacy and sector leadership.

The success of each of these options will depend on being able to garner bi-partisan support and ensuring that processes and outcomes are not tied to a particular government or government process.

What can be done right now?

Scale up successful existing programs nationally. This will require the development of frameworks that facilitate policy and stakeholder collaboration and formalised agreements and mechanisms for collaboration between housing and mental health providers at the local level.

- Option 1:** Scale up and replicate nationally, existing successful programs that integrate housing and mental health support.
- Option 2:** Work towards developing a national framework for inter agency and cross sector collaboration that includes formal agreements and clear guarantees given by parties around outcomes.
- Option 3:** Leverage off existing reform frameworks for mental health to integrate housing related support at a national level, for example, through PHNs.

Provide better access to and more affordable, appropriate and safe housing. The availability of affordable, appropriate and safe housing is a key constraint to scaling up existing programs, however, this can be overcome.

- Option 4:** Work with and educate private rental sector landlords, real estate agents and their peak organisations sector about the housing needs of people with mental ill health.
- Option 5:** Increase the use of private rental housing as a way of providing ready access to established housing to facilitate scaling up of existing programs.

Early intervention and prevention are important interventions to prevent housing instability and homelessness. There is considerable scope to increase and improve early intervention and prevention. Existing tenancy sustainment programs have been shown to be a cost effective way of sustaining tenancies. Building the capacity of social housing providers, tenancy managers and real estate agents to respond appropriately to a mental health crisis is another key measure.

- Option 6:** Expand the use of, and tailor, tenancy support programs to assist people with lived experience of mental ill health to maintain their existing tenancies.
- Option 7:** Educate social housing providers, real estate agents and tenancy managers about how to identify early warning signs of a mental health crisis and the need for early intervention if these are detected.
- Option 8:** Develop materials and work with social housing providers, real estate agents and tenancy managers on how to take appropriate action to link tenants to service providers and supports to assist in sustaining their tenancy.
- Option 9:** Better implement procedures in public housing authorities to identify and monitor people with lived experience of mental ill health and link them with the required supports and services when needed.

Prevent failed discharge planning and exits into homelessness through improvements in discharge planning. This is another form of early intervention and would contribute to better housing and health outcomes for people with lived experience of mental ill health.

- Option 10:** Develop a national discharge policy and a nationally consistent definition of 'no exit into homelessness'.

- Option 11:** Resource hospitals to make thorough discharge assessments and develop appropriate discharge plans.
- Option 12:** Increase knowledge and capability in the acute sector to enable officers to better identify people who are in precarious housing or at risk of homelessness.
- Option 13:** Ensure timely and assertive follow up after discharge.
- Option 14:** Investigate the feasibility of a national roll out of transitional housing treatment programs for homeless people with mental ill health.

Better policy integration between housing and mental health is key to providing better housing and health outcomes for people with lived experience of mental ill health. Findings from the literature and the investigative panels point to the following options.

- Option 15:** Investigate the UK joint commissioning model as a model for service and policy integration across housing and mental health that could be applied in Australia.
- Option 16:** Engage in high level discussions with ministers responsible for health and housing and with central agencies about the need for integrated housing and mental health policies and integrated service provision.

Building collaboration for long-term change

Gaining policy traction and affecting system change will require a clearly articulated position, sustained advocacy and leadership. There are effective mechanisms that could act as a call to action and help articulate a unified position across the mental health and housing sectors, advance understanding of the issues, and gain cross-sectoral support for change.

A **national roundtable** of peak bodies for housing, mental health, consumers, carers and tenants could act as a call to the nation to discuss the issues. The roundtable would identify the problem, identify the policy issues and develop the architecture needed nationally to address these.

- Option 17:** Convene a national roundtable that brings together the peak bodies for housing and mental health and peak bodies for consumers, carers and tenants. The roundtable will act as a call to the nation to discuss the key issues.

A **consensus statement** could be a way to advance the understanding of the issue, gain cross sectoral support and develop a clear advocacy position.

- Option 18:** Work towards developing a consensus statement on housing and mental health, including measurable indicators and outcomes.

The **private sector** has a role in addressing the housing issues of people with lived experience of mental ill health.

- Option 19:** Convene an additional investigative panel targeting key stakeholders in the private sector to generate innovative solutions, access funding, gain a better understanding of the issues and raise awareness of housing and mental health in the private sector.

1 Introduction

The National Mental Health Commission (Commission) has commissioned the Australian Housing and Urban Research Institute (AHURI) to provide evidence and conduct research into the systemic levers and policy options to better understand how to achieve the goals of more and better housing, and more and better services for people with lived experience of mental ill health.

The Commission recognised that mental health issues are central to any discussion on homelessness and housing. To this end, the Commission conducted a broad national consultation in March to May 2017 to build a better understanding of the connections between housing, homelessness and mental health, and the complex relationship between individual and structural factors and housing experiences.

The purpose of this project is to progress the priority areas that emerged from the Commission's consultation process. To this end, the research addresses the following questions:

- 1 What are the successful models in the delivery of consumer and recovery oriented housing and how may these be effectively scaled up for a national program delivery?
- 2 How could current state and federal policies more effectively address housing insecurity for people with lived experience of mental illness?
- 3 What are the specific policy environments and funding gaps that contribute to failed discharge planning and exits into homelessness?

2 Research approach

The research approach consisted of the following:

- an evidence review
- two Investigative Panels
- final report
- policy engagement.

2.1 Evidence review

The first step in the research was to undertake a review of the national and international evidence, since 2008, on housing, homelessness and mental health. The evidence review formed the basis for the Investigative Panel Discussion Paper and used a research synthesis methodology.

The evidence review identified existing policies and programs, critical success factors and gaps in the system. The focus was on interventions that led to sustainable tenancies for people with mental health issues.

Research synthesis is a proven methodology for cost-effective and timely use of existing research findings for a specific policy concern. It is designed to facilitate evidence-informed policy and practice development. The approach was developed to help identify which social policy interventions work for whom and in what circumstances. Research synthesis typically involves the following activities.

Search terms derived from the research questions are used to iteratively search the national and international research and grey literature in order to identify relevant studies published since 2008, including:

- academic journal databases in the housing, homelessness and mental health fields
- general internet searching of online policy communities and information clearinghouses (including government departments)
- follow up of bibliographic references in found studies.

A bibliography is prepared and analysed for overall themes, scope and quality of the evidence base. This includes:

- review of abstracts and executive summaries for an initial assessment of relevance to the research question and quality
- where abstracts and executive summaries provided insufficient information to decide on inclusion or exclusion in the review, the full publication was reviewed
- on the basis of this information, a list of publications for inclusion in the research synthesis was prepared.

The selected studies are appraised and assessed for quality, research rigour and relevance to the policy concern. Data is extracted to construct a synthesis of the evidence, including detailed findings and overall conclusions.

2.2 Investigative Panels

Due to the complexity of the issue and to ensure currency, the project used an Investigative Panel methodology to supplement findings from the evidence review.

Investigative Panels are a research method developed by AHURI, designed to bring about direct engagement between experts. The Investigative Panel approach draws together elements of key informant interview and focus group approaches to generate new knowledge through expert panel discussions. Investigative panels differ from focus groups and consultations in that they seek targeted information from expert informants.

In this instance, experts from the housing and mental health policy community joined representatives from peak organisations, service providers and people with lived experience of mental ill health and carers in deliberations. Panel 1 was held in Melbourne on 21 June 2018 and comprised 14 experts. Panel 2 took place in Sydney on 22 June 2018 and had 15 expert participants (see Appendix 1 for a list of panellists).

Panel discussions were supported by a Discussion Paper and an expert presentation on the day. Deliberations of the Investigative Panels were documented with extensive note taking and audio recording.

3 Key statistics on mental health and housing

- About 45 per cent of Australians aged 16–85 years will experience a mental health disorder, such as depression, anxiety, or a substance use disorder in their lifetime.
 - There is a shortage of approximately 28,000 NDIS support packages for persons with a psychosocial disability.
 - Mental health and homelessness are strongly associated.
 - Homelessness increased around 14 per cent in 2011–16.
 - Factors that affect entries into homelessness include rising housing and rental costs, decline of social housing stock, employment and mental health; discharge from institutions is a moment of significant risk.
-

3.1 Prevalence of mental ill health

The following prevalence estimates are based on data from the Australian Burden of Disease study and draw on the modelling work undertaken in the development of the National Mental Health Service Planning Framework (NMHSPF).

- An estimated 45 per cent of Australians aged 16–85 years will experience a high prevalence mental health disorder, such as depression, anxiety, or a substance use disorder in their lifetime (ABS 2008).
- An estimated 2–3 per cent of the population aged 16–85 years have a severe mental health disorder, 4–6 per cent a moderate mental health disorder, and 9–12 per cent a mild mental health disorder (ABS 2008).
- An estimated 14 per cent of children and adolescents aged 4–17 years were assessed as having mental health disorders in the 12 months preceding the National Survey of Mental Health and Wellbeing (Lawrence et al. 2015).
- Indigenous people experience mental illness at a rate higher than their non-Indigenous counterparts, and have a mental health related hospitalisation rate without specialised psychiatric care more than three times that of other Australians (12.0 and 3.8 per 1,000 persons respectively). Mental health related hospitalisations with specialised care are double the rate of other Australians (12.8 and 6.5 per 1,000 population respectively) (AIHW 2016a: 12).

3.2 Mental health service need

The following figures describe the psychosocial and clinical service needs for persons with lived experience of mental illness in Australia. The figures are sourced from NMHSPF, which derives the estimated psychosocial and clinical care package needs of persons on the basis of the characteristics and severity of mental illness among each cohort.

The NMHSPF assigns a particular care package for people with lived experience of severe mental illness over a 12-month period. According to the NMHSPF methodology, in 2015 there were:

- approximately 470,767 persons (aged 18–64 years) who required a severe mental illness care package
- a total of 289,249 persons (aged 12–64 years) who required some form of psychosocial individual or group community support and rehabilitation (David McGrath Consulting 2017).

3.3 Mental health service provision gap

There is a significant gap in the provision of National Disability Insurance Scheme (NDIS) support for people with lived experience of mental ill health. Initial NDIS modelling by the Productivity Commission allowed approximately 57,000 support packages for persons with psychosocial disability; this has since been updated to 64,000 (David McGrath Consulting 2017).

- The Department of Social Services estimates that 91,916 persons have a severe and complex disorder and would be eligible for a support package under NDIS. This indicates a shortage of approximately 28,000 NDIS places for people with lived experience of mental ill health.
- Using a population health approach, the NMHSPF estimates that 289,249 people (aged 12–64 years) require some form of individual or group psychosocial community support and rehabilitation, which leaves a gap of approximately 225,249 persons (78%) aged 12–64 years who require psychosocial support services but will not gain access to NDIS support.
- Under the National Disability Agreement for specialist mental health services, approximately 40,000 persons were supported through the Partners in Recovery (PiR), Personal Helpers and Mentors (PHaMs), and Day to Day Living in the Community (D2D) psychosocial support programs (David McGrath Consulting 2017).
- The gradual introduction of the NDIS means that funding for these psychosocial support services has been progressively transitioned to the NDIS since 1 July 2016.

3.4 Housing system and homelessness

The links between housing, mental health and homelessness are shaped by the structural factors and dynamics driving the Australian housing system. Key trends are a decline in home ownership, an increase in the number of private renters, rising housing and rental costs, and ongoing decline of social housing stock in relation to population growth.

- Home ownership rates among Australians have fallen from 71 per cent in 1995–96 to 67 per cent in 2015–16 (ABS 2017).
- The share of households renting from a private landlord has increased from 19 per cent in 1995–96 to 25 per cent in 2015–16 (ABS 2017).
- In 2015–16, there were 432,800 social housing dwellings across Australia—a rise of approximately 5,000 dwellings from the previous 12 months, and an increase of around 5 per cent since 2009–10. Despite growth in the number of dwellings, this stock is failing to keep up with Australian household growth, with the social housing share dropping from 5.1 per cent in 2007–08 to 4.7 per cent in 2016 (AIHW 2017).

- Between 2009–10 and 2015–16, public rental housing stock reduced by approximately 4 per cent (333,400 to 320,000 dwellings), and mainstream community housing increased by 81 per cent, from 44,300 to 80,200 dwellings (AIHW 2017).
- There is an absolute shortage of rental housing for households in the lowest 20 per cent of income earners and a distributional shortage for the second lowest income quintile, leading to high levels of housing affordability stress (Hulse et al. 2014).
- Homelessness increased by approximately 14 per cent from 2011 to 2016. The increase in homelessness is most pronounced in NSW (37% to a total of 37,715 persons) with Victoria faring better (11% to a total of 24,817 persons) (ABS 2018).
- Indigenous people are over represented in the homeless population. Indigenous people make up 3 per cent of the Australian population, yet constituted 20 per cent (23,437) of all persons who were homeless on Census night in 2016 (ABS 2018).
- Mental health and homelessness are strongly associated. In 2015–16, 31 per cent (72,364 persons) of Specialist Homelessness Services (SHS) consumers aged 10 years and over had a current mental health issue (AIHW 2018). This is significantly higher than the rate of mental illness among the general population (16.2%).
- Institutional discharge is a significant moment of risk. For example, in Victoria, more than 500 people presented at homelessness services in 2016–17 after leaving psychiatric services—an increase of 45 per cent since 2013–14 (Perkins 2018).

