Final Report

Linkages between housing and support – what is important from the perspective of people living with a mental illness

authored by

Anne O'Brien
Susan Inglis
Tania Herbert
Astrid Reynolds

Australian Housing and Urban Research Institute

Swinburne/Monash Research Centre
Ecumenical Housing Inc.

September 2002

AHURI Final Report No. 25

ISSN: 1834-7223
ISBN: 1 877005 87 8

AHURi
Australian Housing and Urban Research Institute

ACKNOWLEDGEMENTS

This material was produced with funding from the Commonwealth of Australia and the Australian States and Territories. AHURI gratefully acknowledges the financial and other support it has received from the Commonwealth, State and Territory governments, without which this work would not have been possible.

Many people have contributed to this project and the project team would like to particularly acknowledge the contribution of the following:

- the 50 people who agreed to participate in the interviews and so willingly share their experiences;
- the service providers who assisted to identify and engage the study participants and who generously contributed their time to support the project (see Appendix A).
- the Reference Group members who provided important advice and guidance to the project (see Appendix B).

This material was produced with funding from the Commonwealth of Australia and the Australian States and Territories. AHURI gratefully acknowledges the financial and other support it has received from the Commonwealth, State and Territory governments, without which this work would not have been possible.

AHURI FINAL REPORT SERIES

AHURI Final Reports is a refereed series presenting the results of original research to a diverse readership of policy makers, researchers and practitioners.

TABLE OF CONTENTS

ABBREVIATIONS

ABI	Acquired Brain Injury
AHURI	Australian Housing and Urban Research Institute
CAT	Crisis Assessment and Treatment Service (Mental Health, DHS)
CCU	Community Care Unit (Mental Health, DHS)
CRU	Community Residential Unit
DHS	Department of Human Services (Victoria)
GP	General Practitioner
HASP	Housing and Support Program (Victorian Program)
ID	Intellectual Disability
MST	Mobile Support and Treatment Service (Mental Health, DHS)
PCP	Primary Care Partnerships
PDSS	Psychiatric Disability Support Services (Mental Health, DHS)
PRBS	Private Rental Brokerage Service
RTA	Residential Tenancies Act
SRS	Supported Residential Service

TERMINOLOGY AND KEY CONCEPTS

Throughout this paper a number of terms that need explanation are used, as follows:

Mental illness and psychiatric disability

The terms 'mental illness' and 'psychiatric disability' are both used in this paper. In common usage, these two terms are often used interchangeably, however they are different. Mental illness is often used to refer to a broad group of conditions that may or may not require support. Where the effect of the illness limits a person from participating and functioning independently the term *psychiatric disability* may be used. (The characteristics of mental illness and psychiatric disability are more fully discussed in section 2.2 of the report.) For the purpose of this study, we interviewed people who have experienced psychiatric disability and therefore required support.

Housing tenures

Frequent references are made to social housing throughout this report. Social housing is a generic term for non-profit housing, owned and managed for the primary purpose of meeting social objectives such as affordable rents, responsible management and security of tenure. It is a term that encompasses both public housing (government owned and managed housing) and community housing (community owned and managed housing).

Housing attributes

These terms are more fully explored in Chapter 3. Briefly, the concept of housing is not restricted to the condition or feeling about the physical place in which one lives, but encompasses a wider range of variables about the context in which one lives, including the area, suburb, street, neighbours; access to facilities, public transport, family and friends; feelings of safety, level of independence, degree of positive social interaction possible; affordability, security of tenure and the landlord's approach.

'Stable' housing

The term 'stable' housing commonly refers to living in the same dwelling for a particular period of time. However, we know that people often relocate for a range of reasons. In this paper, reference to a person living in 'stable housing' indicates a situation where the individual has maintained control (i.e. has made informed decisions) about their housing. People in stable housing may choose to move but still stay in control of their housing situation. For some people the consequences of their mental illness can jeopardise their housing - for example not paying rent, experiencing difficulty with dealing with neighbours, maintaining the property or managing one's physical health. Those who are living in stable housing are managing risks so they can successfully stay housed.

Support

Support is referred to as a person or service that provides assistance or the kind of assistance itself. Support includes a range of formally provided services as well as informal support. Informal support includes family, friends and neighbours, whereas formal support may be a government or non-government service offered, such as a clinical case manager, psychiatrist, GP; health service, advocacy service, PDSS, emergency relief agency or employment agency. Supports may include treatment of mental illness or health problems, provision of recreational or social opportunities; assistance with skill building, development of personal interests/goals, emotional support, transport, financial support and support to find employment or legal support.

The people we interviewed were all clients of a Psychiatric Disability Support Service (PDSS). PDSSs provide a range of supports to those living with a psychiatric disability. Support is provided via a psychosocial rehabilitation model whereby clients are empowered to make their own decisions and develop daily living skills, improve social interaction, participate in community life and build self-esteem. Such support is available in group settings in drop-in centres, in structured programs and recreational opportunities, as well as in one-on-one relationships between a key support worker and a client.

Linkages

Linkages encompass all the ways that programs, services, sectors, governments and their departments' work together to achieve coordinated responses for individuals. In this study linkages takes a range of forms, including communication between a GP and a psychiatrist about a client, the links between clinical services and a PDSS, links between Public Trustees and service providers to support an individual to make decisions about managing their finances, links between PDSS and Office of Housing to access housing or links between the Office of Housing and Centrelink for direct debit of rental.

EXECUTIVE SUMMARY

Introduction

This paper is the final report of Australian Housing and Urban Research Institute project - *Linkages between housing and support – what is important from the perspective of people with a mental illness*. The overall aim of this project was to understand what people with a mental illness who have experienced psychiatric disability consider are the key factors that support them to maintain stable housing. This project has built on and extended the work of an earlier AHURI project - *Effective Program Linkages – an examination of current knowledge with a particular emphasis on people with a mental illness* (Reynolds, Inglis & O'Brien 2001) http://www.ahuri.edu.au/pubs/finalreports/final_effectiveproglinks.pdf.

Project methodology

The core feature of the project's methodology consisted of interviews with 50 people aged between 25 and 50 who have experienced psychiatric disability, have secured and maintained appropriate rental housing, had support from a Psychiatric Disability Support Service (PDSS) and have not been in the Victorian Department of Human Services' Housing and Support Program. These interviews were designed, conducted and analysed by the researchers involved in this study who have a range of skills that enabled the difficult concepts of housing and support to be carefully explored and reported on for this group of people with complex needs.

The research questions this project sought to answer from the perspective of these people included:

- What is important to people to access and maintain their housing?
- What is it that jeopardises their ability to access and maintain housing?

Interviews were face-to-face, of approximately one-hour's duration, with a mixture of open-ended and semi-structured questions asked.

Participants were obtained through six PDSSs located in different geographic areas in Victoria covering regional, metropolitan and inner Melbourne. This ensured a sufficient sample size and aimed to reflect the diversity in types of rental housing, access to and approaches of different support services, and level of collaboration and cooperation between services in different areas.

In order to have a context for understanding the issues identified by consumers, the project also sought the views of a small number of support and housing providers in the areas from which interviewees were drawn.

To maximise participation in the study the interview questions and process of engaging participants was carefully designed to be non-threatening and a positive experience for the people with a mental illness interviewed. Mental health services were used as key contacts to identify clients who met the criteria and explain the project to them. We are pleased to report that we were very successful in maximising participation, with only a very small number of those identified as eligible unable or unwilling to participate in the study. In addition, positive feedback about the experience of participating in the study was received from participants via the key agencies.

In order to address the key research questions the project also reviewed existing Australian and overseas literature on the views and preferences of people with a mental illness about their housing and support. In addition, discussions were also held with a small number of housing and support providers and key departmental officers.

This project was also designed to complement the recent review of the Victorian Housing and Support Program (HASP) in which provision of public housing and PDSS is formally co-ordinated. Hence some comparisons have been made with this client group with similar characteristics who are in housing linked with support.

Summary of key findings

Attributes of individuals interviewed: For this particular group, it was evident that key supports were vital – from a stable income, to appropriate treatment, to psycho-social rehabilitation. The importance of a specialist key worker or case manager and the supportive role of family and friends were central to these individuals. Such supports helped people to develop a readiness to live independently. Support that was tailored to particular individual needs and aspirations and to the way in which the mental illness manifested was also important. A large proportion received considerable help to access their current housing which appears to be critical in two ways: 1) support was available to engage participants and 2) participants were willing to be engaged. Access to housing that met their needs was also important.

Housing appropriateness and housing stability: Participants confirmed that housing attributes do influence housing stability and mental wellbeing. To be appropriate housing needs to be "acceptable" to the person and even though it may not need to meet all their preferences, it must not have features that make it difficult to manage any disabilities associated with the mental illness.

Accessing housing and staying housed: Two-thirds of the participants received substantial assistance with accessing their current housing and the most important sources of support identified were the key PDSS worker, followed by clinical supports. All but a handful of participants mentioned either one or other of these key psychiatric support services. In addition, more than half identified informal sources of support amongst their most important support. For most participants a combination of elements was important in being able to stay housed, including the house itself, the formal and/or informal supports, their own abilities and resolve, having meaningful goals or regular interests, and strategies for managing on a limited income. The information from participants about the impact their housing has had on them strongly reinforces that stable housing makes a key contribution to wellbeing, often building the foundation for managing their psychiatric disability and consequently their ability to cope with day-to-day life.

Risks to maintaining housing stability: Most participants identified things that could jeopardise their housing, with the most common being neighbours creating problems, high cost of rental and difficulty managing finances. There was often no clear-cut division between what the participant could be held accountable for and the risks arising from what others might do. That is, there are some things that are within a person’s power to manage, with the support of others, and other factors that are outside their control. This might include living in an area with high levels of criminal activity and not having an alternative area to transfer to, having to manage on a very limited income or the existence and consequent effect of discrimination.

Risk management strategies: A key to housing stability is accurate identification of risks to maintaining housing and the development of strategies to manage those risks. Participants had a number of strategies in place to manage risks, some of which were strategies where the person was in control of the situation and had the ability and/or awareness to manage themselves, others involved engaging help and others included avoidance behaviours. These strategies covered aspects such as: paying rent and bills, managing difficulty with neighbours, issues with the landlord, issues with house maintenance, friends that can get one into trouble, problems with medications, periods of being unwell, feelings of loneliness, substance abuse, not eating and dissatisfaction with housing.

Comparisons with findings from previous AHURI study: The foundations for provision of effective support to achieve housing stability identified in the earlier study were confirmed by this study. These included: the need to understand the impact a psychiatric disability can have on achieving housing stability, recognition of the importance of addressing individual housing needs and preferences and developing effective service responses. There were a number of new attributes of service providers identified as important. These included the ability to:

- balance risks to housing with clients' rights to make decisions
- recognise what motivates an individual and gives meaning to their life within the context of their other day-to-day support needs; *and*
- engage the individual to make informed decisions whilst also managing potential housing risks.

Feedback from consumers suggests that the service system has worked well to help them find an appropriate place to live and supports to stay living independently, in many cases with an enormous investment made over many years to achieve housing stability. The criticality of providing highly focussed support at the outset to ensure individuals' access housing that will meet their needs was reinforced.

Victorian Housing and Support Program (HASP) Review comparisons: There were clear similarities between both populations to questions about what they liked and disliked about where they lived. In both populations the strongest theme was liking being located close to shops and public transport, and disliking being located too far from shops and public transport. Participants from both studies expressed the important difference that stable and appropriate housing can make to one's life. In both studies the most frequent response to questions about differences or improvements made by their current housing was that of increased independence, as well as being happier, feeling more stable, secure, having improved social networks and improved mental health.

Participants in HASP properties were more likely to be happy with their housing and more likely to plan to stay, whereas a number of participants of this AHURI study were unsure, didn't know or felt they would like to stay in their current housing, however the lack of the security of tenure meant that this was unpredictable for them. HASP participants were considerably more likely to prefer not to share. Both studies had a number of participants who talked about the particular conditions under which they would share, with the strongest condition under which people would be prepared to share was with family members.

Policy development implications

Housing supply and support, appropriate management models, recognition of the skilled approaches required to assist a person develop the readiness to live independently and risk management strategies are all required to improve housing outcomes for people with complex needs.

There are four key elements that, in combination, appear to contribute to making it work for an individual and these are:

(1) **They live in housing that they find acceptable**, and that does not make it very hard or impossible to manage particular disabilities or manifestations arising from their mental illness.

(2) They have **support, medication and/or treatments that they trust, accept and find helpful**.

(3) They demonstrate **a willingness and readiness** to tackle, with appropriate support, the individual daily challenges and difficulties living independently may present.

(4) Major issues that may place their housing at **risk have been identified and addressed**.

Addressing housing supply and management issues

Suggestions for addressing housing supply and management issues offered are:

- Increase housing allocated to programs such as HASP
- Review public housing stock configuration to increase the availability of housing suitable for people with psychiatric disabilities
- Acknowledge and accommodate the housing risks for people with complex care needs in housing allocation decisions
- Diversify management and supply of social housing

- Create a ‘Private Rental Brokerage Service’ with expertise to support people with complex needs
- Public housing officers to assist clients unable to access appropriate public housing stock to secure private rental
- More actively ensure the availability of direct debit for private rental tenants who are on government pensions
- Reward or provide incentives to families who purchase properties to effectively dedicate to their family members with complex needs
- Employ public housing officers to assist tenants with complex needs
- Provide private rental assistance that adequately enables people with complex needs to live in locations and/or specific dwellings to maximise their ability to stay housed

Supports for those with complex needs

Suggestions are:

- Availability and access to key specialist and other support services for people with complex needs.
- A checklist of effective attributes of key formal support is outlined, which could be used for selection, training and development, and reward and recognition of key supports. This includes support workers who: understand psychiatric disability, each individual person and what gives them meaning; are skilled at engaging the person with complex needs and are prepared to start where the individual is at; understand the range of factors that may jeopardise a person’s housing and actively work with the person to address these; manage the balance between the person’s right to make decisions to do things that may place some aspect of their life at risk, with judgements about their ability to effectively make informed decisions; and are accessible, innovative and flexible.
- Effective recognition and reward systems to ensure consistency of staff are suggested, along with the need to recognise and support informal supports that appear to be critical for some individuals in assisting them to find affordable and appropriate housing and staying house.

Assistance to achieve independence

- The role of **practical skills development, material aid and emotional support** in assisting individuals to achieve independence was highlighted as important, particularly to accommodate fluctuating periods of disability that can set individuals back. The link between important support and sustainable housing is not always found in tangible assistance with housing matters, but in the help that reinforces and assists people to cope with the challenges of daily living and often gradually increases their ability to live independently.

Housing risk management

Within a housing environment where supply is low, the importance of sustaining a person's housing increases as the availability of suitable housing decreases. Risk management can include creating linkages between supports to prevent crises, providing ongoing monitoring, even when individuals are deemed to be doing well, and adopting a simple risk management approach for individuals with complex needs.

- A model for integrating risk management into the service system is proposed, which includes government articulating management of housing risk for people with complex needs as a key objective, developing a policy and procedure, including a framework of housing risk, and funding organizations to take responsibility for housing risk management.
- In addition, a simple Housing Risk Identification and Management Tool is outlined which is a proactive measure for managing an individual’s housing risks. This proposes the collection of key information about a person’s current housing attributes; their level of satisfaction and the existence of things that might make it difficult for a person to stay housed; and the level of assistance a person requires with daily living activities, so that those factors that may jeopardise a person maintaining their housing are understood, analysed for the potential level of risk, and the strategies planned to manage to those risks.

Conclusion

Many people with a psychiatric disability are ready or able to live independently, yet some are homeless or living in temporary or inadequate housing with inadequate support. The number of people with a psychiatric disability who can be effectively supported to maintain stability in their housing may well be limited more by the supply of both support and housing, rather than the limitations and challenges presented by their illness and resultant disabilities. With access to adequate support and appropriate housing, ongoing risk management strategies and assistance to deal with a debilitating illness that can jeopardise maintaining housing, these individuals proved they could live independently, which in turn has improved their enjoyment of life.

1. INTRODUCTION

For vulnerable groups of people and those with complex needs, securing and maintaining suitable housing often requires effective links between housing and support services. This AHURI project was developed to add to the body of knowledge about what is required to support people with complex needs to successfully access and maintain appropriate housing. The focus of the project was on people with a mental illness who experience psychiatric disability. Effective linkages between housing and support can be particularly important for these individuals who are known to confront specific difficulties with finding appropriate housing and staying housed.

The first chapter of the report outlines the project aims, scope, key concepts and terminology used in this report. It also describes the project methodology and outlines the structure and contents of the remainder of the report.

1.1 Project focus and aims

There is a strong interest to understand what people who have experienced a psychiatric disability identify as most helpful and important in supporting them to stay housed. This project deliberately complements earlier (Robson 1995) and current research being undertaken about the Victorian Housing and Support Program (HASP) where provision of public housing and PDSS occur in a formally planned and coordinated way. The as yet unpublished HASP review undertaken by the DHS Mental Health Branch was designed to uncover the perspectives of people in that program, whilst this project set out to analyse the perspectives of people with similar characteristics in public or private rental housing, without formally linked support.

The overall aim of this project was to understand what people with a mental illness who have experienced psychiatric disability consider are the key factors that support them to maintain stable housing. The more specific project aims were:

- To develop an understanding of the views of people who have experienced psychiatric disability on:
    - The relationship between where they live, housing-related services and their success in staying housed
    - What they consider are the services and service approaches that assist them to maintain long-term housing
    - What they identify as the factors that jeopardise their ability to maintain stable housing
    - What is important about how their tenancy arrangements and support services work together to keep them housed and living independently
- To identify the implications of consumer perspectives for the provision of effective and coordinated housing and support which works to sustain tenancies in a way that is useful beyond just the Victorian context.
- To identify any similarities or differences between the HASP clients, based on the research undertaken by DHS, and those living in other forms of private, public or community housing; and comment on the significance of these findings.

The project explored the following three key areas from the perspective of people living with a mental illness:

- Aspects of the housing itself and housing management issues
- The nature of the support services participants receive and how these services have helped them to access housing and stay housed, and
- Issues associated with coordination between housing and support services and whether and how such coordination helps people to access housing and stay housed.

This project has built on and extended the work of an earlier AHURI project - *Effective Program Linkages – an examination of current knowledge with a particular emphasis on people with a mental illness* (Reynolds, Inglis & O'Brien 2001). The findings from this earlier AHURI project have been assessed against the findings of this review to see how closely the perspectives of service providers, government officers and previous research align with the views of the individuals interviewed. The final report from the earlier project can be found on the AHURI website: http://www.ahuri.edu.au/pubs/finalreports/final_effectiveproglinks.pdf).

While the earlier project sought the views of those involved with program development and service delivery, the views and experience of people living with a mental illness were not sought, thus leaving a significant gap in our understanding of the issues of program linkages for these people. This project - *Linkages between housing and support – what is important from the perspective of people with a mental illness* - was developed to address this shortcoming.

People with a mental illness often lack a forum to say what is important to them. An underpinning belief of this study is that it is important to give a voice to those who might otherwise not have the opportunity to talk about their own needs and what works for them. This study has a phenomenological approach; that is, the researchers were committed to understanding the social phenomena of what it is like, from the perspective of the person with the mental illness, to live independently. This has yielded descriptive information that has then been interpreted in the light of other available information (Taylor & Bogdan 1997).

The project has targeted a particular population amongst people living with a mental illness, who are described as follows:

- Aged between 25 and 50
- Living with a mental illness and have experienced psychiatric disability
- Have secured and maintained rental housing appropriate to their needs
- Have recently or are currently accessing a Psychiatric Disability Support Service (PDSS)
- Have not accessed the formal Victorian Department of Human Services Housing and Support Program, however have the same or similar characteristics to people on the program, that is require or have required either:
    - Practical assistance with activities of daily living, e.g. shopping, cleaning, cooking, paying rent etc. or
    - Skill development with activities of daily living

  and who without assistance would not have been able to maintain their tenancy through periods of disability.

1.2 Structure and contents of report

Chapter 1: Introduction

The first chapter of the report outlines the aims and focus of the project. The definitions of mental illness and psychiatric disability are explained and the key concepts of housing, support and linkages. An overview of the study methodology is provided and the structure and contents of the report outlined.

Chapter 2: Context and background

This chapter discusses the background, policy context of relevance for the project, including a summary of the findings from the earlier AHURI study on *Effective Program Linkages* and a summary of the literature review from the Positioning Paper. Particular reference is made to understanding the impacts of mental illness and psychiatric disability on accessing and maintaining stable housing, the housing and support attributes that people with a mental illness identify as important to them, and examples of effective coordination between housing and support.

Chapter 3: Key concepts

Understanding the way the concepts of housing, support and linkages have been used in this project is critical. This chapter provides a detailed outline of housing and support attributes and what linkages between housing and support means.

Chapter 4: Characteristics of the 50 participants

An overview of the personal characteristics and housing circumstances of the 50 people interviewed is presented, with a summary table providing an overview of this information by housing tenure.

Chapter 5: Insights from interviews

This chapter provides the analysis and interpretation of the information gathered through the interview process. In terms of housing, participants experience in accessing housing, their current satisfaction with where they live, the things that make it hard to stay housed and how they have managed risks to staying housed are described. The kinds of support received and the linkages between these supports are outlined. Observations on the difference housing has made to participants' lives are presented, as well as the trade-offs that they have made along the way.

Chapter 6: Findings

The findings are summarised in terms of the participants' views on accessing and staying housed, the key attributes of individuals who have achieved stable housing, the appropriateness of current housing and risks to losing housing. Some practice dilemmas are outlined. Comparisons are made with the findings from the earlier AHURI study *Effective Program Linkages* and with the findings from the recent HASP review.

Chapter 7: Policy and practice implications

The final chapter offers some directions on the policy implications of the study and suggestions on how to improve practice.

2. CONTEXT AND BACKGROUND

The key task of this project was to enhance understanding of how to most effectively support people with complex needs, such as those experiencing psychiatric disabilities, to access housing and achieve stability in their housing and, through this, attain an acceptable quality of life. If housing and support approaches are not effective, people are placed at risk of becoming homeless and/or unwell. This project builds on an existing body of knowledge about factors that both support and hinder achievement of housing stability.

The purpose of this chapter is to outline key contextual and background information that has shaped and informed this research project. This provides a foundation for understanding why the issues examined through this project are important. The material draws on and summarises information from the findings of the earlier AHURI project on *Effective Program Linkages* (Reynolds, Inglis & O'Brien 2001) that are particularly relevant to this subsequent project and also summarises key aspects of an earlier project report – the Positioning Paper available at http://www.ahuri.edu.au/pubs/positioning/pp_mentalillness.pdf.

2.1 Policy context and relevance

Governments and the community are concerned about the issue of homelessness (Victorian Homelessness Strategy Ministerial Advisory Committee 2001, Commonwealth Advisory Committee on Homelessness 2001). We know that people who experience psychiatric disability are a significant proportion of the homeless population and often have complex issues and support needs (Victorian Homelessness Strategy Ministerial Advisory Committee 2001). There is, however, evidence to indicate that many people who experience psychiatric disability and have a history of homelessness can achieve stable housing despite their complex needs and the unpredictable and fluctuating nature of their disability (see for example Keck 1990, McDonald 1993, Center for Mental Health Services 1994, Commonwealth Advisory Committee on Homelessness 1998, Rosenheck & Morrisey 1998, Culhane, Eldridge, Rosenheck & Wilkins 2000). Future policy and program design needs to be informed by an understanding of what supports people who experience psychiatric disabilities and are in stable housing to access and sustain their housing.

It is now recognised that there is usually a need to provide ongoing support to persons with diverse and complex needs, such as the needs arising from experiencing psychiatric disability. Support is not only needed in the initial stage of securing affordable and appropriate housing but also to successfully stay housed. Research has shown that the opportunity to access appropriate housing which is tailored to meet individual needs and preferences and *linked with* the presence of ongoing support can result in increased security of tenure, reduction in hospitalisation rates, increased functioning, increased independence and autonomy, reduction in incarceration times, securing employment, improved quality of life and increased satisfaction with living conditions (see for example Keck 1990, McDonald 1993, Center for Mental Health Services 1994, Commonwealth Advisory Committee on Homelessness 1998, Rosenheck & Morrisey 1998, Culhane et al. 2000). There is emerging evidence to indicate that investment in effective housing and support approaches for people experiencing psychiatric disability can be cost effective for government through achievement of savings in other areas. (Culhane et al. 2001, Jarbrink, Hallam & Knapp, 2001).

A number of studies point out that the difficulties people with a mental illness face in achieving stable housing are largely a result of under-supply of appropriate, secure and affordable housing, inadequate housing systems and services, and the absence of ongoing and timely support to both treat their illness and assist people to live independently (Keys Young 1994, Carling 1995, National Youth Coalition for Housing 1999, Office of the Public Advocate 2001). This raises the difficult question of to what degree improvements can be made if the lack of adequate supply of appropriate housing and support plays such a significant role in creating the problem of homelessness in the first place. While the issue of inadequate supply of both housing and support needs to be tackled, so does the issue of developing cost effective ways of linking housing with support. There is a need to further develop our understanding of what is required to support people to achieve stability in their housing, beyond the supply question.

We know that despite inadequacies in the availability of both housing and support there is a group of people who experience psychiatric disability who are living independently in the community, having accessed and maintained suitable housing. We need to understand what is working for them from their perspective. Seeking this understanding was a prime focus of this study.

2.2 The potential impact of mental illness and psychiatric disability on housing stability

One of the key reasons that people with a mental illness can experience difficulties with accessing and maintaining stable housing relates to the way in which a mental illness can manifest in terms of behaviour and thought patterns. It is important to understand the reasons why a person may have difficulties, as well as to understand the types of approaches that can most assist them to access housing and achieving stable housing. The following provides a brief outline of key factors that need to be understood.

