

# **Mental Health and Homelessness**

## **Final Report**

authored by

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for the

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## **EXECUTIVE SUMMARY**

The NSW Premier's Council on Homelessness is the peak advisory body to Government in relation to homelessness in NSW. The Premier's Council has important functions in relation to providing policy advice and recommendations, identifying effective responses to any gaps identified in the current approach taken, and raising awareness and the profile of homelessness in the broader community.

Mental health and homelessness is a current priority focus area of the NSW Premier's Council on Homelessness.

The Mental Health Commission of NSW is contributing to the work of the Council through the preparation of this report on key issues relevant to the area of mental health and homelessness. The evidence informing this report comes through the preparation of:

- A background paper outlining evidence from published research and evaluations.
- A summary of key outcomes of a stakeholder enquiry which provided an opportunity key partners to bring together policy and practice evidence.

The Mental Health Commission of NSW contracted AHURI to develop the background paper and facilitate the stakeholder enquiry in order to produce this final report. This report brings together evidence regarding the mental health and homelessness interface and provides recommendations on possible key areas for further work.

The evidence on mental health and homelessness provided in this report is focussed on three themes:

- Appropriate delivery of mental health services to people living in social housing with a focus on the sustainability of tenancies and prevention of homelessness.
- Appropriate access to services for people with mental illness living in boarding houses.
- Appropriate delivery of mental health services to people with mental illness who are sleeping rough or staying in crisis or temporary accommodation.

### **Mental health and homelessness**

The national and international evidence identifies mental health issues as a key risk factor for homelessness (Park et al. 2012; Busch-Geertsema et al. 2010; Chamberlain et al. 2007; Johnson and Chamberlain 2011; Bleasdale 2007). In Australia it has been estimated that that 50–75 per cent of homeless youth have some experience of mental illness (Chamberlain et al. 2007; MHCA 2009; Pryor 2011). An emerging risk factor for children and youth is mental health issues within their family unit placing them at risk of homelessness now and into the future.

People with mental health issues are at risk of homelessness due to: uncoordinated service systems; poor support networks; social isolation; and high levels of stigmatisation both within the service system and society (Robinson 2005). People with mental illness also face multiple challenges in accessing housing, including economic disadvantage and discrimination in the private rental market (Beer et al. 2005; 2006; Bleasdale 2007). Other key findings from the literature include:

- Poor mental health is a risk factor for homelessness because people with poor mental health often lack secure and stable housing (Bleasdale 2007).
- The incidence of mental illness amongst the homeless population is significantly higher than for the general population (Kirkpatrick and Byrne 2007).

- Many homeless and at-risk people repeatedly move through mainstream systems and institutions, such as prisons, state psychiatric hospitals, drug treatment programs, foster care, and homeless shelters (Baldry and Dowse 2010).
- Dual diagnosis (i.e. both mental illness and drug/alcohol) can increase the likelihood of someone having unstable housing, and interventions are likely to be lengthy and complex (Hipwell et al. 2000).
- The evidence that does exist suggests that people from culturally and linguistically diverse communities have high mental health support needs (Pryor 2001).
- Australian youth with mental illness or emerging mental health issues are often reluctant to seek professional help (Wilson et al. 2012).
- Distance and 'dislocation' from mental health networks and providers have long been recognised as significant barriers for rural Australians to access appropriate healthcare (Beer et al. 2005).
- Living in a rural or remote area places people with mental health issues at greater risk of homelessness and insecure housing (Beer et al. 2006).

### **Barriers to effective service**

- The lack of coordination and integration within the service system creates greater risk of homelessness for people with mental health issues. Discharge from institutions (e.g. hospitals and prisons) demonstrates gaps in the service system as a result of uncertainty in responsibilities and accountability (NSW Ombudsman 2011).
- While Aboriginal and culturally and linguistically diverse communities are reported to have higher mental health support needs, the evidence also suggests (contradictorily) that lower levels of mental health literacy, results in reduced engagement with the mental health service system (Keleher and Hagger 2007).
- Young people are often unwilling to acknowledge mental health issues and therefore reluctant to seek assistance (Meadows and Burgess 2009).
- Living in rural areas reduces access to mental health services (Beer 2005; 2006).

### **Evidence of effective service provision**

- Discharge planning has been an effective and successful prevention strategy that targets repeated moves through mainstream systems and institutions (Apicello 2010).
- Discharge planning aims to ensure that people who are transitioning out of an institution are not discharged into a homeless shelter or the street, and that their placements are stable enough to prevent future homelessness (Backer et al. 2007).
- Sustaining tenancies programs have been found to increase linkages to health and other social services, including improved access to counselling services, referrals to mental health, drug and alcohol services, and financial counsellors (O'Brien et al. 2002).
- Sustaining tenancies programs, which include rental brokerage and family homelessness prevention programs, have demonstrated effectiveness in reducing evictions.
- Permanent supportive housing has been found to be an effective intervention for chronically homeless people who also have mental health issues (Cooper and Morris 2005).

## **Social housing**

Many people living in social housing have mental health issues and their housing security is often precarious (Hulse and Saugeres 2008). Tenancy sustainment services, particularly those provided to social housing tenants, constitute one early intervention and prevention process that can, in some cases, prevent and lessen the precarious housing circumstances for people with mental health issues (Habibis et al. 2007).

In their Victorian study, O'Brien et al. (2002) identified four elements believed to be critical to the process of sustaining tenancies for people with complex needs, namely that people with complex needs:

- Live in housing that they find acceptable.
- Have support, medication and/or treatments that they trust, accept and find helpful.
- Demonstrate a willingness and readiness to tackle, with appropriate support, the individual daily challenges and difficulties living independently may present.
- Receive support to identify and address the major issues that place their tenancies at risk.

## **Marginal housing**

Some people with mental health issues find themselves living in boarding/rooming houses for a range of reasons, including:

- They fall through the cracks of the service system (Goodman et al. 2013).
- They have histories of insecure tenancies and fall into this accommodation form (Thomson and Jones 2013).
- They prefer this housing form as it can increase their autonomy (i.e. they can come and go from this form of accommodation without penalty) (Thomson and Jones 2013).
- It is one of the limited affordable housing options for some people (Chamberlain 2012).
- Issues of discrimination in other private rental housing options may push people into this form of housing (Thomson and Jones 2013).

## **Chronically homeless**

Rough sleepers are exposed to many risk factors that can either exacerbate an existing mental illness or create conditions that can lead to a mental illness (Phillips and Parsell 2012). The evidence base suggests that the chronically homeless are more likely to have experienced primary homelessness (i.e rough sleeping) or have mental health and/or substance use issues.

The evidence suggests that specialist support is needed for people with complex needs (e.g. drug and alcohol use, mental health issues, disabilities). One such intervention is the Housing First program. Housing First is an intensive response approach for clients with complex needs (Tsemberis and Asmussen 1999). It focuses on providing permanent housing linked to intensive and integrated support. This model has a proven ability to:

- Deliver high levels of sustained tenancies for people with mental health issues and complex needs and a history of homelessness (Andersen and Sherwood 2002).

- Provide a service rich housing environment specifically for people with special needs who are homeless or at risk of homelessness (Greenwood et al. 2005).
- Be particularly effective with people experiencing homelessness and mental illness (Salyers et al. 2007).

## **Outcomes of the stakeholder enquiry process**

A stakeholder enquiry, facilitated by AHURI was held in Sydney in May 2013. The enquiry involved more than 60 participants including representatives from government, service providers, peak bodies, NGOs and academics.

The stakeholder enquiry was an opportunity for key partners from the mental health and homelessness service systems to come together to discuss shared issues of concern. A general set of principles were established by key stakeholders as fundamental to the effective operation of the service system. These principles included:

- Continuation of 'no exits into homelessness' policy direction.
- Early intervention and prevention is key.
- Health service coordination needs to be more effective.
- All mainstream services need to be involved in the generation of solutions.

The stakeholder enquiry process identified five key areas in need of further investigation:

1. Better integration of services.
2. How to best implement a 'no exits into homelessness' agenda.
3. How different service models can be used in rural and remote areas of NSW.
4. What a prevention agenda looks like and how sustaining a tenancy is critical to this process.
5. What data evidence currently exists and what is needed to best assist future policy development.

## **Recommendations**

A series of recommendations for possible areas of future action were developed throughout the enquiry.

**Recommendation 1:** Service integration and care coordination were identified as areas in need of strengthening. To improve service integration and care coordination, the following first steps should be undertaken: the development of a shared understanding of outcomes, outcome measures, and governance arrangements (who is lead agency); funding arrangements that facilitate integration and a client centred approach; plans for exit; entry assessments that include housing need; and information sharing across sectors and services<sup>1</sup>.

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<sup>1</sup> The recommendations use the term service to mean formal programs and activities provided by a range of organisational units within government and by external agencies (e.g. mental health acute and community based services, drug and alcohol services, Emergency Department, acute care services, Medicare Locals, GPs, health clinics within Specialist Homelessness Services).

- Recommendation 2:** Boarding House reforms are being implemented to establish an appropriate regulatory framework for the delivery of quality services to residents of registrable boarding houses in NSW, and for the promotion and protection of the wellbeing of boarding house residents. Explore options for greater involvement of agencies with mental health responsibilities and mental health services in this framework to ensure the needs of residents with mental illness are met.
- Recommendation 3:** Private rental markets constitute a sector of the market requiring additional consideration. Mechanisms that assist people with mental health issues to access the private rental market should be investigated.
- Recommendation 4:** There is a pressing need to establish a robust referral system within and between agencies. The NSW multi-agency transition planning framework potentially provides some of the groundwork in discharge planning and referral mechanisms. In order to avoid duplication, further investigation into how the framework can better assist people with mental health issues should be undertaken. A particular focus should be on initiating processes to plan for housing exits as soon as an individual is admitted into an institutional care setting.
- Recommendation 5:** Develop processes of reporting about mental health and homelessness risks for 'first to know agencies' (e.g. Local Health Districts, Justice and Health agencies, Corrective Services, real estate agencies, landlords and housing providers) when they become aware of risk factors/trigger events that may put an individual at risk of homelessness.
- Recommendation 6:** To determine the nature and type of service demand amongst clients, undertake consultations with mental health and housing consumers.
- Recommendation 7:** Aboriginal people are less likely to access mainstream services. More culturally appropriate and tailored solutions are required for Aboriginal people with mental health issues, including how to better sustain tenancies and how to better facilitate Aboriginal access to mental health services.
- Recommendation 8:** Improve the evidence base for policy solutions with improved data. Use existing data and create new data collection tools to demonstrate need and map supply. In particular, data is needed to better define the populations being targeted and to identify the numbers of people with mental health issues that are in a range of tenures (private rental; social housing; boarding house; rough sleeping). There is a need for data mapping of the service system and identification of data gaps to inform the development of remedial solutions. In

addition, evaluations of existing innovative programs need to be undertaken (see examples in Appendix).

**Recommendation 9:**

Identify opportunities to increase capacity to improve homelessness and mental health data collection. This must include the development of tracking protocols in order to collect unit level data on client outcomes post discharge. This could also include the incorporation of identification of homelessness status into clinical assessment and data entry processes on presentation to health facilities.

# 1 INTRODUCTION

The NSW Premier's Council on Homelessness is the peak advisory body to Government in relation to homelessness in NSW. The Premier's Council has important functions in relation to providing policy advice and recommendations, identifying effective responses to any gaps identified in the current approach taken, and raising awareness and the profile of homelessness in the broader community.

Mental health and homelessness is a current priority focus area of the NSW Premier's Council on Homelessness.

The Mental Health Commission of NSW is contributing to the work of the Council through the preparation of a background paper and facilitation of a Stakeholder Forum on issues relevant to the focus area of mental health and homelessness. The Mental Health Commission of NSW have contracted AHURI undertake this work.

## 1.1 Policy Context

This section briefly describes the national and state based policy context that this work is situated within. Individually mental health issues and homelessness are of concern to all levels of government. This background paper outlines the key policy drivers in each of these areas.

### 1.1.1 Mental Health

In 2012 the Council of Australian Governments (COAG) endorsed a strategy to address mental health issues across Australia, the **Roadmap for national mental health reform 2012-2022**. The roadmap sets out the strategic directions of governments over the next decade. The key components of the policy reform are to:

- Create real improvements in the lives of people with mental illness, their families, carers and communities.
- Reduce stigma and discrimination in society.
- Significantly reduce suicide rates.
- Ensure that people affected by mental health issues and their families have access to appropriate services and supports; stable and safe homes; and are able to participate successfully in education and employment.

