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Housing and associated support for people with mental illness or psychiatric disability

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Abbreviations

AHURI	Australian Housing and Urban Research Institute
ARAFMI	Nongovernment agencies that provides support services for families and friends of people with mental illness and/or psychiatric disability
CALD	Culturally and linguistically diverse
COAG	Council of Australian Governments
CRRAH	Centre for Rural and Remote Area Health
DDHCS	ACT Department of Disability, Housing and Community Services
DSaRI	Disability Studies and Research Institute
DSQ	Disability Services Queensland
HASI	NSW Housing and Accommodation Support Initiative
HASP	Qld Housing and Support Program
HREOC	Human Rights and Equal Opportunities Commission
MHCA	Mental Health Council of Australia
MHCC	Mental Health Coordinating Committee
MHS	Mental Health Service
MMHA	Multicultural Mental Health Australia
PAH	Partnerships Against Homelessness
SAAP	Supported Accommodation Assistance Program
SSCMH	Senate Select Committee on Mental Health
SPRC	Social Policy Research Centre
UNSW	University of New South Wales

Executive Summary

This report examines how housing and support services can provide sustainable housing tenancies for people with mental illness or psychiatric disability so as to support their recovery. The recovery approach to mental illness emphasises a person seeking a valued sense of identity and purpose outside the parameters of mental illness and living a positive life despite any limitations resulting from the illness.

The project is situated within the Queensland policy context, with four participating government agencies: Queensland Housing, Queensland Health, Disability Services Queensland and the Office of the Public Advocate. It has three major components: a review of Australian and international literature; consumer and stakeholder consultations in Queensland; and evidence relating to cost-effectiveness and cost savings made as a result of providing sustainable housing for people with mental illness or psychiatric disability.

Research findings

A discussion of national policies and reviews finds their conclusions about housing and support are consistent, including a person-centred, holistic approach that is responsive to changing needs; a recovery approach; community-based solutions linked to other service sectors; the specific needs of Indigenous people, families and communities; and the importance of addressing both housing and support needs.

Section 4 presents the key themes from the literature review, grouped under goals of housing and support; policy options; and system wide problems. The goals include stable housing, housing choices, consumer participation, a holistic approach, independent living and participating in the community. Literature spanning more than two decades, from the Burdekin National Inquiry into the Human Rights of People with Mental Illness (1993), to more recent studies conducted by the Australian Housing and Urban Research Institute (AHURI) all point to the critical importance of stable housing as a foundation to recovery and living in the community. Also evident, if housing is to be sustainable, is the need to consider people's housing preferences and choices in decisions of housing allocation.

The policy options include the multidimensional nature of support, models combining housing and support, and linkages or partnerships. The range of housing related support that people require includes formal support services, peer support, responses to complex needs, early intervention and mainstream support. Importantly a multidimensional approach to support is inclusive of people with complex needs, for example people with mental illness who also have problems related to drug and alcohol use. The approach is needed when working with Indigenous communities, where health needs cannot be compartmentalised, as health is viewed within a holistic and community framework.

The system wide problems include addressing stigma, social exclusion and discrimination, and diversion from the criminal justice system. Stigma, often resulting in shame and isolation, may be a taboo subject for people from culturally and linguistically diverse communities. Literature examining mental illness and criminal justice points to the need to seek housing and support as an alternative to imprisonment, and as a cost effective strategy to prevent recidivism.

Section 5 applies these findings from the literature with the results from the consultations conducted in Queensland, to inform the development of principles for effective housing and support. The research identifies ten principles as key to effectively achieving sustainable housing for people with mental illness or psychiatric disability within a recovery framework. The principles are: recovery approach, person-centred support, facilitation of the person's housing needs and preferences, choice in independent living, responsiveness to population needs, separation of housing and support, interagency collaboration and coordination, individual and systemic advocacy, long-term perspective of housing and support needs, and preventing homelessness.

While the consultations generally endorsed the principles, they also pointed to a number of shortcomings in their application to services and practice. For example, people with mental illness spoke of the poor quality of the housing they had been offered, and indicated they were rarely given choices regarding where they lived. Examples were provided of government agencies passing responsibility on to other agencies, and where people with mental illness were discriminated against by the private real estate sector. Respondents emphasised that participation in the community was important to recovery and independent living, and the consumers group concluded that housing is fundamental to recovery as you need a home to recover and to have a life. Importantly, a case study showing how an incidence of physical illness can plunge a family into homelessness and mental illness is a reminder that these are issues affecting the whole community.

Section 6 considers the effectiveness principles in the context of economic evaluation of policy options. It presents data about economic analysis of effective policies in operation in other states and internationally, and draws conclusions for decision making about which polices to prioritise in the Queensland context.

Four case studies are presented in Section 7, to demonstrate the principles of effective housing and support in practice. They include Queensland's Project 300, NSW Housing and Accommodation Support Initiative (HASI), Western Australia Local Area Coordinators and the UK Sharing Voices initiative. Sharing Voices demonstrates an innovative way of providing support, through use of a community development approach and engaging with marginalised populations.

Policy implications

The report concludes with a short discussion of the implications for policy and identifies a number of policy directions that have evolved from the research, with the aim of supporting sustainable tenancies and recovery. The implications start from the government commitment that sustainable housing and associated support is a human right. Implementing the principles supports fulfilment of that right.

The implications are drafted in terms of immediate responsibility by the policy, funding and planning agencies for this research, Housing, Health, and Disability; and delivery responsibility by some of these agencies, contracted service providers and related government agencies such as the criminal justice system. Further the Office of the Public Advocate has a role in monitoring and reviewing the delivery of services and facilities, encouraging the development of programs and promoting the provision of services and facilities for adults. The implications relate to the

four types of housing and support (housing, housing associated support, social and personal support and clinical and allied health support). In addition, they also have implications for how agencies and service providers delivering these types of support effectively coordinate with other related mainstream and specialist services.

1. Recovery Approach

Two implications are identified. The first is to review current mainstream and mental health specialist services regarding how to better apply the principles for effective housing and associate support identified in the research. The outcome of the review will be to modify services and propose additional ones to meet the implications of the principles. The second is to consider extension of Project 300 to people with mental illness who are homeless, at risk of homeless or leaving institutional care, including corrective services.

2. Person-centred Services

Improving a person's outcomes is the overarching goal of person-centred services. An implication from the research is to review mainstream and specialist services to ensure they have a focus on housing and support that facilitates consumer outcomes including sustainable housing, quality of life, community participation, family connectedness, independent living and economic security. The outcome of the review will be to modify service delivery processes to meet the implications of person-centred service planning, funding and delivery.

3. Primacy of the Person's Housing Needs and Preferences

We suggest reviewing public and priority housing allocation criteria, with the aim of reflecting the principle of choice in housing for people with mental illness, in particular with regard to fulfilling long-term preferences for location and type of housing. Despite the rhetoric of consumer choice throughout the literature and in policy statements and reports, the consultations indicated that people have very few choices regarding their housing, which contributes to unsustainable tenancies. The outcome of the review will be to modify allocation criteria and processes to respond to people's needs and preferences for sustainable housing and support.

4. Choice for Independent Living

A further implication of person-centred services is reviewing individual and system housing and support policies to incorporate the goal of independent living in the planning, funding and delivery of housing and support to individuals over their life course. This also has implications for the supply, planning and funding of housing and support types so that people can fulfil their choices as they change during their life. The outcome of the review will be to modify housing and support processes and propose new housing and support options to offer sustainable housing and support as required.

5. Responsive to Population Needs

An implication from the research is that planning, funding and delivery of housing and support needs mechanisms to take account of specific needs of particular population groups, including Indigenous, culturally and linguistically diverse communities, women, parents and young people.

This involves three steps: seeking the participation of people and communities in these population groups to identify needs and to comment on policy opportunities; responsive mainstream services that can respond flexibly to particular needs associated with diversity; and specialist services particular to the population needs. Reviewing participatory mechanisms and planning processes will result in changes to housing and support processes for individual housing and support and planning; and propose new mainstream and specialist housing and support options to respond to the needs of particular population groups.

6. Separation of Housing and Support

The structure, funding and delivery of support services need to be reviewed to check whether the principle of separating housing and support has been considered so as to minimise risks of conflict of interest and vulnerability of people receiving support. Where housing and support remains the responsibility of one organisation, the mechanisms within the organisation to address the risks should also be reviewed. Where the functions are separated, mechanisms to effectively coordinate the functions should be reviewed. The outcome of the reviews will be to modify housing and support processes and contractual arrangements to minimise risks of conflict, vulnerability and lack of coordination.

7. Interagency Coordination

Many government and nongovernment organisations are responsible for housing and support and have contact with people with mental health and psychiatric disability. Formal mechanisms and informal processes to facilitate coordination should be reviewed against the aims of effective coordination between the four types of housing and support, to improve outcomes for the person and to implement the principles for effectiveness. Examples include, the Local Partnership Agreements, learning from the experience of the Local Area Coordinator models in other states and agency memoranda of agreements. The outcome of the review will be to modify planning and delivery processes, networks and agreements to improve coordination for individual consumers and policy planning.

8. Individual and Systemic Advocacy

The research has four implications for government agencies to enhance individual and systemic advocacy. First, work with advocacy organisations to establish opportunities in government processes for people with mental illness and psychiatric disability to express their opinions about problems and solutions for housing and support. Second, commit greater resources to increasing the capacity of the advocacy sector to improve access for people with mental illness to individual advocates and to represent the interests of people with mental illness in systemic change in the housing, support and mainstream service sectors. Third, consider implementing a community development approach, such as Sharing Voices, to elicit participation and community responsiveness, and engage with marginalised groups with mental illness and psychiatric disability. Finally, continue to work with the nongovernment sector to develop and implement community awareness and education strategies highlighting diverse and positive images of people with mental illness or psychiatric disability living and participating in the community.

9. Long-term Perspective of Housing and Support Needs

The sustainability of housing and recovery relies on a long-term perspective. This involves reviewing policy processes that prioritise opportunities to allocate permanent housing with support rather than transition models for people with mental illness. In addition, it also involves enhancing social housing by prioritising allocation to people with mental illness and psychiatric disability and focusing on sustainable tenancies through the choices of housing and provision of support to sustain the tenancy. The outcome will be to modify housing allocation and support processes to enhance decision making that takes account of long-term perspectives.

10. Preventing Homelessness

Strategies to prevent homelessness include reviewing housing allocation policy and practice to prioritise access to permanent, dispersed housing for people with mental illness and psychiatric disability. In addition, the affordable housing stock managed by the social housing sector needs to be increased, including methods to engage private housing sector through long term leases.

Short-term implications to preventing homelessness include working with the Supported Accommodation Assistance Program (SAAP) and its new directions under SAAP V, to improve access of people with mental illness to the program, in particular to the SAAP outreach component. Further, at policy and practice levels, SAAP entry criteria that effectively exclude some people with mental illness and psychiatric disability need to be challenged and minimised.

1 Introduction

The UNSW Consortium was commissioned by Queensland Housing, in partnership with Queensland Health, Disability Services Queensland and the Office of the Public Advocate, to undertake research on housing and associated support for people with mental illness or psychiatric disability.

The project aims to identify the characteristics of housing and support and the interface between them, which facilitate sustainable housing tenancies for this population group. It identifies key themes from the literature, best practice approaches and effectiveness principles for combined housing and support services. The study is conducted within a framework of the recovery approach to mental illness, with the aim that housing and support facilitates improvements in the person's quality of life.

The project has three main components: a review of Australian and international literature; consumer and stakeholder consultations in Queensland; and evidence relating to cost-effectiveness and cost savings made as a result of providing sustainable housing for people with mental illness or psychiatric disability. Appendix 1 and the research plan outline the approach and methods for the project (Fisher and Edwards, 2008).

The research questions focus on the:

- facilitators enabling people with mental illness or psychiatric disability in seeking appropriate housing and sustaining tenancies;
- costs and benefits of providing appropriate housing and support to people with mental illness or psychiatric disability, including the methodologies to determine the costs and benefits;
- needs and preferences of people with mental illness or psychiatric disability in terms of housing forms, tenures and associated support services; and
- relationships between different housing forms, tenures and associated support services and recovery from mental illness or psychiatric disability.

The UNSW Consortium comprises the Social Policy Research Centre (SPRC), Disability Studies and Research Institute (DSaRI) and Griffith University.

The limitations of the project relate to the short three-month timeframe. For this reason the project has remained focused on the provision of social housing and support for people with mental illness, rather than policy related to boarding houses and private real estate. Other studies previously conducted by the Social Policy Research Centre have focused on housing and support for people with mental illness and psychiatric disability with respect to boarding houses (Resident Support Program; Review of Disability Services Queensland Referral Processes to Private Residential Facilities; and Research into the Service Needs of Residents in Private Residential Services; available at www.sprc.unsw.edu.au).

2 Background

This research examines how housing and support services can provide sustainable housing tenancies for people with mental illness or psychiatric disability, in such a way as to support their recovery. The literature shows that it is often not sufficient to provide a person with mental illness with a roof over their heads and expect them to survive and sustain the tenancy. A critical factor is the provision of support. Consumer feedback on the need for support and its role in supporting recovery is unequivocal. For example, in a recent AHURI study (Flatau, 2008) on the effectiveness and cost-effectiveness of homelessness prevention and assistance programs, consumers spoke about support in the following ways,

> If I didn't receive support I would probably be living on the streets or squatting in empty buildings … [without support] I would have been suicidal, depressed and not felt wanted by anyone. (single man)
>
> [Without support] I would have lost custody of my five children. (mother)
>
> If this service was not available to me I would be sleeping on the street. This service can assist me by putting me in contact for other help. Having someone to talk to and steer me in the right directions that will better my life … [without support] I would have been forced to return to a violent situation and suffered more assaults and abuse. (woman victim of domestic violence)
>
> Getting rental arrears sorted and finances back on track. Tell me the right avenues and services to get support … [without support] I would be on the street. (tenancy support consumer)

This section discusses background concepts applied in the research, including definitions, recovery and the context of a housing shortage and homelessness.

2.1 Definitions

The following definitions used by the Queensland government are adopted for this research.

Mental illness

Mental illness refers to conditions characterised by a clinically significant disturbance of thought, mood, perception or memory (Mental Health Act 2000 (Qld)).

Psychiatric Disability

Psychiatric disability is the loss or deterioration of personal and social functioning across a range of life activities, due to mental illness or disorder, resulting in the disruption of the person's lifestyle and valued social roles. Psychiatric disability persists and may fluctuate during the person's life (Disability Services Queensland, 2000: 12).

It is important to acknowledge that Aboriginal people have different understandings and language for mental illness and psychiatric disability. For example, the concept of social and emotional wellbeing may be used, in preference to mental health. Understandings of health generally include the wider family and Aboriginal community rather than a person's health--'Health does not just mean the physical wellbeing of the person but refers to the social, emotional and cultural wellbeing of the whole community' (National Aboriginal and Torres

Strait Islander Health Council, 2004). Health and wellbeing therefore require a holistic and whole-of-life view, incorporating the wellbeing of the whole community.

Housing and associated support

Four types of policy are included in the review, defined as follows:

- *housing* refers to actual dwellings and the processes by which people are housed, such as the allocation of affordable housing and arrangements for transitioning people with mental illness or psychiatric disability from homelessness or institutional care to stable housing in the community. It includes housing provided or funded by government and housing accessed in the private market;
- *housing associated support* includes tenancy management, accommodation support and community inclusion;
- *social and personal support* includes development of skills for independent living, life skills and social and economic participation; and
- *clinical and allied health* includes mental health, drug and alcohol services, hospitalisation and general practice.

Goals of housing and associated support policy

The goals of housing and associated support policy are to improve the lives of people with mental illness or psychiatric disability. Improvements are across life domains such as the achievement of mental health recovery; better quality of life; appropriate, affordable and sustainable housing tenancy; choice for independent living; and consumer involvement and community participation.

2.2 Recovery Approach

This Queensland project is innovative in that it examines mental health housing and support approaches within a framework of recovery. The term recovery approach used in this report refers to the concept of recovery-oriented service delivery, rather than a particular service model. Recovery is a '… journey toward a new and valued sense of identity, role and purpose outside the parameters of mental illness; and living well despite any limitations resulting from the illness' (Queensland Health, 2005). Each person with mental illness decides for themselves what 'living well' means to them. The experience of recovery is different for everyone and a range of service models can support recovery. Recovery is consumer led,

> Recovery happens when people with mental illness take an active role in improving their lives, when communities include people with mental illness and when mental health services can enable people with mental illness and their communities and families to interact with each other. (NZ Mental Health Commission, 2001)

The recovery approach is compatible with community models of service provision and promotes the need for community support. The approach looks outward and assists people to find and use community services, support and opportunities (NZ Mental Health Commission, 2001).

Of particular relevance to this project is sustainability of recovery, in the context of sustainability of housing. One key theme explored in this report and common to both recovery and housing is that of independent living. Recovery works with the whole person.

This project explores how mental health support can address not just the person's illness, but also in the context of their whole lives, including housing and support needs.