Explanations of mental illness and psychiatric disability

'Mental illness' is a general term that refers to a group of disorders. These disorders are often separated into two main categories - psychotic and non-psychotic disorders. Psychotic disorders include schizophrenia and related disorders, bipolar affective disorder, delusional disorders and acute mood disorders. The main symptoms are delusions, hallucinations, disorganised communication, lack of motivation and planning ability and mood swings (Jablensky et al. 1999). Non-psychotic illnesses include anxiety disorders (such as agoraphobia, panic disorder, social phobia, generalised anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder), alcohol and drug abuse and depression.

Psychiatric disability is a consequence of mental illness; that is, the behavioural changes that can affect daily living, such as the ability to live independently, maintain employment or develop relationships. People who experience psychiatric disability as a result of their mental illness are the group most likely to experience difficulties with accessing and maintaining their housing.

The presence of a mental illness is not the determinant of need for support, rather the presence of a related psychiatric disability influences support needs. Not all people living with a mental illness will have a psychiatric disability that results in some level of functional impairment and social handicap. In addition, many people with a mental illness who need intensive support at some stage in their lives will develop the skills to effectively manage their illness and thus function independently with no specific supports. There is also a group who are likely to need ongoing support.

Manifestations of mental illness

As outlined in the Positioning Paper for the previous AHURI report on *Effective Program Linkages* (Reynolds & Inglis 2001 pp. 15-16), people with a mental illness can manifest a range of behaviours that may make it more difficult to access and maintain stable housing. For example, functional disabilities because of a psychiatric disability can fluctuate and can range across the following:

- Inability to perform routine tasks, such as dressing, preparing a meal or paying bills, some as a result of an amotivational state of being;
- Persistent feelings of high anxiety, without a discernible cause. Such feelings may make it difficult to leave the house without assistance, with fear of panic attacks making it difficult to use public transport or to shop;
- Extreme mood swings, from depression and sadness to elation and excitement, with symptoms including feeling invincible, over-activity, reduced need for sleep, irritability, rapid thinking and speech, lack of inhibitions, grandiose plans and beliefs and lack of insight;
- Delusions, such as feeling others are plotting against one or feelings of persecution, may create difficulties in living with neighbours and engaging with service providers;

- Hallucinations which can distort one's senses, so that a person may see or hear things that do not exist, creating fear, confusion and unreal beliefs;
- Thought disorders which mean that speech may be jumbled and difficult to follow, and a person may think someone is interfering with their mind; and for some,
- Aggressive behaviours towards others, such as neighbours, authority figures, community workers that can arise from fear, unreal thoughts, frustration or influences of substance abuse (Sach & Associates 1991; Weir 1997; Commonwealth Department of Health and Aged Care 2000a, b, c & d).

Distinguishing features of mental illness compared to others with high support needs

People living with a mental illness have a number of distinguishing features compared to others who may have high support requirements. These were summarised in the *Effective Program Linkages Report* as follows:

> - Unlike the presence of a physical disability, which is often obvious, a mental illness can manifest in many different, but less obvious ways that may not be recognised as the symptoms of an illness. The potential for tenant behaviour to be misconstrued by others, such as neighbours or tenancy managers, can jeopardise housing stability if not understood and well managed.
> - Some individuals may choose to disclose their illness to housing and support services, whilst others may not have an awareness of their illness, acknowledge their illness or may not be willing to disclose their illness to others, for fear of repercussions, such as being ostracised. The ability of providers of housing and support services to respond effectively can depend on whether they are aware of a person's illness and whether they understand the nature of the illness.
> - Living with a mental illness is not always disabling, but can be very disabling at times, with the manifesting disorder often fluctuating in intensity and duration. This can result in periods of very high need for support and periods where less support may be required. Maintaining housing can be particularly difficult when unexpected periods of hospitalisation may be required and, unlike with a physical illness, the timing and duration of these periods is often not predictable.
> - The nature of some mental illnesses can threaten a person's ability to retain their housing. For example, a person may suffer from memory loss, anxiety, phobias or depression that may create difficulties in: managing finances, and therefore paying rent on time; living with neighbours, as neighbours may be regarded suspiciously; maintaining the property; or feeling safe enough to stay, with some delusional behaviours resulting in abandoning a tenancy.
>
> (Reynolds, Inglis & O'Brien 2001, p.10)

In addition to, and sometimes as a consequence of, the behaviours associated with a mental illness, people can also experience a number of other difficulties that can threaten their ability to maintain stable housing. They can be socially isolated, often having less access to support from family and friends to manage the challenges of daily life, compared to the networks enjoyed by others (Robinson 1998; Jablensky et al. 1999). Poor physical health is also often found amongst people with a serious mental illness (Center for Mental Health Services 1994; Jablensky et al. 1999) and this again can affect the ability to undertake the activities needed to comply with responsible tenancy. There is often a strong relationship between problematic drug and alcohol use and the presence of a psychiatric disability, with people living with a mental illness often turning to alcohol and drugs to gain relief from their illness (McDermott & Pyett 1993).

Lack of community understanding of mental illness and the way it can affect people can lead to discrimination, stigma and fear. These responses can adversely affect and often compound difficulties of living in the community with a mental illness.

Clearly, to support people with such a multiplicity of potential issues to access and then maintain their housing requires housing provision approaches that are sensitive to their needs, timely and appropriate support and clinical management, and effective cross program/cross service co-ordination when people are particularly disabled by their mental illness.

Stressors and mental illness

When a person is under stress, they are forced to alter their behaviour in order to cope with a challenge or event in their environment (Mueser & Gingerich 1994). These challenges or events are termed stressors. Stressors include life events, such as moving house, financial problems, loss of job or hospitalisation, daily hassles, exposure to pressures of urban life or hostile family environments (Lefley 1997). There is a large degree of difference between individuals as to what is stressful.

The impact that stressors have on an individual can be largely influenced by their vulnerability. Vulnerability refers to the predisposition that a person has to developing a mental illness (Watkins, 1988). Each person also has a threshold, or a point at which they are unable to cope. If the vulnerability of the person is high, and they are presented with stressors that exceed their ability to cope, then symptoms of their mental illness may appear or may worsen (Watkins 1988).

There have been suggestions that for many people with a mental illness, the effect of stressors can be more pronounced. Watkins (1996) explains that extreme sensitivity is a trait that may be demonstrated by people in this group, and they can therefore experience life with a greater intensity that others. People with a mental illness may be more sensitive to sensory stimuli, and may be affected by things that other people barely notice, such as the noise of a television. They may also experience greater interpersonal sensitivity, and may be more sensitive to the behaviours and feelings of people in social situations. This can include both social interactions with strangers and with people they are close to.

2.3 Findings from the earlier AHURI study on *Effective Program Linkages*

Foundations for effective support

The findings from the earlier AHURI study on *Effective Program Linkages* concluded that there are three foundations for developing effective approaches to program linkages to support people with complex needs, arising out of their mental illness, to sustain their housing. These were as follows (see overleaf).

1. The need to understand the impact a mental illness can have on achieving housing stability. Key features of identified as particularly importance were

- The mental illness and/or resultant psychiatric disability can affect basic abilities required to access and sustain tenancies, including abilities to complete applications forms, maintain regular rent payments, live compatibility with neighbours and initiate seeking of assistance when required.
- A person's capacities for independent living and needs for support can fluctuate and be unpredictable.
- People may need support with diverse areas of their life and assistance with coordination of many services may be required.
- When a person is unwell they are usually heavily reliant on others to ensure required support is available and coordinated. There can be complex issues associated with the person's rights to confidentiality about their illness that, if not well managed, can hinder access to needed assistance.

2. Recognition of the importance of addressing housing needs and preferences. This includes ensuring a range of different types of housing and housing and support models to meet diversity in needs and preferences.

3. Developing service responses that incorporate:

- The capacity for assertive outreach due to the reluctance of many people to seek support and engage with services
- Time to nurture and build a working relationship with the person
- The ability to accommodate unpredictable fluctuations in needs and capacities without jeopardising housing and critical support
- Consistency in service providers providing support
- Undertaking cross service coordination/ case management where the person has no one to assist with this
- The development of crisis management plans in collaboration with the person which include clear and agreed ways that services will support the person when they are unwell and not able to make informed judgements
- Effective approaches to address and balance the issues associated with the release of client information to other services and rights to confidentiality

(Reynolds, Inglis & O'Brien 2001, pp. 42-43)

Different approaches for linking housing and support

A range of different approaches for linking housing and support were identified in this study as follows:

- Housing formally linked to off-site support services
- Interdepartmental agreements/protocols
- Support packages or programs specifically targeted to tenants of particular low cost housing
- Rights to nominate tenants to particular housing in return for guaranteed support for tenants
- Coordination through general case management/care coordination programs
- Provision of on-site support
- Service coordination in local service networks, where services work together to develop approaches that increase the level of coordination of different services provided to individual clients. (Reynolds, Inglis & O'Brien 2001, p.vi)

We know that in Victoria the HASP, which was established to assist people who had experienced psychiatric disability to obtain and maintain stable housing, has been particularly successful because of the formal link and common purpose of both housing and support providers to sustain clients' housing. Ongoing, tailored support is available and efforts are made to secure housing that is aligned to the client's needs (Robson 1995).

In this earlier AHURI study, discussions were held with PDSS and housing workers about the effectiveness of the general public housing program in housing people living with a mental illness. The knowledge and skills of housing officers, processes to address client confidentiality issues, appropriate housing stock and timely availability of housing and supports were all considered important. In community housing, the smaller scale, scope and specialised knowledge of tenant needs, as well as the capacity to develop locally tailored processes, also appeared to enhance ability to sustain housing.

Proposed future directions and policy implications

Improved coordination between services at all levels of the service system, from the various levels of government to local service networks and individual service providers, were recommended to foster more integrated approaches. The underpinning issues of the inadequate levels of housing and support and need to strengthen the focus of social housing on achieving sustainable tenancies, as an explicit service objective, influence the ability of individuals to access and sustain appropriate, affordable and stable housing.

The concluding policy implications from the previous project were that:

- Strong leadership and the development of a more collaborative and coordinated Commonwealth and State Government response is needed to improve coordination between housing and support, with a starting point the creation of performance measures that hold government and service agencies accountable for enhancing coordination of services.
- Individuals at all levels of the service system working with people with psychiatric disability need to strengthen their awareness of how other services work to enhance current approaches.
- Services need to be designed in a way that recognises the particular needs of people with psychiatric disability, such as capacity for assertive outreach, cross service coordination, time to build relationships and so on.
- Generic housing and support services need to understand the ways that psychiatric disability can affect people's capacities and behaviours.
- Each local area needs to have a balanced range of service models/approaches available for linking housing and support.
- Government needs to recognise the cost versus benefits of investment in a greater supply of secure, affordable and appropriate housing and accompanying services to assist individuals with complex needs to access and sustain their housing.
- An explicit and measurable goal of social housing should be to develop policies and practices to support those with complex needs to maintain their tenancies.
- Broad community development and information strategies about mental illness are required to address discrimination that can hamper both access to and sustainability of housing for this group.

As indicated previously, the follow-on study has sought to test the findings from the earlier AHURI project, to see how closely the perspectives of service providers, government officers and previous research align with the views of the individuals interviewed.

2.4 What consumers identify as important

When developing the Positioning Paper for this project (Reynolds, Inglis & O'Brien 2002), a range of Australian and overseas literature reporting on the views and preferences of people with a mental illness about their housing and support services was examined. Throughout the study further literature has been identified and incorporated. The following summarises key insights from the review of the literature.

Preferred housing characteristics and living arrangements

The previous AHURI study reviewed housing needs and preferences of people with a mental illness but found little longitudinal research to show how these factors have influenced housing stability. In reviewing the literature for this study we set out to examine what was known about the housing needs and preferences of people with a mental illness and the likely consequences if housing is not matched to individual needs and preferences.

While there is a considerable body of literature which reports on the nature of the housing that people with a mental illness indicate they prefer, the quality of the information is somewhat compromised by lack of precision of terminology and concepts and often lack of clear reporting on current housing and living arrangements when discussing preferred housing. Taking into account these limitations, the following provides a brief overview of what is known from the existing literature about the housing needs and preferences of people with a mental illness and the likely consequences if housing is not matched to these needs and preferences.

Overall Australian studies have shown that the least preferred options for most people with a mental illness are to live in a group setting or in housing lacking privacy, such as boarding/rooming houses (Horn 1991, Juriansz 1994, Mulvaney 1995, Owen et al. 1996, Lambert et al. 2000). Most have indicated that living in a 'private' house or flat is the preferred option, with the emphasis on living independently which could be in a range of housing tenures including public housing, private rental or home ownership. In addition, there was a strong preference not to live with others with a mental illness, both in these Australian studies and in several North American studies (Keck 1990, Goldfinger & Schutt 1996, Ogilvie 1997).

Based on studies reporting on interviews with people either living independently or aspiring to live independently who have a mental illness, several housing characteristics emerge as being most important. These characteristics are grouped loosely based on Massey & Wu's (1993a) categories:

Table 2.1 Important housing characteristics

Independence and choice	- in own home and alone - autonomous - sense of freedom - independent
Convenient location	- located close to community services, transport, vocational and rehabilitation services - located close to social networks - located close to the person's preferred location
Safety and comfort	- safe - secure tenure - comfortable
Affordable	- leaves enough money for other things
Privacy	- private – have own space
Social opportunity	- compatible social milieu – i.e. like neighbours - physical and social supports available which reduce stress - place to entertain visitors - recreational facilities nearby

(Keck 1990, Horn 1991, Tanzman, Besio & Yoe 1992, Carling 1993, Tanzman 1993, Juriansz 1994, Catholic Social Services 1995, Robson 1995, Burke & Dickman-Campbell 1997, Keys Young 1994, Massey & Wu 1993a&b, Yeich et al. 1994, Mulvaney 1995, Ogilvie 1997, Penumbra 1997, Weir 1997, National Youth Coalition for Housing 1999, Thomas & McCormack 1999, Lambert et al. 2000)

The findings of these studies demonstrate that people with a psychiatric disability have similar housing needs to others in the community. These studies also suggest that people will want to move if there is lack of congruence between where they live and their housing preference.

However, less is reported on potential consequences of not being able to move to housing with preferred characteristics. This is an issue that is important to understand as we know that there is limited capacity to meet consumer preferences because of the lack of availability of suitable housing. The concept of consumer choice can only be put into practice if there is a range of housing options available to cater for varying individual needs (Carling 1993, Hatfield 1993, Carling 1995, Clark & Henry 1997?; Curtis 1997, Penumbra 1997). Research suggests that many people with a psychiatric disability are on low incomes (Bisset et al. 1999) and that there are severe shortages in low cost housing, which limits individual choice of housing type and location (Horn 1991, Deany 1993, Juriansz 1994, Mulvaney 1995) and this may undermine the achievement of stable housing.

It is also important to note that a number of studies have shown that what people themselves want and what others think they need – i.e. family, professionals - can differ (Carling 1993, Massey & Wu 1993a&b, Goldfinger & Schutt 1996). For example, in one North American study (Goldfinger & Schutt 1996), when clinicians were asked about the type of housing they felt was appropriate for 87 people living with a mental illness in a shelter, few felt they should be housed independently. This was in contrast to the responses from individuals themselves who had a strong preference to live alone, but with outreach support.

Appropriate service responses

The literature suggests that diverse forms of support are important to people with psychiatric disability, from help to find housing, live independently, socialise, manage emotional, mental and physical health and travel. The differences found by different studies appears to be influenced by factors such as the study's orientation, purpose of the study and questions asked, and the current housing and support arrangements for those interviewed. These differences also reinforce the diversity of individual needs found amongst people with a psychiatric disability.

One might expect that those who are living in group housing and have never lived independently might need ongoing support and development of living skills as a priority, whereas those already living independently might identify support at particular times to deal with crises as important. In addition studies do not always specify the current living and support arrangements so that one can clearly understand whether the support preferences are influenced by a person's experience. In designing this current study we have worked to ensure that there is clear descriptive information about current living arrangements and supports, so that comments on what is important to individuals can be analysed in context.

While diversity is found between studies some common themes emerge, with the areas of support most commonly identified as important as follows overleaf:

Table 2.2 Important areas of support

Area of assistance	Type of assistance
Access to housing	- seeking appropriate housing, moving and connection of utilities - financial support to access housing and pay for living expenses - managing money - obtaining house furnishings and supplies
Development of daily living skills	- shopping, housekeeping, meals preparation - managing finances - finding and using local community services and resources
Social networks	- assistance to participate in leisure activities - assistance making friends
Managing health and wellbeing	- medication management - access to 24-hour crisis support - limit setting - mental health or drug treatment services - physical health needs - moral and emotional support – needing help with emotional upsets - building self-confidence
Transportation	- access to transport
Activities of daily living	- help with house maintenance - help from family and friends - assistance structuring time

(Keck 1990, Horn 1991, Tanzman, Besio & Yoe 1992, Deany 1993, Tanzman 1993, Carling 1993, Juriansz 1994, Yeich et al.1994, Thomas & McCormack 1999, Ainsworth 2000, Lambert et al. 2000, Jarbrink, Hallam & Knapp, 2001).

2.5 Effective co-ordination between housing and support

Studies that directly seek consumer views on the issue of co-ordination between housing and support are limited. Thus insights into what is needed, what is important and what works draws heavily on the view of professionals or on evidence from outcome studies examining different models or intensities of co-ordination, either between housing and support or between supports alone. Available studies indicate that effective support can achieve positive outcomes in terms of access to housing and housing stability for people with a mental illness.

Housing and Support Program (HASP)

The published evaluation of the Housing and Support Program (Robson 1995), a program that formally links housing and support, found that there were five significant areas that changed in the three-month time frame between interviews. Unfortunately, we do not know how long the 47 people interviewed had been in HASP properties, although we do know that for the total number of people in the Program at this point, most had been there for under 18 months. These were:

- Improved stability of housing
- Increased satisfaction with housing and support
- Increased community connections and integration
- Reduction in hospitalisation rates
- Improved social networks for those in clustered accommodation (p.67)

Another finding was that through the involvement of support workers, tenants were ‘increasingly able to understand their illness and respond quickly to the return of symptoms’, decreasing their reliance on clinical support (p. 70). Some of the findings of the 2001 HASP review are available and some comparisons have been made with our study later in the report.

International linkages examples

Findings from other studies highlight the range of ways of linking housing and support that are known to be effective. For example, the US Toledo study (Keck 1990) showed that as well as meeting housing preference, the existence of intensive case management was critical to housing stability. Slade and Scott (1999), in a UK study, suggest that a number of relatively minor changes to practice are required to sustain tenancies for those with a mental illness. These include closer inter-agency cooperation, allowing housing officers to alert support services early to prevent tenancy breakdown and ensuring housing benefit and rent payments are maintained prior to discharge from periods of hospitalisation.

In a US study Rosenheck & Morrisey (1998) attempted to test the 'services integration hypothesis', which consists of the following propositions: integrated systems provide better access to a range of services, clients treated in such services have better outcomes, and the 'resulting improvement in outcomes is mediated through increased accessibility and continuity of service delivery'. Data was obtained for 1832 clients with psychiatric symptoms three months after entering the Access to Community Care and Effective Services and Supports (ACCESS) program, and then for 1535 participants 12 months later. ACCESS aims to increase service integration through site-specific development strategies.

This large-scale study demonstrated that service system integration was significantly related to an improvement in accessing housing services at the three-month time period. Integration of services was also significantly related to achieving independent housing through these services at the 12-month follow up period. The study suggests that the housing outcomes and wellbeing of clients with a mental illness are improved if services work together.

When interviewing participants in this study the interviewers checked the existence and importance of a range of their supports, ascertained how such services are coordinated and delivered from their perspective and, where possible, obtained participants' views on the effectiveness of coordination between supports and what is most helpful to them.

Living Options Service

In the northern suburbs of Melbourne, a region-wide housing information, intake and referral service for adults aged 16-64 with a psychiatric disability, commenced in 1999 and has proven very successful in simplifying access to supported housing in the region. The Living Options Service is a good example of a computerised linked local system where clients can access region-wide information about supported housing properties, as well as generic housing services, be assessed for their housing and support needs and then matched to available properties. The single point of entry, screening tool and matching for a range of properties has significantly streamlined access. An evaluation by Corbo (2001) showed that collaboration between the 16 services in the region, including housing and support services, generic housing services, clinical services and mental health services has increased, underpinned by memoranda of understanding.

All seven consumers interviewed as part of the evaluation found that accessing the Living Options Service improved their access to housing and support. It was easier, took less time, all realistic options were provided upfront and matched to their needs, explanations were provided on the skills required for different housing circumstances and the referral process was smooth. Ten of the 15 services surveyed found that the Living Options Service had made a positive difference to linkages between services in the region, with workers feeling less isolated, more knowledgeable of other services, part of the service system and better able to influence DHS through participation in the reference group. Other feedback was that workloads had reduced, processes were speeded up and the system was straightforward to use. However, the author of the evaluation noted that there was still some reluctance to be exposed to accountability at the regional level, with individual services somewhat protective of their right to plan and deliver services as they see appropriate.

Primary Care Partnerships

At a broader level, the Primary Care Partnership Strategy, funded by the Victorian State Government, aims to create a genuine primary care service system, by helping providers and professionals, such as GPs, community nurses, and mental health workers to coordinate services for clients they may have in common. The goals are to improve the experience and outcomes for people who use primary care services, such as people with a psychiatric disability, and reduce the preventable use of hospital, medical and residential services by early intervention and health promotion activities. In order to do this voluntary alliances have been funded in local communities between agencies, often spanning two or three local government areas. Each Primary Care Partnership develops and implements a Community Health Plan for their community, involving three key elements:

- service planning to identify the population health needs of the community and address those needs
- service coordination to streamline information systems and infrastructure
- service partnerships to describe how providers and the community will work together

2.6 Summary

This chapter has described the key features that can make it difficult for individuals living with a mental illness and experiencing psychiatric disability to access and maintain stable housing. As summarised in the findings from the earlier AHURI study on *Effective Program Linkages*, there is a need to understand the often unique characteristics of the impact of living with a mental illness on housing stability, with services needing to develop a range of strategies to both better address housing needs and preferences and work with individuals to assist them to live independently. Well-coordinated housing and support services can be critical to achieving positive housing outcomes, and some examples of effective services were the diverse approaches to co-ordination and collaboration outlined in this chapter.

The next chapter provides a framework to understand the key concepts on which the project is based: housing, support, linkages and risks to maintaining stable housing.

3. KEY CONCEPTS

Clarifying key concepts: housing, support, linkages, risks to maintaining stable housing

In embarking on this study to better understand consumer views on what assists them to access and stay housed, it became evident that it would be essential to clarify the concepts of housing, support and program linkages. We therefore spent considerable time in the early stages of the project working on developing frameworks to underpin the way in which we approached exploring housing and support issues with participants. These frameworks have been refined in the light of additional insights gained during the course of the project and are presented in this chapter to highlight the diversity of elements that need to be considered.

Housing

In discussing with participants their housing situations, the elements of housing considered important to take into consideration included not only the dwelling type but all of the following factors:

- Housing supply – the availability of housing
- Housing access – the degree to which the person had the time, ability and/or assistance to find a suitable place
- Housing choice – the degree to which a person had choice over their housing
- Housing meeting individual needs – the relationship between the housing and individual needs
- Attributes of a person's housing manager - purpose of the housing, tenancy agreement, housing manager's approach, degree to which the housing manager has resources/knowledge to support people with a mental illness
- Housing attributes – tenure, nature of rental agreement, dwelling type, size, degree of shared space, furnishings, quality, manageability of housing, disability access, accessibility of support, services arranged by housing provider and social opportunity
- Living arrangements - own or with others and degree of choice in this
- Community context – perceived safety and crime rate in the neighbourhood, tolerance of neighbours, facilities, public transport, public transport, proximity to social networks and preferred location.

Support

In understanding the nature of formal and informal support received, the project explored the following elements of support:

- Sources of support – formal and informal
- Different types of support available
- Characteristics of support
- Characteristics of formal support workers

Linkages between housing and support

The framework for linkages between housing and support was developed to take into consideration:

- Types of linkages
- Nature of relationships
- Client confidentiality
- Nature of local service networks

Risks to maintaining housing stability

At the outset of the project it was thought that risks for individuals in maintaining housing could arise from two key directions:

- Risks related to the person's own attributes, psychiatric disabilities and behaviours when unwell
- Risks arising from what others might do or not do

The nature, consequences and management strategies for risk were explored thoroughly in this study and are comprehensively outlined in the findings section of the report.

3.1 Housing attributes

The following outlines key housing attributes that have been identified as having a possible influence on the ability of a person with a mental illness to stay housed. In some cases, we have ordered the attributes to explain those that might facilitate a positive housing outcome to those that might limit sustainability of housing.

