

Trajectories: the interplay between housing and mental health pathways

Final research report

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Related reports and documents

Trajectories: the interplay between mental health and housing pathways. A short summary of the evidence.

Trajectories: the interplay between housing and mental health pathways. Report for national consumer and carer consultations.

Trajectories: the interplay between mental health and housing pathways. Quantitative evidence on the relationship between mental health and housing.

Trajectories: the interplay between mental health and housing pathways. Report for Indigenous consultations.

Trajectories: the interplay between mental health and housing pathways. Policy options report.

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Contents

List of tables	ii
List of figures	iii
Acronyms and abbreviations used in this report	iv
Executive summary	1
1 Introduction	4
1.1 Concepts and definitions	4
2 Methodology	6
2.1 Evidence review	6
2.2 Quantitative analysis	6
2.3 Consumer consultations	7
2.4 Service provider consultations	9
2.5 Synthesis	10
3 Evidence review	11
3.1 Safe, secure, appropriate and affordable housing is important for mental health recovery	11
3.2 Mental health, housing and homelessness are interrelated	11
3.3 Housing, homelessness and mental health are separate policy systems with little integration	13
3.4 Structural trends constrain access to affordable, safe, secure and appropriate housing	13
3.5 Choice and control over housing contribute to wellbeing and mental health recovery	13
3.6 Integrated housing and mental health services are effective but do not meet demand	14
3.7 Families and carers provide significant support	14
3.8 Service and system gaps	15
4 Ideal pathways and real experiences	16
4.1 Social housing policy	16
4.1.1 Social housing pathways	19
4.1.2 Personal factors affecting social housing pathways	20
4.1.3 Homelessness pathways	21
4.1.4 Housing pathways of people living with mental ill-health	22
4.2 Mental health policy	23
4.2.1 Specialist mental health system	24
4.2.2 Stepped care	26
4.2.3 National Disability Insurance Scheme	26
4.2.4 Care models	27
4.3 Families and carers	28
4.4 Intersection between mental health and housing policy	28

5	The interplay between mental health and housing and mediating factors	30
5.1.1	Summary of previous findings from HILDA	32
5.1.2	Relationship between mental health and housing instability	34
5.1.3	Mediating factors	39
5.1.4	Duration of mental ill-health	46
5.2	Relationship between mental health and housing instability for people at risk of homelessness or homeless	47
5.2.1	Entries into homelessness	48
5.2.2	Mediating factors	49
6	Mental health and housing trajectories	51
6.1	How do people with lived experience and service providers view trajectories?	53
6.2	Excluded from help required trajectory	53
6.2.1	Housing	54
6.2.2	Mental health support	55
6.2.3	Diagnosis	57
6.2.4	Lack of assistance to navigate the system	57
6.2.5	System integration	58
6.3	Stuck without adequate support trajectory	61
6.3.1	Choice and control	61
6.4	Cycling	64
6.4.1	Housing and housing support	66
6.4.2	Mental health support	72
6.5	Stabilising trajectory	76
6.6	Well supported trajectory	79
7	Trajectories for young people	81
8	Conclusion and policy implications	83
	Appendix 1: Mental health policy in Australia	86
	Appendix 2: Risk factors for housing and mental health	88
	Appendix 3: Personal risk factors and duration of mental ill health	95
	References	96

List of tables

Table 1:	Marginal effects of mental health on financial hardship, within one and two years, HILDA	35
Table 2:	Marginal effects of mental health on forced moves, within one and two years, HILDA	36
Table 3:	Marginal effects of deteriorating mental health on housing instability, within one and two years, HILDA	37
Table 4:	Tenure and housing instability as predictors of deteriorating mental health, within the next one or two years, HILDA	38
Table 5:	Marginal effects of mental health on housing tenure, HILDA	39
Table 6:	Marginal effects of housing tenure on mental health, HILDA	40
Table 7:	Marginal effects of deteriorating mental health with symptoms and health service use on housing instability, HILDA	41
Table 8:	Marginal effects of health and social connectedness on duration of a spell of mental ill-health, HILDA	42
Table 9:	Effects of health and social support on housing instability and mental health deterioration, within one and two years, HILDA	43
Table 10:	Marginal effects of life events on mental health status, over the next three years, HILDA	44
Table 11:	Marginal effects of being a victim of physical violence on financial hardship, within the next 12 months, HILDA	45
Table 12:	Marginal effects of life events on forced moves, within the next 12 months, HILDA	45
Table 13:	Recovery periods for people with mental health symptoms (MHI-5 > 48), HILDA	46
Table 14:	Marginal effects of mental health on housing tenure, JH	47
Table 15:	Marginal effects of mental health on housing instability, within the next six months, JH	48
Table 16:	Marginal effect of mental health status on entries into homelessness, within the next six months, JH	48
Table 17:	Marginal effect of tenure and social support on entries into homelessness, within the next six months, JH	49
Table 18:	Risk factors as predictors of housing instability, within six months, JH	50
Table 19:	Housing and mental health risk analysis	88

List of figures

Figure 1: The housing continuum	17
Figure 2: Social housing policy implies a throughput pathway	18
Figure 3: Role of housing and homelessness sector services in pathways to secure housing	19
Figure 4: Pathways into social housing: risk factors, triggers and barriers	21
Figure 5: Indicative housing career for a person with a psychiatric disability	23
Figure 6: Stepped care model	25
Figure 7: Mental health and housing instability: direct effects and mediating factors	31

Acronyms and abbreviations used in this report

ACT	Australian Capital Territory
AHURI	Australian Housing and Urban Research Institute Limited
AOD	Alcohol and other drugs
DSP	Disability Support Pension
GP	General practitioner
HASI	Housing and Accommodation Support Initiative
HILDA	Household, Income and Labour Dynamics in Australia
JH	Journeys Home: Longitudinal Study of Factors Affecting Housing Stability
K6	Kessler Psychological Distress Scale (six-item version)
MBS	Medicare Benefits Schedule
MHI-5	Mental Health Inventory (five-question version)
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NSW	New South Wales
NT	Northern Territory
PHN	Primary Health Networks
PIR	Partners in Recovery
SA	South Australia
SIL	Supported Independent Living
WA	Western Australia

Executive summary

Mind Australia in collaboration with the Australian Housing and Urban Research Institute (AHURI) have conducted a national study, *Trajectories: the interplay between mental health and housing pathways*, to develop a clearer understanding of the housing and mental health pathways of people with lived experience of mental ill-health. The research project aimed to identify typical housing and mental health pathways, the intersection of these pathways, and potential points of intervention.

This report presents the final analysis and findings of the Trajectories research project, which consisted of four streams of investigation:

- an evidence review of academic and grey literature
- a quantitative analysis of the Household, Income and Labour Dynamics in Australia (HILDA) Survey and the Journeys Home: Longitudinal Study of Factors Affecting Housing Stability (JH) datasets in Australia
- interviews and focus groups with carers and people with lived experience of mental ill-health
- focus groups with housing and mental health service providers.

Trajectories is a companion project to the recent AHURI research commissioned by the National Mental Health Commission (NMHC), which examined the issues and policy levers required to provide more and better housing for people with lived experience of mental ill-health (Brackertz, Wilkinson et al. 2018).

Key findings

Housing is the foundation for mental health recovery

Safe, secure, appropriate and affordable housing is critical for recovery from mental ill-health and for being able to access appropriate support services. Yet, there is a shortage of appropriate housing options for people with lived experience of mental ill-health. Key issues are: decreasing housing affordability, social housing shortages, and a lack

of supported housing. The housing, homelessness and mental health policy systems are crisis-driven and are not well integrated, which means that many people struggle to access the supports they need when they need them.

Mental health, housing and homelessness are interrelated

The quantitative analysis showed that poor and deteriorating mental health directly impact housing stability (as measured by forced moves and financial hardship). People who experienced severe psychological distress had an 89 per cent increased likelihood of financial hardship in the following year and a 96 per cent increased likelihood of financial hardship within two years. People with a diagnosed mental health condition had a 39 per cent increased likelihood of experiencing a forced move within one year. Most people within the general population experienced only relatively short periods of mental ill-health: 66 per cent recovered within a year and 89 per cent recovered within three years.

Mediating factors can reduce the likelihood of housing instability

The quantitative analysis showed that mediating factors, such as social support, good general health, and accessing mental health and other health services, can reduce the likelihood of housing instability and shorten the length of time a person experiences mental ill-health. Conversely, an absence of mediating factors and experience of negative life events can amplify the relationship between housing instability and mental ill-health.

People who had deteriorating mental health (to the point where they experienced symptoms of anxiety, depression and mental distress) and who did not access health services were 58 per cent more likely to experience a forced move within the next two years, and were 35 per cent more likely to experience financial hardship within one year.

Social support reduced the likelihood that a person would experience deteriorating mental health to the point where they had symptoms by 33 per cent.

Non-linear trajectories for recovery

Housing and mental health policies use ‘ideal pathways’ to conceptualise how people travel through systems. Contrary to the ideal social housing pathway circumscribed by policy, actual social housing pathways are rarely linear and are shaped primarily by eligibility criteria, a need to ration social housing and target it to those most in need, and the way in which social housing policies are operationalised. Similarly, mental health policies do not accurately reflect the real-life trajectories of many people with mental ill-health. Rather, people experience non-linear trajectories.

The research identified five overarching trajectories: excluded from help required, stuck without adequate support, cycling, stabilising, and well supported.

- The **excluded from help required trajectory** is characterised by a lack of access to housing or mental health care. People may be excluded from housing and mental health care because: they do not meet eligibility criteria; they lack financial resources; housing and supports are not available, inappropriate or difficult to access; the system is crisis-driven, fragmented and difficult to navigate.
- People on the **stuck without adequate support trajectory** are trapped in inappropriate housing, institutions or services due to a lack of options, choice and/or long-term pathways.
- The **cycling trajectory** is marked by a downward spiral in which people enter into and drop out of supports repeatedly, which progressively erodes their resources. Cycling is due to: inadequate transitions between services and different parts of the system; lack of clarity about which services or parts of the system are responsible for providing support; the episodic nature of mental ill-health; lack of continuity; and the preponderance of short-term supports.
- People on the **stabilising trajectory** have access to secure, safe, appropriate and affordable housing, ongoing mental health support, help to facilitate meaningful social

connections, and financial stability, which allow them to focus on recovery and rebuild their lives.

- People on the **well supported trajectory** have the type of housing and level of care that aligns with their individual capacity and needs, and which allows them to develop their independence and achieve their ambitions beyond housing and mental health.

Policy implications

The stabilising and well supported trajectories demonstrate the elements that need to be supported by policy to enable people to get well and stay well.

- **Access to safe, secure, affordable and appropriate housing** that allows for control of space; is in safe neighbourhoods with meaningful social support and connections (close to family and friends, good relationships with neighbours); and provides access to public transport, services, and opportunities for work, volunteering or study.
- **Connection to a trusted worker** with whom a respectful ongoing relationship can be established—someone who has the skills to assist in navigating services and who can provide advocacy and support when challenges arise.
- **Support coordination, and assistance and advocacy to navigate the system.**
- **Access to psychosocial support** to help with day-to-day tasks; maintaining tenancies, relationships and health; establishing and maintaining a routine; and undertaking meaningful activities.
- **Financial security**, either through employment or the Disability Support Pension (DSP).
- **Holistic support that meets the level of need.** The quantitative analysis offers strong evidence of the importance of holistic approaches that integrate housing and mental health support with social support, healthcare and financial support, and effective early intervention (i.e. mediating factors).

- **Timely access to support** when needed.
- **Trauma counselling** to enable people to better deal with the ongoing effects of trauma.
- **Culturally appropriate services.**¹

The well supported trajectory evidences the elements of policies that would enable people to remain well and focus on aspects of their lives beyond housing and mental health recovery. There is no one specific outcome that classifies as ‘well supported’; rather, a well supported trajectory aligns with a person’s individual capacity and their needs in terms of housing and mental health. It means that a person has the necessary support to develop their independence and achieve their ambitions.

Housing that facilitates a well supported trajectory is affordable, safe and secure, and appropriate to the person’s needs. This could be home ownership or social housing, or it could be living with family or carers where this is sustainable, appropriate and safe and there is support for the carer. Mental health support needs to be appropriate to the person’s level of need and offer choice and flexibility to ‘step up’ or ‘step down’ as their needs change.