The provision of housing and support is closely associated with a recovery approach. Housing is an essential foundation of a person's treatment and recovery. As argued in the Burdekin Report, housing is 'an important part of a therapeutic system of rehabilitation and enablement that will help recovery' (HREOC, 1993). The Mental Health Council of Australia (MHCA) advocates the need for,

> … community supported recovery services [that] work alongside people with a mental illness. These programs…assist people with housing, activities of daily living, social skills, community access, social and recreational activities, counseling and advocacy, financial skills and management, vocational and employment support as well as general and specialist information sharing. (MHCA, 2006)

The interaction between clinical and non-clinical services and the participation of a range of psychosocial support services is considered critical. In its report, Smart Services (2006), the MHCA outlines a national framework for Community-supported Recovery Services, including the following components of effective recovery services:

- Partnerships between consumers; family and/or carers; nongovernment agencies, private and government providers; and community-based and clinical services;
- Addresses needs holistically;
- Avoids siloed approaches and thinking;
- Prevention and early intervention approaches at its core;
- Reflects a spectrum of care and offers a range of intensive support options;
- Builds and fosters community understanding and engagement with and around the person;
- Leaves systemic questions to be addressed by the system and providers, not consumers;
- Supports autonomy, independence and freedom of choice while the person is actively engaged in their treatment and support options;
- Incorporates a range of paid non-clinical roles including system advocates and peer support;
- Treats the person with the same human rights as anyone else (MHCA, 2006: 14).

2.3 Housing Shortage and Homelessness

While the purpose of this study does not include examining the shortage in affordable housing, it is clear that unless governments increase the supply of affordable housing, vulnerable people such as people with mental illness will remain at risk of homelessness or institutionalisation. Recent developments at Federal and State/Territory levels suggest that governments are taking a new approach to addressing housing affordability and supply. The newly elected Federal government has taken a first step of establishing the National Rental Affordability Scheme, providing subsidies and incentives to private developers to build rental dwellings where the rent will be charged at 20 per cent below market rents (Australian Government, 2008). At the recent 2008 National Housing Conference, the solution of

increasing the supply of community and social housing received wide endorsement. The NSW Housing Department committed to double the size of the NSW community housing sector; other states also indicated community and social housing were growth areas.

The current statistics on homelessness in Australia are relevant to housing and support to people with mental illness. They are at risk of homelessness if housing and support fails to build sustainable tenancies. The current conservative estimate of nearly 100,000 persons who are homeless in Australia (Chamberlain & MacKenzie, 2003) is likely to include a significant number of people with mental illness (30-80 per cent; Select Committee on Mental Health, 2006: 10.32). International and Australian literature also concludes that for some people the experience of homelessness contributes to mental illness (St Vincent's Mental Health Service, 2006).

This interrelationship between homelessness and mental illness has been highlighted in a recent Melbourne study of the homeless population, *'On the Move: A longitudinal study of pathways in and out of homelessness'* (Johnson, 2006). The study found that those who entered homelessness on the 'mental health pathway' were frequently exploited in the early stages of their homelessness, and most sought to avoid exploitation by isolating themselves which then increased their marginalisation. Of concern is that this group had longer periods of homelessness than other groups who became homeless through different pathways including domestic violence, substance use, housing crisis and youth crisis. Johnson's research found that three quarters of the people with mental health problems developed these after they became homeless.

3 Policy Context

This section discusses the Australian and Queensland policy context for the research. The reports are discussed in relation to a recovery approach to perspectives on homelessness and mental illness.

3.1 Australian Policy Context

With the aim of locating the research project within a broad Australian policy context this section provides a brief overview of relevant policies: National Mental Health Strategy; the Mental Health Council's *Out of Hospital, Out of Mind;* National Standards for Mental Health Services; National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being; and the Commonwealth State Housing Agreement. Findings relevant to the policy context are also summarised from mental health reports and research: Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness (HREOC, 1993); Senate Select Committee on Mental Health (2006); and Not for Service (Mental Health Council of Australia, 2005).

National Mental Health Strategy

The National Mental Health Strategy, initiated in 1992, aimed to be a historic turning point for mental health policy and service delivery in Australia, by delivering a unified, dedicated reform agenda for mental health supported by Federal and State and Territory governments in Australia. The four aims of the Strategy are to: promote the mental health of the Australian community; where possible prevent the development of mental disorder; reduce the impact of mental disorder on people, families and the community; and assure the rights of people with a mental disorder (Australian Health Ministers, 2003).

The National Mental Health Strategy has broadened the mental health agenda from a focus on treatment to incorporating the range of interventions, including mental health promotion, prevention of mental health problems and illness, early intervention, rehabilitation and recovery. The following principles underpin the reform agenda of the Strategy:

- All people in need of mental health care should have access to timely and effective services, irrespective of where they live;
- The rights of consumers, their families and carers, must shape reform;
- Mental health care should be responsive to the continuing and differing needs of consumers, families, carers and communities;
- The quality and safety of mental health care must be ensured;
- A recovery orientation should drive service delivery;
- Investment in the workforce is essential;
- Innovation must be strongly encouraged and supported;
- Sustainability of effective interventions must be ensured;
- Resources for mental health must recognise the impacts of mental health problems and mental illness;
- Mental health reforms must occur in concert with other developments in the broader health sector; and

- Mental health reforms require a whole-of-government approach.

The Strategy's National Mental Health Plan 2003 – 2008 (building on the work of two preceding Plans) identifies four priority themes: promoting mental health and preventing mental health problems and mental illness; improving service responsiveness; strengthening quality; and fostering research, innovation and sustainability.

Many of these aims, themes and principles are relevant to this research project. For example the National Mental Health Plan includes, improving service responsiveness through 'increased access to appropriate, long-term supported accommodation' and 'development of the nongovernment sector to increase the capacity of nongovernment organisations to support consumers, families and carers.' The Plan also argues for continuity of care and support, again a key approach for this project. This involves continuity across the course of an illness and lifespan and an integrated specialist mental health system with appropriate linkages across the clinical and community sectors, government and nongovernment organisations.

Out of Hospital, Out of Mind!

Alongside the National Mental Health Strategy, is the comprehensive report prepared at the same time and authored by the nongovernment sector, *Out of Hospital, Out of Mind!* (MHCC, 2003). It is a nationwide review of the experiences of persons who use and provide mental health services, conducted by the Mental Health Council of Australia. The report concludes that current community-based systems fail to provide adequate services. These services are characterised by: restricted access; variable quality; poor continuity; and lack of support for recovery from illness. In the view of consumers, carers and health professionals who provide services, this does not represent a failure of policy (for example a failure of the policy of deinstitutionalisation).

> Instead, it is a failure of implementation through poor administration, lack of accountability, lack of ongoing government commitment to genuine reform and failure to support the degree of community development required to achieve high quality mental health care outside institutional settings. (MHCA, 2003: 1)

The review argues the urgent need for recovery programs which span mental health, housing, employment, drug and alcohol abuse, benefits and entitlements and medical treatment. With regard to housing, it found a lack of stable and appropriate housing for people with mental illness. When they are discharged from hospital it is not uncommon for them to be left without any accommodation options and end up on the street. Many people lose their housing during their hospitalisation. While boarding houses are closing and the criteria for eligibility for public housing are also getting harder, alternatives for affordable housing are unavailable (MHCA, 2003: 19-20).

National Standards for Mental Health Services

The National Standards for Mental Health Services were developed in 1996 under the auspice of the Federal Government Department of Health and Aged Care (Australian Government 1996). They are included here as a reference point for housing and support services. The eleven Standards are:

- The rights of people affected by mental disorders and/or mental health problems are upheld by the mental health service (MHS).

- The activities and environment of the MHS are safe for consumers, carers, families, staff and the community.
- Consumers and carers are involved in the planning, implementation and evaluation of the MHS.
- The MHS promotes community acceptance and the reduction of stigma for people affected by mental disorders and/or mental health problems.
- The MHS ensures the privacy and confidentiality of consumers and carers.
- The MHS works with the defined community in prevention, early detection, early intervention and mental health promotion.
- The MHS delivers non-discriminatory treatment and support that are sensitive to the social and cultural values of consumers, their family and community.
- The MHS develops and maintains links with other sectors at local, state and national levels to ensure specialised coordinated care and promote community integration for people with mental disorders and/or mental health problems.
- The MHS is managed effectively and efficiently to facilitate the delivery of coordinated and integrated services.
- Clinical activities and service development activities are documented to assist in the delivery of care and in the management of services.
- The care, treatment and support delivered by the mental health service is guided by: choice; social, cultural and developmental context; continuous and coordinated care; comprehensive care; individual care; and least restriction.

Supported accommodation is included in the last standard on care, treatment and support services. The standard is that it is provided in a manner that promotes choice, safety and quality of life for the consumer; the accommodation program is fully integrated into other treatment and support programs; accommodation is clean, safe and reflects as much as possible the preferences of the consumers living there; accommodation maximises opportunities for the consumer to participate in the local community; and the mental health service does not refer consumers to accommodation where they are likely to be exploited or abused (Australian Government, 1996: 47-8). Each of these factors is significant to the Queensland project.

Also of interest is the terminology used in 1996 when the Standards were written, 'supported accommodation', which today would more likely be referred to as 'housing and support.' This reflects a change to more flexible and individualised models of housing and support and where housing and support may be provided by separate organisations, or separate functions within one organisation.

National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being

In addition to the National Standards above, are the principles for Aboriginal and Torres Strait Islander Mental Health, outlined in the National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being (2004-09) (National Aboriginal and Torres Strait Islander Health Council: 2004). It has nine guiding principles:

- Aboriginal and Torres Strait Islander (ATSI) health is viewed in a holistic context, that encompasses mental health and physical, cultural and spiritual health;
- Self determination is central to the provision of Aboriginal and Torres Strait Islander health services;
- Culturally valid understandings must shape the provision of services;
- The experiences of trauma and loss, present since European invasion, have resulted in the disruption to cultural wellbeing; trauma and loss continues to have inter-generational effects;
- The human rights of Aboriginal and Torres Strait Islander peoples must be recognised and respected. Failure to respect these human rights constitutes disruption to mental health. Human rights relevant to mental illness must be specifically addressed;
- Racism, stigma, environmental adversity and social disadvantage constitute ongoing stressors and have negative impacts on Aboriginal and Torres Strait Islander peoples' mental health and wellbeing;
- The centrality of Aboriginal and Torres Strait Islander family and kinship must be recognised as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and sharing;
- There is no single Aboriginal Torres Strait Islander culture or group, but numerous groupings, languages, kinships and tribes, as well as ways of living. ATSI people may currently live in urban, rural or remote settings, in urbanised, traditional or other lifestyles and frequently move between these ways of living; and
- Aboriginal and Torres Strait Islander peoples have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment.

Commonwealth State/Territory agreements

The Queensland government is responsible for implementing the policies in Commonwealth State/Territory agreements in the state. Indigenous housing and support is joint responsibility with the Commonwealth. The three relevant agreements are for disability, housing and supported accommodation assistance.

Commonwealth State/Territory Disability Agreement

Under the Commonwealth State/Territory Disability Agreement 2003-07, the States and Territories have responsibility for the administration of accommodation and other support services including community access support, recreation support and family support for people with disability. The Commonwealth, States and Territories have joint responsibility for advocacy services; while the Commonwealth has responsibility for the administration of employment services to people with disability.

Commonwealth State/Territory Housing Agreement

The Commonwealth State/Territory Housing Agreement 2003 (Commonwealth of Australia, 2003) has guiding principles that provide another important context for the Queensland research project:

- Maintain a core social housing sector to assist people unable to access alternative suitable housing options;
- Develop and deliver affordable, appropriate, flexible and diverse housing assistance responses that provide people with choice and are tailored to their needs, local conditions and opportunities;
- Provide assistance in a manner that is non-discriminatory and has regard to consumer rights and responsibilities, including consumer participation;
- Commit to improving housing outcomes for Indigenous people in urban, rural and remote areas;
- Ensure housing assistance links effectively with other programs and provides better support for people with complex needs and has a role in preventing homelessness;
- Promote innovative approaches to leverage additional resources into Social Housing, through community, private sector and other partnerships;
- Ensure that housing assistance supports access to employment and promotes social and economic participation;
- Establish greater consistency between housing assistance provision and outcomes and other social and economic objectives of government, such as welfare reform, urban regeneration and community-capacity building;
- Undertake efficient and cost-effective management that provides best value to governments;
- Adopt a cooperative partnership approach between levels of government towards creating a sustainable future for housing assistance; and
- Promote national, strategic, integrated and long-term vision for affordable housing in Australia through a comprehensive approach by all levels of government.

Commonwealth State/Territory Supported Accommodation Assistance Program

The Supported Accommodation Assistance Program (SAAP) provides transitional supported accommodation and a range of related support services, in order to help people who are homeless achieve the maximum possible degree of self-reliance and independence. The goals are to help people who are homeless to resolve crises; re-establish family links where appropriate; and re-establish a capacity to live independently of SAAP (Commonwealth of Australia, 2005).

The new directions for SAAP identify strategic priorities that provide the opportunity for the mental health sector to better access the range of SAAP services, including outreach support to people with mental illness living in social housing. The strategic priorities include: early intervention for people at imminent risk of homelessness; post-crisis transitional support for clients exiting SAAP provided accommodation; and better linkages to support services.

Report of the National Inquiry into the Human Rights of People with Mental Illness

In addition to the current policy documents, the policy context of housing and support for people with mental illness is also informed by a number of significant national reports. The first is the seminal report by Brian Burdekin, 1993, prepared for the Human Rights and Equal Opportunity Commission (HREOC), which drew nationwide attention to the inadequacies of housing for people with mental illness.

> One of the biggest obstacles in the lives of people with a mental illness is the absence of adequate, affordable and secure accommodation. Living with a mental illness, or recovering from it, is difficult even in the best circumstances. Without a decent place to live it is virtually impossible. (HREOC, 1993: 337)

The Burdekin Report also drew attention to housing sustainability, 'Finding suitable accommodation is a frustrating enterprise; keeping it is even more difficult.' The Burdekin Report discussion about securing housing and keeping it is at the centre of this research study. Importantly, the Report placed mental health within a human rights framework.

> People with mental illness are human beings with human rights. This simple and fundamental point, which unfortunately still needs to be stressed, has been one of the fundamental tenets of this Inquiry. (HREOC, 1993: 21)

The policy of deinstitutionalisation, moving people with mental illness from large institutions into the community, was introduced into Australia in the 1970s, creating the imperative to provide suitable accommodation options in the community. Subsequent research shows that thirty years on, these accommodation options are woefully inadequate (eg. MHCA, 2005). However, appropriate accommodation is an important determinant in the success or failure of people with chronic mental illness living in the community (HREOC, 1993).

Burdekin's National Inquiry identified that the shortage and in many cases total absence, of appropriate accommodation for people with mental illness was often considered, 'The single biggest obstacle to mentally ill people's treatment and quality of life.' (HREOC, 1993: 338) The Burdekin Report did not just advocate for housing, but also recognised that support is needed as well.

> For people with a mental illness, housing must be more than physical shelter. Their disability means they need support from mental health workers. Without that support, what you're doing is setting people up to fail inside their own home. (HREOC, 1993: 345)

Australian Senate Select Committee on Mental Health

More recently, the Australian Senate Select Committee on Mental Health conducted a wide-ranging inquiry into mental health care in Australia, including an examination of the National Mental Health Strategy (SSCMH, 2006). One of the recommendations of the final report, recognising the importance of combining housing with support, was to, 'Establish more longer term supported, community-based housing for people with mental illness with links to community mental health centres for clinical support.' (SSCMH, 2006) The following key themes were identified during the course of the Senate Select Inquiry:

- The urgent need for more mental health services;
- The limited resources available are not always well utilised;
- Deinstitutionalisation has not been achieved;
- Mainstreaming has its limitations;
- The inadequacy of community-based care;

- Prevention is better than cure;
- Quality of care varies greatly from place to place;
- Some mental illnesses receive more attention than others;
- Service silos are preventing effective care;
- Some people get more mental health care than others; and
- The dominant medical model is hampering improvement.

The Committee also analysed the costs of mental illness to society, including the human costs in terms of time lost to disability or death and the stresses that mental illness place upon consumers, carers and the community generally; the financial costs to the economy from the loss of productivity brought on by illness; and the significant expenditure by consumers, governments and health funds associated with addressing mental illness and facilitating mental health. Total expenditure on mental health services by federal, state and territory governments and private health funds was $3.3 billion in 2002–03. In addition to this direct spending on mental health, governments incur significant indirect expenditure, including expenditure on housing. Further, as the Senate Inquiry demonstrated, a significant number of people who come into contact with the criminal justice system do so as a result of mental illness. This economic cost of poor support for people with mental illness is 'hidden' in the budgets of state and territory correctional services authorities. Other studies suggest that the longer-term personal costs of system failure include suicide, homelessness, unemployment, imprisonment and poverty (MHCA, 2005).