Table 3.1 Housing Attributes

Housing supply	**The availability of housing:** i.e whether there is a: - diverse range of secure, appropriate and affordable housing of different types and in different locations - limited choice of secure, appropriate and affordable housing - lack of secure, appropriate and affordable housing
Housing access	**Circumstances at the time of accessing housing:** - not in crisis – i.e. have had time and ability to look for a place - in crisis – i.e. have been in an emergency situation with time pressures to find a place to live – may not have had much say over where they live or not have been in a position to make a decision themselves
Housing choice	**The degree to which the person has an actual or perceived choice about which housing they live in:** Actual choice: - had choice of housing from a range of options that met expressed preferences and needs – felt in control of decision-making - limited choice available - no choice available Perceived choice: - although there may have been a limited choice of housing available, individual felt they had choice of housing and felt in control of decision-making - individual felt they had a limited choice - individual felt they had no choice of housing
Housing meets individual's needs	**The degree to which the housing meets individual needs:** - meets individual needs - does not meet individual needs
The attributes of a person's housing manager	**Purpose of the housing** i.e. whether it is to: - explicitly assist those who might otherwise find it difficult to access and sustain housing – i.e. specialist social housing or specialist program linking housing and support - provide affordable housing - i.e. social housing - generate an income, with the emphasis on attracting tenants who are financially viable, have a good track record and have minimal requirement for interaction - i.e. private rental

The attributes of a person's housing manager (cont.)	**Tenancy agreement/policies** i.e. whether they: - specifically include processes for working with the tenant and support workers to ensure housing is sustained during periods of crisis and to maximise success - i.e. direct rental debit, client information release form to contact support worker in times of need, use of dispute resolution processes - are neutral - some allowances made for tenants' difficulties - are inflexible - any transgression against the tenancy agreement results in immediate eviction (within Residential Tenancy Act (RTA)), or the tenancy agreement or policies discourage any intervention **Housing manager's level of understanding of mental illness** and their practical sensitivity to the potential impact of living with a mental illness on housing stability: i.e. how they choose to deal with rent arrears, potential problems with neighbours, periods of illness and hospitalisation - positive - housing manager involved in initial case planning for new tenants, takes active steps to ensure illness does not undermine housing - i.e. if rent not paid on time, attempts made to find out why; fosters relationship with support workers to assist tenant - neutral - i.e. not known or known but no special attention given - negative - prejudice shown to the person who has a mental illness - i.e. person meets eligibility criteria but is rejected as a tenant. **Resources/knowledge available to support people with a mental illness:** - trained housing/support workers available either onsite or contactable on a 24 hour basis to assist people with complex needs, make referrals - capacity to recognise mental illness and to make appropriate referrals to other services - no additional resources provided, although housing manager is available and/or written information about services is provided - lack of resources - communicate with tenant by letter, telephone
The attributes of a person's housing	**Tenure** - private rental - public housing rental - community housing rental - other – living in housing not covered by the Residential Tenancies Act (RTA) – e.g Supported Residential Service (SRS), Community Care Unit (CCU) **Legal nature/contents of rental agreement** - length of tenure - right to exclusive occupation of a self-contained dwelling under the RTA - right to exclusive occupation of a room under the RTA - licensed to occupy a keyed room - licensed to occupy a room (not keyed) - license to share a room (not keyed) **Rent payment options** - Direct debit through Centrelink - State Trustees pay - Tenant pays into a bank account - Payment at real estate agent - PDSS pay on behalf of tenant

The attributes of a person's housing (cont.)	**Dwelling type** - single dwelling (no shared entrance or shared external space) - multi-unit dwelling (own entrance but shared external space, e.g. driveway) - self-contained apartment in multi-story building (shared entrance, e.g. high-rise, block of flats) - moveable unit - room (e.g. in private hotel, rooming house) - bungalow - caravan **Size** - house - two or more bedroom flat - one-bedroom flat - bedsit - room **Facilities/areas that need to be shared** - own facilities - no need for sharing - bedroom - laundry - kitchen - toilet - bathroom - lounge - garden/outdoor area **Furnishings provided with housing**, i.e. bed, whitegoods, lounge - provided - some provided - i.e. whitegoods - not provided **Quality of housing** - physical condition, amenities provided, safety - safe and secure - well-maintained - comfortable - good amenities - high risk of theft of property - poor physical condition - lacks basic amenities **Manageability of housing** i.e. outdoor areas, space inside - no outside space to maintain - low maintenance garden - garden requires outside support – i.e., someone to mow lawns - inside space able to be maintained by tenant without outside help - outside help required to maintain inside, i.e., cleaner employed **Disability access** - property is wheelchair accessible throughout - property meets basic disability access requirements - no wheelchair access **Accessibility of support** - housing comes with onsite support 24 hours e.g. caretaker, lead tenant - housing comes with onsite support during business hours - housing staff are able to make appropriate referrals - housing specifically linked to off-site support - no specific link with support

The attributes of a person's housing (cont.)	**Services arranged by housing provider** - meals - room serviced - personal care (SRS) - laundry - monitoring/supervision - medication supervision (SRS, CCU) **Social opportunity provided by housing** - compatible social milieu - i.e. like neighbours - place to entertain visitors - recreational facilities nearby - supports to reduce stress, depression - housing designed with communal social spaces and private spaces
A person's living arrangements	**Lives alone** - by choice - not by choice **Lives with others** - by choice - i.e. family, friends, co-residents, others with similar needs - not by choice - i.e. family, friends, co-residents, others with similar needs
The community context in which a person lives	**Crime rate in neighbourhood** - low crime rate, no visible criminal activity evident - crime may exist in the neighborhood, but not close/immediately evident - high crime rate, visible evidence of criminal activity in immediate vicinity **Tolerance of neighbourhood/direct neighbours** - accepting - assume that this might be a diverse population, diverse socio-economic groups, history of accommodating people with complex needs, unusual behaviours and/or social disadvantage; high local government interest/resources in providing appropriate housing or programs to support people with complex needs - unaccepting - focus on property values, fear of difference and unusual behaviours or appearance, no exposure/experience with people with complex needs - blatantly discriminatory **Facilities** - existence of support services aimed at assisting disadvantaged people in the neighborhood - i.e. alcohol and drug centres, community legal centres, employment programs, housing services, day programs, community health services etc - general facilities - shops, medical services, recreational facilities - i.e. parks, libraries **Public transport** - available, safe, readily accessible - easy to get around without a car **Promixity to** - social networks - family, friends - preferred location - i.e. could be historical connection, desire to live by the beach, in the city etc.

3.2 Nature and attributes of support

The following outlines key attributes of support services that have been identified as having a possible influence on the ability of person with a mental illness to stay housed.

Table 3.2 Nature and attributes of support

Sources of support – informal and formal	**Informal:** - family - friends - flatmates/co-residents - neighbours - (benevolent) landlords **Formal:** - clinical services, including: case managers, psychiatrists, psychologists, nurses, CAT, MST - PDSS - GPs - health centres - advocacy groups/services - self-help groups - employment agencies - food services - community houses - community centres - HACC services - welfare services - other community resources/services, i.e. libraries, recreation centres
The different types of support available	- skill development in activities of daily living - assistance with instrumental activities of daily living - support in accessing services - support getting to services - services addressing practical and basic needs - i.e. health, income, housing, employment - social/emotional/moral support - financial support - support for participation within neighbourhood/local community - advocacy support - case management support - support in developing or rediscovering key interests, i.e. music, art - provision of recreational opportunities - support to engage in educational activities or return to education - support to find employment or training for employment
Characteristics of support	- availability - accessibility - non-judgmental - capacity to provide intensive support when required - timeliness of assistance - solutions focused - work to get good outcomes for individuals - tailored to individual needs - respond to fluctuations in need - i.e. doesn't have to go to the end of a waiting list when next episode occurs because of time delay between receiving services - flexible delivery in terms of when, where, how - holistic - provide assistance taking into account the needs of the whole person - not narrowly focused - inclusiveness – the kinds of limits put on who can be supported - history of a relationship with the individual - formal or informal i.e. kinds of rules that exist

Skills, knowledge and attributes of formal support workers	- skill in supporting people with a mental illness - skill in understanding mental illness - consistency in staffing - i.e. low turnover - quality of their networks/links/relationships with other relevant services - respect for client's wishes - promote self-determination while at the same time supporting a client to manage risks - unconditional positive regard for clients - commitment to building relationships with clients - genuineness of care - acknowledges the need to understand what is important to the client and gives meaning to their life

3.3 Elements of linkages between housing and support

Developing a framework to describe the elements of housing and support linkages for people with a mental illness is complex. This is partly because they vary depending on the housing itself, the housing management approach, and how well both are tailored to meet individual needs. In addition, the nature of the support services is another variable. The role of support services may be different when a housing manager is more understanding of the needs and issues for people with a mental illness. Table 3.4 has been developed to start to clarify the possible expectations of social housing and support services and key elements in their linkages.

The following outlines the different elements and possible attributes of the linkage between housing and support:

Table 3.3 Linkages between housing and support

Types of linkages	- housing formally linked to off-site support services - interdepartmental agreements/protocols - support packages targeted to particular tenants - rights to nominate housing in return for guaranteed support - coordination through general case management programs - provision of on-site support - service coordination in local networks
Nature of relationships between housing and support providers	- informal relationships between individual workers or services - no documented practice/procedures/protocols - formal partnerships between services - agreement, memorandum of understanding, protocols for how services work together - clear information about each others' services, how they operate and how to initiate contact - central coordinating agency, common interface i.e. single point for referrals
Issues of client confidentiality	- joint strategies for addressing client confidentiality requirements and issues, with the focus on achievement of good client outcomes - information about client's illness and the support services they access are available, yet policies preclude sharing information, even at times of crisis (both ways - from support services sharing with housing workers and vice-versa) - no information about client's illness or the support services they access available to housing provider
Nature of local service network	- regular meetings to share ideas - belongs to a Primary Care Partnership (PCP) (Victorian program) - strong spirit of cooperation - integrated client information and management systems – i.e. common referral system

3.4 Summary comments

The aim of this chapter was to provide an overview of the range of elements that the study has taken into consideration in discussing the concepts of housing, support, linkages and risks to maintaining stable housing. The frameworks developed provided the research team with a guide to how these concepts could be described to the participants interviewed, the structuring of the interview schedule and the interpretation of the information offered. This discussion illustrates the multiplicity of factors included in understanding these terms, and therefore the need to be very clear when questioning individuals about their housing experiences and satisfaction, so this broad understanding is shared.

In addition, Table 3.4 provides a perspective on the 'ideal' housing and support environment for those in public and community housing, describing the positive attributes of housing, housing management, coordinated support strategies and local services.

The following chapter provides an overview of the fifty individuals who participated in the interviews for this project, including their individual characteristics and their housing circumstances.

Table 3.4: Requirements for effective provision of housing and support to people with a mental illness in general public housing and community housing

Housing *Assumed that housing manager will formally know some tenants who have a mental illness as well as having some tenants with a mental illness of which they are unaware.*	**Requirements for effective coordination/linkage**	**Local support services**
• Diversity of housing stock and supply, providing ability to offer choice • Allocations policy which supports matching of housing offered with client's needs in terms of type and location of housing • Staff training about mental illness and its implications for tenancy management approaches • Operating policies and practices which are sensitive to the manifestations of mental illness and psychiatric disabilities e.g : ◦ rent arrears policies ◦ responses to absence due to hospitalisation ◦ problematic behaviour when temporarily unwell ◦ special communication needs • Understanding of support services available for people with a mental illness and how they operate and can be contacted	• Joint strategies for addressing client confidentiality requirements and issues that focus on achievement of good client outcomes • Good knowledge of each other's services and how to initiate contact • Effective working relationships built on: ◦ an attitude that is co-operative and seeks coordination and focused on achievement of good outcomes for people with a mental illness ◦ agreed protocols/ collaborative work agreements	• Anticipates potential housing related issues for clients and client agreement obtained on strategies to address these, particularly when the client becomes unwell and temporarily unable to make informed decisions • Capacity to provide required skill develop-ment support to individual clients • Provides assistance to clients in a timely way so that major crises are avoided • Have good outreach capacity and strategies particularly for those with a mental illness who are not in the formal support system, but in the social housing system • Well developed relationship with clinical services

4. RESEARCH APPROACH, ANALYTIC FRAME AND THE CHARACTERISTICS OF THE PARTICIPANTS

This chapter reports on the research approach and the personal and housing characteristics of the 50 people interviewed for this study. It aims to give an overall picture of the demographic characteristics of the participants, their current housing type, how they manage their rental payments and the level of assistance they received in moving in.

4.1 Study methodology

Research questions

The research questions this project sought to answer about housing and support from the perspective of people who have a psychiatric disability included:

- What is important to people to access and maintain their housing?
- What is it that jeopardises their ability to access and maintain housing?
- When housing and support works well, why does it work?
- What do mental health consumers need to know and have in place to make it work for them?
- When doesn't it work? Why doesn't it work? What is needed to make it work?

Literature review

In order to address these key research questions the project first reviewed existing Australian and overseas literature on the views and preferences of people with a mental illness about their housing and support, expanding on the previous literature review conducted for the AHURI Effective Program Linkages project (Reynolds & Inglis 2001). This literature review identified what was already known, as well as highlighting gaps.

Interviews with 50 people with a mental illness

The core feature of the project's methodology consisted of interviews with 50 people with a mental illness who met the target group criteria (see section 1.1). The primary purpose was to elicit the views of individuals who have managed to maintain stable housing and understand what has assisted them stay housed and what they perceive might jeopardise their housing. The approach was qualitative, intended to capture the multiple and subjective perspectives on what has worked and is working for each individual.

The interview schedule was carefully designed and piloted to ensure participants provided specific information on a range of both open-ended and semi-structured questions and also had the opportunity to tell their story. This was considered an appropriate approach for dealing with feelings, attitudes and potentially a wide range of unpredictable responses (Jankowicz 1999)

Interviewer aids were also designed in the form of pictures and lists to assist the interviewer to communicate and explore often quite complex constructs and concepts in acknowledgement of the range of communication styles and abilities of participants.

In addition, the questions and approaches to gathering information were designed to understand individuals' responses within the context of their experience. In developing the interview schedule the critiques of similar studies of housing and support for those with a mental illness were drawn on (Goldman et al. 1995, Newman 2001) to ensure previous methodological flaws were not repeated.

There are a number of limitations in using self-reports for measurement. These are mostly based around the accuracy of the information, which can be affected by memory, the impression the interviewee wants to make, and reluctance to reveal personal information. There are also limitations specific to people with a mental illness, such as difficulties in accurately recalling past events and difficulty responding to the requirements of the situation (Mueser et al., 1995). However, self-reports have also been recognised as the best way to

gain information about the perceptions of individuals. Therefore the participant interviews were conducted once a set of key context questions had been asked of their key worker so that this information was known and could be referred to throughout the interview.

A critical part of the approach to these interviews was the rigour made possible by the fact that the three **interviewers were also the researchers** and authors of this report. They designed the questions and approach, worked very closely together planning the detail of their approach to the interviews, documented clear interviewer instructions that they all worked to. They observed each other in the piloting phase of the interview schedule to ensure the information collected was clean, accurate and comprehensive. Throughout the study the three interviewers/researchers schedules were continually cross-checked and continual debriefing occurred to ensure consistency and accuracy of the information being collected. The collation of the information and the coding of the qualitative data occurred with all three interviewers present interpreting their own interview schedules. This approach ensured that any decisions about coding responses were accurate and consistent and often took into account broader information about the person's story. The interviewer/researchers had a range of expertise that facilitated the project's success, including experience working with people with complex needs, knowledge of the service system and the context in which this research was occurring.

It has been possible to abstract generalisable relationships at a conceptual level from such findings and these have informed the study findings and identification of policy implications.

Sampling

Participants were drawn from a number of different geographic areas in Victoria, both to ensure a sufficient sample size and to reflect the diversity in types of rental housing, access to and approaches of different support services, and level of collaboration and cooperation in different areas. The services assisting with identification of clients for interview covered the following geographic areas:

- One service covered a large middle and outer area of a metropolitan region.
- Three services were closer to the centre of Melbourne, with the area covered by two of these services having high concentrations of public housing.
- One service operated in a regional centre.

In order to have a context for understanding the issues identified by consumers, the project also sought the views of a small number of support and housing providers in the areas from which participants were drawn.

Key features of the approach to successfully interviewing this target group

There were some initial concerns expressed by other researchers and people working in the mental health field that successfully interviewing people with psychiatric disabilities may prove difficult. However, while there have been a few challenges, overall the interviewers experienced very few of the difficulties others anticipated. For the benefit of future research we would summarise the key features of the approach that have contributed to the success of the interviews as follows:

- Interviews were undertaken by a small team of skilled and knowledgeable researchers with an understanding and experience working with people with a mental illness. The interviewers also designed and piloted the questionnaire and coded and analysed the data together.
- The approach relied on staff from the PDSS taking on the role as 'key contacts' to provide prospective participants with information about the project and interview process to ensure they were given a positive introduction to the project and the benefits of participation. These 'key contacts' had already developed rapport and trusting relationships with their clients and this maximised the study's response rate. Management and staff in these

services were well briefed about the research project and characteristics of those sought for interview. This was achieved through providing documentation about the project, as well as conducting a workshop with staff in each service from which participants were drawn.

- The issue of safeguarding confidentiality and minimising risk to individuals was carefully considered. Each PDSS was expected to have a process in place to ensure participants felt their involvement in the project would not cause harm and that information relayed would be kept confidential.
- Liaising with their PDSS support worker, participants had full control over deciding whether to participate, how they would contact the interviewer and the time and location of their interview. Some participants chose to liaise directly with the interviewer, while others sought the support of their PDSS worker to make the arrangements on their behalf.
- A discussion was held with each of the support workers about the clients who consented to participate *before* interviews were conducted. This ensured sensitivity to any particular issues that needed to be taken into account in approaching the interview. The PDSS was asked to ensure those approached were capable of undertaking a one hour interview and would not be adversely affected by participating.
- All interviews were face-to-face.
- The approach to the questions about housing and support were framed in a positive way rather than focussing on what had caused past housing failures. Thus the focus was on what individuals were doing which was working well for them and, as much as possible, framing the questions in terms of what currently works well and what is in place to make things work. Attempts were made to make the process as non-threatening as possible.
- Deliberate efforts were made to use easily understood language as follows: housing is 'the place where you live', support is 'help or assistance' and linkages are 'the ways that people work together to support you'.
- The approach to interviews encouraged people to initially tell their story in their own way, rather than force them to choose from limited and structured answers. However, they were also supported to consider the broader meanings of housing, support and linkages, which they may not have been familiar with. To cover both approaches, the initial questions were open, such as 'What is important to you about the place where you live?', with the subsequent questions canvassing their views on individual housing elements. The interviewer then checked back to see if the initial response given was still what was most important, after we had provided a broader framework in which to view what 'the place where you live' means. In addition, we wanted to ensure that when asking participants about how they have accessed housing and stayed housed and what is important to them that they take into account all the potential factors we know encompass housing, support and linkages.
- Visual aids were also used – including a picture of the range of housing elements referred to and lists of housing and support attributes.
- All interview participants were paid $20 for their participation and any reasonable transport costs associated with attending the interview were reimbursed. This was an important demonstration of valuing their time and ensuring that they did not incur any financial costs associated with participation. Refreshments, such as coffee, cake and lunch were also offered.

Maximising participation

The interview questions and process of engaging participants was carefully planned to maximise their level of participation, ensuring that the data would be useful and could be analysed. The Reference Group and PDSS staff cautioned that it may be difficult to elicit useful responses given the complexity of the content and also sustain the interest of participants. The questionnaire was therefore designed to take about an hour, but took as much or as little time as the participants chose.

We are pleased to report that in this respect we were very successful, with over three quarters of those interviewed able to participate in the whole interview with no difficulties. The remainder were able to participate and to contribute information that was important and useful for the study. The challenges for the interviewers arose due to some participants, for example having concrete rather than more abstract thinking capacity, memory problems, one participant struggling with some concepts being discussed and another showing some fear of responding openly.

The approach to the study was that participants were assured from the outset that their stories would in no way be individually identifiable. This contributed to individuals' preparedness to participate and their frankness in describing their experiences. In writing up the data the research team has been very mindful of honouring this contract in the way that people's stories are reported. For a number of participants it was particularly important that their specific stories were not recounted in any way. Others were happy to have situations they described, or words they used to express what was important to them, included in the report. Therefore, when reporting some potentially identifiable information, the identity of individuals has been masked to protect them from being identified.

It is always difficult to portray the complexity of interactions between supports and housing history without being able to use specific examples. However careful attempts have been made to represent as closely as possible the range of factors that can be involved in this interplay.

Interviews, discussions and a workshop with key service providers

Throughout the data collection phase of this project the researchers collated issues, queries, and themes from the interviews and discussed these broader practice, program and systems issues with key housing and support providers and departmental officers. These discussions took the form of both interviews with key individuals and in one instance a regional workshop including key housing and support providers, departmental officers and other service providers from one of the geographic areas from which study participants came.

Approach to the analysis

This study specifically set out not to report case studies. As a qualitative study of fifty participants with complex and diverse needs, case study material would be a powerful tool to highlight the complexities of individual stories, however it was considered that this approach would limit participation to people who would be comfortable to have details about them published. Our intention not to publish identifiable information about individuals was a necessary and particularly important reassurance to maximise the involvement of a range of participants from this target group.

In analysing the data collected, the numbers of individuals who gave particular responses were counted, however this level of detail has not been reported, except in describing the characteristics of the individuals and their housing circumstances. Rather the dominant themes that emerged have been reported, with these themes rank ordered, in some cases, to give the reader a sense of where there is commonality. To the degree possible quotes are used to communicate the uniqueness of individual stories.

Feedback from the key contact PDSS agencies

Feedback was sought from the agencies supporting the interview participants about any identified positive or negative outcomes arising from participation in the interview. Comments from the two agencies who responded were as follows:

Positive outcomes:

One service reported that *'positive comments have been numerous'*, with participants saying:

- *'It is great to be asked your opinion'*
- *'It was fantastic to get paid'*
- *'It made me feel as if what I thought mattered'*
- *'I enjoy this kind of interview … good to comment on things to an independent person'*
- *'Maybe something will change for the good from what I have said'*

- *'I was paranoid, but soon realised this was my chance to say what I thought'*
- *'My situation is not so isolated as I had believed'*
- *'It is good that they asked consumers'*

Another service commented *'Most participants gained great value and enjoyment with telling their story. All were pleased with the $20. All felt it assisted self esteem as they were part of something important.'*

Comments on negative outcomes:

> *'In one case a level of concern was expressed with needing reassurance about what the information was for and who was going to know about it and why'*
>
> *'There have been very few negative comments re the interviews, except a few individuals have realised that their housing is not meeting their needs and there are very few options for them at the moment.'*

Complementing the HASP Review

As indicated earlier, this project was developed to complement the recent review of the HASP program. It was anticipated that the HASP review report would be completed by late 2001, however this has not been the case and the report is not yet finalised, thus limiting possibilities for comparison of findings. In designing the questions for interviews we took account of the questions that had been used in the HASP review. In the absence of a full report we have been able to compare responses for some specific issues only, namely views on sharing housing with others, what people like and dislike about where they are currently living, impacts/improvements in their life arising from their current housing and how long they are planning to stay in their current housing.

4.2 The characteristics of the participants

The key characteristics and housing circumstances of the study participants are provided in Table 4.1. This table is intended to illustrate the diversity of the individuals interviewed; responses for particular sub groups have not been analysed. Personal characteristics can be summarised as follows:

- **Age**: All were aged between 25 and 50, with more than half aged 35-44.
- **Gender**: Fifty-eight percent were male.
- **Income**: All were in receipt of a Centrelink pension or benefit, with all but two receiving the Disability Support Pension. Thus they were all on low incomes, with limited rental housing choices, due to the shortage of affordable and appropriate rental housing in the areas in which they lived.
- **Mental illness and disability**: All but one had a formally diagnosed mental illness and all had experienced psychiatric disability. Information on the type of mental illness was available for 70 percent of this group or 35 clients. Of this group of 35, over 70 percent had a psychotic illness, with this most commonly being schizophrenia. Amongst the 30 percent with a non-psychotic illness, this was most commonly depression or a personality disorder. Twelve participants (33 percent) had a dual disability (i.e. mental illness and ABI or ID) or a dual diagnosis (i.e. mental illness and substance abuse), with 14 percent (five people) identified to have a current drug/alcohol dependency in addition to their primary mental illness. At least five others had experienced drug or alcohol dependency at some stage, and references to current or past alcohol and drug use were common to a number of participants. In a 1997-98 study of 980 Australian adults with a psychotic disorder (Jablensky et al 1999b) 30 percent had a lifetime diagnosis of alcohol abuse or dependence and 38percent had a history of cannabis or other substance abuse. The current level of alcohol and drug dependence for the group of people we interviewed therefore appears to be relatively low compared to these figures.

- **Living arrangements:** Just over half (52 percent) lived alone. Of those living with others, most lived with family members, with seven living with a partner, six with their dependent children and four with other family members. The other shared living arrangements included three who lived in a group home, three who lived with a flatmate and one person with a family in a supportive boarding arrangement.
- **Diversity in backgrounds and life experiences:** From the life stories we were told, we know that this group represents a range of people from different socio-economic, cultural and family backgrounds and life experiences. The diversity of the group contributed to the variety and richness of the data that emerged and also highlights how individual characteristics influence what is important to a person. For example, some participants had:
    - experienced psychiatric disability early in life and had lived with a mental illness for many years, while for others the onset of mental illness was relatively recent
    - a history of paid employment, ranging from high to low incomes jobs, whereas others had always been dependent on the disability support pension
    - tertiary level qualifications whilst others had not completed high school education nor acquired vocational training
    - raised families, whereas others had always lived alone
    - purchased their own housing, whereas others had always lived with their parents, in rental housing, or had a history of homelessness
    - a series of life experiences that contributed to their difficulty in sustaining housing, such as a history of violence, sexual abuse, drug and/or alcohol abuse, whereas others had minimal exposure to extremely negative influences
    - highly supportive families, whereas others had little contact with their family or family was more a negative than a positive influence
    - high degree of self reliance, whereas others were more dependent on formal and informal supports
    - come from very different cultural backgrounds and were new to Australia
    - the ability to articulate very clearly their experiences, needs and concerns, whereas some were less able or willing to express themselves

4.3 The housing circumstances of the participants

In reviewing other housing and support studies we were cognisant of the fact that the housing characteristics of participants had not been fully described or investigated. Hence for this study we focussed on obtaining as clear a picture as possible about housing characteristics. These were as follows:

- **Type of rental accommodation:** Living in rental accommodation that was appropriate to a person's need was a key selection criterion for participation, but there was no specific sampling for particular types of rental tenure. Just over half lived in social housing, with 44 percent in public housing and eight percent in community housing. Forty-six percent lived in private rental housing and one person lived in a house where some minimal assistance with meals and cleaning was provided on-site. One insight to emerge about private rental was that in at least four instances the person was renting housing owned by their family, which the family had often specifically purchased for them to rent. In additional instances there were special rental arrangements where the landlord had taken a very benevolent approach to their tenant, such as in cases where the landlord personally knew them through family connections and hence did not initially seek references or had not increased the rent for a number of years.
- **Type of dwelling**: Seventy percent were living in a dwelling type that required no sharing of entrances and only a small proportion (ten percent) needed to share a laundry. The literature suggests that for some people with a mental illness there can be difficulty in dealing with social interactions, particularly those over which they have no choice, such as

living with co-tenants and neighbours (Pyke & Lowe 1996). Dwelling types that include sharing of common entrances, foyers and facilities such as laundries, resulting in interactions with others, can create particular stresses and can be difficult and therefore inappropriate for some individuals. Thus the majority were living in a dwelling type that is generally considered appropriate for people with a mental illness. The rest lived in more dense multi-storey housing that would require sharing of common areas. Most commonly this was a small block of flats with less than 15 units (20 percent of all participants), with only a few in large public housing towers.