3.5 Entries into homelessness

Entries into homelessness are affected by a combination of structural and individual factors. Structural factors contributing to homelessness include weak labour markets, tight housing markets and geographic factors (Johnson et al. 2015a; Wood et al. 2015). Individual risk factors include a history of contact with institutions, serious mental illness, drug or alcohol dependency, poor decision making, family and domestic violence, unemployment and relationship breakdown (Flatau et al. 2013; Johnson et al. 2015b; Steen et al. 2012; Stone et al. 2015; Wood et al. 2015).

The following risk factors for homelessness are identified by Johnson et al. (2015), who examined results from the Journeys Home longitudinal survey of homelessness in Australia, and an analysis of findings from the Survey of High Impact Psychosis (SHIP).

- Median rents: an increase in the median market rent of \$100 (a 30% increase at the national median weekly rent) lifts the risk of entry to homelessness by 1.6 per cent (Johnson et al. 2015a).
- Employment: local labour market conditions are a significant cause of entries into homelessness with a 1 per cent increase in the unemployment rate increasing the likelihood of homelessness entry by 1 per cent (Johnson et al. 2015a).
- Incarceration discharge: the risks of homelessness are 9.7 per cent greater for those recently incarcerated, which includes those coming out of juvenile justice, adult prison or remand, than the remaining sample population (Johnson et al. 2015a).
- Mental health: persons diagnosed with bipolar disorder or schizophrenia are 3.2 per cent less likely to enter homelessness than those not diagnosed with these illnesses; this represents a 40 per cent reduction in the odds of slipping into homelessness. This may reflect the impact of service engagement on homelessness prevention as the authors speculate that persons diagnosed with

low prevalence mental illnesses are more likely to engage with health services (Johnson et al. 2015a).

- Hospital discharge: among participants in the SHIP study, 8 per cent reported that they had not been given any help and had nowhere to live upon discharge (Harvey et al. 2012)

3.6 Mental health and housing system capacity

Data indicates that there are significant shortages in the provision of both mental health support services and housing.

The psychosocial support system is being broadly subsumed by the NDIS, and many who are currently receiving psychosocial support through the community mental health services will not be eligible for continued support under NDIS. It is unclear how this capacity shortfall will be addressed, however the Australian Government has stated that they are 'committed to continuity of support for all consumers of Commonwealth community based mental health programs who are not eligible for the NDIS' (Australian Government 2018: 7). Individuals currently receiving a Commonwealth mental health service 'will be supported to achieve similar outcomes, even if the name of the program changes or the support is provided through a different arrangement' (Australian Government 2018: 7).

There is a critical shortage of social and affordable housing in Australia, and a significant share of people with lived experience of mental ill health rely on this form of housing for accommodation (AIHW 2016c). A number of supported housing programs designed for people with lived experience of mental ill health are operating in Australia and have been shown to be effective (see Section 8 and Appendix 6). However, capacity in these programs is very limited with the largest programs, the NSW Housing and Accommodation Support Initiative (HASI) and Victoria's Housing and Support Program (HASP) accommodating 1,135 and 1,200 persons respectively since their establishment (McDermott 2017).

The NSW Ombudsman finding that 'long term and highly supported housing options are very limited' and are contributing to persons overstaying in hospital settings, is further evidence that the long term shortage of housing for people with lived experience of mental ill health in Australia has upstream effects in the health system (NSW Ombudsman 2012: 3). At the time of writing this report, government had taken no action in response to the Ombudsman's finding.

4 Links between housing and mental health

- There is a complex bi-directional relationship between housing, homelessness and mental health.
 - Homelessness may act as a trigger for mental health issues and vice versa, persons with lived experience of mental ill health are more vulnerable to common risk factors for homelessness, such as domestic and family violence, alcohol and other drug addiction, and unemployment.
 - Secure tenure allows people to focus on mental health treatment and rehabilitation.
 - Greater choice and control over housing and support contributes to wellbeing and quality of life.
 - Housing quality positively affects mental functioning, mental health care costs, wellbeing and residential stability.
 - Neighbourhood amenity is a factor for reducing mental health care.
-

Housing, homelessness and mental health are interrelated. A number of structural and individual factors increase the likelihood of mental ill health onset and the likelihood of poor housing outcomes among persons with lived experience of mental ill health. For example, homelessness may act as a trigger for mental health issues and persons with lived experience of mental ill health are more vulnerable to common risk factors for homelessness, such as domestic and family violence, alcohol and other drug addiction, and unemployment.

Contrary to a widely held belief that most homeless people have mental health issues and that mental illness is a primary cause of homelessness, the evidence shows that **while a mental health episode can plunge someone into homelessness, the isolation and trauma often associated with rough sleeping can also precipitate mental illness**. A study of 4,291 homeless people in Melbourne found that 15 per cent of the sample population had mental health issues prior to becoming homeless, and a further 16 per cent had developed a mental illness since experiencing homelessness (Johnson and Chamberlain 2011). The authors found that ‘for some people, **homelessness seems to cause mental health issues, particularly anxiety and depression**’ (Johnson and Chamberlain 2011: 36).

It is often difficult to distinguish the direction of causation between **drug and alcohol** use or addiction and mental illness. Long term substance addiction has been linked to anxiety, depression and paranoia, while persons with lived experience of bipolar, anxiety and antisocial personality disorders are most vulnerable to alcohol or other drug addiction (Shivani et al. 2002). The National Drug Strategy Household Survey found that, in 2016, approximately 27 per cent of persons aged 14 and older with a mental illness used an illicit drug in the previous 12 months. In comparison, approximately 16 per cent of the general population had used an illicit drug in 12 months to 2016 (AIHW 2016b).

Domestic and family violence is a leading cause of homelessness for women, young people, and children. In 2015–16, 37.8 per cent of SHS consumers were escaping

domestic and family violence (AIHW 2016d). Women, young people, and children are also vulnerable to mental ill health as a result of trauma associated with violence in the family home. A cross-sectional study drawing on the 2008 Australian National Mental Health and Wellbeing Survey explored the rate of mental ill health among a nationally representative sample of 1,218 women who had reported gender-based violence. The study found that women who had reported one incident of gender-based violence were more likely to experience mental ill health over the course of their lifetime, including 77 per cent for anxiety disorders, 52 per cent for mood disorders, 47 per cent for substance use disorders, 56 per cent for post-traumatic stress disorder and 35 per cent for suicide attempts (Rees et al. 2011).

A study of risk factors for long term homelessness among 377 newly homeless men and women who were admitted to New York City shelters found that a much shorter duration of homelessness is likely if persons are recently or currently employed, earning income and participating in job training (Caton et al. 2005). However, analysis of Journeys Home data shows that **employment status** does not predict a return to homelessness for people who have since obtained stable housing (Johnson et al. 2015a). Employment is a significant predictor of wellbeing, and is the second highest contributing factor behind health in a study of 3,911 residents in low income areas in Scotland (Bond et al. 2012b). Evidence suggests that the type of employment is critical in relation to wellbeing, with mental health improvement found to be less for persons in lower employment grades among participants in the Whitehall II study (Howden-Chapman et al. 2011).

A person's living situation can affect their mental health—the ability to access secure, quality and appropriately located housing helps to prevent mental health issues from occurring and enables better management of, or recovery from, existing mental ill health.

Greater choice and control over housing and support has been shown to be an important contributor to wellbeing and quality of life of people with lived experience of mental ill health (Nelson et al. 2007). Autonomy with respect to housing aspirations, and any housing situation that fosters the development of meaningful relationships in the home and community are associated with improved wellbeing and quality of life, and decreased symptomatology and service use (Aubry et al. 2016; Nelson et al. 2007).

The relationship between **housing quality** and mental health is significant, with tenants with lived experience of mental illness having been shown to benefit from quality housing through reduced mental health care costs, and greater wellbeing and residential stability (Harkness et al. 2004; Nelson et al. 2007). In the UK, two studies showed that improvements to study participants' housing quality led to improved mental health functioning over time compared to participants living in housing that remained the same quality (Bond et al. 2012a; Egan et al. 2013).

In many cases, however, the mere ability to access housing with stable tenure allows people the capacity to focus their attention on mental health treatment and rehabilitation, which would previously have been directed toward finding a home (Bleasdale 2007). Both poor access to housing and the quality of housing can be detrimental to mental health. Substandard housing quality in relation to home size relative to number of occupants as well as the under-provision of basic sanitary features in the home is a predictor of risk for infectious diseases, high noise levels and low privacy levels, all of which can negatively impact mental health (Waters 2001).

Neighbourhood amenity is a factor for reducing mental health care costs among people with lived experience of mental ill health. Persons with lived experience of mental ill health who move to neighbourhoods with fewer problems, such as crime and dilapidated property facades or outward signs of physical deterioration, are more likely to reduce their mental health care service use (Harkness et al. 2004).

Behaviours often associated with mental illness such as anti-social behaviour, delusional thinking and the inability to prioritise finances can be detrimental to a person's housing situation, leading to eviction or difficulty attaining housing (Jones et al. 2014). Social isolation as a result of lived experience of mental ill health can further exacerbate housing crises by limiting access to emotional and financial support (O'Brien et al. 2002).

5 Housing for people with lived experience of mental ill health

- The housing careers of people with lived experience of mental illness are unstable and often characterised by frequent moves, insecure housing and inadequate accommodation.
 - Complex needs and limited social and financial resources mean that many need housing support.
 - Rental, both private and social housing, is the most common form of tenure for people with lived experience of mental illness and discrimination in the private rental market is common.
 - Social housing is a key tenure for people with lived experience of mental illness, but highly rationed.
 - The social housing system does not adequately monitor and consider the mental health of its tenants.
 - Discrimination in the private rental market and high costs are barriers to appropriate, affordable and stable housing for people with lived experience of mental ill health.
 - There is a lack of affordable private rental housing.
 - There is a lack of supported housing.
 - While landlords and tenancy managers would be well placed to respond to emerging mental health issues, they are not skilled to do so.
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The housing careers of people with lived experience of mental illness are unstable and often characterised by frequent moves, insecure housing and inadequate accommodation (Kroehn et al. 2008).

The long term structural trends in the Australian housing system—falling rates of home ownership, increase in private rental, declining stocks of social housing and lack of affordable housing for low income households—are key factors in the housing issues facing those with mental ill health.

Deinstitutionalisation policies in Australia have led to significant compositional change in the type of housing occupied by people with lived experience of mental ill health. The sale of institutions by government was intended to financially support housing and service provision for former residents, however this has been implemented with limited results (Groenhart and Burke 2014) leading to a shortage of appropriate, affordable and safe housing for people with lived experience of mental ill health.

People with lived experience of mental ill health often have complex needs and fewer social and financial resources relative to the general population, and therefore require housing support. In Australia, they rely disproportionately on social and supported housing.

Rental housing, both private and social, is the most common form of tenure for people with lived experience of low prevalence mental illnesses. If a broad definition of mental ill health is used, tenure distributions are similar to those for the general population. This shows that low-prevalence mental illness significantly impacts on peoples' housing circumstances.

In 2008, SANE surveyed 372 people via the SANE website and helpline. Respondents reported depression (29%), schizophrenia (25%), bipolar disorder (23%), and anxiety disorders (9%). The most common form of tenure reported was private rental (31%), followed by owner occupier (18%), public housing (17%), with parents (16%).

The 2010 SHIP of people living with psychosis found that public housing (26.8%) was the most common form of tenure for people with low prevalence mental illnesses, followed by private rental (21.8%), living in the family home (19.1%), home ownership (13.1%) (Harvey et al. 2012). A further 11 per cent of respondents lived in supported group accommodation, 5.2 per cent were homeless, and 2 per cent were in institutions (Harvey et al. 2012).

An examination of the housing circumstances of people using mental health services and prescription medications by the ABS, using 2011 Census data, examined the tenure of people accessing at least one Medicare Benefits Schedule subsidised mental health-related service in 2011 (ABS 2016). Of these, 69.2 per cent owned their own home either outright (or with a mortgage), 16.5 per cent rented in the private market and 5.46 per cent rented social housing. This compares to figures for the general population, based on 2011 census figures as follows: homeowners with and without mortgage 67.8 per cent, private renters 22.6 per cent, renters in social housing 26.3 per cent (AIHW 2014b).

People with lived experience of mental ill health face a number of **challenges in accessing accommodation in Australia's private rental market**. A 2008 survey conducted by SANE found that 90 per cent of survey respondents among a sample of 372 people experiencing a range of high and low prevalence mental illnesses had reported discrimination, particularly when seeking private rental accommodation. High rental costs were also considered a major barrier to finding a suitable place to live according to most survey participants (83%) (SANE Research 2008).