Key elements of being well supported are as follows.

- **Ability to navigate the system**, whether independently, with low-level support, with informal support (in a way that does not negatively affect relationships in the long term), or with long-term support. Consumers know what services are available and how to access them, and supports are continuously available to the person.
- **Feeling empowered to self-advocate to services**, to engage with the community as equals, to complain if there has been injustice, and to take risks.
- **Being financially secure**, able to pay rent and bills, and feeling in control of finances. Consumers have enough financial support to

socialise and for recreation. They feel comfortable that they could survive financially even if they experienced a long period of ill-health.

- **Having appropriate, secure, safe and affordable housing** in the right location. Tenure is secure, regardless of how long a consumer may be absent from their tenancy due to mental health related issues (such as hospitalisation).
- **Participating in meaningful activities**, such as volunteering, employment or social activities, which provides a feeling that there is structure and purpose in life. Consumers have adequate formal support to maintain existing social relationships and build on them if needed.
- **Having an ongoing and appropriate level of support** that meets basic needs at a level to maintain wellness in the long term and having access to crisis support if needed.
- **Ability to focus on things beyond housing and mental health**—for example, returning to the workforce, studying, volunteering, or rebuilding relationships with friends or family.

The findings suggest that to be effective, policy responses should strive for integration across the housing and mental health systems; increase the use of health and mental health services by people experiencing mental ill-health; implement authentic person-centred approaches that integrate mental health, physical health and social support across the life course; and reorient service systems away from just responding to crises, so that support is immediately available to mitigate negative life events.

Further research is currently underway to develop viable policy options based on the research findings and it is expected that these will be available in mid-2020. All *Trajectories* research reports are available at <https://www.ahuri.edu.au/research/trajectories>.

¹ A separate report details the findings from the research project’s consultations with Indigenous participants and will be available in mid-2020 from <https://www.ahuri.edu.au/research/trajectories>.

1 Introduction

This report synthesises and analyses the findings of the *Trajectories: the interplay between mental health and housing pathways* research project. The project aimed to develop an applied understanding of the housing and mental health pathways of people with lived experience of mental health issues, the interaction of these pathways, and the potential points of intervention identified through this understanding. The project also aimed to identify failure points in the housing and mental health systems—failure points represent missed opportunities for early intervention and prevention, and potential key areas for system improvement.

There is a moderate supply of Australian research examining the interplay between housing, homelessness and mental ill-health. Existing academic research and grey literature primarily focus on system and policy-level factors, the nexus between mental health and homelessness, or evaluation of specific housing and mental health programs and initiatives in a number of jurisdictions. This new research adds to the evidence base by combining analysis of system-level factors, quantitative data examining the links between housing and mental health, and fine-grained qualitative data examining the experiences of people with mental ill-health who have a history of precarious housing or homelessness.

Trajectories is a companion project to the recent AHURI research commissioned by the National Mental Health Commission (NMHC), which examined the issues and policy levers required to provide more and better housing for people with lived experience of mental ill-health (Brackertz, Wilkinson et al. 2018).

1.1 Concepts and definitions

‘Housing pathways’ describe the experiences and mobility of households and residents within the housing system (Clapham 2002; Powell, Meltzer et al. 2019; Wiesel, Easthope et al. 2012). Housing pathways refer to:

patterns of interaction (practices) concerning house and home, over time and space ... The housing pathway of a household is the continually changing set of relationships and interactions, which it experiences over time in its consumption of housing (Clapham 2002).

This research builds upon and extends the concept of housing pathways, and broadens it to describe the experiences of housing and mental health over time and in relation to mobility and place, by individuals who are living with mental ill-health. We refer to these housing and mental health pathways as ‘trajectories’.

Trajectories can be non-linear, circuitous or interrupted. There is no one ‘ideal trajectory’. Rather, the success of a trajectory is judged in terms of how well it aligns with an individual’s capacity and needs in terms of housing and mental health. This conceptualisation acknowledges that there can be multiple trajectories and that people can move between trajectories.

Trajectories reflect the tension between legislation, government policies and services’ operational policies and procedures; individual experiences, choices, capacity, relationships and interactions; and the impact of demographic characteristics and significant life events.

Like housing pathways, trajectories are shaped by induced (push) factors (e.g. personal or health crises, eviction, stigma, issues with neighbours, safety concerns, problems with the dwelling) and pull factors (i.e. personal choice, family formation) (Wiesel, Easthope et al. 2012). It is important to note that trajectories do not reflect a person’s mental health status. Rather, they show people’s transitions through both the housing and mental health systems.

The terms ‘mental ill-health’, ‘mental wellbeing’ and ‘mental illness’ are used inconsistently in the literature and in common usage, and often the meanings of these terms overlap.

This report uses the term mental illness to refer to people with one or more serious mental disorders. Mental ill-health is used as an umbrella term that captures the entire range of mental health issues, comprising the following.

- ‘Low-prevalence’ conditions—including schizophrenia and other psychoses, schizo-affective disorder, bipolar disorder and major depression—which affect approximately 3 per cent of the adult population.
- ‘High-prevalence’ conditions, including depression and/or anxiety and affective disorders. These are the most common mental health disorders, affecting approximately 14 per cent and 6 per cent of adults each year, respectively, with about a quarter of those having more than one disorder. ‘These disorders include diverse conditions (e.g. post traumatic stress disorder, obsessive compulsive disorder, depression, bipolar disorder) that have different treatment requirements and outcomes’ (Commonwealth of Australia 2009).

‘Psychosocial disability’ refers to the functional restriction associated with a mental health disorder on a person’s capacity to manage the social and emotional areas of their life.

2 Methodology

The research consisted of four streams of investigation.

- 1 Evidence review:** a review of the existing evidence and data sources.
- 2 Quantitative analysis:** a quantitative analysis of the HILDA Survey and the JH datasets.
- 3 Consumer consultations:** interviews and focus groups with carers and people with lived experience of mental illness.
- 4 Service provider consultations:** focus groups with housing, homelessness, health and mental health service providers.

2.1 Evidence review

The evidence review was undertaken as a separate study and is summarised in section 3 (Brackertz, Wilkinson et al. 2019; Brackertz, Wilkinson et al. 2018). The evidence review surveyed the evidence base and policy landscape in relation to mental health and housing, and included review of:

- Australian and international mental health and housing programs and models, focussing on interventions that lead to sustainable tenancies for people with mental health issues
- policy levers and system-level drivers relating to housing, mental health and homelessness in Australia
- individual and structural factors contributing to, and the prevalence of, mental ill health, homelessness, and housing precariousness
- datasets capturing mental health prevalence, service use and needs in Australia in relation to housing.

2.2 Quantitative analysis

The quantitative stream of the research analysed the HILDA and JH datasets to better understand the relationship between mental health, housing instability and homelessness, identify the protective and risk factors (mediating factors), and ascertain the duration of mental ill-health.

To this end, the analysis:

- considered the direct effects of mental health status and deteriorating mental health on tenure and housing stability
- modelled the impact of mediating factors (health and mental health services use, physical health, life events, housing and non-housing factors)
- undertook a survival analysis to determine the duration of spells in which people experience mental ill-health.

Both HILDA and JH screen for the presence of mental ill-health. HILDA includes the five-question Mental Health Inventory (MHI-5) annually and the 10-item Kessler Psychological Distress Scale (K10) biennially from wave 7. JH uses the abbreviated six-item Kessler Psychological Distress Scale (K6) in every survey. These measures can be used to indicate a person's mental health status, particularly depression and anxiety, but are not clinical assessments of the person's mental health. Both HILDA and JH include limited information on whether a person has a mental health diagnosis.

The analysis assessed the impact of a person's mental health (as indicated by the MHI-5 and K6 scores) on their tenure and housing stability, as well as the impact of a deterioration in mental health over time. The analysis differentiated between people with good mental health and those with poor mental health by using a model specification that captures deteriorating mental health only for people who have evidence of an underlying mental health issue (i.e. who have an MHI-5 score greater than 48). The K6 is categorised into three risk categories: no evidence of mental illness ($K6 < 5$); mild to moderate mental illness ($K6 = 5-12$); and severe mental illness ($K6 \geq 13$). The analysis also considered the impact of a mental health diagnosis.

Housing instability was measured using three proxies: forced moves, financial hardship and entry into homelessness (JH only).

- The **forced move** variable was constructed as a binary indicator of whether a person had been forced to move from their home since their

previous interview (approximately 12 months prior for HILDA and approximately six months prior for JH). Reasons for forced moves included: eviction, the property becoming unavailable, problematic drug or substance use, housing stress, health problems, relationship breakdown, unemployment, or being required to move between public housing properties.

- HILDA and JH measure **financial hardship** by asking survey respondents whether one of the below events occurred in the previous 12 months (six months for JH) because of a shortage of money. The modelling used information from the current wave to predict if the individual will experience financial hardship in the subsequent survey period.
- Analysis of **entries to homelessness** is only possible using JH data as HILDA does not include variables that measure homelessness. Analysis of entries into homelessness used the same approach as for forced moves. It aimed to predict whether values for the current wave of data have a significant relationship with entry into homelessness by the next survey.

The analysis evaluated the relationships between a person's mental health, changes in their mental health, and their use of health services. HILDA and JH ask whether the respondent used any of a number of health services in the previous 12 months (six months for JH). The analysis included the following items: all health services, mental health services, general practitioners (GPs), dental services, and hospital stays.

Modelling included several control variables to ensure that individual characteristics other than mental health or tenure did not create bias in the model. We controlled for gender, age, Aboriginal and Torres Strait Islander status, family composition, number of children, urban area, state, education level, labour force status, income, level of relative disadvantage, and wave dummies.

The analysis used three different modelling techniques. Multinomial modelling was used when there was more than one possible outcome

and these outcomes were not ordered. Logistic modelling was used for binary questions (e.g. whether or not the individual moved in the past survey). The third technique was survival analysis, which was used to test the length of time individuals experience mental health symptoms (anxiety, depression and mental distress).

2.3 Consumer consultations

Consumer consultations with carers and people with lived experience of mental ill health gathered participants' experiences of housing and mental health. Consumer consultations were designed to have national coverage and ensure that Indigenous consumers, who are at high risk of mental health issues, housing stress and homelessness, were represented.

There were 130 participants, including participants from Victoria (18); Queensland (12); New South Wales (NSW) (12); Australian Capital Territory (ACT) (7); Northern Territory (NT) (22); Western Australia (WA) (31); South Australia (SA) (12); and Tasmania (16).

Sixteen consumer consultations were held in 14 metropolitan and regional locations across the eight states and territories (as listed below). Thirteen consultations focussed on consumers (people who self-selected on the basis of having mental health and housing issues). Four of the consumer consultations focused on Indigenous people. Three consultations focussed on families and unpaid carers of people with mental health and housing or homelessness issues. The consultations consisted of individual interviews with approximately six people in each location, and a focus group with the same people where feasible.

One-on-one interviews were carried out face to face and were approximately 60 minutes in duration, although some lasted up to 90 minutes. Focus groups lasted around 2 hours. Interviews and focus groups used semi-structured narrative techniques designed to elicit people's 'stories' and the meanings they attached to their experiences.

Interviews asked for people's personal accounts of their mental health and housing journeys. Interviews explored people's housing histories and the range of factors that influenced their choices of housing, including their mental ill-health/wellness status; the type of housing they lived in; what housing they could afford; what housing they preferred to live in; and the role and appropriateness of various forms of accommodation.

Focus groups asked for people's perspectives of the housing and mental health systems, including systemic issues.

Interviews and focus groups were audio recorded (with the participants' consent) and transcribed. Consultations were conducted between January and December 2019.

Inclusion criteria included: having experience of mental illness and/or distress, and/or difficulties with housing and/or homelessness—either directly or as the family member or carer of someone with those experiences. Additionally, participants were over 18 years of age, could communicate in English, and were capable of providing informed consent. The criteria recognised the legal right and capability of people with disability to all aspects of social inclusion, as outlined in the Convention on the Rights of Persons with Disabilities.