In order to achieve these, the Roadmap set out six priority areas:

- Promotion of a client centred approach.
- Improve mental health and social/economic wellbeing.
- Prevent mental illness.
- Focus on early detection and intervention.
- Improve access to high quality services and support.
- Improve the social and economic participation of people with mental illness.

**The National Partnership Agreement on Mental Health** is part of the national health and mental health reform agenda negotiated by the Commonwealth and states and territories. The most recent partnership agreement was signed in 2012 to establish a wide set of reform priorities including:

- Improve mental health systems.

- Ensure a better response to the needs of people with severe and debilitating mental illness so they stay well and lead functional lives.

These reform priorities also include a focus on accommodation and support as all governments recognise the role that these factors play in homelessness. The national partnership aims to work alongside the investment under the National Affordable Housing Agreement and National Partnership Agreement on Homelessness (see below) to end the cycle of homelessness for people with mental illness.

The New South Wales government undertook a set of reform processes of the mental health service system including a review of the *Mental Health Act 2007*. The reform priorities include greater accountability in relation to:

- Admission and discharge processes.
- Integration and role of mental health bodies that have oversight of the mental health system in NSW.
- Consent procedures for non-mental health treatment.

The reform process also established the NSW Mental Health Commission in 2012 to monitor and improve the NSW mental health system. As an independent statutory authority, the Commission's role is to strategically plan the future mental health system. A particular focus of the Commission's responsibilities include:

- Monitoring of the system.
- Evaluating and reporting on mental health services.
- Promote evidence on mental health issues.
- Advocate for people with mental health issues.
- Educate the community about mental health issues.

### 1.1.2 Homelessness

The Commonwealth Government's (2009) White Paper, ***The Road Home: a national approach to reducing homelessness***, sets the strategic agenda for reducing homelessness in Australia to 2020, with two headline goals:

- Halve overall homelessness by 2020.
- Offer supported accommodation to all rough sleepers who need it by 2020.

Three strategies guide this response to homelessness:

- Turning off the tap: services will intervene early to prevent homelessness.
- Improving and expanding services: services will be more connected and responsive to achieve sustainable housing, improve economic and social participation and end homelessness for their clients.
- Breaking the cycle: people who become homeless will move quickly through the crisis system to stable housing with the support they need so that homelessness does not recur.

**The National Affordable Housing Agreement (NAHA)**, established in 2009 in response to a significant loss of housing affordability over the last three decades, aims to ensure that all Australians have access to affordable, safe and sustainable housing. The NAHA adopted a whole of housing system approach with an ambitious outcome orientation, which included homelessness services. The objectives are to:

- Increase the supply of affordable housing.

- Improve the integration and coordination of assistance to people who are homeless or at risk of becoming homeless.
- Improve social housing arrangements to reduce concentrated areas of disadvantaged people.
- Improve access of Aboriginal people to mainstream housing, including home ownership.

**The National Partnership Agreement on Homelessness (NPAH)** was one of five National Partnership Agreements established under the NAHA umbrella, providing additional targeted funds and specified program directions. This four-year agreement (2009-2013) between the Australian and state and territory governments will facilitate the implementation of the strategic agenda outlined in the White Paper on Homelessness. A transitional NPAH has been agreed to for the 2013/14 period.

**Going Home Staying Home (GSH)** is a major NSW reform initiative that aims to deliver a better balance between early intervention, crisis support and post-crisis support (FACS n.d.). The reform process is aiming to make it easier for the specialist homelessness services (SHS) to deliver a range of support needs. The overall objective is to achieve a balance in service delivery that is better targeted to peoples needs and circumstances. The review of the SHS is of critical importance to the mental health sector as many services have eligibility criteria that exclude the provision of services; limited capacity of some service providers within SHS to manage mental health issues; and lack of coordination between other mainstream services.

Four core service responses have been identified as the components of the reform. These are:

- Prevention and early intervention – for those at risk of homelessness. This response aims to sustain people in their current accommodation. It includes approaches that enable women experiencing domestic violence to stay safely in their home.
- Rapid re-housing – for those who have recently been identified as homeless. This response identifies people as soon as they become homeless and works quickly to stabilise their housing arrangements. This includes helping to identify affordable private rental, social housing or other secure housing. Rapid re-housing, where necessary, is coupled with supports to stabilise and sustain the housing arrangement.
- Crisis and transition response – for those who require short-term crisis accommodation while their housing situation is resolved. This response incorporates the provision of safe and supported crisis, transitional and other non-permanent accommodation, with a focus on assisting the homeless person or family to move quickly into permanent housing.
- Intensive responses – for those who are chronically homeless and/or have complex needs. This response includes assertive outreach for rough sleepers and chronically homeless people, and Housing First approaches where long-term housing is linked to support. This response recognises that once a person has been homeless for some time, more intensive interventions are required to assist that person out of homelessness.

Across this range of core service responses, GSH recognises the need for a client centred approach in order to prevent or address the client's homelessness. A client centred approach places the client at the centre and determines the service response by taking into account the individual's circumstances and needs.

## 1.2 Objectives

This responds to the priority topic of mental health and homelessness and includes specific focus on identifying evidence related to:

- Appropriate delivery of mental health services to people living in social housing with a focus on the sustainability of tenancies and prevention of homelessness.
- Appropriate access to services for people with mental illness living in boarding houses.
- Appropriate delivery of mental health services to people with mental illness sleeping rough or staying in crisis or temporary accommodation.

The report also includes the outcomes of a stakeholder enquiry which interrogated key themes identified from the evidence, considered additional challenges and options; and developed a set of draft recommendations to take to the out-of-session meeting of the Premier's Council.

Within this context, consideration was given to issues of:

- Dual diagnosis (i.e. mental illness and drug/alcohol)
- Service delivery in rural areas
- Culturally appropriate responses, for Aboriginal or people from culturally and linguistically diverse communities, including for refugees
- Service delivery to young people
- Discharge planning and people exiting from hospital.

### 1.2.1 Research evidence

The research evidence presented in this report has been developed using an approach called research synthesis. Research synthesis is a proven methodology for cost-effective and timely use of existing research findings for a specific policy concern. It is designed to facilitate evidence-informed policy and practice development. The synthesis will focus on identifying recent evidence (2000-present) of models and best practice examples, including both peer-reviewed articles and publications and non-peer reviewed research undertaken for government and non-government bodies. Earlier work may be included if critical to the synthesis.

The research synthesis methodology is based on Ray Pawson's 'realist synthesis' approach developed at the UK Centre for Evidence Based Policy and Practice (Pawson 2006). The approach was developed to help identify which social policy interventions work for whom, how and in what circumstances. As such it aims to identify the *contextual conditions and mechanisms (or means by which)* a social policy intervention produces a particular outcome. The research synthesis process is tailored for purpose and scope, and typically involves the following activities:

- Search for primary studies.
- Quality appraisal and data extraction.
- Synthesis of findings and knowledge transfer.

In order to find documents, reiterative searching techniques will include:

- Searching academic journals in homelessness, mental health, health, disability, and related social science fields using EBSCO.
- Searching the AHURI research database.
- Searching state government websites.

- General internet searching using Google Scholar.
- Following up bibliographic references found in articles.

A bibliography will be prepared and analysed for overall themes, scope and quality of the evidence base. Selected studies will then be appraised in detail and assessed for quality, research rigor and relevance. Data is extracted to construct a synthesis of the evidence, including detailed findings, overall conclusions and recommendations.

Individually the evidence base on mental illness and homelessness are strong. There are however some weaknesses in the evidence. One structural weakness of the evidence base is the cross over in and between areas. For example the homelessness evidence base tells us that young homeless people are increasingly reported as having mental health issues. The evidence base on juvenile justice tells us that young people in this cohort are high users of drugs and alcohol. The evidence from the mental health sector identifies the relationship between mental health issues and drug use, particularly amongst young people. As such there is a gap in the evidence that looks at the relationship between young people, mental illness, drug use and homelessness. The weakness in the evidence results in the requirement to extrapolate this evidence to demonstrate that:

- Young people are increasingly reported to have mental health issues, often with drug abuse as a contributing factor. This subsequently places young people at a disproportionate risk or experience of homelessness.

Other weaknesses in the evidence base include:

- Effective service provision for people from culturally and linguistically diverse backgrounds with mental health issues, particularly recent accounts of crowding.
- People from culturally and linguistically diverse communities and homelessness.
- Aboriginal mental health.
- Rooming and boarding houses and the relationship to mental health issues and/or homelessness.
- Effective responses to crisis and transitional housing.
- Evidence on rooming and boarding houses, particularly on specific service interventions.

### *1.2.2 Stakeholder enquiry*

A stakeholder enquiry, facilitated by AHURI was held in Sydney in May 2013. The enquiry involved more than 60 participants including representatives from government, service providers, peak bodies, NGOs and academics.

The purpose of the stakeholder enquiry was to elaborate on and interrogate the key themes identified through the research synthesis, consider additional challenges and options; and develop a set of draft recommendations to take to the out-of-session meeting of the Premier's Council. The stakeholder enquiry was undertaken over a full day and designed to bring key stakeholders together to informally engage in candid and robust reflection on significant areas of policy concern.

The stakeholder enquiry included a discussion of key findings from the background paper and possible options, and identification and discussion of additional 'burning issues', in order to formulate recommendations to take to the Premier's Council.

The intent of the stakeholder enquiry was to:

- Gauge the nature of the response to the problems, issues and options presented in the background paper
- Identify and discuss additional challenges or options of key importance to stakeholders
- Refine a set of recommendations to take to the out-of-session meeting of the Premier's Council.

### **1.3 Use of key terms**

Defining the key terms used in this background paper will provide a greater understanding of the ways that the evidence base can provide information about the relationship between mental health and homelessness.

#### *1.3.1 Mental health and mental illness*

Definitions of mental illness vary widely, and are typically narrower in a legal and political context than in a clinical one (Karras 2006). The NSW Mental Health Act (2007) defines mental illness as:

a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms: delusions; hallucinations; serious disorder of thought form; a severe disturbance of mood; and/or; sustained or repeated irrational behaviour.

This contrasts with mental health issues (also known as mental health problems), which 'are typically less severe and of shorter duration than mental illness and may (be)... experienced as a reaction to life stressors' (DoCS 2005, p.23).

Nonetheless the terms mental health issues and mental illness are often used inconsistently in the evidence base and operationalized differently across the national and international service systems. This background paper uses the term mental health issues exclusively except when paraphrasing or citing specific evidence where the term mental illness has been applied. Therefore when the term mental health issues is used it may refer to a less severe experience or may indicate a situation where the literature is not clear whether a particular diagnosis is being discussed.

#### *1.3.2 Complex needs*

The evidence base also uses terms like complex needs to refer to people who have 'challenging behaviour' as a result of the combination of mental health issues, drug and alcohol use, and other behavioural problems. Complex needs can relate to needs that fit within multiple service areas, needs which are not met or managed by existing services, behaviours that place a person or others at risk and needs that require a long-term response from a range of services. Cooper, Verity and Masters (2005) conclude that it is accepted that:

Complex needs are the result of a dynamic interplay of personal characteristics, developmental disorders, psychopathology, co-morbidity, environmental factors, historical factors, inadequacies in the service delivery system, and interactions between people with complex needs and other within the social service system (p.2).

#### *1.3.3 Dual diagnosis*

Dual diagnosis is a broad term encompassing a combination of mental health and substance abuse disorders in the one individual such as depression and alcohol addiction or schizophrenia and drug addiction (Coombes et al. 2007; Hipwell et al.

2000). Dual diagnosis can refer to a range of co-occurring conditions, but in this paper refers to co-occurring mental health and drug and alcohol issues. The disorders are comorbid and often augment the severity of each other.

Overall, people with dual diagnosis are more likely to have unstable housing arrangements and experience employment and financial difficulties (Hipwell et al. 2000) and are more likely to be incarcerated than those solely with a mental illness (Pimlott Kubiak et al. 2005).

Individuals with dual diagnosis are also less likely to seek out social support services that are available to them (Meuser et al. 1998), and if they do seek out these services, their utilisation is often erratic and irregular (Hipwell et al. 2000).