Public and community housing are key tenures for people with lived experience of mental ill health, however, this housing is highly rationed.

In Victoria there were approximately 59,556 applicants for **public housing** as at March 2018. Approximately 200,000 people are on the waitlist for social housing for all Australian states and territories (AIHW 2016c). While people with lived experience of serious mental health issues are placed on the priority social housing waitlist, enabling them faster access to social housing, and many are able to access housing within three months, wait times of two years or more are not uncommon (AIHW 2017). While there is a shortage of social housing for disadvantaged Australians, of which people with lived experience of mental ill health form a large component, housing specifically for people with lived experience of mental ill health is also currently underprovided. In relation to supported housing, a 2012 NSW Ombudsman enquiry found that in NSW 'long term and highly supported housing options are very limited' (NSW Ombudsman 2012: 3).

There is also a shortage of housing for persons with lived experience of mental ill health whose needs create challenges to living alone. In many cases, funding for **supported residential facilities and group homes** has been redirected, or no longer guaranteed, as national funding for NDIS mental health packages replaces state

government residential facility subsidies. This is causing a decay of the supported housing sector for people with lived experience of mental ill health, and is compounding the effects of the social housing shortage (Battams and Baum 2010; Royal 2017).

There is evidence to suggest that the social housing system does not **adequately monitor and consider the mental health** of its tenants. For example, it is currently not possible to accurately estimate the number of new and existing tenants with lived experience of mental ill health in Queensland, which limits the ability of housing providers to plan for tenant needs (Jones et al. 2014). Housing workers are often ill equipped (due to lack of training or factors outside their realm of responsibility) to identify and address issues faced by people with lived experience of mental ill health and to link them with needed services.

Anti-social behaviour policies which operate in several Australian states also create barriers and disadvantage people with lived experience of mental ill health. In Queensland, a qualitative study followed the social housing trajectories of 12 tenants with complex needs involving mental health and substance misuse issues and found that anti-social behaviour policies and support services received by this group were highly inadequate for tenancy sustainment and personal wellbeing (Jones et al. 2014). The Queensland study recommended that the state's social housing mental health data collection processes for new and existing tenants be improved.

Community housing providers (CHPs) deliver social and affordable housing for vulnerable and disadvantaged groups, including people with lived experience of mental ill health. A small proportion of community housing is specialist supported housing for people with lived experience of mental ill health, commonly delivered as part of a mental health housing program such as Neami or Doorways linking housing with tenancy and clinical mental health support services.

6 Mental health system

- Australia's mental health system has two principal components, the clinical mental health sector, which is functionally and financially separate from NDIS, and community mental health services focusing on psychosocial wellbeing and participation in home and community life.
 - The NDIS is reshaping Australia's mental health service provision landscape.
 - Many community mental health services are being subsumed by the NDIS.
 - The NDIS mental health component mainly consists of psychosocial support service funding.
 - Stepped care is a key mental health treatment model and is central to the Australian Government's mental health reform agenda and guides the mental health activities of Primary Health Networks.
 - The continuum of care model of housing provision links consumers to housing and clinical support services, but housing is conditional on engagement with services.
 - The Housing First model provides immediate access to housing and complex support needs are addressed through a multidisciplinary team; housing is not contingent on consumers' engagement with support services.
 - Discharge from institutions is a transition that carries significant risks for homelessness and mental health and wellbeing.
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Australia's mental health system comprises two principal components: the clinical mental health sector, which primarily involves medical treatment at hospitals, specialists and General Practitioners (GPs), and community mental health services focusing on psychosocial wellbeing and participation in home and community life (DHHS 2015).

People with lived experience of mental ill health access the system from a range of different points. Consumers with a diagnosis of low prevalence but high severity mental health disorders (e.g. schizophrenia), can enter the health care system via attendance at emergency departments or contact with the justice system, or through contact with primary health care providers (GPs and community mental health teams). Service accessibility for people with lived experience of mental ill health varies, with excellent access to GPs but often difficulties accessing highly rationed public hospital resources. Accessing specialised mental health services outside urban and metropolitan areas is difficult as there are fewer services (National Rural Health Alliance 2017). People with lived experience of mental illness have on average longer bed waits in public hospitals than people presenting with non-mental health issues (Miller 2018).

Many community mental health services are in the process of being subsumed by the NDIS, with state governments who were previously responsible for providing psychosocial support in the form of 'psychiatric disability services', rolling the majority of this dedicated funding into the NDIS (DHHS 2016). Psychosocial support programs,

such as PiR, Personal Helpers and Mentors (PHaMs) and D2D, currently do not rely entirely on diagnostic criteria for admission. However, the rolling up of these services into the NDIS may limit accessibility for some users (Commission 2014).

The NDIS is intended to provide resources for mental health support to people with lived experience of mental ill health who are considered to have significant and enduring disability (PC 2011). The mental health component of the NDIS predominately consists of psychosocial support service funding to assist persons with psychosocial disability. The clinical mental health system is functionally and financially separate from the NDIS.

The *National Review of Mental Health Programmes and Services* report identified significant duplication of mental health service delivery, and particularly duplication of governance, eligibility and reporting structures between the Australian Government and the state and territory governments in program funding and provision. In 2012–13, there were 108 programs and services, excluding hospitals, funded by the Australian Government that provided mental health and psychosocial supports in the community (Commission 2014b: 146). Many of these services, such as headspace, overlap with other community, private and state government services in some regions (Commission 2014a).

The same systemic issues are present in remote areas, including overlapping and competing (often visiting) services, with little information sharing or collaboration between service providers. The report finds that services and programs are fragmented primarily due to a diversity of funding sources and siloed operations within a sector or specialty (Commission 2014a).

Discharge from institutions is a transition that carries significant risks for homelessness. Effective hospital and mental health institution discharge processes, or lack thereof, can have a significant impact on the prospects for improved mental health and wellbeing and housing of people with lived experience of mental illness.

6.1 Mental health treatment models

Mental health treatment models include medical approaches and addressing psychosocial barriers to functioning.

National programs designed to provide psychosocial support to people with lived experience of mental ill health include the PiR, PHaMs, and D2D programs. These are currently delivered through NGOs and complemented by community mental health services. Assertive Community Treatment (ACT) and stepped care are examples of mental health treatment models.

ACT is defined as ‘an integrated treatment that brings together providers from various disciplines to work together as a unified team with a single leader, a common location, and a shared caseload’ (Flatau et al. 2010: 18). This treatment approach targets homeless people with lived experience of mental ill health and primarily involves bringing support to, and collaborating with, the consumers to enable them to live a fulfilling life in the community. ACT does not necessarily include the provision of housing, however support and assistance in applying for private or social housing is a common component of ACT.

Stepped care applies a ‘most effective, least resource intensive’ philosophy, with consumers stepping up to more intensive specialist treatments when necessary. An advantage of stepped care is the prominence of early intervention, and the capacity to

deliver a service matched to an individual's needs. The approach comprises a hierarchy of interventions and broadly includes the following steps:

- publicly available self-help resources and promotion of preventative health
- early intervention for at-risk groups displaying early symptoms or with a previous illness, including access to lower cost, evidence-based alternatives to face-to-face psychological therapy
- low intensity face-to-face services and psychological services for people with lived experience of mild mental illness where required, delivered by GPs, psychologists and allied health professionals
- increased service access rates for people with lived experience of moderate mental illness, including face-to-face primary care and psychiatric support and links to social support
- provision of wrap-around coordinated clinical care through a combination of GPs, psychiatrists, mental health nurses, psychologists and allied health for people with complex needs and lived experience of severe mental illness (DoH 2017c).

In Australia, PHNs have adopted a stepped care approach to regional service delivery. A key responsibility of PHNs is to ensure that sufficient service mix, funding flexibility, efficient and effective referral processes, and accessible service interfacing exists to enable stepped care implementation.

6.2 Housing and support models

The **continuum of care** model links consumers to housing and clinical and psychosocial support services and is sometimes referred to as a treatment first, step-wise approach, linear or staircase transition model (Johnson et al. 2012). Continuum of care programs provide housing that is conditional upon the consumer accepting and engaging with support services and typically target people experiencing homelessness. In some instances, the consumer must have addressed their problems before moving to the next stage of the program or being awarded a tenancy.

Continuum of care approaches have been criticised for failing to permanently resolve rough sleeping, undermining the individual's capacity for choice to develop independence and failing to acknowledge the importance of housing stability to a person's recovery (Johnson et al. 2012).

Housing First (HF) is a philosophy of support provision based on the notion that secure and appropriate housing is fundamental to recovery and should be provided unconditionally to consumers. A key element of HF is the provision of immediate access to housing with no readiness conditions. The HF model has successfully combatted homelessness through a number of large scale programs including the US Department of Housing and Urban Development Veterans Affairs Supportive Housing program (HUD-VASH) and as a national homelessness policy in Canada (At Home/Chez Soi). There are few Australian HF programs practicing all of the key HF principles, however many are operating under what could be considered 'low fidelity' HF programs—that is, support programs that align with the majority of HF principles.

6.3 Combined/hybrid models

Assertive outreach refers to programs that provide a network of support services and housing to the most vulnerable rough sleepers. Persons targeted by assertive outreach programs generally have a high degree of complex needs requiring cross sectoral collaboration in support provision. An Australian example of assertive outreach are the Street to Home programs which have operated in several Australian states and territories. Street to Home programs are delivering moderate health and wellbeing outcomes, including improvements in the experience of physical pain, stress, depression and anxiety, the use of support services, and engagement with friends, family and community (Johnson and Chamberlain 2015b; Parsell et al. 2013b; Parsell et al. 2013c).

The **PiR** model is intended to coordinate care for people with lived experience of severe and complex mental ill health and is implemented by a consortia of local NGO services and PHNs (Smith-Merry et al. 2016). PiR involves a 'no closed door' approach where support facilitators connect consumers to the appropriate services after learning about their needs. The flexibility of PiR considers the non-linear trajectory experienced by most people recovering from mental ill health, while the integrated and client-centred approach of PiR recognises the importance of making the mental health system navigation straight forward for clients who may be at-risk of, or experiencing crisis. PiR has been implemented in rural and remote regions in addition to urban areas and is considered to be 70 per cent within scope for the NDIS, meaning that many people currently receiving PiR who do not qualify for NDIS will lose their service (David McGrath Consulting 2017). The program is yet to be evaluated and there is no government published performance data on the PiR program and its participants (Smith-Merry et al. 2016).

6.4 Discharge programs: pathways out of institutional care models and transition planning to housing

Mental health consumers generally exit mental health institutions and hospital settings into community mental health care, and while some enter into housing and support programs, others exit into unstable housing and inconsistent supports (Bryant Stokes 2012). Post-hospital follow up with consumers by a hospital discharge liaison officer is now common practice in Australia. However, there remain significant delays between discharge and follow up in many cases. Additionally, follow up may only be possible if the consumer has been discharged to a fixed address, with a home address also being a common prerequisite for community mental health service provision upon discharge (Bryant Stokes 2012).

In Western Australia, the current target is for 70 per cent of consumers to be followed up within seven days of discharge, while in NSW the rate of community follow up within seven days of discharge from public sector acute mental health units has improved from 48 per cent in 2010–11 to 63 per cent in 2015–16 (Bryant Stokes 2012; NSW Ministry of Health 2016). However, the NSW Ombudsman called for a state-wide review of discharge planning practices in mental health facilities based on failed discharge planning for over 95 people identified as ready but unable to move into the community (NSW Ombudsman 2012).

The SHIP second wave study conducted in 2010, found that among psychiatric inpatients admitted in the year prior to interview, a range of discharge practices were evident. At the time of discharge, approximately 58 per cent of this cohort recollected

discussing accommodation options with staff, 69 per cent reported not needing further help as they had already had somewhere to live, 23 per cent needed and received help finding accommodation, and 8 per cent reported that they had not been given any help and had nowhere to live in discharge (Harvey et al. 2012). A study analysing the characteristics of 2,388 people attending psychiatric clinics in inner Sydney homeless hostels found that the pathway to homelessness for 21 per cent of patients was discharge from psychiatric hospital (Nielssen et al. 2018).

Hospital and mental health institution discharge processes can have a significant impact on consumers' prospects for improved mental health and wellbeing. In WA, more than one-third of discharged public mental health hospital consumers who committed suicide did so within one month of discharge (DoH 2009). While it is difficult to anticipate a consumer's risk of self-harm, contributory factors such as trauma can be minimised with adequate housing and supports as well as discharge officer follow up upon psychiatric hospital bed discharge.

Clinicians surveyed for the Western Australia Mental Health Commission inquiry into discharge and transfer practices of public mental health facilities have noted recent improvements to discharge processes in some specialist mental health hospitals. This included developing outreach programs to achieve more timely and specialist follow up and assigning priority to post-hospital follow up within five days for all post-hospital consumers (Bryant Stokes 2012).

Transitional housing programs aim to improve living skills and housing stability for tenuously housed patients with mental illness. Queensland established a Transitional Housing Team in 2005 as part of a government response to homelessness among people with mental illness. The team provided time limited housing and intensive living skills training and support to clinically case managed patients.