- **Length of time in current housing**: To be selected for participation in this study, people needed to have achieved some stability in their housing. We did not prescribe a particular minimum length of time, as housing stability varies for different individuals, and length of stay is only one element of housing stability. Fifty percent had lived in their current housing for two years or more and 24 percent had lived in the same housing for over five years, indicating considerable stability. There were few notable differences found in the length of residency between the different tenures. This information shows that people with significant disabilities arising from their mental illness, including fluctuations in their wellbeing and capacity for independent living, have been able to achieve stability in their housing. Discussion in the next chapter outlines what these individuals identify as the things that have assisted them achieve this.
- **Method of rent payment:** Overall, 54 percent of people were fully responsible for regularly paying their own rent, while the others had systems in place to ensure regular payment of rent, usually through a process that, once implemented, happens automatically. It is recognised that difficulties with making regular rent payments and rent arrears can threaten housing stability for some people with a psychiatric disability, and thus these findings are not unexpected. However, there is a very substantial difference between those who are public tenants and those who are private tenants, with 82 percent of those living in public housing having their rent directly paid for them by others, compared to only 13 percent for those living in private rental. The options for automatic deduction of rental from income for those in the private rental sector appear to be more limited.
- **Previous housing**: This study did not deliberately seek information on previous housing history as the prime focus was on what was currently supporting people to stay housed. Nevertheless, many people did talk about their previous living arrangements. From this it was evident that many have had numerous changes in their housing, with housing histories including living in insecure, transient housing and living on the streets. Half of the participants reported that they were in crisis at the time of accessing their current housing, with 60 percent of these 25 individuals in marginal housing, living on the streets, in crisis accommodation or in temporary accommodation. A small number reported having moved through more supported housing and treatment environments, while others had lived with family for periods of time, sometimes returning to their family when their housing arrangements break down.
- **Levels of assistance when accessing current housing:** The level of assistance participants reported having received when accessing their current housing was varied, with higher proportions of public and community housing tenants receiving more extensive assistance. Just under half of all participants (46 percent) reported receiving comprehensive assistance, with seven of these reporting that they required assistance with everything to do with accessing their housing. Comprehensive assistance included someone other than the participant helping with a range of tasks, such as finding, applying, moving and settling the person in. Two people talked about the importance of a community treatment order to manage their illness and allow them to become ready to explore independent living options. Another 11 participants required considerable assistance with three of the major tasks associated with accessing their housing. A small proportion reported receiving no assistance and half of those people had accessed housing prior to their mental health manifesting in functional disability.

This snapshot of the fifty participants provides some context for the discussion that follows about the participants' stories and their perceptions. The characteristics summarised give an insight into the diversity of the people interviewed, both in terms of their personal characteristics and housing circumstances.

Table 4.1: Personal and housing characteristics by housing tenure

	Private n=23	Public n=22	Community n=4	Other n=1	Total N=50	Total%
Percentage in each group	46%	44%	8%	2%		
Age						
24-34	6	4	1	0	11	22
35-44	12	12	3	0	27	54
45-50	5	6	0	1	12	24
Male	13	12	3	1	29	58
Living Alone	11	15	0	0	26	52
Dwelling Type						
Separate dwelling	5	7	2	1	15	30
Attached to one other dwelling	2	2	1	0	5	10
Multi-unit (own entrance)	8	6	1	0	15	30
Small multi-story (<15)	7	3	0	0	10	20
Medium multi-story (16-39)	1	0	0	0	1	2
Large multi-story (40+)	0	3	0	0	3	6
Other/unknown	0	1	0	0	1	2
Length of time at current residence						
≤ 6 months	2	1	1	0	4	8
7-12 months	5	3	0	1	9	18
13-24 months	6	6	0	0	12	24
25-60 months	5	7	1	0	13	26
61-120 months	3	3	2	0	8	16
121+ months	2	2	0	0	4	8
How is rent paid?						
Managed by State Trustees	1	8	0	0	9	18
Direct debit from bank	1	0	0	0	1	2
Direct debit from Centrelink	1	10	0	1	12	24
Person is fully responsible	20	4	3	0	27	54
Person is supported/ monitored	0	0	1	0	1	2
Level of assistance in accessing current housing						
Comprehensive assistance (4 or more aspects)	7	12	3	1	23	46
Assistance with 3 major aspects	4	6	1	0	11	22
Assistance with 1 or 2 practical things	8	2	0	0	10	20
No assistance	4	2	0	0	6	12

5. INSIGHTS FROM THE INTERVIEWS

This chapter reports on the experiences and views of the 50 participants interviewed for this study, including their stories about how they were assisted to access housing, previous experiences and issues which they have managed to help them stay housed, their views on their current housing and support, and preferences for the future.

From analysis of these interviews, it became evident that considering the varied contexts for the individual responses was vital. Responses were influenced by factors such as housing history, personal experiences, situation at the time of interview and their attitude. For example, as noted earlier, some participants had experienced homelessness in the past. Conversely, a number had relatively stable housing prior to where they were living presently. Consequently, it was recognised that the way in which participants responded to questions on their current housing and future needs were likely to be strongly influenced by these previous experiences.

5.1 Accessing housing

From the literature and discussions with service providers and people with a mental illness, it has been demonstrated that people on low incomes can experience considerable difficulty finding appropriate and affordable housing, as this housing tends to be in short supply. Equally, it is known that people experiencing psychiatric disability may need assistance with the practical aspects of readiness, finding, applying, getting, moving and settling into new housing. From the findings of other research studies it can be deducted that for some people the ability to achieve stable housing may be affected by both the selection of housing and the attention to the details of settling into an area. Thus this study has sought to understand what happened for these individuals when accessing their current housing, to see if any insights about important issues or approaches emerged.

Types of important assistance/help

Participants reported three major kinds of help as important at the time they accessed their current housing:

- assistance with finding an appropriate place to live
- getting household goods, and
- assistance moving in.

There were a range of additional factors participants reported as important, but often these were highly individual. One of the additional themes that emerged was the importance of different types of practical assistance, including responses such as assistance with:

- the tenancy agreement
- application forms
- bond
- connecting utilities
- representation to the landlord
- resolving prior debt
- financial assistance.

In addition to these, there were other kinds of important help individuals identified which related to skill building and preparedness to move. These included assistance with:

- *'the confidence to move into a place on my own'*
- decision making about moving (how, where, what, when)
- finding an appropriate and compatible flatmate
- developing independent living skills.

Who provided the important help to access housing

Family were most commonly reported by participants as providing important help at the time they accessed their current housing, followed by PDSS and friends. Help ranged from: siblings or support workers assisting with finding compatible flatmates and moving possessions; friends or key workers helping search for a suitable place to live, either by driving the person around, using their networks to find a place or in providing moral support and confidence for the person to do it themselves; parents purchasing a dwelling to lease to their child; and the support provider finding, applying for, furnishing and moving the person into their current housing.

There was also a broad range of other services reported as providing important help by smaller proportions of participants. Three services reported by more than one participant were the Office of Housing, clinical case management services and State Trustees. Other services reported by individual participants included a housing co-op, tenants union, a number of large welfare organisations, homeless services, a psychiatrist, a residential rehabilitation service and a student housing service.

Relationship between choice and housing satisfaction

The literature asserts that having choice over selection of one's housing is important for housing stability, thus the project sought to understand whether participants perceived they had a choice in relation to selection of their current housing, and whether housing choice impacted on housing satisfaction. This study found that those who had a choice – one third of all participants - were more likely to be satisfied about where they lived than those who didn't. Only one person who felt they had a choice was dissatisfied with their housing, while two others had mixed feelings. The vast majority who reported that they had a choice lived in private rental and were happy with where they lived.

At the time of seeking their current housing, half of the participants were in housing circumstances that they considered intolerable or unsustainable and thus could be considered in housing crisis. Only three of these 25 participants felt that had a choice over selection of their housing. Fourteen of them moved into public housing, while the other eight moved into private rental housing. The lack of sense of choice is not surprising, when it is known that particularly for those in public housing, many are likely to have been priority applicants who, at the time, had to accept the one offer made to them or lose their priority status. (Note: The Victorian Minister for Housing is currently considering a recommendation to change this policy).

Comparison of what service providers and participants reported as key to accessing housing

Prior to interviewing the participants the key contact (usually the key support worker) from the PDSS was asked to identify what they considered was key to their client accessing housing. There were three strong themes in what the service providers reported to be key to people accessing housing:

- **Support from formal service providers**, with PDSS support featuring most strongly. The assistance they reported providing that they felt was key to people accessing housing ranged from encouragement, moral support, motivation, "making it happen", to linking people into services including the Office of Housing priority waiting list system and clinical mental health services. The prevalence of PDSS featuring in these findings is not surprising given the participants were all engaged through PDSS services and the key contacts were all PDSS workers.
- The second strongest theme reported by key support workers as key to their client accessing housing was the **range of attributes of the person themselves**. These attributes were described in ways such as:

- a personal ability to self manage
- a person's high functioning.
- an understanding of the system
- self motivation
- independence
- a strong desire to be independent

- The third notable theme discussed by key support workers was **support from family and friends**. A key form of support identified for four clients was family members who owned a house which was leased to the participant.

While there was considerable congruence between the views of service providers and participants about what was key to accessing housing, there were two notable differences. The participants more strongly emphasised the importance of their families and were less likely to focus on themselves and their own abilities when responding to this question.

Accessing housing urgently

As previously reported, half the participants were in housing situations that they considered intolerable or unsustainable prior to moving into their current housing, and thus there was some urgency in finding their current housing. The interviews highlighted that many of those with an urgent need for housing did not carefully select a place to live with attributes to meet their ongoing, let alone immediate, needs. Often the 'driving force' behind their sense of urgency led them to accept housing, not on the basis of its appropriateness, but because it got them away from a traumatic situation or out of crisis, including imminent homelessness. Under these circumstances, some people felt driven to take the only available option, although retrospectively it may not have met their longer term housing needs, and only addressed their immediate concerns.

The following provides a range of examples of pathways into housing which highlight this notion of a driving force:

- One woman had been living in inappropriate marginal housing (caravan) that did not meet her needs and had been waiting for a long period of time to find stable housing
- A man had been living in an environment which resulted in major alcohol abuse and the associated problems of this (malnutrition, violence, debt, and was not able to make informed decisions)
- Living in a SRS where he experienced an 'abusive manager', for one man getting out of the SRS was critical to his wellbeing
- A woman had come out of hospital with nowhere to call home and no confidence, personal resources or informal supports to rely on, and was particularly vulnerable
- Another person's previous experience was being homeless, and a roof over his head was the primary criteria for housing
- For one woman physical safety was her primary driving force – she wanted a secure premise a long way from previous strife, with some anonymity to feel safe
- Escaping a troubled and unsupportive living arrangement at home with his parents was another man's reason for seeking housing, with the desire for a place of his own most important

For these individuals once their primary need is addressed they may find that the housing they accepted is not appropriate to their longer term housing needs. The type of housing choices made in highly stressful circumstances may depend upon whether people were provided with support to choose housing appropriate to their broader and longer term needs and whether, in fact, any appropriate housing was available within the timeframes required. Participants who felt they had no choice over their housing often accessed their current housing in some type of crisis. For people who said they felt they had a choice over selection of their current housing, much smaller numbers were driven by a crisis.

Three different types of outcomes were evident for those seeking housing in crisis circumstances:

1. Through good support or, in some instances luck, some participants who sought their current housing in a time of crisis have a high level of housing satisfaction, with the place where they live meeting their needs and preferences.
2. Some participants accessed housing that currently does not meet all of their needs and are now receiving support to find more appropriate housing. For this group, although they may not particularly like where they live now, their housing satisfaction is mediated by the knowledge that others are helping them to find housing which will better meet their needs. They are, therefore, prepared to stay in their current housing while they search or wait for more appropriate housing.
3. Some participants are in housing that doesn't meet their needs and are unhappy with where they live. A number actively want to move. These include situations such as:
   - A man who is living too far from his close informal supports and feels isolated and dislocated socially and emotionally. He is actively being supported to move.
   - A woman who is living in densely populated housing, for whom exposure to many people coming and going exacerbates her feelings of paranoia, feeling of claustrophobia and lack of privacy. This is causing ongoing anxiety and results in her resorting to alcohol, which detracts from her ability to function independently.
   - A woman who stated that she had no control or support at the critical time she was seeking housing feels she took what she could, only *'to get out of the fire and back into the frying pan'*. At the time she moved, she had not been formally diagnosed as having a mental illness and mental health services had refused to acknowledge her mental illness. She is very unhappy, and describes the house she moved into as in a terrible condition and not in her favoured area. *'I was told by a lady from housing that if you knock back this house you'll get knocked off the list. The last person who knocked back this house was taken off the list and I didn't want to spend another six months or more in emergency accommodation either, so I took it...'*

For these people, staying in their current housing is not a tenable solution, and they are at risk of not staying housed. It is unclear whether these people, with support, are likely to be able to access alternative housing that would meet their needs.

5.2 Participants' satisfaction with their current housing

Much of the literature reinforces the importance of matching housing to a person's needs and preferences if stable housing is to be achieved. The participants interviewed were identified by PDSS support workers as having achieved stability in their housing. We sought to understand whether there was a relationship between housing stability and their level of satisfaction with where they lived.

Satisfaction with current housing

When asked about whether, overall, they were happy or unhappy with their current housing, two-thirds indicated they felt happy or very happy with where they were living. The other third either had mixed feelings, were unhappy or very unhappy with their current housing. Those living in private rental and community housing were more likely to be happy with their housing, compared to those in public housing.

Participants were then asked to explain what made them happy or unhappy with their housing. Although responses were highly varied, the following five themes emerged as the strongest factors and are listed in rank order:

- **Closeness to things,** such as public transport, shops, family, *'central to everything', 'everything is easy to get to'*
- **Good neighbours** e.g. *'Several neighbours who I've got to know well', 'the people are nice', 'nice neighbours'*

- **Like the area** e.g. *'I'm in the area I was brought up in', 'I'm in a reasonable area as far as people go'*
- **Like living alone** e.g. *'I have my own space', 'I can come and go as I please, because I'm on my own'*
- **Like who I'm living with** e.g. *'Like living with 'Max'', 'good living with my brother'*

Other than the top five, there was a range of other factors mentioned as contributing to housing satisfaction. Physical aspects of the housing itself, such as having plenty of room, being clean, having a yard and being safe were also mentioned. Feelings were also a theme, with responses such as feeling *'at home'*, content, positive and happy, and feeling that it was their own place. Others mentioned that they were happy because they had friends there, had links to important groups or were happy with where they were living simply because it was *'somewhere to live'.* This latter comment illustrates the impact prior individual experiences can have.

The most frequently mentioned reason why participants were unhappy with their housing was related to neighbours causing problems. Other common reasons given were criminals or crime in the area, and being too far from things, such as shops or family. Other responses were highly varied, although most related to physical aspects of the property (such as dirty or hard to maintain), feelings that the housing invoked in people (such as being miserable, lonely, the house being associated with bad memories, feeling isolated, depressing environment) or unhappiness with renting or high rental.

Likes and dislikes

Participants were further questioned about what they liked or disliked about where they were living. The difference between this question and the previous question about housing satisfaction is that this question illustrates that although people may like nearly everything about their housing, *one* factor may cause overall dissatisfaction. For example, some people were very happy with where they lived, yet when asked to find something they disliked, were able to identify any number of things that could be improved. Similarly, those who were unhappy with their housing were often happy with many elements, however they were still unhappy overall. Hence this data gives us a sense of how individuals weight what is important to them.

This data reinforced the previous responses to the question on housing satisfaction, in which closeness to things, the area itself, neighbours and living arrangements were all in the top ten. The additional factors mentioned in this question were around housing condition, which did not feature as strongly as a factor that influences overall housing satisfaction.

The responses to what participants liked and disliked often mirrored each other. That is, if a participant lived close to shops and family they might say that this is what they liked about where they lived; those who lived far away from shops and family often said they disliked their location for this reason. Similarly, a person might like where they lived because of the lack of violence in the area, whereas another might dislike where they live, describing it as a *'bad area'.* Particular features of the property were important; *'It's a home to me'* or *'I don't like that it's public housing and I don't own it.'*

Length of time planning to stay

While we documented the length of time participants had lived in their housing and the amount of time they said they planned to stay, we came to the realisation in exploring this question that the issue of length of stay is a very complex one. While most indicated an intention to stay in their current housing, length of stay is not necessarily a measure of stability. The degree of control a person has over their housing situation is more of an indicator of housing stability. In addition, when recommending a client for the study, one key support worker commented that being housed for three or four months, in the context of a two-decade history of homelessness, was a great success. Therefore intended length of stay can depend on the person's prior housing career and experience.

For those in private rental the ability to predict whether they were likely to stay was determined by factors outside their control – how long the property would be available to rent and how long the rental remained affordable to them. For others, as with the rest of the Australian population, their aspirations varied, with some aspiring to own their own home, some aspiring to secure public housing who were in private rental, some wanting move to a place where they could live alone, some wanting to move to a shared living arrangement and others wanting to relocate to another area. Life transitions and individual preferences therefore also play a part in desire to stay living in a particular house and location. The other difference evident between those in different housing tenures was that none of those in community housing planned to move.

It is important to note that responses appeared to be strongly influenced by individual's perceptions of what constitutes 'staying housed'. From the stories of participants, it became evident that although people report that they do not have plans to move, they may then go on to report that they intend to stay where they are living for only a matter of months, and vice versa – some people who reported that they do not see themselves living in that place for some time then said they intended to stay for a year or more.

The huge variability in length of stay data reinforces the importance of support services who understand the need to work with people with complex needs where they are at to assist people through life transitions, and their housing career.

Compromise and trade-offs and impacts on housing satisfaction

Examination of the responses from participants to issues about their housing showed that many have made conscious trade-offs between different needs and preferences. There was, for example, one group who were relatively content with their housing, despite having made particular trades-off. The following provide examples of the nature of the tradeoffs made by some of these participants:

- One man was not living in his preferred area, felt unsafe, had been the victim of violence where he lived and was living amongst neighbours and other people in the area who were drug dealers. However, the positives were he was able to have his dog with him, which was his main priority, was able to live by himself and was not living in a high rise.
- A woman had three housing attributes she disliked – she was living in public housing, further away from town than she would have liked, and in a 'rough' area. However, she traded these against more important housing attributes of being able to live on her own in a big house that enabled her to store all of the things she collected.
- Another woman would prefer to live in the country in an attractive house, however she was living near to her sister which was why she moved to this housing, the rent was affordable and she could have her cat, which was one of the most important things to her.

There was another group who had a seemingly different perspective, which may have related to their personal disposition to view life positively, and make the best of what they had. The following provide examples of the situations and views of this group:

- One woman, although having security fears living in a high-rise *'with so many people living so close and so many people coming and going'*, felt grateful as she explained that she was aware what might be worse and therefore felt comparatively well off where she was.
- One man was desperate to escape his inappropriate accommodation and so agreed to move from one area to another a long distance from suburbs he was familiar with because of the lack of affordable housing in his familiar area. The concern at the time was dislocation from his formal supports and social networks. This was a conscious trade-off that was successful after he accessed a new service system and developed social networks in his new suburb. He reported a high level of satisfaction with his current support and therefore was very happy with the outcome of his trade-off.
- Another woman had chosen to stay out of public housing after seeing what was on offer and feeling that she would not feel safe living there. She decided she would rather go without food and stay in private rental where she had a sense of security. Her current housing was not visible from the street and she had very good neighbours who *'aren't all at*

home during the day minding your business'. With this as her trade-off, she has managed to stay housed long term (over 10 years) and throughout that time gone without food on a number of occasions when she hasn't had support to pay the rent. She felt exceptionally lucky that the landlord hadn't raised the rent for a long time, and the fact that there was no real estate agent involved, and therefore no threat of intrusion, which was also important to her.

It was also evident that there were a few people who refused to trade-off what is most important, and tried to have it all, but as a consequence placed themselves at considerable risk of not being able to sustain their housing. For example, one person was in denial about his mental illness and therefore was not eligible for a disability pension or priority housing. Due to his illness he was unable to work and therefore unable to earn the income needed to sustain his previous lifestyle and was about to be faced with the need to make a number of trade-offs, including moving to a smaller place or to a different location to reduce rental costs. For this person, refusing to address the reality of his psychiatric disability and make trade-offs will result in depletion of his financial resources, incurring debt and losing the ability to choose more affordable housing.

5.3 Supports

During piloting of the questionnaire participants were asked about what supports them to stay housed. It became evident that questions that simply and directly tied 'supports' to an outcome of 'stable housing' created some confusion for participants. The link between 'staying housed' and the various forms, levels and sources of support is conceptually very broad. These links can be directly associated with housing support, such as practical assistance with paying rent, activities of daily living and household tasks; or indirectly to more intangible factors that can improve a person's mental health and emotional well-being, for example:

- social and community connectedness
- stable and supportive environments
- social and physical activities
- access to social and supportive relationships
- physical security
- opportunity for self-determination and control over one's life
- access to work or meaningful engagement
- access to money (VicHealth Mental Health Promotion Plan 1999-2002)

The premise is that support that is not directly linked to housing needs can support a person to cope with the day to day demands of life generally, which results in a greater likelihood of people being able to sustain housing.

Stable housing, is definitely a foundation upon which to build these determinants of mental health, however is often taken for granted or not explicitly considered when people think about what supports them. For many people, when they think about housing and support, they picture support that relates specifically to housing services. However, it is clear that the supports that are critical to assisting people stay housed are those that assist them holistically manage anything that can jeopardise their ability to stay housed. These factors are 'housing risks' and are outlined in detail in Section 5.6 Management of Risks to Housing Stability.

Participants were asked about the supports important to them in the context that they were chosen for this study because their support workers describe them as successfully housed.

What is important?

When participants were asked about the '*most important support they currently get, have received in the past or know they can get in times of need'*, a number of themes emerged. (See Table 5.1)

Table 5.1 Important support – key themes (in rank order)

THEMES	Direct quotes from participants about important kinds of support
Practical assistance with….	*'Cleaning'; 'Money management'; 'Getting emergency relief'; 'Shopping and household management'; 'Ensuring I get food in the fridge'*
Someone to talk to…	*'Quite often I'm confused, down and angry and I need someone to talk to'; 'When you need to talk to someone, she listens to me'; 'If I have a hard day I can just go and talk to them'*
Treatment	*'Seeing GP & getting injections'; 'Coping with the illness'; 'Cognitive Behavioural Therapy'; 'Alcohol counsellor'; 'Medication being brought to my house'*
Social outlets	*'Just having someone to hang out with'; 'Social activities'; 'PDSS activities give me an opportunity to meet people'*
Skill building	*'Goal setting, courses'; 'GROW program'; 'Employment skills development'; 'Skills coping with illness'; 'Budgeting skills'; 'Assertiveness skills'*
Meaningful activities	*'Art program'; 'Employment'; 'Computer classes'; 'Helping me get a job'; 'Going to art school'; 'Doing a first aid certificate course'*
Linking into other services	*'PDSS support worker organised the Meals on Wheels'; 'The case manager and the psychiatrist talk to work out if I'm unwell or not'*
The balance of supports	*'Combination of things are important'; 'The balance is critical – my wellness is contingent on a few things staying in place.'*

Approximately half of the participants talked about practical assistance, having someone to talk to and the importance of treatment. The 'talking to' and the 'treatment' themes can be closely related, as an articulate person may have described the techniques used by, for example, their clinical case manager (such as Cognitive Behavioural Therapy) which we have considered treatment, however others might have described a similar session as having someone to talk to when they're confused.

Some people who were without family and friends relied on formal supports for 'someone to talk to' and described this as very important. For one participant, the formal supports were particularly important, as these were the only people that this participant talked to in any given week.

