Mental Health, Housing and Homelessness
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Artwork:
*Coming Together by Luke Roma, Rocky Boy, Jagalingu Man from Rockhampton Region, 2013*

This painting represents all Indigenous and Non Indigenous Australians coming together without malice or discrimination.

**Our commitment to Reconciliation**

We acknowledge the Aboriginal and Torres Strait Islander peoples (First Peoples) of Australia as the traditional owners and custodians of this land and that this was never ceded by them at any time. We acknowledge the impact of colonisation on the First Peoples and the trauma this inflicted on their lives, their culture and their rights to live on their traditional lands. We acknowledge and support their rights to self-determination, land and culture.

We acknowledge the over representation of First Australians who experience homelessness. We recognise that invasion and subsequent trauma and loss (cultural loss, family separations, incarceration, and racism) contribute to the mental distress of Aboriginal and Torres Strait Islander Australians. We are committed to working with Indigenous leaders, agencies and communities to create homes, and strengthen connection to family, culture and community for their own people.
1. Introduction

The aim of this review is to synthesise issues and models of practice around the nexus between mental health, housing and homelessness. The context for this review is to better understand how issues of mental health, housing and homelessness might be more sustainably overcome throughout the Brisbane Local Government Area (LGA) from a review of practices employed here and elsewhere. This review brings together evidence based and best practice models that intercede this area.

This review addresses two research questions. The first question is: what are the unmet needs of the target population? Evidence of the unmet needs will be shown by drawing on a general review of the nexus between mental illness, housing and homelessness and through data of the issue in the Brisbane LGA. The second question to be addressed is: what are the solutions or models to deal with the identified unmet needs of the target population group? In this second question, these solutions and models will be critiqued to identify their strengths and weaknesses. Before these questions are answered the following section provides an overview of the relationship and links between mental health, housing and homelessness.
2. The nexus between mental health, housing and homelessness

Mental illness refers to a diagnosable disorder that significantly affects an individual’s cognitive, emotional or social abilities (DoHA 2009). These disorders can vary in severity and include bipolar disorder, depression, schizophrenia, anxiety, eating disorders and personality disorders. Mental illness can have damaging effects on individuals and families, and impacts the whole of society. Poverty, unemployment, reduced productivity and homelessness are all problems associated with mental illness (WHO 2003).

Mental illness affects almost 50% of all Australians aged 16 to 85 at some point in their lives, and 1-in-5 people experience a mental disorder in any given year (Mental Health Council of Australia 2009). About 1.9 million Australians (9% of the population) received public or private mental health services in 2010-11 and during the same year there were an estimated 15 million mental health-related general practitioner (GP) encounters or visits (Australian Institute of Health and Welfare 2013). A number of people with severe and persistent mental illnesses often experience homelessness.

Homelessness definitions vary but the culturally defined minimum acceptable standard in the Australian community is that “…an independent person or couple should be able to expect at least a room to sleep in, a room to live in, kitchen and bathroom facilities of their own, and an element of security of tenure” (Chamberlain 1999: 9). People with severe and persistent mental illness are often homeless in that they are living on the streets or in boarding houses without security of tenure. The three types of homelessness that people often experience include:

1. Primary homelessness: people without conventional accommodation (‘street homelessness’ or ‘rooflessness’ — the most visible form of rough sleeping in parks, streets and so on);
2. Secondary homelessness: people moving between various forms of temporary shelter (including couch surfing, hostels, emergency accommodation); and

Mental illness, housing instability and homelessness are often inextricably linked. People in unstable accommodation or who are homeless often experience mental health issues. Evidence is mounting that people who are homeless tend to have a higher prevalence of mental health issues than the general population. Data from the Australian Bureau of Statistics (ABS) shows that of those who had reported being homeless at least once in their lives, more than half had experienced a mental disorder in the previous 12 months, which is 3 times higher than among those who had never been homeless (ABS 2008).
The relationship between mental illness, housing and homelessness is a complex one. Factors of insecure tenure can impact on mental health while mental health episodes can impact on maintaining tenure. This complex relationship can best be understood by exploring the multifaceted factors that contribute to the melting pot of mental health, housing and homelessness. A summary of many of these factors will be explored below, which draws from a reported developed by the Mental Health Council of Australia (MHCA) entitled ‘Mental Health, Housing and Homelessness in Australia’. It should be noted that these factors mutually reinforce each other adding to the complexity of the issue (Mental Health Council of Australia 2009). Understanding these factors better enables an analysis of the models and practices needed to address the unmet needs of the target group in the Brisbane LGA.