A 2014 Australian study of mental health hospital discharge compared the outcomes of consumers participating in a transitional housing treatment program (THT) to a control group drawn from neighbouring hospital district mental health services without a THT. Consumers from both groups received similar clinical care in terms of length of hospital stay and intensity of treatment and were discharged between 2006 and 2009. The study measured total acute psychiatric inpatient days, problems with living conditions, illness acuity and emergency department presentations for a year before entry and a year after exit from THT (Siskind et al. 2014).

In this sample, the THT averted 22.42 psychiatric inpatient bed-days per THT participant after adjustment for age and Health of the Nation Outcome Scales (HoNOS) score, while the program also resulted in a greater improvement in living conditions. The costs saved on bed-days-averted more than eclipsed the cost of the THT in this case (Siskind et al. 2014). This suggests that post-discharge integrated mental health and housing supports can significantly improve outcomes for people with lived experience of mental ill health and produce downstream savings for government.

Examples of THT currently operating in Australia include the Housing and Mental Health Pathway Program delivered by HomeGround and St Vincent's Inpatient Mental Health Service in Victoria. This program targets consumers at St Vincent's and The Alfred Hospital psychiatric wards who are not currently case managed, and are experiencing or at risk of homelessness after being discharged (Launch Housing 2018).

7 Housing and mental health programs: outcomes and success factors

- Many successful models of supported housing for people with mental ill health operate in Australia, however, most are pilot programs, are small in scale, localised, or have time limited funding.
 - Positive outcomes include cost savings to government (especially in health), tenancy stability, reduction in hospital admissions and length of hospital stay, improvements in mental health, social connectedness, and modest improvements in involvement in education and work.
 - Critical success factors include effective mechanisms for coordination at the state and local levels, cross sector collaboration and partnerships, immediate access to housing (social housing or private rental), and integrated person centred support.
-

Over the past 25 years, Australian state and territory governments have established a number of small-scale housing programs for people with lived experience of mental ill health, often in partnership with service providers. Most of these housing and mental health programs feature some, but not all, components of the HF philosophy, and therefore could be considered 'low fidelity' HF programs. One reason for this is Australia's social and affordable housing shortage, which limits the degree to which support programs can offer immediate access to housing.

Examples of housing and mental health programs in Australia include HASI, HASP and the Doorway program, which are outlined below.

Program evaluations show that these programs are successful and lead to government cost savings and positive outcomes for consumers in relation to both housing and mental health. However, the programs tend to be small in scale, localised, pilot programs or have time limited funding.

7.1 NSW Housing and Accommodation Support Initiative (HASI)

The Housing and Accommodation Support Initiative (HASI) began in NSW in 2002 and involves collaboration between NSW Health, Housing NSW and NGOs to provide:

- accommodation support and rehabilitation associated with disability (delivered by NGOs, funded by NSW Health)
- clinical care and rehabilitation (delivered by specialist mental health services)
- long term, secure and affordable housing and property and tenancy management services (delivered by social housing providers) (Costello et al. 2013).

HASI was initially targeted to meet the needs of mental health consumers with high support needs, but has since been expanded to provide a range of support. The program evaluation showed that between 2002–2012, HASI had supported 1,135 mental health consumers in NSW, ranging from very high support (8 hours

per day) to low support (5 hours per week). The annual cost of HASI per consumer was between \$11,000 and \$58,000 (Bruce et al. 2012).

Positive outcomes for consumers included an overall reduction in hospital admissions and length of hospital stay, clinically significant improvement in mental health, tenancy stability, independence in daily living, social and community participation, and involvement in education or paid and unpaid work (Bruce et al. 2012). However, the physical health of consumers remained below the general population (Bruce et al. 2012).

The evaluation identified effective mechanisms for coordination at the state and local levels and regular consumer contact with Accommodation Service Providers as factors that were critical to the success of HASI (Bruce et al. 2012).

There are several HASI spin-off programs operating in NSW, including HASI Plus, HASI Aboriginal, and HASI Boarding House. HASI Plus targets a higher-needs demographic compared to HASI, providing accommodation and 16 or 24 hours of support to people living with severe or persistent mental illness. The program is designed to assist the transition to independent community living through the provision of recovery focused, wrap-around support services including psycho-social rehabilitation, daily living skills, physical health and workforce participation. Eligibility for the program extends to persons who have been living in long term institutional care, including mental health facilities, correctional facilities and hospitals.

In December 2017, there were 58 HASI Plus packages available in Northern Sydney, Hunter New England and Western Sydney, which also deliver access for people living beyond these Local Health Districts (NSW Department of Justice 2017). HASI Plus is an initiative of the Mental Health Drug and Alcohol Office within the Ministry of Health NSW, and is delivered through NGOs.

7.2 Doorway

The Doorway program is a Victorian Government initiative delivered by Wellways, which provides integrated housing and recovery support designed to assist people with lived experience of persistent mental ill health who are at risk of, or experiencing homelessness. Doorway is a collaboration between hospitals, housing and mental health service providers and landlords. The program links consumers with private rental housing and psychosocial support while providing time limited rental subsidy, brokerage and tenancy support (Dunt et al. 2017). The model is based on HF principles, but is highly innovative, as it diverges from the predominant model of providing housing via social housing providers, in favour of the private rental market.

Doorway supports participants to choose, access and sustain their own private rental accommodation by subsidising their rental payments where required. In addition, Doorway's housing and recovery workers support participants to develop tenancy skills and build natural support networks. Doorway creates integrated support teams for each participant.

Doorway housing and recovery workers are embedded in the public sector Acute Mental Health Services (AMHSs) within the relevant hospital catchment areas and provide housing and recovery inputs to care. AMHS staff also form part of these integrated support teams, providing clinical care, including case management. Other community based health services may also be involved for specialised purposes. AMHSs, and specifically the case manager, exercise governance for these different program inputs into an individual participant's care (Dunt et al. 2017).

An independent evaluation of the Doorway pilot program showed that during the evaluation period (July 2011–November 2013), of an intake of 77 people, 59 entered into private rental and 50 were still in residence at the end of the evaluation period. The evaluation found that participant usage of bed-based clinical service and hospital admissions reduced significantly during the program, totalling annual cost savings to government ranging from \$1,149 to \$19,837 per individual. Outcomes for participants included modest improvements in the proportion of tenants in paid or unpaid employment, taking steps to find work, seeing an employment consultant, accessing education and vocational training opportunities and receiving qualifications for their vocational training (Dunt et al. 2017).

Properties sourced through the open rental market, the provision of appropriate rental subsidy and brokerage support and collaboration between hospitals, housing and mental health service providers and landlords were identified as critical success factors by the evaluation (Dunt et al. 2017).

7.3 Queensland Housing and Support Program (HASP)

The Housing and Support Program (HASP) is a Queensland Government HF initiative, which at the time of evaluation in 2010 involved the collaboration of Queensland Health and the Department of Communities. HASP consumers are generally in tenuous accommodation or homeless when signing up to the program, and are immediately connected with mental health services, disability support service and regular community housing. Between 2006 and 2010, there were 204 HASP consumers, 82 per cent of which agreed with the statement that involvement in HASP had helped them achieve their goals (Meehan et al. 2010).

The government recorded significant cost savings as a result of the program. HASP consumers who without HASP would have been in a community care unit (CCU) saved the government approximately \$74,000 annually, while consumers who would have been in acute inpatient units saved the government \$178,000 annually (Meehan et al. 2010).

Critical success factors identified by the evaluation were a strongly targeted specific mental health service user cohort, immediate access to long term housing and key government agencies and NGOs working in collaboration (Meehan et al. 2010).

7.4 International case studies

Two international case studies, the Canadian At Home/Chez Soi and the US HUD-VASH provide insights into how barriers to successful program delivery can be overcome.

7.4.1 At Home/Chez Soi

At Home/Chez Soi is Canada's \$110 million HF trial, which operated from October 2009 to June 2013 in Vancouver, Winnipeg, Toronto, Montreal and Moncton and was conducted by Health Canada through the Mental Health Commission of Canada. The study was the world's largest on HF and focused on assessing housing stability, social functioning and quality of life among 2,298 homeless people with lived experience of mental ill health (Nelson et al. 2014).

The At Home/Chez Soi study found that both the treatment as usual group and intervention groups showed improvement in all outcomes over time. However, the HF

intervention group experienced more significant and persistent improvement in all outcomes at both 12 months and program completion (Bourque et al. 2015).

Many systemic issues were faced during the life of the project and strategies to overcome these issues, for example through stakeholder collaboration, were effective in some instances. Successful collaborative efforts with stakeholders during the life of the program included the following:

- Drawing on the strength of existing services in the community. In Winnipeg, project participants benefitted from access to existing services such as vocational training and food and drop-in programs.
- Partnerships with government agencies and departments. Securing access to housing units, mental health and homelessness services, and government income supports was critical to the project. In Vancouver, collaboration with the Ministry of Social Development helped increase access to services and substantially reduce wait times.
- Moncton members also spoke of the importance of partnerships with senior bureaucrats and ministers in government, while in Ontario good relationships with Ontario Works and the Ontario Disability Support Program helped facilitate timely access to income support.
- Landlord and landlord association partnerships. One of the major challenges in the program was the lack of affordable and available housing, particularly in Toronto and Winnipeg where some participants waited up to five months for housing. This was mitigated by developing relationships with over 40 landlords, which helped secure more than 1,000 apartments needed across Canada. In Montreal, strong relationships with a network including clinicians, consumers and superintendents were beneficial (Nelson et al. 2014).
- Landlord appreciation and education events were held in some of the project sites. This is perceived to have encouraged landlords to more readily consult with service team members when issues arise, rather than notifying the police or moving toward tenant eviction.

Other barriers to implementation of the program included deficiencies in Moncton's public transport system, causing participants to have difficulties regularly attending medical and support related appointments. There was also a perceived lack of cultural sensitivity training among service providers, while suicidal behaviour training was also viewed by some providers as insufficient (Nelson et al. 2014).

7.4.2 Housing and Urban Development Veterans Affairs Supportive Housing program

Since 1992, the Housing and Urban Development Veterans Affairs Supportive Housing program (HUD-VASH) has operated in a joint HF initiative between Housing and Urban Development (HUD) and Veterans Affairs (VA). HUD-VASH provides veterans and their families with permanent supported housing, with HUD supplying housing through a voucher program and VA providing case management and supportive services through its healthcare system. Approximately 80 per cent of homeless veterans in the US experience mental health issues (Smelson and Chinman 2017).

A study comparing HUD-VASH groups to case management or standard care found greater housing sustainment of the HUD-VASH group and discovered a statistically significant reduction of drug and alcohol abuse among this group (Cheng et al. 2007).

There was only a marginal difference in psychiatric outcomes recorded between groups.

HF programs in the US have faced significant systemic challenges in their implementation. This has included difficulty finding housing options that do not require sobriety or treatment participation, a lack of available 'moving-in cost' funds, and poor coordination with local public housing authorities. HF program management officers in the US developed a number of strategies to overcome these practical barriers. VA staff cultivated relationships with private landlords that were committed to housing veterans, while other strategies included holding public housing fairs, and working with local authorities to streamline bureaucratic procedures.

8 Policy analysis and system integration

- Housing, homelessness and mental health policy are essentially separate systems with little integration.
 - Policies at national and state levels recognise the need for greater integration and coordination across housing and mental health, but they rarely make systematic connections.
 - This contributes to poor housing and health outcomes for people with lived experience of mental ill health.
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Analysis of state, territory and federal housing, homelessness and mental health policies shows that they are essentially separate systems with little integration (see Appendices 2–5). This contributes to poor housing and health outcomes for people with lived experience of mental ill health.

8.1 Mental health policies

Mental health policies in Australia are guided by a national 10-year strategy, *The Roadmap for National Mental Health Reform 2012–2022* (Roadmap) (COAG 2012), and *The Fifth National Mental Health and Suicide Prevention Plan* (DoH 2017a), as well as more detailed plans and strategies at state and territory level.

Mental health policies promote a diversity of interventions depending on need. Public health programs promote good mental health to those in the general community while efforts around early intervention and prevention are targeted to those at risk (e.g. young people in school). Clinical support for people with lived experience of mental illness ranges from community based support through PHNs, through to specialised or residential care in public and private hospitals and forensic mental services. Both the federal Roadmap and most state plans argue for a person centred approach whereby the needs of the person (and their carers) are prioritised, with services wrapping around in a seamless fashion.

Mental health policies often mention housing as being important in a general sense as part of supporting good mental health in the community. Stable and secure housing, and supported housing services are often cited as important in supporting people recovering from mental illness in the community. Some policies acknowledge the links between mental illness and homelessness. Similarly, policies recognise supported housing in the community as an important means to support those with complex needs including those with mental illnesses (who are at higher risk of becoming homeless).

Policies at national and state levels recognise that greater integration and coordination is needed between mental health services and housing services in the community. However, the **plans rarely make systematic connections between these services, and connections at a program or strategic level are limited to a few jurisdictions** (NSW and Queensland).