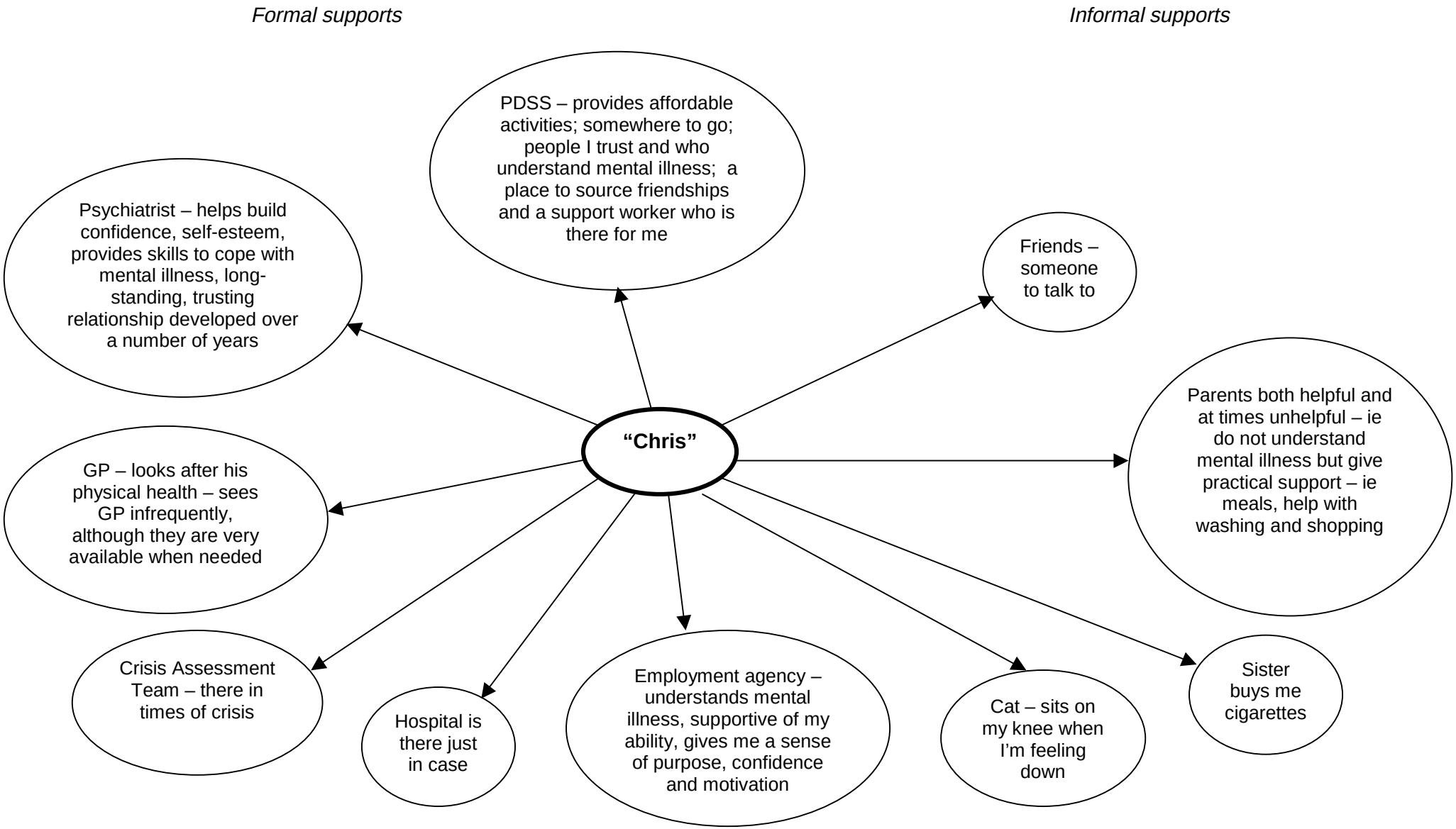
Social outlets and skill building were the next strongest theme.

While the themes 'linking into services' and 'the balance of things' appear in only a few of the participants' responses, the concepts are quite significant. The 'balance of supports' theme refers to the explanation a number of participants had in response to being asked to choose what is most important from the range of supports they receive. Some participants explained that they don't simply rely on one or two supports, in fact, they rely on a range of supports, <u>all</u> of which are very important.

> *'The clinic because they help me five days a week. They help me with medicine – that's where the case manager is if I need him. The centre here (PDSS) is important and my family support is important too. Because I'm sort of not very …. I don't know what's going on as much sometimes.'*

Figure 5.1, demonstrates the range of kinds of support a participant may receive.

Figure 5.1 The range of supports an individual may have in their life and their significance from a participant's point of view



The linking of participants into services has often happened through their association with either the PDSS or the Mental Health Clinic. In a number of cases a service that a participant cited as important was accessed through another service. For example, PDSS and case managers cross-refer to each other, depending on who works with a person first. PDSS and case managers will link people into other key services – a number of which were mentioned in the course of the interviews including:

- Centrelink
- Public Trustees
- Legal Aid
- Mental Health Legal Services
- Meals on Wheels
- Cleaning services
- Financial counselling
- Drug and alcohol counselling
- Social networks or volunteer friends organisation
- Self help groups
- Education and skill building courses
- Vocational and employment services
- Emergency relief agencies

Where State Trustees were involved they may employ services on behalf of the participant to manage activities such as lawn mowing or house cleaning which are critical to supporting people to manage living independently and staying housed. Often the PDSS was the service providing the formal support in terms of activities, a social network, practical support to shop, buy things, manage money, as well as help in managing the mental illness.

Participants' frameworks for what support is important differed depending upon what the person's support needs were. Participants' priorities were affected by their experiences and situation. For example, for some participants who were parents and had been separated from their children, access to their children can be paramount to them. Being mentally unwell has meant being kept away from their children, so mental health means seeing the children. Therefore access to children can be the most important support to a participant. It follows that important supports aren't always tangible formal support types. Participants often associated feeling supported with particular issues that had meaning to the individual. This could be realising a personal goal, feeling connected or cared about. Or they may be other reasons, such as availability of support, or closeness in location to where the participant lives, or longevity of the relationship e.g. *'I've been seeing him for ten years', or 'because he talks to me like I'm a normal person'*.

<u>Why</u> is this support important?

When participants were asked about what it was that makes support important, six key themes emerged:

- People providing the support understanding mental Illness
- Having someone to talk to / Someone who listens
- The availability and accessibility of support
- People who give me positive feelings about myself
- People who care (about me)
- Participants having some form of meaningful activity e.g. programs/employment/purposeful engagements

These themes are discussed in detail below.

- **Understanding mental illness*:*** In explaining what makes support important, many participants highlighted the importance of people who understood their mental illness or disability, were accepting of them and made them feel good about themselves. Sometimes this was a family member, although other participants talked about informal supports wanting and expecting something different or better or more from them. In one case the

family provided high levels of practical supports, yet did not understand the requirements of the individual and were not listed by the participant as important support. In these latter cases it was the support worker, case manager or psychiatrist who was important because, in one person's words, they felt they understood their mental illness and *'don't judge or condemn or expect a person to snap out of it'.* Dealing with people in a supportive, helpful way that is insightful to the person's disability is a key characteristic of important support to this group.

> One person referred to their PDSS key worker e.g. *'It's who he is and how he does it – if I'm in trouble – it could be a personal issue or something to do with my illness – he is there to support me – he knows how to help me out – what I need and where I'm at.'*
>
> Another participant referred to the importance of Cognitive Behavioural Therapy *'Being able to test reality with them (clinical case manager) and help me to see what is going on….even if they've got appointments they'll talk over the phone for ten minutes.'* For one individual this was specifically important for understanding the disabling anxiety caused by unreal beliefs (about neighbours).

- **Someone to talk to:** For a person whose disability affected them by *'creating confusion'*, *'getting me down'* and/or *'making me angry'* – having someone to talk to could be key. Having a range of people to talk to might also be important for back up. For example, one participant talked about the crisis help line for out of hours support when other supports weren't available. For a group of people who frequently expressed feelings of loneliness and isolation having someone to talk to can be very important. One person expressed this by saying *'I have nothing but time alone with my thoughts'*.

> *'I've got someone to listen to me – and if I haven't got someone to listen to me that's when I get into trouble – end up in jail because I'll stab someone or….If I'm ever in trouble I call her or I come here (to the PDSS) straight away.'*

- **Availability** was another theme which emerged from what participants said was important support.
  - *'Can call at any time'*
  - *'There if I need him'*
  - *'She'll come to my place if I'm really in trouble … she'll get on the phone and talk to me and help me'*
  - *'Availability – even if they've got appointments – they'll talk over the phone for ten minutes.'*
  - *'We have contact at least weekly'*
  - *'Generally accessible'*
  - *'I see her every week'*
  - *'I know she is available'*
  - '*They come to me on the dot – they're very reliable'*
- **Positive reinforcement:** Another strong theme in what made support important to participants were positive reinforcements, e.g.
  - *'The fact we can have a good laugh'*
  - *'Keeps me on track'*
  - *'Helps me integrate into the community'*
  - *'Self esteem and self confidence that I can do something'*
  - *'Feeling respected'*
  - *'Helps me feel secure about myself - it takes a lot of talking and crying'*
  - *'Talks common sense when I'm feeling negative'*
  - *'Feel valued'*
  - *'Gave me a kick up the bum'*
  - *'Gives me confidence and strength'*
  - *'Helps me snap out of it when I'm feeling down'*
  - *'Can bounce me back up again'*
- **People who care:** The existence of someone in the person's life who cared about them was another theme. Connections with family, a partner, or friends often are valued

relationships where they exist or are desired; that is, some people aspire to have a partner or close friendships in the future. *'Someone you can trust, who'll be there because they do care'.* Sometimes participants talked about key support workers or clinical case managers who they particularly valued in these terms – *'like family', 'a real friend'*, *'they really care about me'*.

> *'She's like a big sister (clinical case manager). (She) makes sure you're not doing anything stupid – makes sure you're taking your medication and tries to help you be more responsible'*

- **Meaningful activity**

  It was evident that having a meaningful activity was important for this group. Meaningful activity included hobbies, day activities, various programs, courses, volunteer appointments, supported employment and part time employment.

> One man referred to his most important support being the opportunity to work as a volunteer *'making me important in society, getting me doing something, (building) self confidence that I can do something, self esteem, motivates me because I get in there and I have to do it. Positive feedback from people that I'm good at it.'*

The interconnectedness of these themes: All of these themes are related to each other and begin to form the logic of what makes up important support for people who are successfully maintaining their housing. Availability of support is important to many people often due to the nature of their mental illness. The particular manifestations may require support either regularly, or spasmodically when they occur or when support is critical to their functioning. Skilled positive input from a person who understands mental illness and can effectively engage, relate, impart skills and techniques, focus a person, or assist with a reality check as needed can be critical. The link between important support and sustainable housing is not always found in tangible assistance with housing matters, but in the help that reinforces and assists people to cope with the challenges of daily living and often gradually increases their ability to live independently.

<u>Who</u> are the most important supports assisting participants to stay housed?

- **Sources of Support:** Both formal and informal supports were identified as important. Formal supports featured more strongly, with PDSS and clinical services most frequently mentioned. On average, each participant mentioned two formal supports as important and less than one informal support as important.
- **PDSS:** Participants were receiving a range of supports, with around three-quarters of the participants mentioning the PDSS as the most important support. The prominence of the PDSS may have been due, in part, to accessing participants through a PDSS.
- **Formal Clinical Supports:** Another strong theme was that two-thirds of participants listed the various sources of formal clinical supports as important. This included support from clinical case managers, psychiatrists, psychologists, references to the Mobile Support Treatment Teams (MST) and Crisis Assessment and Treatment Services (CAT) and, in a number of cases, the GP who was supporting the person with their mental illness. Only a small number did not describe either a PDSS or clinical support as important, and these participants only described their informal supports as most important.
- **Other formal supports**: About half of the participants listed other formal supports as most important. These services included: Centrelink, Crisis Line, other (non-psych) community support workers, cleaners, Meals on Wheels, an alcohol counsellor, the Mental Health Legal Centre, Commonwealth Rehabilitation Service, GROW (a self help organisation for people with a mental illness), State Trustees, an organisation which arranges volunteers for socialising, an employment agency, a supported employment agency and teachers at places of study.
- **Informal supports:** Over half of the participants listed some form of informal support amongst the supports that were most important to them. For those few who only described informal support as important, these informal supports were a parent or parents. In fact, family members featured strongly as being important throughout, with parents the most frequent familial support mentioned.

- **Self-management:** The interviewers observed that for many participants their own ability to manage themselves was key to them staying housed. This was substantiated by the number of times participants referred to their own ability to understand and manage their illness, their concerted attempts to stay physically well and engage in activities, and their capacity to seek help when needed.

5.4 Linkages between support

We asked participants to identify whether any of the people who supported them, either currently or in the past, knew each other. The question sought to understand the person's knowledge of direct linkages between any of the supports they had. Most said that they knew some of the people who supported them also knew each other, with the most common linkages as follows:

- Psychiatrist knew clinical case manager
- PDSS support worker knew clinical case manager
- PDSS support worker knew the psychiatrist
- PDSS support worker knew the family

Linkages mentioned were sometimes as a result of an initial referral - from a clinical case manager or PDSS support worker to the psychiatrist, or from a GP to a clinical case manager or psychiatrist. They could also be the result of communication at times when the participant is unwell – as one participant noted *'if there is any drama they collaborate'*. The PDSS was the most common link, and in some cases the PDSS worker acted as an intermediary, facilitating communication with the clinical services or the family or arranging joint meetings.

One participant noted that the PDSS support worker talks to the clinical case manager which saves her from having to see the case manager as often, and another that the PDSS worker, clinical case manager and Mobile Support Team administrator *'all talk about what needs to happen when things come up'.* For others who self-manage, the knowledge that others were there to work together to support them in times of need was reassuring. *'I think my clinical case manager would get in touch with my psychiatrist if need be.'* Another participant stated that when she turned up unwell to the GP's office he had put her straight in a taxi to the clinical case manager.

Those participants who identified some connection between their supports were asked for more details about these linkages, with the questions, *'Do they have ways of working together?'*, *'How does this work for you?'* and *'Are you happy with how this works for you?'* In general this group was happy with the way people work together to support them.

Information about the linkages between different kinds of supports was limited. An explanation might be that clinical practitioners note that good practice in supporting people with a mental illness can involve intentionally working in an unobtrusive way. Much of what might be "good practice" can therefore be obscured from some clients.

The most predominant services that participants identified were services within the mental health system, where there are mechanisms for creating linkages. It is not surprising that the PDSS support worker featured as a central point of coordination given all participants were PDSS clients. One would also expect PDSS support workers to be mentioned given the frequency of contact clients have with them, as compared to the more limited contact they appear to have with other common formal supports, such as GPs, psychiatrists and clinical case managers.

For some participants in private rental there were strong linkages with their landlord, particularly where their landlord was family and/or had a benevolent approach. The majority, however, did not appear to have formal links with housing managers or services. This group in private rental also does not have the linkage of Centrepay for direct debit of rental.

In summary, most participants were aware that some of their formal and informal supports knew each other, although were less able to describe the kinds of ways they worked together.

Potential forms of linkages

It was clear from the interviews that different types of linkages exist in individual's lives at different times. Figures 5.2 and 5.3 outline the linkages for one person during a time of wellness and when increased support was needed. When "Jill" becomes unwell the linkages between services are important. She has previously been initiating contact with her supports – when she doesn't initiate contact this alerts the key support worker to make contact, as it can be a trigger that she is unwell. She is then supported and linked back in with clinical support services by the PDSS. The clinical support services make contact with the psychiatrist and the GP to manage "Jill's" treatment.

Figure 5.2 When well – minimal formal support required - able to initiate contact as needed

(note: the arrow heads indicate the communication flow)

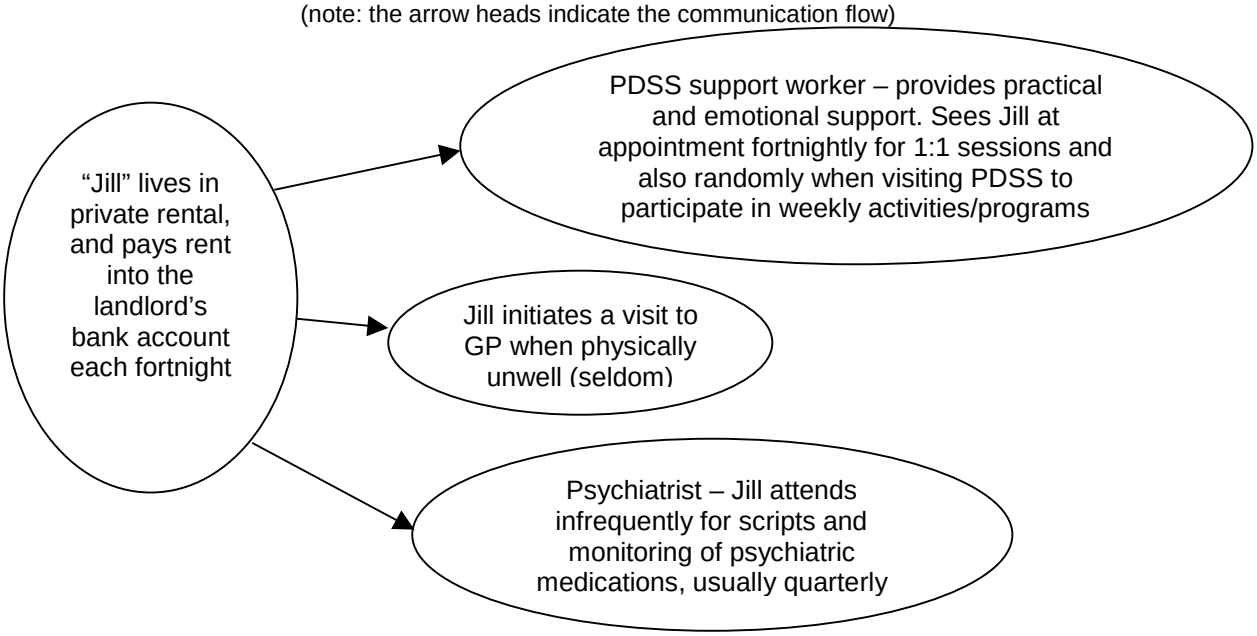
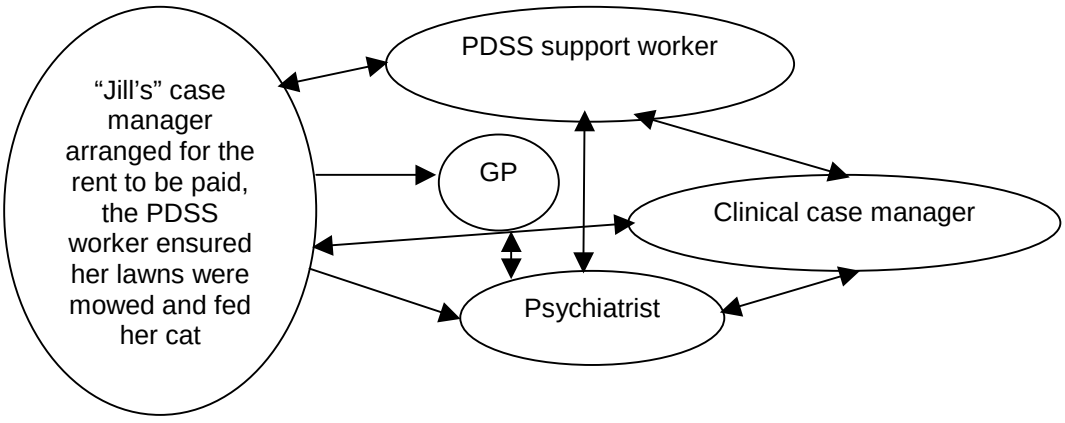


Figure 5.3: When ill – requires intensive support from a range of people.



5.5 Things that make it hard to stay housed

At the outset of this project, it was hypothesised that a key to staying housed is successfully managing factors that can put one's housing in jeopardy. The research team explored these factors with the participants, who were asked if there was anything that makes it hard or might make it hard to stay where they were living. The intention of this question was to obtain the participants insights into the potential risks to them maintaining housing. The responses to this question are rank ordered below.

- Neighbours actual behaviour creating problems
- Cost of rental
- Difficulty managing finances
- Fear of what neighbours might do
- Danger/violence in the area
- Insecurity of tenure
- Poor house condition
- Absence of support
- Loneliness

Neighbour behaviour

A strong theme to emerge was the importance of good, or even neutral, relationships with neighbours. Participants reported that this was very important to lessen their fear of discrimination, create a sense of belonging in the community and contribute to their sense of wellbeing. Some of these comments were about discomfort with current neighbour conflicts, direct discrimination and neighbour behaviour which is disturbing, such as:

'My dogs are noisy and I've been getting complaints…I get panicky when they bark because of the neighbours – I get a bit scared.'

'The next door neighbour who has been causing problems - whether they keep that up.'

Other comments were fear of what might happen if neighbours did create problems. These fears are equally real, as follows:

'Yes probably to do with my neighbours. Something could go wrong – they might start being openly rude.'

'For people with a mental illness the danger of being judged (discriminated against).. I always worry because I don't associate with them that they might think "Why doesn't he say hello?" But if I do talk to them...'

'If someone moved into the neighbourhood that caused a problem for me.'

'If people gave me trouble – other tenants. So far they've been good.'

Acknowledging and having ways to deal with current and perceived neighbour problems is a key risk management strategy.

Financial factors

Another strong theme was difficulty paying rental, with these comments offered mostly by those in private rental, including finding it hard to pay rent and foreseeing a problem if rental increased.

'Plus I'm a pensioner- I can't afford it.'

'Putting up the rent would make it hard.'

'Yes paying the high rental is making it hard.'

For others, managing their finances is difficult, and some would find it hard or have found it hard to manage without help. For others, they recognise that ensuring that rent is paid is critical to sustaining where they live:

'Financial management has been hard but I'll be alright when I'm with the State Trustees.'

'Finances - that's most stressful.'

'Finances - that's the only thing. My rent is paid every fortnight even if gas, electricity gets cut off. But things could go wrong…'

'Rent is directly paid - as long as rent is paid.'

Violence/criminal activity in area

A recurrent theme throughout the interviews was the desire to live in a 'good area' away from bad people. Some participants live in areas where they feel unsafe, have been discriminated against and have direct experience of crime through being robbed, raped or assaulted. Others may not have been directly discriminated against or been threatened but are nonetheless fearful of this happening. Some participants made comments suggesting the safety of where they live could affect them staying there in the longer term:

'Don't like drugs - girl next door is drug addict - police always there…'

'Yes - the violence around the place and my ex-friend might come back after the intervention order finishes.'

'People living around me are criminals and discriminate against me.'

'Getting beaten up.'

Insecurity of tenure

Insecurity of tenure was another response to this question, and is a particular problem for those in private rental. The fear of the unknown and lack of power over future housing stability was unsettling, which could take the form of the owner wanting to sell or the relationship with the landlord turning sour: *As long as everything stays cool with the landlady.*

Poor house condition

A small number of participants mentioned that they were unhappy with the state of their current housing, and that this might cause them to want to move.

'If the Office of Housing don't do work on the house I won't want to stay - condition of the place is not up to scratch - makes me feel less inclined to stay.'

'Just being there - that place - it's miserable. It's depressing.'

Other comments

Participants also identified a range of other issues. For some, having important support around them was helping them to stay where they lived, for others it was having something to do or being able to manage their mental illness:

'If I don't take my medication I would probably freak out.'

'What I'm doing is a survival mechanism – I don't have the bed in the bedroom because I believe there are monsters in the cupboard and I don't know if this will happen anywhere else.'

'Sometimes if I'm going through a rough patch I feel like I need to be in care - say to myself "hang in there and things will improve"... I think tomorrow is a new day - have a good sleep - try and be positive and exercise.'

For others loneliness was an ever-present issue

'Living on a pension is a way of life…you get isolated, you get depressed and lonely- lots of negative thoughts so if someone comes it breaks that (cycle).'

'I get very lonely – and it means I need to get out of the house.'

5.6 Management of risks to housing stability

The literature review and discussion with service providers had identified a range of factors as potentially presenting a risk for people living with a mental illness. These were as follows:

- problems paying rent
- difficulty with neighbours
- issues with the landlord
- issues with maintaining your house
- friends that can get you into trouble
- problems with medications
- periods of being unwell/hospitalisations
- feelings of loneliness or isolation

Participants were firstly asked whether they had experienced any of these issues and if so, how they had sorted them out. Where participants had experienced any of the above problems, they were prompted to talk about whether they had any help in sorting them out, whether the help worked well, what happens now and how important sorting this out has been to their success in staying housed. In many cases the participant had not experienced problems. This was often because, on further enquiry, problems had been averted because systems were in place to manage the potential risk factor, such as a direct debit system preventing problems paying rent. These strategies for managing risks were noted.

An additional question asked was were there other things the individual had in place to assist them to stay where they were living. Additional strategies that participants referred to included management of substance use, managing unresolved issues and access to children. The interviewer also asked whether there were back up plans in place or agreements to sort these out if support was needed. Most were not aware of specific plans, but some participants mentioned a person or service who would help them if needed.

The risk management strategies reported ranged from very active approaches, such as taking a course in budgeting, making a point to help neighbours and developing friendships with people who are a positive influence, to avoidance strategies such as keeping to oneself, purposely avoiding neighbours and meeting the landlord, and not inviting friends to one's home. In addition, the level of support required to stay housed varied from person to person, with some self-managing rental payments, maintenance issues and general problem-solving to formal supports actively managing finances, dealing with the landlord or addressing neighbour issues on behalf of the person with the mental illness. The level of dependency on others may be related to level of disability, length of time in independent living, the person's attitude and skills and availability of formal and informal supports.

The following outlines a number of the key ways in which the identified risks to housing stability were being addressed.

Problems paying rent/bills/managing money

There were several strategies and sources of support, both formal and informal, for managing finances, including rent and bill payment, paying debts and obtaining emergency relief. We know that over half of all participants are responsible for paying their own rent. Many comments were about their ability to manage on a limited income by budgeting, prioritising rent payment above other expenditure, paying off debts in instalments, being 'disciplined', having some savings, and developing a system for setting aside money for bills. At the other end are those participants who have relinquished control of their finances to the State Trustees or the PDSS, sometimes as a result of a previous financial crisis or to avert a crisis. In addition, the support of family and the PDSS were mentioned several times to help budget, provide loans, help pay bills and buy things. In a couple of instances the clinical case manager helped manage debts that had accumulated during a period of illness. One participant was struggling to maintain rental payments as their income had significantly reduced, so the person regularly forgoes food in order to pay the rent.

Difficulty with neighbours

Nearly half of the participants reported that they had difficulty with neighbours either currently or in the past, ranging from neighbours engaging in criminal activities, such as drug dealing or stealing things, to neighbours playing loud music. For a few, there was a concern that neighbours were watching or may be thinking about them, whilst others had specific arguments with individual neighbours over particular circumstances. These responses were consistent with the strong neighbour themes raised in other parts of the report.