The following points outline key factors that contribute to this issue, which have been taken verbatim from the report, or added to or edited.

1. Obstacles that interfere with homeless people receiving adequate health care include financial barriers, a lack of transportation to treatment facilities, a lack of a Medicare card or health insurance, a lack of a fixed address or permanent contact details, limited insight into their illness, a lack of awareness of available services, and a reluctance to access services due to past negative experiences.

2. Transient lifestyles may increase the likelihood of people not continuing their treatment as many find it almost impossible to take medicine regularly while living on the streets. Thus, regardless of whether mental illness precedes homelessness or vice versa, what is apparent is that homeless people experiencing mental illness find it extremely difficult to continue appropriate treatment.

3. Substance use disorders very frequently coexist with mental illness, and in combination these conditions result in a particularly high risk of homelessness. People who have a mental illness and are homeless are very likely to also experience a substance use disorder. When mental health and substance use issues are present, people may encounter obstacles in obtaining or retaining appropriate housing. Drug and alcohol use are known factors in increasing relationship tensions within families, between neighbours or landlords. The financial costs of ongoing addiction may compete with housing costs.

4. People who are homeless and have a mental illness are both more likely than the rest of the population to come into contact with the criminal justice system. The MHCA’s ‘Not for Service’ report found that homeless people with a mental illness were more than 40 times more likely to be arrested and more than 20 times more likely to be imprisoned than those with stable accommodation; and offenders without stable accommodation were more than 3 times more likely to offend than those with stable accommodation.
5. When they are unwell, some people with a mental illness exhibit behaviours or symptoms that may threaten their housing stability, such as causing disturbances to neighbours, causing a threat to themselves or others, missing rent or utility payments, not opening mail or neglecting their housekeeping.

6. Housing stock shortage, housing affordability and insecure tenure are all factors that contribute and impact on mental health and subsequently can lead to homelessness.

7. Some people experiencing mental illness who can usually retain stable housing may find that their accommodation is put at risk due to a period of poor health or an acute episode. According to the SANE housing survey, 87% of respondents reported that lack of support around the time that they became unwell and were hospitalised had contributed to the loss of their accommodation. The episodic nature of mental illness, which may result in periods of hospitalisation or other absences from the home for treatment, can make it especially difficult for those affected to meet housing payments, thus putting them at risk of losing their accommodation.

8. Stigma and discrimination is a key factor affecting people’s ability to find housing. Nearly 90% of respondents in a SANE housing survey believed that they had been discriminated against at some point in their search for appropriate housing, particularly when seeking private rental accommodation.

9. The deinstitutionalisation of mental health services has resulted in a failure to increase community-based treatment and support services, which has contributed to and exacerbated difficulties for people with a mental illness in accessing the stable and appropriate housing that is an essential prerequisite for effective treatment and support.

In summary, there are strong correlations between mental illness, housing insecurity and homelessness. The importance of housing as the critical component cannot be understated. When housing insecurity exacerbates mental health and mental health in turn can impact so greatly on housing, then models of care and support must address both.
3. Unmet needs of the target group in Australia generally and specifically the Brisbane LGA

This section will explore the unmet needs of the target group in the Brisbane area. People with severe and persistent mental health needs who are homeless typically fall within four categories. The first category are those that are homeless and do not receive any services to support their mental health issues. There are a high proportion of people in this category. This category is generally the focus of law enforcement agencies due to behavioural issues or signs of mental health issues and those affected end up at the Emergency Department (ED) where they are often not seen. Often, they return to the streets untreated where their mental health issues are exacerbated by their homelessness. A second category of people are those that are attended to and hospitalised by medical practitioners. Those affected recover from an episode and are referred to a community mental health clinic or something similar, but generally end up back on the streets not subscribing to their treatment plan. The services that exist don’t support them out of homelessness and this means that treatment plans and compliance are hard to maintain and mental health deteriorates again. A third category is those people who are treated in a psychiatric facility in hospital and remain hospitalised without a discharge or exit strategy back into the community. This is a growing category of institutionalisation because of limited support, services and housing to enable people to reconnect with the community. A final category are those that experience secondary or tertiary homelessness in substandard and insecure tenures who struggle to manage their mental health either through hospitalisations and community mental health clinics and their homelessness perpetuates their mental health issues. Those affected are continually at risk of primary homelessness particularly during mental health episodes (adapted from the Senate Community Affairs Committee 2008).