Not for Service

The final contextual report is the national review of the views of people with mental illness and their family and carers about service provision, *Not for Service* (MHCA, 2005). It was conducted by the Mental Health Council of Australia, the Brain and Mind Research Institute and the Human Rights and Equal Opportunity Commission. Consumers, family and carers prioritised the following aspects of delivering quality mental health care services:

- Access to professional care, particularly in emergency and other acute care settings;
- Treatment with dignity and concern for the person irrespective of location;
- Safe and high quality services;
- An emphasis on clinical care, rather than containment of people with mental disorders;
- Earliest possible access to professional care in acute and non-acute circumstances;
- Response to individual needs, including recognition of the complexity of co-morbid substance abuse or socio-economic deprivation;
- Coordination of health, welfare and related community support services;
- Access to programs and support to live independently and work;
- Respect for the legitimate interests of family and carers in accessing care and participating in ongoing treatment decisions;
- Support for organisations and professionals that provide direct clinical services;
- Provision of appropriate community housing options; and

- Access to appropriate medical as well as psychological services.

Summary of the Australian context

The Australian policy context is currently one that where governments and consumer organisations are giving significant attention to improving the quality of service provision to people with mental illness and psychiatric disability. The national policies and reviews discussed above are consistent in their conclusions about quality housing and support, including a person-centred, holistic approach that is responsive to changing needs; a recovery approach; community-based solutions, linked to other service sectors; specific needs of Indigenous people, families and communities; and the need to address both housing and support needs.

3.2 Queensland Policy Context

A number of recent Queensland policies and initiatives are briefly summarised here to place the project within the local context. The four participating government agencies to this research are Queensland Housing, Health, Disability Services and the Office of the Public Advocate. The section introduces the legislative framework and indicates potential ways the project may be applied to social policies and programs in Queensland. Information is included from the Queensland Alliance of Mental Illness and Psychiatric Disability Groups and the Centre for Rural and Remote Mental Health to include nongovernment and rural and remote perspectives.

Legislative Framework

Three Acts are relevant to this research.

Disability Services Act 1992 (Qld)

The Disability Services Act affirms that people with disability have the same rights as other citizens. It sets objectives for disability service development and establishes the Disability Funding Program to enhance provision of services and support that assist people with disability to achieve their maximum potential as members of society.

Disability Discrimination Act 1992 (Cmwlth)

The Commonwealth Disability Discrimination Act makes it unlawful to discriminate against a person because of disability in areas such as work, education, access to public premises, goods and services, accommodation, disposition of land, clubs and associations, sport and the administration of Commonwealth laws and programs.

Guardianship and Administration Act 2000 (Qld)

Guardianship and Administration Act sets out the functions of Office of the Public Advocate for systemic advocacy for adults with impaired capacity (for example people with a psychiatric disability), including:

- promoting and protecting their rights;
- promoting their protection from neglect, exploitation or abuse;
- encouraging the development of programs to assist the adults reach the highest possible degree of autonomy;

- promoting the provision of services and facilities; and
- monitoring and reviewing the delivery of services and facilities for adults with impaired capacity (Office of the Public Advocate, 2007).

Responding to Homelessness Strategy

In addition to requirements from legislation and agreements, the Queensland government has introduced a number of relevant policy strategies. The Responding to Homelessness Strategy (2005) reflects the strong connections between homelessness and mental illness (Section 2.3). Among the Strategy solutions are: providing more housing and support options for people affected by homelessness; connecting people with services; responding to the use of public space; and targeting mental health in the community (Department of Housing, 2007). The Strategy includes a commitment to ensure an equitable spread of services and initiatives across the whole State.

A number of initiatives under the Homelessness Strategy have the potential of improving access and provision of housing and support for people with mental illness (Department of Housing, 2007). The initiatives include:

- Extension across the state of the Homeless Persons Information Queensland service, to provide a central entry point for people needing information about services and support available for homeless people;
- Services hubs for homeless people in Brisbane, Cairns, the Gold Coast and Townsville to respond to the information, referral, support and advocacy needs of homeless people;
- Homelessness early intervention services will be established to provide support to people at risk of homelessness, in key locations across the State;
- Implementation of Local Level Agreements between government agencies to ensure coordinated services including health, accommodation and legal support meet the needs of people affected by homelessness; and
- Establishment of Homeless Health Outreach Teams in Brisbane, Gold Coast, Townsville and Cairns and the expansion of the program to Mt Isa to address the complex mental health and drug and alcohol needs of homeless people in the area.

One Social Housing System for Queensland

In response to increasing demand for social housing assistance, the Queensland government is working with community and local government-managed housing providers to implement changes through the One Social Housing System. The aim of the new system is to implement a better and fairer way for people to access housing assistance for the time that it is needed. Implementation of the One Social Housing System includes: common eligibility criteria for social housing assistance; one application form for long-term social housing and one combined waitlist; streamlined allocation policies for matching clients to vacancies; and the provision of social housing assistance for people with the greatest need for as long as it is needed. These changes are progressively rolling out across the housing programs and services delivered by registered providers (Queensland Housing, 2008).

Queensland Housing Five Year Strategic Plan for People with Disability

The Queensland Housing Five Year Strategic Plan for People with Disability (2001-06) addresses housing needs including affordability; discrimination, for example from private

landlords; suitability of housing location and design; access to housing related support services; tenancy sustainability; and security of tenure.

Disability Services Queensland Strategic Plan for Psychiatric Disability Services and Support

The Disability Services Queensland Strategic Plan for Psychiatric Disability Services and Support (2000-05) outlines six principles for the provision of services and support to people with a psychiatric disability, in Queensland (Disability Services Queensland, 2000: 13). The principles are applicable to housing and associated support services.

- Services and support are provided in a similar way as to other people within their community of comparable age, gender and cultural background;
- Equitable access to services and support as afforded other people with disability within the community;
- Services and support that are flexible and responsive to their fluctuating needs;
- Services and support within their local community that promote family connections, friendships and social inclusion;
- An holistic response to the needs of people with a psychiatric disability, through services and support networks working collaboratively; and
- Disability services that are separate from and complementary to, clinical and other services.

Office of Public Advocate

The Office of Public Advocate, in its *Submission to the Senate Select Committee Inquiry into Australian Mental Health Services* (2005), described the experiences of people with mental illness as characterised by: poor housing; long-term or periodic homelessness; low income; discrimination; unemployment; low labour force participation and loss of vocational capacity; substance abuse; poor social networks; and frequent interaction with the criminal justice system (Public Advocate, 2005: 8). The Public Advocate submission promotes the concept of recovery to take people beyond the role of 'consumer', towards 'living a hopeful, satisfying and contributing life.' They submitted that recovery includes the following meanings, many of which are relevant to this project (Public Advocate, 2005: 8-9):

- Having a secure, stable home and the support necessary to sustain the tenancy in the community;
- Enjoying close and mutual relationships;
- Having meaningful work and the necessary training and support to sustain employment;
- Contributing purposefully to the wider community;
- Having seamless access to both mental health and substance use services;
- Interacting in the mainstream community without fear of discrimination or stigma; and
- Diversion from the criminal justice system into appropriate treatment.

Improving Mental Health for Queenslanders

During 2007, Queensland Health developed a draft Queensland Plan for Mental Health 2007-2017, which provides a comprehensive framework for mental health reform. The plan recognises the importance of both clinical treatment and non-clinical community services in

facilitating recovery for people with mental illness. Supporting participation and engagement in the community for people with mental illness is a key focus of the Plan, with strategies identified to improve access to appropriate housing, personal support, employment and training. Secure housing is identified as a fundamental requirement for mental health and wellbeing, and there is a focus on ensuring linkages between access to housing and delivery of the personal support services required to ensure people with mental illness are able to live stable, productive and satisfying lives in the community.

To commence implementation of the draft Queensland Plan for Mental Health, funding for the first four years of mental health reform was allocated in the 2007-08 State Budget, as outlined in *Improving Mental Health for Queenslanders, Outline of the 2007-08 State Budget Outcomes for Mental Health (2007)*. This funding includes cross agency initiatives and partnerships:

- $40 million for the Department of Housing to build and purchase specially designed social housing for people living with mental illness;
- $22.4 million for Disability Services Queensland to provide a range of personal support services to people living in this new accommodation; and
- $35.64 million for Disability Services Queensland to purchase a range of additional personal support and accommodation services from the nongovernment sector to assist people with mental illness to live meaningful lives in the community. This includes increased personal support for people living in boarding houses and hostels; new residential recovery-focused services within community settings; consumer-operated crisis and respite services; and for people with mental illness transitioning from prison back into the community.

Queensland Alliance of Mental Illness and Psychiatric Disability Groups

The Queensland Alliance is a peak organisation representing nongovernment and non-profit organisations working to meet the needs of people with mental illness or psychiatric disability across Queensland. The Alliance uses the approaches of recovery, human rights, social justice and universal access to health care; and aims to promote, strengthen and develop the growth of nongovernment, recovery-oriented responses and services in Queensland. One of the stated strategic directions of the Alliance is to promote positive representations of mental health (www.qldalliance.org.au).

The Alliance's Submission to the Senate Inquiry recommends strengthening the focus on prevention, early intervention, health promotion, psycho-social rehabilitation and consumer and carer participation (Queensland Alliance, 2006). The Alliance also recommends a significant increase in funding to mental health to reflect the burden of disease of mental illness within the community.

Queensland Centre for Rural and Remote Mental Health

The Centre for Rural and Remote Area Health (CRRAH), based in Toowoomba, conducts health-related research and training in rural and remote communities for the benefit of the community and the health workforce. The Centre's vision lies in improving the wellbeing and health of rural and remote communities in Queensland.

In 2006 the CRRAH conducted workshops in Southern Queensland to consult with services regarding the key health needs of people living in the bush. Mental health was one of the four key needs identified by the 85 workshop participants; the other problems were workforce;

access to services; and community perceptions and expectations of health services. (Eley, R. et al, 2006). After workforce, mental health was the most important theme raised at the workshops.

> Mental health was considered to be the greatest health condition affecting people in rural and remote areas. The theme was raised in all workshops … The need for a proactive approach with early intervention, early and positive exposure was identified but lack of staff and services and client culture were seen as major obstacles. (Eley, R. et al, 2006: 17)

Participants said mental health problems were caused or exacerbated by the drought and changes in economic climate. Poor resources for early intervention and cultural considerations in seeking assistance were perceived to compound the problem. The results of the 2006 workshops corroborate results from previous workshops in Toowoomba conducted by CRRAH in 2003. People at risk ranged from the general public to particular groups such as young people, people with disability and people who are older or have a mental illness.

The greatest concerns were expressed in the areas of services for people with mental illness and psychiatric disability, facilities such as respite for carers, general transport needs and support in the aged care sector. They referred to accommodation in relation to the lack of hospital and in-patient care for people with mental illness. Social or community housing were not discussed.

Another study conducted by the CRRAH, at its branch in Cairns, concluded that Indigenous residents of rural and remote Australia experience high levels of mental disorder (Hunter, 2007). The study identified the high suicide rates of Aboriginal people, which have increased dramatically over the last three decades.

> In Queensland the Indigenous suicide rate for 1999-2001 was 56 per cent higher than for the state as a whole, with the rate for young men aged 15-24 years 3.5 times higher. Some 83 per cent of Indigenous suicides were less than 35 years of age (42 per cent for the state), with 90 per cent of these deaths by hanging. (Hunter, 2007)

4 Key Themes from the Literature

This section presents the themes about facilitators of effective housing and support for people with mental illness or psychiatric disability identified in a review of Australian and international literature, with a focus on Queensland. The themes are grouped in the following way:

- goals – stable housing, housing choices, consumer participation, holistic approach, independent living and participating in the community;
- policy options – multidimensional support, combining housing and support and linkages; and
- system wide problems – addressing stigma, social exclusion and discrimination and diverting people with mental illness from the criminal justice system.

Each of these themes is discussed below. Section 5 analyses the themes in combination with the consultation data to identify principles for effective housing and support.

4.1 Stable Housing as a Foundation to Recovery and Living in the Community

The first group of themes are goals of housing and support policies. The first is the importance of stable housing as a foundation for recovery. This goal is contrary to both the negative experiences of many people with mental illness with histories of unstable housing, including homelessness; and contrary to transition housing models in community-based programs for people with mental illness. 'How long can I stay?' can be the first question asked by a service user accessing short-term supported accommodation. The question indicates a history of short term stays in refuges and hostels; it also indicates the importance of secure long term housing for consumers (HREOC, 1993: 383). Bleasdale points to 'the connection between increased recovery of people with mental illness and the stability of their accommodation.' (Bleasdale, 2007: 24) His stakeholder interviews found that unstable and unsuitable accommodation can cause and be an ongoing stimulus for mental illness. Once the need for accommodation has been addressed, the client can begin to focus with confidence on becoming well (Bleasdale, 2007: 25).

At the core of housing and support models reviewed in Section 7 is the provision of stable housing in the community, with support to sustain the tenancy. One example is the NSW Housing and Accommodation Support (HASI). It provides permanent housing and support rather than a transition program. This permanency is powerful for the HASI participants, many of whom have experienced periods of homelessness, short term housing, refuge-hopping, transitions and hospitalisations over life-times of housing instability. The longitudinal evaluation of HASI showed most people achieved stable social housing tenancies, with 70 per cent still living in their first HASI property and 85 per cent remaining with the same housing provider. Stable tenancies were attributed to: the housing provider and support provider striving to match available accommodation to individual need and choice; relocation when housing did not match requirements; high levels of participant satisfaction; good property care; consistent rental payments; amicable neighbour relations; and ongoing support from housing and support providers (Muir et al, 2007: 6).

Similarly, the New York-based Pathways Housing First model provides immediate, independent, permanent housing for people who are homeless and with co-occurring serious mental illness and substance abuse. The model incorporates client-driven treatment and support aimed at recovery and community integration. As the program name Housing First

suggests, permanent housing and long term support is the prerequisite for any successful treatment of drug and alcohol problems. Unlike some other US social programs it does not require treatment or sobriety as a precondition to housing. The program offers clients housing as an immediate and practical solution to their homelessness, not as a reward or incentive for participation in treatment. This is based on the program's explicit values that housing is a fundamental human right. Other guiding principles include recovery and the person's ability to make competent choices (Pathways to Housing, 2005).

Pathways operates through multidisciplinary assertive community treatment teams, employing harm-reduction approaches, trust and relationship building and a recovery focus. Consumer involvement and client advocates elected by their peers are priorities in the program.

> The team puts the decision-making authority in the hands of clients, providing clients the opportunity to gain control over their lives and to determine their own path of healing and recovery … The voice and the power of the clients are heard and honoured on every level. (Pathways to Housing, 2005:1304)

Recent Queensland Office of the Public Advocate research indicated that if housing was to adequately meet the needs of people with mental illness it needed to provide: choice; control over one's environment; privacy; stability; optional permanency; opportunities to increase levels of functioning; autonomy; safety and freedom (Office of the Public Advocate, 2008). These findings are consistent with Annison's (2000) study of the meaning of home, within the context of housing for people with disability. She identified why having a place to call home is critical. It provides: a sense of security, happiness and belonging; a reflection of one's own ideas and values; continuity and the ability to maintain relationships with friends and family; a centre of activities; a refuge from the outside world; and personal status. The importance of 'home' is reflected in this comment by a HASI participant,

> When I saw it, when I got inside, I was like … this is home, this is definitely home…you know how you just feel at home some place, where you feel comfortable, things are right…I loved the fact that I felt secure. (Muir et al, 2007: 7)

4.2 Consumer Choices about Housing and Support

The second theme is that mental health consumers have diverse needs and preferences. The policy implication is that a range of choices and options are necessary to reflect the diversity of people with mental illness. For example for some people the impact of their illness can be minimal, for others the impact can be highly disabling. Differences of gender, age, geography, cultural background and mental illness diagnoses and other compounding vulnerabilities, such as drug and alcohol use, intellectual disability, socioeconomic status and criminal justice histories affect needs.

Reynolds et al (2002: 13) summarised consumer preferences regarding housing characteristics and living arrangements as: independence and choice; a location convenient to transport and services and close to the person's preferred location; safe, secure and comfortable; affordable; and provides for both privacy and social opportunity. In addition, Bleasdale (2007) argues that housing choices and support options are made real by ensuring an individualised approach. He concludes that the notion of individual choice and client-

directedness is gradually becoming a hallmark of successful housing and support arrangements.

> People with disability and people with mental illness experience their lives differently and have very different housing needs and so an individual approach is warranted when it comes to determining the housing they wish to access and the support they require for it. (Bleasdale, 2007: 62)

St Vincent's Mental Health Service (2005) found that consumer preferences for housing show that most adults with mental illness prefer to live independently rather than in a group home. They identified in the Australian literature that the least preferred housing options were shelters, crisis accommodation and hospitalisation. They conclude from the literature that affordability and support are more critical to sustainable housing than housing type or model.