The sample was not intended to be representative but aimed to reflect a breadth of experiences. Participants represented a diverse cohort in terms of age; gender; sexual orientation; mental health condition; current living arrangement; and location (urban, regional, remote). Ethics clearance for this component of the research was received from the University of Wollongong (20218/402).

The locations for the consumer consultations were as follows.

- Melbourne (Victoria), 16–17 January 2019, five interviews and one focus group
- Brisbane (Queensland), 21–22 January 2019, six interviews and one focus group

- Adelaide (SA), 30–31 January 2019, six interviews and one focus group
- Wangaratta (Victoria), 25–26 February 2019, six interviews and one focus group
- Hobart (Tasmania), 12–13 March 2019, seven interviews and one focus group
- Bathurst (New South Wales), 26–27 March 2019, six interviews and one focus group
- Canberra (ACT), 8–9 April 2019, seven interviews and one focus group
- Berri (SA), 12–13 April 2019, six interviews and one focus group
- Sydney (NSW), 21–22 May 2019, six interviews and one focus group

The locations for the Aboriginal and Torres Strait Islander-specific consultations were as follows.

- Port Hedland (WA), 20–23 May 2019, 14 interviews and one focus group
- Alice Springs (NT), 12–13 August 2019, 10 interviews
- Darwin (NT), 15–16 October 2019, 12 interviews
- Melbourne (Victoria), 3, 5, 9 and 16 December 2019, seven interviews

The locations for the carer's consultations were as follows.

- Hobart (Tasmania), 28 May 2019, one focus group
- Perth (WA), 12–13 June 2019, nine interviews and one focus group
- Mackay (Queensland), 31 July and 1 August 2019, six interviews

Participant recruitment took place through identified organisations that typically provide support, information and/or advice to adults with mental health issues, or with difficulties with housing or who are experiencing homelessness, in the relevant areas where the research took place.

Several organisations assisted in recruitment, including: EACH Social and Community Health, Wellways, Flourish Australia, Neami National, HelpingMinds, Danila Dilba Health Service, Larrakia Nation, TeamHEALTH, Yilli Rreung Housing, Tangentyere Council, Mental Health Association of Central Australia, Central Australian Affordable Housing, Bloodwood Tree Association and NT Shelter. Participants were paid \$60 for participation in the interview and \$60 for participation in the focus group. They were also reimbursed for travel expenses to and from the consultation location/s.

Interviews were transcribed and repeatedly read by researchers to achieve immersion and obtain a sense of the key themes across the range of interviews. Key thoughts, ideas and concepts from the manifest content were highlighted throughout the interviews using a coding scheme. These codes were then used to identify a series of typologies that reflect typical housing and mental health pathways, experiences of the intersection between housing and mental health systems, and the role of individual contributory factors.

Demographics were collected for 63 people with lived experience of mental ill-health. The average age of consumers was 42 years, with one-third of the cohort aged under 34 years. Participants in the consultations represented a roughly equal distribution of gender. A majority of participants were born in Australia and spoke English as their primary language. Most of the participants were not employed: around a third were not employed and not seeking employment; while around half were not employed and seeking part-time or full-time work. Of those participants who reported their income, around half were earning between \$15,000 and \$29,999 per annum.

The most commonly reported disability status was physical disability, followed by intellectual disability and dual physical/intellectual disability. The most often disclosed mental conditions were anxiety and depression. Around a third of participants reported that they were living with post-traumatic stress disorder (PTSD), schizophrenia or schizo-affective disorder, or bipolar affective disorder. Two-thirds

of participants disclosed that they had multiple diagnoses. Transitional housing was the most common tenure, with one-third of participants living there. Around a tenth of participants were living, respectively, in private rental, in public housing, with family, or as home owners.

2.4 Service provider consultations

The service provider consultations consisted of focus groups with mental health, housing and homelessness service providers. The consultations aimed to develop an understanding of: typical client pathways (ways of entering, navigating and exiting the support system); potential intervention points; and challenges from a service provider perspective. Mental health providers from both community organisations and hospitals were encouraged to attend due to differences in their focus and role in treatment. Participation was open to all service providers in the field of housing and mental health in Australia. All providers that could be identified were contacted and invited via email.

The consultations were held in the eight Australian capital cities and included a total of 109 participants.

Within each focus group, housing and mental health service providers were represented to ensure the discussions captured both perspectives. The duration of each focus group was around three hours. After a brief introduction to the project, the focus groups were structured around several open-ended lead questions, enabling participants to discuss key points of interest from their perspective in detail.

The locations for the service provider consultations were as follows.

- Sydney (NSW), 6 June 2019, 10 participants
- Canberra (ACT), 7 June 2019, 13 participants
- Hobart (Tasmania), 18 June 2019, eight participants

- Melbourne (Victoria), 21 June 2019, 24 participants
- Adelaide (SA), 26 June 2019, 12 participants
- Perth (WA), 28 June 2019, 18 participants
- Brisbane (Queensland), 2 July 2019, 15 participants
- Darwin (NT), 26 August 2019, nine participants

The focus groups were audio recorded, transcribed and then thematically coded using NVivo software. This coding allowed the researchers to identify key themes and narratives. The codes were then used to identify a series of themes reflecting typical housing and mental health pathways, and experiences of the intersection between housing and mental health systems.

2.5 Synthesis

The final step in the research was the synthesis of findings across the four streams of investigation. This involved integration of qualitative and quantitative findings, and triangulation of these within the literature. Based on this work, a conceptual framework was developed and applied to the analysis. This framework was used to test for robustness of the findings and to generate a number of 'typical' housing and mental health trajectories.

3 Evidence review

- Safe, secure, appropriate and affordable housing allows people to focus their attention on mental health recovery.
- Housing/homelessness and mental health have a bidirectional relationship: mental ill-health increases the likelihood of poor housing outcomes; housing instability and homelessness may act as a trigger for mental ill-health.
- The mental health, housing and homelessness policy systems are not well integrated. A policy system that addresses both housing and mental health would lead to better housing and mental health outcomes.
- Several integrated mental health and housing support models operate in Australia, but do not meet demand for services.
- Crisis-driven and reactionary mental health and housing systems contribute to inadequate housing and exacerbate mental health issues.

This section summarises the evidence on the relationship between housing and mental health in Australia.²

3.1 Safe, secure, appropriate and affordable housing is important for mental health recovery

Safe, secure, appropriate and affordable housing allows people to focus their attention on mental health recovery (Bleasdale 2007; Honey, Nugent et al. 2017) and can improve mental health by facilitating independence, social relationships and networks (O'Brien, Inglis et al. 2002). Unaffordable housing is detrimental to mental health for low-income earners (Bentley, Baker et al. 2011, 2016; Ong, Wood et al. 2019).

Good-quality housing benefits tenants with mental ill-health through reduced mental health care costs, greater wellbeing, and residential stability (Adair, Kopp et al. 2016; Harkness, Newman et al. 2004; Nelson, Sylvestre et al. 2007), and better mental health functioning (Aubry, Duhoux et al. 2016; Bond, Egan et al. 2012; Egan, Katikireddi et al. 2013; Evans, Wells et al. 2000; Wells and Harris 2007).

Good neighbourhood amenity is a factor in reducing mental health care service use among people with mental ill-health (Friesinger, Topor et al. 2019; Harkness, Newman et al. 2004).

Housing quality factors, such as perceived security and the interior of the home, affect a person's psychosocial status and can relate to an improvement in mental health (Clark and Kearns 2012; Ecker and Aubry 2016; Nemiroff, Aubry et al. 2011).

3.2 Mental health, housing and homelessness are interrelated

The evidence demonstrates a complex bidirectional relationship between housing/ homelessness and mental health. A number of structural and individual factors increase the likelihood of mental ill-health onset and the likelihood of poor housing outcomes among people with lived experience of mental ill-health. For example, mental ill-health can lead to homelessness. Conversely, homelessness may act as a trigger for mental ill-health, and people with lived experience of mental ill-health are more vulnerable to common risk factors for

² This evidence review provides a summary of the detailed review undertaken as a separate study (Brackertz, Wilkinson et al. 2018; Brackertz, Wilkinson et al. 2019).

homelessness, such as domestic and family violence, alcohol and other drug addiction, and unemployment (Bevitt, Chigavazira et al. 2015; Flatau, Conroy et al. 2013; Johnson, Scutella et al. 2015a; Steen, Mackenzie et al. 2012; Stone, Sharam et al. 2015; Wood, Batterham et al. 2015).

Housing choice and access to secure, affordable and appropriate housing allows people to focus on mental health treatment and rehabilitation, while precarious housing and homelessness make it difficult for people to access mental health treatments and supports (Bleasdale 2007; Honey, Nugent et al. 2017; Johnson, Scutella et al. 2015a; Pearson and Linz 2011).

Individual risk factors for housing instability and mental ill-health include the following.

- **Homelessness.** The prevalence of severe and persistent mental illness is higher among homeless people than the general population (Lourey, Holland et al. 2012) and the risk of homelessness among people with mental ill-health is significant. However, an Australian study shows a reduced chance of entering homelessness among people diagnosed with bipolar disorder or schizophrenia (Johnson, Scutella et al. 2015b) as this cohort is more likely to receive formal supports (Pearson and Linz 2011). The isolation and trauma often associated with rough sleeping can also precipitate mental illness (Johnson and Chamberlain 2011).

Westoby (2016) identified four typical categories of people with severe or chronic mental illness who are homeless: (1) homeless and did not receive any mental health support; (2) attended to and hospitalised by medical practitioners but not adequately supported when released back into the community; (3) treated in a psychiatric facility in hospital and remained hospitalised without a discharge or exit strategy back into the community; and (4) experienced primary or secondary homelessness in substandard and insecure tenures, and struggled to manage their mental health.

- **Lack of social support.** People often draw on the financial and emotional support of friends and family during crises. The symptoms of

mental illness can cause individuals to withdraw from or overtax their support networks, thereby eroding the informal resources available to them in times of crisis (Gaebel, Rössler et al. 2016; O'Brien, Inglis et al. 2002).

- **Alcohol and other drugs (AOD).** Long-term substance addiction has been linked to anxiety, depression and paranoia, while people with bipolar disorder, anxiety or antisocial personality disorder are most vulnerable to alcohol or other drug addiction (AIHW 2016a; Shivani, Goldsmith et al. 2002).
- **Domestic and family violence (DFV).** DFV contributes to homelessness for parents and children, and those escaping DFV are vulnerable to mental ill-health as a result of trauma associated with violence in the family home (AIHW 2016c; Gilroy, McFarlane et al. 2016; Rees, Silove et al. 2011).
- **Interaction with the criminal justice system.** People with mental ill-health who enter prison or forensic care are at elevated risk of housing instability and homelessness (Baldry, Dowse et al. 2012; Forensicare 2011; Johnson, Scutella et al. 2015b; Robinson 2003).
- **Unemployment.** Employment can mitigate homelessness by facilitating greater access to longer-term accommodation options such as private rental, while also improving mental health through feelings of empowerment and self-worth (Bond, Kearns et al. 2012; Caton, Dominguez et al. 2005; Howden-Chapman, Chandola et al. 2011; Johnson, Scutella et al. 2015b).
- **Physical ill-health.** People with physical ill-health have a higher rate of entry into homelessness, and the presence of a chronic health condition predicts longer duration of, and lower rates of exit from, homelessness (Bevitt, Chigavazira et al. 2015).
- **Complex and high needs.** People experiencing both homelessness and mental ill-health represent a hard-to-reach group for service providers (Brackertz and Winter 2016). Ineffective service responses can have significant impacts given that causation flows in both directions with regard to the worsening of mental health and homelessness (Johnson and Chamberlain 2011).

- **Difficult behaviours.** Some behaviours associated with mental ill-health (e.g. antisocial behaviour, delusional thinking, inability to prioritise finances) may be detrimental to a person's housing situation. For example, difficult behaviours may trigger antisocial behaviour management policies for people living in public housing, sometimes causing eviction (Jones, Phillips et al. 2014).