A brief summary of some Australia-wide statistics:

- In the previous census (2011), 105,237 people were considered homeless, which is equivalent to 1 in every 200 people (Homelessness Australia 2014).
- In 2011-12 there were 229,247 people who received support from specialist homelessness services with an average of 19,128 people accommodated each night (Homelessness Australia 2014).
- The number of community mental health care service contacts has continued to increase, with over 7.1 million contacts reported for about 350,000 patients in 2010-11. About 1 in 7 contacts were provided on an involuntary basis; that is, the consumer was compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care (Australian Institute of Health and Welfare 2013).
- In 2010-11, there were an estimated 243,444 ED occasions of service with a mental health-related principal diagnosis. Of the 223,261 non-ambulatory admitted patients, mental health-related separations specialised psychiatric care was provided for 59.5% of these separations (132,917) in 2010-11.
About one-third of mental health-related separations with specialised psychiatric care were from involuntary admissions (Australian Institute of Health and Welfare 2013).

- Clients with a current mental health issue represented 23.8% (40,405) of all Specialist Homelessness Services Collection clients in 2010-11 (169,989 clients) (Australian Institute of Health and Welfare 2013).

For the Brisbane LGA, the statistic relevant data comes from publically available census data and 500 Lives 500 Homes Registry Fortnight data, which collected vulnerability and other important data on over 1,400 homeless or vulnerable housed individuals. The below is a summary of some of the important data from the area:

- Based on the 2011 census, there were 4,316 individuals in the Brisbane LGA who were counted as being homeless in some form. A number of these homeless individuals were in boarding houses, others were in Supported Accommodation Assistance Program services, many were couch surfing with friends or family, and a smaller proportion were rough sleepers (ABS 2013).

From the 500 Lives 500 Homes data, the following evidence for the target group in the Brisbane LGA was identified:

- Of the 190 rough sleepers surveyed, 57.4% had some form of mental health issue and 77.9% had substance abuse issues. Within that group of rough sleepers, 37.9% have been taken to hospital for mental health reasons against their will, 39.5% have gone to the ED due to mental health concerns, and 49.5% have spoken to a psychiatrist, psychologist or other mental health professional in the last 6 months because of mental health concerns (voluntarily and involuntarily). On conservative estimates, from self-reported questioning, these 190 individuals cost $2.3 million to the health system in ED presentations, ambulance call-outs and hospitalisations alone (500 Lives 500 Homes Factsheet 2014).

- The GAP analysis tool, from the 500 Lives 500 Homes Campaign, has been able to map out some of the issues that people face in the Brisbane LGA who have severe or persistent mental health issues and are primary, secondary or tertiary homeless. The market within Brisbane LGA is very difficult to allow for people to find appropriate accommodation. This is particularly difficult for those with high acuity of need. The private rental market vacancy rate in Brisbane is 2.3% and is largely unaffordable for the target group, not to mention the lack of supported housing models in Brisbane that allow for people to have support come to them. The public housing vacancy rate is 1.2% or 197 government managed properties that are determined predominately on a waitlist basis without support for people to maintain tenancy and manage their mental health and substance abuse issues. Finally, the vacancy rate for community managed housing is 1.2% or 42 properties in Brisbane showing the significant demand not just for rough sleepers in the LGA but also the target group who are secondary or tertiary homeless (GAP Analysis Tool 2014).
The unmet needs of the target group in the Brisbane LGA are apparent from the data presented above. The next section turns to a number of models adopted in other parts of Australia or internationally that have been used to target and address such unmet needs of housing and support for the target group of this review.
4. Various models to tackle the unmet needs of the target group

