

## The integration of homelessness, mental health and drug and alcohol services in Australia

authored by

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## ACRONYMS

ACCESS	Access to community care and effective services
ACT	Assertive community treatment
AIDS	Acquired immune deficiency syndrome
AOD	Alcohol and other drugs
ASI	Addiction Severity Index
ATSI	Aboriginal and Torres Strait Islander
BISDIV	Brisbane Inner South Division of General Practice
BSCHSI	Brisbane South Centre for Health Services Integration
CALD	Culturally and linguistically diverse
COAG	Council of Australian Governments
DAART	Domiciliary Allied Health Acute Care and Rehabilitation Team
DoCS	NSW Department of Community Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
ED	Emergency department
GP	General practice
HDDT	Homeless and Drug Dependency Trial
HIP	The Homelessness Intervention Project
HIV	Human immunodeficiency virus
HOPS	Homeless outreach psychiatric services
HOST	Homeless outreach and support team
HUD	US Department of Housing and Urban Development
HUD-VASHP	US Department of Housing and Urban Development and US Department of Veterans Affairs Supported Housing Program
ICD	International Classification of Diseases
ICM	Intensive case management
NAHA	National Affordable Housing Agreement
NCADA	National Campaign Against Drug Abuse
NDS	National Drug Strategy
NPAH	National Partnership Agreement on Homelessness
NSW	New South Wales
NSW Health	NSW Department of Health
SAAP	Supported Accommodation Assistance Program
SHASP	Social Housing and Advocacy Support Program
SUD	Substance use disorder
VA	US Department of Veterans Affairs

WHO

World Health Organisation

# 1 INTRODUCTION

## 1.1 Background

Homelessness does not have one root cause. The pathways followed by people into (and out of) homelessness do not conform to any set pattern. Nevertheless, there are important 'stylised facts' of homelessness that shape policy and service responses to homelessness. One of these concerns the nexus between homelessness and mental health. The existing evidence suggests that homeless people are more likely to experience mental health conditions than those who are not homeless. Moreover, it suggests that prevalence rates of substance use disorders among homeless persons exceed general population estimates and that co-morbidity (co-occurrence) of substance use and other mental disorders is common (Jablensky et al. 1999; Andrews et al. 2001; Herrman et al. 2004; Teesson et al. 2004; Kessler et al. 2005).<sup>1</sup>

Homeless people experiencing mental health conditions face significant hurdles in accessing and sustaining long-term housing and in addressing their personal, social and health needs. The vast majority of homeless people are supported in this endeavour by a range of agencies, including: specialist homelessness agencies, which provide personal and social support and emergency and medium-term accommodation; alcohol and other drug treatment services; mental health services; and a range of other services. However, these services may work independently from each other, cross-sector coordination of services being restricted to referrals from one service domain to another.

An independent or autonomous service delivery system (i.e. where services provide for clients defined by particular conditions such as homelessness or substance abuse issues, operate independently of each other) is unlikely to provide an appropriate environment to address the needs of homeless people, particularly those who have high and long-standing needs. This is so for five main reasons.

First, the various services supporting clients may pull clients in different directions and provide conflicting advice and support and treatment options. The overall effectiveness of support and treatment is thereby undermined.

Second, under an autonomous service system, specialist services may not know enough about the individual needs of clients outside their areas of specialisation or the range of services available in domains outside their own areas of specialisation. As a result, clients may not be referred to an appropriate agency for support. This will result in gaps in service delivery.

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<sup>1</sup> The evidence on the link between homelessness and mental health is reviewed in the publication Mental Health Council of Australia (2009). Johnson and Chamberlain (2009) argue that prevalence rates of mental illness in the homeless population in Australia are lower than those cited in the literature. Their view is based on a detailed assessment of caseworker notes and assessment forms of 4291 homeless clients in Melbourne. Johnson and Chamberlain (2009) further suggest that caseworker notes indicated that the onset of mental illness in a significant proportion of cases they examined followed entry into homelessness rather than preceded it. They suggest that environmental factors associated with the experience of homelessness play a major role in the onset of mental illness. While their study provides a rich source of data, caseworker client notes may not provide an accurate reflection of the true underlying prevalence of mental health conditions in the homeless population. It is possible to argue that caseworker notes may result in an under-reporting of the incidence of mental health disorders among clients. First, methods of recording are not standardised and caseworker notes may not always record a caseworker's knowledge of clients' mental health conditions. Second, and more importantly, caseworkers may not be aware of a client's mental health condition. Third, Johnson and Chamberlain (2009) do not follow the standard approach in mental health classification systems of listing substance use-related disorders as mental health conditions.

Third, information about the needs of clients, their backgrounds and the services they are receiving may not be communicated to the different agencies in the support system and so get lost in it (i.e. 'fall between the gaps'), particularly if channels of communication between service providers are poor.

Fourth, clients may be overwhelmed by the myriad of support services and workers they need to deal with and get confused by the different practices and requirements of the various services.

Finally, clients may face higher transaction and transportation costs as a result of dealing with a large number of services. This, in turn, may reduce their ability to access relevant services.

Because of the potential problems with an autonomous service system (which revolve around the issue of disconnected services), it is now commonplace in policy and service delivery circles to promote integrated care arrangements as the way forward in delivering services to homeless people with mental health needs.<sup>2</sup> There is no one accepted definition of integrated service delivery. However, in general terms, integrated responses involve services in diverse sectors, including homelessness, health and other human services, working in a joined-up and coordinated way to deliver holistic and tailored interventions for clients. Such responses have the potential to generate improved outcomes over and above those evident in independent service delivery.

The two key hypothesised benefits of integrated service delivery for homeless people are that:

- They provide homeless people with better access to a broad range of services.
- Clients treated via integrated service responses experience better outcomes than would otherwise be the case; for example, through improved access to housing services and increased rates of independent housing (Rosenheck et al. 1998).

However, realising the benefits of integration is not a foregone conclusion, and there may be issues associated with integrated care arrangements. First, the coordination of services can be costly, unwieldy and time-consuming. Such costs need to be balanced against the benefits of closer integration of services. Second, agencies may have quite different cultures and ways of working, which can be difficult to mesh together. Successful coordinated service delivery requires considerable goodwill on the part of the services involved and that goodwill may not be forthcoming. Third, individual agencies may not be prepared to adapt to a partnership-like arrangement and may seek to maintain their existing ways of working. Fourth, integrated care arrangements require leadership and good management which may not always be evident. Fifth, specialisation in service delivery brings with it significant benefits in terms of the quality and level of support provided to clients and such benefits may be diluted in an integrated care environment. Finally, the funding and governance of homelessness services (likewise mental health and drug and alcohol services) is generally undertaken in programs which are not established as integrated programs.

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<sup>2</sup> This study is concerned with the issue of integrated service delivery for homeless people with mental health conditions. However, there are many other issues and challenges beyond those concerned with integrated care involved in providing support to homeless people with mental health conditions. Homeless people with substance use disorders may continue to use alcohol and other drugs in a manner inconsistent with the rules of supported accommodation providers and other services, thereby affecting their chances of accessing accommodation options. Challenging behaviours may also be more evident among homeless people with drug and alcohol-related and/or other mental health conditions as compared with other homeless people. As a result, homeless people with mental health conditions may be excluded from the very services which are designed to assist them (Fountain et al. 2003; Glasser and Zywiak 2003; Herrman et al. 2004).

In this context, there is little direct incentive for services to pursue an integrated approach.

Given these issues, there is certainly no guarantee that an integrated care approach will always generate net benefits to clients.

The issue of the effectiveness of integrated service responses has been addressed in a number of international studies, for example, in respect of the economic evaluations of the Access to Community Care and Effective Services (ACCESS) program in the United States (Goldman et al. 2002) reviewed further below. However, the Australian literature remains very much underdeveloped as it relates to homelessness service linkages (St Vincent's Mental Health Service and Craze Lateral Solutions 2006).

A full examination of the nature and extent of integrated service delivery responses covering the homelessness, drug and alcohol and mental health services domains has yet to be undertaken in Australia. Not surprisingly in light of this, no robust evidence currently exists on the effectiveness of various forms of integrated service delivery in Australia centred on the needs of homeless people with mental health conditions. Nevertheless, greater integration across the homelessness and health service delivery system and other mainstream human service systems is a major theme of Australian policy discussions on homelessness in recent years and is particularly evident in the Australian Government's White Paper on homelessness *The road home*.

## **1.2 Aims**

This study aims to increase our understanding of the ways in which homelessness, mental health and drug and alcohol services can be coordinated or integrated to provide services to homeless people, the extent to which system and service integration is occurring in Australia at present and the effectiveness of various integrated service delivery responses. By system-level integration, we mean cross-sectoral governance and interventions which bring together services from different service systems under purpose-built, centrally funded and managed, coordinated programs. Service level integration refers to the coordinated delivery of services across different sectors irrespective of whether or not the coordination which occurs is part of a purpose-built, system-wide integrated service delivery program or reflects the actions of individual services working together at the local level.

The study addresses three research questions.

1. What do we mean by the 'integration of services' in the homelessness context? How do we measure the extent of integration and assess its form and structure?
2. What is the current level and nature of service and system integration in Australia as it relates to the provision of support services to homeless people with poor mental health and problematic substance use?
3. Does system and service integration lead to better access to services on the part of homeless people with poor mental health outcomes and problematic substance use? Does it lead to improved client outcomes over and above what would otherwise occur?

Specifically, this research project aims to provide: (1) a typology of integration in the homelessness context; (2) an account of how and over what dimensions homelessness services in Australia coordinate and partner with mental health and drug health services (and vice versa) and the extent to which they do so; and (3) indicative evidence of the effectiveness of such linkages. We hope that the evidence to be gathered in this study will provide a foundation for further research and the

informed development of national policy on homeless service integration and best-practice service delivery models, which address the housing and mental health needs of homeless persons.

The present Positioning Paper sets the scene for the study. It reviews the relevant literature, surveys the policy environment, develops typologies and models of homelessness service integration, and outlines our methodology. Descriptive case study evidence is provided to illustrate how a select group of homeless services in Australia are currently engaged with mental health and drug and alcohol issues and the partnerships and forms of coordinated service delivery currently being practised by services and through various government programs.

The Final Report of the study will provide detailed case study and survey-related evidence on the nature and form of integrated service delivery across the homelessness and mental health domains in Australia. The Final Report will also provide indicative evidence on the benefits of different models of integrated care in the Australian context. This is critical as the homeless population is a heterogeneous group with poor mental health and international research suggests that a range of integrated service delivery models is needed to meet the needs of different populations of homeless persons and to be responsive to the changing needs of individual clients over time (Bebout 1999).

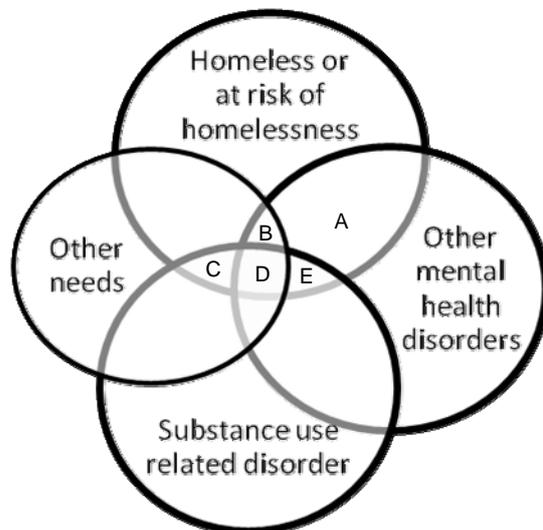
### 1.3 Scope

There is clear evidence that mental health disorders often co-occur (the disorders are “comorbid”) and this type of comorbidity is highly prevalent in the homeless population. Our study is therefore concerned with homeless people and those at imminent risk of homelessness who also have problematic substance use and poor mental health and who may experience more than one mental health problem simultaneously.

Figure 1 below provides a pictorial representation of those individuals who fall within the scope of the study.

Those in scope are homeless people whose needs are represented by the area covered by the letters A–E in Figure 1.

**Figure 1: The mental health and other needs of homeless people and those at risk of homelessness**



In other words, those in scope are:

- Homeless.
- Experience either a substance use disorder (areas C, D & E) or another mental disorder (A, B, D & E) or both a substance use disorder and another mental disorder (B, D & E).

Those in scope may also experience other needs in addition to their mental health needs. Those who experience substance use disorders, other mental disorders and other non-mental health needs simultaneously are located in D.

## **1.4 Key definitions**

### *Homelessness and associated services*

There is a lack of consistency in the use of the term 'homelessness' in the international literature. However, the general consensus is that it is not just being 'house-less', but is associated with marginalisation and social exclusion and the lack of social connection and opportunity for meaningful activity (e.g. Baum & Burnes 1993; Daly 1996; Lipton & Sabatini 1984).

