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Housing, homelessness and mental health
Towards systems change

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Definition of mental health

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- Mental **illness is**

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

- **Mental ill-health** is used as an umbrella term that captures the range from people with temporary, periodical and manageable conditions through to people with serious permanent disability.

Affordable and appropriate housing

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- Decline in home ownership
  - → 71% in 1995–96; 67% in 2015–16 (ABS 2017)
- Increase in private rental
  - → 19% in 1995–96; 25% in 2015–16 (ABS 2017)
- Increasing housing and rental costs, lack of affordable housing
  - → absolute shortage of rental housing for lowest income quintile
  - → distributional shortage for second lowest income quintile
  - → leads to high levels of housing affordability stress)(Hulse et al. 2014).
- Decline of social housing stock in relation to population growth
  - → social housing share 5.1% in 2007–08; 4.7% in 2016 (AIHW 2017)

8%

of people with a severe and persistent mental illness reported that they had not been given any help and had nowhere to live upon discharge from hospital.[1]

More than 20%

of residents in Sydney homelessness hostels experienced homelessness after being discharged from psychiatric institutions.[2]

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1 in 5

of the population will experience a common mental disorder in a 12-month period.[3]

27%

people who sought assistance from Specialist Homelessness Services in 2016–17 had a current mental health issue.[4]

↑12%

yearly growth of specialist homelessness services clients with a mental health issue since 2012–13.[5]

Government cost offset of $13,300 per person

(which includes offsets from health, mental health and justice services) when permanent supportive housing was provided to people experiencing homelessness.[6]

↓65%

reduction in episodes requiring mental health services as a result of providing permanent supportive housing to previously homeless people[7]

Homelessness

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- Homelessness increased c. 14% from 2011–16
- Indigenous people are over-represented in the homeless population
  - → 3% of the Australian population
  - → 20% of homeless people on Census night in 2016
- Mental health and homelessness are strongly associated
  - → 31% of SHS clients aged 10 years and over had a current mental health issue in in 2015–16
  - → Compared to 16% of the general population
- Institutional discharge is a significant moment of risk
  - → e.g., in Victoria, more than 500 people presented at SHS in 2016–17 after leaving psychiatric services—an increase of 45% since 2013–14

Factors that affect entries into homelessness

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- Median rents
  - → $100 (30%) increase in median rent lifts the risk of entry to homelessness by 1.6% (Johnson et al. 2015)
- Employment
  - → 1% increase in the unemployment rate increases the likelihood of homelessness entry by 1% (Johnson et al. 2015)
- Mental health
  - → Persons diagnosed with bipolar disorder or schizophrenia are 3.2% less likely to enter homelessness; a 40% reduction in the odds of slipping into homelessness (Johnson et al. 2015)
- Incarceration discharge
  - → Risk of homelessness is 9.7% greater for those recently incarcerated than the remaining sample population from the Journeys Home study (Johnson et al. 2015)
- Hospital discharge
  - → 8% of participants in SHIP reported that they had not been given any help and had nowhere to live upon discharge (Harvey et al. 2012)

Mental health service provision gap

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- NDIS allows approx. 64,000 support packages for persons with a psychosocial disability (McGrath Consulting 2017)
- DSS estimate 91,916 persons have a **severe and complex disorder** (aligns with NDIS definition)
  - → shortage of approx. 28,000 NDIS places

Using a less stringent definition

- 289,249 persons aged 12–64 years need some form of psychosocial individual or group community support and rehabilitation (McGrath Consulting 2017)
- Gap of approximately 225,249 persons (78%) aged 12–64 years who require psychosocial support services but will not gain access to NDIS

Links between housing and mental health

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- The housing careers of people with mental illness are unstable and often characterised by frequent moves, insecure housing and inadequate accommodation
- Mental ill-health can cause homelessness
- Homelessness can trigger mental ill-health
- Persons with mental ill-health are more vulnerable to common risk factors for homelessness (DFV, AOD, unemployment)