This section will explore various models that exist to address the unmet needs of the target group. Some of these models focus on care of the target group, others focus on the housing needs of the target group, and others blend the mental health and housing needs into one model. It is important to note that no one model is a one-size-fits-all approach. Each model has strengths and weaknesses and various models should be used to address the unmet needs of the target group. One example of this is the first model described – community mental health clinics – that can support people once they are stabilised and housed but generally fails to assist people who are homeless and have a severe and persistent mental health issue. Another example of this is the growing trend towards Housing First approaches. While this approach may involve permanent supportive housing for people with severe and persistent mental illness, which is appropriate in some instances, it should not be at the cost of other models that might enable an individual to support themselves with assertive outreach. Nor should it prevent homelessness of other people with severe and persistent mental health by diverting funding and services away that enable people to maintain tenancy and work through episodic periods in their lives. In total, seven model examples will be explored in this section. Each of these will be discussed in turn.

4.1. Support Models

This section examines both clinical support models (two models) and hybrid support models (three models), which are all used to address the unmet needs of the target population group.

4.1.1. Clinical Support Models

4.1.1.1. Community Mental Health Clinic Model

The first model to explore is the community mental health clinic model. This model is relevant because it aims to prevent homelessness among people with mental health issues and has a role in this, but generally with the target population group it has failed on a number of levels. Because this has been such a predominant model in Australia, where funding has been directed, it means that people who are homeless, with severe and persistent mental health issues, have largely been excluded from care.

The clinics work with an expectation that clients will turn up for an appointment and accept treatment. Clinic staff have high caseloads, typically do not do home visits and if they do home visits they expect people to have a fixed address. Quiet obviously for the target group, this model does not fit with the transient nature of homeless individuals’ movements either rough sleeping or in and out of crisis accommodation. Housing issues and support in this context are not seen as a part of the mental health clinic model in most discussions of clinical services (Newman 2001). Appropriate and affordable housing for people with mental health issues
who are homeless and connected with these services are rarely considered through such a model (Carter et al 2008).

Freidin (2014: 10) argues eloquently about the problem at hand for the target group and how this model does not meet their needs.

For any person, gaining benefit from a community mental health clinic requires some degree of acceptance that having treatment is an important priority for them, and some degree of capacity to attend appointments and comply with treatment recommendations. The experience of being homeless can limit both.

This model fails to target and address the unmet needs of the target population. It can prevent others from becoming homeless by assisting them through periods of difficulty so that they can maintain tenure, employment and other needs but those that are homeless with mental health issues do not get treated or end up hospitalised, and either, remain there, or end up back on the streets, with no long-term treatment plan or support.

4.1.1.2. Assertive Community Treatment Model

Assertive Community Treatment (ACT) originated in the 1980s as an experimental home-based treatment service providing an alternative to people being admitted to psychiatric hospitals and finally evolved into ACT’s current form. ACT is typically applied to people with serious mental health issues who have experienced frequent hospital admissions and who struggle to engage with mainstream services (Harvey et al 2012). According to Salyers et al (2013: 117), ACT is “...recognized as an evidence-based practice that is successful in engaging consumers with severe mental illness (SMI), reducing hospitalization, increasing housing stability, and reducing homelessness”. While not directly targeted at the homeless population, evidence suggests that care costs are reduced by lower numbers of admissions and length of stays in hospital of those who receive the service (Harvey et al 2012).

ACT is a platform for integrating primary and behavioural health care that incorporates nursing, psychiatric and medical staff working along side rehabilitation professionals. Typically, ACT involves a multidisciplinary team, low client/staff caseloads and often 24-hour available of the service (Costello et al 2013). If undertaken correctly with the target group, ACT can work with people with severe mental health issues to maintain stable housing (Coldwell and Bender 2007, cited in Salyers et al 2012). ACT tries to incorporate active consumer treatment planning and the promotion of self-management, which works to enable greater agency for the individual. An example of this model was the Burke St Mental Health Clinic which is part of the Princess Alexander Hospital that delivers outreach services by mental health nurses, occupational therapists and others to service users and has a 24-hour support service for client users.
4.1.2. Hybrid Support Models

4.1.2.1. Assertive and Collaborative Outreach Models

Assertive and collaborative outreach is a strong variation from traditional street outreach programs. “Assertive outreach is defined as the deliberate and strategic attempt to end homelessness through the provision of outreach services to immediately intervene in individual homelessness or outreach to people’s homes to sustain their tenancies” (Phillips and Parsell 2012 cited in Costello et al 2013: 47). Assertive outreach is not a standalone intervention with someone from the target group, rather it is outreach that extends for a long period of time to support an individual to enter into housing and sustain their tenancy (Costello et al 2013).