In the Australian context, the so-called 'cultural definition' of homelessness is used. The cultural definition of homelessness was formulated by Chamberlain and McKenzie (1992; 2003; 2008) and broadens the definition of homelessness from one revolving around the absence of shelter to one revolving around the lack of access to own adequate housing. Chamberlain and McKenzie together with the Australian Bureau of Statistics utilised the cultural definition to enumerate homelessness using 2001 and 2006 Census data and most recently it was adopted in the National Partnership Agreement on Homelessness (NPAH) between the Australian and state/territory governments.

Under the cultural definition, homelessness is divided into three tiers: namely, primary, secondary and tertiary homelessness. Primary homelessness refers to those without conventional accommodation, e.g. people living on the streets or sleeping in parks. Secondary homelessness refers to those in temporary accommodation, including those staying in emergency or transitional accommodation and temporarily living with other households because they have no accommodation of their own and people staying in boarding houses on a short-term basis. Tertiary homelessness refers to those living in boarding houses on a medium- to long-term basis. There are, of course, a number of housing states which are close to homelessness which can be defined as marginal housing, including living in own accommodation which is inadequate because of over-crowding or poor amenities.

This study utilises the cultural definition of homelessness but also considers the position of those who are at risk of homelessness. As such, we specifically include those support programs targeting those who are at imminent risk of homelessness and those services that aim to break the cycle of homelessness. Included in the latter are so-called 'street-to-home' programs, which support homeless people living on the street to access and sustain long-term housing.

Specialist homelessness services provide supported accommodation to otherwise homeless people and those escaping domestic violence, tenancy support to those at risk of homelessness, and outreach support to rough sleepers. They seek to link homeless people to long-term housing options, assist people to address the issues they face and link them to relevant support services.

### *Mental disorders and associated disorders*

The World Health Organization (WHO) defines health as ‘a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity’ (see <http://www.who.int/about/definition/en/print.html>). Mental health is an integral part of this definition. In defining mental health, there are many terms used and these reflect whether measurement is focused on diagnosis and determining the absence of a major mental disorder, or a more holistic approach that considers social, cultural and physical aspects.

In determining whether a major mental disorder is present, two methods of classifying mental health disorders have been developed. These are the *International Classification of Diseases* (ICD-10), produced by the WHO, and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) produced by the American Psychiatric Association. Both list categories of disorder and provide standardised criteria for diagnosis.

The ICD-10 classification uses the term ‘mental and behavioural disorders’ and includes within that classification ‘mental and behavioural disorders due to psychoactive substance use’. The DSM-IV adopts a similar approach. In other words, substance use disorders are treated as mental health disorders in both classification systems.

Some approaches to classification do not employ distinct categories based on cut-offs separating the ‘abnormal’ from the ‘normal’. They are variously referred to as spectrum, continuum or dimensional systems.

Mental health and drug and alcohol services do not include the presence of a major mental disorder as a criteria for entry to treatment. As such, in this study, we will take a broad approach to the definition of services and programs that provide mental health services. Mental health services include acute and non-acute inpatient services, community mental health services, emergency services and supported accommodation services.

### *Substance use disorders and associated services*

As with mental health, there are many ways of defining and classifying problematic substance use.<sup>3</sup> In general, measures focus on the quantity and frequency of the substance consumed, and the degree to which patterns of consumption have a negative impact on health and interfere with a person’s functioning.

The concepts of *intoxication*, *dependence* and *withdrawal* are central to the notion of a substance use disorder. Dependence centres on tolerance (needing more of a substance to gain the same effect) and withdrawal (a set of physical symptoms that occur when a substance is ceased or significantly reduced in a person who is dependent on that substance). Both abuse and dependence involve continued use of a substance in spite of school-, home-, social-, legal-, interpersonal- or work-related problems. In the DSM-IV classification system, the terms substance abuse and substance dependence are mutually exclusive and refer to different states on the continuum from substance use, substance abuse and substance dependence.

The concept of a substance use disorder incorporates both substance dependence and substance abuse and, more broadly, includes substance-induced mental health disorders (e.g. drug-induced psychosis). In this study, as with mental health more

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<sup>3</sup> Although substance use disorders are classified as mental health disorders within the ICD and DSM systems, they have often had a separate system of funding and service delivery. As such, we will be describing them separately within this project.

generally, we will take a broad approach to the definition of substance use services and programs incorporating those that target all forms of substance use disorders and problematic substance use.

Alcohol and other drug services provide a range of support services to clients including sobering up centres, assessments, outpatient services through community drug services and community clinical programs, and residential withdrawal services. Alcohol and other drug services can include a range of specialist staff providing physical, psychiatric, psychological, and social support.

### *Integration*

There is no standard definition of integration. Rather, the term integration is used in different ways by different authors. Most use integration as an umbrella term to cover various possible forms of working together, of service linkage, cooperation, coordination and partnership. However, some authors use the term to refer to the final endpoint of a continuum stretching from independent or fragmented service delivery involving autonomous providers working independently from one another, through to full integration involving 'a single system of needs assessment, service commissioning and/or service provision' (Care Services Improvement Network, Integrated Care Network 2009, p.7).

In this study, we examine the broad spectrum of partnership-based coordinated approaches to service delivery and do not restrict attention simply to those forms of integration that are of a 'full integration' nature. In other words, the term 'integration' in this study refers to all structures and processes that bring services together in the homelessness, housing, mental health, and drug and alcohol domains, to improve outcomes for homeless people. We shall also examine linkages with other parts of the service system, in particular employment-related services.

Many definitions of integration are available in the literature. Perhaps the simplest definition of integration in the human services area is that 'integrated care refers to advanced arrangements for joint working' (Care Services Improvement Network, 2009 p.7). Konrad (1996, p.6) suggests 'integration is a process by which two or more entities establish linkages for the purpose of improving outcomes for needy people'.

Integration may occur at the system or policy level or at the service level. As noted previously, system-level integration refers to purpose-built, top-level down coordination of services under designated cross-sectoral programs. At the service level, integration refers to the way that services across different human service domains coordinate activities to meet the multiple needs of the client, irrespective of the funding and governance arrangements surrounding the different services. This may occur via intensive case management that facilitates links with external agencies as required, or the delivery of integrated treatment within a single setting by a multidisciplinary team.

Integration can occur at any functional level and involve any number of different processes or dimensions. As Leutz (1999, pp.77-78) suggests:

Integration can occur at the policy, finance, management, and clinical levels. The means of integration include joint planning, training, decision making, instrumentation, information systems, purchasing, screening and referral, care planning, benefit coverage, service delivery, monitoring, and feedback.

Finally, there is the distinction between integration at the user level and integration at the provider level. High levels of *provider* integration may not guarantee that *clients* experience high levels of integration in their access to services (Lloyd & Wait 2006, p.10).

## **1.5 Method**

The study is concerned with developing a typology of integration, scoping the need for, and current existence of, integration in Australia, and providing indicative findings on the effectiveness of integration involving homeless people with mental health conditions including substance use disorders.

The present Positioning Paper reviews the literature on integration and provides preliminary descriptive results from case studies conducted with three medium-to-large community agencies providing specialist homelessness services (Ruah Community Services in Perth, The Haymarket Foundation in Sydney and HomeGround Services in Melbourne). The common feature of the three agencies chosen is that they manage a broad range of programs, including those with links to drug and alcohol services and mental health services.

The next stage of the study will extend the case study approach by examining the nature and extent of integration in mainstream mental health and drug and alcohol services and to relevant whole-of-government initiatives. We will also undertake further critical analysis of the construct of integration through a series of in-depth interviews.

Additionally, comparative data on the extent, mechanisms and effectiveness of integration will be collected via a survey of homelessness and mental health and drug and alcohol agencies.

## **1.6 Structure**

The structure of the Positioning Paper is as follows. Chapter 2 provides an overview of the existing literature relating to integration and develops a typology of integration based on the results of the literature review.

Chapter 3 describes the policy context to the study with particular reference to the White Paper on homelessness, *The Road Home*, and subsequent policy initiatives linked to the NPAH.

Chapter 4 sets out the key elements of the research design and the methods which will be used in this study. It also describes brief findings from indicative case study evidence on the integration typology and on how homelessness services are engaging with mental health and drug and alcohol services to provide integrated support to homeless people with substance use disorders and other mental health conditions.

## 2 A REVIEW OF THE LITERATURE

This chapter reviews the literature on the integration of services. It is divided into five sections.

Section 2.1 explores the meaning of integration, discusses the benefits and possible costs of the closer integration of services and briefly examines the key drivers of integration.

Section 2.2 presents and analyse typologies of integration. In section 2.3, we review different approaches taken in the literature to the measurement of integration.

Section 2.4 examines the existing empirical evidence on the effectiveness of integrated service delivery. We focus on research concerned with the integration of homelessness, drug and alcohol, and mental health services. This research is based almost exclusively on USA, and to a lesser extent, Canadian and European experiences of integration. The integration of services has been examined in the Australian context, but only in relation to health care-specific models of integration.

### 2.1 What is integration?

#### *Heightened collaboration*

Integration is a term used in a number of different ways in the literature. However, common to all definitions of integration is the notion that integration involves 'joint working' in one form or another (Care Services Improvement Network 2009, p.7). As Konrad (1996, p.6) suggests, integration is 'a process by which two or more entities establish linkages for the purpose of improving outcomes for needy people'. Browne et al. (2004, p.1) use the term 'service integration' 'to describe types of collaboration, partnerships or networks whereby different services that are usually autonomous organisations, work together for specific community residents to improve health and social care'. As these definitions suggest, the term integration is used in the literature to cover a range of models of working together, not simply the most comprehensive form of service interaction; namely, the case of 'a single system of needs assessment, service commissioning and/or service provision' (Care Services Improvement Network 2009, p.17).

Much of the work on the issue of the integration of services has been undertaken in the health care context. A commonly cited definition of integrated care in the health care context is that developed by the WHO European Office for Integrated Health Care Services:

Integrated care is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency (Gröne & Garcia-Barbero 2002, p.1).

Another prominent definition of integration is that used by the Canadian Council on Health Services Accreditation. It defines integration in the following terms:

Services, providers, and organizations from across the continuum working together so that services are complementary, coordinated, in a seamless unified system, with continuity for the client (cited in Suter et al. 2007, p.7).

Similarly, Leutz (1999, p.77–78) defines integration in the health care context as:

The search to connect the health care system (acute, primary medical, and skilled) with other human service systems (e.g. long-term care, education, and

vocational and housing services) in order to improve outcomes (clinical, satisfaction, and efficiency).

Leutz's definition of integration points to the key objective of integrated care arrangements as more effective outcomes for clients than would otherwise be the case. As Provan and Milward (1995, p.2) suggest:

The prevailing view among many service professionals, policy makers, and researchers is that by integrating services through a network of provider agencies linked through referrals, case management, and joint programs, clients will gain the benefits of reduced fragmentation and greater coordination of services, leading to a more effective system.

### *Client-centred approach*

A number of authors also point to another related aim of integrated care arrangements, namely, the implementation of a client-centred approach to care. As Lloyd and Wait (2006, p.7) suggest:

Integrated care seeks to close the traditional division between health and social care. It imposes the patient's perspective as the organising principle of service delivery and makes redundant old supply-driven models of care provision. Integrated care enables health and social care provision that is flexible, personalised, and seamless.

In much the same vein, Allen and Stevens (2007) and Goodwin (2008) suggest that the prime objective of integrated care is to shift the focus of attention from a service delivery to a client-centred approach.<sup>4</sup> In a social housing context, Phillips et al. (2009) suggest that the key objectives and potential benefits of the integration of services are improved client outcomes, enhanced client access to services, greater equity and consistency, increased efficiency and enhanced accountability and control.

### *What drives integration?*

What are the key drivers of integration? What determines whether service integration achieves the promised benefits?

Williams and Sullivan (2009) suggest the major drivers influencing integration are agency and structural forces. Individuals and agencies create outcomes (termed 'agency') but they do so within the structural parameters of their environment (termed 'structure'). Agency comes into play in various ways through motivation, goals, leadership and personal skills, experience and capabilities. In terms of structural forces, Williams and Sullivan (2009) focus on the role of economic and social drivers, the legislative and institutional framework, available resources, histories of collaboration, accountability structures and organisational cultures.

Ouwens et al. (2005) focus on a number of key enablers of successful integration. They include: supportive service information systems; agreement between personnel involved on the nature of the integration; leaders with a clear vision of integrated care; resources for the implementation and maintenance of integrated care approaches; management commitment and support; clients capable of, and motivated for, self-management; and a culture of quality improvement. At the other end of the spectrum, key barriers to successful integration include entrenched professional values and

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<sup>4</sup> There are, of course, other benefits of integration. In the health care context, Allen and Stevens (2007) refer to these potential benefits as: coordinated and timely health service delivery; client participation in health care decisions; consistency in health information provided to clients; improved working relationships among health professionals; minimisation of barriers between health services; and development of best practice guidelines.

approaches, which are often oriented toward specialisation and fragmentation (Grone & Garcia-Barbero 2002; Goodwin 2008).