3.3 Housing, homelessness and mental health are separate policy systems with little integration

The detailed evidence review undertaken by AHURI for the National Mental Health Commission identified that housing, homelessness and mental health are separate policy systems with little integration, and this contributes to poor housing and health outcomes for people with lived experience of mental ill-health (Brackertz, Wilkinson et al. 2018). In addition, each of the states and territories has different policy settings for housing, homelessness and mental health, which further contributes to the fragmentation of the system.

Current national policy does not provide guidance as to whether, and to what degree, it is incumbent on the housing system, mental health system, or mainstream health system to address issues of precarious housing and homelessness for people with mental ill-health.³

Policies at national and state levels recognise that greater integration and coordination is needed between mental health, homelessness and housing services in the community. However, plans for policy implementation rarely make systematic connections between these services; connections at a program or strategic level are limited to a few jurisdictions and plans fail in implementation. Overall, housing and mental health system integration is a recent phenomenon in Australia and has occurred in an ad hoc manner, with significant

differences between the states and territories in the scope of system integration.

3.4 Structural trends constrain access to affordable, safe, secure and appropriate housing

The long-term structural trends in the Australian housing system—falling rates of home ownership, an increase in private rental, declining stocks of social housing, and lack of affordable housing for low-income households—are key factors in the housing issues facing those with mental ill-health (ABS 2017; AIHW 2016b). Most people with lived experience of mental ill-health rent in the private market, yet many struggle with discrimination, insecure tenure and housing affordability (Harvey, Killackey et al. 2012; SANE Research 2008; Wiesel, Pawson et al. 2014). Social housing is also a key tenure for this group, but is highly rationed. Additionally, the evidence suggests that the social housing system does not adequately monitor and consider the mental health of its tenants, missing opportunities for early intervention by linking tenants with appropriate supports before a crisis eventuates. Antisocial behaviour policies in several Australian states and territories have been shown to disadvantage people with lived experience of mental ill-health (Jones, Phillips et al. 2014). There is a shortage of supported housing with integrated mental health support (Brackertz, Wilkinson et al. 2018).

3.5 Choice and control over housing contribute to wellbeing and mental health recovery

Choice and control over housing and support contribute to wellbeing and quality of life for people with mental ill-health (Nelson, Sylvestre et al. 2007). Autonomy with respect to housing aspirations, and access to housing that fosters meaningful

³ For a detailed analysis of relevant policies see Brackertz, Wilkinson et al. (2018).

relationships in the home and the community, are associated with improved wellbeing and quality of life, and decreased symptomatology and service use (Aubry, Duhoux et al. 2016; Nelson, Sylvestre et al. 2007).

Control over housing can deliver indirect positive mental health outcomes to individuals through feelings of empowerment and belonging. Empowerment and personal control are associated with greater resilience and ability to cope with stressors among people with severe mental illness (Aubry, Duhoux et al. 2016). The sense of belonging engendered by stable, secure and appropriate housing is critical to mental health recovery and reduces the risk of depressive symptoms, particularly among people in assisted living facilities (McLaren, Turner et al. 2013).

3.6 Integrated housing and mental health services are effective but do not meet demand

Several integrated mental health and housing support models operate in Australia, including permanent supported housing (the ‘housing first’ approach), continuum of care, and combined hybrid models (e.g. assertive outreach targeting rough sleepers and focussing on discharge pathways for people exiting institutional care).

Critical success factors for integrated models include: rapid access to appropriate, affordable and stable housing; and effective policy and stakeholder coordination at the state and local levels, which can be facilitated via formal agreements, memoranda of understanding, and cross-sector and local collaboration (Brackertz, Wilkinson et al. 2018).

Examples of integrated housing and mental health models include NSW’s Housing and Accommodation Support Initiative (HASI), the Doorway program in Victoria, Queensland’s Housing and Support Program, and South Australia’s Housing and Accommodation Support Partnership Program. Program evaluations show that these programs are successful, lead to government cost

savings, and have positive outcomes for consumers in relation to both housing and mental health (Bruce, McDermott et al. 2012; Dunt, Benoy et al. 2017; Meehan, Madson et al. 2010). However, the schemes tend to be small in scale, localised, pilot programs, or have time-limited funding—they therefore do not meet the need for such programs (Brackertz, Wilkinson et al. 2018).

Barriers to scaling up successful programs nationally include: lack of a national framework, lack of commitment to innovative funding models, lack of formalised agreements for collaboration between housing and mental health providers at a local level, and constraints on the organisational capacity in the housing sector around mental illness and mental health provision (Brackertz and Badenhorst 2015).

3.7 Families and carers provide significant support

Families and carers are an important source of support for people experiencing mental ill-health. However, assistance to support families and carers is limited, which negatively affects their own health and wellbeing. A survey of NSW carers of people with mental health issues reported poorer general health and mental health than any other group of carers, despite being more likely to access supportive services (Broady and Stone 2015).

In 2015, the Australian government spent approximately \$1.2 billion on mental health carer services in Australia, though a substantial number of families and carers do not receive any government support for their caring activities (Diminic, Hielscher et al. 2017; Hielscher, Diminic et al. 2018). A survey by Hielscher, Diminic et al. (2018) highlighted several issues relating to mental health carer support services, including:

- a paucity of information about mental health carer support services
- carer exclusion from treatment and discharge planning and discussions about recovery by mental health professionals

- a need for greater respite care and emotional support provision for mental health carers and family
- responsibility and burden falling entirely on carers due to gaps in mental health services for care recipients
- the problem of a support service system which fails to consider the episodic caring needs of mental health carers
- difficulties for mental health carers accessing sufficient financial supports.

3.8 Service and system gaps

A number of service and system gaps contribute to inadequate housing and exacerbate mental health issues for people with lived experience of mental ill-health (Brackertz, Wilkinson et al. 2018). These gaps are due to factors such as: crisis-driven and reactionary mental health and housing systems that do not adequately promote preventative support; a focus on time-limited, fee-paying support rather than ongoing support that is not contingent on ability to pay; expertise and workforce gaps; lack of flexibility in the system to consider the individual economic, social and health circumstances of people; and inpatient treatment and private psychology not providing continuity of care (services often end abruptly, leading to premature discharge from care and a lack of follow-up support). Key service and system gaps are as follows.

- **Location constraints.** Programs that assist people with both appropriate housing and mental health support are not available in most jurisdictions and are especially difficult to access in regional and rural areas.
- **Housing supply gaps.** An inadequate supply of affordable and appropriate housing puts people at risk of homelessness and deterioration of mental health. Some people exiting residential mental health programs or hospitals cannot access appropriate and affordable housing in a timely way. This can result in higher costs for hospitals unable to discharge and can lead to homelessness for people who are discharged without viable housing options.
- **Discharge planning inadequacies.** Some jurisdictions have protocols for post-discharge arrangements following exits from psychiatric facilities; however, protocols for mental health and tenancy supports for people exiting other institutional care settings are underdeveloped.
- **Insufficient integration.** Some housing programs, such as tenant support programs, provide generalised tenant support but are not integrated with mental health services. Agreements or protocols between mental health and housing departments are often limited in scope and focussed on things like antisocial behaviour or sharing of client information.
- **Eligibility and capacity limitations.** While a number of effective programs exist, places in these programs are rationed and many who require these services miss out. For example, some programs limit eligibility to people with lived experience of mental illness, noting severity or duration, and some housing is demarcated for particular usage, making it off limits to potentially suitable people.
- **Barriers to collaboration.** Privacy legislation can present a barrier to collaboration and service integration. For example, where arrangements to facilitate communication or teamwork between housing and mental health service providers are not in place, privacy protocols can mean that housing officers cannot effectively discuss consumers and refer them to appropriate supports. Thus, people accessing housing support or homelessness programs may have mental illnesses that go undiagnosed, leading to problems in identifying a need.
- **Lack of information collection and sharing.** Many jurisdictions do not share information about consumers across agencies.

4 Ideal pathways and real experiences

- Mental health and housing policies build on models that conceptualise linear pathways for people with mental ill-health. However, these concepts do not accurately reflect the trajectories of people's lived experience.
- People with mental ill-health are more likely than the general population to experience housing instability and rely on social housing. Their social housing pathways are rarely linear, but are shaped by eligibility criteria, long waiting lists, and circuitous mobility in and out of social housing.
- The trajectories of people with mental ill-health are not continuous, but are disrupted by limited access to support services, short-term solutions, and inadequate transition planning. Mental ill-health does not necessarily progress from mild to severe symptoms and can be episodic, changing the level of support needed.
- Policies recognise that better intersection and coordination is needed between mental health and housing services.

Housing and mental health policies use 'ideal pathways' to conceptualise how people travel through systems. The current ideal pathway for mental health service delivery is described by the stepped care approach, while housing policy references the housing continuum (or housing spectrum) to describe how people access different tenures throughout their lives.

4.1 Social housing policy

The housing continuum is a concept policy-makers use to describe the range of housing options available to households in different tenures to access affordable and appropriate housing (see Figure 1).

The housing continuum is an important conceptual reference for understanding and determining housing and affordability outcomes for different target groups, spanning from homeless people, very-low-income groups and people with high support needs through to low- and moderate-income families. Not all tenures offer the same amount of security and sustainability. Home ownership and social housing are considered to be the most secure tenures. People living in private rental have few protections against tenancy terminations and consequently experience

relatively high levels of forced mobility. Many people in private rental, especially those on low incomes, experience housing affordability stress due to high rents and a lack of available rental housing they can afford (Hulse, Reynolds et al. 2014).

People living with mental ill-health tend to experience a greater degree of housing instability than the general population and many rely on social housing (this includes public housing, community housing and Indigenous community housing) (AIHW 2016b; SANE Research 2008; Beer and Faulkner 2009). It is therefore important to understand social housing policy and how social housing can be accessed.

Social housing policies vary across providers and jurisdictions. However, all agencies have eligibility criteria and operational policies that determine access to social housing and the experience of tenants within social housing. These include policies about: application processes; eligibility criteria (for entry and continuing); rent; use of premises by tenants; eviction processes; tenant transfers between social housing properties; change in household circumstances; and portfolio management by landlords (Powell, Meltzer et al. 2019).

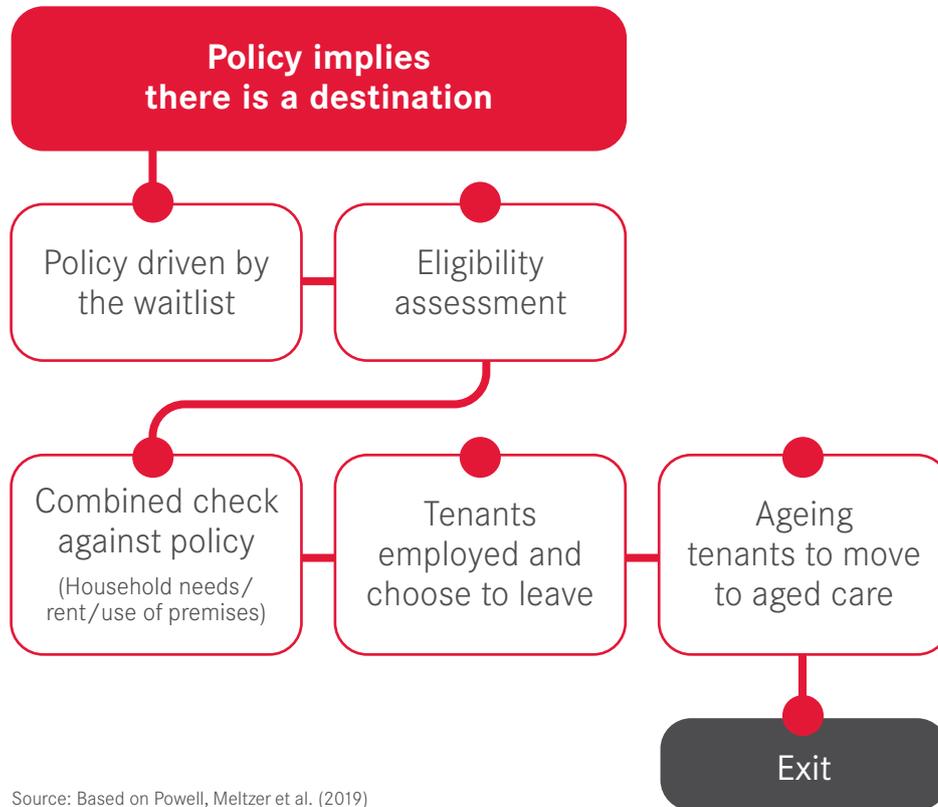
Figure 1: The housing continuum



Source: The authors.