Whilst problems with neighbours can be common place, people with a psychiatric disability may need extra support in sorting them out due to consequences of their disability such as difficulty distinguishing between reality and unreal thoughts/beliefs, lack of assertiveness skills, prior bad experiences with neighbours, the stigma of mental illness, lack of self-esteem, fear of being evicted, fear of conflict, discrimination and lack of understanding of rights. In addition, some difficulties appear to be imagined rather than real, and therapy such as Cognitive Behavioural Therapy or talking to another neighbour was reported to have been helpful in sorting through a problem.

Issues with the landlord

Service providers mentioned to the research team that in many cases people with a psychiatric disability are considered to be ideal tenants as they often have lower expectations about the condition of their housing and therefore make less demands in terms of maintenance. Because of the scarcity of low-cost housing, fear of losing housing is potentially a factor that contributes to low expectations. For a couple of individuals issues with the landlord were putting their housing in jeopardy. In one case issues with individual tenant behaviour are discussed at management committee meetings made up of co-tenants, so that the person feels their privacy is at risk. Although the housing is secure and meets most other needs, for this person this tenancy management practice is unsettling, to the extent that they are considering leaving.

In another instance, the participant became unwell as a result of the public housing she was living in being renovated while she and her child were living in it. Her attempts to resolve these major upheavals were unsuccessful and this situation resulted in hospitalisation, the garden being out of control on her return and a persistent feeling of depression with where she lives, because of the association of this house with these events. There appears to have been a lack of foresight in considering the impact renovating the house whilst this tenant was living in it might have. In a further case, the tenant was fearful of the landlord and actively avoided him, which meant not reporting accumulating maintenance issues.

On the other hand, there were several instances of benevolent landlords, including landlords keeping rental low, showing understanding and being responsive to maintenance issues. In four cases we learned that the landlord was a family member, and whereas this worked well for three of those individuals, for one the family member is unresponsive to maintenance concerns and this created some problems for the tenant. Others had minimal dealings with the landlord.

Issues with maintaining house

'The lawns are taller than me', *'I have trouble with the watering – just knowing I have to do it can set my anxiety off'*, *'I find it very difficult. I get very tired and can't get motivated'*, *'I have ants, dust, dishes, washing – just try to get on top of it…it gets out of control'* – these are some of the concerns expressed by participants who were trying to keep on top of where they live, but in some cases were feeling overwhelmed by the enormity of the task at hand. At the other end of the spectrum were those living in housing which they were able to manage themselves, without any outside help, many reporting being taught skills to live independently by either their parents or a formal support. However, over half had some form of outside help, usually to clean, shop, and manage the garden. Help was either provided by the PDSS, a family member, through the landlord, by a house cleaner or was sometimes organised through the State Trustees.

The mental illness itself may contribute to an inability to maintain housing, with behaviour such as uncontrolled spending resulting in an accumulation of possessions, lack of motivation, and unreal beliefs (i.e. people living in the taps or the walls) either creating or masking recognition of a maintenance problem or making 'minor' problems seem insurmountable. Assessment of the manageability of housing for the individual, additional support during times of illness and, for some who have difficulty recognising or initiating help, monitoring their needs, would appear to be key to ensuring that maintenance issues do not become overwhelming to the extent of exacerbating the illness and/or putting a person's housing at risk.

Friends that can get you into trouble

A feeling of vulnerability and the need to protect oneself from the bad influences of others was very common. This included friends who have created particular problems in the past, substance users, people who are not supportive or understanding of the person's mental illness or just *'bad people in the area'*. A common strategy was to keep to oneself: *'I stay away from people who might get me into trouble'* or *'I choose friends very carefully'*. Some participants specifically avoided inviting people to their home, or in one case even letting others know where they live, as a way of maintaining a sanctuary away from potential - and often former - bad influences. Others had specifically chosen housing that was hidden from the street, with the physical invisibility of the place a strategy for avoiding contact with others. A source of friendship was often the PDSS day program location or other formal services that provided an external safe meeting place.

It appeared that some of the participants we interviewed had difficulty developing or maintaining positive friendships. Aspects causing difficulty included lack of clarity about their personal boundaries, limitations in confidently knowing and asserting what might be good for them and a low sense of coherence or self-esteem, leading to a:

- susceptibility to people taking advantage
- vulnerability to trouble and trouble makers
- higher likelihood of making bad decisions
- tendency to attract the 'wrong' people for them

Many of the participants had an awareness of these tendencies and were actively making decisions to disassociate from negative relationships and start afresh.

Problems with medication

As with the other risk factors, there were some participants who were able to manage their own medication, whereas others either had some form of help in taking it (i.e. dosette box, reminders, visit pharmacist daily), it was brought to their home or they were on a Community Treatment Order. For some, help was required taking the correct dosage, remembering to take it, counselling to sell the benefits of taking it and managing the side effects. A couple mentioned crises that occurred through not taking medication and overdosing and others talked about the time it had taken them to find appropriate medication to manage their illness.

Periods of being unwell

One of the differentiating characteristics of having a psychiatric disability compared to many other disabilities are the unanticipated and fluctuating periods of illness that can lead to periods of hospitalisation or inability to live independently without help. This study sought to understand how individuals who have stable housing managed during these times. Again there was a diverse range of strategies, from those who had a preventative approach to managing their illness by keeping physically well, thinking positively, and actively engaging in interests, to those who relied on regular clinical assistance or an emergency CAT response as a back up.

'Having someone to talk' to was mentioned by one third of the participants, including regular formal and informal supports, such as the clinical case manager, psychiatrist, GP or family, or using crisis telephone services such as Lifeline. Weekends, evenings and public holidays were reported to be more difficult and were times when telephone support was particularly

important. Others stated that their own ability to deal with their illness has been important, such *as 'I've got a bag of tricks I use'*, *'I understand my limitations'*, or *'I do things like read a book'*. Another important support was having someone to look after the house during times of hospitalisation; in most cases this was family.

Some useful linkages between supports during times of illness were described, such as the clinical case manager arranging for the State Trustees to contact the Office of Housing and arrange rental payment; the PDSS support worker who took the person to the psychiatrist at a critical time who in turn called the CAT; and the GP who referred a person to a psychiatrist.

In terms of maintaining housing, automatic rent deduction, a low-maintenance house (or maintenance that is included as part of the tenancy), and support to re-engage once well, were all important mechanisms to ensure periods of illness did not jeopardise the stability of housing.

Feelings of isolation and loneliness

There were a few participants for whom feelings of isolation or loneliness were a current issue that appeared to be unresolved, leading to a feeling of vulnerability, depression and, in one case, self-harm. Over a third had strategies for managing loneliness, including calling or visiting others, focussing on the positive – *'I count my blessings'* and engaging in activities such as reading, walking and cycling. Others have ensured that loneliness is countered by their living arrangements – by living with another person, or caring for a pet – or having others who care for them who will keep in touch. Some participants relied on others calling on them and many utilise the social networks provided by services, such as the PDSS, neighbourhood house, or self-help groups.

Additional issues

It was apparent that for this group of people a number had other important issues that they were resolving which could put their housing at risk, in terms of undermining their mental or physical health. Some cited substance use issues, with alcoholism and drug taking using up finances, whereas not eating well was also mentioned as a problem. Insecurity of tenure was a concern, as was assistance dealing with previous abuses, legal issues or help in accessing children, who were often a source of motivation to stay well.

Participants at risk

Whilst at the outset we endeavoured to interview individuals who had been identified by the PDSS as successfully housed, in fact a few participants reported current significant risks that could result in losing their housing. In discussing the issue of risk management with service providers, it became clear that a number of factors are at play in the client/service provider relationship.

- The existence of risks to staying housed may be a constant underlying issue for those renting on a low income, who are prone to periods of disability. This was a reality for this group of often highly vulnerable people with limited housing options, and often fluctuating ability.
- The client may not be aware of the extent to which their housing is at risk or may not discuss this with the service provider.
- There may be multiple pressing issues that the service provider is working with the client to resolve and their housing is not the issue the individual prioritises as most important to them.
- The service provider may be aware of looming risks yet be obliged to respect the wishes of the client, even if they feel the decisions the client makes are detrimental to their housing stability. The service provider can often only suggest solutions and reiterate the concerns they have and be available to support the individual should a crisis occur.

In addition, there was a high degree of resilience and awareness amongst participants of when they needed assistance and a preparedness to seek and accept help offered was also strongly evident. Most participants recognised when they were in difficulty and had developed

a range of well thought out strategies to manage risks. Participants were currently experiencing and had experienced in the past varying levels of risk.

The following describe the scenarios for some of the individuals who the interviewers considered were at risk of not staying housed. For some of these people it was the multiplicity of factors that contributed to them either wanting to move, with no options available, or needing help to stay housed, whereas for others it was one single overriding factor, such as feeling unsafe, lack of privacy or inability to sustain rental payments when, in other respects, their housing appeared stable.

- **Multiple stressors detracting from ability to focus on managing mental health:** One woman, for whom English is a second language, was in poor physical and mental health, and had a highly dependent adult child needing her financial and emotional support. They were living in cramped accommodation, beyond her affordability, without core household furnishings and goods and in an area where she felt very unsafe. She was unable to concentrate on becoming well as she was on Newstart and so was required to look for work (she was not on a disability support pension). Although she chose her current housing there were limited options available. She felt overwhelmed, alone and unable to cope with the emotional demands, lack of social network and lack of financial resources to look after her family, let alone herself.
- **Inappropriate tenancy arrangements:** Another participant was a single man who was very concerned about privacy violations. In this case, a management committee made up of tenants, regularly met to discuss tenants behaviour when it affected their housing. Although his housing met many of his needs, he felt highly vulnerable and lacking in control, to the extent that he was considering leaving.
- **Difficult living arrangements:** An older man was living in a shared home with other people with a mental illness and, although he was very happy to be living independently and had ongoing support, he described his co-tenant's behaviour as very frightening. The co-tenant was often distressed at night and screamed out. Although the manifestations of the co-tenant's behaviour were not directed at this individual, he was finding the aggressive outbursts distressing. He told the interviewer this was an issue he hadn't discussed with anyone.
- **Housing renovation as a trigger of period of illness:** This woman felt she became unwell as a result of the public housing she was living in being renovated while she and her child were living in it – this resulted in hospitalisation, the garden being out of control on her return and a persistent feeling of depression with where she lived, because of the association with her child being removed from her care. She said, *'I don't think I'm managing so well – I just exist nowadays'.*
- **Disempowerment:** Another woman attempted to beautify her public housing apartment, putting a considerable amount of time into the garden. Some months later, without apparent consultation, the Office of Housing destroyed the garden when they erected a fence. She felt deeply disturbed by her efforts to create a home being destroyed, and subsequently felt very unhappy with living in that place.
- **Feeling unsafe**: This young, vulnerable female lived in public housing in what she described as a very unsafe area, and which the interviewer, who met her at her home, agreed felt very unsafe. She felt discriminated against by her neighbours who called her names, was frightened by the criminal element in the neighbourhood, hated the area and felt no sense of belonging. *'I get scared there sometimes – nothing has happened to me personally but...'* She described the screaming, fighting and frequent police presence. She was hoping to transfer to another area, but wondered how long this would take.
- **Effect of changes in income status:** This man was living in private rental however, as he had lost his income, was no longer able to sustain the rental payments on a pension. He had exhausted his savings, was not eating properly in order to pay the rent, and was reluctant to move as he liked the area and the house. He knew that on a pension his choices would be very limited and feared the alternatives would be worse. He was fearful of neighbours, was avoiding medication, and had few friends. He described his current state - *'I feel like I've got no shell anymore to shield me from things'*.

- **Precarious effect of diminishing support due to increased wellness:** This man had worked hard over time to build his skills to live independently, had found appropriate housing (his family purchased a place which he rented), and was in a neighbourhood he liked. He was well enough to be undertaking a formal course of study. His formal supports had diminished as his level of independence had increased. However, the toll of studying full-time and managing living independently and coping with the manifestations of his illness were proving difficult. He was struggling to feed himself and maintain the place and appeared to be in danger of sliding down the other side of the hill because of the combination of the withdrawal of support at a time of critical life transition.

These stories illustrate the kinds of risk factors that can influence housing stability for people living with a psychiatric disability. These factors are exacerbated by the lack of affordable, available alternatives to enable individuals to choose to move elsewhere.

5.7 The difference housing has made to participants' lives

As a final question, participants were asked, '*What difference to your life has living where you are now made?* Overwhelmingly, positive changes were reported, with the vast majority of those interviewed describing at least one positive difference that their current living arrangements had made to their lives. The themes that emerged in rank order were:

- Increased independence
- Improved social relationships/networks
- Happier
- Improved mental health
- Feel more safe/secure
- Grown personally
- Improved physical and/or emotional health
- Now have access to services

A very strong theme was that of a feeling of increased independence, with over one third of the participants making comments such as *'more freedom'*, *'able to do whatever I want'*, *'taking care of my life'*. The opportunity to be independent was often associated with a feeling of progressing towards wellness, leading to a sense of achievement; *'I've made the Big Step on my own'*, *'Step in the right direction'*.

Another theme was a feeling that there had been improvements in the quality of the participant's relationships and level of participation. In some cases this meant increasing the breadth of friendships and for others this meant being in a position to leave friends behind who had been a negative influence. *'I feel like I'm more in the part and part of society*'; *'I'm more active than I was'*, and *'Social life is better here'*.

Many simply stated they were happier: *'A lot of difference – to live a normal life in a happy and relaxed way, being in a happy environment makes a big difference'* and *'A good achievement in life – just happy, good times, that's it.'* For others, their mental health had improved, *'Lot less anxiety', 'I've still been unwell a couple of times but not as much'*, *'It's helped me get out of my dream world and into reality'* and *'My illness is much more manageable'.* For some, feelings of safety and security had made a difference.

Some participants mentioned they had grown personally from the experience of living independently, in terms of maturing, getting along better with family, becoming more responsible and *'made me wake up to myself'.*

Very few stated that there had been no difference to their life, although these same individuals did say they were happy with where they lived. A few participants mentioned only negative changes, with comments including *'I hate it – it makes me worry'*, *'I've been going downhill since I've been here'*, *'I've had some bad experiences here – I associate the house with them'*. Interestingly, half of those who cited negative changes stated that overall they were happy with their housing.

For a few there were mixed responses, with some of the things they were unhappy about including feeling cramped in the house, further from family, and *'people coming over in the middle of the night'*.

In summary, whilst for many the manifestations of their mental illness still needed to be actively managed, being in stable accommodation had made significant improvements to their well-being, self-esteem, and capacity to cope during times of disability.

Examples of positive differences specifically related to housing

The following stories show the positive relationship that exists between participants' perception of how their life is for them now and where they live. These stories provide us with insights into how appropriate housing has made a difference to not only maintaining housing stability, but to quality of life outcomes.

- **A hide away:** One woman was rebuilding her life after experiencing a series of bad relationships and friends who had gotten her into trouble. Her priority was to be away from bad influences. She was living in a flat behind a house, so had no street frontage and was effectively anonymous. She didn't divulge where she was living to others and stated that her house was her refuge while she worked towards setting other life goals. She said, *'I have control over who I allow to come and see me – I have total control over that, and that's really important – it's a must at this point in my life. This place is perfect.'*
- **Good neighbours plus:** When this person went looking for a rental place to live, he had a list of ten things he wanted, including a backyard, shops nearby and gas heating, and this place met all ten needs. There were only two other units on the site, with one neighbour very quiet and the other a person who he often chatted to. He liked the fact that he was surrounded by 'normal people' who were friendly, without interfering. Although he was paying higher rental than he would in public housing, he felt safe living in the area and that was very important to his wellbeing. He said, *'I'm happy and contented here'.*
- **A progression to independent living:** This individual has progressed from living in a residential rehabilitation facility to a group home and was living independently in private rental in a multi-unit dwelling. She was surrounded by neighbours who helped each other out, could turn her music up loud without feeling she was bothering anyone, and was close to public transport, shops, her volunteer job and the PDSS. She was thankful for all the support she received to get her to this point in her life, and fiercely valued her independence, saying *'I've never lived on my own before and now I'll never look back'*. The friendly, safe environment, privacy and closeness to important things contributed to meeting her needs.
- **Purchased housing:** This woman had been sharing with a flat mate and was told to move out. Her Dad bought her a flat, which she was renting from him. She was involved in choosing the flat, with a key criteria being close to services and to things she liked. She loved the independence of living alone and intended to stay for *'years and years'*. The only thing that worried her was loneliness at night, but she managed this by listening to the radio and planning the next day's activities.
- **Feet on the ground:** Having lived in a number of private rental properties, which had been financially stressful, this person had his name put on the public housing priority list. He managed to secure a newly built public housing unit, which he loved. He suggested that the interview for this study take place in his home, which was spotless. He explained that he was very house proud and that the good condition of the house contributed to his sense of wellness. *'I've been through hardships. It's nice to have my feet on the ground for once – I'm very content. I appreciate every little thing I have'.*
- **Colours we want!:** Two women had been sharing a place for several years in public housing high-rise. One lived in several places before getting public housing. She liked having someone to talk to, liked the closeness to public transport to visit her psychiatrist (she didn't own a car) and thought the suburb she lived in was *'the best in Melbourne'*. In addition, the Office of Housing had renovated the flat, allowing them to choose the new colour scheme. She loved the security of living in public housing and the flexibility of being able to transfer elsewhere if she needed to.

For others, their current living arrangements were the key to sustaining their housing, as follows:

- **A successful match:** Two men lived in a community-managed property and were introduced to each other and to the house through a PDSS. Both were easy going, positive individuals who supported each other. They shared the same network of friends, had strong family support and had developed the skills to live independently through a number of formal support services. The successful matching of these two people, together with ongoing support, had created an ideal environment.

5.8 Summary of insights from interviews

The insights from the interviews with the 50 participants provides a detailed picture of what was important to these individuals in accessing housing and staying housed. What emerges is that practical help in accessing housing is particularly important, as are ongoing supports from a range of sources and of a diverse nature. Most participants had a range of strategies in place to manage potential risks to staying housed, some with a heightened awareness of risk factors that they needed to manage or be assisted to manage, through to those with limited insight into what might put their housing at risk. For these individuals, the presence of others who have identified risks and supported them to manage such risks was often critical.

The level of satisfaction with current housing was high, with some dislikes mentioned, but overall a desire to stay living in the same dwelling for some time. Participants reported very positive changes when exploring what difference living where the person lives now has made to their life. Increased independence, improved social networks, increased happiness and improved mental health were all high on the list of outcomes for participants.

The next chapter analyses the conclusions that can be drawn from the information gathered throughout this study, including both the participants' views and broader observations.

6. FINDINGS

This study set out to understand what individuals with a psychiatric disability consider are the factors that support them stay housed. In the process of developing a context for understanding participants' comments, and working to broaden their understanding about the concepts of housing and support, a range of important insights emerged. In addition, the study was further assisted to understand the issues raised by participants through discussions with support and housing providers and Reference Group members.

This chapter summarises the characteristics of this group who have achieved stability in their housing. Awareness of these characteristics assists to identify what is important and what potentially contributes to them being able to stay housed. This is followed by a summary of what the participants reported to us was important for them to access and stay housed. The appropriateness of housing and risks to maintaining housing are explored. Importantly, a framework of risk management strategies is provided, as one of the key findings of the study is that effective risk management is critical to maintaining housing stability.

6.1 Key attributes of individuals who have achieved stable housing

All participants had a set of similar characteristics by virtue of the criteria established for their selection. They:

- are living with a mental illness and are experiencing or have experienced psychiatric disability, and as a result needed assistance with practical daily living skills or with skill development
- have secured appropriate private, public or community rental housing and achieved stability in their housing;
- are currently or have been supported through PDSS and have remained outside the formal HASP program.

The study provides additional insights into the personal and housing circumstances of people with a mental illness that may have contributed to their ability to achieve housing stability, even when living with, in some cases, a significant disability.

- **On pension or benefit:** All participants were in receipt of a pension or benefit, with almost all on a Disability Pension, thus they were all on stable low incomes. They demonstrated housing needs and desires similar to other community members, but in common with many other people on low incomes, they have adjusted or adapted these to accommodate their limited financial resources. Most had learned to manage on a low income and had strategies for ensuring rent payment and other essential payments were given high priority. The presence of an ongoing, stable income source, albeit low, was very important.
- **Acknowledged mental illness:** Overall, they were a group who have acknowledged their mental illness and disability to themselves. They usually had considerable insight into how their mental illness can affect them and had developed ways of living that take account of the consequences of their mental illness and its potential effect on their wellbeing and housing stability. Often the ability to do this has been the result of skilled and effective support. The ongoing availability of support for some is critical to them being able to recognise and address issues that might reduce their wellbeing or jeopardise their housing stability. Nearly all had medication and or treatments that were effective and had individually tailored approaches to ensuring that they did what was necessary to manage their mental illness.
- **Desire to live independently:** This is a group who want to live in the community, and overall want to live as independently as possible. Many demonstrated that they were prepared to take responsibility for their own wellbeing but also recognised that to do this they needed to accept assistance. Most received support from a range of services, and acknowledge and appreciate the importance of the assistance offered. Specialist mental health services providing support and clinical treatment were rated highly by this group as

important to them. These services coordinate their efforts, with a key support worker or case manager providing a central point of reference in the majority of cases. For many, but not all, family, friends and other sources of informal support play central roles, usually complementing the way that formal support services assist them.

- **In suitable housing:** Overall, support workers selected participants for the study based on an assessment that their housing was suitable for them. However, often this was in the context of recognising the limited alternatives available for people on low incomes. Over two thirds of the participants were satisfied with their housing, despite at times disliking some aspects about their housing that might cause them difficulties. Just under two thirds saw themselves as staying where they were for some time. Some in public housing had been waiting for some time to transfer to housing more suited to their needs, while some in private rental were on waiting lists for public housing in order to live in more affordable housing.
- **Strategies to manage mental illness:** In addition to medications and treatments, which assist the management of their mental illness, many have developed important ways of enhancing their mental wellbeing. They have achieved this through avoiding things that make them unwell, working to address past or present addictions to alcohol and drugs, seeking out people and activities that enhance their self esteem and build their skills and confidence, and knowing how and when to seek assistance. They demonstrate a motivation and willingness to participate in activities that give meaning and purpose to their life. Ongoing access to appropriate mental health treatment and support services has for many been a central factor for developing the skills and attitudes to live in such a way. Their age, associated maturity and life experience also helps.
- **Vulnerability:** Despite many positive attitudes and approaches to managing their illness, and their access to skilled support, most still face daily challenges and struggles in living their life as a result of the consequences of their mental illnesses and resultant disability. Most remain vulnerable and live with risks that if not well managed, can seriously jeopardise their housing. In addition, many participants mentioned that their mental health still fluctuates and change or other stressful life events can create major hurdles to maintaining their mental health and therefore ability to cope.

Conclusions

For this particular group, it was evident that key supports were vital – from a stable income, to appropriate treatment, to psycho-social rehabilitation. Such supports have helped participants to develop their own readiness to live independently. Support that was tailored to particular individual needs and aspirations, and to the way in which the mental illness manifested was also important. A large proportion received considerable help to access their current housing which appears to be critical in two ways: 1) support was available to engage participants and 2) participants were willing to be engaged. Access to housing that met their needs was also important.

6.2 Housing appropriateness and outcome

Common sense tells us that there are likely to be a complex set of issues that influence one's capacity to access housing appropriate to one's needs and aspirations and achieve 'control over' where one lives. For people on low incomes, living with a disability arising from their mental illness, housing choices are more limited, particularly in areas where social housing and affordable and quality private rental is in short supply. Housing appropriateness is related to many different factors for different individuals, including ability to choose location (which could include proximity to shops, family, or support services), the nature of the local neighbourhood and whether it feels safe or not, to the nature of the space available (e.g. amount of privacy, closeness to neighbours, type of housing). Such factors can increase or mitigate particular manifestations of a person's mental illness.

The qualitative approach of this study has enabled some exploration of the links between housing appropriateness and housing stability. While the small scale of this study limits the degree to which its findings can be generalised, the findings nevertheless contribute important insights into a key and complex issue that needs to be better understood to usefully inform housing and support policy and practice for people with a mental illness.

Examination of the information provided by the participants confirms that housing attributes can influence housing stability and mental wellbeing. For housing to be appropriate for a person it appears that:

- The housing needs to be "acceptable" to the person, but may not be their ideal or meet all their preferences. We have seen how some people will and can accept trade-offs and live successfully with some housing attributes that might not match their needs or preferences.
- The housing must not have features that make it very difficult or impossible to manage any disabilities associated with the mental illness or attributes of their mental illness e.g. phobias, their behaviours, extreme sensitivity to noise, major difficulties managing interactions with others.

It is also important to note that housing stability is most usefully defined as maintaining control over housing choices and not having to move as a result of a housing crisis, such as eviction. People can still be considered to have achieved stability over their housing if they choose to move because their needs change, because better opportunities become available or because they make a conscious trade-off.

6.3 Accessing housing and staying housed – participants' views

Understanding consumers' views on what is helpful to them and what matters to them about the way in which they are assisted is critical for the development of effective housing and support programs and services. While service providers, advocates and families all have their perspective on these issues, these alone are not sufficient yet are often the most well articulated and available perspectives. A range of important insights into what people with a psychiatric disability who have achieved some stability in their housing see as the factors that support them to stay housed, as well as what jeopardises their housing, have been gained through this study and they are as follows.

Important assistance with accessing housing

Two thirds of participants reported receiving substantial assistance with accessing their current housing. Overall the assistance most commonly identified as important was assistance with finding an appropriate place to live, getting household goods and assistance with moving in. In addition, a number also identified assistance with practical aspects of becoming a tenant and assistance to build the skills needed to live independently, as important. Participants most commonly identified their family as the ones providing this important support followed by PDSS services and friends. Hence the presence of supportive family and friends is one key form of support and access to PDSS support is another. A wide range of other services were also identified as important by smaller numbers and these included the Office of Housing, clinical case management services and State Trustees.