8.2 Housing and homelessness policies

The National Housing and Homelessness Agreement (NHHA) came into effect on 1 July 2018. It replaces the National Affordable Housing Agreement and a series of agreements to address homelessness, the National Partnership Agreement on Homelessness. NHHA differs from the previous agreements as it exhibits greater policy breadth in that it targets the entire housing spectrum from crisis accommodation to home ownership.

The NHHA is negotiated as a combination of a multilateral agreement outlining the objective and outcomes to which the jurisdictions agree, and a series of bilateral agreements between the Australian Government and the states. At the time of writing, QLD, SA, TAS, ACT and the NT had signed the bilateral agreements. The agreements vary in detail and content. While people leaving institutions are identified as a priority group for homelessness, none of the plans include specific initiatives for this cohort.

Under the NHHA, funding to state and territory governments is linked to specified outcomes in priority areas, including targets for social and affordable housing, residential land planning and zoning reforms, inclusionary zoning arrangements, renewal of public housing stock and transfer of public housing to community housing providers, and homelessness services. Reform priorities for homelessness are achieving better outcomes for people, early intervention and prevention, and commitment to service program and design.

Funding is contingent upon jurisdictions having publicly available housing and homelessness strategies, improving data and transparent reporting, and matching homelessness funding in line with previous arrangements under the NPAH.

Australia has no national housing strategy, which means that national policies (e.g. taxation and income support for renters) affecting housing cost and demand are outside the scope of the agreement, and the NHHA therefore has only limited scope to address Australia's housing problem.

Federal housing funding arrangements are fragmented across different tenure types, from home purchase assistance and private rental assistance, through to social housing, and support and accommodation for those who are homeless or at risk of homelessness.

At the state and territory level, some housing policies make links with mental health issues or services, from anti-social behaviour policies through to training of staff in trauma and mental health first aid. Most recommend there be better alignment or coordination between social housing and mental health systems including non-government providers of psychosocial supports for long term mental health consumers.

Two states have implemented integrated support programs that link clinical support services for those experiencing mental ill health with tenancy support: HASI in NSW and HASP in Queensland. A number of other jurisdictions (Northern Territory and ACT) have piloted or announced their intention to start similar programs, though the ACT scheme has since ceased.

Homelessness policies also make links with mental health. Some policies relate to prevention (such as strengthening tenancy and other support for those with mental illness like HASI, and improving exit planning from mental health facilities) and strengthening responses (assertive outreach programs to address rough sleeping such as Street to Home, Resident Recovery, Opening Doors).

8.3 Funding for mental health services and housing support

Although mental health policy in Australia is guided by the Roadmap and successive plans, the Australian and state and territory governments are separately responsible for the funding and provision of services in different domains. Under the *National Health Reform Agreement* (COAG 2011), states, territories and the Australian Government are jointly responsible for funding public hospital services. Much of the treatment of and support related to people with lived experience of mental ill health is funded nationally through the Medicare Benefits Schedule. The Australian Government funds private hospitals, private psychiatric and psychological services, most primary mental health care, the Pharmaceutical Benefits Scheme, some specialist treatment and prevention programs, disability and carer payments. Other services, such as dedicated acute and clinical mental health services in public hospitals and community based support services are typically funded by states and territories.

Many jurisdictions fund community service organisations to provide support services for mental health, though few include longer term housing support in the community. Many clinical services involve residential components though these are usually temporary, and problems can arise after consumers are discharged if their housing circumstances are unstable or uncertain.

Funding for housing and homelessness policy is also shared across the Australian and state governments, with affordable housing and homelessness services coordinated through the NHHA, though much assistance for home owners and private renters is effectively the purview of the Australian Government. While some housing assistance (such as social housing) is targeted by need, a consumer-centred focus is less apparent in the housing sector, and assistance is fragmented by tenure type.

Programs exist at the state and territory level to support tenancies of social housing tenants and those at risk of homelessness, though few make connections to mental health services. People in some tenures (social housing, marginal housing and those at risk of homelessness) are more likely to receive these forms of housing support compared to those in private rental or home ownership. Some anti-social behaviour policies of social housing authorities can link in with mental health services. Some housing and homelessness programs (for chronically homeless or rough sleepers) include health related services to identify mental health issues, but many housing and homelessness workers lack expertise to identify mental illnesses.

8.4 Housing and mental health system integration

A number of Australian state and territory governments have achieved a degree of system integration in housing and mental health service provision. However, this is a recent phenomenon and has occurred in an ad hoc manner, with significant differences between states and territories in the scope of system integration.

The **Housing and Mental Health Agreement** (Agreement), which commenced in 2011, is an example of collaboration between the housing and mental health systems in Australia. The Agreement replaces the Joint Guarantee of Service (JGOS) for People with Mental Health Problems and Disorders Living in Public Housing, Community Housing and Aboriginal Housing.

The Agreement is between NSW Health and the NSW Department of Family and Community Services encompassing all its agencies: Housing NSW; Aboriginal Housing Office; Ageing, Disability and Home Care, and Community Services. It recognises that NGOs are key providers of services to people with mental ill health and signatory

departments are committed to working in partnership with NGOs, and their peak organisations to improve outcomes for this group of people.

The Agreement provides the overarching framework for planning, coordinating and delivering mental health, accommodation support and social housing services for people with mental ill health who are living in social housing or who are homeless or at risk of homelessness. It includes a high level action plan to support the implementation of the Agreement.

Commitments within the JGOS and the Agreement have enabled the implementation of programs such as HASI. **The success of HASI shows that high level system integration and the support of interagency collaboration can lead to the establishment and long term sustainment of an effective housing and mental health program in Australia.**

The **MOU between Housing SA and SA Health, Mental Health and Substance Abuse** is another example of system integration in mental health and housing provision. It was established in 2007 and updated in 2012 to 'guide the coordinated delivery of mental health services, psychosocial support and general housing services' (South Australian Government 2012). The agreement provides management guidelines for information sharing; timely pro-active, early intervention and preventative approaches; sensitive tenancy monitoring approaches, and collaborative and flexible arrangements between housing agencies (South Australian Government 2012).

Historically **in Victoria, well established non-government agencies have been the primary drivers of 'joined-up' mental health service provision approaches at the local level.** This was shown in the implementation of the Psychiatric Disability Rehabilitation and Support Service (PDRSS) framework (Bleasdale 2007), which has since been replaced by NDIS psychosocial supports. While the PDRSS highlighted effective integration in the mental health system, the housing system was a peripheral concern in the framework, with only 3 per cent of PDRSS framework funding dedicated to housing and homelessness (DoH 2012).

Current housing and mental health programs in Victoria such as Doorways demonstrate program level integration involving hospitals, the peak industry bodies and mental health service providers. Government system level integration with the purpose of mandating the long term, large-scale provision of housing and mental health programs in Victoria is not yet evident.

9 Scaling up programs nationally

- Opportunities exist to scale up successful programs nationally to meet demand and to extend them to serve new cohorts.
 - Successful programs could be promulgated at a national level through national frameworks, formal interagency agreements, and clear guarantees given by parties around outcomes.
 - Coordination with the private rental sector can facilitate access to an immediate and greater supply of established homes, potentially enabling program providers to readily scale up in response to increased program demand.
 - Policy and stakeholder coordination at the local and state levels can be achieved via formal agreements, MOUs, cross sector collaboration, and local coordination.
 - Reform frameworks around mental health already have good potential to integrate housing related support and housing provision at a national level using an integrated, person centred approach.
 - No one particular program approach is suitable for all circumstances or consumers (one size fits all); there is a place for a variety of programs accommodating specific needs.
 - Barriers to scaling up successful programs nationally include the lack of a national framework, lack of commitment to innovative funding models, lack of formalised agreements for collaboration between housing and mental health providers at a local level, and constraints on the organisational capacity in the housing sector around mental illness and mental health provision.
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The evidence shows that existing programs that integrate housing and mental health supports are effective in generating government cost savings, bringing about tenancy stability and improving consumer mental health and wellbeing. However, existing programs have limited capacity. Opportunities exist to scale up successful programs nationally to meet demand and to extend them to serve new cohorts.

Successful programs at a state level (such as HASI and HASP), provide models that are being emulated in other states (HASI-NT), and could be promulgated at a national level through national frameworks and formal interagency agreements, together with clear guarantees given by parties around outcomes (DoH 2017b). Funding to roll out such programs at a national level would also be needed. These programs could also be extended in existing states to serve new cohorts of people.

The evidence does not suggest that there is one particular program approach that is suitable for all circumstances or consumers (one size fits all). Rather, there are certain factors and principles that are essential to facilitating good outcomes.

This section synthesises key factors that should inform the design and implementation of such programs nationally, drawing on evaluations of current and past Australian programs integrating support and housing for people with mental ill health (Appendix 6).

9.1 Access to housing

Rapid access to appropriate, affordable and stable housing is central to program success. This housing can be either public housing, community housing or private rental.

Appropriate and affordable housing is critical to the effectiveness of interventions to stabilise a person's housing (Johnson and Chamberlain 2015a). While state governments have repeatedly shown that it is possible to provide immediate access to public housing for people with lived experience of mental ill health (Individualised Community Living Initiative (ICLI), HASP, Project 300), it is often highly dependent on the availability of existing housing stock or the willingness of governments to construct additional housing, and may come at the expense of other people on the public housing priority or general waiting lists.

The HASP (VIC, QLD and SA), Project 300 (QLD), and ICLI (WA) mental health and housing programs have successfully facilitated rapid access to housing. The Victorian HASP placed participants in public housing while non-government service providers delivered mental health services. The majority of Victorian HASP participants were placed during the 1990s, when there was comparatively less pressure on the state public housing system from applicant waiting lists. The South Australian HASP program differs from its Victorian and Queensland counterparts by placing participants in community housing rather than public housing.

The Queensland Government enabled Project 300 to deliver immediate access to housing by allocating sufficient public housing resources, while also offering a finite number of places (300). Other HF principles such as involvement of consumers in the selection of housing and enabling participation in community life contributed to the success of the Project 300 program. Enabling participants to choose their housing paid dividends for the Project 300, with over 95 per cent of participants satisfied with their housing (Edwards et al. 2009).

Some programs, such as the HASI and HASP (SA) have successfully collaborated with community housing providers, who have greater flexibility than government to expand or draw on their existing dwelling portfolios. HASI does not allocate bricks and mortar housing resources to participants, but provides tenancy and mental health service assistance to eligible persons who are currently in housing or who have applied for social housing through the social housing register (Bruce et al. 2012).

The Doorway program provides an alternative approach to facilitating housing access, by enabling participants to source and choose private rental housing. The program then delivers private rental assistance in the form of financial subsidies, brokerage and tenancy support. This is similar to the model adopted by the Platform 70 program in NSW, which assisted chronically homeless people into scattered-site private rental housing. Tenancy sustainment in the Doorway program was high (50 of 59 at the time of evaluation), and exits were due to positive factors such as financial sustainability, as well as negative factors (Dunt et al. 2017).

A critical factor in the success of the Platform 70 and Doorway programs was the ability to collaborate with private landlords. Coordination with the private rental sector can

facilitate program participants' access to an immediate and greater supply of established homes, potentially enabling program providers to readily scale up in response to increased program demand. By comparison to the private rental market, public and community dwelling portfolios possess a number of constraining factors including relative geographic concentration, extremely low vacancy rates, and high demand—all which limit the capacity of housing and mental health programs.

From a bureaucratic perspective, it may also be more feasible to scale up a private rental housing and mental health program to the national level, rather than programs that rely on public housing, given the absence of jurisdictional barriers.

9.2 Policy and stakeholder coordination

Coordination at the local and state levels is critical to the success of housing and mental health programs. This encompasses formal agreements, MOUs, cross sector collaboration, and local coordination.

In NSW, programs were started under the auspices of the *Housing and Mental Health Agreement 2011* which aimed to 'improve the housing outcomes and general wellbeing of people with lived experience of mental ill health who are living in social housing or who are homeless or at risk of homelessness' (FACS 2011: 6). The agreement binds state and local governments to collaborate with NGOs as equal partners in providing services, which enabled the sustained delivery of the HASI program among other initiatives (Bruce et al. 2012).

High level system integration through MOUs, such as the MOU between Housing SA and SA Health, Mental Health and Substance Abuse (South Australian Government 2012), institutionalise systemic approaches to service provision and provide a framework for stable, long term program delivery. A critical success factor in the HASP (SA) program is the coordinated approach between consumers, carers, NGO housing providers and government mental health services (SA Health 2017).

NGOs providing services through the individual psychosocial rehabilitation and support services (IPRSS) program identified the importance of collaboration between government and non-government sectors to the program's success. Strong collaboration in the IPRSS allowed good working relationships at the senior and middle management level to filter through to NGO support workers and government mental health services providers (SA Health 2011). In relation to HASP (QLD), case manager and support facilitators held the view that the model of having key government agencies (Hospital and Health Services, Housing and Homelessness Services, Disability and Community Care Services and Queensland Health) and NGOs working in collaboration is an effective way to provide coordinated supports. However, there were significant challenges to effective collaboration, including a difference in philosophies, backgrounds and understandings of service provision and governance (Meehan et al. 2010).