In the past, social housing was a tenure for low-income workers, and tenants (once they had achieved social housing) often lived there indefinitely. At present, there is not enough social housing to meet demand. Nationally, approximately 200,000 households are on the waitlist for social housing (AIHW 2016b). Consequently, access to social housing is highly rationed, with long waitlists and availability usually only for those who are considered highest priority. Consequently, many people who are eligible for social housing miss out. In addition, tenants are encouraged to move from social housing into other tenures, primarily private rental. Powell, Meltzer et al. (2019) describe this as a ‘throughput pathway’ (see Figure 2).

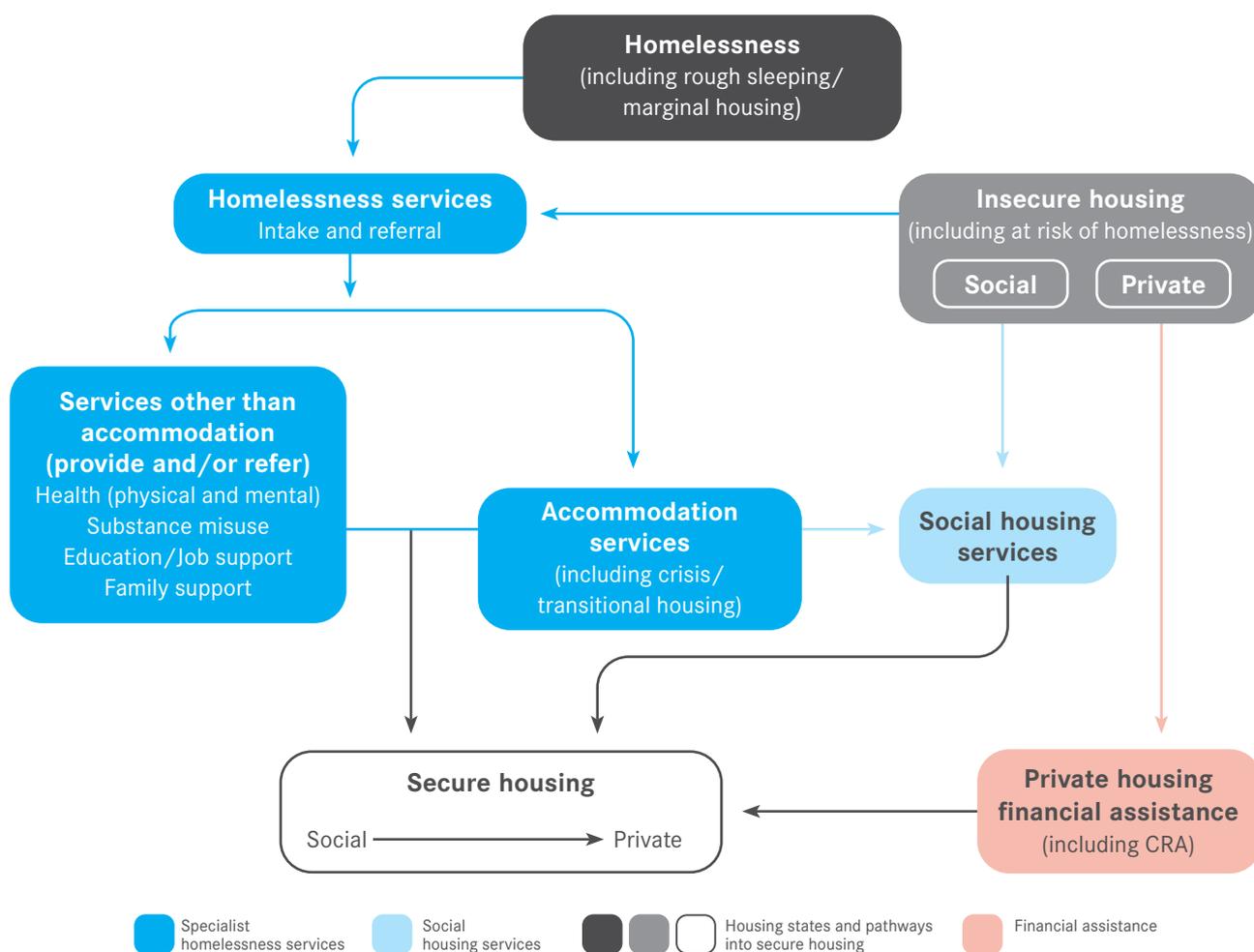
Figure 2: Social housing policy implies a throughput pathway



The homelessness system has become a key access point for social housing. The Productivity Commission (2018) recently identified three main housing assistance pathways into secure social housing. The housing assistance pathways map presented in Figure 3 shows that specialist homelessness services (including crisis/transitional accommodation services, as well as other support

services) were the most common pathways into social housing—either directly or via referral to social housing services. Alternatively, people experiencing insecure housing in social or private tenancies could enter into secure social housing via social housing services; while those in long-term receipt of Commonwealth Rent Assistant (CRA) could enter directly into secure social housing.

Figure 3: Role of housing and homelessness sector services in pathways to secure housing



Source: Productivity Commission (2019: Figure G.1).

4.1.1 Social housing pathways

Contrary to the ideal social housing pathway circumscribed by policy, actual social housing pathways are rarely linear and are shaped primarily by eligibility criteria, a need to ration social housing and target it to those most in need, and the way in which social housing policies are operationalised. Mobility into and out of social housing is often circuitous, with some tenants leaving and re-entering social housing as their personal and financial circumstances change (Wiesel, Easthope et al. 2012). Some tenants experience a ‘revolving door’ pattern of multiple exits and re-entries into social housing, with episodes of homelessness

in-between (Wiesel, Pawson et al. 2014). Indigenous tenants often experience highly unstable housing due to multiple factors, including domestic violence, mental illness, discrimination in private rental, and high mobility involving frequent residential moves (Wiesel, Pawson et al. 2014).

Broader factors that affect social housing pathways include the lack of affordable housing, the lack of social housing supply that is ‘fit for purpose’, long social housing waiting lists, tight private rental markets, and the intersection of housing policies with the National Disability Insurance Scheme (NDIS) (Powell, Meltzer et al. 2019).

Pathways into social housing are largely determined by policies that shape application processes and eligibility criteria (Powell, Meltzer et al. 2019):

- Most jurisdictions have centralised application processes.
- Eligibility criteria refer to income and assets, citizenship, residence status, age, tenancy history, etc.
- Meeting eligibility criteria is often insufficient to access social housing, as priority is given to households with specific or complex needs. The definition of complex needs varies by jurisdiction, but usually includes disability, poor physical or mental health, experience of family violence, exiting institutions, and/or being homeless or at risk of homelessness.
- The most common pathway into social housing is homelessness or risk of homelessness.

Tenants move out of social housing when they initiate a transition to private housing or are evicted by the landlord. Social housing exit decisions typically involve a combination of several push and pull factors (Wiesel, Pawson et al. 2014).

Common push factors that discourage participants from staying in social housing include: difficulties with neighbour; an unsafe neighbourhood; unsuitability of the social housing (e.g. size, design, maintenance); rent arrears; and the difficulty of transferring to another, more suitable, social housing tenancy. Common pull factors include personal choice and moving in with (or closer to) a new partner or relative (Wiesel, Pawson et al. 2014).

Exits from social housing are made possible by income from: paid employment; a lump sum inheritance; insurance or superannuation payments; financial or other assistance from family members or a new partner; government-funded financial assistance (e.g. CRA, bond loans); lower costs of private rental and home purchase in regional areas; and moving into informal rental arrangements or sharing (Wiesel et al., Pawson 2014).

Analysis of HILDA data shows that many people who exit social housing experience difficulties sustaining private rental tenancies or home ownership (Wiesel, Pawson et al. 2014). About a third experienced significant deterioration in their financial circumstances over a period of 10 years, and 17 per cent re-entered public housing. Challenges included financial hardship due to loss of employment or deteriorating health, and difficulties sustaining sharing arrangements, new relationships and informal situations.

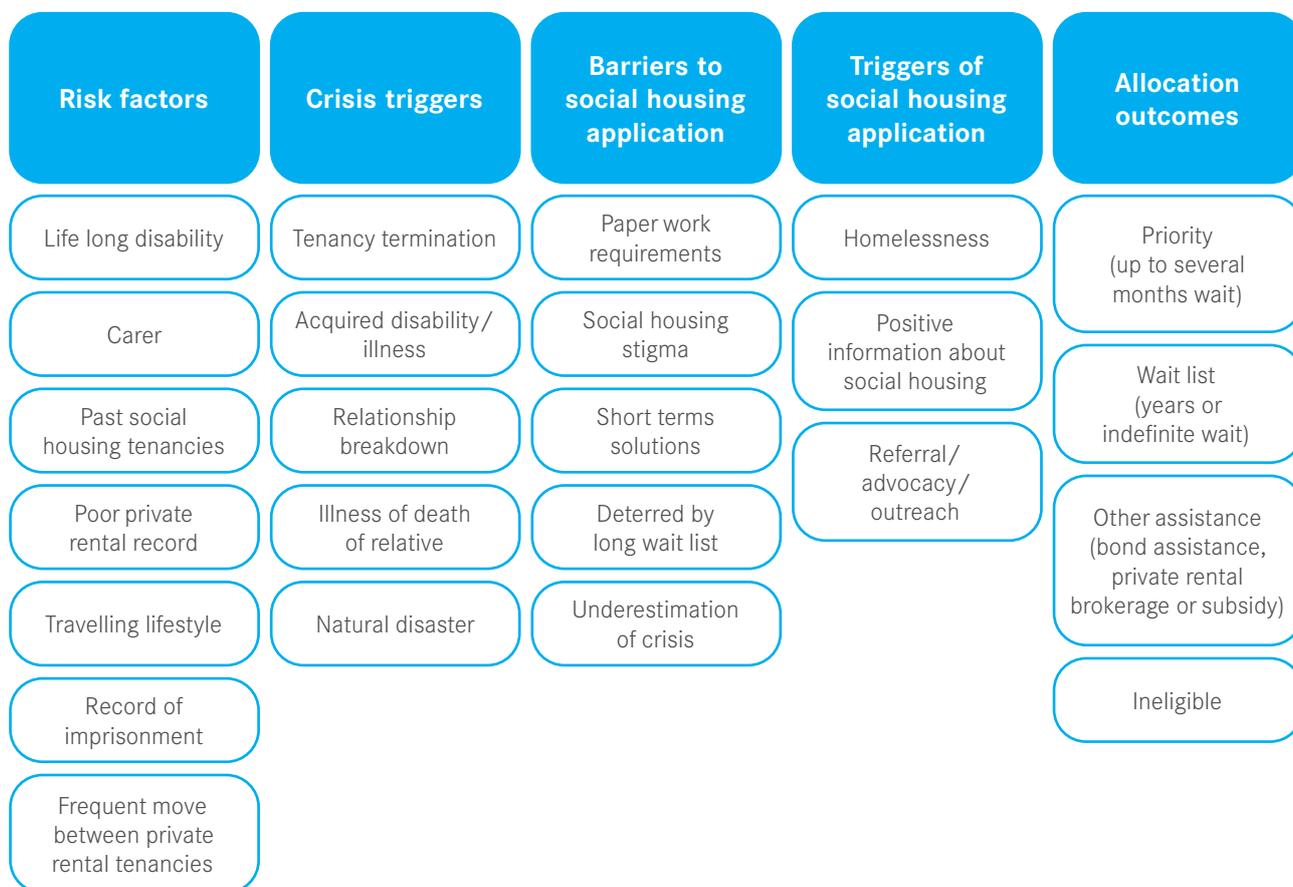
4.1.2 Personal factors affecting social housing pathways

In addition to social housing policy, procedures and operational factors (outlined above), tenants' personal circumstances also affect their social housing pathways. This includes personal choices regarding their housing needs, their ability to meet these needs within personal and market constraints, life-course events and demographic characteristics (Wiesel, Easthope et al. 2012).