Important assistance and supports and what makes supports important

Participants identified a range of assistance that was important to them. These were in order of the frequency with which they were identified: practical assistance with, for example, cleaning, money management, someone to talk to, appropriate treatment for their mental illness and other related problems, social opportunities, independent living skill building, meaningful activities and linking into other services.

Participants highlighted the key role of specialist mental health services. The most important sources of support identified were the PDSS worker, followed by clinical supports. All but a handful mentioned either one or both these supports as most important, often with both mentioned as important. Others identified a range of other services as most important, from Centrelink to State Trustees, to an employment assistance agency. In addition, more than half identified informal sources of support amongst their most important support, with a few only mentioning this type of support. For many of those identifying informal support as important,

this was from families, for others it was from neighbours, friends, co-tenants and the local church. Many identified multiple sources of important support that provided them with a 'balance of supports.'

Participants identified these supports as important not only because they provided the type of assistance they required and were available and accessible when required, but also because those supporting them had an understanding of mental illness, gave them positive feelings about themselves, and demonstrated that they cared about them. The participants' explanations of how and why this support is important were compelling and convincingly demonstrate that sound understanding of mental illness and the way it impacts is central to supporting people with a psychiatric disability stay housed.

Links between support

For most individuals there were a range of sources of support and types of support, many of whom did work together to assist the individual, particularly in times of greatest need. Nearly all participants were aware of some form of linkage between their supports and most were happy with the way their supports worked together.

For those in private rental in particular (which was close to half this group of participants), specialist mental health services and/families are often needed to assist to identify and ensure risks are managed. Thus, for this group, the issues of linkage relates more to formal services understanding housing risk issues and how to address them, rather than necessarily a structural linkage to a housing service.

For those in public housing the issue is slightly different, as this housing system has some responsibility to be aware and sensitive to the needs of particular client groups, including people with a mental illness. To some degree the need for linkage strategies around individuals and between services may well be reduced when systems are put in place for automatic payment of rent, as happens for a large proportion of participants in public housing. Also, as the participants are usually in regular contact with skilled mental health support services, other known problems that people with mental illness can face with their housing and housing managers may not escalate to a level where they are noticeable and problematic, precisely because the person is receiving appropriate support services. We also know that some housing offices have protocols for supporting people to sustain tenancies and protocols for working with other services, albeit it appears that no systematic statewide approach is in place to ensure that housing risks are identified and managed in a timely way.

What was key to this person staying housed?

This analysis reviews what was key to participants staying housed, taking into account their comments over the course of the interview. A major theme was the presence of support of various kinds and the people who provided it. The keys to staying housed were identified as having someone to talk to or listen (usually providing by an informal source of support), practical support with activities of daily living and places to go/people to see/social network (usually provided by some formal kind of support). The other emerging themes were the important skills or strategies the participant themselves possessed and the fact that the housing met the individual's preferences and needs.

A number of comments on what was key to the person staying housed related specifically to individual needs and personalities, reinforcing the unique nature of each individual circumstance. For example, for one person a key to staying housed was their pet dog, for another it was their medication, for another having a culturally appropriate service to access and for another the negative past experience of being hospitalised propelled him to stay well.

The difference that housing can make

The majority of those interviewed identified that their current housing had made a positive difference to their lives. The nature of the differences they identified varied between individuals, with some of the more frequently identified improvements relating to increases in independence, improvements to social relationships/networks, feeling happier and improvements in mental health.

Factors that might jeopardise their housing

All but a few participants identified things that could jeopardise their housing, with a range of different issues identified. The most commonly identified were neighbours creating problems, high cost of rental and difficulty managing finances. Other issues identified by a number of participants included fear of what neighbours might do, danger/violence in the area, insecurity of tenure and the poor housing condition. For some participants, the factors that could jeopardise their housing were being actively managed, for example systems were in place for automatic payment of rent and applying for public housing when private rental was too expensive. For others, the factors identified pose real threats to their housing stability if they reach a point where they cannot be tolerated or managed by the individual.

Conclusions

As has been noted throughout this report, the variety of responses for what has helped people stay housed reflects the diversity of the individuals interviewed. For most it was a combination of elements, including the house itself, such as design, location and privacy offered, that was important, the formal and/or informal supports, their own abilities and resolve, having meaningful goals or regular interests, and strategies for managing on a limited income.

The information from participants about the impact their housing has had on them strongly reinforces that housing does make a key contribution to people's wellbeing. At the same time, for many of the participants, there were factors they identified that could jeopardise their ability to stay in their current housing. The high prevalence of risk to staying housed for this group indicates that identifying and managing risks is key to successfully support ongoing housing stability for people with complex needs.

6.4 Risks to maintaining housing stability

In developing the Positioning Paper for this study a list of factors were identified, from both the literature and from discussion with service providers working with people with a mental illness, that appeared to jeopardise a person's housing stability. These factors were as follows:

Risks related to the person's own attributes, psychiatric disabilities and behaviours when unwell:

- exhibiting behaviour which is problematic to others
- non-payment of rent
- periods of hospitalisation resulting in absence and possible non payment of rent
- not maintaining internal or external areas of property to an acceptable standard
- behaviour which is self-harming
- fear, lack of confidence, self-esteem and thus reduced skills to live in the community
- lack of practical independent living skills – shopping, cleaning, cooking
- loneliness/isolation
- poor management of medication taking
- difficulties with managing finances and payment of bills

Risks arising from what others might do or not do:

- negative neighbour response to the individual because they have a mental illness, not because of their behaviour - ie the neighbours response is outside the person's control
- negative housing or service management response to the individual
- misinterpretations of behaviour by others - ie behaviour such as not answering the door to the landlord or not confronting difficulties may be because of paranoia (illness) whereas it is interpreted as hiding/avoidance or not taking responsibility
- friends that can get one into trouble
- lack of appropriate, timely and skilled support

Whilst this framework is useful, what we have found is that there is often not a clear-cut division between what the person can be held accountable for and the risks arising from what others might do. For example, issues with neighbours can sometimes be about the relationship itself turning sour. A better framework is to consider where the person's locus of control is. That is, there are some things that are within their power to manage, with the support of others, and other factors that are outside their control that others cannot help them to change. This might include living in a bad area and not having an alternative area to transfer to, having to manage on a very limited income or the existence of discrimination.

6.5 Risk management strategies

The information arising from the interviews has identified quite clearly that this group of people live with a set of factors that can jeopardise their housing stability and their overall mental health and capacity to manage independent living. A key to maintaining their housing stability is accurate identification of these risks and development of strategies to manage them.

The following table provides a snapshot of the range of strategies people had used to manage potential or actual risks to their housing. In compiling this list it is acknowledged that some of these factors are common to other people on a low income in rental housing, and are not particular to people with a mental illness, such as many of the strategies to address problems paying rent and bills. Other risk factors are more closely related to the presence of a psychiatric disability, such as unexpected periods of illness, or imagined difficulties with neighbours that are the manifestation of the mental illness, e.g. paranoia. The existence of a psychiatric disability in many instances further exacerbates the difficulties associated with being on a low income in rental housing.

Strategies for managing risk are described in order of:

1. Active strategies (i.e. where person is in control of the situation and has the ability and/or awareness to manage themselves)
2. Strategies engaging help from others
3. Passive approach – i.e. avoidance behaviours, keeping low profile

These are strategies when the housing itself is deemed appropriate and support is provided.

Table 6.1 Risk management strategies

Factors that jeopardise maintaining housing	Risk management strategies
Problems paying rent/bills/ managing money	Self-manage finances – stick to a budget; recognise criticality of paying rent above all other expenses and have a routine for paying rent and bills as a top priority. Engage formal and informal supports to pay debts, loan money, buy things, help in times of emergency Pay bills via instalment schemes Direct debit rent through Centrelink State Trustees, PDSS or clinical case manager help manage finances, physically pays bills

Difficulty with neighbours	Take action if serious problem – i.e. call police Talk about the problem with other neighbours, landlord, PDSS, clinical case manager (sometimes to test that the problem is real) and work out ways to resolve it Tolerate anti-social behaviour – i.e. loud music Minimise contact with neighbours – keep to oneself, just say hello, avoid conflict situations
Issues with the landlord	Behave as a 'good tenant' – i.e. pay rent on time, keep house well-maintained Obtain formal support to maintain tenancy – i.e. to help pay rental, mow lawns, clean house Choose to live with another/others who can deal with the landlord or tenancy and maintenance issues Choose housing which is managed by a supportive landlord – i.e. community housing may be more amenable Family as landlord Draw on formal and informal supports to help deal with landlord issues i.e. provided advocacy, coaching, skill development or practical assistance Keep quiet/avoid landlord
Issues with maintaining your house	Have developed skills to maintain house and be able to use formal mechanisms to complain about maintenance issues Chose a place to live that is physically manageable – e.g. low maintenance house and garden or no garden The tenancy arrangement includes others maintaining outside areas Obtain formal or informal support to clean, mow lawns, do shopping etc. Ignore maintenance issues – i.e. make do, stay invisible, avoid
Friends that can get you into trouble	Choose friends carefully, stay away from trouble Develop friends through formal services in a safe, neutral environment, such as a PDSS, where there is an external staffed venue to meet and socialise Avoid making friends, avoid inviting people to house, avoiding talking to people
Problems with medications	Self-awareness of benefits of medication and ability to self-monitor Use dosette box Obtain help in taking medication – ie others remind one to take it Visit service providers regularly to take medication, i.e. clinic, pharmacy, doctor Medication is brought to home Community Treatment Order to ensure medication is taken

Periods of being unwell	Adopt preventative health management strategies – i.e. regular exercise, eat well, take medication, engage in activities/interests, positive thinking, goals, friends Seek help when unwell – someone to talk to i.e. case manager, PDSS support worker, family, Lifeline, GP; somewhere to stay – with family, hospital; someone to look after the house – i.e. family, neighbour, friend Linkages exist between supports to sort out problems when unwell Regular help is provided to monitor wellness – i.e. visits from clinical case manager, CAT, phone calls from PDSS to psychiatrist, GP etc. Others admit to hospital
Feelings of loneliness or isolation	Visit or call others (formal or informal) Have things to do or places to go (formal or informal) to alleviate feeling lonely Live with others or a pet Others visit
Substance use	Stopped drinking/smoking dope Undertaken counselling or participated in formal programs, i.e. methadone State Trustees manage money so unable to spend it all on alcohol and drugs
Insecurity of tenure	Social housing provides sense of permanency Supportive landlord Family as landlord
Limited access to children	Assistance to access children or work towards children visiting or living with the person acts as a motivator and a reason for recovery or even a reason for living.
Unresolved past issues	Support to work through past issues i.e. sexual abuse, violence, emotional abuse, parenting issues - can help develop or maintain emotional stability and develop personal and emotional resilience.
Legal issues	Support to resolve legal issues, such as attending Administrative Appeals Tribunal, linking with Legal Aid, Mental Health Legal Services, dealing with criminal convictions etc.
Not eating	Support to shop, ensure food in the house, buy a refrigerator, deal with bulimia/anorexia
Dissatisfaction with housing	Support to seek an alternative place to live which better meets needs.

6.6 Comparisons with findings from previous study

Foundations for effective support

The findings from the earlier AHURI study on *Effective Program Linkages* concluded that there are three foundations for developing effective approaches to program linkages to support people with psychiatric disability to sustain their housing (referred to in detail in Chapter 2):

1. *The need to understand the impact a psychiatric disability can have on achieving housing stability*

2. Recognition of the importance of addressing individual housing needs and preferences

3. Developing effective service responses

It was clear from the interviews with participants and discussions with service providers that each of these was important to achieving housing stability, as follows:

1. The need to understand the impact a psychiatric disability can have on achieving housing stability

As hypothesised, it was clear from the study that many participants needed support in undertaking the basic steps to access housing, including finding a place, getting bond, moving in and so on. Some also required ongoing support to stay housed, with assistance in tasks such as paying rental and other bills, help with activities of daily living, social and emotional support. As shown in Figure 5.2, even those who are managing their illness well and are largely independent still require support during sporadic times when they are unwell. The interviews clearly illustrated the diversity of needs between individuals, and that, for some, many skilled formal and informal supports are involved in helping the person to stay housed. Figure 5.1 illustrates the range of supports utilised by one participant, and this is not an unusual case.

2. Recognition of the importance of addressing housing needs and preferences

In the previous study it was concluded that individual housing needs and preferences can affect the likelihood of staying housed. In our interviews with participants living in stable housing it was confirmed that housing attributes do influence a person's housing satisfaction, emotional wellbeing and mental health, as substantiated in section 5.3.

3. Developing service responses with a range of particular characteristics

The earlier study identified a number of attributes that constituted an effective service response, some of which were confirmed in this study, some of which were unable to be explored and some that were not strongly reported by the participants. Factors that were confirmed as important were: having time to build a relationship on the basis of understanding the individual's needs; having a skilled understanding of mental illness and being able to provide skilled support to people living with a mental illness; accessibility and consistency of support.

This project also identified other attributes as being important which had not been previously articulated, such as service providers being able to balance risks to housing with clients' rights to make decisions and the ability to recognise what motivates an individual and gives meaning to their life. Factors such as being able to balance the issues associated with release of client information were not explored with participants, and others, such as the importance of developing crisis plans, did not feature strongly when raised with participants.

Different approaches for linking housing and support

The existence of a range of different approaches for linking housing and support were identified as important in the previous report, including: housing formally linked to off-site support services (as in the HASP), interdepartmental agreements/protocols, coordination through general case management/ care coordination program and service coordination in local service networks.

The focus of this study was on participants in rental housing where the support offered was all off-site, and not specifically linked to their housing. A common thread was the existence of a key support person, either a clinical case manager or a PDSS worker, who coordinated support. The presence of a key support who understood the range of supports a person needed and was receiving, had regular contact with them and was able to intervene in times of crisis appeared to work very successfully for many participants.

There were also a number of key linkages evident in the regions this study covered including:

- In one region there were recent protocols that had been developed by local mental health services and regional Office of Housing staff to ensure that links exist between them to support clients/tenants in common to manage key housing risks and sustain their tenancies.
- In one region there was a region-wide housing information, intake and referral service for people with a psychiatric disability linking 16 services in the region, including housing and support services, generic housing services, clinical services and mental health services. Here clients can access region-wide information about supported housing properties, as well as generic housing services, be assessed for their housing and support needs and then matched to available properties (referred to in detail in section 2.6).

Proposed future directions and policy implications

The concluding policy implications from the previous project centred around the importance of:

- Collaborative and coordinated responses between housing and support services, including increased awareness of how others services work
- Increased understanding of mental illness in the service system and in the community to prevent discrimination
- Recognition of the cost versus benefits of investment in a greater supply of secure, affordable and appropriate housing and accompanying services
- An explicit and measurable goal of social housing should be to develop policies and practices to support those with complex needs to maintain their tenancies

The feedback from participants who have achieved stable housing suggests that, for them, the service system has worked well to help them find an appropriate place to live and stay living independently, with the provision of mental health services and other supports critical for achieving that ongoing stability and managing potential risk to housing. This project showed that when services are tailored to meet the various needs of individuals experiencing psychiatric disability, as is the case with both the case manager and for the PDSS within which these participants were clients, the outcomes are reportedly more successful.

Whereas evidence from service providers suggest that, for others, the service system does not work as well, with lack of key protocols and linkages between organisations such as the Office of Housing and the key supports contributing to housing crises. It was apparent that the level of information those in the mental health system have about housing and potential risks to housing varies. The same can be said for the level of understanding of mental illness and associated psychiatric disability within the housing sector. The transfer of information between services with clients in common receiving housing and support would appear to be critical to achieving good service responses according to the participating services.

The issue of actual discrimination and fear of discrimination loomed very large in the stories participants told, suggesting that community understanding of mental illness and efforts to eliminate discrimination are indeed very important. Often the issues centred around neighbour or landlord discriminatory behaviour which created an underlying tension and often fear for their future housing access and stability.

From the housing histories of the individuals we interviewed, it became clear that an enormous investment has been made over many years to achieve housing stability that, without ongoing monitoring and support, can readily be undermined. The project reinforced

the criticality of providing high focussed support at the outset to ensure individuals receive housing that will meet their needs as inappropriate housing and lack of housing choice creates an enormous strain on the service system.

The goals of social housing to date have centred on maintaining occupancy rates and managing rent arrears, without specifically including a goal to support those with complex needs to maintain their tenancies. For the individuals we interviewed in social housing, the presence of PDSS and clinical support was often critical to assist participants to stay housed. Few mentioned the active support of social housing managers, apart from those in community housing. It appears from these participants that the level of support provided by the Office of Housing is minimal, although planned initiatives such as the appointment of special housing officers to liaise with those tenants with complex needs should contribute towards addressing this gap.

6.7 Comparison with findings from the HASP Review

As mentioned earlier in the report, this project deliberately set out to complement a review undertaken by the Victorian Department of Human Services Mental Health Branch of their program, which formally links housing and psychiatric disability support (HASP). The HASP review was designed to explore the perspectives of people in HASP, while this study set out to analyse the perspectives of people with similar characteristics in social or private rental housing, without formally linked support.

Below is a comparison of the responses collected in the fifty-three consumer surveys returned by consumers in HASP, to the face-to-face interviews conducted in this study. There were a number of significant differences in the methodologies between these studies and therefore there were limitations in the extent to which the findings of the two studies could be compared. This also is due, in part, to the timing and level of analysis available from the HASP study.

Likes and dislikes

There were clear similarities between both populations in their responses to questions about what participants liked and disliked about where they lived. The broad range of responses across both populations included liking housing that was affordable, safe, had security of tenure, in a good area, with a backyard. In addition, size and space of dwellings meeting the particular needs of individuals were referred to in both studies. The importance of access to services, informal supports, family, friends, shops and transport were also similarly described by both populations.

The strongest theme from the likes and dislikes questions in both studies was that of participants liked to be located close to shops and public transport, and disliked being located too far from shops and public transport.

The incidence of dissatisfaction with the location of houses, the suburb, the area, the street and negative comments about neighbours were much less prevalent in the HASP study. While the housing details of the participants who responded to the HASP survey is unknown, it is likely they were in either properties spot purchased with the particular client or client group in mind, or properties chosen from public housing stock by the HASP provider, again with the particular client or client group in mind. Hence it is more likely that HASP properties would meet individual preferences and less likely that HASP participants would be housed in ‘rough’, ‘unpleasant’, ‘violent’ or high crime concentrated locations, which were comments made by participants of this study. Unlike the HASP study, this study found the elements that participants disliked that occurred with notable prevalence were the area, the neighbours and particular features of the place where they lived.

What difference or improvements does housing make to participants lives?

While the context of these questions was similar in both studies, the HASP review question asked about improvements the participant may have experienced in their life and referred to both housing and support, while this study asked about the difference living ‘where you are now’ has made.

Participants from both studies confirmed that stable housing had an important impact on their lives. In both studies the most frequent response to these questions was that of increased independence. In both studies participants reported being happier, feeling more stable, secure, having improved social networks and improved mental health. Other comments included the benefits of skill development, personal improvements and increased feelings of confidence, self respect, normality, being less anxious, having a sense of well-being, peace of mind and having control over one's life. Both studies had a small proportion of people who perceived no difference.

Participants in HASP properties were more likely to be happy with their housing and more likely to plan to stay in their current housing. A number of participants of this AHURI study were unsure, didn't know or felt they would like to stay in their current housing, however the lack of the security of tenure meant that this was unpredictable for them. This was never the case for participants of the HASP study.

Both studies had a proportion of participants with longer term plans to move with the reasons for this found to be similar in both studies. Reasons included: intentions to move out of the area, out of the state, to a larger dwelling, away from a neighbour, closer to shops, and into a place of their own. Many of these reasons are possibly similar to why many Australians would have plans to move.

HASP participants were considerably more likely to prefer not to share. Both studies had people who preferred not to share, referring to past negative experiences of sharing, to the stressors of sharing and the ways that they perceived sharing could upset their ability to cope. For this study, a number of the participants explained their situation as being caught between the loneliness of living alone and the fear of the possible consequences of sharing with someone who wasn't compatible. A number of people from both studies simply had people who preferred to live alone.

Both studies had a number of participants who talked about the particular conditions under which they would share. The strongest condition under which people would be prepared to share was with family members. Also, in both studies, participants referred to the difficulty of choosing and finding compatible flatmates.

7. IMPLICATIONS FOR PRACTICE AND POLICY

This study has examined housing and support in the context of a model where these two aspects are not formally linked, compared to the Victorian Housing and Support Program, where housing and support are linked in one program. The participants in this study, who have been identified by PDSS workers as similar in characteristics to those in the HASP, were successfully sustaining housing. There are four key elements that, in combination, appear to contribute to making it work for an individual and these are:

- They mostly live in **housing** that they find acceptable, and that does not make it very hard or impossible to manage particular disabilities or manifestations arising from their mental illness. A smaller number do not like where they live, but are being actively assisted to seek more appropriate housing and are managing to "hold together" until their housing problem is solved. (For the small number outside these groups, their housing stability and wellbeing does appear to be at considerable risk).
- They have **support, medication and/or treatments** that they trust, accept and find helpful. This is predominantly from formal mental health clinical or support services (and often both), often in combination with informal support from family, friends or neighbours.
- They demonstrate **a willingness and readiness** to tackle, with appropriate support, the individual daily challenges and difficulties living independently may present.
- Major issues that may place their housing at **risk have been identified and addressed or are being addressed**.

It is difficult to separate out any one of these as pre-eminent and it is most likely that these factors all need to exist together to achieve a good outcome in terms of stable housing and wellbeing. However the support received, usually through formal services, and sometimes from family, is critical to help them find and secure housing that is appropriate, develop the skills and confidence to live independently and find ways to address factors that may jeopardise their housing. Policy and practice recommendations relating to these four key elements follow.

7.1 Housing supply and management issues

Finding affordable and appropriate public or private rental housing, particularly in developed urban areas, is a challenge for low-income people. Within this context, finding housing that has the attributes that will not add to the difficulties a person with a psychiatric disability can experience is usually even more difficult. Within the HASP program, finding appropriate housing is addressed within the integrated model. In this study, people and their support workers had to find the housing within a limited supply, much of which is known to have limitations. In thinking creatively about the development of social housing, there is a range of initiatives possible to increase access to appropriate housing for people with complex needs.

- **Increase housing allocated to programs such as HASP:** Programs such as HASP, which are known to be successfully providing appropriate housing and support to people with complex needs, should be increased.
- **Review public housing stock configuration:** In many areas where people with complex needs require accommodation, there is still predominantly estate-based public housing, which is not suitable to many individual needs. The limited choice of housing types available is a major issue, as there appears to be a relationship between choice and housing satisfaction. There is a need to look at stock configuration to diversify stock available.
- **Include potential housing risks in public housing allocation decisions**: Consideration needs to be given to understanding the potential housing risks for individuals with complex needs to maximise the sustainability of tenancies. For example, living in close proximity to others and sharing facilities may create particular stresses and therefore be inappropriate for some individuals.

- **Diversify management and supply:** This could be promoted through funding the development of organisations with the expertise to manage housing for people with complex needs, such as Supported Housing Development Foundation. Such organisations could be located in each major region and could manage public stock directly, find and secure properties in the private rental market, and develop their own stock. Best practice requires a high level of expertise, accessibility of services, continuity of staff, retention and transfer of organisational intelligence. This is more likely to be achieved outside a large, bureaucratic government department.
- **Create a Private Rental Brokerage Service (PRBS):** This is another model to maximise access to the private rental market, given that social housing is not appropriate or available to all people with complex needs. As suggested in a report by Ecumenical Housing Inc (1996), the purpose of a PRBS is to "provide assistance to eligible clients which enables them to access private rental accommodation and establish stable tenancy arrangements". It is envisaged in this case that a PRBS would develop expertise in:
  - identifying, assessing and managing housing risks for individuals with complex needs
  - accessing appropriate rental properties
  - building relationships with the private rental industry
  - building relationships with the service system, particularly within support provision and social housing networks
  - providing services such as: information and advice on rental options, assisting clients to register for social housing, referrals to real estate agents/landlords and other housing providers, information and advice on tenancy rights and advocacy of behalf of clients with regard to tenancy matters

  These services would have skilled "housing risk managers" and the capacity to access funding and determine eligibility for that funding for people who need housing assistance, in the forms of:
  - subsidising rent, given that appropriate properties are likely to incur rent costs beyond the affordability of individuals
  - the ability of the agency to enter into lease agreements and sub-lease to the tenant so that the agency is responsible for meeting the contractual obligations and carries the risk
  - paying for the costs associated with moving such as bond payment, rent-in-advance, relocation costs, essential whitegoods and utility connection fees
  - debt resolution.
- **Public housing officers to assist waiting list clients to secure private rental:** A suggestion explored by key housing and support providers at a regional workshop as part of this study was provision of a resource within the public housing authority to assist people on public housing waiting lists find appropriate rental housing. This is based on observations that real estate offices are becoming intimidating. Some have shifted their rental offices behind the 'glossy' shop front, to separate out contact between prospective house purchasers from renters. In a competitive market, where image is becoming more critical, private rental is becoming less accessible to this group. Not dissimilar to the model above, it was suggested that the public housing authority could broaden its role for waiting list clients to include:
  - debt resolution
  - developing relationships within the private rental industry in each region
  - accompanying individuals to estate agents or to visit prospective places to locate appropriate properties
  - assisting with the completion of bond application forms
  - establishing rental payment arrangements to minimise potential rent arrears, where necessary

- **Provide direct debit for those in private rental:** though there is a Centrelink system called Centrepay whereby rental payment can be deducted from pensions prior to remittance to the client – there is scope for Centrelink to more actively encourage private real estate agents to participate in the scheme. While this is widely utilised by public housing tenants – in this research we found this system wasn't available to private rental tenants.
- **Offer rewards or incentives for families who purchase housing for their family member with complex needs:** Given the high number of people renting from family, some thought should be given to financial subsidies/incentives to enable families to purchase appropriate properties dedicated for their family member. One suggestion is to offer assistance such as low interest loans. Another is a trust arrangement or tax incentives (which would require whole of government initiatives).
- **Employ public housing officers to assist tenants with complex needs:** While specialist housing officers with a prime role to assist tenants with complex needs to sustain their tenancies are an established initiative in NSW, they are only a recent initiative within the Victorian Office of Housing. There are two possible models. One is to employ specific complex needs officers to work directly with the tenants. The advantage of this is particularly skilled workers work one-on-one with people with complex needs. The other approach is to employ a complex needs officer to resource other housing officers to work with people with complex needs. The merit of the latter approach is that it has the potential for a long term, wider reaching benefit to the public system, particularly given high staff turnover in these positions.
- **Provide private rental assistance:** There is a need to enable private renters to effectively sustain successful tenancies, particularly those who have lived in their current house for many years, and are highly vulnerable to rent increases, placing their current housing beyond their affordability. There are few satisfactory alternative options available when this happens and it can represent a risk to longer term housing stability for many, as the current rental assistance appears to be inadequate.