## 2.2 A typology of integration: construct

A number of typologies of integration exist in the literature. The typologies are centred on a number of overlapping elements. For the sake of clarity, we have addressed these as (1) the intensity, depth and breadth of integration; (2) the dimensions, forms and ingredients of integration; (3) vertical versus horizontal integration; and, (4) integration at the user and provider levels.

### *Intensity, breadth and depth of integration*

One typology of integration that has been influential and which we find particularly useful is that provided by Konrad (1996). Konrad's (1996) typology of integration is organised around two key main principles: the *intensity* of integration and the *dimensions* of integration.

By the intensity of integration, Konrad (1996) means the extent or strength of integration. His Integration Continuum begins with fragmented or independent service delivery undertaken by autonomous agencies. It then moves through various stages ending finally with 'integration'. The continuum is set out below:

- information sharing and communication
- cooperation and coordination
- collaboration
- consolidation
- integration.

The least intense type of (informal) integration involves information sharing and communication between independent services or agencies. A stronger form of informal integration involves inter-agency cooperation and coordination revolving around loose arrangements in relation to activities such as reciprocal client referral.

The next level of intensity involves collaboration between agencies. Collaboration involves still-autonomous agencies working together to achieve a common goal or outcome and may involve activities such as partnerships with written agreements, cross-training and shared information systems.

A stronger form of integration in Konrad's typology involves an umbrella organisation delivering services on a consolidated basis with functions being centralised but with each organisation retaining its independent authority. The fully integrated system in Konrad's approach involves a single authority covering all relevant needs of clients and doing so in an individualised form with a blending of all activities and a common funding pool.

Glasby (2005) takes a similar although less detailed approach to a typology of integration. He distinguishes between the *depth* of integration (similar to Konrad's intensity of integration) and the *breadth* of integration. The depth of integration is measured on a continuum from sharing information and consulting each other, to coordinating activities, joint management, partnerships and mergers. The breadth of integration refers to the coverage of the integrated care response across different sectors or domains.

Keast et al. (2007) and Ahgren and Axelsson (2005) also use a continuum approach to conceptualise integration (see Figures 2 and 3 below). Keast et al. (2007) incorporate in the continuum the so-called three 'Cs' of cooperation, coordination and



- *Service delivery system or model.* How are the goals of the initiative carried out? How are service delivery structures and relationships designed and organised?
- *Stakeholders.* How are stakeholders involved in the project?
- *Planning and budgeting goals.* How are financial needs determined and resources deployed?
- *Financing.* Who funds and how do they fund?
- *Outcomes and accountability.* How is success defined? How are performance measures determined and progress tracked?
- *Licensing and contracting.* How are providers and services procured?
- *Information systems and data management.* How are data collected, stored, shared and analysed?

Of the above dimensions, the nature of the service delivery model is particularly emphasised. Konrad (1996) defines it further in terms of the following elements:

- Nature and extent of communication (e.g. staff forums, newsletters, policy and procedure manuals).
- Staff deployment and reporting systems (e.g. whether the project is administered as a unified project in terms of staff deployment).
- Training (e.g. are staff trained across the programs participating in the initiative?).
- Geographic location and service configuration—the extent to which project services are provided in one location.
- Case management (e.g. the extent to which case management is provided by one person or a team or alternatively by independent program-specific case managers) and the scope of case managers' responsibilities.

A number of conceptualisations of integration refer to the various levels at which integration can work or the strategies involved in integration. Kodner and Spreeuwenberg's (2002) structure, replicated in Table 1, differentiate between integrated care strategies at the funding, administrative, organisational, service delivery and clinical levels.

Leutz (1999, p.77) suggests that integration can occur at the policy, finance, management and clinical levels and may involve various means, including 'joint planning, training, decision making, instrumentation, information systems, purchasing, screening and referral, care planning, benefit coverage, service delivery, monitoring, and feedback'. Ramsay et al. (2009, pp.3–4) suggest that effective integration requires that integration takes place across a number of domains, including:

- Organisational (e.g. mergers, contracts between different parties).
- Functional (e.g. merging different functions such as non-clinical support and back office functions).
- Service—different services provided are integrated at an organisational level.
- Clinical (e.g. patient care being integrated within a single process).
- Normative (e.g. shared values in coordinating work and securing collaboration in delivering health care).
- Systemic—coherence of rules and policies at all organisational levels.

**Table 1: Kodner and Spreeuwenberg (2002). Continuum of integrated care strategies**

<p><b><i>Funding</i></b></p> <ul style="list-style-type: none"><li>→ Pooling of funds (at various levels)</li><li>→ Prepaid capitation (at various levels)</li></ul> <p><b><i>Administrative</i></b></p> <ul style="list-style-type: none"><li>→ Consolidation/decentralisation of responsibilities/functions</li><li>→ Inter-sectoral planning</li><li>→ Needs assessment/allocation chain</li><li>→ Joint purchasing or commissioning</li></ul> <p><b><i>Organisational</i></b></p> <ul style="list-style-type: none"><li>→ Co-location of services</li><li>→ Discharge and transfer agreements</li><li>→ Inter-agency planning and/or budgeting</li><li>→ Service affiliation or contracting</li><li>→ Jointly managed programs or services</li><li>→ Strategic alliances or care networks</li><li>→ Consolidation, common ownership or merger</li></ul> <p><b><i>Service delivery</i></b></p> <ul style="list-style-type: none"><li>→ Joint training</li><li>→ Centralised information, referral and intake</li><li>→ Case/care management</li><li>→ Multidisciplinary/interdisciplinary teamwork</li><li>→ Around-the-clock (on-call) coverage</li><li>→ Integrated information systems</li></ul> <p><b><i>Clinical</i></b></p> <ul style="list-style-type: none"><li>→ Standard diagnostic criteria (e.g. DSM-IV)</li><li>→ Uniform, comprehensive assessment procedures</li><li>→ Joint care planning</li><li>→ Shared clinical record(s)</li><li>→ Continuous patient monitoring</li><li>→ Common decision support tools (i.e. practice guidelines and protocols)</li><li>→ Regular patient/family contact and ongoing support</li></ul>
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***Provider and user integration***

Lloyd and Wait (2006, p.10) extend the analysis of integrated care arrangements by developing a matrix of integration that involves the dimensions of *provider integration* and *user (or client) integration*. High levels of provider integration do not necessarily result in high levels of user integration or vice versa. User integration requires that clients experience a seamless system of care and that may not occur even with high levels of provider integration.

Mirroring the distinction between provider and user integration is Gröne and Garcia-Barbero's (2002) distinction between the notions of *integrated care* and *continuity of care*. The former is a broader term referring 'to the technological, managerial and economic implications of service integration' (p.3), while continuity of care is a term referring to the experiences of clients/patients and workers in relation to the care or support that is provided or received. The continuity of care is defined in terms of longitudinal or provider continuity – continuity across service areas and continuity of information (through shared records).

### *Vertical and horizontal integration*

A final perspective on integration is the distinction between vertical integration and horizontal integration. Varying definitions of vertical integration and horizontal integration exist. Gröne and Garcia-Barbero (2002) suggest that horizontal integration refers to strategies linking similar levels of care, while vertical integration relates to strategies linking different levels of care within a hierarchy (e.g. primary, secondary and tertiary care). Ramsay et al. (2009) use the term 'vertical integration' somewhat differently to describe a situation where different components of a supply chain are brought together in a single organisation. A closely related approach is that vertical integration refers to the one organisation providing support to clients across a number of different domains. A very different use of the terms 'vertical' and 'horizontal' integration is offered by Leutz (1999) who refers to a vertical authority-driven, formal, structural orientation to integration as opposed to a horizontal, relationship-based approach.

## **2.3 The measurement of integration**

Much of the early literature on integration focused on the development of a typology of integration and the examination of the integration of services within a case study context. However, in recent years the emphasis has shifted to its quantitative measurement. Nevertheless, the literature on the measurement of integration remains highly fragmented.

In their systematic review of papers measuring integration in the health care delivery context, Strandberg-Larsen and Krasnik (2009) concluded that all papers that passed the criteria for inclusion in the review adopted separate approaches to the measurement of integration (see also Granner and Sharpe (2004) for a similar finding). They concluded that 'due to the relative newness of this area, established, off-the-shelf measures that suit any given purpose are not yet available' (Strandberg-Larsen and Krasnik 2009, p.8).

Strandberg-Larsen and Krasnik (2009, p.4) suggest that measures of integration should account for the *structural*, *cultural* and *process* aspects of integration. The structural aspects of integration are the mechanisms and structures (e.g. referrals, guidelines, network managers and pooled resources) that are in place within or between organisations that indicate the degree of integration (*what we have*), while the cultural aspect refers to the willingness to implement integration and the process component reflects the actual coordination processes taking place ('what we do'). Empirical studies may not always distinguish between structural and process aspects of integration and generally ignore the cultural aspects of integration. This may reflect the discipline and context in which the measure is used. For example, a sociological perspective will be more likely to incorporate culture and structure than a purely medical approach.

Browne et al. (2004) developed a measure of the extent and depth of human services integration, the Human Service Integration Measure, and applied that measure to the

case of two programs in Canada, the Healthy Babies and Healthy Children program and the Early Years initiative. These programs were designed to provide integrated health, social services, education, housing, childcare, recreation, labour and correctional/custodial services for families and young children.

The Human Service Integration Measure assesses integration across three dimensions. In the context of Browne et al.'s (2004, p.5) study these dimensions were:

- *Extent of integration*: the identification of services and the number of services within programs or sectors involved in a specified partnership or integrated care domain.
- *Scope of integration*: the number of services that have some awareness or link with others in the specified partnership or integrated care domain.
- *Depth of integration*: the depth of links among services along a continuum of involvement involving the following elements.
  - Non-awareness = 0.
  - Awareness = 1.
  - Communication = 2 (services actively share information and communicate on a formal basis).
  - Coordination = 3 (services modify their own service planning to avoid service duplication or to improve links among services, using their knowledge of other services or programs).
  - Collaboration = 4 (services jointly plan offered services and modify their own services as a result of mutual consultation and advice).

The Browne et al. (2004) Human Service Integration Measure can be adapted for a range of circumstances. For example, rather than being implemented in the context of a specific program or framework, it could be used to measure the extent to which services in specified domains (e.g. specialist homelessness agencies, drug and alcohol agencies, mental health agencies and job search and training agencies) are integrated in a defined geographical area.

An alternative measure of the depth of integration is that provided by Ahgren and Axelsson (2005). Using their Integration Continuum structure (see Figure 3 above) they give a rank of 0 to complete segregation and a rank of 100 to full integration. In between these two points are five overlapping nodes, each of 25 points in length, covering areas of the Continuum. Each node is broken down into ten equal areas of 2.5 points each. The nodes are:

- Patient referrals (0–25), complete segregation through to linkage.
- Clinical guidelines (18.75–43.75), linkage.
- Chains of care (37.5–62.5), coordination in networks.
- Network managers (56.25–81.25), cooperation.
- Pooled resources (75–100), cooperation through to full integration.

In determining a figure for the depth of integration between any two services, a researcher needs to first designate the highest node that reflects the existing relationship between the services and then pick a rank point within that node.

Browne et al. (2007) significantly extend their integration measurement framework. First, their Human Service Integration Measure is revised by redefining the extent of integration as simply the number of broad sectors involved in the partnership (e.g.

health, education, etc.) and the scope as the agency or service types involved in the partnership (e.g. child care, mental health). The depth of integration for a given service is measured in the manner set out above. To these three components, they add two further items: congruence and reciprocity. Congruence measures the difference between the observed and expected depth of integration for a service, while reciprocity measures the difference between an agency's depth of integration score and the group-reported depth of integration score.

Second, Browne et al. (2007) argue for the incorporation into the measurement of integration additional measures to account for the *functioning of integration* in terms of the quality of integration and its ingredients and the *outputs from integration* in terms of what is accomplished (or network capacity). In order to capture these various elements, Browne et al. (2007) suggest that a range of instruments be used simultaneously.

Weiss' (2002) Partnership Self-Assessment tool covering issues of quality of integration in terms of the efficiency of the partnership involved and participants' perceptions of the benefits and costs of participation, is suggested as a measure of the quality of integration. Henrard et al.'s (2006) *Ingredients of Integration Questionnaire*, covering working arrangements (e.g. funding and governance, coordination structure, team meetings, referrals, points of access) and client support activities, is suggested as a measure of the ingredients of integration. Finally, Browne et al. (2007) suggest that Provan and Milward's (2001) networks activities measure, covering both agency and client dimensions, provides a measure of the outputs from integration.