Factors that can trigger moves into social housing (and transfers within social housing) include the onset of a sudden personal or health crisis, eviction from private rental, and a need for security of tenure. Factors that discourage entry into social housing include personal choice, stigma of social housing, the complexity of the application process, disinformation about social housing (e.g. wait times), miscommunication between housing officers and applicants, and discrimination (Wiesel, Easthope et al. 2012).

Wiesel, Easthope et al. (2012) summarise the risk factors, triggers and barriers that affect social housing entries (see Figure 4).

Figure 4: Pathways into social housing: risk factors, triggers and barriers



Source: Wiesel, Easthope et al. (2012)

Recent research has shown that tenants' experiences of social housing are profoundly influenced by the level of care (or lack of care) shown to them by housing provider staff members (Flanagan, Levin et al. 2020).

4.1.3 Homelessness pathways

Homelessness or risk of homelessness is the most common pathway into social housing (see Figure 4). Chamberlain and Johnson (2011) identified five typical pathways into homelessness.

- **Housing crisis** due to loss of employment, sustained poverty, or gentrification of inner-city housing markets, leading to an inability to afford rent/mortgage.

- **Mental ill-health** raises the risk of homelessness due to difficulty getting or sustaining employment, difficulty accessing and sustaining housing, lack of family support or stigma.
- **Family breakdown** can mean that women (and sometimes men) have to leave their homes, often accompanied by children. Domestic violence is also associated with stigma and low income due to constrained employment.
- **Substance abuse** consumes available income, dominates an individual's daily life, is associated with stigma, and makes it difficult to sustain employment.
- **Youth homelessness** due to the young person experiencing conflict with family is one of the most common pathways into homelessness.

Some cohorts remain homeless for longer than others. For example, people on a housing crisis or family breakdown pathway have shorter spells of homelessness as they do not form strong friendships in the homeless subculture or accept homelessness as a way of life. In contrast, people on the substance abuse and youth homelessness pathways tend to experience longer periods of homelessness as they often become involved in the homeless subculture and engage in social practices that make it difficult to exit from homelessness. People on the mental health pathway also experience long-term homelessness, but they do not endorse homelessness as a way of life; rather, they remain homeless because they have few exit options (Chamberlain and Johnson 2011).

In their analysis of the mental health pathway to homelessness, Chamberlain and Johnson (2011) distinguished between people who were aged 24 or younger and those who were 25 years or older when they experienced homelessness for the first time. For young people experiencing mental ill-health, parents were the most important source of support that enabled them to remain housed. However, families could find it difficult to deal with their children's behaviour, which created tensions and some young people were evicted from the family home as a result (Chamberlain and Johnson 2011: 6).

People who developed mental health issues in their late teens or early twenties tended to receive ongoing family support while their parents were alive. When their parents died or became unable to care for them due to age, this group became homeless in their thirties, forties or fifties. People experiencing mental ill-health who did not have family to support them often became homeless (Chamberlain and Johnson 2011: 6–7).

People with mental ill-health often experienced long-term homelessness because there were few sustainable housing options available to them and because they had eroded their social networks by the time they became homeless. Many ended up living in boarding houses, where they were vulnerable to victimisation from other tenants. This could worsen existing disorders and place

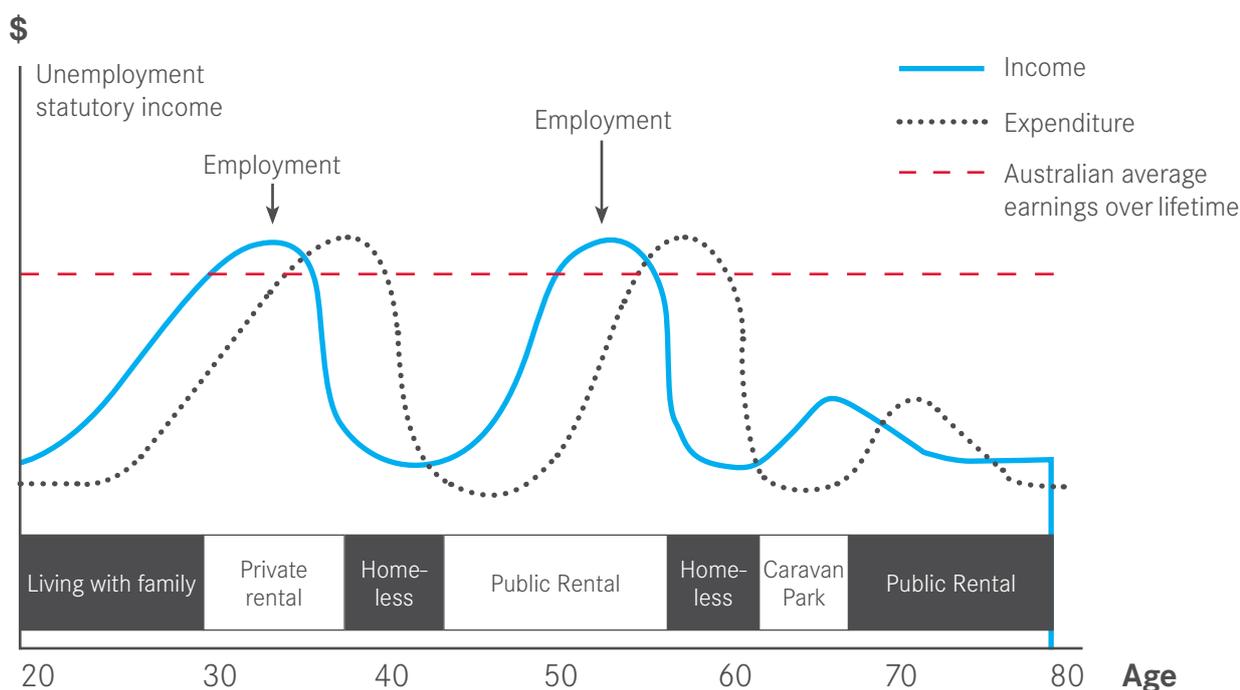
them at risk of physical harm. Coping strategies included avoiding communal areas, sleeping rough or isolating themselves from other tenants, which further contributed to their social isolation (Chamberlain and Johnson 2011: 14).

4.1.4 Housing pathways of people living with mental ill-health

People living with mental ill-health have distinct housing pathways that are characterised by more hectic housing careers, often moving between parental home, private rental, homelessness, social housing and caravan parks (Beer, Faulkner et al. 2006: 9). This variability in their housing pathways is due to the episodic nature of much mental illness, which results in periods in and out of employment, as well as significant transitions through the housing market. People affected by a psychiatric disability have a high probability of eviction and experience ongoing transitions from one tenure to the next.

Figure 5 attempts to show how periods of mental illness have lag effects that flow through to the transitions an individual makes in the housing market. The researchers suggest public rental housing, rather than home ownership, as the outcome of the housing career for this group (Beer and Faulkner 2009).

Figure 5: Indicative housing career for a person with a psychiatric disability



Psychiatric disability

Source: Beer and Faulkner (2009:158).

4.2 Mental health policy

Like social housing policy, mental health policy is underpinned by a model that is intended to assist policy-makers to develop policy, supports and services that provide interventions according to a cohort's needs. However, as is the case with social housing policy, the model does not accurately reflect the real-life trajectories and experiences of many who live with mental ill-health. Unlike housing policy, however, mental health policy is not defined by the ideal pathway, but instead offers a continuum of support as defined by the stepped care model (see Figure 6).

All state and territory mental health policies and plans align (to varying degrees) with the Commonwealth priorities and policy direction described in *The Fifth National Mental Health and Suicide Prevention Plan* (the Fifth Plan) (Department of Health 2017). These policies prioritise: integrated service delivery and coordinated access; person-centred and

recovery-based approaches; suicide prevention; Aboriginal and Torres Strait Islander mental health; workforce capability; community education and stigma reduction; and the social determinants of health (outlined in Appendix 1).

Although several plans (SA, NSW, NT, Queensland, WA) include actions or strategies, most provide limited detail on how policy may be implemented in practice. The policy rhetoric aims for clearly defined care pathways to positive mental health and wellbeing. However, it is acknowledged that these aspirations are stymied by a fragmented service system and disjointed care coordination (Department of Health 2017). The achievement of a linear pathway to optimal mental health is further challenged by: (a) managing complex needs (AOD use, dual intellectual and psychiatric disability, and involvement in the criminal justice system); (b) the episodic nature of mental illness; and (c) a personal recovery trajectory that is non-linear and emphasises recovery as a process, as distinct from a clinical (absence of symptoms) outcome. Despite

these challenges, federal government policy claims that a range of reform interventions will create ‘real improvement in the lives of people with mental illness, their families, carers and communities’ (COAG 2012).

Australia provides both public and private access points to mental health care. The Commonwealth Government distributes funding to the jurisdictions, each of which oversees the delivery of its own mental health service system. States and territories provide hospital-based, specialised, clinical and community-based mental health services, both directly and through partnerships with non-government organisations. Private mental health providers also deliver in-hospital and community support. Rebates under the Medicare Better Access initiative or an individual’s private health insurance may be available for people seeking support from private mental health practitioners (COAG 2012). Each state/territory has its own Mental Health Act which has provisions for involuntary inpatient or outpatient treatment where there is a deemed risk to self or others. Although state-run voluntary hospital services and community services available to the public share some similarities, they are not consistent and limited resources restrict these services to people with serious mental illness or those at risk of suicide (Gee, McGarty et al. 2016).

4.2.1 Specialist mental health system

Australia’s specialist mental health system has two principal components: the clinical mental health sector, which is functionally and financially separate from the NDIS; and community mental health services, which focus on psychosocial wellbeing and participation in home and community life. The notion of recovery and person-centred care (described below) are foundational principles of the mental health system. The landscape of mental health policy and support provision has been disrupted as the community mental health sector is being reshaped by the introduction of the NDIS. In fact, many community mental health services are being subsumed into the NDIS. The mental health component of the NDIS mainly consists of psychosocial disability support service funding.

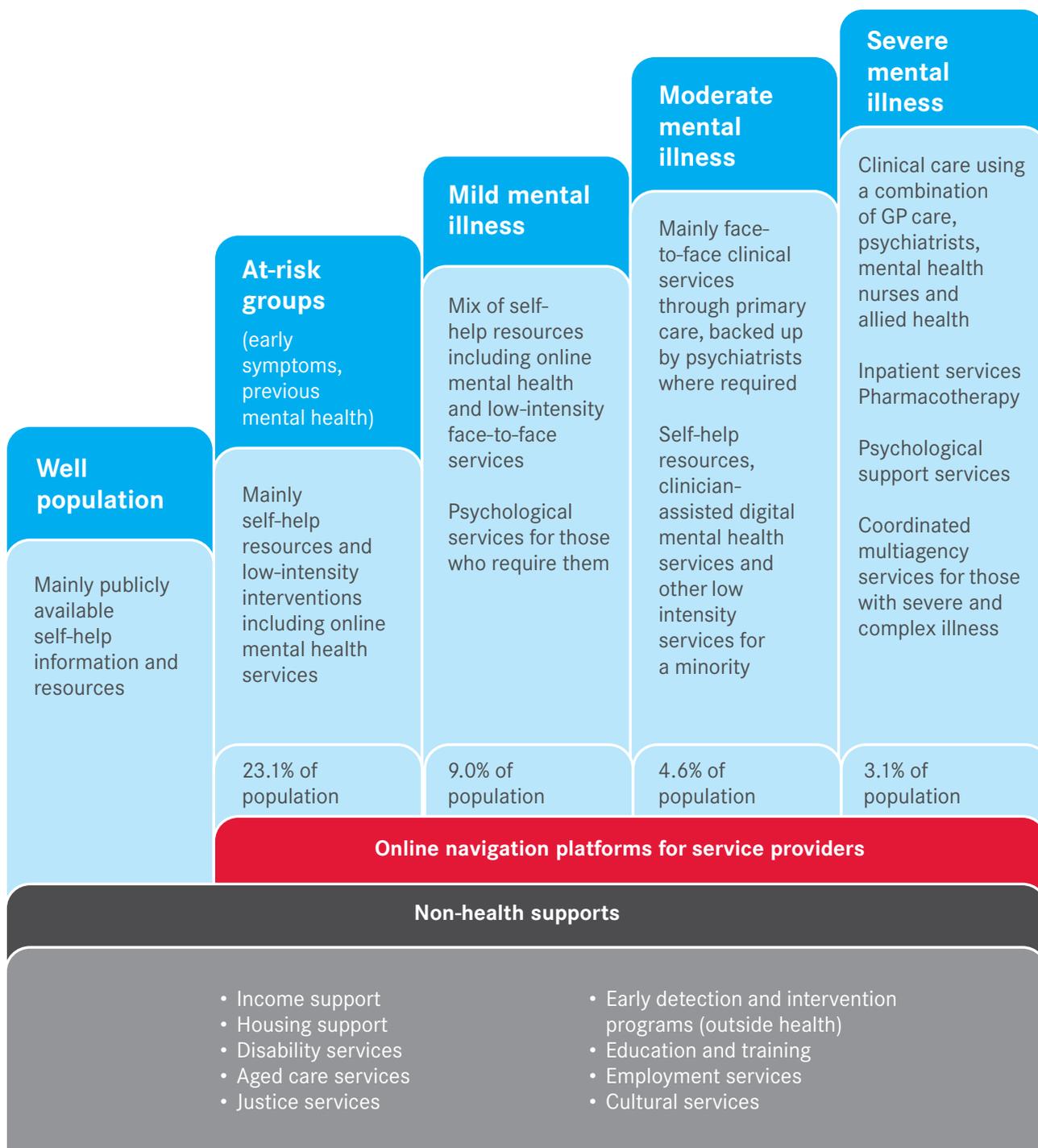
Mental health policies promote a diversity of interventions depending on need. Public health programs promote good mental health to those in the general community, while efforts around early intervention and prevention are targeted to those at risk (e.g. young people in school). Clinical support for people with lived experience of mental illness include: community-based support; government Primary Health Network (PHN) programs; and specialised or residential care in public and private hospitals, forensic mental health services, and area mental health residential services. *The Roadmap for National Mental Health Reform 2012–2022* (COAG 2012) and most state plans argue for a person-centred approach, whereby the needs of the person (and their carers) are prioritised, with services wrapping around in a seamless fashion.