Providing people with housing choices and considering their preferences were at the core of the Queensland Project 300 success. It is interesting that 98 per cent of Project 300 participants chose to live on their own, as opposed to share housing (which may have been interpreted to mean group housing). This finding needs to be balanced by one of the findings in the HASI evaluation, where almost half of the 100 participants (42 per cent) wanted to share their housing with a friend, relative, partner or flatmate.

> They wanted to share with people who they trusted and with whom they had a meaningful relationship, rather than with strangers or acquaintances, such as a group housing situation. (Muir et al, 2008: 9)

4.3 Consumer Participation

The third theme is the importance of consumer participation in decisions to address their housing and support needs. Consumer participation is an important principle in the recovery approach, which promotes consumer-driven practice. An approach that focuses on consumer participation is characterised by the person at the centre of all decisions; recovery; relationships; empowerment; self-determination and self-efficacy (Community Resource Unit, 2005). The Queensland Consumer Participation Project, conducted by the Community Resource Unit and funded by Disability Services Queensland (2005), identified the following defining features of consumer participation:

- A recognition that the consumer is a unique person;
- A recognition of the interaction between consumer and environment;
- Consumers developing the confidence to express an opinion;
- Consumers expressing an opinion rather than giving support staff an answer that consumers think staff want to hear;
- Support services and the consumer working in partnership on decisions that affect the consumer;
- Consumer and support staff creating a working relationship that fosters opportunities for engagement in the community;
- A working relationship between support staff and the person that aims to create a sense of respect for each other, integrity and rapport;

- The consumer learning about his or herself and beginning to understand that with participation and decision-making comes associated responsibilities;
- An understanding that services can delegate decisions to the consumer and that the person can take on (or learn to take on) the consequent responsibility and accountability; and
- Changing the balance of decision-making and control.

The Queensland Multicultural Mental Health Plan 2003-08 identifies ways of engaging culturally and linguistically diverse (CALD) consumers and carers in meaningful and participatory ways continues to be a priority. The Plan calls for,

> … a culturally appropriate model of consumer and carer participation, developed in partnership with CALD communities that facilitates participation at the individual care and treatment level, at the service development level and at the program and policy level. (Queensland Health, 2005)

One of the key CALD mental health needs identified in the literature is a focus on culturally appropriate strategies for mental health promotion and prevention (Queensland Health, 2005).

Strategies to facilitate young people's participation in mental health services involve a number of methods, such as ensuring information and education is appropriate for a younger audience, use of the internet and digital technologies and participating in peer support programs. One example of effective young consumer participation is Platform Team (ORYGEN Youth Health) where current and past clients advise the service and provide peer support (James, 2007). Elements of young people's participation at ORYGEN include:

- Peer support by past clients, who visit the ORYGEN inpatient unit and also staff a drop-in centre in the outpatient unit. Peer support workers receive training and mentoring and are paid for their time;
- The *Jargon Filter*, a newsletter produced by ORYGEN clients, which provides information about the service, personal experiences of illness and the scope for recovery;
- Contribution to community education about mental health, for example speaking at schools, talking to youth workers and presenting to the media; and
- Membership of selection panels for staff applying to work at ORYGEN Youth Health.

James (2007) notes that it is important that young people's participation strategies do not entrench young people as 'professional advocates', but instead support their recovery from mental illness. A young consumer of mental health services provides this advice,

> For society to develop youth-friendly mental health services, it must learn to listen to young people, do so willingly and frequently and take notice of what it hears. A company designing a new mobile phone would ask their market what they would like and then design the product. Mental health care is no different – the more the authorities and the experts listen to young people, the more successful our health care system will be. (ORYGEN Youth Health consumer; in James, 2007).

The Canadian Mental Health Association has taken the concept of consumer participation further, by advocating an approach based on a partnership between the mental health

consumer and the service (Trainor et al, 2004). Consumers and families are included as full partners, along with mental health service providers and generic social agencies, in the process of planning and operating the mental health system.

> These ideas of partnership and the redefinition of consumers and families as key players and change agents with a wealth of practical and experiential knowledge ... are the foundations for a policy approach that is centred on the lives of people with mental health problems. (Trainor et al, 2004: 1)

This shift from a consumer participation model to consumer partnership model has implications for services and mental health advocates in Australia, where the partnership practices have been more typically focused on partnerships between services and across agencies.

4.4 Holistic Approach to the Person

The fourth theme from the literature is to take a holistic approach to the person and their needs. This approach enables responses to a person within their community in all of their diversity and complexity. The approach is beginning to be adopted in some service provision, for example, following the advice from Aboriginal and Torres Strait Islander community practice, as reflected in the first guiding principle of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being. This principle states that health is viewed in a holistic context, encompassing mental health and physical, cultural and spiritual health. Equally, all people with mental illness and psychiatric disability benefit from a holistic approach to their recovery. The case studies in Section 7 exemplify the benefits of the approach.

The complexity of needs faced by Aboriginal people and communities is evident when understanding that problems associated with social and emotional wellbeing result from a systemic history of dislocation, loss, racism and social disadvantage (National Aboriginal and Torres Strait Islander Health Council, 2004: 3). Clearly, multi-dimensional approaches responding to the whole person's needs are required, alongside community based healing processes.

Similarly, a holistic approach to the provision of support also takes cultural understandings of mental health into account. For example, mental health problems experienced by migrants and refugees in Australia may be the result of the experience of torture, trauma, war and other human rights violations (Mental Health Coordinating Council). Refugees held in detention in Australia, including children, have been diagnosed as suffering from mental illness (for example depression and psychosis) as a result of the detention. A culturally appropriate mental health service response needs to understand and be sensitive towards these needs and their effect on culturally and linguistically diverse people and communities. A participant in *Reality Check* (Multicultural Mental Health Australia, 2004) summed up the shortcomings of not applying a holistic approach, 'It's a quick fix, they give you tablets instead of addressing the whole issue of you as a person.'

4.5 Living Independently

The fifth theme is to facilitate the person's independent living, in terms of their ability to live and enjoy normal lives in the community, as ordinary community members. Queensland Alliance and Queensland Health's 2006 state wide consultations for the Growing Mental Health Services across the Community Project found,

> The consistent message from both government and nongovernment service providers was that the most urgently needed services to support the recovery of people with severe to moderate mental illness were independent living and social support. (Queensland Alliance, 2006: 5)

They found that people need independent living skills and social support, defined as,

> … working in partnership with the person affected by a mental health issue to participate actively in their day to day living in the community. Independent living skills and social support is provided in the place where the person is residing on an as needed, or desired, basis. The intention of independent living skills and social support is to maximise a person's independent functioning and social competence in the community.' (Queensland Alliance, 2006: 5)

A social program in the United Kingdom, *Supporting People,* supports them to achieve a better quality of life through living more independently and maintaining their tenancies.

> The program provides housing related support to prevent problems that can often lead to hospitalisation, institutional care or homelessness and can help the smooth transition to independent living. (Office of the Deputy Prime Minister, 2004)

In 2004, the program provided housing related support services to over 1.2 million vulnerable people across the UK, with the purpose of developing and sustaining a person's capacity to live independently in their accommodation (Office of the Deputy Prime Minister, 2004).

A range of services and activities is tailored and packaged to a person's specific needs and may include assisting people to access their correct benefit entitlement; assistance with tenancy questions; advising on home improvements; and weekly home visits. The program operates through local Supporting People teams at a local authority (council) level and has recently introduced 'hub services' at a more regional level to improve coordination and information dissemination. An independent review of the program has recommended that *Supporting People* should be mainstreamed and become part of the everyday working of local authorities.

4.6 Participating in the Community

The sixth theme is that one of the keys to recovery in mental health is participation in the community. Recovery involves a process of restoring and developing a meaningful sense of belonging and rebuilding a life in the broader community despite or within the limitations imposed by that disability (Davidson, 2004). Stable housing provides the opportunity for people with mental illness to live and become connected to a local community. Consumer feedback and narratives have identified involvement in meaningful activities in the community as important to their recovery (Davidson, 2004). The social researcher and writer, Hugh McKay, in his address to the National Housing Conference (2008) concluded, 'Home is about belonging, being connected to the wider community.'

The HASI evaluation identified that one of the successes of the program was the increase in community participation. The evaluation showed that of the 100 clients who had complex mental health problems and high levels of psychiatric disability, 94 per cent had established

friendships, 73 per cent were participating in social and community activities and 43 per cent were working or studying. As reported to the evaluation by one of the participants,

> Without them (HASI Support Provider) I wouldn't be in as good a place as I'm in now, not just physically but having achieved some of the things I wanted to achieve – like my independence in living and in running my own life and stability in housing. (Muir et al, 2007)

The evaluation found that facilitating meaningful access to community can build a sense of social inclusion, build relationships and overcome feelings of loneliness. One participant said,

> If it wasn't for the [support provider] I would have just barricaded myself inside everyday and not gone anywhere; and because I have got good medication now and I have had the support from the HASI people, I can actually start to function a bit and get out and about in public and realise that there is a world out there and I should be a part of it. (Muir et al, 2007)

4.7 Multi-dimensional Support

The next group of themes relate to policy options. The first theme is about the range of housing related support that consumers require. These include formal support services, peer support, support for complex needs, early intervention and mainstream support.

Formal support services

Consumers in the Reynolds et al (2002) research identified the following areas of support as important:

- Assistance with practical and financial support to access housing;
- Assistance with daily living skills;
- Support to develop and maintain social networks;
- Assistance to manage health and wellbeing;
- Transport and mobility; and
- Assistance to live independently.

The Reynolds study (2002: 27) summarised the sources of support as including family, friends, co-residents, neighbours and mainstream community resources and services, as well as specialist mental health and disability services. The Mental Health Council of Australia (2006) refers to these supports as 'natural support', to encompass the broad range of people consumers identify as supporting them, for example local shop owners and youth mentors.

The HASI evaluation identified the three combined approaches to support applied in the program:

- A person-centred rehabilitative approach where support aims to change the person's cognition and behaviour to enhance personal efficacy and wellbeing;
- A person-centred disability support approach that acknowledges the practical difficulties of daily living and community engagement and aims to improve quality of life; and

- An advocacy approach that seeks to help people assert their rights and take greater control of the circumstances of their daily life (Muir et al, 2007: 26).

The evaluation identified the following as good practice approaches to support, within the context of the HASI program:

- Support plans are participant driven and reviewed regularly;
- Participant skills and strengths are identified and goals set with achievable steps;
- Support is flexible and follows routine and structure when required;
- Support is decreased when participants feel the program is too intrusive;
- Daily living skills are an important focus, along with recreation and social activities;
- Boundaries of responsibility are maintained;
- Key workers are trained to understand early warning signs of poor mental health;
- Key workers participate in social and recreational activities with clients to help build rapport and improve social skills;
- Key workers provide a preventive and interventionist role to help avoid mental health crises and failed tenancies; and
- Staff training includes core competencies, including first aid, behaviour management and substance use disorders.

The Mental Health Council of Australia (2006: 15) identified a number of housing and support factors as important for people with high support needs, including:

- Illness prevention and early intervention support at the initial signs of illness and prevention of relapse;
- Assisting people to live independently in their homes;
- Assisting people to participate in education, employment and the social life of their community; and
- Services to address the complexity of needs affecting people's lives, including dealing with coexisting drug and alcohol problems.

Peer support

Consumers also considered peer support processes, continuity of support with trusted workers and self-advocacy as important (MHCC, 2006). Queensland ARAFMI & Queensland Health (2004: 15) defined peer support as,

> … based on mutuality, equality, shared power and transparent decision making. The uniqueness of people and their life history is respected and through the sharing of stories peer support helps people understand their experiences and attach meaning to them.

Peer support provides a social network based on common experiences and that provides a sense of hope and role models. The ARAFMI (2004) paper reports on an evaluation of a peer support scheme in Victoria (Sweester Peer Centre, Brunswick Maine) in 2003 and identified the following successful features of the model:

- A sense of community and security that is not about fixing things, but about validation, acceptance, support, non-judgment and witnessing the experiences of others;
- Flexibility where a range of possibilities are explored;
- Potential for learning;
- Respectful mutuality and honesty with self;
- Safety in self-disclosure and a responsibility to ensure the safety of others; and
- Respecting the limits of individuals and the tolerance of the community.

The case study, Sharing Voices in the UK (Section 7.4), provides further evidence of the efficacy of using peer support in recovery approaches with people with mental illness.

Support for complex needs

In addition to other formal and peer support, a multidimensional approach to support is also inclusive of clients with complex needs, for example people with mental illness who also have problems related to drug and alcohol abuse, past experiences of violence and sexual assault or a history of involvement with the criminal justice system. Services and workers need to be highly skilled and trained to work across disciplines. A multidimensional approach to support is important when working with Aboriginal and Torres Strait Islander communities (Section 4.4). Health needs cannot be individualised or compartmentalised, as health for ATSI people is viewed within a holistic and community lifestyle framework (Brown, 2001).

An example of this broad community-based approach to support is reflected in the Social Health Teams, located within Aboriginal Community Controlled Health Services (ACCHS). The multi-skilled and multi-disciplinary teams provide social health services and support, responding to a wide range of support needs including suicide, mental health crises, substance misuse, grief, loss, trauma and violence. Teams may include mental health professionals, young people and family support workers, drug and alcohol specialists, sexual health workers, traditional healers, counsellors and mental health promotion workers (National Aboriginal and Torres Strait Islander Health Council, 2004: 30).

Early intervention

A fourth aspect of multidimensional support is an early intervention approach to mental health problems, as seen in recent government and community responses to young people with mental illness. Headspace is a good example. It is a Federal government early intervention program targeting young people with mental illness and substance use disorders.

Health promotion and improving mental health literacy are both early intervention strategies targeting the younger population. They also support wider community efforts to address the stigma, discrimination and ignorance associated with mental illness (Section 4.10). Mental health literacy programs for young people may include: whole-of-community campaigns; campaigns targeting young people; school based interventions aimed at developing young people's resilience; and programs training people to better intervene in a mental health crisis (Kelly et al, 2007). Patrick McGorry, Professor of Youth Mental Health, University of Melbourne argues for the need for specialist mental health services for young people. Young people need youth-friendly services that recognise and respond to their lifestyle and developmental needs (McGorry, 2007). McGorry (2007) argues specialist services strengthen the existing system with a better targeted stream of care and provide access to integrated mental health, substance use and vocational-recovery services.

Mainstream support

While much of the current literature on support refers to individualised support and individual support packages, most people, with or without mental illness receive support from mainstream services. Consideration of support needs of people with mental illness within these services is therefore necessary so that appropriate responses are embedded in the service system (Department of Human Services, 2006). Examples include co-location of mainstream services with support services for people with mental illness; a housing allocation system that respects the principle of consumer choice; training staff to work well with highly disadvantaged people; and planned and coordinated service responses. The aim is to develop 'supportive' systems able to underpin and strengthen local service models and approaches. Systems level support also has the ability to better provide access to mainstream housing and support services, not exclusively specialised (mental health or disability) services.

4.8 Diverse Approaches to Combining Housing and Support

The next policy option theme is the availability of a range of approaches to combining housing and support to meet consumers' needs and preferences. This includes various models of housing and support and overlaps with the Supported Accommodation and Assistance Program.

Models of housing and support

Rather than seeking to identify one 'best practice' model, the research points to the success of diverse approaches and models to effectively respond to the complex social needs of mental health and housing provision as well as to individual needs (Reynolds et al, 2002). The study identified the advantages in separating housing and support, either by having separate organisations or separate functions within the one organisation providing the housing and support. Separation aims to minimise conflict of interest and vulnerability of the tenant; and ensure the integrity of the landlord and support functions. Reynolds et al (2002) identified diverse models for linking housing and support, including:

- Housing formally linked to off-site support services;
- Interdepartmental agreements and protocols;
- Support packages or programs specifically targeted to tenants of low cost housing;
- Rights to nominate tenants to particular housing in return for guaranteed support for tenants;
- Coordination through general case management and care coordination programs;
- On-site support; and
- Local service networks, where services work together to develop approaches that increase the level of coordination of different services provided to individual clients.

A different approach to models that combine housing and support is suggested in the ACT *Housing for People with a Disability Discussion Paper* (2006), prepared by the ACT Department of Disability, Housing and Community Services (DDHCS). While the focus is more on housing than on support, they suggest the housing models incorporate support within the model, to maximise the sustainability of the approach compared to risks of support that is a separate 'add on' to housing. The housing and support models in the discussion paper include:

- Co-tenanting in social housing, where a person with disability co-tenants in a public or community housing dwelling with someone who does not have a disability. The tenant provides assistance and companionship to the person with disability, often in exchange for reduced or waived rent;
- Responsive landlord model for social housing, where the landlord provides tenancy support for people with disability (including tenancy management skills and life skills) to ensure they maintain their tenancy;
- Committed public housing stock for people with disability, where a fixed number of dwellings are committed for people with disability each year;
- Homeownership for people with intellectual disability;
- Family-governed models of housing, where families of people with disability establish housing cooperatives to provide homes for their children and members of the public within a community setting; and
- Support within family homes, for example through the provision of respite, day options and clinical support services (DDHCS, 2006: 7-10).