An evaluation of 50 Lives 50 Homes in WA found that key to the project was the collaborative partnership model, which supported collaborative case management, working groups, and integrated wrap-around support provision. The collaborative partnership model was particularly conducive to information sharing, which in turn enabled service providers to deliver rapid responses to meet consumer needs (Wood et al. 2017).

Successful outcomes might not be dependent on government providers. Innovative non-government providers such as those implementing Doorway show that integrated

forms of support can also be delivered by non-government providers who are required to work with homelessness service providers across the board. The Doorway program has benefited from effective coordination between non-government service providers, hospitals, and private landlords (Dunt et al. 2017). Coordination could be contracted out to external organisations provided objectives and outcomes are clearly specified and performance measured.

Some programs have joined-up community health services and homelessness outreach (e.g. Street to Home, Resident Recovery Program). These programs have adopted different models to engage groups that may have been difficult to engage through mainstream mental health services and could be expanded to operate in different locations (Johnson and Chamberlain 2015a; Parsell et al. 2013a).

9.3 Integrated, person centred support

A person centred approach places the consumer (and their carer or family) at the centre of the program with seamless wrap-around services delivered as needed.

Reform frameworks around mental health already have good potential to integrate housing related support and housing provision at a national level. The work of the National Mental Health Commission at federal level and also by state Mental Health Commissions (NSW, WA, SA and QLD) affirms the desirability of a 'person centred approach' to delivery of mental health services, and affirms the importance of stable and secure housing and tenancy support as an important foundation for recovery from mental illness (COAG 2012). This approach is affirmed in federal and state/territory plans (New South Wales Government 2017; Northern Territory Government 2014; South Australian Government 2016). The services would be provided when and where they were needed. This focus is also apparent in the NDIS framework (NDS 2016).

9.4 Targeted clientele

It is not clear whether programs targeting a particular cohort are more effective or better suited to up-scaling than others. Currently, there is a place for a variety of programs accommodating specific needs. Individual mental health factors, e.g. a predisposition to developing schizophrenia, are common to persons in all states and territories. However, there are systemic housing and mental health issues creating negative individual circumstances that are unique to a particular jurisdiction—such as the inability to facilitate exit from mental health facilities (NSW Ombudsman 2012). Problems that are unique to a state or territory may be more effectively addressed through small-scale, locally implemented programs. This question is not addressed in the evidence base.

The housing and mental health programs examined for this report accommodate a range of demographic cohorts. HASI has broad eligibility criteria with lower and higher support level packages depending on the participants' level of functioning (Bruce et al. 2012). In contrast, HASP (QLD) is designed primarily to meet the needs of people who require intensive psychiatric care and psychosocial support. The program targets members of this cohort who are precariously housed, have no address and are unable to be discharged from hospital, or currently sleeping rough (Queensland Health 2016). The South Australian HASP is similarly targeted toward high needs and precariously housed individuals, while Project 300 catered exclusively to long term residents of psychiatric hospitals (SA Health 2013). The ICLI also targets a specific higher needs

cohort. Entry into the initiative is limited to people unable to be discharged from inpatient facilities who are homeless or at risk of homelessness (McDermott 2017).

There were limitations to the HASI model of providing support to a broad spectrum of needs. Accommodation support staff and mental health staff noted that in some instances consumers were provided with packages that were lower than required due to a shortage of higher support packages. However, this may be attributable to inadequate resource allocation rather than any inherent unsustainability in the program's model of support (Bruce et al. 2012). Chronically homeless people were the focus of the Platform 70, Common Ground, Michael Project, Project 40, Way2Home, Journey to Social Inclusion, 50 Lives 50 Homes, and 500 Homes projects.

9.5 Barriers to scaling up existing programs nationally

Barriers to scaling up integrated housing and mental health programs nationally including the following.

- A lack of commitment to new innovative funding models whereby services might be jointly commissioned by mental health and housing providers, or funds for care and support might be pooled by agencies from both areas.
- A lack of formalised agreements for collaboration between housing and mental health providers at a local level. Mental health policy makers have envisaged that a person centred approach can be facilitated only through local service coordination, with a key role provided through PHNs and local health networks (LHNs). Such health networks are not accustomed to coordinating housing related services as well as health services.
- A lack of organisational capacity in the housing sector around mental illness and mental health provision.
- Separate national level agreements, policies and accountability mechanisms across sectors can lead to competing goals and measures across sectors and a lack of responsibility for cross sector issues
- Continual reorganisation and reform in both sectors has interrupted personal links and advocacy networks.

10 Investigative panel findings

- Lack of affordable, appropriate and safe housing is a key factor in homelessness and housing insecurity and places significant constraints on the system's ability to effectively deliver mental health services and plan for discharge.
 - Families and carers are crucial to recovery and tenancy sustainment.
 - There is uncertainty about the quality and quantum of services available to people with lived experience of mental ill health under the NDIS.
 - There is ample evidence on effective models of consumer and recovery oriented housing.
 - Panellists identified the key policy challenge as the need for systematic change to increase the supply of affordable and appropriate housing, with a range of models where formal and informal support and clinical services enable people to access and sustain housing.
 - This will require an integrated approach across the housing and mental health sectors, effective advocacy underpinned by a unified and well-articulated voice across sectors, private sector engagement and public support for the issues.
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This chapter presents the findings from the Investigative Panels. The findings from the Investigative Panels were largely consistent with the evidence review. However, the Investigative Panels also highlighted gaps in the literature, especially in relation to the roles of family and carers, and provided innovative suggestions for policy development and ways forward.

The Investigative Panels considered the following questions:

- 1 What are the successful models in the delivery of consumer and recovery oriented housing and how may these be effectively scaled up for a national program delivery?
- 2 What are the specific policy environments and funding gaps which contribute to failed discharge planning and exits into homelessness?
- 3 How could current state and federal policies more effectively address housing insecurity for people with lived experience of mental illness?

10.1 Key issues

Three key issues cut across all panel discussions. These were the impact the lack of affordable, appropriate and safe housing has on the effectiveness of consumer and recovery oriented care, the role of families and carers and the impact of the NDIS.

10.1.1 Lack of affordable, appropriate and safe housing

Participants in both panels agreed that the lack of affordable, appropriate and safe housing (home ownership, rental, social housing, supported housing) is a key factor in

homelessness and housing insecurity for people with lived experience of mental ill health, and places significant constraints on the system's ability to effectively deliver mental health services and plan for discharge. Consequently, systemic change to increase the supply of appropriate and affordable housing is central to solving the housing problems of people with lived experience of mental ill health. This housing needs to be linked with a range of support models (informal and formal support, clinical services) that assist people with lived experience of mental ill health to access and sustain housing.

Support should primarily look at the provision of more housing, and this must underpin everything else. We are just fiddling around the edges until this is addressed. (Panellist)

Housing is a social determinant of health. Panellists agreed that housing is more than a place of accommodation. Panellists emphasised the role of stable, affordable and appropriate housing in mental health and wellbeing and in recovery. They noted that housing is a fundamental building block, not just for mental health, but also for the community.

10.1.2 Families and carers

Families and carers are crucial to recovery. Panellists strongly emphasised the role of families and carers in providing and facilitating access to and contributing to tenancy sustainment. Families and carers are also instrumental in providing support and care and in facilitating access to services.

Participants noted that the service system is built around the individual rather than the family or community. Consequently, participants in both panels felt that the current system does not sufficiently recognise and resource families and carers in their important roles.

There are two support systems for people with lived experience of mental ill health to assist with housing and recovery. One is informal and is provided by families and carers who have financial and other needed resources. This support system is not funded or subsidised by government. In essence, this means that families and carers are positioned as an unfunded residual system. The other system is designed for people who are poor and who do not have family support. Here support is provided by government and the not for profit sector. Having these two parallel systems generates inequities in resourcing and outcomes.

Some panellists felt the disparity in resourcing between these two systems was worsening under NDIS. For example, one panellist noted that there are perverse outcomes associated with the framing of NDIS eligibility and priority for service; e.g. by considering the availability of family and informal supports in determining eligibility for NDIS, consumers are pushed down the order despite the need for family respite.

Some panellists were concerned that an over-reliance on families to provide support is to their financial detriment and causes further disadvantage.

Panellists saw scope to improve how homelessness and mental health organisations work with family and carers.

10.1.3 NDIS

Most panellists were concerned about the effects of the NDIS on the quality and quantum of services available to people with lived experience of mental ill health. Key points from the discussion include:

- Because support providers have less funding post-NDIS, they have had to make redundancies to hire less skilled people in their place.
- There is concern that there will be a significant gap in the provision of psychosocial support under NDIS, with many consumers who previously received support no longer being eligible for support services provided through the NDIS.
- Choice can be problematic for some consumers. Past trauma, institutionalisation or symptoms of mental illness can mean that choice is a foreign concept and is hard to exercise. For example, how do we overcome the problem of impaired ability to make sound decisions of some people eligible for support, or the difficulty in making aspirational choices?
- There is uncertainty around how well the NDIS will be able to respond to the need for quick activation of support in response to relapses.

10.2 Successful models in the delivery of consumer and recovery oriented housing

Both panels agreed that there is ample evidence on effective models of consumer and recovery oriented housing (refer to Appendix 6 for a list and evaluation of some of these programs).

Panellists identified the key policy challenge as the need **for systematic change to increase the supply of affordable and appropriate housing, with a range of models where formal and informal support and clinical services** enable people to access and sustain housing. Key points of discussion were as follows.

- **Housing first** is an important principle in the delivery of consumer and recovery oriented housing, as it is important to unbundle housing and support services. Housing first models do not make housing contingent upon consumer engagement with services.

We have to get rid of the idea of 'housing readiness'. (Panellist)

The Common Ground model has proven successful, but is small scale. Its successes justify the high financial costs.

Limited social housing options and a lack of affordable rental housing in the private market pose obstacles to successful implementation of housing first models.

- The **private rental market** could be better utilised for social housing. Models utilising the private rental market can provide a greater range of housing options (e.g. Victoria's Doorway model, see Section 8.2) and were viewed positively by panellists. However, not all states and territories have such models of collaboration and these models depend on appropriate (amount and duration) rental subsidies if they are to provide sustainable tenancy outcomes. There is scope for community housing providers to branch out into the private rental market to subsidise social housing.

- **Early intervention** is about stabilising people in their existing tenancy.

Every eviction is a failure of the system. (Panellist)

- **Tenant sustainment program** (sometimes also referred to as tenancy support program) are effective in assisting people to maintain their tenancies, are cost effective (Zaretsky and Flatau 2015) and are a model that could be more widely used. Tenancy sustainment services have an important role to

play in short term crisis management and early intervention and prevention of homelessness. Tenant sustainment programs are prevention and early intervention initiatives aimed at preventing people at risk of eviction from losing their tenancy and becoming homeless. These programs are usually short term. They encompass Private Rental Assistance programs, which operate in all jurisdictions and typically provide financial relief in the form of bond loans and rental grants, subsidies and relief (AIHW 2018; Tually et al. 2016). Private Rental Brokerage Programs are tenant advice schemes that frequently adopt a case management model and provide targeted early intervention and assistance in the form of information, advice and brokerage services designed to build tenancy capacity. They also aim to establish links with the local private rental industry.

- **Mainstream tenancy management** could play a greater role in early intervention and prevention and tenancy sustainment. In private rental housing, real estate agents are often the first to detect that something is wrong (e.g. missed or delayed rent payments, property damage, observations from property inspections, complaints from neighbours or contact from police) but often do not intercede, or do not know what to do or whom to contact. There is a need for landlord and real estate agent education and support so they may understand when or how to intervene early, before the tenancy reaches crisis point. The situation is similar in social housing. Personal relationships with housing officers are important for tenancy sustainment and to identify early warning signs. There is an opportunity to work with real estate agents and property managers to identify early warning signs and take appropriate action to link tenants to service providers and supports to assist in sustaining their tenancy.
 - **Programs need to cater to short term mental health crises** so consumers can be assisted quickly and be transitioned back to their original housing once the crisis is overcome. Short term crises leading to eviction can cause consumers to be placed on the tenancy blacklist causing ongoing disadvantage in the private rental market. This makes recovery from a crisis difficult and can lead to people being placed in inappropriate housing, which can trigger further crises.
 - **Flexible funding and brokerage** are key to providing effective short term crisis intervention and should be made available quickly and easily.
 - Following recovery from a crisis, systems need to be in place so that a former consumer can **‘retrigger’ supports**, i.e. quickly and easily re-engage with services that previously assisted them, in the event of relapse.
 - **Mainstream services** (e.g. schools, GPs) offer a unique opportunity for broad-based screening to identify people who are at risk and link them with supports for early intervention and prevention (preventative or general supports, specialist and acute services, etc.).
- **Choice** is an important principle in the provision of housing. However, rationing of social housing and housing affordability stresses in the private market mean that people with lived experience of mental ill health are often forced to choose inappropriate housing. This in turn has negative outcomes for tenancy sustainment and mental health and wellbeing. Choice enables the housing experience for people with lived experience of mental ill health to be normalised.
- It is important to understand the **consumer perspective** and their journey through the housing and health systems. Consumer consultation and tenancy journey

mapping can be useful for gaining knowledge of consumer perspectives and should be used more widely.