We have drawn strongly on Browne et al.'s (2007) measurement framework in the development of our own survey of integration to be administered among services in Australia (see Chapter 4).

As noted previously, one of the key projected benefits of integrated care arrangements is that they create a more client-centred and seamless support system. It is therefore important to test the validity of this claim in terms of the range and quality of services received by clients given their needs and their perception of the integrated nature of care.

In a study of the US-based collaborative initiative to help end chronic homelessness (CICH), Mares et al. (2008) examined whether or not client-level measures of integration were strongly related to system-level measures of services integration.<sup>5</sup> Mares et al. (2008) utilised three client-centred measures of integration:

- The extent to which CICH clients received support in various domains of documented need.
- The number of outpatient service mental health visits CICH clients received.
- CICH clients' perception of the extent to which their service providers worked together in a coordinated manner or provided fragmented service delivery.

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<sup>5</sup> The CICH initiative provides permanent supported housing and primary healthcare and mental health services for those who are chronically homeless. The measures used by Mares et al. (2008) draw on a significant body of literature, which we will examine in some detail, surrounding the CICH initiative and a similar US program, the access to community care and effective services and supports (ACCESS) program. The latter demonstration program was designed to examine the impact of efforts to enhance system integration on the outcomes of homeless persons with serious mental illness. Surprisingly, there is little overlap between this literature on the integration of housing/homelessness services and health services and that referred to above on integration in the general health services sector (e.g., Browne et al. 2004; Browne et al. 2007; Ahgren and Axelsson 2005).

The two inter-agency or system-level measures of integration used by Mares et al. (2008) were a services coordination and planning measure, and an inter-agency trust and respect measure. The former measure was based on the extent to which key informants in CICH agencies rated the relationships of their agencies with each other agency in the CICH network across four dimensions. The trust and respect measure was based on the responses of key informants in the various agencies on the extent to which their agency trusted and respected each of the other agencies comprising their local network of CICH homeless service providers.

Interestingly, Mares et al. (2008) found that the client-level measures of services integration 'were, at best, weakly associated with measures of system-level integration' (p.367). No significant associations were found between two of the client-level measures (per cent of needs addressed and perceived coordination) and the two system-level measures suggesting that 'system-level processes may not translate directly into client experience' (p.374).

## **2.4 The effectiveness of models of integration: outcomes**

In this section, we review results from the literature on the effectiveness of particular models of homelessness and health care integration. As far as we are aware, there is no robust evidence on the extent and effectiveness of integrated care arrangements surrounding homelessness in Australia. However, there does exist a body of international evidence on the integration of homelessness and health services for those who are homeless in the US, Canada and Europe and some evidence surrounding health care integration in Australia.

### *The ACCESS program*

An important US example of the integration of services involving homeless people is the Access to Community Care and Effective Services and Support (ACCESS) program.<sup>6</sup> The ACCESS program was a US Federal Government demonstration program which used a quasi-experimental design to assess the impact of integrated systems of care on outcomes for homeless persons with mental illness. Nine experimental sites from nine US states were randomly selected for the implementation of integration strategies. Nine comparison sites from the same states were also selected. All 18 sites received funds to support Assertive Community Treatment (ACT) options. Rosenheck et al. (2003, p.78) define ACT 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'. On this definition, we would view ACT itself as a form of integrated care. On this basis, the study is concerned with examining the difference the introduction of formal systems of integration per se have on client outcomes as opposed to the use of inter-disciplinary teams of workers as occurs in the case of ACT.

The key goals of the ACCESS program were to increase the integration of services across different human service domains through site-specific development strategies and to determine the impact of these strategies on client functioning, quality of life, and housing for homeless clients with mental illness (Rosenheck 1998, p.1610; Coccozza et al. 2000, p.397). In their review of the research literature conducted in relation to the ACCESS program, Goldman et al. (2002, p.968) found that practical strategies for the integration of services can be identified and implemented, but that

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<sup>6</sup> See Rosenheck et al. (1998); Johnsen et al. (1999); Goldman et al. (2002); Morrissey et al. (2002); Rosenheck et al. (2003); Mares et al. (2008).

the implementation of integration strategies takes time and requires both technical assistance and resources integration.

In terms of client outcomes, clients at all sites in the demonstration showed improvement. However, there was no extra improvement at those sites which implemented integrated care arrangements in addition to ACT options other than in terms of housing outcomes. In other words, ACT programs make a difference to client health, social and housing outcomes but closer formal integration makes no additional difference to health outcomes but do in terms of housing. As Goldman et al. (2002, pp.968–969) suggest, 'systems that are better integrated have significantly better housing outcomes' but that beyond housing, 'extensive and targeted efforts to promote systems integration do not produce desired social and clinical outcomes at the individual client level'. Therefore, they suggested that 'investment in systems integration cannot be expected to produce desired clinical outcomes and mental health authorities should be encouraged to provide substantial resources to develop housing, outreach, and ACT teams'.

### *Supported housing models*

A key component of a number of models providing integrated care to homeless people is the provision of what is termed in the US context *supported housing*. Supported housing is defined as the provision of long-term housing to homeless people that is additionally linked to a range of on-site and off-site supports (Cheng et al. 2008). Examples of supported housing models include Housing First and Common Ground, both of which originated in the US. In Australia, Housing First and Common Ground models have been initiated in South Australia, Victoria, NSW and Queensland. Overseas studies evaluating these particular integration approaches typically show improved housing outcomes when compared with case management-only interventions but no demonstrable impact on clinical outcomes (Tsemberis et al. 2004; Morse 1999).

Nelson et al.'s (2007) systematic review of supported housing models, ACT, intensive case management and residential treatment models (where housing is provided only during the treatment phase) for homeless persons with mental disorders, found that positive housing outcomes were largest for supported housing models (see also Rog 2004). Residential treatment models were not associated with any improvement in housing outcomes. However, only one study of those reviewed by Nelson et al. (2007) demonstrated any improvement in psychiatric symptoms among those supported, although the models that included substance use treatment as part of the intervention, demonstrated improvements in substance use outcomes. Nelson et al. (2007) note that none of the studies directly compared the two most efficacious models, supported housing and ACT, and suggested future research could evaluate a supported housing plus ACT model against one involving ACT only. The authors also suggest that the efficacy of the models in relation to non-housing outcomes may have been poor because they did not include components specifically aimed at addressing these outcomes.

In another study of supported housing programs, Clark and Rich (2003) compared two supported housing programs with a 'case management only' approach for mentally ill homeless persons residing in Florida. The supported housing programs included guaranteed access to housing and housing support services plus case management. The case management only condition comprised a homeless outreach and support team (HOST) operating out of a large community mental health facility. The HOST model was based on short-term case management and included outreach and engagement, limited counselling, medication management, housing assistance, and referral to psychosocial support services. Participants ( $n=152$ ) were currently

homeless or at imminent risk of homelessness and had at least one mental disorder diagnosis. A quasi-experimental design was used.

At baseline, Clark and Rich (2003) found a higher proportion of participants in the case management only scenario had experienced multiple episodes of homelessness, greater severity of psychiatric symptoms and used substances on more days compared to the supported housing group. To control for these baseline differences, a propensity score sub-classification was derived by logistic regression analysis for each participant. Among those with a high propensity score, participants showed less gain in stable housing and less reduction in functional homelessness under the case management scenario compared to the supported housing scenario. In contrast, there was no difference in outcomes between the two scenarios for participants with low or moderate propensity scores. With regard to substance use and psychiatric symptoms, no differences were found for either intervention type or propensity score. These findings suggest the efficacy of different models of integration is moderated by the complexity of the client's presentation. Correspondingly, these findings imply that a range of services needs to be available, from least to most integrated, so that clients can be matched to a level of integration according to the level of complexity of need.<sup>7</sup>

### *Veterans*

In the US, veterans represent a significant part of the homeless population. In 1992, the US Department of Housing and Urban Development (HUD) and the US Department of Veterans Affairs (VA) initiated a trial of the provision of intensive case management linked to rental subsidies across nine sites. The target focus of the program was clients who were homeless and had a substance use and/or other mental disorder. Four of the participating sites agreed to an evaluation of the program using an experimental design which included the random assignment of clients to one of three groups: (1) a supported housing program (HUD-VASH); (2) intensive case management only (no rental subsidy); or (3) short-term broker case management (treatment-as-usual).

An initial evaluation found clients in the HUD-VASH demonstrated improved housing outcomes when compared to the other two client groups; however, there was no impact on clinical outcomes (Rosenheck et al., 2003). However, there was substantial missing data which was highest for the HUD-VASH group and lowest for the treatment-as-usual group. Additionally, missing data was associated with a greater number of days intoxicated at baseline. A re-analysis of the data was undertaken using multiple imputation to restore missing data. Significant improvement in substance use outcomes was shown for the HUD-VASH group and this result was sustained after controlling for housing status (which was independently associated with reduced substance use). The authors interpret the result to mean that the intensive case management component of the HUD-VASH was responsible for the improved clinical outcome.

### *Single agency integration: the Community Connections Housing Continuum program*

As noted previously, fully integrated support entails the provision of different forms of care under the one organisational banner. It would be hard to imagine that an

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<sup>7</sup> Another supported housing arrangement we examined was 1811 Eastlake, a Housing First program in Seattle that targets homeless persons with problematic alcohol use and who constitute high-end users of health and justice services (Larimer et al. 2009). The model does not stipulate substance use treatment; rather on-site case management aims to engage residents and facilitate appropriate behaviour change. Medical and mental health care was located on site. Larimer et al. (2009) found that alcohol use and utilisation of health and justice services both declined with increasing length of time housed.

integrated service covering all forms of support exists. However, an example of an integrated care arrangement that approximates such an approach is the Community Connections Housing Continuum program in the US. The Community Connections Housing Continuum program is a program operated by a single agency, Community Connections, a large private non-profit mental health provider, which combines intensive case management, integrated dual-diagnosis treatment, and other clinical services, with a continuum of housing support (Bebout 1997; 1999).

The key elements of the Housing Continuum component of the model adopted by the Housing Continuum program include:

- A crisis residential service.
- A transitional housing program (a 3–6 month program of flexible duration with 24-hour live-in staff) with a focus on remedying problematic behaviour patterns that have contributed to residential instability.
- Supported independent living in permanent accommodation located in relatively close proximity to the mental health agency and typically comprising one- and two-bedroom properties leased or owned by the agency.

In addition to housing-related support, Community Connections provides comprehensive mental health services, including assertive outreach, intensive case management, psychiatric medication monitoring, psycho-educational groups and referral. A clinical coordination team conducts weekly visits and coordinates on-site meetings for the purpose of problem-solving, living skills and conflict resolution. Case managers provide both clinical and support services; that is, the role of housing case management and clinical intervention is merged into a single staff position.

Integrated treatment of co-morbid disorders and housing assistance is provided within a four-stage framework of engagement, persuasion, active treatment and relapse prevention; the process toward stability of housing and stability of substance use and other mental disorders are taken to be analogous pathways. A key feature of the Housing Continuum model is the framework employed to manage relapse to ensure housing stability. Given that substance use disorders are chronic, relapsing conditions, relapse to substance use does not incur immediate exclusion. A decision frame is applied to the use-related behaviour and appropriate remedial action is employed.

The clinical coordination team conducts weekly visits and coordinates on-site meetings for the purpose of problem-solving, living skills and conflict resolution.

The Housing Continuum program developed by Community Connections rests on the premise that housing assistance and mental health treatment need to be fully integrated; mere coordination of services is insufficient for persons with complex needs. Moreover, that responsiveness is critical to integrated care and is best achieved by co-locating housing and clinical staff within a single agency.

Bebout et al. (1997) examined outcomes under the Housing Continuum model for a sample of 158 formerly homeless people diagnosed as having both severe mental illness and a current substance use disorder. The group was studied over an 18-month period during which participants received integrated dual diagnosis services and housing supports under the Continuum model. Of the 122 participants for whom complete data were available, 64 (52 percent) achieved stable housing, defined as participants living continuously in high-quality housing with no housing loss or nights of homelessness during the final 6 months of the study. Stable housing was associated with lower substance use, greater progress toward substance abuse recovery and higher quality of life.

### *Substance use models*

Integrated care models have been trialled in a number of substance use treatment settings. McLellan et al. (1999) report on an initiative designed to integrate clinical case managers into existing outpatient services using a 'strengths based' model. The original set of services was subsequently expanded to also include medical screening (e.g. blood-borne viral infections), housing assistance and legal assistance. The evaluation compared clients at treatment entry and at six-month follow-up who were allocated a clinical case manager ( $n=184$ ) and those who were not ( $n=353$ ). Both groups showed reductions in substance use, psychiatric symptoms, and family and legal problems at six-month follow-up. However, the clinical case management group demonstrated greater improvements in these areas compared to the control group. The evaluation demonstrated that integrating clinical case managers into existing outpatient treatment improved access and utilisation of support services and had a significant impact on client outcomes. An important finding of the study was that the positive results of this initiative were only demonstrated after two years, following expansion of the core set of social support services to include housing assistance and drug-free accommodation and removal of administrative impediments to the referral process. This suggests the need for integration of services to be a long-term rather than quick fix approach.