All these factors suggest that individuals with dual diagnoses are at heightened risk of homelessness, as they are more likely to be part of several at-risk groups (such as older and younger individuals, ex-prisoners, people with mental illness and people with substance abuse issues) and are more likely to require intensive and lengthy interventions.

#### *1.3.4 Disability*

Often times disability and mental health issues are conflated. Likewise mental illness is often understood and/or categorised as a psychiatric disability. For example Baldry et al. (2010) in their work on the relationship between incarceration and mental health issues found that people with cognitive disabilities are a group particularly susceptible to incarceration and homelessness. Subsequent to this, the research also found that people with cognitive and intellectual disabilities are often mis-categorised as having a mental illness. As such a service system response is often complicated by misdiagnoses or interpretation of a person's health status or abilities.

#### *1.3.5 Homelessness*

In Australia, the cultural definition of homelessness described by Chamberlain and Mackenzie (1992) has been accepted as a productive way to understand the different experiences of homelessness. This definition describes three types of homelessness:

- Primary – rough sleeping.
- Secondary – temporary accommodation and includes people moving frequently from one form of temporary accommodation to another, including emergency housing, boarding houses or staying with family or friends (called 'couch surfing').
- Tertiary – inappropriate housing (e.g. rooming houses) and refers to people staying for longer than 13 weeks in the same rooming house.

The ABS released a definitional change of homelessness in 2012 in order to better operationalise the homelessness count across a range of different data sets.<sup>2</sup> The ABS (2012b), in consultation with a wide variety of key stakeholders, defines someone as homeless if they do not have suitable accommodation alternatives and their current living conditions include:

- Living in a dwelling that is inadequate; or
- Having no tenure, or if their initial tenure is short and not extendable; or
- Does not allow them to have control of, and access to space for social relations (ABS 2012b, p.2).

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<sup>2</sup> There has been a significant critique of the ABS definitional change from both the academic research community, policy makers and practitioners. The definition now used by the ABS is not accepted as productive by all stakeholders.

The ABS identifies 6 operational categories to distinguish homelessness:

- Persons living in 'severely' crowded dwellings
- Persons in other temporary lodging
- Persons staying in boarding
- Persons staying temporarily with other households
- Persons in supported accommodation for the homeless
- Persons who are in improvised dwellings, tents or sleeping out.

## 2 RECOMMENDATIONS AND FUTURE DIRECTIONS



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This chapter presents the outcomes of the stakeholder enquiry and proposes a set of recommendations for possible areas of action that emerged from the research and practice evidence bases.

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### 2.1 Key issues from the stakeholder enquiry

The stakeholder enquiry was an opportunity for key partners from the mental health and homelessness service systems to come together to discuss the range of issues of concern. Stakeholders outlined the following areas of concern in relation to mental health and homelessness. A general set of principles were established by key stakeholders as fundamental to the effective operation of the service system. These include:

- Continuation of the 'no exits into homelessness' policy direction.
- Early intervention and prevention is key.
- Health service coordination needs to be more effective.
- All mainstream services need to be involved in the generation of solutions.

A range of other issues were also considered as being important in the development of recommendations. The following set of issues provides information from stakeholders regarding which areas of the service system require continued focus:

- Ensuring that future initiatives take into account the different needs or challenges within rural and remote areas, particularly given the limited supply of both housing and support services and distance travelled for people accessing services/support.
- Future responses need to attend to the needs of Aboriginal people. There was general agreement that current policy settings were not working for Aboriginal people with mental health issues who are homeless.
- The lack of affordable housing is delaying the discharge of people with mental health issues from institutional settings and hindering their move to independent living. It was acknowledged that increasing supply of affordable housing was of critical importance, however this is not going to occur quickly or without substantial government investment. It was also established that social housing can no longer be relied upon as a housing solution for people with mental health issues due to shortages in supply. In order to account for these housing market problems, the private rental market is likely to represent the most important segment of the housing market for people with mental health issues.
- There are a range of data issues that need to be resolved. These include a greater understanding of the volume of people within different parts of the service system and their current housing circumstances. Without up-to-date and rigorous data, effective policy development is difficult. For example, numbers of people with mental health issues are living in social housing, boarding houses, or are sleeping rough; and how many people with mental health issues are supported in the private rental market. Some of this data is administrative and service providers acknowledged there were differing reporting standards across the sector. The provision of reliable and robust linked data is critical for future policy development for people with mental health issues.

- The availability of program evaluations provides evidence to inform future policy development. There was general acknowledgement that more evaluations are required in order to identify areas of innovation currently operating in the service system.
- Consent, privacy and confidentiality are important to maintain for people with mental health issues. However there exists a real challenge in retaining client confidentiality and ensuring adequate communication in service coordination/integration.
- People with mental health issues, particularly those with dual diagnosis, can be reluctant to disclose their mental health status for fear of child protection interventions. The reluctance to disclose mental health and drug/alcohol issues limits opportunities for early intervention and prevention strategies

The stakeholder enquiry process identified five key areas in need of further investigation:

1. Better integration of services. There is a need for early intervention referrals at critical contact points. This means referring clients to the right organisation at first contact (rather than waiting until second or third contact, at which point the client's problems may have escalated to crisis level). The first time a client presents to an organisation (such as Centrelink, Housing NSW, health clinics, community housing organisations, mental health NGOs, welfare organisations, tenant services or youth services), there should be an assessment of their support needs (both mental health and housing) and appropriate referrals should be made at that time. Referring to the right organisation requires each agency having a thorough understanding of what services exist and a greater willingness to refer to those services. This requires relationship building and network building across the full range of service providers. Networking events are one practical way of achieving this.

Referrals need to consider both the mental health recovery and homelessness recovery needs of the client. These are related but not one and the same. A client may need to be referred to mental health specialist services but they also may need to be referred to non-clinical, social/peer support services that will assist with the recovery from homelessness. When a client is referred to a service provider, it should be the responsibility of the service provider to contact the client and not the other way around.

There is a need for follow-up mechanisms from 'first contact organisations' in order to check that the client has been contacted by the organisations to which the client has been referred. The client should have one case manager (not more than one) who oversees and facilitates their access to different service providers.

There is a need for flexibility in the level of support offered to individuals. A lack of flexibility was identified as a problem in a number of support services. For example, some service providers offer only two levels of support – high and low. If an individual decides that the high support option is too high and the low support option is too low, they can find themselves with no support at all. There is also a need for a 'no closed door' approach which allows clients to return to a service provider if/when they need assistance, in recognition that recovery from mental illness is not a linear process. The Partners in Recovery initiative is a good example of what flexible, integrated, client-focused support can look like.

Overall better service integration was identified as critical to the development of an effective service system. In order to achieve better service integration the development of more sophisticated mechanisms were suggested including:

- Development of referral protocols that minimise the risk of homelessness or insecure housing for people with mental health issues.
  - Coordinate the collection of data across the service system.
  - Coordinate service delivery across agencies.
  - Minimise the fracturing of services.
  - Utilise flexible brokerage.
  - Maintain privacy, trust and consent while also attending to cross agency collaboration and coordination.
2. Maintain a 'no exits into homelessness' agenda. Of critical importance is discharge planning and a clear understanding of what best practice looks like. It is important not to delay release from mental health facilities when individuals are ready to leave; however, it is equally important not to release individuals to inappropriate or unsustainable housing. This requires a sophisticated assessment of the individual's recovery.
  3. Investigation of how different service models can be used in rural and remote areas of NSW. This also extends to the applicability of accommodation and support for Aboriginal people with mental health issues.
  4. Consideration of what a prevention agenda looks like and how sustaining tenancies is critical to this process. The sustaining social housing tenancies evidence is very strong. However how to sustain tenancies in the private rental market is equally critical, specifically a better understanding is needed about the levels of on-going support required by tenants. This process can potentially assist in developing mechanisms to transition people out of social housing into the private rental market.
  5. Scoping what data and other evidence currently exists and what future data and research evidence is needed. This also includes undertaking evaluations. There is a need for more research from the lived experience of clients. Research findings need to be 'tested' with clients; often clients themselves can provide useful explanations of why an initiative succeeded or failed to achieve particular outcomes.

## 2.2 Areas of innovation

Three presentations at the stakeholder enquiry provided valuable information about current areas of innovation being undertaken in New South Wales. Good practice examples included:

- **Boarding houses.** The NSW Reform of Boarding Houses currently underway has developed new regulations to create a standardised housing option. The discussion from the stakeholder enquiry included questions regarding the capacity for boarding houses to become a viable housing option for people with mental health issues and/or people who are homeless. It was acknowledged from participants that boarding houses have a place in the housing market and can be a suitable housing option for some people with mental health issues. There was an acknowledgement amongst participants that boarding houses should be analysed in the context of their business models. Boarding houses that are regulated and well run are not limited to metropolitan areas. It was reported that boarding houses are generally unsuitable for Aboriginal people in cases where overcrowding is likely because of family obligations.
- **Support programs.** One program currently operating in NSW is the HASI program (discussed in Chapter 3). HASI assists with stable housing through the

provision of various levels of care. HASI has also been able to reach into boarding houses and has other variations such as HASI Plus and Aboriginal HASI. The evidence from HASI evaluations suggests it is a successful model. Questions remain about the capacity to scale-up the delivery of HASI due to the costs involved.

- **Service integration and coordination.** Peter McGeorge from St Vincent's Hospital discussed a number of programs in operation to target people with mental health issues and who are homeless. The programs have different aims to traditional mental health services. These programs take a population based approach in preference to symptom/diagnosis response. The programs stress the need for collaboration and partnerships.

## 2.3 Additional areas of reform in NSW

The stakeholder enquiry discussed the issue of 'no exits into homelessness' and the pressing issue of discharge planning. NSW is currently developing implementation plans for the roll out of a framework for multi-agency transition planning to reduce homelessness. The development of this Framework includes a cross agency agreement under the NSW Homelessness Action Plan. The aim of the Framework is to reduce and prevent the incidents of people transitioning from statutory care, custody, disability or health facilities into homelessness. The Framework target groups including:

- Young people leaving statutory care or being released from juvenile justice centres.
- Patients transitioning from health facilities/settings.
- People released from adult correctional facilities.
- Aboriginal people transitioning from all of the above facilities/settings.

The Framework provides service principles for all signatory agencies including:

- Person-centred and culturally appropriate transition planning.
- No exits into homelessness principles to be embedded in policies and procedures.
- Multi-agency transition planning should commence at entry into care or custody.
- Linking housing solutions to support.
- Appropriate services should be available for clients when leaving care or custody.
- Transition planning should involve co-operation and collaboration, including NGOs.

## 2.4 Recommendations

Many of the discussions at the stakeholder enquiry mirrored the key issues in the literature. A series of recommendations for possible areas of future action were developed throughout the enquiry. The recommendations use the term service to mean formal programs and activities provided by a range of organisational units within government and by external agencies (e.g. mental health acute and community based services, drug and alcohol services, Emergency Department, acute care services, Medicare Locals, GPs, health clinics within Specialist Homelessness Services).

- Recommendation 1:** Service integration and care coordination were identified as areas in need of strengthening. It is recommended that in order to improve service integration and care coordination the following first steps should be

undertaken: the development of a shared understanding of outcomes, outcome measures, and governance arrangements (who is lead agency); funding arrangements that facilitate integration and a client centred approach; plans for exit; entry assessments that include housing need; and information sharing across sectors and services.

**Recommendation 2:** Boarding House reforms are being implemented to establish an appropriate regulatory framework for the delivery of quality services to residents of registrable boarding houses in NSW, and for the promotion and protection of the wellbeing of boarding house residents. Explore options for greater involvement of agencies with mental health responsibilities and mental health services in this framework to ensure the needs of residents with mental illness are met.

**Recommendation 3:** Private rental markets constitute a sector of the market requiring additional consideration. It is recommended that mechanisms that assist people with mental health issues to access the private rental market be investigated.

**Recommendation 4:** There is a pressing need to establish a robust referral system within and between agencies. The NSW multi-agency transition planning framework potentially provides some of the groundwork in discharge planning and referral mechanisms. In order to avoid duplication, further investigation into how the framework can better assist people with mental health issues should be undertaken. A particular focus should be on initiating processes to plan for housing exits as soon as an individual is admitted into an institutional care setting..

**Recommendation 5:** Develop processes of reporting about mental health and homelessness risks for 'first to know agencies' (e.g. Local Health Districts, Justice and Health agencies, Corrective Services, real estate agencies, landlords and housing providers) when they become aware of risk factors/trigger events that may put an individual at risk of homelessness.