Phillips and Parsell (2012) concluded in a study of various assertive outreach programs in Australia that it has been successful in responding to homelessness and meet the needs of the rough sleepers target group. Assertive outreach, combined with health components, has been noted in Sydney as a highly successful process. The Street to Home and Community Health Nurses programs at Micah Projects are a form of assertive and collaborative outreach that combines housing, health and support. With the target population group being homeless and having mental health and/or substance abuse issues then incorporating health components into the program improves individual’s health and wellbeing and assists people maintain tenancy.

An extension of this model has been trialed with great success in two homeless outreach organisations: Sacred Heart Mission and Hanover Welfare Services Southbank. At these organisations, mental health clinicians from St Vincent’s Hospital have been embedded into the teams enabling the target population who often fall through the cracks of mental health services to be directly connected for the first time. According to Freidin (2014: 10):

> …evaluation of this model demonstrated that by breaking down the formal barrier between different providers to homeless people, there could be development of more appropriate support to meet their needs. It also fostered organizational collaboration, resulting in benefit to many other individuals with severe mental illness beyond those who were directly affected by the service model.

Through such an approach a traditional homelessness organisation has been able to become a hybrid assertive outreach team that directly meets the target group that this review is focusing on.

4.1.2.2. Discharge Programs: Pathways out of Institutional Care Models

Appropriate discharge planning for the target group should involve “…identifying and organising the services and connections a person with mental illness, substance abuse, and other vulnerabilities will need when leaving an institutional or custodial setting and returning to the community” (including housing needs) (Backer et al 2007, cited in Costello et al 2013: 29). Furthermore, the discharge
program also needs ensure that the following people and agencies are involved: those who offer services for stable and permanent housing; those who provide ongoing psychiatric and psychosocial treatment/rehabilitation; and those who provide community services such as transportation, financial and medical management. The involvement of all these agencies will support independent living (Backer et al 2007, cited in Costello et al 2013).

As alluded to previously, people who are homeless and hospitalised in mental health wards are often either inadvertently institutionalised in a cycle of psychiatric care at the hospital or are often discharged back onto the streets. In New South Wales (NSW) a report by the NSW Ombudsman (2011) found that roughly one third of people currently in mental health facilities could be discharged back into the community. The problem is that there is either no support or accommodation to assist them in the transition back into the community or if they do get out the support is often limited and they end up back on the streets. Compounding this issue is a reputation of poor discharge planning, limited knowledge of hospital nurses and social workers of the housing and support options for the target group, and long referral times to community service providers. From these weaknesses that exist in Brisbane and in other cities in Australia new discharge programs have been developed for the target population group.

An example of one such program is the Housing/Mental Health Pathways Program (HMHP) delivery by HomeGround Services and St Vincent’s Inpatient Mental Health Service that began in 2002. HMHP had a number of objectives including:

- Undertaking housing-focused assessments;
- Advocacy work;
- Improving collaboration between the mental health and housing systems;
- Ensuring appropriate support and housing linkages are in place;
- Support to stabilise medium-long term housing;
- Reduction of unnecessary psychiatric hospitalisations;
- Improvement in the quality of life for homeless consumers; and
- Identification of barriers and improvements to the service system (HomeGround Services 2008).

The program involved a referral being made from St Vincent’s Inpatient Mental Health Wards to HomeGround, where an initial assessment was undertaken with the client. Discharge planning was done collaboratively with the hospital, the client and the HomeGround worker. The discharge planning was in line with the definition of approach discharge planning with the target group. Housing was shored up and long-term support provided once discharge occurred. Based on a review of the service in 2008: “Significant improvements in housing status, support linkages and psychiatric stability were achieved for clients of the Housing/Mental Health Pathways Program (HMHP), compared with their situation prior to hospital admission” (HomeGround Services 2008: 1).
4.1.2.3. Partners in Recovery Model

A major problem with the target group who have severe and persistent mental health issues is that their needs are multiple and complex and thus require multiple agency coordination for success. Each of these agencies tends to isolate those needs based on their service delivery provision. A new Australian Government program, established in 2013, Partners in Recovery (PIR), attempts to address this by providing coordinators to assist individuals and agencies develop coordinated plans to best meet the client’s needs (Freiden 2014).