De Leon et al. (2000) undertook an evaluation of an alcohol and other drugs (AOD) residential treatment program for persons with co-morbid mental disorders. Clients were referred from homelessness services and psychiatric facilities. Three treatment groups were compared: (1) moderate-intensity therapeutic community intervention ( $n=183$ ); (2) low-intensity therapeutic community intervention ( $n=93$ ); and (3) treatment as usual ( $n=66$ ). The therapeutic community intervention was less demanding, more flexible and more individualised in its approach compared to typical therapeutic communities; these modifications were designed to provide a better fit to the clinical presentations of homeless, mentally ill persons. Treatment as usual was varied, reflecting the reality of services available to homeless persons who also have a mental disorder but the services received were less organised and cohesive. Clients were followed up at 12 months and 2 years following treatment entry. The least intensive therapeutic community group demonstrated greater improvements in substance use outcomes, possibly as a result of the higher completion rate in this condition. These findings suggest less structured interventions may be more palatable or manageable for persons with complex needs.

Homelessness has been associated with lower retention rates in drug and alcohol services and repeated presentations to these services. Post-detoxification stabilisation services provide accommodation and support for clients waiting to enter residential rehabilitation. Initially conceived as *holding* services, they have since evolved to provide a structured program of support, including self-help and peer-support groups, as well as individual counselling. Initially, stabilisation services were conceived as an adjunct to detoxification units. However, they have also been successfully incorporated into accommodation services for homeless persons.

In a study comparing client outcomes across the two setting types, 773 clients leaving detoxification were randomly assigned to either a detoxification-based or a homelessness-based stabilisation service (Argeriou & McCarty 1993). Sixty-three percent of the client sample completed the stabilisation program. The different sites shared similar core program elements and there was no difference in client characteristics upon entry or client outcomes (measured using the Addiction Severity Index) at the 270-day follow-up. Although a similar proportion of clients who did and

did not complete the stabilisation program were readmitted to detoxification, time to readmission was longest for clients who completed.

Another prospective study of clients attending a medically supervised inpatient detoxification service compared homeless and non-homeless persons with respect to the number of days to first substance use post-detoxification (Kertesz et al. 2003). Homeless persons (defined as having slept on the street or in a shelter for at least one night in the six months prior to treatment entry) were more likely to have been incarcerated, to nominate alcohol as their preferred substance, had a greater severity of depressive symptoms, and were more likely to be taking psychiatric medication compared to non-homeless clients. Clients were followed up 6 months after discharge; there was no main effect for time to first use between homeless and non-homeless clients.<sup>8</sup> However, a significant interaction effect was found for homelessness and stabilisation programs. Homeless persons who attended a stabilisation program post-detoxification had a significantly longer time to first use compared to non-homeless persons (regardless of stabilisation program status) and homeless persons who did not attend a stabilisation program. The authors suggest that the demands of being homeless (e.g. finding accommodation and food, transportation) impede successful and ongoing engagement with appropriate treatment services.

### *Australian studies*

There are relatively few analyses of the extent and form of integration of services in the Australian context and those that do exist are restricted to integrated health care initiatives.

Jackson et al. (2007) evaluated the Brisbane South Centre for Health Services Integration (BSCHSI) initiative. This initiative sought to integrate service delivery across three agencies: Domiciliary Allied Health Acute Care and Rehabilitation Team (DAART, Brisbane South Community Health Service, Queensland Health), the Mater Centre for Integrated Health Care and General Practice (Mater Private Hospital), and Brisbane Inner South Division of General Practice (BISDIV). The three agencies were co-located at the Community Services Building on the Mater Private Hospital campus between December 2002 and April 2004. Additional strategies included: (1) multidisciplinary education; (2) clinical interaction between the agencies; (3) integrated information management and information technology systems; and (4) an integrated governance structure. The governance structure included a steering committee (strategic focus) and a management committee (operational focus). Management agreements were signed by each agency.

Integration outcomes were measured across three domains: (1) communication and access; (2) cultural change and teamwork; and (3) commitment and incentives to integrate. A questionnaire was distributed to staff across two time-points ( $n=61$  and  $n=51$  at  $T_1$  and  $T_2$ , respectively). Jackson et al. (2007) found significant positive change between  $T_1$  and  $T_2$  with regard to knowledge of the other staff groups and reduced duplication of services, and a negative association with expectations of relationships with professionals from outside BSCHSI. Staff groups who participated in fewer integration strategies scored lower on the integration outcome measures compared to staff groups who had higher levels of involvement; this was true at both

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<sup>8</sup> The study has two important limitations. First, homelessness was defined in terms of primary and secondary homelessness only; persons who were 'couch surfing' or staying in other unstable or insecure accommodation were classified as non-homeless. Second, the substance use outcome was defined as a single use at 6 months, despite lapses being common during initial stages of abstinence and distinct from a relapse, which is a return to regular pattern of use.

T<sub>1</sub> and T<sub>2</sub>. Referrals to DAART from the other two partner organisations in BSCHSI increased during the evaluation period. Staff reported four key positive outcomes: improvements in both the quality of, and opportunities for, communication; increased knowledge of staff groups resulting in better referrals and working relationships; an increased opportunity for collaboration; and better access to facilities.

Jackson et al. (2007, p.265) suggest that 'opportunities to identify service gaps and plan innovative ways of addressing these gaps using an integrated model were facilitated with physical co-location'. The groups that had a shared client base attached a higher value to the co-location. Shared physical space (e.g. common meeting rooms and staff amenities) was a necessary but not sufficient condition for integration; other strategies such as the development of integrated care pathways, investment in infrastructure to assist with communication and client referrals, and regular clinical and non-clinical meetings, facilitated integration (as indicated by the higher outcomes among staff groups with greater participation).

## **2.5 Conclusion**

### *Construct*

The literature on the construct behind the integration of services has expanded rapidly over the last decade. There now exists a well-developed, although diverse, literature on typologies of integration, which can inform the way we conceptualise the integration of services in the homelessness context. The two key components of a typology of integration include the intensity or degree of integration (from fragmented service delivery through to full integration) and the ingredients, dimensions and working arrangements surrounding integration. Also important to an understanding of integration is whether services are integrated horizontally between different agencies or vertically within agencies and user or client perspectives on integration.

### *Measurement*

The literature on the measurement of the integration of health and social services is of more recent origin and is largely fragmented. Nevertheless, the framework developed by Browne et al. (2007), which brings together a range of instruments to measure the degree and nature of integration, its ingredients and impacts, provides a fruitful line of inquiry on the empirical measurement of integration. We shall make use of this framework in our own study and in the design of our survey. Our proposed research design is set out in Chapter 4.

### *Effectiveness*

The empirical evidence on the effectiveness of integration approaches in the homelessness sector is limited and inconclusive as to the effects of integration on client outcomes. The quasi-experimental results from the ACCESS program, for example, provide evidence of improved client outcomes from the introduction of Assertive Community Treatment (ACT) programs but no further improvement other than in terms of housing outcomes from formal systems integration beyond ACT. However, as argued in the text, ACT approaches themselves include team-based interdisciplinary care and so represent one form of coordinated support. While formal systems of integration may not generally improve health-related client outcomes, they may aid in removing institutional barriers to an improvement in other areas, such as in accessing and sustaining long-term housing.

### 3 POLICY CONTEXT

The Australian Government's White Paper on homelessness *The road home* (Australian Government 2009a) and the subsequent National Partnership Agreement on Homelessness (NPAH) between the Australian Government and the states and territories placed homelessness at the forefront of the Australian Government's social inclusion agenda. Never before in Australia's history has homelessness attracted so much policy interest and attention both at the national level and from the states and territories.

*The road home* and the NPAH both call for a better-connected service system and for closer integration of specialist homelessness and mainstream services as an important ingredient to achieving a reduction in homelessness in Australia. At a more general level, the integration of services is a theme that runs through Council of Australian Governments (COAG) reform processes involving human service delivery.

In the mental health sector, the National Mental Health Policy and associated COAG *National Action Plan on Mental Health* and *Fourth National Mental Health Plan* includes a specific commitment to develop integrated programs between mental health support services and housing agencies for those at risk of homelessness (Australian Government 2009b). Similarly, the *National Co-morbidity Initiative*, coordinated by the Australian Government Department on Health and Ageing, seeks to address the gaps in service delivery, clinician competencies and integrated treatments to improve client outcomes for Australians with co-occurring mental health conditions.

This chapter provides a brief overview of the policy environment and initiatives surrounding the issue of the integration of homelessness and mainstream drug and alcohol and mental health services in Australia. Section 3.1 examines this issue in the context of how the homelessness reform agenda embraces the concept of closer integration of services, while section 3.2 examines the corresponding question of how the mental health and drug and alcohol sectors at the policy level take account of homelessness issues.

#### 3.1 The homelessness reform agenda and service integration

The White Paper *The road home* and the National Affordable Housing Agreement (NAHA), which commenced on 1 January 2009, frame the current national approach to reducing homelessness. The supporting agreements under the NAHA include the NPAH and the National Partnership Agreements on social housing and Indigenous Australians living in remote areas.

The headline goals of the White Paper are to halve homelessness by 2020 and offer supported accommodation to all 'rough' sleepers who need it. To this end, the White Paper targets three areas for intervention.

- *Turning off the tap*: where services will intervene early to prevent homelessness.
- *Improving and expanding services which aim to end homelessness*: to ensure services will be more connected, integrated and responsive to achieve sustainable housing, improve social and economic participation and end homelessness for their clients.
- *Breaking the cycle*: ensuring people who become homeless move quickly through the crisis system into stable housing with the support needed so that homelessness does not reoccur.

The NPAH is based on three key strategies to address homelessness. These are:

- Effective prevention and early intervention programs.
- Investment in services that 'help people get back on their feet, find stable accommodation and, wherever possible, obtain employment' particularly with respect to those who are regular rough sleepers, repeatedly homeless, 'disempowered due to mental illness' and unaccompanied children.
- A better-connected service system.

In respect of the third of these strategies, the NPAH envisages reforms to the service system, which 'will build more connected, integrated and responsive services' aimed at achieving sustainable housing, and improve economic and social participation of those at risk of homelessness. More specifically, the NPAH calls for improved links between homelessness services and mainstream services, which it is suggested will enable faster transition from temporary accommodation for the homeless to stable housing.

The NPAH between the Commonwealth of Australia and the states and territories and the subsequent state and territory Implementation Plans envisage a major role for integrated service delivery in a number of areas. Two of these are street-to-home initiatives for 'chronic homeless people' defined in the Agreement as 'rough sleepers' and assistance for people at risk of homelessness leaving child protection services and correctional and health facilities so that they can access and maintain stable and affordable housing.

Under the NPAH, each state and territory developed Implementation Plans, which included a range of initiatives designed to operationalise the three strategies listed above. Among the NPAH priorities are services to assist homeless people with substance abuse or mental health issues secure or maintain stable accommodation; improvements in service coordination and provision, and outreach programs (street-to-home programs) to connect rough sleepers to long-term housing; and specialist clinical teams for mental health, drug and alcohol assessment, treatment and referral.

Street-to-home programs are not new to Australia. However, the NPAH has significantly increased the emphasis put on such programs and the resources devoted to them. All states and territories now administer street-to-home programs. The NSW Implementation Plan, for example, incorporates a street-to-home program involving assertive outreach linked to long-term supportive housing for rough sleepers in inner Sydney and Newcastle. In the case of Sydney, the program is an expanded version of the current Inner City Homelessness Outreach and Support Service. The NSW street-to-home programs include health and specialist homelessness services conducting assessment and referral processes, access to a range of long-term housing options and access to mental health and drug and alcohol services, counselling, case management and specialist homelessness support. The same profile of support services and model of support is evident in other jurisdictions' street-to-home initiatives.

By their very nature, street-to-home programs represent inter-disciplinary team-based approaches to the provision of support combining Assertive Community Treatment and Supported Housing models of support. Services from different domains are brought together in a partnership framework and funding and governance arrangements are structured around an integrated service framework. Street-to-home programs, therefore, represent excellent case studies in integrated service delivery in the homelessness context.

Other common service initiatives incorporated in State/Territory NPAH Implementation Plans across the various jurisdictions involving an integrated care focus are coordinated exit planning from emergency departments and residential health facilities and supported housing initiatives for young people combining long-term housing responses with health, education and training, and job placement supports.