Links between housing and mental health

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- Secure tenure allows people to focus on mental health treatment and rehabilitation
- Greater choice and control over housing and support contributes to wellbeing and quality of life
- Housing quality positively affects mental functioning, mental health care costs, wellbeing and residential stability
- Neighbourhood amenity is a factor for reducing mental health care

Findings from HILDA Tenure

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- Tenure and mental health are not related (Baker et al. 2013)
- A person's housing situation can have a moderating effect on their mental ill-health in the presence of other negative factors, such as unemployment and disability acquisition (Bentley et al. 2016b; Bentley et al. 2011)
- Private renters and people experiencing housing unaffordability are generally most at risk of mental ill-health under adverse circumstances

Findings from HILDA
Housing affordability

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- Housing affordability stress affects mental health
  - → Housing affordability stress leads to deterioration in mental health for low income renters (Baker et al. 2011)
  - → Bi-directional relationship between housing affordability and health, especially mental health (Baker et al. 2014)
  - → Entering unaffordable housing is detrimental to mental health of low-to-moderate income households (Q1 & 2) but has no effect on higher income households (Bentley et al. 2011)
  - → Unaffordable housing affects the MH status of renters and home purchasers differently; private renters' MH declines but not that of home owners / purchasers (Mason et al. 2013)
  - → Interventions that improve housing affordability for low income households (e.g. increase of household income, reduction in housing costs) are likely to be the most effective in reducing inequalities in mental health.

Findings from HILDA Geographic location

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- Area effects, such as geographic location, have not been shown to correlate with mental health (Butterworth et al. 2006)
- Individual risk factors are a predictor of mental health (Butterworth et al. 2006)

Findings from HILDA
Individual risk factors

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- Mental health decreases upon disability acquisition for all tenures, private renters experience the largest decrease in mental health (Kavanagh et al. 2016)
- Persistent employment insecurity leading to housing affordability stress can contribute to a decline in mental health (Bentley et al. 2016b)
- Social capital is a protective factor for poor mental health. Poorer physical health is correlated with poorer mental health. People with poor physical health have better mental health when they have greater levels of social capital (Berry and Welsh 2009)

Findings from JH

- There are two distinct pathways for homelessness and mental illness:
  - → those who are homeless before they develop a mental illness, and
  - → those whose mental illness is present prior to becoming homeless (Scutella et al. 2014)

Findings from JH

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- MH diagnosis and psychological distress are highest in people with chronic instability and homelessness (Johnson 2014)
- People with mental illness who are homelessness are much more likely to exit homelessness within six months (possibly to due higher rates of service use) compared to the broader JH homeless population (Bevitt et al 2015)
- The greater the level of housing instability, the poorer respondents' circumstances in relation to mental health diagnosis; serious psychological distress; weekly illicit drug use (Johnson et al. 2014)

Findings from JH

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- Seeking help for MH related issues from a mental health or medical professional does not reduce homelessness (Johnson et al. 2014)
- Seeing a mental health professional or a GP does not prevent homelessness for people with a first-time diagnosis (Scutella et al. 2014)
- Only 21% of respondents who needed help with MH related issues saw a mental health professional at all (Scutella et al. 2014)

Housing for people with mental ill-health

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- Complex needs, limited social and financial resources mean that many need housing support
- Social housing is a key tenure, but highly rationed
- Social housing system does not adequately monitor and consider the mental health of its tenants
- Anti-social behaviour policies
- Discrimination in the private rental market and high costs are barriers
- Lack of affordable private rental housing
- Lack of supported housing

Mental health system

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- Two principal components
  - → clinical mental health sector (functionally and financially separate from NDIS)
  - → community mental health services focusing on psychosocial wellbeing and participation in home and community life
- Many community mental health services are being subsumed by the NDIS
- NDIS mental health component mainly consists of psychosocial support service funding
- Significant duplication of mental health service delivery
  - → duplication of governance, eligibility and reporting structures between the Commonwealth and state and territory governments in program funding and provision (NMHC 2014)