7.2 Supports

Both formal and also informal supports provide valued support by working alongside individuals to help them live on a low-income, through times of disability, in neighbourhoods where they may be discriminated against and where there may be few opportunities to participate in the community. Such diverse support is critical, with the investment committed to finding appropriate housing likely to be wasted if there is not an equal emphasis placed on tailoring support to individuals to help them develop the skills to stay housed.

- **Access to key specialist support services:** For this group of people a common thread was the existence of a key support person, either a clinical case manager or a PDSS worker, who coordinated support. Access to and the availability of, a key support worker who understands the range of supports a person needs and is receiving, has regular contact with them and is able to intervene in times of crisis is important for people with psychiatric disabilities to effectively stay housed.
- **Checklist of effective attributes of key formal support:** A range of attributes and approaches of key formal support have emerged for directly or indirectly assisting people to achieve good housing outcomes. The following support worker characteristics could be used as a checklist for selection, training and development, and recognition of best practice for those working with people with a psychiatric disability. Support workers who:
    - Have a sound understanding of mental illness, psychiatric disability and how it can affects all aspects of people's lives and functioning
    - Work to understand each individual person – what gives them meaning – or understand how to work with a person to assist them with what is important to them.
    - Are skilled at engaging the person and developing a "therapeutic relationship", conveying trust, interest in them, a sense of caring for them.

- Are prepared to start where the individual is at, acknowledging and understanding the difficulties they are experiencing.
- Understand the range of factors that may jeopardise a person's housing and actively work with the person to address these.
- Manage the difficult balance between the person's right to make decisions to do things that may place some aspect of their life at risk, with careful judgements about their responsibility to a client whose illness and consequent disability may, at times, limit their capacity to make fully informed decisions.
- Are accessible to people when they are in need of support.

- **Improve consistency of support:** Long-term relationships are valued by individuals. Yet the combination of high demands on support workers and low monetary rewards can lead to high turnover. Effective recognition and reward systems to retain and develop support staff are required.
- **Recognise and support informal support:** The report shows that informal support is often critical for individuals to find appropriate housing and stay housed. Recognising, valuing and supporting important relationships is another potential policy initiative. This could be achieved in many ways, including through financial assistance to those supplying housing; emotional support, information and advice to those supporting family members or friends who have a disability; and better education and training about mental illness and available support services to families who may be struggling as carers.
- **Education and training**: It was apparent that the level of information those in the mental health system have about housing and potential risks to housing varies. The same can be said for the level of understanding of mental illness and associated psychiatric disability within the housing sector. The transfer of information between services with clients in common receiving housing and support would appear to be critical to achieving good service responses. One possible way of facilitating such knowledge and linkage is the joint training of housing and support workers and opportunities to learn about each other's fields of expertise.
- **Promotion of community understanding and anti-discrimination**: The issue of actual discrimination and fear of discrimination loomed very large in the stories participants told, suggesting that community understanding of mental illness and efforts to eliminate discrimination are indeed very important

7.3 Developing the capacity to live independently

As indicated, a common characteristic of participants was that they were willing and able to live independently. Often this is the result of years of support by many people, both at a practical and emotional level.

- **Continue to provide access to practical support:** For many, a critical factor in achieving independence, in addition to the availability of mental health services, are other formal supports to assist individuals to develop or re-develop practical skills to live independently. Such as services that coordinate supports for individuals, services that assist people learn to manage finances, provide training and employment, cook, shop and clean, are critical. In addition, skill development, such as dealing with conflicts with neighbours and assertiveness skills can be critical to assisting people manage to stay housed.
- **Continue to provide access to emotional support:** Providing appropriate housing is only the first step toward achieving housing stability. A number of key approaches to supporting participants illustrated in this study cannot be underestimated:
    - an ongoing reinforcement of people's own abilities
    - a commitment to minimising the potential effect of negative experiences
    - a constant focus on improving coping skills
    - a belief in the individual's capacity to be a 'successful' community member, when a person's previous housing history may have been fraught
    - constant reinforcement that people are doing well.

This is particularly important for those who experience fluctuating periods of disability that have the potential to set them back. Positive messaging encourages individuals, helps to build their confidence and self-esteem and enables people to believe in themselves.

7.4 Housing risk management and practice

Within a housing environment where supply is low, the importance of sustaining a person's housing increases as the availability of suitable housing decreases. There can be a direct relationship between staying housed and managing the consequences of one's mental illness, particularly during periods of psychiatric disability. Understanding and addressing risk management is therefore important.

- **Provide ongoing monitoring:** It is clear that PDSS and clinical services are required to ration support to individuals, with those who are deemed to be doing well gradually weaned off intensive support. However, there are those for whom "doing well" means engaging in new activities which may act as stressors, which then undermine physical or mental health. These new activities or major life changes could include embarking on employment, moving out of a shared living arrangement to live on one's own, starting an educational program, moving to a new home, entering a new relationship or the death of a parent. The notion of transition management needs to be firmly embedded in the service system to ensure that new hurdles do not make a person vulnerable to the onset of disability as a result of a lack of support available to manage key life stressors.
- **Adopt a simple risk management approach:** There needs to be key support workers involved in supporting people with complex needs, who understand their role to be assessing, identifying and helping to manage their client's housing risks. A network of people who know and support the individual and know each other may be well placed to read the signs that a person requires assistance. However, without specific expertise to systematically identify and address housing risks, housing crises may not be averted. A possible solution is a risk management approach (see Appendix B Risk Management Process), built on a foundation of understanding the various kinds of potential housing risks for individuals with complex needs and then building sound risk management strategies.

  Following is a suggested model for integrating risk management into the service system:

  1) Government articulate the management of housing risk for people with complex needs as a key objective.
  2) Government develop a policy and procedure, including a framework of housing risk management for people with complex needs to enable and facilitate staying housed.
  3) Government strategies to fulfil this policy could include providing funding within a program context which will clearly articulate who in the service system will take responsibility for housing risk management and specify guidelines for the delivery of this service.
  4) Organisations that accept the responsibility and funding for this role then develop organisational policies and procedures for the management of housing risks, including: training of staff, developing procedures for monitoring and reviewing outcomes and systems for managing housing risks.
  5) These organisational procedures will ensure that a housing and risk assessment for individuals with complex needs is implemented by key support staff who are accountable for delivering support against this objective.

  In order to be effective, the overarching risk management approach requires ongoing monitoring and review.

  In section 7.1 there are suggestions for developing expertise to support people with complex needs access suitable housing and manage ongoing housing risks. One such suggestion was a private rental brokerage service model that would have housing risk managers for this group, another was dedicated public housing officers and another non-government organisations. All of these possibilities require "housing risk" assessment frameworks to be developed to enable housing risks to be managed.

Below is a simple Housing Risk Identification and Management Tool. We see the use of this tool as a proactive risk management approach that is low cost, covers fundamental housing information and is simple to administer.

Services would collect key information about a person's current housing attributes; their level of satisfaction and the existence of things that might make it difficult for a person to stay housed; and the level of assistance a person requires with daily living activities. The outcome of this assessment process would be documented, including those factors that may jeopardise this person maintaining their housing, an analysis of the level of risk for each of those factors, and the strategies planned to manage to those risks.

Table 7.1 Example of a potential Housing Risk Identification and Management Tool

Factors that may jeopardise maintaining housing	Risk Analysis	Level of Risk	Evaluation of risk	Risk management strategies	Monitoring and Review
Problems paying rent/bills/ managing money	Unable to manage finances and consistently pay rent without assistance	High level of risk	High priority - if rent is unpaid high risk of losing housing (in private rental)	Establish and maintain direct debit of rental Set up bill pay via instalment schemes with budgeting support from PDSS staff	Fortnightly meeting with client to assist with financial planning. Bi-annual review of this strategy in light of client's support needs and housing aspirations
Issues with maintaining house	Able to maintain house and garden, however experiences difficulty during periods of disability	Generally low. Higher level of risk when experiencing disability and post hospitalisations	Lapses in house maintenance usually precipitate a period of illness	Requires ongoing monitoring of personal ability to cope. Obtain formal support to clean, mow lawns when required	Quarterly review of this strategy in light of client's support needs and housing aspirations
Security of tenure	In private rental with landlord threatening to renovate the property and raise the rent	Low short term risk as 12 month rental agreement in place, although likely high risk post agreement & longer term	Not immediate priority, although important to pursue in the longer term	Investigate the other housing options available with the client Plan in place for relocation	Check that relocation plan is in place by (stated date) Check that relocation activities are occurring
Etc.					

7.5 Summary of policy and practice implications

Housing supply and support, appropriate management models, recognition of the skilled approaches required to assist a person develop the readiness to live independently and risk management strategies are all required to improve housing outcomes for people with complex needs.

8. CONCLUSIONS

We know that the housing and support systems in Australia are facing considerable challenges in working to effectively support people with a psychiatric disability. There is strong evidence arising from practice, and increasingly from formal research studies, that stable housing provides an important foundation for achieving independence and enhanced wellbeing. This study has provided an important opportunity to understand what it is that allows some people with significant disability to stay housed, and particularly to understand what individuals themselves view as important for being able to achieve this.

The findings of this study reinforce the importance and value of the Victorian HASP model, which addresses both the availability of adequate support and appropriate housing. For the group examined through this study, the availability of appropriate, adequate and timely support, in combination with the availability of suitable, affordable housing, assisted them to achieve housing stability and often enhanced their wellbeing.

Support in the form of skilled positive input from a person who understands mental illness and can effectively engage, relate, impart skills and techniques, focus a person, or assist with a reality check as needed can be critical. The link between important support and sustainable housing is not always found in tangible assistance with housing matters, but in the help that reinforces and assists people to cope with the challenges of daily living and often gradually increase their ability to live independently.

Many people with a psychiatric disability are ready or able to live independently, yet some are homeless or living in cobbled together temporary or inadequate housing with inadequate support arrangements. The number of people with a psychiatric disability who can be effectively supported to maintain stability in their housing may well be limited more by the supply of both support and housing, rather than the limitations and challenges presented by their illness and resultant disabilities. With access to adequate support and appropriate housing, ongoing risk management strategies and assistance to deal with a debilitating illness that can jeopardise maintaining housing, these individuals have proved they can live independently, which in turn improves their enjoyment of life.

9. REFERENCES

Ainsworth, E. 2000, *Housing Clients with Psychiatric Disabilities: Enhancing Service Responsiveness,* OT820 Supervised Project, Occupational Therapy, University of Queensland.

Bisset, H., Campbell, S. and Goodall, J. 1999, *Appropriate Responses for Homeless People whose Needs Require a High Level and Complexity of Service Provision*, *Final Report.* Prepared for Department of Family and Community Services by Ecumenical Housing inc and Thomson Goodall Associates, Canberra, ACT.

Burke, P. and Dickman-Campbell, S. March 1997, *Housing for People with a Psychiatric Disability in the City of Yarra*, Ecumenical Housing Inc.

Carling, P.J. 1993, 'Housing and supports for persons with mental illness: emerging approaches to research and practice' *Hospital and Community Psychiatry, 44* (5), pp.439-449.

Carling, P.J. 1995, Return to Community: Building Support Systems for People with Psychiatric Disabilities, The Guilford Press, New York, NY.

Catholic Social Services. 1995, Having Nothing and Needing Everything: The Mental Health Needs of homeless People Using Catholic Social Services Agencies in Melbourne, Catholic Social Services, Melbourne.

Center for Mental Health Services. 1994, Making a Difference: Interim Status Report of the McKinney Research Demonstration Program for Homeless Adults with Serious Mental Illness, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, Publication No. (SMA) 94-3014.

Commonwealth Advisory Committee on Homelessness. 1998, 'Issue Paper No. 4: Preventing Homelessness Among People with Mental Health Care Problems', *CACH Issues Papers*. Canberra

Commonwealth Advisory Committee on Homelessness. 2001, *Working Toward a National Homelessness Strategy,* Commonwealth Department of Family and Community Services, Canberra

Commonwealth Department of Health and Aged Care (CDH&AC). 2000a, *What are Anxiety disorders?* (Pamphlet), Mental Health Branch, March.

Commonwealth Department of Health and Aged Care (CDH&AC). 2000b, *What is Bipolar mood disorder?* (Pamphlet), Mental Health Branch, March.

Commonwealth Department of Health and Aged Care (CDH&AC). 2000c, *What is Schizophrenia?* (Pamphlet), Mental Health Branch, March.

Commonwealth Department of Health and Aged Care (CDH&AC). 2000d, *What is Depression?* (Pamphlet), Mental Health Branch, March.

Corbo, E. 2001, *Living Options Service Evaluation,* A Project of the Northern Residential Mental Health Services Reference Group, Neami Incorporated, Melbourne.

Culhane, D., Eldridge, D., Rosenheck, R. and Wilkins, C. 2000, 'Making homelessness programs accountable to consumers, funders and the public', *The 1998 National Symposium on Homelessness Research,* Department of Health and Human Services USA.

Culhane, D. Metraux, S. and Hadley, T. 2001, *The impact of supportive housing for homeless people with severe mental illness on the utilization of the public health, corrections and emergency shelter systems: The New York-New York Initiative*, Center for Mental Health Policy and Services Research, University of Pennsylvania.

Ecumenical Housing Inc., 1996, *Access to the private rental market and homelessness research project: Volume II: Proposed Model for Transitional Housing Assistance delivered by Private Rental Brokerage Services.*

Goldfinger, S. and Schutt, R. 1996, 'Comparison of clinicians' housing recommendations and preferences of homeless mentally ill persons', *Psychiatric Services 47* (4), pp.413-415.

Goldman, H., Rachuba, L. and Van Tosh, L. 1995, 'Methods of assessing mental health consumers' preferences for housing and support services', *Psychiatric Services, 46* (2), pp.169-172.

Hatfield, A. 1993a, 'A family perspective on supported housing', *Hospital and Community Psychiatry, 44* (5), pp.496-497.

Horn, M. 1991, Opening Doors: A study of the Housing and Related Support Needs for Consumers of Mental Health Services in the North-East Sector of Melbourne. North Eastern Alliance for the Mentally Ill, Victoria

Jablensky, A., McGrath, J., Herrman, H., Castle, D., Gureje, O., Morgan, V. and Korta, A. 1999, *People Living with Psychotic Illness: An Australian Study 1997-98.* National Survey of Health and Wellbeing Report 4, Commonwealth of Australia, Canberra..

Jankowicz, A.D. 1999, *Business Research Projects for Students*, Chapman and Hall, London.

Jarbrink, K., Hallam, A. and Knapp, M. 2001, 'Costs and outcomes management in supported housing', *Journal of Mental Health, 10* (1), pp.99-109.

Juriansz, D. 1994, My Own Space! What Mental Health Consumers in Melbourne's Inner South Have to Say About Their Needs for Housing and Support: The Inner South Accommodation Survey. Inner South Community Health Services, Prahran, Victoria.

Keck, J. 1990, 'Responding to consumer housing preferences: The Toledo experience' *Psychosocial Rehabilitation Journal, 13* (4), pp.51-58.

Keys Young, 1994, *The Needs of People with Psychiatric Disabilities Living in Public Housing: Issues and Options,* Prepared for Australian Housing Research Council, Supervised by Research and Policy Unit, NSW Department of Housing, Surrey Hills, NSW.

Lambert, G., Ricci, P., Harris, R. and Deane, F. 2000, 'Housing needs of consumers of mental health services in rural New South Wales, Australia' *International Journal of Social Psychiatry, 46* (1), pp.57-76.

Lefley, H.P. 1997, Families coping with mental illness: Changing theories, models and services. *Weaving the Threads Together- Proceedings of 7th Annual THEMHS Conference*.

Massey, O.T. and Wu, L. 1993a, 'Important characteristics of people with mental illness: Perspectives of case managers and consumers', *Psychosocial Rehabilitation Journal, 17* (2), pp.81-92.

Massey, O. and Wu, L. 1993b, 'Service delivery and community housing: Perspectives of consumers, family members, and case managers', *Hospital and Community Psychiatry, 2* (3), pp.9-15.

McDermott, F. and Pyett, P. 1993, *Not welcome anywhere: People who have both a serious psychiatric disorder and problematic drug or alcohol use*, A VICSERV Report, Victorian Community Managed Mental Health Services.

McDonald, P. 1993, *Confronting the Chaos: A report of the SANS Project,* The Salvation Army Crossroads Housing and Support Network.

Mueser, K. T. and Gingerich, S. 1994, *Coping with Schizophrenia: A Guide for Families*. Oakland, CA: New Harbringer Publications.

Mueser, K. T., Drake, R. E., Clark, R. E., McHugo, G. J., Mercer-McFadden, C., and Acherson, T. H. (1995). *Evaluting Substance Abuse in Persons with Severe Mental Illness*. Prepared for the Evaluation Cnetre@HSRI.

Mulvaney, J. 1995. *Current research into housing for people with psychiatric disabilities*, AHURI forum held on 30 June 1995 level 6, 20 Queen Street, Melbourne, at which J. Mulvaney reported on the findings from a recent study.

National Youth Coalition for Housing 1999, *Accommodating Homeless Young People with Mental Health Issues: National Research Project 1999*. Funded by the Department of Family and Community Services, National Youth Coalition for Housing, Dickson, ACT.

Newman, S.J. 2001, 'Housing attributes and serious mental illness: Implications for research and practice. *Psychiatric Services, 52* (10), pp.1309-1317.

Office of the Public Advocate. 2001, *Annual Report of Community Visitors 2001*, Office of the Public Advocate, Melbourne.

Ogilvie, R. J. 1997, 'The state of supported housing for mental health consumers: A literature review', *Psychiatric Rehabilitation Journal, 21* (2), pp.122-131.

Owen, C., Rutherford, V., Jones, M., Wright, C., Tennant, C. and Smallman, A. 1996, 'Housing accommodation preferences of people with psychiatric disabilities', *Psychiatric Services 47,* (6), pp.628-632.

Penumbra. 1997, *International Review of Supported Housing Programmes for People with Long Term Mental Health Problems*, Presentation to the World Federation for Mental Health Conference, Finland (unpublished).

Pyke, J. and Lowe, J. 1996, 'Supporting people, not structures: Changes in the provision of housing support', *Psychiatric Rehabilitation Journal, 19* (3), pp.5-12.

Reynolds, A. and Inglis, S. 2001, *Effective Program Linkages: An Examination of Current Knowledge with a Particular Emphasis on People with a Mental Illness: Positioning Paper.* Australian Housing and Urban Research Institute, Swinburne/Monash, Melbourne, http://www.ahuri.edu.au/pubs/positioning/pp_effective.pdf.

Reynolds, A. Inglis, S. and O'Brien, A. 2002, *Linkages between Housing and Support – What is Important from the Perspective of People Living with a Mental Illness*: *Positioning Paper.* Australian Housing and Urban Research Institute, Swinburne/Monash, Melbourne. http://www.ahuri.edu.au/pubs/positioning/pp_mentalillness.pdf.

Reynolds, A. Inglis, S. and O'Brien, A. 2001, *Effective Program Linkages: An Examination of Current Knowledge with a Particular Emphasis on People with a Mental Illness: Final Report.* Australian Housing and Urban Research Institute, Swinburne/Monash, Melbourne, http://www.ahuri.edu.au/pubs/finalreports/final_effectiveproglinks.pdf.

Robinson, C. 1998, *Overview of Down and Out in Sydney: The prevalence of mental disorders and related disabilities among homeless people in inner Sydney*, St Vincent de Paul Society, Sydney City Mission, the Salvation Army, Wesley Mission and the Haymarket Foundation, April.

Robson, B. 1995, *Can I Call This Home? An Evaluation of the Victorian Housing and Support Program for People with Psychiatric Disabilities*, VICSERV, Melbourne.

Rosenheck, R. and Morrisey, J. 1998, 'Service system integration, access to services, and housing outcomes in a program for homeless persons with a severe mental illness', *American Journal of Public Health, 88* (11), pp.1610-1615.

Slade, M. and Scott, H. 1999, 'Risk factors for tenancy breakdown for mentally ill people', *Journal of Mental Health, 8* (4), pp.361-371.

Standards Australia. 1999, *Risk Management* AS/NZS4360: 1999.

Tanzman, B. 1993, 'An overview of surveys of mental health consumers' preferences for housing and support services', *Hospital and Community Psychiatry, 44* (5), pp.450-455.

Tanzman, B.H., Besio, S.W. and Yoe, J.T 1992. 'Mental health consumers' preferences for housing and supports: The Vermont consumer housing and supports preference study'. In J.W. Jacobson, S.W. Burchand & P.J. Carling (Eds), *Community Living for People with Developmental and Psychiatric Disabilities*, Johns Hopkins university Press, Baltimore, MD.

Taylor, S. and Bogdan, R. 1997, Introduction to Qualitative Research Methods: A Guidebook and Resource, 3rd ed, John Wiley, New York.

Thomas, K. and McCormack, C. 1999, ‘Adequate housing for people with a serious mental illness: policy obstacles and practice solutions’ *Australasian Psychiatry, 7* (2), pp.81-84.

VicHealth (Victorian Health Promotion Foundation). 1999, *Mental Health Promotion Plan 1999-2002*, VicHealth.

Victorian Homelessness Strategy Ministerial Advisory Committee. 2001, Building Solutions for Individuals and Families Who Experience Homelessness: Working Report of the Victorian Homelessness Strategy Ministerial Advisory Committee. Victorian Government Department of Human Services, Victoria.

Watkins, J. 1988, *Learning about Schizophrenic Conditions: A Self Help Guide by John Watkins*. Prahran: Schizophrenia Australia Foundation.

Watkins, J. 1996, *Living with Schizophrenia: An Holistic Approach to Understanding, Preventing and Recovering from “Negative” Symptoms.* Melbourne: Hill of Content.

Weir, W. 1997, *Housing and Supported Accommodation Strategies: For People Seriously Affected by Mental Illness,* Report on project commissioned by the Centre for Mental Health, NSW Health Department.

Yeich, S., Mowbray, C.T., Bybee, D. and Cohen, E. 1994, ‘The case for a "Supported Housing" approach: A study of consumer housing and support preferences’. *Psychosocial Rehabilitation Journal, 18* (2), pp.75-86.

APPENDIX A: SERVICE PROVIDERS

The reference group made a decision not to include individual staff names in the acknowledgements to ensure the maximum confidentiality of participants. You know who you are and we are indebted to you all - THANK YOU.

Staff from the following PDSS were the key contacts for engaging participants in this study:

Macaulay Community Support Association Inc

20 Bryant Street Flemington

NEAMI

Shop 3, The Arcade 296 Hight Street Preston 3072

Outreach Victoria

219 Napier Street Fitzroy 3068

Pathways Rehabilitation and Support Services

61 Pakington Street Geelong West 3218

Western Regional Health Centre

72 Paisley Street Footscray 3011

APPENDIX B: REFERENCE GROUP MEMBERS

Gary Batzloff (from January 2002); Meg Carter (to December 2001)
Victorian State Office, Partnerships and Participation Branch
Commonwealth Department of Family and Community Services

Isabell Collins
Director, Victorian Mental Illness Awareness Council (VMIAC)

Margaret Grigg
Senior Lecturer, Centre for Rural Mental Health, Bendigo Health Care Group

Phyl Halpin
Senior Project Officer, Service Planning and Development
Mental Health Branch, Department of Human Services

Jo McInerney
Office of Housing, Policy and Standards, Department of Human Services

Paul Napper
Director, Pathways Rehab and Support Services

Judith Player
CEO, Association of Relatives and Friends of the Emotionally and Mentally Ill (ARAFEMI)

Project Team Members from Ecumenical Housing Inc:
Astrid Reynolds, Anne O'Brien, Susan Inglis and Tania Herbert

APPENDIX C: RISK MANAGEMENT PROCESS

Standards Australia (1999) provides a generic framework for establishing the context, identification, analysis, evaluation, treatment, monitoring and communication of risk. This framework is a useful tool for designing and implementing management systems.

The main elements of the risk management process are:

- Establish the context (strategic, organisational, risk management)
  - Develop criteria & decide the structure
- Identify risks
  - What can happen
  - How can it happen
- Analyse risks
  - Determine the likelihood & consequences then estimate the level of risk
- Evaluate risks
  - Compare against the criteria
  - Set risk priorities
- Treat risks
  - Identify treatment options
  - Evaluate treatment options
  - Select treatment options
  - Prepare treatment options
  - Implement plans

AHURI Research Centres

Sydney Research Centre
UNSW-UWS Research Centre
RMIT Research Centre
Swinburne-Monash Research Centre
Queensland Research Centre
Western Australia Research Centre
Southern Research Centre

Affiliates

Northern Territory University
National Centre for Social and Economic Modelling

AHURI
Australian Housing
and Urban Research Institute

Australian Housing and Urban Research Institute
Level 7 20 Queen Street, Melbourne Victoria 3000
Phone +61 3 9613 5400 Fax +61 3 9629 8536
Email information@ahuri.edu.au Web www.ahuri.edu.au