### **3.2 Mental health and drug and alcohol strategies and initiatives**

In 1992, the Australian Health Ministers' Conference endorsed the National Mental Health Strategy. The Mental Health Strategy represents a commitment by Australian governments to improve the lives of people with mental health conditions. Since that time, a number of revisions to the *strategy* have taken place. In its present form, the National Mental Health Strategy is built around four components: the National Mental Health Policy, the National Mental Health Plan, the Mental Health Statement of Rights and Responsibilities and the Australian Health Care Agreements. For our purposes, the relevant component is the National Mental Health Plan.

The *Fourth National Mental Health Plan* sets out an agenda for collaborative government action in mental health 2009–2014. The National Mental Health Plan takes a 'whole of government' approach by involving sectors other than health in achieving mental health objectives. More specifically, the National Mental Health Plan refers explicitly to the need for the development of 'integrated programs between mental health support services and housing agencies to provide tailored assistance to people with mental illness and mental health problems living in the community' (Australian Government 2009b, p.iv). It also calls directly for 'integrated approaches between housing, justice, community and aged care sectors to facilitate access to mental health programs for people at risk of homelessness and other forms of disadvantage' (Australian Government 2009b, p.iv). However, the National Mental Health Plan includes little by way of practical detail concerning the implementation of such an approach.

The COAG National Action Plan on Mental Health (2006–2011) is another major national initiative in the mental health sphere. The National Action Plan on Mental Health includes a large range of measures most of which are not directed at homelessness per se. However, one particular Commonwealth initiative of interest is the Personal Helpers and Mentors Initiative. The program provides support for those who have a severe functional limitation resulting from mental illness in their recovery process to help them overcome social isolation and increase their connections to the community. The program assists those most in need, including those who are homeless or who have unstable accommodation. Delivery of services commenced from May 2007.

The National Drug Strategy (NDS) and its forerunner, the National Campaign Against Drug Abuse (NCADA), have been operating since 1985. They represent the national approach for the management of substance use in Australia. The NDS aims to improve 'health, social and economic outcomes for Australians by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in our society'. Related strategies include the National Drug Strategic Framework, the National Alcohol Strategy, the National Amphetamine-Type Stimulant Strategy 2008–2011, and the National Cannabis Strategy.

The NDS is a coordinated, 'integrated response to reducing drug-related harm in Australia' (Australian Government 2004, p.12). References to integrated responses at the system-wide level within the *NDS* are all health-specific (e.g. the National Hepatitis C and National HIV/AIDS Strategies, the National Mental Health Strategy

and the National Suicide Prevention Strategy). There is, however, no explicit attention to integration with the homelessness support system or to homelessness as a prime site of activity.

As previously noted, substance use and other mental disorders are highly co-morbid. Compared to unilateral approaches, integrated treatments for substance use disorders and severe mental disorders result in superior outcomes for clients. The *National Comorbidity Initiative* recognises this and was allocated \$17.9 million over 7 years from 2003–2004 to 2009–2010 with the specific aim of improving service coordination and treatment outcomes for people with co-existing mental health and substance use disorders.

The initiative focuses on the following priority areas: (1) raising awareness of co-morbidity among clinicians/health workers and promoting examples of good practice resources/models; (2) providing support to general practitioners and other health workers to improve treatment outcomes for co-morbid clients; (3) facilitating resources and information for consumers; and (4) improving data systems and collection methods within the mental health and AOD sectors to manage co-morbidity more effectively. The rationale for the National Comorbidity Initiative, that co-morbidity is the norm rather than the exception, is now well recognised. However, explicit attention to issues around housing and homelessness are not directly addressed in the initiative.

At a jurisdictional level, individual states and territories over the last decade have implemented targeted homelessness-specific mental health and drug and alcohol services, which typically involve team-based ACT options and have begun to focus on homelessness issues in state/territory mental health and drug and alcohol plans. For example, in Victoria, homeless outreach psychiatric services (HOPS) have worked for some time in partnership with homelessness services, using an assertive outreach approach providing specialist clinical and treatment responses for homeless people who do not engage readily with mental health services. In 2001, the Victorian Government implemented the Homeless and Drug Dependency Trial (HDDT), a partnership between Hanover Welfare Services, The Salvation Army, St Vincent de Paul Aged Care and Community Services and the Victorian Department of Human Services. The trial aimed to build capacity within crisis accommodation services to better work with and assist drug-dependent clients.

### **3.3 Conclusion**

The recent homelessness reform process initiated by the White Paper on homelessness and continued by the NPAH has placed considerable emphasis on the role of integrated service responses in achieving reductions in homelessness. This is nowhere more evident than in the street-to-home initiatives which involve teams of specialist homelessness agencies, housing authorities and clinical and community mental health and drug and alcohol services supporting the transition of chronically street-homeless people into long-term housing.

National mental health and drug and alcohol plans and strategies do not include a major focus on homelessness issues, or on the closer integration of mental health and drug and alcohol services and homelessness services, but there are signs that this is changing. However, both the Australian Government and individual states and territories have implemented homelessness-targeted programs in recent years, bringing together specialist homelessness services and mental health and drug and alcohol services.

## 4 RESEARCH DESIGN AND PRELIMINARY FINDINGS

This chapter outlines the study's research design and presents descriptive findings from the preliminary case study investigations undertaken. It also provides an overview of the study's *Australian Homelessness, Mental Health and Drug and Alcohol Services Integration Survey*, which seeks to measure the extent, nature, form and structure of integration in relation to services for homeless people and those at risk of homelessness with mental health and drug and alcohol needs in selected sites around Australia.

Our research study is divided into two stages outlined in Table 2 below.

The first stage of the study lays the foundation of the project. It includes a review of the relevant literature, a presentation of preliminary case study evidence and the development of a survey of homelessness service integration, the *Australian Homelessness, Mental Health and Drug and Alcohol Services Integration Survey*. The results of this stage are included in the Positioning Paper.

Stage 2 of the study involves the implementation of the *Australian Homelessness, Mental Health and Drug and Alcohol Services Integration Survey* and the full roll-out of the case study and in-depth interview module of the study.

**Table 2: Stages of the research plan**

<p>Stage 1: Scoping the study</p> <ul style="list-style-type: none"><li>→ Literature review focusing on the measurement and effectiveness of service integration.</li><li>→ Overview of policy context.</li><li>→ Pilot case studies of specialist homelessness services and key expert interviews with policy makers.</li><li>→ <i>Australian Homelessness, Mental Health and Drug and Alcohol Services Integration Survey</i> design.</li></ul> <p>Stage 2: Data collection and analysis</p> <ul style="list-style-type: none"><li>→ Full roll-out of case study and key expert interview approach across a wider range of services, including in the mental health and drug and alcohol sectors.</li><li>→ Implementation of the <i>Australian Homelessness, Mental Health and Drug and Alcohol Services Integration Survey</i> and analysis of results from the survey.</li></ul>
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### 4.1 Case studies

#### 4.1.1 Preliminary case study evidence: stage 1

In the first stage of the study, we undertook a pilot case study examination of three medium to large non-government agencies that provide a number of different services to homeless people and those at risk of homelessness. The three agencies were Ruah Community Services (Perth), HomeGround Services (Melbourne) and The Haymarket Foundation (Sydney).

Each of these organisations offers a suite of services for homeless people and those at risk of homelessness under a range of different programs. The aim of the pilot was to understand the ways in which agencies work across the homelessness, mental health and drug and alcohol domains, gather background material for the purposes of

developing the *Australian Homelessness, Mental Health and Drug and Alcohol Services Integration Survey* and determine the feasibility of the case study approach adopted to examining concepts around integration.

Meeting workers and managers in these agencies enabled us to gain practical insights into how agencies with a specific charter to assist homeless people support clients who also have mental health and/or drug and alcohol needs and engage with mental health and drug and alcohol agencies across a range of programs. We also interviewed a small number of key government informants in each of the three relevant jurisdictions to gain an insight on the issue of integration of services from a policy and funder perspective.

Approximately ten interviews were conducted for each agency. Interviews were undertaken with relevant homelessness staff for selected programs within each agency. This included: case managers, clinicians; consultants to the service; service managers; and executive managers. Interviews were generally undertaken on site and at a time convenient to the participant. Once informed consent was obtained, the interview took approximately 1 hour. The interviews were taped and transcribed and will subsequently undergo analysis. The transcriptions will then be analysed using qualitative methods to determine themes and variations from these themes.

The programs we were interested in were tenancy support programs for those at risk of homelessness, community outreach support programs for those homeless or at risk of homelessness linked to mental health and drug and alcohol services, and mainstream drug and alcohol-related programs with a target population that encompasses homeless people. Where appropriate and available, a key expert, representing a relevant government funding authority, was also interviewed.

All interviews were conducted using the same set of standard questions and were directed at the service level with some questions also asked of the agency and the program within which the service was funded and administered.

We addressed the following topics in interviews in relation to the service, its clients, approaches to integration, forms of integration practised, and individual respondent's views and experiences of integration.

- *Structure*: source of referrals; eligibility criteria; duration, level and type of support provided.
- *Funding*: how the service is funded.
- *Objectives*: in terms of client outcomes, client accessibility, training, advocacy and education, homelessness prevention and early intervention.
- *Target client groups*: sex, culturally and linguistically diverse (CALD), Aboriginal and Torres Strait Islander (ATSI), youth, family and other.
- *Client needs*: the homelessness, mental health and drug and alcohol needs of clients.
- *Approach to integration*: philosophy of integration taken by the service and the agency.
- *Mechanisms in place to facilitate integrated care for clients of the service*: case conferencing/case review; joint assessment protocols; cross-agency client information and referral protocols; consultation and liaison; co-location of services; sharing of transport; shared information systems; inter-agency meetings; common application processes; staff secondments; joint delivery processes; and staff recruitment.

- *Depth and extent of integration in particular domains*: shared guidelines; common targeting strategies; joint or pooled funding arrangements; organisational protocols; memoranda of understanding between services/agencies; ministerial or executive interagency coordination structures; advisory committees; agency amalgamation; government funding directives and protocols; policy and strategy documents; and policy units.
- *Role and responsibilities of the interviewee*: the role of the interviewee whether policy/strategic or operational, responsibility level, length of time in current role, length of time in agency; length of time worked in homelessness, mental health, drug and alcohol areas.
- *Interviewees' own past experiences and views of integration*: what does the term 'integration' mean to you; how can integrated service delivery work; perceived impact on client outcomes; intended and unintended consequences; critical ingredients that enable good integrated care; and barriers to providing good integrated care.

The case study approach was well received by the specialist homelessness agencies and government key experts. All interviewees were very open in discussing the topic and very interested in the project.

#### 4.1.2 *The Haymarket Foundation*

The Haymarket Foundation is a non-government organisation with an objective of providing medical, psychological and welfare services to the homeless people of inner Sydney, particularly those who are chronically homeless. In addition to providing crisis accommodation, The Haymarket Foundation runs a primary health care clinic, a needle and syringe program, a psychological counselling service, transitional housing for homeless persons leaving drug rehabilitation, and stabilisation beds and case management for homeless persons with complex needs. The joint focus on homelessness, mental health and drug and alcohol issues at the Haymarket reflects the origins of the Haymarket Clinic in the 1970s as a clinic for Sydney's homeless and socially disadvantaged people provided by volunteers from Sydney Hospital.

The co-location of both homelessness-focused and mental health and drug and alcohol services within the one agency makes The Haymarket Foundation one of the few examples in Australia of an agency providing integrated service delivery across the homelessness, mental health and drug and alcohol domains. It relies more so than most agencies supporting homeless people on funding from health sources. The Foundation engages with services providing support to human immunodeficiency virus (HIV)-positive and acquired immune deficiency syndrome (AIDS) clients. The extent of integrated care across homelessness, particularly chronic homelessness, mental health and drug and alcohol services was a primary reason for choosing the Haymarket Foundation for the study.

All services of the Haymarket Foundation were examined as part of the case study analysis. These were the:

- Homelessness Intervention Project (HIP).
- AOD Integrated Care Project.
- Bourke Street Project.
- Haymarket Centre.
- Haymarket Clinic.

The HIP is a pilot program funded by the NSW Department of Premier and Cabinet under the NSW Implementation Plan 2009–2013 initially for 12 months but extended recently for a further 18 months. It comprises two elements, the Homelessness Intervention Team (HIT) in the inner city and the Nepean Youth Homelessness Project. The Haymarket Foundation is engaged in the former initiative.

Eligibility for the project is restricted to those chronically homeless people (prolonged or multiple episodes of homelessness) living on the streets with high needs, including substance use and/or mental health problems. Funding is provided for three case workers to be employed at The Haymarket Foundation. Support for case workers is made available through a team comprising one representative from each of NSW Department of Corrective Services (DoCS), NSW Health and Housing NSW linked into the Haymarket Foundation and Mission Australia, the other major non-government provider in the Project. The project seeks to bring together health, homelessness and housing services within an assertive case management model. Accommodation in the first instance is provided at The Haymarket Foundation and clients are assisted to move into long-term housing; twenty social housing tenancies are allocated to the project.