People with mental ill-health access the mental health system from a variety of points. Access to GPs is generally good, but public hospital resources are highly rationed. Families and carers form a significant, though largely unacknowledged, component of the mental health system.

Consumers diagnosed with a low-prevalence but high-severity mental health disorder (e.g. schizophrenia) generally enter the healthcare system through emergency departments or the justice system in the acute phase, or through contact with primary healthcare providers (GPs and community mental health teams) when the illness is episodic. People with lived experience of mental illness have, on average, longer waits for beds in public hospitals than people presenting with non-mental health issues (Miller 2018).

The housing system forms another avenue into the mental health system. Access to mental health supports through state and territory housing systems is usually via referral to a mental health service provider by government departments responsible for public housing, specialist homelessness services, tenancy support programs, or community service providers contracted by public or community housing providers.

Figure 6: Stepped care model



Source: Adapted from Productivity Commission (2019: 18); Department of Health (2017: 20).

4.2.2 Stepped care

Stepped care (see Figure 6) is a key mental health treatment model and is central to the Australian Government's mental health reform agenda, and also guides the mental health activities of PHNs. Mental health treatment models include medical approaches and approaches addressing psychosocial barriers to functioning.

Stepped care applies a 'most effective, least resource intensive' philosophy (see Figure 6). The approach comprises a hierarchy of interventions and broadly includes the following steps.

- Self-management: publicly available self-help resources and promotion of preventative health.
- Low-intensity care: early intervention for at-risk groups displaying early symptoms or with a previous mental illness, including access to lower-cost, evidence-based alternatives to face-to-face psychological therapy.
- Moderate-intensity care: a mix of face-to-face services and psychological services for people with lived experience of mild mental illness, where required, delivered by GPs, psychologists and allied health professionals.
- High-intensity care: increased service access rates for people with lived experience of moderate mental illness, including face-to-face primary care and psychiatric support, and links to social support.
- Complex care: wrap-around coordinated clinical care through a combination of GPs, psychiatrists, mental health nurses, psychologists and allied health professionals, for people with complex needs and lived experience of severe mental illness (Department of Health 2017; Productivity Commission 2018).

In Australia, PHNs have adopted a stepped care approach to regional service delivery. A key responsibility of PHNs is to ensure that sufficient service mix, funding flexibility, efficient and effective referral processes, and accessible service interfacing exists to enable stepped care implementation.

Conceptually, the stepped care model enables people to access more intensive levels of support as symptoms worsen or step down support as they improve. However, in reality, not all components of the model are equally accessible and well resourced. Mental health services are characterised by two 'poles', reflecting the level of government providing the service funding. One pole represents services for people with mild and moderate symptoms and impairment, who can be treated online or in primary care by GPs or psychologists—mainly via Australian Government funding under the Medicare Benefits Schedule (MBS). The other pole represents services for people requiring specialist treatment and often hospitalisation (mainly through state and territory government funding). There is a large service gap between these two poles, sometimes referred to as the 'missing middle' (Productivity Commission 2019: 18).

The stepped model of care, as it currently operates in Australia, does not account for the episodic nature of mental health, nor does it account for the fact that, epidemiologically, many people do not progress from mild mental health problems to serious issues.

4.2.3 National Disability Insurance Scheme

The National Disability Insurance Scheme Act 2013 outlines the disability eligibility criteria for access to NDIS supports, including psychosocial support packages (Australian Government 2013). While many severe mental illnesses are permanent, their symptoms can be episodic in nature, and there remains uncertainty whether NDIS criteria are appropriate for people with psychosocial disability. In 2019, 27,974 people with a primary (severe) psychological disability received NDIS funding, representing 9.1 per cent of all active participants across the scheme (NDIA 2019).

Packages for NDIS for eligible people with psychosocial disability may include a Supported Independent Living (SIL) component, which provides funding specifically for managing

domestic and independent-living tasks in the home, including overnight support. SIL is delivered in the home, typically in a shared accommodation environment, and is available to people with evidence of a functional impairment who are able to live on their own with support. Approximately one-third of NDIS total budget is expected to be allocated toward SIL (NDS 2018).

The NDIS provides housing support via Specialist Disability Accommodation (SDA) packages. SDA is currently only available to people with a psychosocial disability who also have a severe physical or intellectual disability. However, home modifications are available for many NDIS-eligible people with a psychosocial disability through the Capital Supports budget, which is used for the ‘design, construction, installation of or changes to equipment or non-structural components of the building, and installation of fixtures or fittings, to enable participants to live as independently as possible or to live safely at home’ (NDIA 2018: 40).

4.2.4 Care models

As in Australia, recovery and person-centred planning is well established in international policy and is emphasised within acute mental health care pathways (Davies, Davies et al. 2019). Person-centred practice that promotes the involvement of the consumer in the direction of their care is a potentially effective method of improving consumer engagement and outcomes, addressing health disparities, and enhancing the cost-effectiveness of care (Doherty, Bond et al. 2019). Person-centredness is widely accepted as an approach that focusses on the person, in contrast to the condition or illness.

The *Roadmap for National Mental Health Reform 2012–2022* (COAG 2012) considers consumer and carer participation key to the person-centred approach. Australian researchers argue, however, that consumer involvement is given nominal attention and that genuine participation involves providing opportunities for improved consumer empowerment and increased input into their care planning. Gee, McGarty et al. (2016) advocate

the development of a cooperative community model whereby consumers work together with frontline workers, policy-makers and government in a democratic way. This model is supported by findings from a systematic review of UK practice that determined that consumers continue to feel marginalised in the planning of their care (Bee, Price et al. 2015).

Other models of care, such as the ‘intensive case management’ and ‘assertive community treatment’ models (including Australian models), provide an alternative to in-patient care and improve outcomes for people with severe mental illness, who are most at risk of psychiatric crisis and hospitalisation. These models are also associated with providing better pathways to integrating the individual in the community (Storm and Edwards 2013; Vijverberg, Ferdinand et al. 2017).

The ‘self-direction program’ (also known as the ‘individualised funding model’, or in the Australian context the NDIS) also upholds person-centred principles, giving consumers control over a budget to support them in choosing services that will help them achieve mental health outcomes and personal recovery goals. A US study (Croft, Dsvan et al. 2018) compared housing independence and employment outcomes for individuals who participated in self-direction and those who did not. They found that the self-direction model had positive effects on employment and housing outcomes.

The pathway to effecting change in personal recovery (as distinct from clinical recovery, which focusses on the absence of symptoms) is defined as a dynamic process, realised through relationship and connection, and characterised by equality, partnership and choice (Watson, Thorburn et al. 2014). It is an ongoing individual journey, premised on the notion of what it means to live a fulfilling life, even in the presence of mental illness (Davidson and Roe 2007). With growing interest in, and support for, this approach, ‘personal recovery’ has become influential in mental health policy and service delivery in the US, England, New Zealand, Canada, Australia and elsewhere (see

Davidson, Tondora et al. 2010; Horsfall, Paton et al. 2018; Slade, Oades et al. 2017). However, the personal recovery-oriented approach in practice is not clearly understood. This is often due to diverse and multidimensional understandings of recovery. For example, in their systematic literature review of the characteristics of mental health recovery narratives, Llewellyn-Beardsley, Rennick-Egglestone et al. found that consumer interpretations of recovery are ‘non-linear and reject coherence. To a greater extent than illness narratives, they incorporate social, political and rights aspects’ (2019: 2).

According to Davidson and Roe (2007), a truly personal recovery-oriented system of support is one which delivers a range of culturally responsive interventions and builds on consumers’ strengths and capabilities whilst also enabling them to meaningfully connect with the broader community.

Despite the positive uptake of recovery models in policy, the challenge confronting service providers in delivering the ideal program (such as that described by Davidson and Roe 2007) is that the model is difficult to implement. Slade, Oades et al. (2017) explain that there is a limited evidence base to support a personal recovery orientation in mental health services. This delay is due, in part, to the embryonic ‘development of an empirical science of recovery [which] lags behind policy’ (Slade, Oades et al. 2017: 2). However, there is an emerging body of qualitative research that supports the efficacy of recovery-oriented practice.

4.3 Families and carers

Families and carers form a significant, though largely unacknowledged, component of the mental health system. They provide a large amount of emotional and practical support to people with mental ill-health that would otherwise have to be paid for by the government, yet they receive little government support themselves.

A 2017 study by The University of Queensland (UQ) and commissioned by Mind Australia found that mental health carers provide a substantial amount of unpaid support to care recipients (Diminic, Hielscher et al. 2017). Data collected for the study through the UQ Carer Survey 2016 showed that primary mental health carers provided on average 36.2 hours of support per week to care recipients. The Australian *National Survey of Mental Health and Wellbeing 2007* (ABS 2008) recorded data from a broader sample of carers and showed that other (non-primary) mental health carers provided on average 11.0 hours of support per week. In aggregate, this support is estimated to have a value of \$14.3 billion and be equivalent to 173,198 full-time formal support workers (Diminic, Hielscher et al. 2017; Hielscher, Diminic et al. 2018).

The predominant form of mental health support provided by family and carers is emotional support (68% of support provided), which includes tasks such as emotional support and encouragement, supervising and monitoring, and responding to behaviour. Support for practical tasks, such as transport, literacy and communication, and healthcare coordination, comprises 29 per cent of family and carer mental health support, while support in daily living activities comprises 3 per cent (Diminic, Hielscher et al. 2017). In comparison to physical disability carers, mental health carers provide a much larger share of emotional support to care recipients.

4.4 Intersection between mental health and housing policy

There is limited integration between housing and mental health policies in Australia (Brackertz, Wilkinson et al. 2018). Mental health policies often mention housing as being important in a general sense, as part of supporting good mental health in the community. Stable and secure housing, and supported housing services, are often cited as important in supporting people recovering from mental illness in the community. Some policies acknowledge the links between mental illness and homelessness. Similarly, policies recognise supported housing in the community as

an important means by which to support people with complex needs, including those with mental illnesses (who are at higher risk of becoming homeless).⁴

At the state and territory levels, some housing policies make links with mental health issues or services, from antisocial behaviour policies through to training of staff in trauma and mental health first aid. Most recommend there be better alignment or coordination between social housing and mental health systems, including non-government providers of psychosocial supports for long-term mental health consumers.