- **Coordination and collaboration at the local level** has proven to be effective in providing consumer and recovery oriented housing. Face to face meetings with housing and mental health providers are a key component as they generate a holistic understanding of people's issues. However, coordination and collaboration is often not systematically implemented and largely relies on the personal initiative and relationships of service providers and carers. Open dialogue between support providers is critical to service delivery. Multidisciplinary teams work.
- **Social isolation** is a big problem for many people recovering from mental ill health. It is not enough to merely place a person in housing. Ongoing support and connection to community is just as important.
- Panellists were divided on the merits of **transitional housing**. Some thought that transitional housing worked well and delivered good outcomes and high satisfaction ratings due to the support provided. Good quality housing contributes to high satisfaction ratings. Other panellists felt that transitional housing reinforces feelings of inadequacy among people with lived experience of mental ill health. Some panellists were strongly of the view that housing should be normalised, i.e. housing in which people are placed should be of a similar style and quality to mainstream housing.

10.3 Scaling up existing programs for national program delivery

Panellists emphasised that many existing programs work well, but have limited capacity, are pilot projects, serve only specific geographic areas or cohorts, or have time limited funding. Overall panellists identified that there is a large gap between need and availability of effective programs for consumer and recovery oriented housing.

Panellists emphasised that we do not need more one off projects and pilots, but that the way forward is to institutionalise what we know works.

The models are there, there is just a need to scale up. (Panellist)

Some panellists felt strongly that there is no need for more crisis, transitional, and conditional models of accommodation. Rather there is a need to provide normalised housing in which people can feel at home (Housing First).

Some panellists felt that it would be dangerous to introduce a normative 'one size fits all' model for national program delivery and that tailored and place based responses work best.

Collaboration between sectors was seen to be central to scaling up existing programs successfully. Key issues raised in relation to this include the following.

- There are no complex needs, just complex systems. Individuals have needs and must navigate a complicated and fragmented system in order to access services. There is a need to untangle the systems.
- The current system is reactive, rather than proactive, due to shortfalls in funding and a lack of flexibility.
- Successful programs have to be targeted and require financial commitments from governments, a common purpose and common accountability between governments and sectors to enable greater cooperation.

- Primary Health Networks (PHNs) could play an important role in early intervention and system integration.
- Housing and health use different languages and concepts. This can engender miscommunication and contributes to system failures; for example, housing and health may define the problem differently and therefore prioritise solutions that are at odds with each other. It is necessary for housing and health to understand each other's roles, priorities, timelines and constraints if successful collaboration is to occur.

10.4 Discharge planning

Participants in both panels commented on discharge planning and procedures, but discussions on this issue were not as in depth as those of the other questions.

Transition points between institutions or in and out of institutions can be periods of instability, which expose people to a range of stressors and challenges that can act as triggers which destabilise people. At these transition points, people can fall through the cracks in the system due to poor discharge planning, because risk factors are not identified, because there is a lack of coordination in responding to consumer needs, and because there are limited options for exit into appropriate and secure housing options.

Key observations included the following. Discharge into homelessness and precarious housing happens due to:

- inadequate discharge planning and procedures
- hospitals undertaking discharge assessments in time pressured environments mean people in precarious housing are not identified
- hospitals need to be resourced to make thorough discharge assessments and to facilitate internal transitions from one service to another
- a lack of knowledge and capability in the acute sector means officers often do not know the right questions to ask to identify people who are in precarious housing or at risk of homelessness; questions about the quality of the home are not asked
- frequent patients are often treated quickly and then assessed for discharge quickly, with discharge officers not asking the right questions or getting corroboration of patient answers from friends and family
- delays in or lack of follow up after discharge
- difficulties accessing GPs and specialists after discharge due to long wait times or specialists already being at capacity and not taking on new patients
- GPs being giving insufficient discharge information
- patients are being discharged too quickly because of capacity constraints in the medical system.
- Members of Panel 1 noted that discharge planning from institutions would be a less significant issue if early intervention and community based supports and services were more accessible and better resourced.

Panellists noted that data on post discharge nights often do not reflect the truth, as people are sometimes discharged from hospital into a hotel for several days and then back into homelessness.

Precarious housing or homelessness post discharge negatively affects people's recovery, ability to access needed services, and puts them at risk of relapse.

Panellists noted that a lack of clarity about who has responsibility ensuring people are securely and adequately housed post discharge exacerbated the risk of homelessness for people with lived experience of mental ill health. There is a conceptual question about where health ends and housing begins.

Housing NSW are in charge of supporting the accommodation needs of people who are discharged, however, the organisation is often unable to access data on the housing needs of prisoners until after discharge, when it would be more useful to have this data prior to discharge. There is need for income support after a long admission or discharge from prison.

Panellists observed that while some hospitals had good discharge policies and procedures, many did not. They identified the need for a national discharge policy and a consistent definition of 'no discharge into homelessness' across Australia. There are some good models worth noting, e.g. in Queensland discharge planning from prison takes place 2–3 weeks prior to discharge and then again six months after discharge.

It was noted that discharge and transitional housing reform has to be done in a scaled way given the capacity constraints of homelessness services.

10.5 How could current state and federal policies more effectively address housing insecurity for people with lived experience of mental illness?

Panellists were clear that there is enough evidence to support that housing and mental health programs are effective in achieving outcomes for consumers and lead to whole of government cost savings. It is now necessary to tackle system change and institutionalise solutions that until now have been small scale.

Both panels identified a lack of political commitment as a stumbling block to systems change and strongly agreed that there was a need for leadership and joint advocacy across the housing and mental health sectors and that this should encompass all levels and portfolios of government, as well as the not for profit and private sectors. However, panellists were divided on how best to tackle this. Participants in Panel 1 had a clear preference for government guidance and intervention. Panel 2 favoured private sector initiatives as a way of addressing the housing and mental health crisis.

Both panels agreed that the housing and mental health sectors would need to agree on a common purpose and common accountability, and common reporting and outcomes in order to facilitate system change.

10.5.1 Government role

Panellists identified government silos as a barrier to systems change. Housing and mental health are two separate policy systems with separate funding streams and separate reporting and outcomes measures. There is very little policy integration across the two systems. Silos mean that there are competing policy agendas and funding and outcomes measures are tied to differing priorities, making it difficult to get traction across the housing and mental health divide.

A lack of pooled funding across portfolios was seen as an impediment. The UK joint commissioning model was identified as a possible means to overcome issues associated with silos and lack of pooled funding.

Both panels identified that any successful policy initiative would need to involve:

- Treasury, which sits above government funding silos
- regular face to face meetings between health and housing
- all levels of government, including local government.

Some panellists were of the view that while there are gaps in the service delivery continuum, there remain opportunities for efficiencies within the system. As the likelihood of increased government funding into housing and mental health was slim in the near future, the sectors should focus on getting better results from existing programs and services. This could be done by integrating existing systems to generate efficiencies and improved knowledge.

We need to maximise what we have now and minimise waste. (Panellist)

Joint Commissioning Model—housing and mental health services

‘Joint commissioning of services’ is a model of service integration now operational in the UK. The model came about as part of a forward plan for the National Health Service (NHS), which identified the need for health and social care to work together in designing future services (National Health Service 2014). The need for better housing outcomes for health was a particular issue, costing the NHS at least £1.4bn in first year treatment costs, because of higher admissions, delayed discharge, and higher readmission rates. (National Health Service 2016)

In 2017–18, the NHS allocated around £73.6bn to ‘Clinical Commissioning Groups’ (or CCGs) for commissioning local health services including mental health and community services (National Health Service 2017). CCGs are groups of local GP practices whose governing bodies include GPs, other clinicians, patient representatives, general managers and sometimes local authority representatives (Wenzel 2017).

CCGs sometimes work with local authorities to commission non-government housing organisations, which are seen to be well placed to assist in improving health outcomes because they are in touch with many vulnerable people including those with complex needs or mental health issues. While the joint commissioning model has been used to address a range of housing related health issues (e.g. providing assistance to adapt homes for frail older people at risk of falls), housing support has also been provided for those with mental health issues. Examples include the following (National Health Service 2016):

- **Service coordination.** Staffordshire Housing Group coordinate a range of services (health, housing, financial, social and navigation services) for older and vulnerable people with complex health needs being discharged from hospital, resulting in low rates of readmission to hospital.
- **Step down services.** Bradford Respite and Intermediate Care Support Services and Tile house provide accommodation and support for people with complex mental health problems including forensic histories to ‘step down’

from hospital to stable housing, helping to reduce reliance on residential care and hospital readmission.

- **Housing support.** Supporting People off the Streets provides temporary accommodation to assist people find a more permanent home solution.
 - **Health promotion.** St Mungo's Hammersmith and Fulham Health and Homelessness Project improves health outcomes through health and wellbeing fairs, health screening events and fitness initiatives.
-

10.5.2 Private sector role

Both panels strongly emphasised the need to move beyond government and mobilise the private sector to access funding and innovative solutions. Suggestions included:

- social investment bonds to finance mental health service delivery associated with housing
 - encourage private sector involvement via tax incentives and rebates
 - develop new ways to generate the required capital or land; e.g. meanwhile use agreements for government land for housing, such as Launch Housing's initiative to build portable 'tiny homes' on vacant land belonging to Vic Roads
 - banks are a sector that needs to establish social responsibility and would be well placed to contribute capital
 - get landlords and real estate agents involved; there is sympathy for enabling low income people into rental if they are good tenants and many mainstream real estate agents would like to know more about how they can help
 - need to identify the benefits the private sector gains for their contribution.
-

Meanwhile use agreements

Meanwhile use agreements could become a template for building social housing on state owned land. One such example is a collaboration between Launch Housing, Vic Roads and a philanthropic donor (Harris Capital), to build up to 57 studio sized units on nine unused blocks of land in Ballarat Road in Footscray and Maidstone. The model involves the leasing of unused land from Vic Roads at a 'peppercorn rate', where a lease agreement states that the land must be vacated if the road authority requires its use after an initial five years. The units themselves are portable and could therefore be moved elsewhere if VicRoads requires the land. The transportable units are designed by Schored Architects and have a six-star green rating and acoustic engineering. The transportable units, designed for singles or couples, will be built in a factory in Horsham (rural Victoria) before being transported to the sites (Carey 2017; Raynor 2017).

10.5.3 Advocacy

An integrated viewpoint and voice across sectors, strong leadership and a compelling story that affects all Australians were identified by both panels as key to successful advocacy.

- Successful advocacy will require public support. Effective campaigning will require a communications strategy, with expert communications strategists working pro-bono to achieve this. Campaigning will require champions as well as institutions.

I think we need to have a compelling story that affects all Australians to have any success with politicians. Firstly, we need to convince people with lived experience and people in the industry to advocate and come together in a collective narrative. It is critical to also involve the private sector in solutions.
(Panellist)

In relation to a proposed focus of advocacy, panellists noted the following:

- It is necessary to win the economic argument as there is little chance of other arguments being successful.
- While government tends to be swayed by the clinical model, what happens at home and in the community is much more important.
- Advocacy work should focus on bringing government awareness to housing affordability as an electoral issue and encourage support of affordable and supported housing.
- Short political cycles mean that government cost offset arguments, which are founded on long term whole of government savings, are not compelling; bi-partisan support is required.
- The Commission and the state mental health commissions have a role as commissioners and system integrators.

10.5.4 Cost savings

The evidence shows that consumer and recovery oriented housing and effective discharge processes generate a range of benefits for consumers and also lead to government cost savings. Panellists were aware of this evidence and it was consistent with their own experiences. However, this has not led to greater investment in these programs and services. Panellists expressed frustration that despite solid evidence of cost whole of government savings there was little commitment by government to fund and implement integrated mental health and housing services on a broader scale than was currently the case.

Panellists suggested that housing should be framed as infrastructure, so as to not compete with recurrent costs in the budget, such as education and health.

Panellists were of the view that economic arguments fail to get traction because the evidence of cost savings in the future comes up against short term electoral cycles. Furthermore, the evidence identifies whole of government savings via costs offsets (e.g. in justice). Siloed government structures mean that spending in one part of government leading to cost savings in another part of government is not an incentive. Panellists emphasised that it was important to get Treasury involved in discussions about funding housing and mental health services, as Treasury is responsible for allocating resources across government.

It was noted that there was plenty of revenue in the government system related to housing (e.g. stamp duty, capital gains tax), but that this needed to be better utilised and allocated.

Panellists identified that there was a need for innovation in funding ongoing support for people with lived experience of mental ill health; this could be addressed by social impact bonds.