The AOD Integrated Care Project is a NSW Health (South Eastern Sydney and Illawarra Area Health) funded program, which was established following the closure of Foley House, a crisis accommodation service for chronic homeless people who are HIV-positive. Funding is provided for two case workers, one each located at The Haymarket Foundation and the Bobby Goldsmith Foundation. Support is provided to those who meet a number of criteria: they are HIV-positive, are currently homeless, have an existing AOD addiction, experience mental illness and exhibit one other complex need. Intake for the project is provided through the AIDS Dementia and HIV Psychiatry Service of NSW Health located within St Vincent's Mental Health Service.

The AOD Integrated Care Project integrates housing support, HIV-related support (for physical, mental and social needs) and alcohol and other drug support. The AOD Integrated Care Project aims to produce positive outcomes for clients across a number of domains. These include: transitioning to independent housing in the community; compliance with HIV treatment (and subsequent delay in onset of AIDS dementia complex resulting in prolonged capacity to remain housed in the community); linkages with relevant community services, including drug health services; and harm minimisation, including risky injecting and sexual behaviours.

The Bourke Street Project is a drug and alcohol transitional housing program administered by The Haymarket Foundation and funded by NSW Health (South Eastern Sydney and Illawarra Area Health). The program works closely with the Haymarket Clinic in the provision of primary health care and psychological services.

The program is targeted to those with a substance use disorder exiting from an AOD rehabilitation service who are homeless or at risk of homelessness. In other words, the program is designed for those who cannot return to a long-term home after rehabilitation. Transitional housing is provided in Haymarket properties and support is provided for approximately 9 months.

The aim of the program is to achieve the goal of independent housing in the community, continued abstinence or minimal substance use, established links with relevant support services in the community, self-management of a tenancy and health/social support appointments.

The Haymarket Centre provides accommodation for homeless men and women with AOD problems, mental illness and/or challenging behaviours, with core funding for this purpose being provided through the Commonwealth (SAAP) and administered by

NSW DoCS. Management of the HIP and AOD Integrated Care Program is located at the Centre.

Residents are linked into a broad range of services provided by The Haymarket Clinic, including access to primary health care and AOD counselling. AOD relapse prevention groups are conducted onsite and facilitated by the Haymarket psychologist. A mental health clinic provided by Sydney South West Area Health Service operates weekly at the service. Weekly on-site clinics for primary health care, podiatry and dental health care run by community health teams are also provided. The Centre has good external links with homelessness-friendly local GPs and community-based mental health and drug health services.

The two objectives of the Haymarket Centre are stable accommodation and addressing substance use and mental health problems.

The Haymarket Clinic is funded by the Commonwealth Department of Health and Ageing and provides primary health care and welfare services for inner-city homeless and disadvantaged people. The Clinic team comprises medical doctors, nurses, a clinical psychologist and social worker. Additionally, Haymarket Clinic has an arrangement with SESIAHS to provide a psychiatrist for a weekly clinic. Thus the Haymarket Clinic provides a 'one-stop shop' for physical and mental health care. The clinic is also the site of a secondary needle exchange (managed by The Kirketon Road Centre, SESIAHS) and provides a range of Day Centre services.

The clinical psychologist provides clinical supervision of case workers across all services and sites. Weekly meetings are held involving case presentation by case workers using a structured format plus discussion regarding management strategies. A memorandum of understanding between the Haymarket Clinic and SESIAHS facilitates referrals between the two entities without the need for a repeat assessment. The general aim of the Clinic is to reduce harm associated with substance use and improve the mental health of clients.

#### *4.1.3 Ruah Community Services*

Ruah Community Services is a non-government organisation that operates across the Perth metropolitan area, providing community mental health services, housing and homelessness services, and also works with issues of domestic/family violence, addiction, employment and family support for disadvantaged people.

Ruah services are funded under a range of different programs administered by Western Australian and Australian Government departments. These include: homelessness early intervention tenancy support programs in both the public and private rental market; a day centre for adult homeless people, a community centre for Aboriginal women experiencing homelessness, women's and children's crisis accommodation service; community mental health services; support for women exiting prison; and specialist employment services for people living with mental illness to find and maintain employment.

In stage one of the study, we focused on a relatively small set of very different types of services administered by Ruah which were funded by different bodies and had quite different points of focus with respect to the integration of services. These were:

- Ruah tenancy support services.
- Ruah Intensive Program.
- Ruah Specialist Support Program.

Ruah tenancy support services are funded by the WA Department of Housing and the WA Department of Child Protection under a number of different programs and provide support to tenants at risk of homelessness to sustain tenancies. These services include: Ruah Tenancy Support-South East, which provides support services to households at imminent risk of homelessness in the private rental market; the Fast Track Tenancy Support service which seeks to fast track those families newly at risk of homelessness into private residential tenancies and away from crisis accommodation; a service providing support to those entering tenancies from homelessness through referral sources; and the Ruah Aboriginal Tenancy Support service, which provides intensive tenancy support to former residents of town-based Aboriginal communities to transition into WA Department of Housing tenancies across the Perth metropolitan area.<sup>9</sup>

The tenancy support services operated by Ruah are part of programs which have as their ultimate objective sustainable tenancies. While there is recognition on the part of funders of the many different personal, social and economic causal forces driving tenancy instability and the need to address these underlying causal forces, the tenancy programs are not established by the relevant funders on an integrated basis. Hence, the specific actions taken by community support agencies to support tenants across the various personal and social domains will reflect in large part their own philosophy, approach and network capital.

In the case of the Ruah tenancy support services, the approach taken has been to address holistically the needs of tenants by developing both tenancy support plans and personal support plans for tenants. The latter requires an assessment of the underlying issues contributing to the tenancy becoming vulnerable, including problematic drug and alcohol use, mental illness, social isolation and marginalisation, unemployment, lack of community and social supports, low income and a poor financial position, domestic violence and family breakdown. In making such assessments, the Ruah tenancy support service case workers draw on the established methods of assessment and linkages built up in the organisation in the area of community mental health, drug and alcohol-related services and homelessness services. As such, programs which are established on a largely independent basis display elements at the ground level of partnership and collaboration which starts in the first instance with a plan to assist clients with respect to a broad range of personal needs, an ability to assess the relevant needs of clients and to connect clients to various services because of established network linkages.

The Ruah Intensive Program is funded by WA Department of Health (Mental Health WA) with a small level of additional funding provided by the Disabilities Services Commission. It provides support to those with serious and persistent mental illness and/or HIV/AIDS. The Ruah Intensive Program targets those experiencing homelessness or who move location frequently, with substance abuse issues, and with tenuous or no links to relevant mental health services, and difficulty accessing or working with support systems. It is a professional case management service and receives referrals from hospitals, community services, medical practitioners, and mental health and other specialist services. Support is offered on a metropolitan area-wide basis and not provided on a time-limited basis. It may last for several months or for several years, depending on the client's needs and situation.

Under the program, case managers provide psychosocial support under a holistic model with the aim of achieving stable accommodation, stable mental health and improved overall wellbeing of the client. Case managers provide support in close

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<sup>9</sup> See Flatau et al. (2009) for a review of these services.

contact and consultation, including weekly, monthly and bi-monthly meetings with a range of health agencies, including Royal Perth, Fremantle and Graylands Hospitals, Mental Health WA and relevant Community Disease and Hepatitis C Committees.

The Ruah Intensive Program focuses on maintaining a client's contact with relevant mental health, drug and alcohol services and supporting individuals to live independently, learn living skills and maintain security of tenure. In that respect, case managers work closely with tenant support workers.

The Ruah Specialist Support Program is a dual diagnosis program funded by the Australian Government Department for Health and Ageing. It provides intensive one-to-one support to assist homeless people or those at risk of homelessness with problematic drug use and mental health issues or intellectual disability, to maintain their links with mental health and substance use treatment services by assisting clients to attend appointments. The service complements clinical services in providing community-based care to clients in respect of developing and supporting skills across various dimensions, including personal skills, interpersonal skills, life skills and community living skills. It is an assertive outreach service visiting people in their own living environments, including on the streets, in crisis accommodation services and in flats and hostels.

The Ruah Specialist Support Program is located with two other services under the banner of Ruah Outreach Support. Two of the three services are tenancy support services but a significant number of the relevant clients have high needs and histories of homelessness. The three services are managed by one manager. A primary objective of the services is to locate the client in stable housing, alongside mental health recovery, and reduction in drug and alcohol related harm.

#### *4.1.4 HomeGround Services*

HomeGround Services works in the areas of homelessness, housing, community development and social justice advocacy. It is an independent, not-for-profit and secular organisation formed in December 2002 from the merger of Argyle Housing Service and Outreach Victoria. Outreach Victoria was established in 1990 as George Street Outreach Services in Melbourne's inner north. The organisation was created by a partnership between key agencies concerned about a gap in the existing service system for people with complex needs who were chronically homeless. Argyle Housing Service was established in 1997 to assist homeless people in Melbourne's inner south and from 2002 in the City of Yarra. The two organisations were based on different sides of the Yarra River and provided complementary services; intensive housing-focused outreach in the inner north and crisis and transitional housing assistance in the inner south.

As with Ruah, HomeGround runs a large range of homelessness early intervention, support and outreach services funded under a number of different programs. It has a focus on providing integrated high-quality housing-focused services across the entire inner urban region.

We focused on a relatively small set of different types of services administered by HomeGround in this stage of the study. For the purposes of the Positioning Paper we have focused on the following four services:

- ConnectED.
- The Outreach Service.
- Court Integrated Services Program.
- Social Housing and Advocacy Support Program (SHASP).

ConnectED is an integrated health, housing and social care program delivering support to those who make regular, multiple and preventable presentations to Prince Alfred Hospital's Emergency Department (ED) and inpatient services in Melbourne. Invariably clients are homeless and have a range of complex needs.

A large number of partners are engaged in the program, including the Alfred Hospital ED, Royal District Nursing Service Homeless Persons Program, Port Phillip Community Group, Bentleigh Bayside Community Health Service, Inner South Community Health Service and Prahran Mission, together with HomeGround Services which is the key provider of housing-related support. In addition, the program has strong links with mental health services in community and GP clinics and service agreements with various providers.

Referral is from the ED and based on presentation at ED three times or more within a 12-month period. Support is for 12 months duration but this is flexible. The immediate aim of the program is to reduce presentations at ED with a longer-term aim of stabilising clients in terms of their needs.

The Outreach Service is funded out of four separate funding streams. The service is designed to provide support to homeless people with complex needs (defined as psychiatric disability, acquired brain injury or alcohol-related brain injury, frail/aged, or not accessing/excluded from other services) within the City of Yarra. The aim of the program is to provide the range of supports necessary to transition homeless people into long-term accommodation and to provide support once housed until the tenancy is stable.

The model behind the Outreach Service is based on continuum of support combined with developing and working on partnerships across different service systems. HomeGround works with the Yarra Alliance of Clinical Mental Health and Psychiatric Disability Rehabilitation and Support Services in providing support to those with complex needs. Monthly meetings are held with the City of Yarra and weekly meetings and community BBQs are held with local services. The Outreach Service works with similar case management tools, strategies and goal plans as other services in the Yarra Alliance and collaborates with other case workers from other services with the same client.

The Justice Housing Support Program (JSHP) provides transitional support to 55 homeless individuals in contact with the Justice system. It receives these referrals from the Court Integrated Support Programs (CISP), Credit-Bail Program and the Neighbourhood Justice Centre, all parts of the Department of Justice. Ten of these houses, managed by Womens Housing Ltd, are allocated to Indigenous women, single women and women with families via the Better Pathways Program.

Clients typically present with a long history of homelessness or insecure housing, are eligible for segment 1 classification (3–4 moves in 2 years), and have multiple/complex needs. Practice protocols are in place with the Department of Justice and other Transitional Housing Providers supported through quarterly meetings with the Department of Justice, a representative from the Office of Housing and other support services.

The clients are case-managed by the HomeGround JHSP worker, requiring referrals to external support agencies for the client's psychosocial needs, including mental health and drug and alcohol issues. There are no formal partnership arrangements with the external agencies. The HomeGround case worker will continue to case manage the client during their transitional tenancy, usually for a period of between 18 months to 4 years, with a view to accommodate the client in long-term housing. Some

follow up support is also provided to try to ensure the viability of the long-term tenancy.

The Social Housing and Advocacy Support Program (SHASP) is funded by the Department of Human Services, Office of Housing program, with HomeGround as the largest provider of SHASP in Victoria. The program operates under statewide guidelines with regional meetings every 6 weeks with Department of Human Services and other regional providers.