Mental health treatment models

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- Mental health treatment models target
  - → health and physical wellbeing
  - → psychosocial barriers to functioning
- Provided in clinical setting, the home, or on the street
- National programs for psychosocial support
  - → Partners in Recover (PiR)
  - → Personal Helpers and Mentors (PHaMs)
  - → Day to Day Living in the Community (D2D
- Assertive Community Treatment targets homeless people with mental ill-health
  - → involves bringing support to, and collaborating with, the person to enable them to live a fulfilling life in the community

Mental health treatment models

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- Stepped care
  - → publicly available self-help resources/ promotion of preventative health
  - → early intervention for at-risk groups with early symptoms or previous illness (lower cost, evidence-based alternatives to face-to-face psychological therapy)
  - → low intensity face-to-face and psychological services for people with mild mental illness (GPs, psychologists, allied health professionals)
  - → increased service access for people with moderate mental illness (face-to-face primary care, psychiatric support, links to social support)
  - → wrap-around coordinated clinical care combining GPs, psychiatrists, mental health nurses, psychologists and allied health for people with complex needs and severe mental illness

Housing support models

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- Continuum of care model (treatment first)
  - → links consumers to housing and clinical and psychosocial support services
  - → housing is conditional on engagement with support services
- Housing First (HF)
  - → secure and appropriate housing is fundamental to recovery
  - → immediate access to housing with no readiness conditions
  - → complex support needs addressed through a multidisciplinary team, e.g. drug and alcohol counselling or mental health treatment
  - → housing is not contingent on engagement with these services

Combined/hybrid models

- Assertive outreach
  - → provides a network of support services and housing to the most vulnerable rough sleepers
  - → consumers generally have a high degree of complex needs requiring cross-sectoral collaboration in support provision (e.g. Street to Home)
- Partners in Recovery (PiR)
  - → coordinates care for people with severe and complex mental ill-health
  - → implemented by a consortia of local NGO services and PHNs
  - → 'no closed door' approach where support facilitators connect consumers to the appropriate services according to need (incl. housing)

Supported housing programs for people with mental ill-health

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- Many evaluated and found to be successful
- Most are pilots, small in scale and localised or have time limited funding
- Limited capacity
  - → NSW Housing and Accommodation Support Initiative (HASI) 1,135 people 2002-2012
  - → Victoria's Doorway program has assisted 59 people 2014-2017

Housing and Accommodation Support Initiative (HASI)

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- Collaboration between NSW Health, Housing NSW and NGOs to provide
  - → accommodation support and rehabilitation associated with disability (delivered by NGOs, funded by NSW Health)
  - → clinical care and rehabilitation (delivered by specialist mental health services)
  - → long-term, secure and affordable housing and property and tenancy management services (delivered by social housing providers)
  - → initially targeted mental health consumers with high support needs but has since been expanded to provide a range of support

HASI contd.

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- Evaluation in 2012 showed
  - → HASI supported 1,135 people 2002-2012
  - → support ranged from very high (8 hrs/day) to low (5 hrs/week)
  - → annual cost per consumer was between $11,000 and $58,000
- Positive outcomes for consumers
  - → reduction in hospital admissions and length of hospital stay
  - → clinically significant improvement in mental health
  - → tenancy stability
  - → independence in daily living, social and community participation
  - → involvement in education or paid and unpaid work
  - → physical health of consumers remained below the general population

HASI contd.

- Critical success factors
  - → effective mechanisms for coordination at the state and local levels
  - → regular consumer contact with Accommodation Service Providers

Doorway program

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- Victorian government pilot initiative delivered by Wellways
  - → designed to assist people with persistent mental ill-health who are at risk of, or experiencing homelessness
  - → links consumers with private rental housing and psychosocial support while providing a rental subsidy, and brokerage and tenancy
- Critical success factors
  - → properties sourced through the open rental market, with appropriate rental subsidy and brokerage support
  - → collaboration between hospitals, housing and mental health service providers and landlords

Doorway contd.