The objective of PIR is to improve the system response to and outcomes for people with severe and persistent mental illness who have complex needs by:

- Promoting a community-based recovery model to underpin all clinical and community support services delivered to people experiencing severe and persistent mental illness with complex care needs;
- Strengthening partnerships between clinical and community support organisations responsible for delivering services to PIR clients;
- Facilitating better coordination of clinical and other services to deliver wrap-around care uniquely tailored to the individual’s needs; and
- Improving referral pathways that facilitate access to services and support needed by PIR clients.

The program is expected to assist 24,000 individuals with severe and persistent mental illness over the next three years and has been funded for $549.8 million nationally over five years. While homelessness is not a criterion of the program, it is anticipated that many of the target group will be connected through PIR (Freiden 2014). In the Brisbane LGA, Metro North Brisbane Medicare Local (MNBML) operates with a consortium of 11 partners to deliver PIR and Greater Metro South Brisbane Medicare Local (GMSBML) has partnered with 10 non-government organisations (NGOs) that specialise in servicing the community with an understanding, empathetic approach to deliver PIR.

4.2. Housing and Support Models

There are various models of housing and support that are located on a continuum between ‘custodial housing’ at one end, in the middle is ‘supportive housing’, and at the other end of the continuum is ‘supported housing’. In ‘custodial housing’, residents live in a quasi-institutional setting with high levels of control by staff. In ‘supportive housing’, self-contained accommodation in high-density settings allow for 24 hour on-site staffing to support the residents. Finally, ‘supported housing’ is where residents live alone or with others of their choosing, they have tenure that continues in the long-term and irrespective of their needs, which varies greatly, support is provided to them (Gordon 2008). Two of these models will be explored in this section. One is a supported housing model example and one is a permanent supportive housing model example.
4.2.1. Supported Housing Model

Supported housing is a model where support comes to the home. The Housing and Accommodation Support Initiative (HASI) in NSW is an example of supported housing which provides adults with a mental health problem with access to stable housing, clinical mental health services, psychosocial rehabilitation services and accommodation support (Costello et al 2013). HASI supports over 1,000 mental health consumers across NSW living in social and private housing, and this support ranges from very high (8 hours per day) to low (5 hours per week) (Bruce et al 2012).

Under this supported housing model example, NSW Health, Housing NSW and NGOs collaborate to provide:

* “Rehabilitation and support for accommodation is provided by NGOs, with funding from NSW Health;*
* Clinical care and support is provided by specialist mental health services in Area Health Services; and*
* Housing, property and tenancy management services are provided by public and community housing, funded by the Department of Housing” (Mental Health Council of Australia 2009: 43).

This model approaches the issues of the target group in multiple ways to create a more holistic approach. Mental health is tackled to support the person in a recovery philosophy, such that housing for homeless individuals is sought after and once obtained then support is provided to assist in maintaining tenure. Reflecting on the complex issues of this target group, this model example tackles a number of these at the same time.

A number of evaluations have been undertaken of HASI including Muir et al (2007) and Bruce et al (2012). Some of the findings reflect how this model has made inroads for the target population group and may be relevant to explore in the Brisbane LGA. Findings from these evaluations include:

* Over two-thirds of participants (70%) retain their tenancy for 12 months or more, and most participants (85%) remain with the same housing provider;*
* Time spent in psychiatric units and EDs decreased by 81% for 84% of participants, an average of 70 days per person per year;*
* Other measured outcomes included improved health and social networks, a 77% decrease in imprisonment, a tenfold increase in education and training participation, and a threefold increase in paid or voluntary work; and*
* When housing is linked to clinical and rehabilitation support, people are better able to overcome the effects of mental health issues and live more independent lives.

However, two challenges exist in this model example. One is the waiting time to get into the program due to housing supply shortages that mean people have to wait to connect with the HASI program. The other is the cost of the program: “The annual cost of HASI per person ranged between $11,000 and $58,000, plus project
management costs of between $200 to $500, depending on the level of accommodation support and the method of calculating the annual unit cost” (Bruce et al 2012: 9). Yet when factoring in the reduced hospitalisations, incarcerations, improved wellbeing and so many other benefits and savings, this example of supported housing might be a good model to adapt in the Queensland context.