By intervening in at-risk tenancies and undertaking some short-term case-management of the client, the program seeks to prevent the client from becoming homeless. Referrals are received from the Office of Housing or clients can self-refer. There are no specific target groups but clients must be over 18 years of age.

Under the program, the client is housed in public housing with the Office of Housing as the landlord and the SHASP agency advocating on behalf of the client. The client will be case-managed under the SHASP for up to 4 years with the aim to sustain long-term housing.

#### *4.1.5 Preliminary findings and themes*

It is important to recognise that specialist homelessness agencies and mainstream agencies, which have a special interest in working with homeless people in Australia, are generally non-government organisations which typically operate via service agreements with government funders. The funders in question are generally a single state/territory or Australian Government department, typically a community services or housing department or in some cases, health and corrective services.

In light of the institutional and governance framework surrounding the provision of support for homelessness people, the extent, depth and form of integration in relation to the work of a specific homelessness service will reflect two main forces. First, the specifications of the program under which the service is funded and whether the program has a specific aim of developing integrated care arrangements. Second, the extent to which homelessness services themselves have developed linkages with services in the mental health and drug and alcohol sector, their general philosophical approach to partnerships and integration, and any additional underlying drivers of and barriers to integration.

Our brief review of services provided by the three homelessness agencies indicated that the three agencies are engaged in a number of services, which have been established on an ACT team-based model involving homelessness and personal support services together with mental health and drug and alcohol support services. In other cases, the agencies are providing services to homeless people and those at risk of homelessness which have been funded without an explicit integrated care focus. Even here, the agencies in question are moving beyond the specific housing and homelessness needs of clients and focusing on a broader range of personal and social support needs. However, this may not always involve a coordinated service delivery with mental health and drug and alcohol services.

#### *Entrenchment and visibility of services*

The three agencies provide a mixture of long-standing services and more recent services or projects. The longer-term projects were obviously at a point where patterns of integration between services were already established, while the shorter-term projects were at a much more embryonic stage, often involving high-profile projects with relatively significant funding and public scrutiny attached. Projects involving a direct collaboration between services in the health and

homelessness/housing domains require an intensive process of inter-service meetings and coordination to ensure their workability.

### *Differing philosophical approaches*

While an overall goal for the best possible outcomes for the client was espoused by each service, differing philosophical approaches between services in collaboration may hinder integration. For example, there are differing frameworks that guide policies and practices both between and within the health and housing sectors. For example, clients with drug and alcohol problems also often have mental health problems. However, the approach of mental health agencies is often somewhat different from drug and alcohol services, with the former more likely to engage in assertive outreach practices, while that of drug and alcohol services is focused on the philosophy that a client must be at a stage where they are ready and willing to seek behaviour change. In order to be of most benefit to the client, these issues need resolution at the service level.

While a view is held that independent living is the goal for many, for those clients who are long-term homeless and have mental health problems, a number of issues must be accepted by each of the services. For example, it must be acknowledged that relapse to substance use is a matter of course for those with drug and alcohol problems, rather than a view that this is an aberrant behaviour that requires punitive measures. In the provision of housing to this group, relapse should be expected and a cross-disciplinary policy developed to address this issue to ensure a seamless service is provided for all needs, and that clients do not leave programs prematurely.

### *The need for advocacy*

Respondents were also clear that for clients who are homeless, and especially those who are long-term homeless, there is a significant advocacy role that goes beyond simple service provision, to incorporate social inclusion through mechanisms such as developing numeracy/literacy, daily living skills and social supports. Unfortunately, individuals who are homeless and who also have mental health/drug and alcohol problems are often stigmatised by mainstream services who limit their access to these services, therefore perpetuating the problem.

### *Mechanisms of service delivery*

A number of mechanisms were noted to achieve service-level integration. In the case of a traditional tenancy support program, some degree of integration was developed out of a service focus on personal support plans and agency-based networks with mental health and drug and alcohol services. In another case, service-level integration was achieved as a result of the co-location of health and housing supports. Brokerage for requisite services was another model that was used. Additionally, formal mechanisms such as memoranda of understanding incorporating release of information agreements were deemed important to enable full and frank discussions about client goals and strategies. The commitment and support of senior management, the Chief Executive Officer and Board of Management in particular, was noted as critical.

#### *4.1.6 Case studies: stage 2*

In this present Positioning Paper, we have provided preliminary case study evidence in relation to three homelessness agencies and the extent to which these agencies in selected services, which support homeless people, are integrated with mental health and drug and alcohol services. The analysis at this stage is purely of a descriptive nature.

In the second stage of the study, we will return to the agencies in question and examine further the nature of integration in those services in light of the knowledge developed. Detailed discussion of the extent and dimensions of integration and perceptions of the effectiveness of integration strategies in the selected services for the three agencies will be presented in the Final Report.

In the second stage of the study, we will also extend our case study research to the following:

- Additional agencies providing specialist homelessness services, particularly in the same programs as those examined with respect to Ruah Community Services, HomeGround and The Haymarket Foundation.
- Undertake case studies with a small number of mental health and drug and alcohol specialist services and to several initiatives established recently in a number of jurisdictions involving multi-disciplinary teams to support rough sleepers transition from the street to the home.

## **4.2 Australian Homelessness, Mental Health and Drug and Alcohol Services Integration Survey**

The second stage of the study involves the implementation of the *Australian Homelessness, Mental Health and Drug and Alcohol Services Integration Survey*.

The purpose of the *Australian Homelessness, Mental Health and Drug and Alcohol Services Integration Survey* is to gather information on the extent to which services providing support to homeless people with mental health and/or drug and alcohol needs are integrated and how clients perceive the level of integration with respect to services delivered to them. We shall examine both vertical and horizontal perspectives of integration. In other words, we shall examine whether the needs of clients across a range of domains, including homelessness, housing and health domains, are being met by a single agency (or organisation) or across different agencies and, if the latter, the degree of coordination and integration involved. Furthermore, the *Survey* seeks to understand the nature, structure and ingredients of integration and the perceived benefits (and costs) of integration.

Findings from the *Australian Homelessness, Mental Health and Drug and Alcohol Services Integration Survey* will be used to understand the extent to which specialist homelessness, mental health and drug and alcohol services (and other mainstream support agencies) work together in an integrated manner to deliver a range of services to clients. It will also provide evidence on the degree to which integration is influenced by program parameters (the framework of service provision funded by governments) on the one hand and agency-specific factors on the other hand. The *Australian Homelessness, Mental Health and Drug and Alcohol Services Integration Survey* will also include a client section eliciting information from clients as to their experiences of service provision.

As noted previously, a critical determinant of the degree to which an individual service is working within an integrated service delivery approach is given by the program in which a service is located and its particular focus on integration. Some programs have traditionally operated on the basis of a narrow set of client objectives, with funding and management of the program based solely around a single funding department. Service delivery is likely to be less integrated than might otherwise be as a consequence. In other cases, programs are established on the basis of coordinated service delivery across sectors. This has often involved a number of separate departments engaged in the funding and management of the program. Not surprisingly, services within such programs will be more likely to display such

coordination than other services. Nevertheless, there are both agency-specific and service-specific factors at work in influencing the extent, depth and form of integration and it is important to reflect the various roles of service, agency and program in terms of the final extent and form of integration of services.

Respondents to the *Australian Homelessness, Mental Health and Drug and Alcohol Services Integration Survey* are specialist homelessness services, and mental health and drug and alcohol services whose client base includes a reasonable proportion of persons who are homeless or at risk of homelessness.

The *Australian Homelessness, Mental Health and Drug and Alcohol Services Integration Survey* has four parts.

Part A elicits information about the auspicing agency within which the service operates. This component of the *survey* includes questions on organisational type (e.g. non-government organisation, government agency) and the types of services provided by the agency. More than one service from a given agency may be selected in the sample frame for the *survey*.

Part B asks questions in relation to the program under which the respondent service is funded. In particular, information is sought on sources of funding for the program, target client groups, the aims of the program and whether some form of integration is built into program specifications in terms of the types of services participating in the program and the nature of that participation.

In the case where services are engaged in formal partnership arrangements with other services in outside agencies, Weiss' (2002) Partnership Self-Assessment tool, covering participants' perceptions of the quality and efficacy of the partnership and the benefits and costs of participation, is administered.

Part C of the *Australian Homelessness, Mental Health and Drug and Alcohol Services Integration Survey* focuses on the respondent service itself. This component of the *survey* is broken down into a number of different sections.

In section 1, information is sought on the objectives of the service, target client groups, the needs of clients, and assistance provided by the service to clients. Questions are included on the extent to which the various needs of clients are met by the service itself and other services in the auspicing agency. If the needs of clients across distinctly different domains are met by the agency in question, then evidence of vertical integration is apparent. If an agency meets all the needs of clients across all relevant domains through assistance provided by different services of the agency, then full integration is evident.

Section 1 examines the issue of the actual and ideal depth of horizontal service integration. By horizontal service integration, we mean integration between services located in different agencies performing the same or different functions. The depth of horizontal service integration is operationalised using Gina Browne's Integration of Human Services Measure (Browne et al. 2004). The Integration of Human Services Measure involves assessments made by individual services of their involvement with other identified services in a specific geographical or targeted program catchment area along a continuum of involvement, involving the following elements: Non-awareness = 0; Awareness = 1; Communication = 2; Coordination = 3; Collaboration = 4; and Full Integration = 5. Each respondent service makes an assessment of the extent to which it is involved with other services listed and the extent to which it should be involved with other identified services.

The integration of human services measure concludes with three open-ended questions.

- What helps you when collaborating with services in other agencies? Why?
- What hinders you from collaborating with services in other agencies? Why?
- What other services should be part of the identified list?

Section 2 examines the nature, practices and ingredients of horizontal service integration. There are a myriad of ways services may engage with others, including: funding, planning/budgeting, governance, case conferencing/case review; joint assessment protocols; cross-agency client information and referral protocols; consultation and liaison; co-location of services; sharing of transport; shared information systems; inter-agency meetings; common application processes; staff secondments; joint delivery processes; and staff recruitment. The *Survey* seeks to assess the extent to which particular services engage with others in these different ways. This section of the *Survey* incorporates Milward and Provan's (1998) Network Activities Measure.

Section 3 of Part C of the *Survey* ends with open-ended questions: how best can integrated service delivery work; the perceived impact of integration on client outcomes; intended and unintended consequences of integration; critical ingredients that enable good integrated care; and barriers to providing good integrated care.

Part D of the *Australian Homelessness, Mental Health and Drug and Alcohol Services Integration Survey* is a short client form. It includes a small number of background socio-demographic questions followed by a set of questions related to the needs of clients. Following Mares et al. (2008), we ask clients whether they received support in various domains of documented need and using a five-item subjective scale, measure clients' perceptions of the extent to which their service providers are working together in a coordinated manner, or provided fragmented service delivery.

The *Survey* will be administered in two inner-city and outer western areas of both Sydney and Melbourne and inner and south-east Perth to specialist homelessness agencies, and mental health and drug and alcohol agencies which provide services to clients who may be expected to be homeless or at risk of homelessness. All in-scope services in the identified catchment areas will be supplied with the survey. Five randomly selected clients from each service which participates in the *Survey* will be asked to complete the client form. Services and clients will be reimbursed up to a set dollar limit for participating in the *Australian Homelessness, Mental Health and Drug and Alcohol Services Integration Survey*.

## 5 CONCLUSION

Homeless people have disproportionately high levels of poor mental health leading to increased disability in many walks of life. Our human services delivery system is often too fragmented, failing to address particular needs and providing conflicting advice and treatment to clients with such needs. Clients may not always be referred to an appropriate service for support, resulting in gaps in service delivery.

One response to such outcomes is to provide for a more coordinated or integrated response to service delivery. The call for a greater integration of homelessness and health service delivery is evident in both the Australian Government's White Paper on homelessness *The road home* and subsequent NPAH as well, but to a lesser extent in the *Fourth National Mental Health Plan*.

While an extensive US and UK literature has developed in this area, there exist no detailed studies in Australia on the extent, depth and form of integration involving the delivery of homelessness, mental health and drug and alcohol services. This study aims to increase our understanding of the ways in which homelessness, mental health and drug and alcohol services are presently coordinated in Australia and shed some light on the effectiveness of various integrated service delivery responses.

The Positioning Paper sets the scene for the study by reviewing the relevant literature and surveying the policy environment and providing elements of a typology and measurement framework of homelessness service integration. It has also provided indicative case study evidence detailing how new programs and services are being developed which bring together homelessness, mental health and drug and alcohol services to support homeless people, particularly the chronically homeless.

The Final Report will provide detailed findings from the *Australian Homelessness and Mental Health Integration Survey* on the extent and form of integrated service delivery across the homelessness and health domains in Australia and also provide extended case studies on homelessness service integration in Australia.

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