Tually (2007) examined government strategies to improve housing and support assistance for people with disability, including psychiatric disability. These strategies include increasing the capacity of new and existing support services; increasing the number, range and quality of in-home support services and community-based supported accommodation options; ensuring that people with disability or mental illness are able to access both mainstream and specialised support services; researching, developing and trialling new models of accommodation and support; building and ensuring the sustainability of the social housing sector as a viable and appropriate housing option for people with disability and /or mental illness; and increasing affordable housing options for this population group.

A recent Queensland model which combines housing and support is the Housing and Support Program (HASP). HASP supports people with a psychiatric disability to transition from Queensland Health extended treatment mental health facilities or acute care and integrate back into their communities. This is achieved through a collaborative partnership between Disability Services Queensland, Queensland Health and the Department of Housing.

Disability Services Queensland provides funding to non-government service providers to enable them to support people who have transitioned into the community. The program acknowledges that people may need a range of supports during their stages of recovery and aims to provide support to strengthen people's capacity to respond to any planned and unplanned changes in their lives.

Supported Accommodation Assistance Program

The Supported Accommodation Assistance Program (SAAP) is the major national program for responding to homelessness. SAAP services providing short, medium or long term supported housing for young homeless people, women and children escaping domestic violence and homeless men and women. The program does not specifically target people with mental illness and some SAAP services actually exclude them. However given the high prevalence of mental illness in the homeless population, SAAP services – by default if not by design – find that many of their clients have a mental illness.

SAAP services provide housing support (for example assistance to obtain and maintain independent housing); financial support (for example financial counselling); general support and advocacy (for example assistance with legal problems and court attendance); personal support (for example sexual assault support); specialist support (for example drug and alcohol intervention); and basic support (for example meals and transport) (NSW Department of Community Services, 2007).

While SAAP now funds a range of non-accommodation and outreach services, SAAP services have typically followed a transitional model of supported housing, beginning with a short-term refuge and moving on to medium and then longer-term accommodation. Transitional models of housing have been criticised for not offering secure housing or ways of building community participation and strong community connections (Muir et al, 2008). An American review of over 100 studies on transitional models of support (Carling, 1990), concluded that this approach potentially increases stigma, limits the development of transferable living skills and fails to effectively integrate people into the wider community. Transitional housing may simply continue people's housing uncertainty.

SAAP recognises outreach as a key service component of its funded services and is a priority in the current Agreement (Section 3.1); and outreach is recognised in the literature as an effective service approach for people with mental illness. As described in the NSW SAAP guidelines,

> Outreach services are seen as an integration of early intervention and post crisis approaches to service provision. Outreach services are delivered by SAAP support workers at a place where the client is currently living. This includes clients and their family living independently in either their own premises or in premises provided by the agency. (NSW Department of Community Services, 2007)

4.9 Linkages

In addition to housing and specialist support, responsive services also take account of links within housing support and to other parts of the service system. Recent research studies conducted by the Australian Housing and Urban Research Institute (AHURI) focus on the concept of 'linkages' between housing and support services for people with mental illness (Reynolds et al, 2002; Bleasdale, 2007). Reynolds defines linkages as:

> The term program linkages encompasses all of the ways that programs, services, sectors, governments and their departments interact, interrelate, work together, cooperate, network and collaborate to achieve coordinated responses for individuals. (Reynolds et al, 2002)

Reynolds et al identified three foundations for developing effective program linkages: the need to understand the impact mental illness can have on achieving housing stability; the importance of addressing housing needs and preferences; and effective service responses. The study identifies the following as key elements of effective service responses for people living with mental illness:

- The capacity for assertive outreach;
- Time to nurture and build a working relationship with the person;

- The ability to accommodate unpredictable life fluctuations and episodic illness without jeopardising housing and critical support;
- Consistency in service support providers;
- Undertaking cross service coordination and/or case management;
- Development of crisis management plans in collaboration with the person; and
- Addressing problems related to the sharing of consumer information, while respecting the rights to confidentiality.

Reynolds et al examined linkages in Victoria's Housing and Support Program, public housing and community housing. They found the features of the Housing and Support Program that were key to its success included: cooperative cross department planning; sufficient and reliable support services; protocols outlining working relationships between the housing and support services; effective approaches for obtaining client permission for release of information; and good working relationships between local housing officers and the psychiatric disability support staff.

In relation to the general public housing program in Victoria, the study identified the following factors as enhancing outcomes for people with mental illness:

- Broad understanding by housing officers of mental illness, how it can affect people's behaviour and how to work with such clients;
- Housing officers have a general knowledge of support services available in the local area;
- Good working relationships between housing and support providers;
- Gaining clients' permission for release of information to enable the housing officer, support providers and clinical services to work in an informed and coordinated manner to support the tenancy;
- Housing officers know who to contact if a tenant has a mental illness episode;
- Diversity in housing stock;
- Greater flexibility in the ability of local housing offices to respond to the needs of tenants, including the ability to match stock to the client's needs;
- Involvement of housing officer in the initial planning for new tenants with complex needs;
- Appropriate support services to respond in a timely manner; and
- When necessary, clinical support services and Community Treatment Orders to ensure the client takes their medication to manage the illness and increase chances of sustaining their tenancy (Reynolds et al, 2002: 31).

The study identified that the community housing sector did not face the same constraints and challenges of public housing in supporting tenants with complex needs to sustain tenancies. Reynolds et al argue for strengthening the focus of social housing on achieving sustainable tenancies.

> The smaller scale, scope and often more specialised knowledge of tenant needs in community housing, as well as the capacity to develop locally

> tailored processes, enhances their ability to achieve effective coordination between housing and support. (Reynolds et al, 2002: vii)

The more recent AHURI study on housing of people with complex needs identifies three factors as key to successful linkages: individualised solutions; local area solutions; and less emphasis and reliance on 'models' (Bleasdale, 2007).

Better linkages, also referred to as partnerships or inter-agency cooperation, is central to the whole-of-government and cross-agency approaches now routinely employed by governments across Australia at Federal, State and local government levels. For example, the NSW government has established the Partnerships Against Homelessness (PAH) to provide a cross-government response to homelessness. One of PAH's initiatives is the Joint Guarantee of Service (JGOS) to coordinate support services for people with mental illness accessing housing and homelessness services. JGOS aims are to better assist and enhance the wellbeing of existing social housing tenants whose tenancy may otherwise be at risk; and assist social housing applicants who have mental health problems who may be homeless or at risk of homelessness to successfully establish a tenancy (NSW Department of Housing, 2008).

Better linkages are a characteristic of the ACCESS Program in the USA, which aims to prevent homelessness among people with mental illness. The program successfully engaged homeless adults with severe mental illness in psychiatric treatment and community-based housing with support. The evaluation of the ACCESS demonstration projects identified the following policy implications:

- Service systems must be integrated at all levels to remove barriers and promote efficient use of services through integration of psychiatric services with housing, social services, substance abuse treatment and the criminal justice system;
- Substance abuse treatment must be an integral part of comprehensive psychiatric services for people with severe mental illness;
- A range of housing options is required. While independent living with the availability of support services is preferred by most people with mental illness, a diversity of choices is important to reflect personal preferences;
- Preventive health care and education are critical, especially relating to the risks of HIV/AIDS, tuberculosis and smoking; and
- Longer-term follow-up studies should focus on how to sustain early gains (as reported in Homelessness and Mental Health Linkages).

4.10 Addressing Stigma, Social Exclusion and Discrimination

The final two relevant themes from the literature relate to system wide problems. The first is stigma, social exclusion and discrimination experienced by people with mental illness (eg. Boardman, 2004). Their experience of exclusion from relationships, communities and services is exacerbated by co-morbidity and difference, for example discrimination because of cultural difference, drug and alcohol use and rural location. Stigma, often resulting in isolation, was the most common problem raised in a series of national consultations to better understand the needs, concerns and aspirations of people from culturally and linguistically diverse backgrounds with mental illness (MMHA, 2004). The consultations were conducted in 2001 by the National Ethnic Disability Alliance, Multicultural Mental Health Australia and the Australian Mental Health Consumer Network.

Stigma led to feelings of shame, resulting in significant barriers for people seeking support. As reported by participants, 'Mental illness is a taboo subject, it is very sensitive and people are embarrassed so they don't go to mental health services.' (MMHA, 2004) CALD participants spoke about how mental illness was considered a private and personal matter, compounded by a range of cultural beliefs and norms,

> We come from cultures and countries where if you have a mental illness, you end up being locked up and the keys are thrown away … [mental illness] is seen as a price for past sins or a family curse and the family has to cop it without outside help. (MMHA, 2004)

Stigma and discrimination may be internalised, serving to further isolate the person with mental illness from support, for example in the case of culturally and linguistically diverse communities. 'Some ethnic communities experience high levels of stigma and shame associated with mental illness and are consequently less likely to access services.' (MHCC, 2008) Often associated with stigma and shame are social isolation and feelings of loneliness. Despite the positive evaluation of the HASI program and increase in community participation and inclusion for its participants, the study showed that feelings of loneliness persisted for approximately half of the group (Muir et al, 2007).

Exclusion is also aggravated by other co-morbidities such as drug and alcohol use because of the complexity of their support needs (Section 4.7). For example, *Not Welcome Anywhere* found that people with mental illness and drug and alcohol problems are often excluded from services, in some cases they will be on the 'banned' list of clients, whether the list be official or not (McDermott, 1993).

South Australian research examined stigma around mental illness and psychiatric disability existing in rural and remote communities (Fuller, J. et al, 2000). Respondents living in northern and western South Australia were interviewed, including mental health and generalist health professionals, other human service workers and mental health consumers. Three themes were identified: reluctance to acknowledge mental health problems and avoiding appropriate help; stigma and avoiding mental health services; and the influence of rural and remote circumstances. Most informants considered that many mental health problems were amenable to help from generalist workers, with backup support from mental health specialists. Informants thought this generalist and backup intervention to be appropriate because a common view of mental health problems as 'insanity' and a culture of self-reliance created a reluctance to seek help from a mental health specialist. The study recommended these themes be taken into account when designing mental health interventions for rural and remote communities (Fuller, J. et al, 2000).

Comprehensive and concerted community wide responses are necessary, incorporating systemic advocacy and community education, to redress the stigma and discrimination currently experienced by people with mental illness and to build communities based on social inclusion rather than exclusion.

4.11 Diversion from the Criminal Justice System

The final system theme is the relationship between the needs of people with mental illness and the criminal justice system. The multidirectional relationship between mental illness and corrective services and failure to divert people to more appropriate support has raised questions about whether prisons are mental health institutions of the 21st Century, given the very high numbers of prisoners who also have a mental health or psychiatric disability (White

& Whiteford, 2006). At the extreme, some literature refers to the criminalisation of mental illness (Sigurdson, 2005), suggesting that therapists and hospitals have been replaced with police and the criminal justice system. The sharp rise in the prison population in Australia over the last decade only exacerbates the problems for people with mental illness (Baldry et al, 2006).

White and Whiteford (2006) noted the shortage of appropriate housing and rehabilitation available to prisoners on release, with efforts to divert prisoners on remand to better treatment and support programs as an alternative to incarceration. They argue that imprisonment should be the last resort for people with mental health problems. Baldry et al (2006) concluded that accommodation instability is a predictor of return to prison. They identified a strong association between ex-prisoners, poor accommodation and lack of social integration and argued that, 'close coordination among agencies and a greater variety of housing types with support, not just ex-prisoner hostels, are required to begin to address post release housing problems.' (Baldry et al, 2006) They interviewed 339 inmates in NSW and Victorian prisons about to be released and found that 73 per cent in NSW and 58 per cent in Victoria reported they were given no information on accommodation or support options pre-release. Sixteen per cent expected to be homeless or did not know where they were going post release. Participants interviewed post release identified two critical factors in preventing their return to prison: the suitability of their accommodation and support that they assessed as helpful.

> Any support associated with housing post release was investigated with 151 [people] saying they received some support, mainly moral with other forms being financial, social and counselling. Participants' self-assessment as to whether the support was helpful, like the suitability of their accommodation, was highly correlated with recidivism. Only 14 (18%) who said the support was helpful returned to prison, whereas 52 (69%) of those who said it was unhelpful returned to prison. (Baldry et al, 2006)

Aboriginal and Torres Strait Islander people are particularly vulnerable to coming into contact with the criminal justice system. As was reported to the Burdekin Inquiry by an Aboriginal mental health worker, 'We know that [Aboriginal] people that have a lot of mental health problems are picked up by the police and they usually end up in jail ... We feel that's not good enough.' (HREOC, 1993: 698)

4.12 Summary of Themes from the Literature about Facilitators

In summary, an identification of the key themes from the literature on mental illness and housing, with an emphasis on Australian literature, has identified facilitators to effective housing and support as focusing on goals for people with mental illness; a range of policy options to meet housing and support and the links between them and to other parts of the human service system; and system wide problems of discrimination and failure of support leading to repeated contact with the criminal justice system.

The common theme to these facilitators is the recovery approach, focusing on sustainable participation and inclusion in the community. Section 5 applies these findings from the literature and the consultations with people using and working in the Queensland mental health system to inform the development of principles for effective housing and support.

5 Principles for Effective Housing and Associated Support

The research identifies ten principles as key to effectively achieving sustainable housing for people with mental illness or psychiatric disability: recovery approach, person-centred support, facilitation of the person's housing needs and preferences, choice in independent living, responsiveness to population needs, separation of housing and support, interagency collaboration and coordination, individual and systemic advocacy, long-term perspective of housing and support needs and preventing homelessness**.** The facilitators are applicable to the four policy types (housing, housing associated support, social and personal support, and clinical and allied health; Section 2.1).

The section structure is a description of the principle, examples and evidence from the Queensland consultations, which asked respondents to comment on the principles (Appendix 1). The consultations affirmed the ten effectiveness principles, agreeing they were sound and sufficient. They identified a missing link as achieving a path from principle to practice. Section 6 discusses the implications of the principles for cost effectiveness analysis of policy options. Section 7 presents some case studies of the principles in practice and Section 8 discusses implications of the principles for policy change.

5.1 Recovery Approach

A recovery approach to housing and support policy aims to achieve sustainable housing through translation of recovery into supporting daily activities in a socially inclusive environment. 'Recovery in severe psychiatric disability involves a process of restoring or developing a meaningful sense of belonging and positive sense of identity apart from one's disability and then rebuilding a life in the broader community despite or within the limitations imposed by that disability.' (Davidson, 2004)

An example of a program based on the recovery approach is Project 300, a Queensland government initiative that provides housing and support to people with a psychiatric disability who previously lived in institutions. The purpose of Project 300 is 'to assist people with a psychiatric disability to live as community members.' The project's principles are that:

- consumer involvement is paramount;
- relationships and community involvement is needed;
- advocacy is critical; and
- recovery underpins everything.

A more recent program initiated in Queensland and also based on the recovery approach is the Housing and Support Program (HASP). HASP operates under the Council of Australian Governments (COAG) Mental Health Plan, with the Queensland government committing to provide places for 80 people in the first year and 40 people per year from 2006 to 2011. Our interview with a Department of Housing manager noted that HASP has had good outcomes, having housed and supported 100 people, with only one eviction to date.

The consultations emphasised the need for meaningful activities in the community as important for recovery and sustained housing tenancies. Queensland Alliance suggested that without meaningful activities people may become negatively involved in Department of Housing disputes and conflicts, or they may become inwardly focused resulting in the deterioration of their mental health. The consumer focus group spoke of the need to have

something meaningful to do during the day and 'not being forced to go basket weaving or work in a sweatshop.'

The multidirectional relationship between homelessness and mental illness was demonstrated in the history of a mental health consumer in the consultation. While she and her husband fell homeless due to mental and physical illness; their son became mentally ill after four years of housing insecurity involving 'couch surfing', living on the streets, experiencing violence and being placed on the private real estate TICA black ban list.

Access to housing, a prerequisite of recovery, was raised in the consumers group. For example one respondent spoke positively about a community housing organisation that provided access ('let me in') without references or waiting. Another respondent said that access to housing had been facilitated by 'presenting well – and this is wrong!'

While a recovery approach supports the right of people with mental illness to housing, the reality can be the opposite, where landlords have the 'attitude that you should be grateful for what you've got and if you don't like it you can leave.' Such attitudes undermine the right to housing. The consumers group concluded that 'housing is a fundamental issue for recovery – you need a place to recover and to have a life that is broad and beyond the recovery focus too.' The Housing Department manager suggested that housing tenancies were 'sustainable in the long term as long as the recovery paradigm is the driver, as the person changes over time, the person themselves is a key part of the process.'

5.2 Person-centred Services

Person-centred services aim to plan and implement housing and support around the person's identified needs and preferences. The approach is characterised by assertive outreach; time to nurture and build a working relationship between the person and support workers; commitment to ongoing regular support, including periods of intensive support during the initial settlement and when the person is may be unwell; ability to provide support outside business hours; consistency in the service providers and workers offering support; clinical intervention when the person is unwell or in crisis; consumer advocacy; and working with the whole person in all their complexity and diversity, including drug and alcohol and criminal justice.