Brisbane Common Ground

Brisbane Common Ground (BCG) is a model of supportive housing comprising 146 units in a 14-storey building in South Brisbane. BCG aims to assist tenants sustain housing, improve their quality of life (health, social and economic) and reduce their use of acute, crisis and emergency services. BCG targets tenants who have low to moderate incomes and/or have experienced chronic homelessness.

BCG is a partnership between the Queensland Government, Commonwealth Government, Grocon Pty Ltd, Micah Projects and Common Ground Queensland Ltd.

An evaluation showed that BCG removed barriers for people experiencing chronic homelessness with support needs to access housing, and fostered the conditions for tenants to sustain housing (Parsell et al. 2016).

Analysis of linked administrative data was undertaken to measure service usage in the 12 months prior to commencing a BCG tenancy (i.e. homelessness). This was compared to service usage in 12 months during which tenants resided in BCG.

The analysis showed that as a cohort, tenants used an estimated \$1,976,916 worth of services (health, criminal justice, homelessness) in the 12 months pre BCG tenancy commencement, compared to an estimated \$852,314 worth of services in the 12 months post BCG tenancy commencement. Once the cost of providing BCG is factored in, this equates to a cost saving of \$13,100 per tenant per year. In other words, housing a previously homeless person in BCG saves the government \$13,100 per year per person in reduced service usage.

A 65 per cent reduction in episodes requiring mental health services demonstrates that the model contributes to improved mental health and wellbeing. Table 1 below provides a summary of cost savings.

Table 1: Brisbane Common Ground cost offsets summary

N=41	12 months pre-tenancy commencement	12 months post-tenancy commencement	Difference between pre and post
Admitted patients	\$1,064,167	\$472,673	-\$591,495
Mental Health	\$372,498	\$129,958	-\$242,540
Emergency	\$102,510	\$104,860	+\$2,350
Ambulance	\$41,600	\$40,950	-\$650
Subtotal Health difference	\$1,580,775	\$748,441	-\$832,335
Corrective Services	\$32,296	\$1,452	-\$30,844
Court	\$23,400	\$13,217	-\$10,183
Police	\$165,832	\$83,955	-\$81,877
Subtotal Criminal Justice difference	\$221,528	\$98,624	-\$122,904
Specialist Homelessness Services	\$174,613	\$5,249	-\$169,364
Total cost difference	\$1,976,916	\$852,314	-\$1,124,603

Source: (Parsell et al. 2016)

10.6 Progressing the agenda

Panellists noted that steps are already under way to address key issues in housing and mental health.

A robust agenda to develop more social housing already exists and is being advocated for by organisations such as National Shelter, the Community Organisations Housing Alliance and the National Affordable Housing Consortium. Planning and tax reform, initiatives such as the National Rental Affordability Scheme (NRAS), better direct investment from the Australian Government to the states and territories, economies of scale in the delivery of social housing, funding the incentive gap for private investors are all part of an infrastructure agenda to increase the supply of affordable housing.

Similarly, the cost to the health and housing systems of homelessness is well established, as are the cost savings that result from effective interventions. There is also a good body of evidence on programs and interventions that are effective in addressing the housing needs of people with lived experience of mental ill health.

The fact that housing is currently low on the policy agenda is a key challenge that will need to be addressed.

Investigative Panels agreed that in order to address the issues identified in this report, it will be necessary to develop an integrated approach across the housing and mental

health sectors that will influence health and housing departments to work together. To achieve this, it will be necessary to develop a unified and well-articulated voice across sectors to influence policy development. At the same time, it will be necessary to raise awareness of the issues with the private sector and engage the private sector in developing and delivering solutions. Public support for the issues will be essential to the success of advocacy and in bringing about policy and systems change.

11 Policy development options

This chapter draws together the evidence from the literature and the Investigative Panels and outlines options by for affecting systemic levers and policy to achieve the goals of more and better housing and more and better services for people with lived experience of mental ill health. The first section provides options for what needs to be done to address the identified issues. The second section identifies options for how this may be achieved in terms of advocacy and sector leadership.

The success of each of these options will depend on being able to garner bi-partisan support and ensuring that processes and outcomes are not tied to a particular government or government process.

It is clear from the evidence and the Investigative Panels that housing and service provision for people with lived experience of mental ill health face a number of significant challenges. However, there are also opportunities to build upon and expand existing programs and policies and develop a clear advocacy position to facilitate this.

Key issues identified are a lack of affordable, safe and appropriate housing; integrated programs addressing housing and mental health are effective but do not meet demand for these services; discharge from institutions poses significant risks for homelessness and mental health. At the policy level, a lack of policy integration between housing, homelessness and mental health and government silos impede the development of national, cross sectoral and integrated policy solutions for housing and mental health that are underpinned by cross sector accountability mechanisms. Mechanisms for tenancy sustainment and early intervention are lacking or underdeveloped.

Affecting policy and system change will require effective advocacy underpinned by a unified and well-articulated voice across sectors, private sector engagement, and public support for the issues.

11.1 What can be done right now?

Changing the system to provide better and more housing and services for people with lived experience of mental ill health will require policy integration, scaling up of existing programs, better discharge planning and procedures and a greater emphasis on early intervention and prevention. A number of options exist that could be quickly acted upon.

11.1.1 Scale up existing programs for consumer and recovery oriented housing

There is sufficient and reliable evidence that existing programs that integrate housing and mental health support are effective and lead to cost savings. Most successful programs are based on a Housing First approach, have effective mechanisms for coordination at the state and local levels, involve cross sector collaboration and partnership and offer integrated person centred support.

Rather than investing in further demonstration and pilot programs, it is now appropriate to institutionalise what we know works and scale up existing programs to meet demand and extend existing programs to new cohorts.

Option 1: Scale up and replicate nationally, existing successful programs that integrate housing and mental health support.

Successfully scaling up existing programs nationally will require the development of frameworks that facilitate policy and stakeholder collaboration and formalised agreements and mechanisms for collaboration between housing and mental health providers at the local level.

Option 2: Work towards developing a national framework for inter agency and cross sector collaboration that includes formal agreements and clear guarantees given by parties around outcomes.

Option 3: Leverage off existing reform frameworks for mental health to integrate housing related support at a national level, for example through PHNs.

11.1.2 Provide better access to and more affordable, appropriate and safe housing

The availability of affordable, appropriate and safe housing is a key constraint to scaling up existing programs, however, this can be overcome.

There is an existing infrastructure agenda to increase the supply of social and affordable housing and this is being advocated for by key organisations. The private rental market is an as yet underutilised resource in providing appropriate and affordable housing, though some programs, such as Doorways and Platform 70, have shown that this is feasible. Coordination with the private rental sector can facilitate access to an immediate and greater supply of established homes, thereby enabling the scaling up of existing programs.

Option 4: Work with and educate private rental sector landlords, real estate agents and their peak organisations sector about the housing needs of people with mental ill health.

Option 5: Increase the use of private rental housing as a way of providing ready access to established housing to facilitate scaling up of existing programs.

11.1.3 Early intervention and prevention

Many early intervention strategies can be implemented quickly and cost effectively to provide more secure housing and better mental health outcomes for people with lived experience of mental ill health.

The goal of early intervention should be to stabilise people in their existing tenancy and to avoid evictions. The evidence and the investigative panels show that early intervention is an important mechanism to prevent housing instability and homelessness and that there is considerable scope to increase and improve early intervention.

Mainstream tenancy sustainment services, which exist in all jurisdictions and typically provide financial relief in the form of bond loans and rental grants and subsidies, have been shown to be effective and cost effective in managing short term crises, sustaining tenancies and preventing homelessness. They provide a model that could be more widely used to assist people with lived experience of mental ill health.

Option 6: Expand the use of, and tailor, tenancy support programs to assist people with lived experience of mental ill health to maintain their existing tenancies.

Tenancy managers and real estate agents in both social and private housing have a role to play in early intervention and prevention and tenancy sustainment as they are

often the first to notice early warning signs. The evidence suggests that the social housing system does not adequately identify, monitor and consider the mental health of its tenants. There is a lack of knowledge in the profession about what actions to take in response to early warning signs and to avoid a tenancy reaching crisis point.

Option 7: Educate social housing providers, real estate agents and tenancy managers about how to identify early warning signs of a mental health crisis and the need for early intervention if these are detected.

Option 8: Develop materials and work with social housing providers, real estate agents and tenancy managers on how to take appropriate action to link tenants to service providers and supports to assist in sustaining their tenancy.

Option 9: Better implement procedures in public housing authorities to identify and monitor people with lived experience of mental ill health and link them with the required supports and services when needed.

11.1.4 Prevent failed discharge planning and exits into homelessness

Transition points between institutions or in and out of institutions are points of risk where people can fall through the cracks and be discharged into homelessness. This can be due to inadequate discharge planning and procedures, hospitals undertaking discharge assessments in time pressured environments and therefore not identifying risk factors, a lack of coordination across sectors, and because there are limited options for exit into appropriate and secure housing. In addition, there is a need for a national discharge policy and a nationally consistent definition of 'no discharge into homelessness'.

Option 10: Develop a national discharge policy and a nationally consistent definition of 'no exit into homelessness'.

Option 11: Resource hospitals to make thorough discharge assessments and develop appropriate discharge plans.

Option 12: Increase knowledge and capability in the acute sector to enable officers to better identify people who are in precarious housing or at risk of homelessness.

Option 13: Ensure timely and assertive follow up after discharge.

Precarious housing or homelessness post-discharge negatively affects people's recovery, ability to access needed services and puts them at risk of relapse. Transitional housing programs aim to improve living skills and housing stability for tenuously housed patients with mental illness.

Option 14: Investigate the feasibility of a national roll out of transitional housing treatment programs for homeless people with mental ill health.

11.1.5 Policy integration

Better policy integration between housing, homelessness and mental health has the potential to contribute to better housing and health outcomes for people with lived experience of mental ill health. Successful policy integration will depend on overcoming competing policy agendas, competing accountability measures and separate competing funding streams.

Policy integration will need to take place across all levels of government and across government structures. Within sector solutions for affordable housing (housing sector)

or separate supported housing (mental health sector) are unlikely to address systemic issues. Siloed government structures mean that spending in one part of government leading to cost savings in another part of government is not an incentive to provide better housing and services and a segmented funding across portfolios is an impediment to joint policy and service integration.

Overcoming government segmentation will require new models for designing and financing policies and programs, as well as for service integration. It will be important to involve central agencies, particularly the Treasury, in discussions about funding housing and mental health services, given the role of central agencies in allocating portfolio responsibilities and the Treasury in allocating resources across government. Central agencies may also be expected to take a broader view of government priorities and a longer-term view of whole of government savings, including projection of future savings resulting from investment in the present.

Findings from the literature and the investigative panels point to the following options.

Option 15: Investigate the UK joint commissioning model as a model for service and policy integration across housing and mental health that could be applied in Australia.

Option 16: Engage in high level discussions with ministers responsible for health and housing and with central agencies about the need for integrated housing and mental health policies and integrated service provision.

11.2 Building collaboration for long-term change

Gaining policy traction and affecting system change requires a clearly articulated position, sustained advocacy and leadership. here are effective mechanisms that could act as a call to action and help articulate a unified position across the mental health and housing sectors, advance understanding of the issues, and gain cross-sectoral support for change.

11.2.1 National roundtable to develop an integrated advocacy position

A national roundtable of peak bodies for housing, mental health, consumers, carers and tenants could act as a call to the nation to discuss the issues. The role of the roundtable would be to:

- identify the problem
- identify the policy issues
- develop the architecture needed nationally to address these.

State and territory bodies could organise similar roundtables at the jurisdictional level. These roundtables would be well positioned to articulate consumer voices. This would provide a forum for consumers to tell their stories and to express how consumers are affected by the gaps in the system. Generating media interest in consumer stories will contribute to raising public awareness of the issues and gather support for policy and practice change.

An independent organisation, like AHURI, could host and facilitate the roundtables.

Option 17: Convene a national roundtable that brings together the peak bodies for housing and mental health and peak bodies for consumers, carers

and tenants. The roundtable will act as a call to the nation to discuss the key issues.

11.2.2 Develop a consensus statement

A consensus statement could be a way to advance the understanding of the issue, gain cross sectoral support and develop a clear advocacy position.

The roundtable described in Option 15 above could form a key input for the consensus statement. To be effective, the consensus statement will need to make reference to measurable indicators and outcomes, and have broad-reaching buy-in.

A housing and mental health consensus statement could act as a vehicle to articulate a unified position and a call to organisations to support change.

Option 18: Work towards developing a consensus statement on housing and mental health, including measurable indicators and outcomes.

11.2.3 Involve the private sector

There is a role for the private sector in addressing the housing issues of people with lived experience of mental ill health. This includes development of additional housing, better access to the private rental market and educating real estate agents, landlords and tenancy managers.

At present, the private sector is an insufficiently engaged resource and the appetite, potential and willingness of the sector to address housing and mental health issues is not sufficiently understood.

Option 19: Develop a process and mechanism to involve private sector stakeholders to generate innovative solutions, access funding, gain a better understanding of the issues and to raise awareness of housing and mental health in the private sector.

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