POLICY EVIDENCE SUMMARY

November 2018

Integrating Australia's housing and mental health support systems

AHURI
Australian Housing and Urban Research Institute

Based on the AHURI Report for the National Mental Health Commission:
Housing, homelessness and mental health: towards systems change

What this research is about

This research examined the issues and policy levers required to provide more and better housing and services for people with lived experience of mental ill-health.

The context of this research

An estimated 2–3 per cent of the population aged 16–85 years have a severe mental health disorder, 4–6 per cent a moderate mental health disorder, and 9–12 per cent a mild mental health disorder. Furthermore, around 45 per cent of Australians aged 16–85 years will experience a high prevalence mental health disorder, such as depression, anxiety, or a substance use disorder in their lifetime.

There is a complex bi-directional relationship between housing, homelessness and mental health.

Homelessness may act as a trigger for mental health issues and vice versa, persons with lived experience of mental ill-health are more vulnerable to common risk factors for homelessness, such as domestic and family violence, alcohol and other drug addiction, and unemployment.

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

The key findings

Homelessness and mental health

Mental health and homelessness are strongly associated. In 2015–16, 31 per cent (72,364 persons) of Specialist Homelessness Services (SHS) consumers aged 10 years and over had a current mental health issue. This is significantly higher than the rate of mental illness among the general population (16.2%).

A study of 4,291 homeless people in Melbourne found that 15 per cent of the sample population had mental health issues prior to becoming homeless, and a further 16 per cent had developed a mental illness since experiencing homelessness.

Housing and mental health

Housing choice

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

The relationship between housing quality and mental health is significant, with tenants with lived experience of mental illness having been shown to benefit from quality housing through reduced mental health care costs, and greater wellbeing and residential stability. In the UK, two studies showed that improvements to study participants' housing quality led to improved mental health functioning over time compared to participants living in housing that remained the same quality.

The ability to access housing with stable tenure allows people the capacity to focus their attention on mental health treatment and rehabilitation, which would previously have been directed toward finding a home. Poor access to, and quality of, housing can be detrimental to mental health. Infectious diseases, high noise levels and low privacy levels can negatively impact mental health, and these factor are often impacted by inadequate home size relative to the number of occupants as well as the under-provision of basic sanitary features.

Neighbourhood amenity

Neighbourhood amenity is a factor for reducing mental health care costs

among people with lived experience of mental ill-health. Persons with lived experience of mental ill-health who move to neighbourhoods with less problems such as crime and dilapidated property facades or outward signs of physical deterioration are more likely to reduce their mental health care service use.

Private rental housing

Private rental housing is the most common form of accommodation among people with lived experience of mental ill-health. However, it can often be challenging for people with lived experience of mental ill-health to access accommodation in Australia's private rental market. A 2008 survey conducted by SANE found that 90 per cent of survey respondents among a sample of 372 people experiencing a range of high and low prevalence mental illnesses had reported discrimination, particularly when seeking private rental accommodation. High rental costs were also considered a major barrier to finding a suitable place to live according to 83 per cent of survey participants.

Public and community housing

Public and community housing are key tenures for people with lived experience of mental ill-health, however, this housing is highly rationed. While people with lived experience of serious mental health issues are placed on the priority social housing waitlist, enabling them faster access to social housing (sometimes within three months), wait times of two years or more are not uncommon. A 2012 NSW Ombudsman enquiry into supported housing found that long term and highly supported housing options in NSW are very limited.

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

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

A small proportion of community housing is specialist supported housing for people with lived experience of mental ill-health, commonly delivered as part of a mental health housing program.

The Mental Health system

Australia's mental health services delivery comprises two principal components: the clinical mental health sector, which primarily involves medical treatment at hospitals, specialists and General Practitioners (GPs), and community mental health services focusing on psychosocial wellbeing and participation in home and community life.

Many community mental health services are in the process of being subsumed by the NDIS, with state governments who were previously responsible for providing psychosocial support in the form of 'psychiatric disability service', rolling the majority of this dedicated funding into the NDIS. Psychosocial support programs, such as PiR (Partners in Recovery), Personal Helpers and Mentors (PHaMs) and D2D (Day to Day Living in the Community) currently do not rely entirely on diagnostic criteria for admission. However, the rolling up of these services into the NDIS may limit accessibility for some users.

Discharge programs

Mental health consumers generally exit mental health institutions and hospital settings into community mental health care, and while some enter into housing and support programs, others exit into unstable housing and inconsistent supports.

Post-hospital follow up with consumers by a hospital discharge liaison officer is now common practice in Australia. However, there remain significant delays between discharge and follow up in many cases. Additionally, follow up may only be possible if the consumer has been discharged to a fixed address, with a home address also being a common prerequisite for community mental health service provision upon discharge.

A research project (the SHIP second wave study) conducted in 2010 found a range of discharge practices were evident for psychiatric inpatients admitted in the year prior to interview. At the time of discharge, approximately 58 per cent of this cohort recollected discussing accommodation options with staff, 69 per cent reported not needing further help as they had already had somewhere to live, 23 per cent needed and received help finding accommodation, and 8 per cent reported that they had not been given any help and had nowhere to live in discharge.

A study analysing the characteristics of 2,388 people attending psychiatric clinics in inner Sydney homeless hostels found that the pathway to homelessness for 21 per cent of patients was discharge from psychiatric hospital.

Existing programs

Australian state and territory governments have established a number of small-scale housing programs for people with lived experience of mental ill-health, often in partnership with service providers. Most of these housing and mental health programs feature some, but not all, components of the Housing First (HF) philosophy, and therefore could be considered 'low fidelity' HF programs.

Table 1 provides a summary of some of the supportive housing programs in Australia and their evaluations.