The consultations emphasised the need for people who have been homeless to receive the 'right support', including non-clinical support to assist people to engage with the community and maintain tenancy (Queensland Health Senior Policy Officer). A case example from a nongovernment service provider suggested that the significant reduction in hospitalisations for a client (from 42 hospitalisations in 52 weeks to 5 hospitalisations over the last 13 years) was attributed to 'having meaningful support in her life.' The importance of having good primary care and access to general practice was raised by several respondents. 'Physical health is often not looked after properly and if people get physically sick, their mental health suffers.' (Queensland Alliance)

A consumer's narrative demonstrated the importance of working with the whole person in all their complexity; she and her husband suffered from a number of intellectual disability, mental health and physical health problems. The researcher found, 'She felt they are trapped between the disability sector and the mental health sector, with no-one willing to take them on.' When asked what would help them, the consumer responded 'more personal service – people actually coming to see what the problems are, not relying on the phone.'

The consumer focus group discussion also underlined the importance of person-centred services that treat consumers with respect and that 'do what people say they need – solve immediate problems and work to develop a plan to resolve long term issues.' Participants identified the importance of outreach support so they did not have to go to hospital; in addition, support to meet new neighbours. The importance of natural support was raised. To the question, 'What has helped you get and keep housing?' respondents' replies included their mum's friend and brother.

Stakeholder interviews confirmed the complex needs that many of their clients have and suggested that even with support, tenancies can fall apart. However, even in a failed tenancy, the consumer may have learnt valuable lessons from the tenancy and the next tenancy may succeed and be longer term.

Evidence relating to the efficacy of the person-centred approach is in Sections 6.2 and 7.2, which report the evaluation findings of the NSW Housing and Accommodation Support Initiative (HASI). HASI is an example of person-centred services for people with mental illness.

5.3 Primacy of the Person's Housing Needs and Preferences

Facilitating the primacy of person's housing needs and preferences in the allocation of a housing tenancy aims to prioritise the person's interests over organisational interests. Examples of preferences and needs include housing affordability (such as public or community housing); location (such as close to public transport, shops, family and community networks); and a choice of living arrangements (such as who to live with and whether the housing is dispersed in the community or co-located with other people with similar needs).

The quality of the housing was raised by participants in the focus group, who were concerned about the 'boxy little bed-sits' they had been offered. Participants indicated they had very little choice regarding their housing; for example being forced to share housing to make it affordable; living in 'dumps' because of the long waiting lists for public housing; and having 'no choice of where you live.' Another problem raised was the slow response time for repairs and maintenance, which, 'can disturb people's balance and negatively affect their mental health.' The importance of living in a 'mixed community' was reiterated.

5.4 Choice for Independent Living

Facilitating choices in independent living applies a developmental approach to skills, decision making, financial management and community participation. It has the expectation of widening consumers' choices for independent living through maximising their abilities. Examples include support for managing tenancy, such as taking out a lease and paying the rent; living skills, such as cooking, cleaning and budgeting; and participation in the community, for example using public transport, community facilities and employment and training.

Focus group members' responses to 'What does good support look like?' emphasised participation in the community as important to recovery and independent living. Respondents spoke of 'connectedness,' 'where you're a part of a living, breathing community' and 'thinking about the long term life!'

5.5 Responsive to Population Needs

Service and system-wide approaches that are sensitive and responsive to the cultures and needs of different population groups aim to be inclusive of diversity by addressing preferences and needs likely to be associated with these groups. Examples include addressing the needs associated with Indigenous communities; culturally and linguistically diverse (CALD) communities; gay and lesbian people; responsive to gender and age, including women, parents, younger and older people with mental illness; and different co-morbidities including drug and alcohol and criminal justice histories. Service examples include employing Indigenous workers, providing information in community languages about the treatment and prevention of mental illness. It also has implications for housing stock, such as physical access, location, size and co-location.

The consultations raised shortcomings in the support for Indigenous people with mental illness or psychiatric disability, particularly in northern Queensland. A homeless project has been initiated in Mount Isa and the government is considering establishing family supported housing for Indigenous people with mental illness.

A nongovernment organisation provided case examples showing how housing problems for women with mental illness can be different than for men, including having fewer shelters for women, lack of safety in sleeping rough, having lost possessions that make up a woman's home, losing contact or custody with her children and becoming dislocated from her family. Women with mental illness often face cyclic domestic violence relationships. The example was given of the domestic violence centre on the Sunshine Coast working closely with mental health services to respond to this interrelationship.

5.6 Separation of Housing and Support

Separating the organisation of housing and support by independent organisations or by separate functions within the one organisation aims to minimise conflict and ensure integrity of landlord and support functions. For example, housing provided by a public or community housing provider or private landlord and other support contracted to a local nongovernment organisation. While the consumer group spoke of the importance of separating the housing from the support, emphasising that 'having them connected makes you too vulnerable', a stakeholder interview suggested this was not a 'black and white' issue, and in some cases 'blended support' had benefits for people with mental illness. The separation of housing and support relies on good coordination and sharing of information on a need to know basis, with the knowledge and consent of the person.

5.7 Interagency Coordination

Interagency collaboration and coordination aims to focus the service on the needs of the person rather than the organisational boundaries. It includes partnerships between housing providers and providers of support; and referral to the range of clinical, nongovernment, government and private services relevant to people with mental illness. It also includes supporting informal social networks of families and friends. Examples are sharing client information without infringing privacy and confidentiality rights; forming local area housing and support networks to provide integrated services to people with mental illness. A benefit is capacity to provide integrated support to a wider population group through referral to mainstream and specialist services.

To the question of what works well, one respondent in the consultations identified the need for the three agencies (clinical, non-clinical and housing) to 'work together around and with

the individual.' Respondents raised the importance of having a single point of contact for the person, 'a lead person who will communicate with the other points of the triangle to resolve problems.' Coordination was viewed as so vital, that without it 'things will fail.' (Queensland Health Senior Policy Officer)

A risk of joint agency responsibility for programs is that government agencies pass responsibility to another agency, unless protocols are agreed. The consultations raise the case example of a person with mental illness funded under the Queensland Housing and Support Program, which has a tripartite agreement between Housing, Health and Disability Services.

> We're struggling because we have a duty of care to this person, but the three government departments that do have a duty of care to her are all saying they don't want anything to do with her.' (nongovernment service provider)

Government agencies do not always collaborate in ways that produce positive outcomes for the consumer. An example was given of a woman with mental illness at risk of eviction. While the Housing Department asked Queensland Health to provide her with assistance, the health agency would not assist unless the client agreed to enter into drug and alcohol treatment. The woman was evicted, according to a Housing Department manager.

Local Partnership Agreements seem to work well at promoting effective local collaborations across government and nongovernment agencies, according to a Housing manager. However, limits to the capacity of the non-clinical support sector, along with a perceived lack of expertise, were also raised. An example reported was delayed releases from hospital because support organisations did not have staff to support the consumers. Similarly, the consumers gave examples where the impact of one poorly trained or performing worker, for example from Centrelink or Mental Health Services, can have a greater impact on the lives of people with mental illness, than the policies of government agencies or nongovernment organisations. 'If they are having a bad day, or just don't like you, you don't get anything.'

5.8 Individual and Systemic Advocacy

Individual and systemic advocacy approaches based on the rights, interests and well-being of people with mental illness aim to address discrimination, social exclusion and stigma experienced by people with mental illness in their homes and communities. Advocacy can be understood as speaking, acting or writing, with minimal conflict of interest, to promote and protect the interests, well-being and rights of people with disability. Examples include individual advocacy for Indigenous people with mental illness, unable to access private rental market tenancies due to discrimination and racism; and individual advocacy for older homeless people with mental illness to obtain public housing.

Systemic advocacy seeks to address society-wide issues of abuse, neglect and exploitation of people with mental illness or disability. Importantly systemic advocacy moves beyond direct housing and support services to advocating and building inclusion in mainstream services, community networks and civil society. According to the Combined Advocacy Groups of Queensland (CAGQ) systemic advocacy seeks to influence or secure positive long term changes that remove barriers and address discriminatory practices to ensure the collective rights and interests of groups of people with disability are upheld. This may occur through pursuing positive changes to legislation, informing people with disability about their rights and influencing positive community attitudes towards people with disability.

One of the systemic issues identified in the consultations was negative community perceptions of people with mental illness as a barrier to recovery. Participants suggested considering 'how to promote people in a positive light so they are not discriminated against.' (Queensland Health Senior Policy Officer) Discrimination by private real estate agents was raised in the focus group discussion, with a number of participants on the TICA black-ban list. Consumers said that landlords make negative judgements about the sort of tenant they will be. One consumer reported that emergency hospitalisation can result in placement on the blacklist. A focus group participant also discussed the advantages of having an individual advocate, 'Unless you've got someone who knows the system, you don't get anything.' An implication arising from these views is that there needs to be increased support and resources to enable consumers to express their views, and increase opportunities to access individual advocacy, which would require resources to increase the capacity of agencies that currently provide advocacy, or to establish individual advocacy agencies. In this regard, consideration needs to be given to the issue of what resources would be required to develop the capacity of the advocacy sector to improve access to individual advocacy for people with mental illness. Further, similar consideration need to be focused on capacity in the systemic advocacy sector

5.9 Long-term Perspective of Housing and Support Needs

A long-term perspective of housing and support aims to achieve continuity of support through sustained tenancies and support. It contrasts with a short-term focus on a current housing crisis that compromises the goals of housing and support policy (Section 2.1). A long term perspective aims to nurture and strengthen family, peer and informal support; allocate appropriate long-term housing and provide support to develop the ability to sustain the tenancy. The limitation of providing short term, time limited transitional support was identified in the consultations. A nongovernment service provider reported that longer term support was required to recover from the experience of institutionalisation and long term mental illness and that 'people you see in transition need more than 6 months – they need 3-5 years' to achieve sustainable housing.

5.10 Preventing Homelessness

Preventing homelessness aims for housing conditions and support that strengthen the sustainability of the tenancy. Examples are where support incorporates risk management and service fluctuation to address the episodic nature of some mental illness, such as maintaining housing and support when the person is hospitalised for a short period while unwell; or using early intervention planning to offer clinical support at the early signs of illness.

The consultations raised the problem of how preventing homelessness is increasingly difficult because of financial pressures and housing costs. Another key problem identified was intergenerational homelessness and mental health, with a mental health consumer speaking about how her son is now facing homelessness and mental illness experienced by his parents. Their story also showed how incidence of ill health, either physical or mental, can plunge a family who were purchasing their own home into long-term housing insecurity and periods of homelessness.

Prevention of homelessness is difficult to achieve when affordable housing is in such short supply. A stakeholder interview cited hostel closures as further reducing housing availability. She gave the example of the day before the interview where 30 people in a Brisbane suburb were given 2 hours notice to leave due to a hostel closure, causing housing dislocation and stress.

6 Cost-Effectiveness Factors

This section considers the principles for effectiveness in the context of economic evaluation of policy options. It presents data about economic analysis of effective policies in operation in other states and internationally and draws conclusions for decision making about which policies to prioritise in the Queensland context.

6.1 Economic Appraisal of Housing and Support

Economic appraisal is a technique that systematically analyses all the costs and benefits associated with the various ways of meeting an objective (NSW Treasury, 2007). The distinction between standard evaluations of process and impact and economic appraisal or evaluation lies in the importance of measuring costs as well as activities and benefits (Meadows, 2007). Two main types of economic appraisal are relevant to housing and support for people with mental illness or psychiatric disability: cost effectiveness analysis (CEA) and cost best analysis (CBA).

In the health area, the most widely used economic evaluation framework is CEA. With CEA, the costs and outcomes of housing and support for people with mental illness or psychiatric disability are compared with the costs and outcomes of an alternative program with no intervention (Flatau et al., 2006). CEA compares alternative programs to examine the least expensive way to produce a particular outcome, or what is equivalent, maximise a particular type of outcome from a given expenditure (van Kool, et al., 2008). CEA is appropriate for projects for which the major benefits cannot be valued in dollar terms or when it would be unduly expensive to undertake the valuation (NSW Treasury, 2007).

The practice of CBA is to monetise costs and benefits recognising that, regardless of the activity chosen, there are opportunity costs and forgone benefits to other stakeholders. CBA is generally conducted from the perspective of society at large; that is, the benefits and benefits forgone affecting not only the people with mental illness or psychiatric disability and families participating in the support or intervention program but also the whole of society. The hidden, implicit and indirect benefits to different members of society are considered not only over the life of the program but also into the future; that is over the expected timeframe for which the program is anticipated to have an impact on participants (van Kool, et al., 2008).

Pinkney and Ewing (2006) found that there was no tradition of cost-benefit analysis in the field of homelessness research in Australia and very few international economic evaluation analyses that include CBA or CEA, beyond cost analysis (Flatau, et al., 2006). The remainder of the section reviews some of the analyses.

A review of the literature on the effectiveness of housing and support interventions for people with mental illness who have been homeless was conducted by Nelson, Lafrance and Aubry (2007). Their appraisal was conducted on 16 controlled outcome evaluations of housing and support, assertive community treatment (ACT) and intensive case management (ICM) interventions for people with mental illness who have been homeless. Nelson et al., (2007) computed the effect sizes for housing outcomes to determine the magnitude of impacts of different interventions enabling them to conduct comparison of the relative impacts of the different types of housing and support, ACT and ICM. They concluded that although housing and support, ACT and ICM appear to be successful, the provision of permanent housing to homeless mentally ill people produces relatively large effects on their housing status (average

effect size=0.67)[1] and higher than those for ACT (average effect size=0.47) (Nelson, et al., 2007: 358). This study concluded that money is saved from the different forms of interventions because of reduced use of shelters, jails and hospitals. However, overall costs increased, at least in the short term, by about US$2,000 per person per year (US 2003 dollars) from the utilisation of other services. They concluded this additional cost is a small investment because savings could be expected to be achieved once long-term housing stability is achieved (Nelson, et al., 2007).

6.2 NSW Housing and Accommodation Support Initiative (HASI)

The Housing and Accommodation Support Initiative (HASI) in New South Wales is a program funded by the NSW government to ensure stable housing linked to a range of levels to specialist support for people with mental illness, discussed elsewhere in this report, and in detail in Section 7.2. Cost-effectiveness analysis was undertaken to provide information about the value added by HASI with the benefits of the program detailed in physical and social terms (e.g. quality of life gained) and not monetised (Muir, et al., 2007: 32). The cost per person was estimated for start-up at $110,337.88 and a recurrent annual cost of $57,530. This does not include a number of costs factors such as the recurrent program management costs by the NSW Health Department, the cost to HASI participant, family and other services providers (such as GPs), or foregone costs because resources (such as management and housing stock) were spent on HASI rather than elsewhere (Muir, et al., 2007). The measured outcomes from this project were as follows:

- The provision of secure affordable housing, with 85 per cent of participants remaining with the same housing provider;
- An increase in community participation, with 94 per cent of participants establishing friendships, 73 per cent participating in social and community activities and 43 per cent working and/or studying;
- Improved physical health, with over 50 per cent of participants reporting improved physical health from regular access to general practitioners and specialists, as well as improved diet and increased physical exercise;
- Improvement in psychological wellness, with 68 per cent of participants reporting improvement in symptoms, social and living skills and a decrease in psychological distress;
- Reduced hospitalisation rates, frequency and duration, for 84 per cent of participants;
- Increased connection with community mental health services, with 92 per cent of participants in regular contact with their case managers; and
- Improved family connectedness, for 81 per cent of participants.

6.3 Cost-effectiveness of Homelessness Prevention and Assistance Programs

Flatau et al., (2006) undertook a study on the effectiveness and cost-effectiveness of homelessness prevention and support programs operating in Western Australia. The study is restricted to services operating in Perth and South-West and Southern regions of Western

[1] 'Effect Size' is a way of quantifying the effectiveness of a particular intervention. An effect size is the size of the relationship between two variables and is usually defined as the difference in mean outcomes between the treatment and control group.

Australia. The programs covered by the project are the main support programs for people who might otherwise be without shelter or people escaping domestic violence – SAAP and the Crisis Accommodation Program (CAP) – and a range of homeless prevention programs in West Australia funded by the West Australian government. The later comprise of the Community Transitional Accommodation and Support Services (TASS) and the Community Re-entry Coordination Services program designed to assist prisoners re-enter into the community on release; and the Supported Housing Assistance Program (SHAP) and Private Rental Support and Advocacy Program (PRSAP) designed to assist public and private tenants maintain their tenancies (Flatau, et al., 2006: 4).