**Recommendation 6:** To determine the nature and type of service demand amongst clients, undertake consultations with mental health and housing consumers.

**Recommendation 7:** Aboriginal people are less likely to access mainstream services. More culturally appropriate and tailored solutions are required for Aboriginal people with mental health issues, including how to better sustain tenancies and how to better facilitate Aboriginal access to mental health services.

**Recommendation 8:** 18. Improve the evidence base for policy solutions with improved data. Use existing data and create new data collection tools to demonstrate need and map

supply. In particular, data is needed to better define the populations being targeted and to identify the numbers of people with mental health issues that are in a range of tenures (private rental; social housing; boarding house; rough sleeping). There is a need for data mapping of the service system and identification of data gaps to inform the development of remedial solutions. In addition, evaluations of existing innovative programs need to be undertaken.

**Recommendation 9:**

Identify opportunities to increase capacity to improve homelessness and mental health data collection. This must include the development of tracking protocols in order to collect unit level data on client outcomes post discharge. This could also include the incorporation of identification of homelessness status into clinical assessment and data entry processes on presentation to health facilities.

## 3 MENTAL HEALTH AND HOMELESSNESS



**This chapter briefly outlines the key finding from the evidence base on the relationship between mental health and homelessness.**

### **Summary**

- The national and international evidence reports that many people with mental health issues are homeless or live in precarious housing circumstances.
- People with mental health issues have been found to represent a large proportion of rough sleepers.
- Homelessness exacerbates existing mental health issues.
- Homelessness can contribute to the onset of mental health issues (e.g. depression, anxiety).
- More integrated, assisted and holistic approaches are needed to better manage the often complex and overlapping needs of people with mental health issues in order to reduce their risk of homelessness and housing stress.
- In Australia it has been estimated that 50–75 per cent of homeless youth have some experience of mental illness.
- The risk of homelessness for young people can be due to their own mental health issues or those experienced by their parents.
- People with mental health issues are at risk of homelessness due to: uncoordinated medical treatment; poor support networks; social isolation; and high levels of stigmatisation (both within the service system and societally).
- Some Aboriginal households experience overcrowding. Overcrowding has been shown to contribute to poor health and mental health outcomes.
- A lack of literacy (and by extension, mental health literacy) in Indigenous and migrant/refugee communities results in lower engagement and participation rates in community health and outreach programs, which may contribute to lower use of available services and reduced help-seeking behaviours.
- Living in a rural or remote area places people with mental health issues at greater risk of homelessness and insecure housing.

### **3.1 Framing homelessness and mental health**

The national and international evidence identifies mental health issues as a key risk factor for homelessness (Park et al. 2012; Busch-Geertsema et al. 2010). However the relationship between homelessness and mental health is reciprocal. According to a study by Kirkpatrick and Byrne (2009), a third of homeless individuals have a severe mental illness. Likewise homelessness is considered to be a contributor to some mental illnesses, such as depression. The evidence also illustrates that for people with existing mental health issues, homelessness can exacerbate their conditions (Johnson and Chamberlain 2012).

Homelessness is also of specific concern to policy makers due to the rise in mental health issues amongst children and young people. In Australia it has been estimated that 50–75 per cent of homeless youth have some experience of mental illness (Chamberlain et al. 2007, p.6; MHCA 2009; Pryor 2011, pp.14–17). A range of factors are emerging in relation to youth, mental illness and homelessness. Baldry and Dowse (2010), for example found that young people in the juvenile justice system were also found to engage in high levels of drug and alcohol use, particularly amongst Aboriginal youth. These young people in juvenile justice facilities were also found to have high levels of psychological disorders.

The risk of homelessness for young people can be due to their own mental health issues or those experienced by their parents (Noble 2012). This has been found to be a result of mental health issues within households causing unstable housing circumstances. Unstable housing and households in childhood was found by McDonagh (2011) in a recent UK study that traumatic childhood experiences can lead to chronic homelessness in adulthood. These findings are confirmed by a recent Australian evaluation by Johnson and Chamberlain (2012).

The evidence has also found that:

- People with severe mental illness and who are rough sleepers represent a large cohort of the homeless across Europe (Busch-Geertsema et al. 2010).
- People with mental health issues are disproportionately incarcerated (Baldry and Dowse 2010).
- People with mental health issues are at risk of homelessness due to: uncoordinated medical treatment; poor support networks; social isolation; and high levels of stigmatisation (both within the service system and societally) (Beer 2005; 2006).
- The incidence of mental illness amongst the homeless population is significantly higher than that of the general population (Johnson and Chamberlain 2011).
- The risk of homelessness is heightened due to the limited capacity for some people with mental health issues to generate income through sustained employment (Parkinson and Horn 2002).
- Mental illness continues to impact upon daily life once people become homeless (Robinson, 2003).
- People with mental illness face multiple challenges in accessing housing, including poverty and discrimination in the private rental market (Bleasdale 2007, p. 42).
- People with severe mental illness are at high risk of incarceration and therefore homelessness post release. Ex-prisoners have been found to have high rates of mental illness, high rates of homelessness post release, and high rates of recidivism (Baillargeon et al. 2010).
- Some Aboriginal households experience overcrowding. Overcrowding has been shown to contribute to poor health and mental health outcomes (Flatau et al. 2009).
- The evidence that does exist suggests that people from culturally and linguistically diverse communities are over represented in accessing mental health services (Keleher and Hagger 2007).

### 3.2 Housing preferences for people with mental illness

An Australian study found the most preferred housing option among adults with mental illness was their own home, followed by public housing, private rental – alone and then family home, boarding house (alone) and boarding house (shared), and then unsupervised group home. The housing options placed at the bottom of the list included shelter, crisis accommodation, long-term hospitalisation and being homeless (Owen, Rutherford, Jones, Wright, Tennant & Smallman, 1996 in St Vincent's Mental Health Service 2005, p. 27).

The housing characteristics which were identified by Reynolds et al. (2002) as being preferred by mental health consumers were summarised by Edwards et al. (2009, p. 19) as follows:

- Independence and choice.
- A location convenient to transport and services and close to the person's preferred location.
- Safe, secure and comfortable.
- Affordable.
- Provides for both privacy and social opportunity.

Strong evidence supports the preference of people with mental illness for living as independently as possible (Seilheimer & Doyal 1996, Warren & Bell 2000, Yeich et al. 1994, Browne & Courtney 2005a,b, in Browne & Hemsley 2010a, p. 579-580; Nelson et al. 2003). A review of the evidence by Browne and Hemsley (2010a) found most consumers with mental illness want to live in their own house or flat, alone or with a partner or friend, and are opposed to living in supervised settings with other consumers (p. 579). Warren and Bell (2000) found that congregated housing was rejected by the mental health consumers in their qualitative study because they did not want to be easily identified as former psychiatric patients. Rather, the participants in this study indicated a desire to live a 'normal' life. A quantitative study by Browne and Courtney (2004) involving 3,231 people with schizophrenia, found an association between living in one's own home and having better outcomes regarding global functioning, employment and social support, compared to living in boarding houses.

Other important housing characteristics were identified by carers of loved ones with mental illness who participated in a study by Browne and Hemsley (2010b, p. 25-26). These carers reported the need for supported accommodation to include:

- Support workers on site to monitor and prevent the use of alcohol and drugs, which can jeopardise mental health and lead to hospital re-admissions.
- The option for women and men to live separately in shared accommodation to increase the safety of women. Women in mixed housing arrangements should have the option of locks on their doors.
- Opportunities for activities such as gardening, which assists with recovery.
- A gradual reintegration into the community and into independent housing.

The housing preferences for people with mental health issues expose a mis-match between preference and availability of housing. The accommodation types available to people with mental illness include institutional accommodation such as large psychiatric hospitals, nursing homes and community care units (replacing the old psychiatric institutions in some states of Australia), group homes, boarding and rooming houses. Research has found that some people with high support needs tend to live in forms of institutional accommodation. At the other end of the continuum,

people with lower support needs are often housed in supported housing options including public housing with flexible support offered by psychiatric disability support outreach workers (St Vincent's Mental Health Service 2005, p. 26). People with mental illness also live in the private housing market, in their own homes and in different forms of private rental housing.

The evidence presented by Browne and Hemsley (2010b) indicates the importance of decent, affordable housing. Without this, the evidence shows that other treatment and rehabilitation approaches are jeopardised (Moxam & Pegg 2000; Stroul 1989) and consumers risk becoming homeless (Schizophrenia Fellowship 2005) (Browne & Hemsley 2010b, pp. 22-23).

### **3.3 Aboriginal communities**

Within Aboriginal communities the distinction between mental and physical ill-health is often blurred (Kelly et al. 2009). As such some psychological issues may manifest themselves as physical symptoms or complaints, which may complicate any diagnosis of mental health issues (Cross & Bloomer 2010, Kelly et al. 2009).

Many Aboriginal communities have different understandings of, often recognising only the most severe forms of mental illness (such as psychosis and schizophrenia). Often times mental health issues are considered to be a result of social factors such as racism or hostility towards particular groups rather than psychological ones (Cross & Singh 2012, De Anstiss & Ziaian 2010).

Implementation of culturally specific health care services has mainly focused around Aboriginal Australians, with initiatives such as the Aboriginal and Torres Strait Islander Mental Health First Aid (AMHFA) program (Kanowski et al. 2009) and Aboriginal Community Controlled Health Services (ACCHS) (Kelly et al. 2009) adapting existing frameworks to cater explicitly to Aboriginal groups. Important elements of these programs include:

- Taking account of existing community and cultural attitudes to mental health.
- Utilising these understandings in the teaching and enactment of treatment programs.
- Fostering ownership of the programs and initiatives by the community itself.

### **3.4 Culturally and linguistically diverse communities**

The evidence related to people from culturally and linguistically diverse backgrounds, homelessness and mental health issues is small. The evidence that does exist suggests that people from culturally and linguistically diverse communities have high mental health support needs (Pryor 2011; Allimant and Ostapiej-Piatkowski 2011). However poorer literacy levels in migrant/refugee communities often results in lower engagement and participation rates in community health and outreach programs, which may contribute to lower use of available services and reduced help-seeking behaviours (Keleher & Hagger 2007).

Research into culturally and linguistically diverse communities by De Anstiss & Ziaian (2010) identified trust as a barrier to some culturally and linguistically diverse communities accessing mental health services, particularly of health care professionals. This trust, or lack there-of, was exacerbated by:

- Cultural and procedural unfamiliarity with the health care system.
- Unfamiliarity with treatments.

Trust of health-care professionals has also been cited as a significant factor, with many citing lack of trust in the efficacy of treatments, cultural and procedural unfamiliarity with healthcare providers, and consideration of different cultural backgrounds as major reasons to avoid mental health services.

In a general sense the wider evidence base has found that people from culturally and linguistically diverse backgrounds are likely to be more disadvantaged when it comes to dealing with housing department staff, often due to communication problems and the lack of staff experience in dealing with both people from different language backgrounds and people with disabilities (MDAA 2003 in Bleasdale 2007, p.39).

Other evidence has shown that:

- A lack of familiarity with the background, concepts and techniques of Western health care (Cross & Bloomer 2010), coupled with a lack of understanding of how the Australian healthcare system works, often compels culturally and linguistically diverse people to seek help outside mainstream healthcare providers, particularly with informal services within their own community such as traditional healers and alternative medicine specialists (Cross & Singh 2012, Phan 2000).
- Young refugees often have mental health issues resulting from traumatic experiences prior to resettlement. These include: imprisonment, torture, the witnessing of murder, separation from family members, sexual and physical assault and the deprivation of human rights (Ransley & Drummond 2001, in Couch 2011, p. 42). These are issues that have been found to be a contributor to mental health issues for all refugees, not just youth (Kissoon 2010).
- Similarly poor mental health has been identified as a major contributor to young refugee homelessness (Couch 2011).
- De Anstiss & Ziaian (2010) found that adolescent refugees were more likely to seek mental health advice and help from close friends, a finding which largely accords with non-refugee adolescents evidence (Rickwood et al. 2005). However unlike non-refugees, young refugees were less likely to confide in parents and older family members for support or advice. The reasons for this include:
  - Culturally-specific factors such as proscribed relationships between children and parents.
  - The difficulty of confiding in parents who are often experiencing significant psychosocial and psychological trauma of their own.
  - A belief that their parents were incapable of understanding their perspective or point of view, owing to the significant cultural, geographic and social disruption/s which have occurred as a result of their becoming refugees (De Anstiss & Ziaian 2010).