Table 1: Supportive housing program evaluations

Program	State	Years in operation	Description	Critical Success Factors
Housing and Accomodation Support Initiative (HASI)	NSW	2002–	Assisted 1,135 people with lived experience of severe mental illness. Program participants are awarded priority access to permanent social housing and provided supports based on a recovery framework. Support ranges from 24/7 to 2–3 hours, 1–2 days per week (McDermott 2017).	Effective mechanisms for coordination at the state and local levels. Regular consumer contact with Accommodation Service Providers (ASPs) (Bruce 2012).
Housing and Support Program (HASP)	VIC	1995–	Assisted people with lived experience of severe mental illness into 1,200 public housing dwellings, and provided support through the Home Based Outreach Support Program. Five days of one-on-one support for daily living and other activities is provided every week (McDermott 2017).	Immediate access to long-term public housing. Provision of housing close to amenities and services (McDermott 2017).
Outreach support	NSW	NA	There is no common program or eligibility criteria as outreach support is run by local area health services. In-home and clinical support has been provided to 655 people with lived experience of mental illness while 42 people have received transitional accommodation (McDermott 2017).	Not assessed as there is no common program or eligibility criteria.
Individual Psychosocial Rehabilitation and Support Services (IPRSS)	SA	NA	Provided housing access assistance to 936 people with lived experience of severe mental illness and psychiatric disability. In-home support is provided through a partnership between NGOs and government mental health services (McDermott 2017).	Partnership between NGO providers and government mental health services, including strong senior and middle management level relationships (Health Outcomes International 2011)
Independent Living Program	WA	1995–	Assisted 1,705 people who are homeless, at risk of homelessness or living in unsuitable accommodation into permanent accommodation. Tenancy support is provided by NGOs (McDermott 2017).	Not assessed.
500 Homes/Micah Projects	QLD	2015–2017	Assisted 580 homeless individuals and families into permanent housing. Mental health, disability, aged care, Indigenous and youth services were also available through service organisations when required (Micah Projects 2017).	Localised coordinated entry and assessment approach. Targeted allocation of permanent supported housing for rough sleepers (Micah Projects 2016).
Non-Clinical Rehabilitation packages	TAS	NA	Rehabilitation packages have supported 62 people with lived experience of mental illness into social housing and recovery-based care provided by NGOs (McDermott 2017).	Not assessed.
Common Ground	NSW, SA, QLD, VIC, TAS	NA	Purpose-built permanent community housing provided to approximately 345 vulnerable, long-term homeless people. On-site case management and a range of other support services are provided (McDermott 2017).	Affordability of rent is a key contributor to the success of the model. Establishment of an integrated model as a deliberate response to chronic homelessness (Parsell et al. 2016).
Housing and Support Program (HASP)	QLD	2006–	Assisted people unable to leave mental health facilities due to lack of housing and support into 194 priority social housing dwellings. Participants were provided with support services through the Disability and Community Care Services (McDermott 2017).	Strongly targeted program to specific mental health service user cohort. Immediate access to long-term housing Key government agencies (HHS, DCCS, and QH) and NGOs working in collaboration (Meehan 2010).

Note: this is only a sample of programs reviewed by the research. Refer to the full report for all programs and evaluations at *https://www.ahuri.edu.au/research/research-papers/housing-homelessness-and-mental-health-towards-systems-change*

What this research means for policy makers

The research identified that there are successful models in the delivery of consumer and recovery oriented housing. It is now appropriate to institutionalise what is known to work, scale up existing programs to meet demand and extend existing programs to new cohorts.

The evidence does not suggest that there is one particular program approach that is suitable for all circumstances or consumers. Rather there are certain factors and principles that facilitate good outcomes including:

- Access to housing: rapid access to appropriate, affordable and stable housing is central to program success. This housing can be either public housing, community housing or private rental.
- Policy and stakeholder coordination: coordination at the local and state levels is critical to the success of housing and mental health programs. This encompasses formal agreements, MOUs, cross-sector collaboration, and local coordination.
- Integrated, person centred support: places the consumer (and their carer or family) at the centre of the program with seamless wrap-around services delivered as needed.
- Targeted clientele: it is not clear whether programs targeting a particular cohort are more effective or better suited to up-scaling than others. There is a place for a variety of programs accommodating specific needs. Problems that are unique to a state or territory may be effectively addressed through small-scale programs.

Other program requirements include:

- early intervention to stabilise people in their existing tenancy;
- tenancy sustainment services have an important role to play in short term crisis management and early intervention and prevention of homelessness;
- mainstream tenancy management could play a greater role in early intervention and prevention and tenancy sustainment. For example, real estate agents could receive training as they are often the first to detect that something is wrong;
- programs need to cater to short-term mental health crises (e.g. bipolar) so consumers can be assisted quickly and be transitioned back to their original housing once the crisis is overcome;
- greater clarity about who has responsibility ensuring people discharged from a mental health facility are securely and adequately housed.

Barriers to scaling up programs

Barriers to scaling up integrated housing and mental health programs nationally include:

- a lack of organisational capacity in the housing sector;
- a lack of affordable, appropriate and safe housing;
- insufficient recognition of the role families and carers play;
- separate national level agreements, policies and accountability mechanisms across sectors leads to competing goals and measures and a lack of responsibility for cross sector issues;
- continual reorganisation and reform in both sectors has interrupted personal links and advocacy networks;
- concern about the effects of the NDIS on the quality and quantum of services available to people with lived experience of mental ill-health.

Methodology

This research reviewed national and international evidence since 2008 on housing, homelessness and mental health, and met with experts from the housing and mental health policy community, including peak organisations, service providers and people with lived experience of mental ill-health and carers in deliberations.

Further information

TO CITE THE AHURI RESEARCH, PLEASE REFER TO:

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↓ **Available** from the AHURI website at

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