Net costs using population offsets

Target group/program	Program cost per client $ (1)	Program costs net of 'population offsets'			
		Health & justice offsets / person/year $ (2)	Cost/client net of annual offsets $ (3)=(1)-(2)	Average life outcomes/ person $ (4)	Cost/client net of average life outcomes $ (5)=(1)-(4)
SAAP-DV & Single Women	4,625	9,701	-5,076	241,068	-236,443
SAAP- Single Men	4,625	10,212	-5,587	267,776	-263,151
SAAP-Families & General	4,625	11,967	-7,342	312,080	-307,455
PRSAP	2,842	7,647	-4,805	188,846	-186,004
SHAP	3,835	13,184	-9,349	332,315	-328,480
TASS	14,340	39,690	-25,350	1,141,948	-1,127,608
Re-entry Link-no accom	1,826	39,690	-37,864	1,141,948	-1,140,122
Re-entry Link with accom	6,326	39,690	-33,364	1,141,948	-1,135,622

Source: Flatau et al (2008)

For all programs, it was determined that the value of annual 'population offsets' is greater than the annual value of program recurrent funding plus capital costs. In most cases annual population cost offsets are more than twice the annual values of program recurrent funding plus capital costs. Flatau et al., (2008) concluded that there is significant potential for net government cost savings from the provision of housing assistance.

6.4 Supportive Housing for Homeless Persons with Severe Mental Illness

Culhane et al (2002) assessed the impact of public investment in supportive housing for homeless people with severe mental disability in New York, between 1989 and 1997. The program was funded to develop 3,600 community-based permanent housing units for homeless persons with severe mental illness. The two models used were: the first, supportive housing, included scattered-site housing with community-based service support and single-room occupancy housing; and the second community residence facilities, includes community residences, long-term treatment facilities and adult home (more clinical). The study focused on the costs associated with shelter use, mental health services, medical care and criminal justice. The mean cost of service utilisation for the two-year pre placement period was US$40,451 (1999 US dollars), the bulk of the expenditure occurred in health services and in emergency shelter services. Placement in the housing programs cost US$12,146 (1999 US dollars), a net reduction in service use per annum per person, with 95 per cent of the cost reductions associated with reduction in health and shelter services. The results demonstrated by the project are as follows:

- An 85.6 per cent pre/post placement decline in the mean number of shelter days used by persons with placements;
- Holding other factors constant, a placement is associated with an estimated reduction of 75.3 days state in state hospitals; and
- A placement was found to be associated with a reduction of 7.9 days of incarceration, representing an 84.8 per cent reduction in the mean pre-intervention days spent incarcerated (Culhane, et al., 2002).

This study is criticised by Flatau et al. (2006) as having overlooked some indirect and direct costs of services used by this group such as outreach services, drop-in centres, costs to victims of crime, court cost and the social cost of accommodating homeless people in public spaces. Culhane et al. (2002) paper is further critiqued for not including potential benefits of supported housing for this group of people, such as paid employment, quality of life and value of reduced homelessness (Flatau et al., 2006).

6.5 Costs of Homelessness

Eberle et al (2001) analysed the cost of homelessness in British Columbia, Canada in relation to health care, social services and criminal justice. They analysed whether the provision of adequate and affordable housing is a preventive cost to the government. The method is an exploratory use of case histories and service use records for two subsets of people – homeless people and housed formerly homeless people (Eberle, et al., 2001: 1). Their study found that in 1998-99, providing major government health care, criminal justice and social services (excluding housing) to the homeless people cost on average 33 per cent more than the housed people (Can$24,000 compared to $18,000 Canadian 1999 dollars).

Eberle et al. (2001) identified that supportive housing options have the potential to stabilise illness and reduce the need for the more intense levels of service. This was identified as an effective option for people who may have been chronically homeless and who have the greatest difficulty in obtaining and maintaining housing. This model had been recognised as helping people end the cycle of homelessness, stabilise their lives and re-establish connections with the community. When combined, the service and shelter costs of the homeless people in the study ranged from Can$30,000 to $40,000 on average per person for one year. This is more than the housed people range of Can$22,000 to $28,000 per person per year (Can 1999 dollars) (Eberle, et al., 2001: 4). The study concluded that by providing adequate supportive housing for the homeless people saves the provincial [state] government money.

6.6 Housing Costs for Adults with Mental Illness, Massachusetts

Dickey et al. (1997) evaluated the costs to the Massachusetts mental health agency of two different housing conditions for adults who are homeless and mentally ill. One hundred and twelve clients that were living in psychiatric shelters were randomly assigned to one of two housing types: Independent Living (IL) apartments and Evolving Consumer Household (ECH). The ECH model offers residents permanent secure housing without the requirement of treatment compliance. ECH staff were trained to promote resident independence and staff time is gradually reduced as the residents learn how to manage their house themselves and set their own house rules. In addition, the other goals for ECH model were to assist residents to reduce isolation, to provide paraprofessional monitoring of the residents' clinical condition and to offer skills training in managing the house (Dickey et al., 1997: 292). IL apartments were one or two-room single apartments in public housing subsidised by the State public

housing authority. The residents assigned to IL apartments received a variety of support services from the mental health department.

Dickey et al. (1997) estimated that all per person expenditures for treatment, case management and housing mean annual cost per person for people assigned to an IL apartment was US$29,838. It was significantly less than the mean of US$56,434 for people assigned to ECHs (1997 US dollars). Of the total costs, housing represented about 44 per cent of costs for people assigned to apartments and 76 per cent for people assigned to ECHs, a difference accounted for largely in the ECH staffing costs (Dickey et al., 1997: 300). Two measures of housing outcomes were used in the analysis: the percentage time housed, defined as the proportion of days homeless and housing stability. The housing and treatment outcomes showed no difference between people assigned to ECHs or ILs. The provision of permanent housing did not prevent future sessions of homelessness for some people. About 25 per cent of the participants became homeless sometimes during the study period. Most of the 25 per cent spent a few days in homeless shelters (Dickey et al., 1997: 302). Modest negative associations were noted between mean annual treatment expenditures and percentage time house and housing stability. No relationship was found between changes in mental health status and treatment or case management costs (Dickey et al, 1997: 303).

6.7 Homeless Chronically Mentally Ill Veterans Program

Rosenheck et al (1993) evaluated the impact of a Department of Veterans Affairs (VA) outreach and residential treatment program for homeless mentally ill veterans on utilisation and cost of health care services provided by VA. The study used American national databases maintained by the VA to examine changes in homeless mentally ill veteran's utilisation of VA health services and in the costs of those services after entry into the VA Homeless Chronically Mentally Ill (HCMI) Veterans Program. The program was designed to facilitate access of homeless mentally ill veterans to medical psychiatric services through community outreach, placement for a limited time in residential treatment facilities and continuing case management (Rosenheck et al, 1993: 1116).

A longitudinal program evaluation was undertaken of nine of the 43 participated program sites involving 1,748 eligible veterans who were assessed for participation in the HCMI program between 1987 and 1988. Service costs were estimated for the participants using VA's national Cost Distribution Report to distribute directs costs and indirect costs among the health care programs at each facility. An experimental cost-effectiveness study was undertaken of an 8-month follow-up from this program of 155 veterans who received an average of 99 days of contract residential treatment and 147 veterans who received case management services without any residential treatment. Veterans in the residential treatment group had better outcomes and general VA medical and mental health costs were not significantly different between people admitted to residential treatment (US$9,053 per year; 2000 US dollars) and people who were not (US$8,205 per year). However, when special program costs for case management and residential treatment were included, people admitted to residential treatment had 53 per cent higher costs than people who were not. HCMI contract residential treatment was associated with modestly better outcomes at 53 per cent greater cost (Rosenheck, 2000: 1567).

6.8 Conclusion on Cost-effectiveness

The cost-effectiveness studies reviewed above demonstrate positive outcomes to the people using the support, their community and government. This was further supported by the detailed review of literature of effectiveness of housing and support for people with mental

illness conducted by Nelson et al. (2007) who demonstrated that the provision of supported housing to homeless mentally ill people provides government cost saving from other forms of interventions because of reduced use of shelters, jails and hospitals. The findings are summarised in Table 6.1.

Specific examples were HASI, where the cost per person of providing stable housing linked to a range of levels of support for people with mental illness was estimated in NSW at $110,337.88 for start-up and annual recurrent cost of $57,530 (Muir, et al., 2007). For housing only support, like the Western Australian Community Transitional Accommodation and Support Services (TASS) program that provides transitional accommodation and support but access to housing that is provided by the Department of Housing and Works (that undertakes the property and tenancy management and maintenance), the cost per client per annum was estimated at $14,340 (Flatau, et al., 2008). The benefits to providing this support was estimated as the health and justice offset per person per year by Flatau (2008) for the TASS as $39,690 giving a saving per client net of annual offset of a saving of $25,350. While Muir (2007) study of HASI in NSW demonstrated benefits to the community of: almost fifty percent of participants working or studying and reporting improved physical health; almost seventy percent reporting improvements in psychological wellness; and eighty four percent reported reduced hospitalisation rate rates (Muir, 2007).

Table 6.1: Summary of Costs and Benefits from Housing and Support to the Person, Community and Government

	Person	Community	Government
Costs	Fees, expenses eg. travel, phone	-	Cost of service – capital, recurrent and management
	Rental contribution	-	Cost of other services used
	Financial and time opportunity cost of accessing other goods and services	Opportunity cost of receiving other government funded services	Opportunity cost of funding other government services
Benefits	Sustained tenancy	Neighbourhood relations, property maintenance, rental payments, property values, increased affordable housing stock	Cost savings from reduced service use – emergency housing, public property damage, rent arrears
	Health and wellbeing, quality of life,	Opportunity benefit of access to health, community and emergency services	Cost savings from reduced service use – health and community services eg. GPs, emergency, allied health
	Skill development – independent living, empowerment, confidence, education, training	Increased education and trained members of the community	Increased community contribution and workforce productivity
	Participation – community and economic	Increased community, economic activity and employment	Increased tax collection and reduced welfare payments
	Social relations – family, friends, neighbours and community	Increased family and community connectedness	Cost savings from reduced service use – integration, social support
	Less contact with criminal justice system	Safety and community wellbeing eg. reduced incidence of crime	Cost savings from reduced service use – criminal justice, policing

7 Case Studies of the Principles Applied in Practice

This section presents four case studies of the principles of effective housing and support in practice. The first three case examples are provided to demonstrate effective models of housing and support for people with mental illness. The examples have been chosen because they incorporate the four types of policy in which this study is interested (housing, housing associated support, social and personal support and clinical and allied health). They are examples of programs that combine housing and support, tailored to the needs of the individual consumer. The fourth case example illustrates an inclusive, innovative approach to support in the community. The case examples also reflect the ten principles key to achieving sustainable housing for people with mental illness or psychiatric disability discussed in Section 5**.**

Case studies are the Queensland Project 300, NSW Mental Health Housing and Accommodation Support Initiative (HASI) and Western Australia Local Area Coordinators. While the WA Local Area Coordinators target group is people with a physical or intellectual disability, it could be adapted to the needs of people with mental illness and psychiatric disability. The final case study from the UK Sharing Voices is included because it demonstrates an innovative way of providing support, through use of a community development approach to engage with marginalised populations.

7.1 Project 300

> Project 300 demonstrates that given adequate support and good case management, the accommodation needs of people with long-term psychiatric disabilities can be met through ordinary/normal housing in the community. (Meehan, 2001)

Project 300 was established in Queensland in 1995 to assist 300 people with psychiatric disability to move from institutional to community accommodation in their region of origin or choice. In what was a ground-breaking approach nearly 15 years ago, the Project brought together the Queensland government agencies of Housing, Disability Services and Health to ensure that people with mental illness returning to the community had the support and infrastructure necessary to maximise participation and integration in their chosen community. As outlined in the 2001 evaluation of Project 300, each person was provided,

> … with a support package consisting of mental health services, disability support services and normal community housing in keeping with their needs. Clinical supports were provided by local Mental Health Services while lifestyle support services were provided by Community Support Agencies. (Meehan, 2001)

The evaluation identified the critical role of the Department of Housing in providing accommodation that met the individual needs of consumers accessing Project 300 and concluded that the involvement of consumers in the selection of housing was critical to this process. The evaluation found that the majority of clients (95 per cent) were satisfied with their accommodation. Of the 181 clients who participated in the evaluation, only 22 (12 per cent) were relocated to alternative accommodation in the initial 18 months of community living.

The evaluation confirmed the critical role of the disability support workers to the success of Project 300. The multidimensional nature of the support provided and the range of skills exercised by support staff, were both critical factors identified in the evaluation.

> Our assessment of the work carried out by the 19 disability support agencies involved with Project 300 indicates that support workers are involved in providing practical help with financial matters, home making and community access. They also provide friendship, emotional support and advocacy.

On average, consumers received 23 hours of support each week. This high level of support reflects consumers' needs. Consumers had high or severe levels of psychiatric disability and had previously been living long-term in one of the state's psychiatric institutions, receiving 24 hour support each day. Importantly, the evaluation found that the participants,

> … were very positive about their new homes in the community and the support provided to them, especially by support workers. While they missed the company of staff and the other patients in hospital, they felt that the freedom, autonomy, dignity and the sense of hope that community living has to offer more than compensated for this.

The current purpose, values and vision for Project 300 were drawn up by stakeholders following a Future Directions and Planning Forum (2000). They are identified in the Disability Service Queensland (DSQ) report *Project 300 Funding Program,* as follows:

- Purpose: To assist people with a psychiatric disability to live as community members.
- Values: Consumer involvement; relationships and community involvement; advocacy and recovery.
- Vision: True community integration (DSQ, 2007: 8).

The different components and roles of support are identified in the DSQ report, which argues that it is necessary to maintain a 'dynamic approach to support and be sensitive and responsive to changes in support needs over time.' The consumer needs to be involved at all times, as 'the leader in shaping their own supports' (DSQ, 2007: 9). The support provided include clinical treatment and support by the Mental Health Service, using a case management approach and outreach services; and disability support that are often provided by nongovernment services. Disability support services include:

- Providing practical support in everyday areas of household management and independent living;
- Supporting people to participate and be included in community life;
- Working with people to identify support needs and goals and provide support and strategies to achieve them;
- Supporting people to create and maintain relationships; and
- Building networks (DSQ, 2007: 16).

Again the fundamental importance of the Support Worker to the success of Project 300 is made clear in the DSQ report (2007: 18).

> Support workers play a vital and ongoing role in supporting consumers during transition to the community and in maintaining their living arrangements and lifestyle … The nature of the Support Worker/consumer relationship is fundamental to the success of the consumer's transition to the community. The development of good rapport and trust is vital, especially at those times when consumers need additional emotional and practical support.

In conclusion, Project 300 is a successful cross agency program operating in Queensland, with good outcomes for people with mental illness. The fact that it has been operating now for nearly 15 years, that it is characterised by genuine collaboration and partnerships, that a number of evaluations and reports have demonstrated significant consumer outcomes, all combine to suggest the strategic opportunity in Queensland exists to extend Project 300 to a wider group of mental health consumers.

7.2 Housing and Accommodation Support Initiative (HASI)

HASI aims to assist people with mental illness to maintain successful housing tenancies, participate in the community, improve quality of life, increase access to specialist and generalist community services and assist their recovery from mental illness. The program began in 2002 and provides permanent social housing, long-term accommodation, community participation support and active mental health case management for over 100 people with complex mental health problems and high levels of psychiatric disability (Muir et al, 2007). HASI is a partnership between NSW Health, the Department of Housing (DoH) and nongovernment organisations (NGO). Jointly funded by NSW Health and DoH, HASI operates as a coordinated response with NGO accommodation support workers, Area Mental Health Service case managers, housing providers (primarily community housing) and HASI participants working together. Outcomes of the program are discussed in Section 7.2. The HASI evaluation process identified the following practices that resulted in positive participant outcomes:

- Effective partnerships in local areas;
- Sound communication between partners at both managerial and direct support levels;
- Staff from Accommodation Support Providers (ASP) and Area Mental Health Services having a well developed understanding of the HASI model and the roles and responsibilities of various stakeholders;
- Local stakeholders having a primary role in the referral and assessment process;
- Stable case managers and ongoing training for key workers;
- ASP staff actively working within a rehabilitative, rather than a supervisory, framework;
- Key workers and clients having a strong rapport, often established through social interaction;
- ASPs organising social activities that enhance confidence and social skills to facilitate community participation;
- The provision of relevant information about HASI participants to housing providers to assist in allocating the most appropriate housing;
- Client choice and active involvement in the selection of available accommodation;

- Active involvement of family or carers; and
- Increased linkages across and within government agencies.

The evaluation concluded that the HASI model has provided people with mental illness and high levels of psychiatric disability with,

> … the opportunity for stable housing; intense support for living skills, community participation and service referral; and the regular monitoring and maintenance of mental health. By providing a stable, consistent and integrated support system, HASI is mediating the effects of mental illness for most participants.

The central importance of providing housing appropriate to the needs and preferences of the consumer and the positive impact such housing can have on the consumer's mental health, is highlighted in this response by a HASI case manager,

> She thinks the accommodation is the bee's knees. She's never had anything new in her life, not even a new kettle … she loved it … and it's doing wonders for her mental health.