### **3.5 Young homeless people**

The National Youth Commission (NYC) report into Australia's Homeless Youth (2008) found that while there was a causal link between homelessness and the onset of mental health issues, whether homelessness was responsible for the development of severe mental illness (for example, psychosis or schizophrenia) was less clear. Alternatively, mental health issues were often cited as a 'trigger' for homelessness, particularly in cases of inadequate family care or support (NYC, 2008).

The benefits of providing homeless youth with secure, stable housing are well documented (NMHC, 2012), but the addition of mental illness and associated comorbid behaviours means this is not always possible. Given the high rates of

mental health issues in the homeless community, and particularly amongst homeless youth, this is an issue that needs to be addressed.

Homeless youth cite a number of reasons why they do not access primary mental health services including:

- Perceived attitudes of health care workers (Dixon & Lloyd 2005).
- Previous negative experiences with health care providers and poor resolution of issues (Herman & Manuel 2008)
- Negative social perceptions of their situation and stigma - i.e. their status as 'street rats'- which contribute to low overall self-worth (Dixon and Lloyd 2005).
- Fragmentation of support services and lack of clear direction between them may cause confusion amongst young people and a reluctance to seek further help and access services (NYC 2008).

### *3.5.1 Service delivery to young people*

Approximately one in four young Australians experience mental health issues at some point in their adolescence (ABS 2008), and up to three quarters of Australian youth with mental illness or emerging mental health issues don't seek professional help (Wilson et al. 2011). Previously this was thought to be due to fear of social stigma and self-disclosure, however new research has identified that a major proportion of young people:

- Simply don't believe they have a mental health issue (Meadows & Burgess 2009).
- Believe they need to manage it alone, common amongst young men who are less likely to access available services and seek help with mental health issues (Rickwood et al. 2005; Wilson et al. 2012; Collin et al. 2011).
- Believe that they only require the intervention and advice of friends and family (Rickwood et al. 2007).

Recent research has also found:

- Young people with disabilities experience worse mental health outcomes than their peers (Honey et al. 2007), with increased isolation and social exclusion, decreased mobility, and fewer services tailored to their specific needs. However, these differences are less pronounced in individuals with stronger family support and higher socio-economic status (Honey et al. 2007).
- An inverse relationship between desire/intent to seek help for mental health issues and substance abuse was identified (Reavley et al. 2007). Among American youth, substance abuse was identified as a coping mechanism or a way of self-medicating mental health issues (Christiani et al. 2008)
- Knowledge of mental health awareness programs is increasing among youth (particularly of established and well-funded programs such as beyondblue) (Morgan & Jorm 2007, Collin et al. 2011).

Australia appears to be at the forefront of innovative and youth-oriented mental health initiatives (Roberts 2012; Rickwood 2011). However McCann & Lubman (2012) identified several issues in accessing local services (specifically, Headspace youth centres), including location-specific transport difficulties; institutional difficulties such as initiating appointments and unfamiliarity with the workings of the system; and financial difficulties such as shortcomings in the funding model for youth-based services. However, they highlighted the importance school counsellors (and school structures in general) play in initiating and facilitating access to youth health services.

Online support services (such as ReachOut.com) have better outcomes in engaging with and targeting youth at risk of mental health issues, and are more effective at promoting help-seeking behaviours (Collin et al. 2011).

The evidence base provides a number of best practice principles to assist recovery and ensure housing stability for young people living with a mental illness. These include:

- Intensive case management, in which a housing worker establishes a relationship of trust with the young person (Roberts 2009).
- The placement of young people in housing, either supported accommodation or transitional, needs to ensure suitability in terms of availability of local amenities, access to transport and public space. This can assist in ensuring that young people do not suffer isolation and exclusion from the local community (McCann and Lubman 2012).
- The placement of young people in housing, either supported accommodation or transitional, needs to ensure the availability of support networks. This includes formal networks (e.g. mental health services and employment and education programs) as well as informal networks (Honey 2007).

### **3.6 Service delivery in rural areas**

Service delivery across different geographic scales has emerged as an important policy requirement (Beer et al. 2005). Much of the evidence base is focused on urban contexts, and the policy responses have then been implanted within rural or regional contexts. This is generally acknowledged as having been unsuccessful (Robinson 2004; Robertson et al. 2007).

Distance and 'dislocation' from mental health networks and providers have long been recognised as significant barriers for rural Australians to access proper healthcare (Crowther & Ragusa 2011), and these difficulties are often amplified in rural youth, who frequently lack the means of accessing appropriate services, such as private transport (Newnham et al. 2008).

Another barrier to accessing mental health services occurs particularly for rural youth due to negative community attitudes to mental health issues (Kurtin et al. 2009, Newnham et al. 2008, Griffiths et al. 2009). One pervasive attitude in rural communities is that mental illness and mental health issues are considered signs of weakness (Griffiths et al. 2009, Newnham et al. 2008). For those rural youth who do access services, they often report feelings of discomfort and intimidation at the clinical nature of formal health services, unfamiliarity with patient appointment and referral procedures and occasional insensitivity on behalf of care providers (Kurtin et al. 2009, Happell, 2008). While all these factors are also common to urban youth, the lack of options available to rural young people often means treatment time and assistance with mental health issues are reduced or even entirely eliminated.

Rural youth accessing mental health services often face the barrier of service restrictions (Morley et al. 2007), which include: staff shortages; underfunding; and a mis-match in staff skill sets (i.e. staff may not have the training and education to deal with more complex needs such as those found in people with mental illness (Griffiths et al. 2009, Deans 2005).

Living in a rural or remote area places people with a mental health issues at greater risk of homelessness and insecure housing. This is because:

- The number of services available to people with mental health issues in rural communities is lower than in urban areas (Beer 2006)

- Access to suitable and affordable accommodation options for people with mental health issues is constrained. Rural housing markets are, on the whole unaffordable for young people (Beer et al. 2011). Housing is also of a lower standard than much urban rental stock, so high proportions of rural renters live in substandard housing.
- People living in rural environments cannot access the same amount of service provision that is provided in metropolitan areas. This lack of service support in remote areas can render people with medical, behavioural, mental and substance abuse issues more vulnerable to homelessness (Robertson et al. 2007). Lack of infrastructure which supports employment also impacts on the incidence and continuation of rural homelessness including, for example, childcare and public transport (Robertson et al. 2007).
- The nature of rural labour markets has the potential to place people at risk of homelessness. Beer et al. (2005) suggest this makes rural renters more vulnerable to homelessness where any economic shock (such as losing a job) can render them unable to keep up with rental payments.
- The lack of social supports and homelessness services in rural areas can result in homelessness (Beer et al. 2006).
- Crowther & Ragusa (2011) found that mental health nursing in rural areas (specifically, rural NSW) was facing a severe decline, and reported difficulties in recruitment and retaining of nurses which adversely impacted patient outcomes.
- The level of mental health literacy has been reported as lower in rural areas than urban locations (Griffiths et al 2009; Eckert et al. 2010; Wilson et al. 2012).

### **3.7 Discharge planning**

Research has shown that many homeless and at-risk people repeatedly move through mainstream systems and institutions, such as jails and prisons, state psychiatric hospitals, drug treatments programs, foster care, and homeless shelters (Apicello 2010). The NSW Ombudsman's Report (2011) estimated that one third of the people currently in mental health facilities in NSW could be discharged into the community. The inability to move people back into the community was a result of a range of factors:

- Lack of appropriate accommodation and support services.
- Mismatch between funding eligibility/criteria and diagnosis leaving some people to fall through the gap in the service system.

Other barriers identified in the report that exacerbated the lack of discharge of people or inappropriate discharge included:

- Poor discharge planning.
- Limited knowledge on the part of key staff of housing and support options.
- Long referral times.

This link has encouraged the development of prevention strategies that target this 'institutional circuit' through discharge planning efforts.

The aim of discharge planning in the context of homelessness prevention is to ensure that people who are transitioning out of an institution are not discharged into a homeless shelter or the street, and that their placements are stable enough to prevent future homelessness.

In NSW, the *Transfer of Care from Mental Health Inpatient Services* policy directive sets out the principles and requirements for safe transfer of a mental health consumer's care across health settings. It particularly focuses on the ongoing care needs of consumers who are returning to the community following an episode of inpatient care or who are on approved leave from an inpatient unit. The policy sets out the treating team's responsibilities in relation to advice, information sharing, and documentation to ensure continuity of care and safety are maintained during the transfer process (NSW Government 2012).

Discharge planning involves identifying and organising the services and connections a person with mental illness, substance abuse, and other vulnerabilities will need when leaving an institutional or custodial setting and returning to the community (Backer et al. 2007).

Good discharge planning weaves together people and agencies who provide services for stable and permanent housing, integrated with ongoing psychiatric and psychosocial treatment/rehabilitation, as well as community services (e.g. transportation, money management, medication management etc.) to support independent living (Backer et al. 2007).

Backer et al. (2007) describe discharge planning as part of a continuum of care, starting with assessment and treatment, and ending with services and service coordination back in the community. As set out by Backer et al. (2007), the following elements are involved in the continuum of care:

- **Assessment / treatment** - ideally begins at the time of intake and continues throughout the period of residency. Assessment should be based on the assumption that individuals at risk of homelessness are likely to have multiple issues, for example mental health issues and substance abuse.
- **Discharge planning** - Discharge planning typically results in a written plan developed by a case manager or the clinician working most closely with the individual. Ideally, discharge planning involves a planning team that includes the patient / individual leaving the facility, family members where appropriate, a community support worker, resource specialists and representatives from community service providers.
- **Service coordination and integration** - To implement a plan effectively, community service providers must work with the individual and his/her family. Communication about the timing and delivery of services is key, along with ongoing case management.

## 4 PEOPLE AT RISK OF HOMELESSNESS: SUSTAINING TENANCIES



This chapter briefly describes the key evidence for people at risk of homelessness who reside in social housing and have mental health issues. The chapter focuses specifically on early intervention and prevention mechanisms used to sustain their tenancies.

### Summary

- Many people with severe mental illness have housing careers characterised by frequent moves.
- People with mental health issues are disadvantaged in the private rental market and have high levels of housing insecurity.
- A large proportion of people renting from a social housing landlord have mental health issues.
- Access to familiar services and social networks can reduce social isolation for people with mental health issues and reduce tenancy risks.
- Sustaining tenancies for people with mental health issues requires effective and efficient referrals to specialist services.
- Successful tenancies for people with complex needs can be facilitated when there is careful assessment, and the matching of individual aspirations and circumstances with the available accommodation.

### 4.1 Introduction

The evidence base clearly identifies people with mental health issues as a group at high risk of homelessness. Social housing does provide stability in accommodation for people with mental health issues. Research by Srebnik et al. (1995) found that choice in housing has been positively related to housing satisfaction, residential stability and psychological wellbeing. More recent research has found that housing stability has positive effects on children's wellbeing (Dockery et al. 2010).

There is some evidence on the role of community housing on the health outcomes of people with mental illness. Shern et al. (1997) found that community housing was a viable housing option for homeless people with severe mental illness. The success of community housing as a stable housing option for this study group was only possible through an intensive assertive case management program.

### 4.2 Housing instability

The evidence base is strong in making the link between poor housing and poor mental health outcomes. Evans, Wells and Moch (2003) suggest that existing research establishes a clear link between housing quality and psychological health. The authors identify a number of factors that impact on housing and health:

- Stigmatisation of public housing can result in poor wellbeing.
- People living in low-cost housing have greater instances of mobility. The frequency of moves of instability can contribute to poor mental health.
- Social isolation and a lack of social support within public housing have been linked with poor mental health outcomes.