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- Tenancy outcomes
  - → Intake of 77 people, 59 entered private rental
  - → 50 still in residence at the end of the evaluation period
- Cost savings
  - → participant usage of bed-based clinical service and hospital admissions were reduced significantly during the program, which totalled annual cost savings to government ranging from $1,149 to $19,837 per individual
- Outcomes for participants
  - → modest improvements in the proportion of tenants in paid or unpaid employment, taking steps to find work, seeing an employment consultant, accessing education and vocational training opportunities and receiving qualifications for their vocational training

Queensland Housing and Support Program (HASP)

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- Housing First initiative
- collaboration QLD Health and Department of Communities
- targeted at consumers in tenuous accommodation or homeless when signing up to the program
- consumers are immediately connected with mental health and disability support services and regular community housing
- 2006-2010, there were 204 HASP consumers

- Critical success factors
  - strongly targeted to specific mental health service user cohort
  - immediate access to long-term housing.
  - key government agencies and NGOs working in collaboration

Queensland Housing and Support Program (HASP)

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- 82% of consumers agreed HASP helped them achieve their goals
- Generated significant cost savings
  - → people who would have been in a community care unit without HASP saved government approximately $74,000 annually
  - → people who would have been in acute inpatient units saved government $178,000 annually

Mental health programs

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- Success factors
  - → immediate access to housing
  - → cross-sector collaboration and/or partnerships
  - → integrated person-centred support

Discharge programs

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- Consumers generally exit mental health institutions/ hospital settings into community mental health care
  - → some enter into housing and support programs
  - → others exit into unstable housing and inconsistent supports
- Discharge from institutions carries significant risks for homelessness, mental health and wellbeing
  - → increased risk of suicide post discharge
  - → discharge follow up often delayed or inadequate
  - → discharge delayed due to lack of housing or supported accommodation
  - → housing insufficiently considered during discharge procedures

Discharge programs

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- Post-hospital follow up by a hospital discharge liaison officer is now common practice
  - → often there are delays between discharge and follow up
  - → follow up may only be possible if the consumer has been discharged to a fixed address
  - → a home address is a common prerequisite for community mental health service provision upon discharge
- Recent improvements to discharge processes in some specialist mental health hospitals
  - → outreach programs to achieve more timely and specialist follow up
  - → assigning priority to post-hospital follow up within five days for all post-hospital consumers

Transitional housing treatment program (THT)

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- Established in Queensland in 2005 as part of a government response to homelessness among people with mental illness
- THT team provided time limited housing and intensive living skills training and support to clinically case managed patients

Transitional housing treatment program (THT)

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- Post-discharge integrated mental health and housing supports
  - → can significantly improve outcomes for consumers
  - → produce downstream savings for government
- THT compared to control group
  - → averted 22.42 psychiatric inpatient bed-days per after adjustment for age and HoNOS score
  - → greater improvement in living conditions
  - → costs saved on bed-days averted more than eclipsed cost of THT
- Examples of THT programs
  - → Housing and Mental Health Pathway Program (HMHPP) delivered by HomeGround and St Vincent's Inpatient Mental Health Service in Victoria

Opportunities to scale up

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- Access to accommodation
  - → coordination with the private rental sector can facilitate access to established homes, potentially enabling program providers to readily scale up in response to increased program demand
- Targeted clientele
  - → unclear whether programs targeting a particular cohort are more effective or better suited to up-scaling than others
- Policy and stakeholder coordination
  - → coordination at the local and state level is critical

Opportunities to scale up

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- Successful programs could be promulgated at a national level through national frameworks, formal interagency agreements, and clear guarantees given by parties around outcomes
- Funding to roll out programs at a national level will be needed
- Successful programs could be extended to serve new cohorts
- Integrated support can be delivered by innovative non-government providers who are required to work with homelessness service providers across the board; e.g. the Doorway program has benefited from effective coordination between non-government service providers, hospitals, and private landlords
- Coordination could be contracted to external organisations provided objectives and outcomes are clearly specified and performance measured

Housing and mental health system integration

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- Significant differences between states/territories in the scope of system integration
- Some have achieved a degree of system integration
  - → NSW Joint Guarantee of Service for People with a Mental Illness (JGOS) enabled the implementation of programs such as HASI
  - → MOU between Housing SA and SA Health, Mental Health and Substance Abuse, which guides 'the coordinated delivery of mental health services, psychosocial support and general housing services'
  - → In Victoria, Doorways demonstrates program level integration involving hospitals, peak industry bodies and mental health service providers