7.3 Local Area Coordinators

The Western Australia Disability Services Commission provides Local Area Coordination support in Perth and throughout all regional areas of the state. Local Area Coordinators (LACs) are based in local communities enabling support to be personalised, flexible and responsive. LACs aim to build and maintain effective working relationships with people with disability and families, in their local area. Local Area Coordination is available to people with physical, sensory, neurological, cognitive and/or intellectual disability under the age of 60 years. The LAC operates as a service coordinator rather than service provider and, as such, can help the person with disability and their families/carers to plan, select and receive needed support and services.

LACs also contribute to building inclusive communities through partnership and collaboration with people and families, local organisations and the broader community. The overall stated aim of Local Area Coordination is to support people with disability to live within welcoming and supportive communities. Local Area Coordinators are based in local communities and each provides support and assistance to between 50 and 65 people with disability. The roles of the Coordinator are summarised below:

- Build and maintain effective working relationships with people, families and their communities.
- Provide accurate and timely information. Assist people, families and communities to access information through a variety of means.
- Provide people and families with support and practical assistance to clarify their goals, strengths and needs.
- Promote self-advocacy. Provide advocacy support and access to independent advocacy when required.
- Contribute to building inclusive communities through partnership and collaboration with people and families, local organisations and the broader community.

- Assist people and families to utilise personal and local community networks to develop practical solutions to meet their goals and needs.
- Assist people and families to access the support and services they need to pursue their identified goals and needs (Disability Services Commission).

A review of the Local Area Coordination Program (Disability Services Commission, 2003) found generally high levels of satisfaction with LAC among consumers. Identified strengths included:

- The empowering value base and capacity to develop flexible, respectful personal relationships;
- The local nature, accessibility and relevance of the service; and
- The hands-on, practical approach.

The review concluded,

> Overall and across all outputs, Western Australia compares very favourably with other states on key benchmarks related to service uptake, cost and consumer satisfaction. Comparisons to national benchmarks indicate that Individual Coordination (LAC in Western Australia) is providing services for a greater proportion of service users at lesser cost per person, than for Australia as a whole. All Western Australian key output areas had a higher level of consumer satisfaction than national equivalents.

The primary recommendation from the LAC Review was that the Disability Services Commission continues to develop the program as a community based government service, with the dual roles of supporting people with disability and their families/carers and supporting the development of inclusive communities.

One of the strengths of the local coordination model is its adaptability to other locations and other population groups. For example, Victoria's Local Area Service Networks bring local services together to provide housing and support to homeless persons in a seamless (or organic) way. The Network facilitator plays a coordinating and leadership role, ensuring key actions and decisions are implemented. Activity focused on four key practice areas: entry points for homeless people; resource sharing; referral pathways; and prioritisation and allocation of housing. A recent review of 5 pilot local area service networks identified the networks' ability to improve responses to homeless people through changes to existing systems and practices, in particular the introduction of integrated local service approaches (Australian Institute of Primary Care, 2008). The model could also be adapted to provide integrated housing and support for people with mental illness or psychiatric disability.

7.4 Sharing Voices, a Community Development Approach

Innovative support for vulnerable people, who often face social exclusion, isolation and discrimination is evident in an example from the United Kingdom, Sharing Voices, which uses a community development approach to engage with marginalised populations. Sharing Voices, based in Bradford, is a community development mental health project focusing on developing and raising awareness of mental health wellbeing amongst marginalised black and migrant communities and people. Sharing Voices develops services that are culturally appropriate to the needs of these communities and that contribute to improved health outcomes. The project also works with statutory and voluntary services to help them improve

services and enable them to meet the needs of black, migrant and multicultural communities. One way it achieves this aim is by providing training for mental health professionals through the Centre for Citizenship and Community Mental Health at the University of Bradford.

A community based approach is utilised; engaging communities in dialogue to articulate their own understanding of mental health and illness and to design solutions appropriate for black and minority ethnic communities. Sharing Voices supports a number of community groups that meet weekly. The groups may be gender-specific, faith-based or issue-based, or may focus on physical fitness and wellbeing. The groups emphasise the concept of mutual aid and self-help; the role of the community worker is to respond to the needs identified by local participants. To complement the centre-based gatherings, social exclusion outreach teams work with people in their homes to assist them access mainstream services and activities. The project promotes independent living and engagement in community activities, by developing capacity within communities and supporting the development of self-help initiatives and community networks (www.sharingvoices.org.uk).

A case study (reported on the psychminded.co.uk website) shows how the Sharing Voices project makes a difference in the lives of people with mental illness. The project participant was described as a black Rastafarian adult male who has experienced compulsory psychiatric detention and treatment. Diagnosed with schizophrenia, he had been in and out of psychiatric hospitals for more than 10 years. Through the involvement of the Sharing Voices project over the last two years, he has not been hospitalised and his confidence has grown dramatically to the extent that he has new friends and attends community meetings. The case study reports that, 'For someone whose previous lonely existence six months ago meant he could not even summon the courage to walk to the shops on his own, these are massive steps.' (psychminded.co.uk)

The UK government hopes Sharing Voices and other similar community development projects, can help prevent institutionalised racial discrimination in mental health services, where Afro-Caribbean men are between two and eight times more likely than their white contemporaries to be sectioned under the Mental Health Act. Another example cited is Asian Muslim women who have been victims of sexual and physical violence. For them, explains the Sharing Voices manager, spiritual assistance can be vital for recovery. 'You're more likely to find such support from a mosque than a psychiatric ward….They were not asking for latest drug treatments, they were asking for practical support, for safe places.'

Sharing Voices seeks culturally-appropriate pathways to recovery, for example by working with young Muslims who feel excluded and discriminated by society. Discussions with young Bengali mental health consumers from Bradford have indicated that, 'People talk about their distress without the language of psychiatry… they refer to it in terms of racism and what it's about to be a young Muslim in a society where Islamophobia is rife.' As part of the government's Delivering Race Equality plan, funding was released for 500 extra community development workers around the country, to engage black and ethnic minority community organisations to act as partners in working to create less discriminatory and more inclusive mental health services.

8 Implications for Policy Change

This final section suggests some implications of the principles for effective housing and support for policy change in Queensland. It aims to identify policy directions indicated from the research with the aim of supporting sustainable tenancies and recovery. Rationales for the suggestions are discussed in the report. The implications start from the government commitment that sustainable housing and associated support is a human right. Implementing the principles support fulfilment of that right.

The implications are drafted in terms of immediate responsibility by the policy, funding and planning agencies for this research, Housing, Health and Disability; and delivery responsibility by these agencies, contracted service providers and related government agencies such as the criminal justice system. The implications relate to the four types of housing and support (housing, housing associated support, social and personal support and clinical and allied health support). In addition, they also have implications for how agencies and service providers delivering these types of support effectively coordinate with other related mainstream and specialist services.

8.1 Recovery Approach

Two implications are identified. The first is to review current mainstream and mental health specialist services regarding how to better apply the principles for effective housing and associate support identified in the research. The outcome of the review will be to modify services and propose additional ones to meet the implications of the principles. The second is to consider extension of Project 300 to people with mental illness who are homeless, at risk of homeless or leaving institutional care, including corrective services.

8.2 Person-centred Services

Improving a person's outcomes is the overarching goal of person-centred services. An implication from the research is to review mainstream and specialist services to ensure they have a focus on housing and support that facilitates consumer outcomes including sustainable housing, quality of life, community participation, family connectedness, independent living and economic security. The outcome of the review will be to modify service delivery processes to meet the implications of person-centred service planning, funding and delivery.

8.3 Primacy of the Person's Housing Needs and Preferences

We suggest reviewing public and priority housing allocation criteria, with the aim of reflecting the principle of choice in housing for people with mental illness, in particular with regard to fulfilling long-term preferences for location and type of housing. Despite the rhetoric of consumer choice throughout the literature and in policy statements and reports, the consultations indicated that people have very few choices regarding their housing, which contributes to unsustainable tenancies. The outcome of the review will be to modify allocation criteria and processes to respond to people's needs and preferences for sustainable housing and support.

8.4 Choice for Independent Living

A further implication of person-centred services is reviewing individual and system housing and support policies to incorporate the goal of independent living in the planning, funding and delivery of housing and support to individuals over their life course. This also has implications for the supply, planning and funding of housing and support types so that people

can fulfil their choices as they change during their life. The outcome of the review will be to modify housing and support processes and propose new housing and support options to offer sustainable housing and support as required.

8.5 Responsive to Population Needs

An implication from the research is that planning, funding and delivery of housing and support needs mechanisms to take account of specific needs of particular population groups, including Indigenous, culturally and linguistically diverse communities, women, parents and young people.

This involves three steps: seeking the participation of people and communities in these population groups to identify needs and to comment on policy opportunities; responsive mainstream services that can respond flexibly to particular needs associated with diversity; and specialist services particular to the population needs. Reviewing participatory mechanisms and planning processes will result in changes to housing and support processes for individual housing and support and planning; and propose new mainstream and specialist housing and support options to respond to the needs of particular population groups.

8.6 Separation of Housing and Support

The structure, funding and delivery of support services need to be reviewed to check whether the principle of separating housing and support has been considered so as to minimise risks of conflict of interest and vulnerability of people receiving support. Where housing and support remains the responsibility of one organisation, the mechanisms within the organisation to address the risks should also be reviewed. Where the functions are separated, mechanisms to effectively coordinate the functions should be reviewed. The outcome of the reviews will be to modify housing and support processes and contractual arrangements to minimise risks of conflict, vulnerability and lack of coordination.

8.7 Interagency Coordination

Many government and nongovernment organisations are responsible for housing and support and have contact with people with mental health and psychiatric disability. Formal mechanisms and informal processes to facilitate coordination should be reviewed against the aims of effective coordination between the four types of housing and support, to improve outcomes for the person and to implement the principles for effectiveness. Examples include, the Local Partnership Agreements, learning from the experience of the Local Area Coordinator models in other states and agency memoranda of agreements. The outcome of the review will be to modify planning and delivery processes, networks and agreements to improve coordination for individual consumers and policy planning.

8.8 Individual and Systemic Advocacy

The research has four implications for government agencies to enhance individual and systemic advocacy. First, mechanisms that provide opportunities for people with mental illness and psychiatric disability to express their opinions about problems and solutions for housing and support need to be enhanced. This needs to be accompanied by resources to support those mechanisms. Second, more resources need to be provided to increase the capacity of the advocacy sector to improve access for people with mental illness to individual advocates and to represent the interests of people with mental illness in systemic change in the housing, support and mainstream service sectors. Current advocacy agencies do not have the capacity to do more with the current resources. Third, consider implementing a

community development approach, such as Sharing Voices, to elicit participation and community responsiveness, and engage with marginalised groups with mental illness and psychiatric disability. Finally, continue to work with the nongovernment sector to develop and implement community awareness and education strategies highlighting diverse and positive images of people with mental illness or psychiatric disability living and participating in the community.

8.9 Long-term Perspective of Housing and Support Needs

The sustainability of housing and recovery relies on a long-term perspective. This involves reviewing policy processes that prioritise opportunities to allocate permanent housing with support rather than transition models for people with mental illness. In addition, it also involves enhancing social housing by prioritising allocation to people with mental illness and psychiatric disability and focusing on sustainable tenancies through the choices of housing and provision of support to sustain the tenancy. The outcome will be to modify housing allocation and support processes to enhance decision making that takes account of long-term perspectives.

8.10 Preventing Homelessness

Strategies to prevent homelessness include reviewing housing allocation policy and practice to prioritise access to permanent, dispersed housing for people with mental illness and psychiatric disability. In addition, the affordable housing stock managed by the social housing sector needs to be increased, including methods to engage private housing sector through long term leases.

Short-term implications to preventing homelessness include working with the Supported Accommodation Assistance Program (SAAP) and its new directions under SAAP V, to improve access of people with mental illness to the program, in particular to the SAAP outreach component. Further, at policy and practice levels, SAAP entry criteria that effectively exclude some people with mental illness and psychiatric disability need to be challenged and minimised.

Appendix 1: Methodology

A mixed methodology with a literature review, consultation and cost savings framework was used to address the research questions. This form of analysis develops an understanding of policy approaches that effectively and efficiently respond to the housing and support needs of people with mental illness or psychiatric disability. The consultation component allows for the engagement and contribution of people with mental illness and their advocates.

Research Framework

Due to the limitations of the timeframe, the research concentrated on the following framework.

- Outline principles to effectively manage mental health recovery with housing and associated support for application in the Queensland policy context.
- Focus on good practice examples of housing, housing associated support, social and personal support and clinical and allied health approaches that illustrate the principles, especially examples outside Queensland.
- Present recorded evidence of cost savings in the good practice examples, including changes in service usage and clients outcomes (quality of life, participation and sustainable tenancy).
- Include services provided by government, NGO and private organisations; prioritise recovery, early intervention and prevention services; and be inclusive of co-morbidities, such as drug and alcohol, intellectual disability and other cognitive impairment.

Literature Review

The literature search and review included relevant Australian and overseas research and evaluation reports on housing and associated supports for people with mental illness or psychiatric illness. Priority was given to new state, national and international policy directions.

The review builds on initiatives already occurring in Queensland and in other states, such as the Mental Health Housing and Accommodation Support Initiative (HASI) in NSW and Integrated Rehabilitation and Recovery Care Program (IRRCP) in Victoria. It includes literature reviews previously undertaken about housing and support needs for people with mental illness or psychiatric disability by the Office of the Public Advocate.

The data from the literature review are situated in the Queensland context. It also reviews how specific situations, such as geographic location (metropolitan, regional, rural and remote), cultural background (including Indigenous and culturally and linguistically diverse populations) and age, affect housing support needs among individuals with mental illness or psychiatric disability.

It involves searches of recent Queensland government research; electronic databases; published material; government and provider reports; contact with international research colleagues and disability and housing agencies; responses to unpublished material and reports from people with disability, service organisations and academics; and any other research that has been recently completed or is current. The review includes relevant state and territory disability, housing, health and aged care policy and service documentation. We sourced these

documents from the Research Steering Committee members, key informants and people identified in the primary data collection. This document review is supplemented by targeted telephone interviews to be conducted with government representatives in disability, housing, health and aged care departments and service providers. We include policy documents, conference papers, agency reports and discussion reports identified by key informants. The project relies on previous research on the cost effectiveness of housing and support options (eg. Fisher et al, 2005, 2007a; Knapp et al 2005; Lakin 2004; Stancliffe & Keane 1999).

The findings from the literature review inform the other components of the project. The research team builds on the extensive literature reviews and primary data sets developed in the course of conducting other recent disability and housing research projects, for the Queensland government as well as for other state governments. The review includes evaluations of Australian and international housing and support services for the population group, with an emphasis on evidence-base and innovation.

Consultation with Stakeholders

In addition to secondary information through the literature review, the methodology also included consultation with stakeholders. This is important for data specific to the lived experience of people with mental illness or psychiatric disability in Queensland and the experience of families, carers, advocates, service providers and policy officials. The consultation with stakeholders is inclusive of the three main groups: consumers, advocates and family members; peak bodies and service providers; and government agencies. Peak bodies invited to participate included the Queensland Alliance of Mental Illness and Psychiatric Disability Groups, Queensland Shelter and Queensland Council of Social Services (QCOSS).

Participants in the research were 9 people living with mental health issues who participated in the research through focus group and/or individual interview, and 5 key stakeholders from both government and non government arenas, all of whom brought extensive knowledge and experience of the mental health sector.

Due to the time frame of the research, a targeted consultation process was used, identifying and approaching key players in the sector for participation. The purpose of the consultation was to hear the views and experiences of stakeholders regarding the research questions and provide the opportunity for stakeholders to test and comment on the early research findings. Participants were asked to comment on the outline from the literature of principles of good housing and support. Within this framework, they were asked:

- what helps people find and keep housing;
- services and supports that have helped people find and keep their housing;
- the sorts of housing and support that you think work well; and
- how well parts of the housing and support services and government work with each other to support people.

Research participants were contacted and focus groups, face-to-face interviews and telephone interviews were conducted in March and early April 2008.

People participating in the research were selected through an ethical consent process. An ethics application, including the Participant Information and Consent Form and Topic guides

were approved by the UNSW Human Research Ethics Committee (HREC). The project is very short, so to maximise effectiveness of consultation, a communication strategy is necessary. In order for Queensland Housing to promote its project effectively to state-wide stakeholders, Queensland Housing's Project Manager prepared information on the project and an email letter to stakeholders inviting their participation in the consultation process.

Cost Benefit Analysis

The third part of the research is to identify methodology for estimating cost savings for the human service sectors affected by investment in housing and associated supports that contributes to recovery of people with mental illness and psychiatric disability. The cost benefit analysis approach includes financial and opportunity cost economic data. In order to compare between approaches to housing and associated support, we included projected economic costs and benefits to government, consumers and society, including economic implications for other parts of government not providing housing and associated support such as criminal justice, health, education and social security. We discuss methods consistent with existing research to enable comparisons to international and Australian research (eg. Knapp et al 2005; Lakin 2004; Stancliffe & Keane 1999).

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