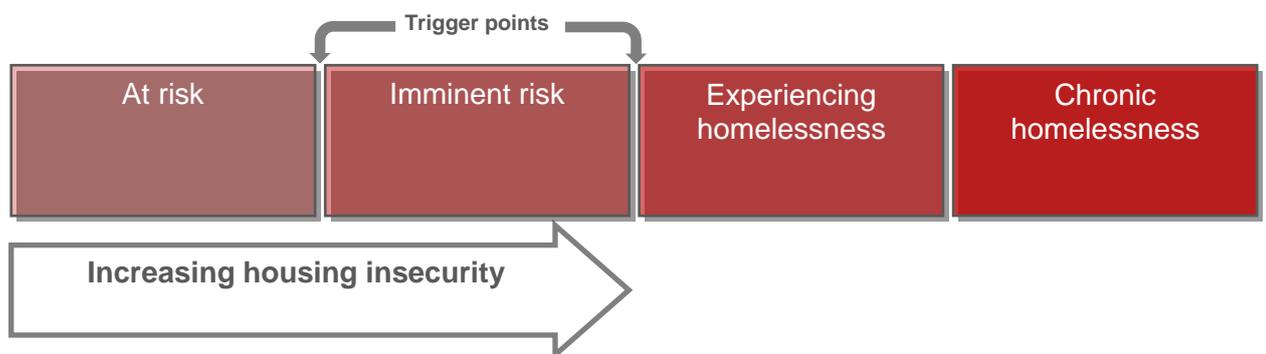
The evidence base has established that housing insecurity is positively correlated with poor mental and physical health outcomes as well as marginal workforce participation. Hulse and Saugeres (2008) identify a number of dimensions of housing insecurity such as:

- High levels of mobility.
- Limited choice of housing.
- Lack of privacy particularly for people living in public housing and private rental.
- Lack of personal safety, particularly for people living in public housing or boarding houses.
- Social isolation.

The researchers found that housing insecurity contributed to health insecurities. Hulse and Saugeres (2008) also found that existing mental health problems were exacerbated after episodes of housing insecurity.

Housing and support are critical components for people with mental health issues at risk of, or experiencing, homelessness. As the diagram below illustrates, interventions into homelessness occur at different points on the housing instability continuum. Housing instability along with trigger events can place individuals and households at risk of housing stress and homelessness. The housing instability continuum differentiates between people at risk of homelessness and people who experience homelessness.

**Figure 1: The housing instability continuum**



The housing and support interventions for people in these four sectors are distinctly different. For example research by Flatau et al. (2010) shows the significance of formal support programs provided by government and non-government agencies in reducing the risk of homelessness or promoting recovery for people experiencing homelessness. In addition to formal supports, recent research by Duff et al. (2013) found that informal supports for young people with mental illness are important to long term housing stability. The study concluded that:

- Informal support can promote recovery and enhance housing security.
- Successful housing security for youth requires more than the provision of adequate and safe housing. It requires informal supports which can enhance and promote social inclusion and community belonging. The research suggests that, while social supports are increasingly integrated into mental health and housing programs, there is a case for 'scaling up' these services and offering greater diversity in the range of supports available to enhance community participation (p. 3).

For those people at risk of homelessness, support to sustain their tenancies is a vital component of any early intervention and prevention strategy.

### **4.3 Sustaining tenancies**

Sustaining tenancies is a term that describes a range of housing management policies and practices designed to primarily assist social housing tenants to manage their tenancy successfully and to achieve improvement in their lives. These housing management policies and practices assist vulnerable tenants to avoid tenancy failure through eviction or exit under duress (Habibis et al. 2007). The substantial national and international evidence on sustaining tenancies has shown that the simple provision of a tenancy is not enough to ensure a transition to a settled life; tenancy support is critical (Pawson and Munro 2010).

Tenancy sustainment services are one early intervention and prevention process that can, in some cases, prevent problems from reaching crisis point. Tenancy sustainment services can be implemented both at the point of entry into social housing and at the point of possible loss of the tenancy. The literature emphasises key components of successful tenancy sustainment processes:

- Allocations - Assessing issues and if necessary implementing support during the allocations phase when tenants are first assigned a social housing tenancy (Cooper and Morris 2005).
- Monitoring - Early intervention strategies work best when they are able to change due to a change in circumstance or behavior (e.g. rent arrears, reports of anti-social behavior, interaction with the justice system and health facilities, and family changes such as child protection issues, family break up or the death of a partner). A systematic mechanism of monitoring enables these changes in circumstances to be identified early (Atkinson et al. 2007).
- Ensuring longer term and sustainable tenancies through building the capacity of tenants (Habibis et al 2007).

Tenancy support schemes range from general housing advice at one end of the spectrum to intensive family support schemes at the other. Support can include:

- Help with budgeting, welfare benefits, self-esteem and employment.
- Support workers assisting clients by making referrals to specialist services to address problems such as mental ill health.
- Low level support / practical assistance includes tenancy advice, debt counselling and financial management, resolution of rent arrears, access to health services.
- Intensive tenancy management includes intense support and supervision provided through either: core residential units; dispersed accommodation; or outreach support.

Evidence demonstrates that social housing tenancy sustainment programs produce positive client outcomes and reduce evictions. Programs are increasingly being designed as an integrated package of financial and non-financial measures aimed at resolving a household's immediate housing problem and assisting them to prevent future housing instability (Hulse et al. 2011, p. 168). Although tenancy sustainment services cannot prevent or solve all the problems that lead to tenancy failure, they can in many cases prevent problems from worsening or recurring (Neuburger 2003). The following tenancy sustainment initiatives, while not directly related to mental health, provide evidence of best practice, some of which has the potential to be transferred across sectors.

#### 4.3.1 Brokerage funding

Brokerage funding has been identified as an effective financial mechanism to alleviate housing stress and to sustain tenancies. Housing NSW has evaluated a range of homelessness programs that incorporate brokerage funding to sustain tenancies for people in social housing. Brokerage funding in these projects has been utilised in a variety of ways, for example paying an electricity bill, buying food or medicine or entering a rehabilitation program. The effectiveness of brokerage funding include:

- Case management without access to brokerage funds was found to be ineffective given that brokerage funds can provide the necessary resources to attend to clients' pressing needs.
- Using brokerage funding to support individuals through the purchase of goods and services was found to be effective.
- Brokerage funding provided some rural projects with flexibility to purchase services where other options were not available locally.

#### 4.3.2 Family Homelessness Prevention pilot

The Family Homelessness Prevention Pilot (FHPP) was established under the 2001 Australian Government budget as an early intervention initiative to develop approaches to reduce family homelessness. The program was piloted in eight sites (one in each state and territory) over a two-year period from July 2002 to June 2004. The sites operated on a service partnership model, with Centrelink and community service providers funded to work collaboratively.

The FHPP sought to intervene early to prevent families drifting into homelessness, while also helping families to gain the resources they need to remain housed for the long term. The FHPP aimed to:

- Establish stable family circumstances so that families' economic, housing, health and social participation improved.
- Develop families' capabilities by strengthening family relationships and increasing their support networks.

The program also aimed to improve the broader service system for families by:

- Developing innovative and collaborative partnerships between agencies so that families could be helped more effectively.
- Developing strategies to identify families at risk of homelessness and to engage them more effectively (including strategies to reach Aboriginal and Torres Strait Islander families, who are over-represented in homelessness services).

An evaluation of FHPP carried out by Ryan and Merlo (2005) found evidence of significant improvement in the housing and financial circumstances of the families. Families left FHPP services with greater capacity to sustain stability in housing, including:

- A reduction in the number of families paying a high proportion of their household income on housing.
- An increase in the expectation of future stable housing.
- Overall debt reduction for the majority of families.
- An increase in the number of families who had buffer funds available in case of emergency.

While many families remained vulnerable after support (because of dependence on income support and reliance on the private rental market), their situations had been stabilised.

The pilot was effective in improving families' resilience to stress and sense of ability to direct their lives—according to the research, this indicates the success of the holistic and strengths-based approaches adopted in the FHPP model.

The evaluation identified factors that may account for these successful outcomes. Different approaches by the pilot sites seem to have contributed to specific improvements, particularly: identifying and reaching families at high risk of homelessness but not actually homeless; providing intensive support over a longer period; providing coordinated support by a number of agencies (in relation to improvements in labour-force participation); using brokerage funds to stabilise circumstances; and engaging families in multiple ways to help build connections to other families, community and services.

#### **4.4 Sustaining tenancies for people with mental illness**

Two of the key themes in the evidence are the ability to meet people's housing preferences and the process of maintaining stable tenancies. O'Brien et al. (2002) put forward four elements they believe are critical to the process of sustaining tenancies for people with complex needs, namely that people with complex needs:

- Live in housing that they find acceptable.
- Have support, medication and/or treatments that they trust, accept and find helpful.
- Demonstrate a willingness and readiness to tackle, with appropriate support, the individual daily challenges and difficulties living independently may present.
- Receive support to identify and address the major issues that place their tenancies at risk.

Cooper & Morris (2005) suggest that successful tenancies for people with complex needs can be facilitated when there is careful assessment, and the matching of individual aspirations and circumstances with the available accommodation. This assistance includes help with finding the house, having help with the tenancy requirements, relocating and obtaining furniture and other goods (O'Brien et al. 2002). Other important supports are encouragement and affirmation, and connections into the local community (Cooper & Morris 2005). O'Brien et al. (2002) concluded that key workers (i.e. mental health workers, support workers or advocates) were found to be important in these initial housing and settling-in processes. Effective workers were seen to understand the importance of getting the 'right house' and the 'house right'.

According to Cooper & Morris (2005) partnerships, service coordination and interagency linkages are key elements in the web of supporting people with complex needs to stay housed satisfactorily—for example, through the establishment of inter-sectoral links between mental health services, housing services, disability services and other social services; the use of inter-departmental agreements or protocols; and the implementation of interagency staff training.

##### *4.4.1 Housing and accommodation support initiative (NSW)*

The Housing and Accommodation Support Initiative (HASI) provides people with mental health problems with access to stable housing that is linked to clinical and

psychosocial rehabilitation services.<sup>3</sup> Under this initiative, NSW Health, Housing NSW and non-government organisations (NGOs) collaborate 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).

Successful integration of secure housing and mental health support is able to sustain tenancies for homeless adults with severe mental illness as demonstrated in the evaluation of HASI. This evaluation demonstrates the cost-effectiveness of combined housing and support programs for homeless adults with mental illness. According to Muir et al. (2007) the program achieved significant improvements across all the measured outcome domains, including:

- More than two-thirds of participants (70%) retained their tenancy in the same home for 12 months or more, and almost all participants (85%) remained with the same housing provider.
- Time spent in hospital in psychiatric units and emergency departments decreased by 81 per cent for 84 per cent of participants, an average of 70 days per person per year.
- Other measured outcomes included improved health and social networks, a 77 per cent decrease in imprisonment, a tenfold increase in education and training participation, and a threefold increase in paid or voluntary work.

An evaluation of HASI undertaken in 2012 (Bruce et al., 2012) found the following:

- HASI supports over 1000 mental health consumers across NSW living in social and private housing and ranging from very high support (8 hours per day) to low support (5 hours per week) levels.
- When housing is linked to the appropriate clinical and rehabilitation support, people are better able to overcome the effects of mental illness and live more independent lives.
- The majority of HASI consumers were successfully maintaining their tenancies (around 90%), their mental health was improving and they were spending less time in hospital since they joined the program. In addition, consumers were regularly using appropriate services in the community and demonstrating a high degree of independence in daily living.
- The annual cost of HASI per person ranged between \$11,000 and \$58,000, plus project management costs of between \$200 to \$500, depending on the level of accommodation support and the method of calculating the annual unit cost.
- The waiting list for social housing in many locations means that some people who require assistance wait for many months before entering HASI. These shortages within the elements of HASI undermine the coherence of HASI as a service model, which aims to link housing, clinical services and accommodation support and prevent or address homelessness for people with mental illness (Bruce et al., 2012, p. 173).

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<sup>3</sup> Housing NSW website:

<http://www.housing.nsw.gov.au/Changes+to+Social+Housing/Partnerships/Housing+and+Mental+Health/Housing+and+Accommodation+Support+Initiative.htm>

Overall, the HASI service model operated well to provide an integrated response to its target group. There is anecdotal evidence that there is a gap between demand for HASI type services and the supply. However there is not published evidence on the extent or existence of this gap.

Partners within HASI have established effective mechanisms for coordination at both the state and local levels. The partnership seems to be working relatively well due to four factors (Bruce et al., 2012, p. 22):

- Clear roles and responsibilities: The clear delineation of clinical and non-clinical roles and responsibilities was crucial to developing positive working relationships with HASI partners. Where roles and responsibilities were unclear, tensions emerged and partnerships were compromised.
- Open communication: It is crucial that HASI partners promptly share information that could be relevant to staff and client risk management, while respecting client confidentiality. The type of information that needs to be shared promptly should be defined in the HASI manual.
- Commitment to working together: Effective partnerships require a commitment to the program and to respecting other organisational values.
- Sound governance processes: Effective local governance structures are facilitated by: the commitment of people involved; strong formal and informal communication channels; the use of regular meetings to discuss a range of processes; and service level agreements.