Mental health policies

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- *Roadmap for National Mental Health Reform 2012–2022*
- *Fifth National Mental Health and Suicide Prevention Plan*
- State and territory plans and strategies
- Recognition at national and state levels that greater integration and coordination is needed between mental health services and housing services in the community.
- Systematic connections between these services, and connections at a program or strategic level are limited to a few jurisdictions (NSW and Qld)

Mental health policies

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- Housing is important in a general sense as part of supporting good mental health in the community
- Stable and secure housing/supported housing is important in supporting recovery from mental illness in the community
- Links between mental illness and homelessness acknowledged
- Supported housing in the community recognised as an important means to support those with complex needs including those with mental illnesses

Housing and homelessness policies

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- National Affordable Housing Agreement (NAHA)
  - → funding for affordable housing provision
  - → improve integration between housing and human services
- Transitional National Partnership Agreement on Homelessness (NPAH) 2017–2018
  - → targets those exiting mental health institutions
  - → support services to assist homeless people with mental ill-health

Housing and homelessness policies

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- Some state/territory housing policies make links with mental health issues or services (e.g. anti-social behaviour policies training of staff in trauma, mental health first aid)
- Most recommend better alignment or coordination between social housing and mental health systems
- Two states have implemented integrated support programs that link clinical support services with tenancy support: HASI in NSW and HASP in Queensland
- Some homelessness policies emphasise prevention (strengthening tenancy and other support for those with mental illness, improving exit planning from mental health facilities) and strengthening responses (assertive outreach programs, e.g. Street to Home, Resident Recovery, Opening Doors)

Barriers to scaling up successful programs nationally

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- lack of national framework
- lack of commitment to innovative funding models
- lack of formalised agreements for collaboration between housing and mental health providers at a local level
- capacity constraints in the housing sector around mental illness and mental health service provision
- barriers at implementation level (poor inter-sectoral linkages)
- availability of affordable housing
- lack of strategic integration across sectors
- lack of integration across policy silos
- bi-lateral funding agreements
- differing accountability measures across sectors

Findings: Key systemic issues

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- Lack of affordable, safe and appropriate housing
- Integrated programs for housing and MH are effective but do not meet demand
- Discharge from institutions poses significant risks for homelessness and mental health
- Mechanisms for tenancy sustainment and early intervention are lacking or underdeveloped
- The NDIS is reshaping the mental health system and there are indications of a service provision gap under the NDIS
- Lack of integration between housing, homelessness and MH policy areas. Government silos and disparate funding arrangements impede the development of national, accountable, cross-sectoral policy solutions for housing and mental health.

Scale up existing models for consumer and recovery oriented housing

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

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

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

Early intervention and prevention

- Provide more, and more tailored, support to sustain existing tenancies

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

Early intervention and prevention

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- Identify the early warning signs of a mental health crisis and respond appropriately

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

Early intervention and prevention

- Prevent failed discharge planning and exits into homelessness

10. Develop a national discharge policy and a nationally consistent definition of ‘no exit into homelessness’.
11. Resource hospitals to make thorough discharge assessments and develop appropriate discharge plans.
12. Increase knowledge and capability in the acute sector to enable officers to better identify people who are in precarious housing or at risk of homelessness.
13. Ensure timely and assertive follow up after discharge.
14. Investigate the feasibility of a national roll out of transitional housing treatment programs for homeless people with mental ill health.

Policy integration

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

Building collaboration for long term change

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17. Convene a national roundtable that brings together the peak bodies for housing and mental health and peak bodies for consumers, carers and tenants. The roundtable will act as a call to the nation to discuss the key issues.
18. Work towards developing a consensus statement on housing and mental health, including measurable indicators and outcomes.
19. Develop a process and mechanism to involve private sector stakeholders to generate innovative solutions, access funding, gain a better understanding of the issues and to raise awareness of housing and mental health in the private sector.

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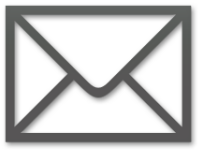

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