4.2.2. Permanent Supportive Housing Model

Housing First is a model developed out of New York in 1992 initially intended to support and house people with psychiatric diagnoses and substance abuse problems. The philosophy behind Housing First grew out of consumer choice: they always wanted a home first. No longer was housing contingent on drug and alcohol rehabilitation or any other restriction. This approach was revolutionary compared to traditional programs which undermined choice and autonomy, put strict limits on tenancy rights and segregated those with mental illness from others (Greenwood et al 2013).

While Housing First does not require adherence to treatments or any other requirements, permanent supportive housing, a type of Housing First initiative, focuses on housing linked with intensive and integrated support. An example of permanent supportive housing is the Common Ground model from the USA, which has been adopted in Victoria (as HomeGround Supportive Housing) and in Brisbane (as Brisbane Common Ground). Twenty-four hour wrap-around services, nurses, doctors, case workers that assist in income management and a host of other supports (e.g. education opportunities, social activities, wellbeing activities) are all provided on-site for those that live in permanent supportive housing (Costello et al 2013).

The points below describe some of the key features of permanent supportive housing collected from a range of studies into this model. Key elements of permanent supportive housing include:

- Tenants have full rights of tenancy, including a lease in their name; the lease does not have any provisions that would not be found in leases held by someone without a mental disorder.
- Housing is not contingent on service participation.
- Tenants are asked about their housing preferences and provided the same range of choices as are available to others with a mental disorder.
- Housing is affordable, with tenants paying no more than 30% of their income toward rent and utilities.
- Housing is integrated; tenants live in scattered-site units located throughout the community or in buildings in which a majority of units are not reserved for individuals with mental disorders.
- House rules are similar to those found in housing of people without mental disorders.
- Housing is not time limited, so the option to renew leases is with the tenants and owners.
Tenants can choose from a range of services based on their needs and preferences; the services are adjusted if their needs change over time” (Rog et al 2014: 289).

Permanent supportive housing has been successful in its ability to sustained tenancy rates for people with complex needs, mental health, substance abuse and histories of homelessness. Housing First can only go so far with the target group but permanent supportive housing, with its supports, is critically for tenancy maintenance and improved wellbeing of the individuals housed and supported (Costello et al 2013).

Economic evaluations of permanent supportive housing have shown its cost-effectiveness as a model that challenges traditional approaches to ‘managing’ the target group of this review. The impact and burden of the target group, if not effectively supported and housed, on the jail system, health care system, emergency room system and inpatient mental health system are all factored in economic savings. A study by McLaughlin (2010) from the USA found that after 12 months of permanent supportive housing within a cohort from Maine that there were:

- 57% saving of the cost of mental health service money after housing;
- 97% saving in the cost of temporary/emergency shelters after housing;
- 14% saving in cost of emergency room visits;
- 95% saving in the cost of incarceration; and
- 32% saving in the cost of ambulance call-outs.

Similar savings have recently been found at Brisbane Common Ground with a small cohort. This is coupled with consumers improved self-worth, functioning, productivity (e.g. someone being housed and paying rent through social security payments instead of using all their money living on the streets often consuming more drugs and alcohol) and other social benefits to the individual and community.
5. Conclusion

Within the target population group in the Brisbane LGA, homelessness and mental health is synonymous with untreated conditions, hospitalisations, crisis accommodation, insecure transitional housing and rough sleeping. The models that have been presented highlight that supported housing, if stocks were available, would be a good option for some in the target group. Similarly, permanent supportive housing expansion in the Brisbane LGA would create vast in-roads for many who suffer from severe and persistent mental health issues. It has been argued that the traditional mental health model that transformed into a community-based model has largely excluded the target group of this review. ACT expansion could assist in getting treatments to the target group but fall short of housing first principles by still focusing on clinical domains almost exclusively. The support models explored including: assertive outreach and collaborative outreach models; discharge program models; and PIR all operate at the intercession of addressing both housing and mental health issues. These support models can work with the target group and transition them into either supported or supportive housing or public or social housing if continuity of care and support is maintained over the long-term. Each of these models are typically backed by evidence to show their efficacy for the target group, as well as better economic and social outcomes for the broader community.
6. References