#### **4.5 Sustaining Aboriginal tenancies**

Aboriginal people's access to mainstream public rental housing has increased but across Australia, Aboriginal tenancies are typically shorter than average (Flatau et al. 2005). Addressing this issue and sustaining social housing tenancies for Aboriginal people is an important to reducing disadvantage.

Previous research has identified factors which contribute to tenancy problems for Aboriginal households and several constraints that may reduce the effectiveness of tenant support programs, including:

- Discrimination by landlords and neighbours (Flatau et al. 2009).
- Unsafe neighbourhoods contributing to Aboriginal people's lived experience of racism and stigmatisation (Birdsall-Jones & Corunn 2008).
- Aboriginal patterns of migration from rural areas where people may not have 'urban-based' life skills necessary to maintain a tenancy (Flatau et al. 2009).
- Tenants not at home due to family commitments which prevents support plans from being implemented (Habibis et al. 2007).
- Conflictual relationships with the public housing authority – sources of conflict including: housing-related debt; waiting list processes; and a lack of responsiveness to maintenance and repair requests (Birdsall-Jones & Corunn 2008).
- Failure of landlords and housing agencies to appropriately address cultural behaviour and imperatives such as duties of hospitality, extended family responsibilities and demand sharing (Flatau et al. 2009).
- Lack of understanding of Aboriginal patterns of occupation and use of housing (domiciliary behaviour) (Flatau et al. 2009).

- In regional areas, service workers may have too large an area to cover and there may not be the range of external support agencies to link clients to support (Flatau et al. 2009).

These negative experiences for Aboriginal applicants or tenants of public rental are a combination of precarious social or financial circumstances combined with a mismatch between social housing policies and Aboriginal housing needs, and the poor quality of allocated social housing stock (Birdsall-Jones & Corunn 2008). However, in their review of the provision of tenant support programs to Aboriginal people, Flatau et al. (2009) found good practice targeted initiatives for sustaining Aboriginal tenancies to include:

- Community development and education in the local community to promote a positive image of Aboriginal culture.
- Employment of Aboriginal tenancy officers.
- Recognising and responding to the needs of special groups such as those with specific health needs, including renal failure, or those relocating from rural and regional areas to the city.
- Making services more accessible by providing information in community languages, using consumer advocates, co-locating housing and translation services.
- Establishing strong partnerships with Aboriginal organisations.
- Providing personal development programs such as life skills and parenting skills, with involvement and co-operation of Aboriginal organisations to ensure the programs are culturally sensitive and appropriate.

## 5 PEOPLE LIVING IN MARGINAL HOUSING



**This chapter presents evidence about the role that rooming and boarding houses play in providing accommodation for people with mental health issues. A discussion of the organisation and framing of service provision is also considered.**

### **Summary**

- Many people with disabilities or mental health issues resort to living in marginal forms of accommodation, particularly rooming and boarding houses.
- Boarding and rooming houses serve a dual role as short-term crisis accommodation and longer-term rental accommodation.
- The general profile of boarding house residents includes more males than females; people in receipt of income support; and disproportionately lower incomes.
- Boarding/rooming houses are not generally considered to be an appropriate solution for all people with mental health issues, however, this housing form does meet housing needs for some individuals.
- Boarding/rooming houses are often unregulated and have lower levels of supervision (Chamberlain 2012).

### **5.1 Marginal housing**

As the previous chapters outlined, the lack of affordable housing, particularly in the private rental market means that people with mental health issues rely heavily on income support and housing assistance, including social housing. However, demand for social housing outweighs supply. These factors can push people into marginal forms of private rental housing.

Marginal rental housing refers to the range of private rental housing options, usually accessed by the most marginalised households in the community. Marginal rental housing operates in the market 'gap' between the low-cost end of the private rental market, the social housing system and homeless specialist services. Marginal rental housing can include:

- Boarding and rooming houses
- Backyard bungalows and sheds
- Caravan parks / residential villages
- Motels
- Backpacker hostels
- Holiday homes

Boarding and rooming houses are two forms of marginal housing. This report will focus only on boarding and rooming houses.

In the literature and within policy discussions they are often used interchangeably. The main distinction comes from a tradition where in boarding houses, residents were provided with meals, however this distinction is less common today.

Many people with disabilities or mental health issues resort to living in marginal forms of accommodation, particularly rooming and boarding houses. A proportion of people with mental health issues find themselves living in boarding/rooming houses for a range of reasons, including (Goodman et al. 2013):

- They fall through the cracks of the service system, through inappropriate eligibility criteria or mis-diagnosis..
- Have histories of insecure tenancies and fall into this accommodation form.
- Prefer this housing form.
- It is one of the limited affordable housing options for some people.
- Issues of discrimination in other private rental housing options may push people into this form of housing.

## 5.2 Boarding and rooming houses

Boarding houses represent a significant proportion of the marginal rental market that is accessed by people with disabilities and mental health issues. The ABS defines boarding houses as including rental housing where five or more residents occupy a dwelling that is also comprised of non-family members. In contrast rooming houses include buildings which have been divided into separate private spaces. They are rented on a room by room basis, but include common areas such as a bathroom, toilet, kitchen and laundry (Goodman et al. 2012).

Boarding and rooming houses can include:

- Traditional rooming/boarding houses – Two- to three-storey converted mansions in inner-city areas. Easily identifiable due to long-term ownership and operation as a rooming house and appearance from street. In some jurisdictions (eg NSW) this form of accommodation is required to be registered but is it is hard to regulate.
- Conversion of family homes – Multiple-occupancy dwellings in suburban and outer-suburban areas. Long-term ownership. More difficult to identify.
- Smaller, temporary rooming houses – Variety of private rental properties run by head-leasing operators. Very difficult to identify.

Boarding and rooming houses serve a dual role as short-term crisis accommodation and longer-term rental accommodation. While they have traditionally been a source of accommodation for people with disabilities and/or mental health issues, they are more recently targeted towards international students, young people, arts workers, families, backpackers, people escaping homelessness and young people exiting state care.

According to the ABS (2011), which defines boarding houses as form of non-private dwelling, NSW had approximately 540 boarding houses. This represents 44% of the total number of boarding houses across Australia. Of those boarding houses in NSW, just over 5700 people are accommodated in this form of housing.

The general profile of boarding houses residents includes:

- More males than females (76%).
- Large proportion Not in the Labour Force (40%), indicating receipt of income support.
- Disproportionately low incomes (ABS 2011).

Chamberlain's (2012) study of rooming houses across Melbourne revealed that they encompass a wide variety of housing types and are run by a variety of networks- both formal welfare agencies and informal landlords- which are subject to varying degrees

of supervision and regulation. Recent AHURI research by Goodman et al. (2012) suggests that the ABS definition of boarding houses is creating an under count. The authors suggest that in Greater Sydney, there are approximately 5500 people living in large non-student group households. While this is not a proxy measure for boarding houses it does reveal the possibility that the number of boarding houses is larger than the ABS count would suggest.

Recent work undertaken by AHURI in Victoria has found that boarding and rooming houses operate under two main business models. These include:

- Individual investors - with few rental properties in portfolio, operating rooming houses to cover mortgage on property as a form of superannuation. Includes 'mum and dad investors'.
- Head-leasing operators- with large portfolios making substantial profit by sub-letting individual rooms for disproportionately high rent. These boarding houses can generate sufficient profit to purchase and lease out properties and employ property managers. Landlords may collect Commonwealth Rent Assistance for tenants and charge additional rent on top of this. This model was reported to be increasingly prevalent. It is reportedly difficult to distinguish this kind of rooming house from a standard share house because:
  - at least some of the tenants may be included on the lease (and may be told by the head-leasing operators to pretend they know each other);
  - the houses do not look different to other share houses; and
  - each house may be used as a rooming house for a limited period so that council is unlikely to discover the arrangement (Thomson and Jones 2013).

In addition to these private, for-profit models, community organisations also run not-for-profit rooming houses.

There are a range of issues related to boarding and rooming houses that impact on residents, particularly those most vulnerable (Anderson et al. 2003; Drake 2010; Thomson and Jones 2013). Housing related issues include:

- Limited availability of affordable housing.
- Limited access to housing due to discrimination (reportedly some marginal rental housing providers discriminate by country of origin or skin colour).
- Sub-standard buildings and a lack of basic facilities.
- High costs of rent and utilities (especially relative to the poor quality of housing).
- Lack of facilities (e.g. to store, prepare and cook food).
- Lack of privacy.
- Compliance with the Residential Tenancy Act (see Anderson et al. 2003 p. 63).
- Fire safety issues.
- Housing related legal issues (Karras et al. 2006).

Tenancy related issues include:

- Insecurity of tenure (due to no lease being signed).
- Inability to gain a rental reference or rental record.
- Interference from landlord.
- Limited access to information about rights (especially for those with limited literacy or English as a second language).

→ Overcrowding.

Health and wellbeing related issues include:

→ Lack of safety (in relation to other tenants and to the building itself)

→ Social isolation (especially where there are no communal areas)

→ Lack of support services (e.g. mental health; drug and alcohol)

→ Poor cleanliness and hygiene

→ Poor health (e.g. as a result of rising damp/mould) (Anderson et al. 2003).

### **5.3 Effectiveness of boarding/rooming housing**

Boarding/rooming houses are not generally considered to be an appropriate solution for all people with mental health issues, however, this housing form does meet housing needs for some individuals. For example, in a study by Anderson et al. (2003) boarding house residents identified both advantages (affordability, location, proximity to services and transport, and the 'easy to manage' nature of boarding house accommodation) and disadvantages (problems with other residents, lack of privacy, low standards of accommodation and insecurity of tenure) to boarding house life.

Boarding houses can be appropriate for people with episodic psychiatric disabilities who prefer the freedom to come and go without the restrictions associated with a lease (Thomson and Jones 2013).

The evidence base has also identified a number of other features of boarding house accommodation for people with mental health issues:

→ People with schizophrenia living in boarding houses do not have higher rates of psychiatric issues/symptoms, but have greater difficulty in securing social and practical support than people in their own homes (Brown and Courtney 2004). Browne et al. (2004) used archival data to investigate the outcomes for people with schizophrenia discharged to two types of accommodation: the person's own home and for-profit boarding houses. Results suggest that people with schizophrenia who were discharged to boarding houses are significantly more likely to be readmitted to the psychiatric unit of Gold Coast Hospital, although their length of stay in hospital is not significantly different.

→ Older boarding house residents are generally satisfied with their boarding housing experience, but this could be influenced by reluctance to criticise operators, due to the insecurity of tenure (Cleary et al. 1998).

→ Research has compared the quality of life of residents in boarding houses and hostels. Both groups reported satisfaction with their quality of life, irrespective of the quality of housing, although the boarding house residents reported more personal freedom (Horan et al 2001).

→ A study by Deane et al. (2012) in NSW explored the needs and experiences of owners and managers of unlicensed boarding houses who have residents with mental health and alcohol and drug issues. The research found that most boarding house managers had limited understanding of different types of mental health and substance use disorders. Almost all reported problems with individuals who they believed had such problems. Several boarding house managers found themselves in the role of 'accidental counsellors', but their responsiveness to residents needs was highly variable. According to the research, options for addressing residents' needs include educational strategies for boarding house managers and facilitating links with support agencies.

## 5.4 Support programs for boarding house residents

### 5.4.1 Boarding House Reform Package

New South Wales, along with a number of other jurisdictions, has undertaken a reform of boarding/rooming houses. Specifically NSW revised the Boarding Houses Act 2012 to ensure the protection of residents and included a variety of changes that:

- Required new standards for boarding/rooming houses including provisions for safety and privacy.
- Ensured adequate support is provided to residents.
- Relocated high needs clients into more appropriate accommodation and support.
- Developed procedures to prevent inappropriate entry into boarding and rooming houses, particularly for high needs clients.
- Developed procedures where boarding/rooming houses are registered which can assist with compliance to minimum standards.

The distinction is made in NSW between registered and unregistered boarding houses. The aim of the Act is to “establish an appropriate regulatory framework for the delivery of quality services to residents of registrable boarding houses, and for the promotion and protection of the wellbeing of such residents, by:

- (a) providing for a registration system for registrable boarding houses, and
- (b) providing for certain occupancy principles to be observed with respect to the provision of accommodation to residents of registrable boarding houses and for appropriate mechanisms for the enforcement of those principles, and
- (c) providing for the licensing and regulation of assisted boarding houses and their staff (including providing for service and accommodation standards at such boarding houses), and
- (d) promoting the sustainability of, and continuous improvements in, the provision of services at registrable boarding houses.”

In 1998 the Minister for Disability Services and Community Services announced a Boarding House Reform Package (BHRP) which included provision of new support standards for residents of Boarding Houses with the aim of improving the standards of support provided. One of the elements was the Primary and Secondary Health Care (P&SHC) program, which is designed to improve access to suitable primary and secondary health services for these residents who typically have a range of chronic health conditions. Mercury Advisory (see Family and Community Services (2010)) undertook an evaluation of the program services in NSW in 2010, key findings included that:

- Residents were accessing GP services, and the majority of residents with psychiatric disability were accessing psychiatrist/mental health teams on a regular basis.
- There was significant variation in service across and within regions, and even within regions there is no standard approach. This can in part be attributed to the varied backgrounds of the organisations contracted to provide P&SHC.
- There is clear evidence that residents were accessing health and allied health services; however, it was unclear if all services provided were appropriate and designed to meet individual needs due to the limited data available.

- The funding provided was effective in reducing barriers for residents to access health services. However, transport was a potential barrier for access in some areas.

#### *5.4.2 Active Linking Initiative (ALI)*

The NSW Department of Ageing, Disability and Home Care (DADHC) commissioned the Social Policy Research Centre (SPRC) to evaluate the Active Linking Initiative (ALI). The ALI began in 2000 as one part of the NSW Boarding House Reform Program. ALI aims to link people who live in Licensed Residential Centres (LRC, commonly known as licensed boarding houses) into the community in ways which are meaningful and sustainable. ALI support is a contracted service funded by DADHC and provided by nongovernment organisations (NGO). It aims to facilitate community based activities based on a person's goals, building individual skills to enhance their independence and integration within the community. Four case study residents who had benefited from participating in ALI were interviewed. Their experiences demonstrate how ALI fosters and builds client outcomes and how outcomes could be strengthened. Key findings of the evaluation include that:

- ALI provides positive consumer outcomes for some residents of boarding houses.
- Residents' positive personal wellbeing ratings on life domains and their future may be related in part to their involvement with ALI. Some residents also spoke about having positive relationships with the boarding house manager, who assisted them with their problems.
- The relationship between the ALI worker and residents seems critical to the effectiveness of ALI. Most residents said they liked the ALI workers.
- Residents participated in community access and recreational activities, but had done little formal skills development and generally could not name new skills they had acquired through the ALI activities
- Social and family relationships improved for some people. For others it remained a long term goal to reconcile with family members and gain friendships outside the LRC.
- Employment and formal education did not increase because of disability, stigma and availability of suitable opportunities (Edwards and Fisher 2010).

## 6 PEOPLE WHO ARE HOMELESS



This chapter presents evidence regarding the pathways and interventions for people with mental illness who are already homeless. The evidence base on crisis and transitional housing is small and does not focus on people with mental health issues. For this reason the chapter focusses on rough sleepers and the operation of the service delivery system for those people.

### Summary

- Older people who are homeless are more likely to have mental health issues if chronically homeless.
- The evidence base suggests that the chronically homeless are more likely to have experienced primary homelessness or have mental health and/or substance use issues.
- The evidence suggests that specialist support is needed for people with complex needs.
- Housing First has proven particularly effective with people experiencing homelessness and mental illness.
- Other successful interventions targeting people with mental health issues and who are homelessness include Assertive Community Treatment and Assertive Outreach.

### 6.1 Introduction

The evidence regarding the nature of the relationship between mental illness and homelessness is unclear. The literature illustrates that rough sleepers are exposed to many risks that can either exacerbate an existing mental illness or create conditions that can lead to a mental illness. These risks include:

- Lack of shelter and security.
- Poorly coordinated medical treatment.
- Poor social support networks.
- High levels of stigmatisation (socially and within the service system) (Johnson and Chamberlain 2011).

Significantly, the chronically homeless are now found to include both individuals and family groupings and this cohort of the homeless are vulnerable to repeat homelessness even if housed. This is due to the following factors:

- Significant specialist support is needed for people with complex needs (e.g. drug and alcohol use, mental health issues, disabilities).
- The ability to sustain housing becomes more difficult the longer an individual or family experiences homelessness.
- Access to affordable and appropriate housing and individualised support is necessary to sustaining tenancies, but is not always possible (Culhane et al. 2002).

### 6.2 Pathways for rough sleepers

The evidence base suggests that the chronically homeless are more likely to have:

- Experienced primary homelessness (Johnson and Chamberlain 2012).
- Mental health and/or substance use issues (Culhane et al. 2002).

A recent evaluation of the Australian Street to Home program found that the pathways into homelessness impact on the length and experience of homelessness. For example, people who become homeless due to family breakdown or housing crisis are more likely to be homeless for a short period of time (less than 3 months). A small number of this group become chronically homeless. In contrast people whose pathway into homelessness is indicated by substance abuse and/or mental health issues are more likely to become rough sleepers and chronically homeless (Johnson and Chamberlain 2012).

### **6.3 Programs for rough sleepers**

Research demonstrates that there are effective and varied ways to address homelessness for those with severe mental illnesses, although Padgett (2007) notes a divide between two main philosophies. 'Treatment first' views the need for acceptance of oneself as mentally ill and treatment prior to being housing ready. 'Housing first' does not make housing contingent on treatment.

#### *6.3.1 Housing first*

Housing First is an intensive response approach for clients with complex needs. Housing First is a model that provides homeless individuals with immediate access to permanent, independent housing with post-housing support and without treatment contingency (Stefancic & Tsemberis 2007).

It focuses on providing permanent housing linked to intensive and integrated support. Permanent supportive housing has a proven ability to:

- Deliver high levels of sustained tenancies for people with complex needs and a history of homelessness (Substance Abuse and Mental Health Services Administration 2010; Andersen & Sherwood 2002).
- Provide a service rich housing environment (e.g. wrap around services) specifically for people with special needs who are homeless or at risk of homelessness (Andersen and Sherwood 2002).

An important finding from the evidence base is that while permanent housing is critical to the success of the Housing First model, the support component is equally critical for ensuring that tenancies are sustained.

The critical mechanisms of Housing First are:

- Secure permanent housing as quickly as possible.
- Ensure that client choice is maximised both by involving the person in the choice of housing option and in not requiring abstinence or other treatment compliance for housing access (Greenwood et al. 2005).
- Provide very active, assertive support and tenancy management (including for example, income management to guarantee rental payments particularly where active substance abuse is an issue) (Tsemberis & Asmussen 1999).
- Ensure that post-housing support encompasses social re-integration interventions including targeting education, employment and social connectedness (Yanos, Felton & Tsemberis 2007).

The success of permanent supportive housing at sustaining tenancies relies on assertive and comprehensive support both before and after housing.

Recently Johnson (2012) has provided an important analysis of the capacity of Housing First in the Australian context. His critique includes a discussion about how Housing First is approached and operationalised to provide enduring outcomes for homeless people. For example, he disputes the claims that Housing First approaches can decrease drug and alcohol use. Johnson suggests that the results are inconsistent as a result of how Housing First has been implemented in different countries. He argues that in the Australian context this means that it is important to consider what resources and policy interventions are needed to reduce risks 'posed by serious drug dependency' (2012; p.186). These concerns are also duplicated with respect to the ongoing issues related to mental health, disability, poverty, unemployment that exist for many people who are chronically homeless.

Johnson's (2012) overall concern is that Housing First policies may dominate the responses to homelessness, particularly focusing on the chronically homeless, at the expense of early intervention and prevention. He also suggests that housing affordability and housing supply issues create the greatest risk to the success of Housing First.

### **Housing First and dual diagnosis**

The importance of dealing with and treating individuals with dual diagnoses has become increasingly prominent in health services and social services, as the nature of relations between the disorders and the complexity of treating such individuals is recognised. As the table below demonstrates, Housing First programs are primarily working with rough sleepers who have dual diagnoses.

**Table 1: Housing first and dual diagnosis**

<i><b>Program Name</b></i>	<i><b>Location</b></i>	<i><b>Objective</b></i>	<i><b>Outcome</b></i>
Pathways- Housing First Program (Tsemberis et al. 2012)	USA	Housing and treatment for highly complex-needs individuals (5+ years homeless, mental illness and substance abuse disorders)	Positive initial outcomes in housing retention, demand for intensive support services, mental health and substance abuse treatments
Treatment First vs. Housing First programs (Padgett et al. 2011)	USA	Comparing Treatment First vs. Housing First intervention and assistance programs to determine better outcomes in substance abuse and mental health disorders	Housing First outcomes better across all factors- engagement with social and health services, retention in programs and housing and decrease in comorbid substance abuse

### **6.3.2 Assertive Community Treatment**

While not the only possible support model, the core evidence-based support practice associated with the success of Housing First is Assertive Community Treatment (ACT) case-management. ACT case management has been a critical feature of Pathways to Housing and Housing First and has proven particularly effective with people experiencing homelessness and mental illness.

ACT was pioneered and tested in the 1980s as a means to successfully deliver community based care of persons with severe mental illness (Stein & Test 1985). The resulting ACT principles have been widely adopted in Australia and Europe.

ACT is now a well-documented, and extensively evaluated case management model originally designed for community mental health and adapted for people experiencing both homelessness and serious mental illness (Salyers & Tsemberis 2007, pp.619-21; Wolff et al. 1997, pp.342). Coldwell and Bender describe ACT as:

- Case management by a multi-disciplinary team.
- Low client/staff caseloads that enable frequent service contacts.
- Community-based services that are directly provided rather than brokered through other agencies.
- 24-hour availability to the client (Coldwell & Bender 2007, p.393).

### 6.3.3 *Assertive Outreach*

Assertive outreach differs significantly from traditional street outreach programs. Assertive outreach is defined as the deliberate and strategic attempt to end homelessness through the provision of outreach services to immediately intervene in individual homelessness or outreach to people's homes to sustain their tenancies (Phillips and Parsell 2012). Assertive outreach works with clients for extended periods of time to support their entry into housing and to sustain their tenancy.

Preliminary research findings by Phillips and Parsell (2012) conclude that assertive outreach has been successful in responding to homelessness, particularly for rough sleepers. Phillips and Parsell (2012) undertook a series of case studies of assertive outreach services in Australia. The program operated in Sydney was highly coordinated across health and housing components of the program, and this was one of its critical success factors.

The findings are however unable to conclude whether the initial success in accessing stable housing and moving rough sleepers into permanent accommodation can be maintained and tenancies sustained over time. The research also contends that any longer term benefits of assertive outreach for rough sleepers, such as social inclusion, employment, education and community connectedness should not be considered to be automatically achievable given the acute vulnerability experienced by rough sleepers. For example, achieving participation in the labour market, training, education, health, wellbeing, community connectedness and indeed social inclusion are difficult objectives for some people.

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## APPENDIX 1

The following list of program initiatives were identified throughout the course of the stakeholder enquiry as examples of innovative programs. These programs have not undergone formal evaluations, so their efficacy is unknown. However practitioners identified these initiatives as offering potential. There is capacity to undertake formal evaluations of these programs to provide evidence of their applicability to the NSW context.

- Project 40 - Wentworth Community Housing (NSW)
- Housing and Mental Health Agreement (HAMHA)
- South Eastern Sydney Local Health District (SESLHD) Homelessness Implementation Plan is an example of a systemic approach to homelessness within one LHD.
- Housing and Accommodation Support Initiative (HASI)
- Joint Guarantee of Service (JGOS)/ District Implementation and Coordinating Committee (DIACC)
- Psychiatric Emergency Care Centre (PECCs)
- Outreach clinics
- Partnership models e.g. with Specialist Homelessness Services.
- Partners In Recovery
- Home in Queanbeyan, Melbourne and Queensland
- Psychiatric Disability Rehabilitation and Support Services PDRSS (Victoria)
- Jewish House

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