Homelessness policies also make links with mental health. Some policies relate to prevention, such as strengthening tenancy support and other support for people with mental illness (such as HASI) and improving exit planning from mental health facilities. Others focus on strengthening responses, such as assertive outreach programs to address rough sleeping (such as Victoria's Street to Home and Opening Doors initiatives, and Queensland's Resident Recovery Program).

Housing, homelessness and mental health policies at national and state levels generally recognise that greater integration and coordination is needed between mental health services and housing services in the community. However, they rarely make systematic connections between these services, and connections at a program or strategic level are limited to only two jurisdictions (NSW and Queensland).

⁴ For a detailed analysis of national, state and territory mental health and housing policies refer to Brackertz, Wilkinson et al. (2018).

5 The interplay between mental health and housing and mediating factors

- Poor and deteriorating mental health and housing instability are directly related. Unstable housing increases the likelihood of mental health deteriorating to a point where a person experiences symptoms. Conversely, deteriorating mental health and/or a diagnosed mental health condition increases the likelihood of housing instability.
- Mediating factors can either soften or amplify the impact of housing instability on mental health and vice versa.
- Good general health and social support can work as mediators to protect people from housing instability when they are experiencing deteriorating mental health. Conversely, acquisition of serious personal injury or illness, or a long-term health condition will increase the likelihood of housing instability and deteriorating mental health.
- Factors such as social support, good general health, and accessing health and mental health services can act as circuit breakers reduce the likelihood of housing instability and shorten the length of time a person experiences mental ill-health. Negative life events and an absence of mediators can amplify the relationship between housing instability and mental ill-health.

In order to better understand the relationship between mental health, housing instability and homelessness, and identify the effects of mediating factors, the research analysed two longitudinal panel datasets: the HILDA Survey, which represents the general population; and JH, which represents a vulnerable cohort of people who are homeless or at risk of homelessness.

The analysis:

- considered the direct effects of mental health status and deteriorating mental health on tenure and housing stability
- modelled the impact of mediating factors (health and mental health services use, physical health, life events, housing and non-housing factors)
- undertook a survival analysis to determine the duration of spells in which people experience mental ill-health.

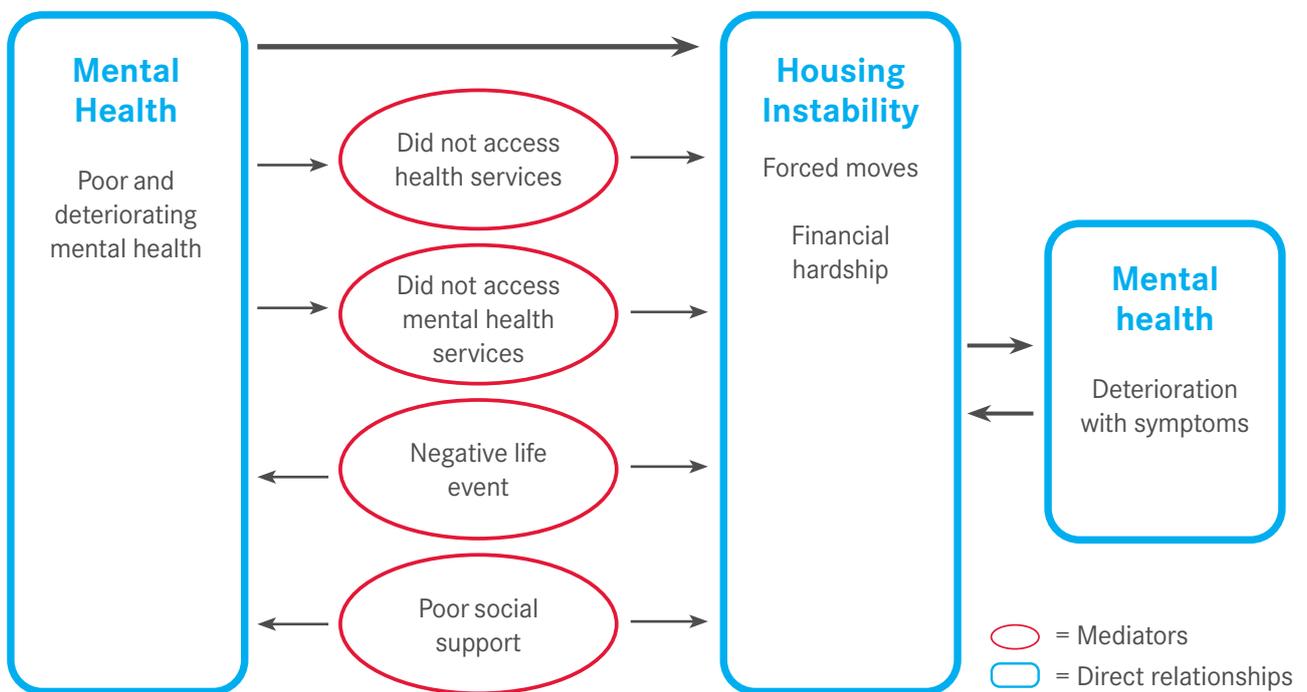
The analysis of HILDA data identified that there is a direct relationship between poor and deteriorating mental health and housing instability. In turn, housing instability, especially as measured by financial hardship, is correlated with deteriorating mental health to the point where a person experiences symptoms of anxiety, depression or mental distress (see Figure 7). In other words, it's a mutually reinforcing pattern: poor and deteriorating mental health increase the likelihood of housing instability, which in turn increases the likelihood that mental health will deteriorate to the point where a person experiences anxiety, depression and severe mental distress (referred to as 'symptoms' in this report).

Mediating factors, such as good general health and social support, protect from housing instability during periods of deteriorating mental health. Conversely, acquisition of a serious personal injury or illness, or a long-term health condition, can increase the likelihood of housing instability and deteriorating mental health.

Mediators such as social support, good general health and accessing mental health and other health services can act as circuit breakers that reduce the likelihood of housing instability and shorten the length of time a person experiences mental ill-health. Negative life events and an absence of mediators can amplify the relationship between housing instability and mental ill-health.

Mediating factors largely work on an individual level and can therefore be understood as individual risk or protective factors. However, the magnitude of the impact mediating factors can have on a person’s mental health and housing trajectory is also determined by the availability and adequacy of housing and mental health services at a systems level.

Figure 7: Mental health and housing instability: direct effects and mediating factors



Source: The authors.

5.1.1 Summary of previous findings from HILDA

Bentley, Baker et al. (2011) used HILDA data to investigate whether people experiencing housing affordability stress⁵, over and above other forms of financial stress, experience a deterioration in their mental health (measured using the SF36 Mental Component Summary score⁶). They found that mental health and social functioning worsened for low- to moderate-income households that entered unaffordable housing. The decline in mental health appeared to be limited to households in the two lowest income quintiles. They posit that interventions (e.g. increasing household income, reducing housing costs) that can improve housing affordability are likely to be the most effective for low-income groups and could reduce inequities in mental health (Bentley, Baker et al. 2011).

Baker, Lester et al. (2012) used HILDA data to research the influence of housing tenure on mental health. While international research has found a relationship between tenure and mental health, with most studies pointing to owner-occupiers as the 'healthiest' cohort, this study determined that the mental health score of individuals increased with income. However, no evidence of a relationship between tenure and mental health was found, even when individuals changed residence between waves. The authors suggest that poorer mental health among renters is more a reflection of the demographic composition of the cohort rather than being linked to the tenure type. Although tenure was not found to have a direct effect on mental health, the authors state that secure tenure is likely to have other intrinsic benefits, such as financial, educational and ontological benefits (Baker, Lester et al. 2012).

Baker, Mason et al. (2014) used HILDA data to study the relationship between housing and health. They found that a bidirectional relationship exists between housing affordability and health, especially mental health, which suggests that

health may influence affordable housing outcomes, while housing affordability may also predict health outcomes.

UK studies have shown that renters report poorer general health than home owners, but suggest that the differences between tenures are due to the household characteristics of renters rather than being a causal effect of tenure (Bentley, Prevalin et al. 2016).

Bentley, Prevalin et al. (2016) used longitudinal data from HILDA and the British Household Panel Survey to examine and compare relationships between housing affordability, tenure and mental health in the UK and Australia. They found that Australian private renters whose housing became unaffordable experienced a small but significant decline in mental health, while the same change in affordability for home purchasers did not, on average, alter their mental health. The reverse was found to be true for the UK. The study authors speculate that more generous government support for UK private renters, relative to Australian private renters, may explain the difference in mental health sensitivity to housing affordability by tenure type. Bentley, Prevalin et al. (2016) also examined the effect of employment security and housing affordability on mental health (measured using the SF36 Mental Component Summary score). Their study examined 10 annual waves of HILDA data for people aged 25–64 years, and found that households containing people who experience persistent employment insecurity are more likely to experience a decline in mental health as a result of their housing becoming unaffordable compared to households containing people with secure employment.

Butterworth, Rodgers et al. (2006) examined the variance of mental health scores, expressed through the SF36, using HILDA datasets at the individual, household and area levels. Results show a modest level of variance in mental health scores at the area level, with a significant variance

⁵ That is, whose housing costs were more than 30 per cent of their household income (a common measure of housing stress).

⁶ The 36-Item Short Form Health Survey.

at the household level. Observed area effects are thought to reflect the clustering of individual-level risk factors (e.g. age, physical health, financial hardship). The results of the study contribute to the discourse on whether community-level or household-led intervention is the most appropriate strategy for addressing mental ill-health.

A study by Kavanagh, Aitken et al. (2016) used 12 waves of HILDA data to investigate whether housing tenure and affordability were effect modifiers of the relationship between disability acquisition and mental health. The study showed that middle- and low-income earners had greater mental health deterioration than high-income earners after acquiring physical disabilities. The mental health of people in all tenure types declined after disability acquisition, with the largest decline observed in private rental housing tenants, whose mental health score was 2.8 points lower than that of people in home ownership. Mortgagees and private renters in unaffordable housing had the greatest declines in mental health after disability acquisition. Importantly, those individuals living in unaffordable housing at the time of disability acquisition (7% of the sample pool) were more likely to experience severe mental health effects, with potential consequences for ongoing workforce participation and health costs. The study's results show that an individual's housing characteristics before disability acquisition may modify the mental health effects of disability acquisition (Kavanagh, Aitken et al. 2016).

Mason, Baker et al. (2013) used 10 waves of HILDA data to examine the mediating effect of tenure on housing affordability and mental health (using the SF36). The study showed that unaffordable housing affects the mental health status of renters and home purchasers differently. The study found a small but statistically significant difference in the mental health scores of private renters when their housing became unaffordable compared to when it was affordable (i.e. 20% of one standard deviation lower). Home purchasers, in contrast, had the same mental health scores regardless of whether their housing was affordable or unaffordable. Analysis of the relationship between housing affordability and mental health by tenure revealed

moderate evidence in support of the difference between private renters and home purchasers.

Berry and Welsh (2009) examined the relationship between components of social capital and three aspects of health—mental, general and physical—using wave 6 HILDA data. 'Social capital' is commonly defined using Robert Putnam's description: 'the connections among individuals' social networks and the norms of reciprocity and trustworthiness that arise from them' (Putnam 2000). Social capital is related to better general and physical health and, even more strongly, to positive mental health. While respondents with poorer physical health had lower mental health scores, people within this group reported better mental health when their levels of social capital were higher.

The study showed that women engage in higher levels of community participation and have better social cohesion than men, generating greater social capital. However, women also reported poorer mental health than men, suggesting that the relationship between social capital and mental health may be complex. The authors speculate that social capital in women experiencing socio-economic disadvantage may involve unmanageable demands, rendering social capital a risk for mental ill-health among this cohort (Berry and Welsh 2009).

Dalton and Ong (2005) investigated the effect of housing tenure on people accessing the Disability Support Pension (DSP). At the time of the study, approximately 25 per cent of DSP recipients had a mental health disorder. Outright owners represented 34 per cent of all DSP recipients, owner-purchasers 12 per cent, private renters 28 per cent, and public housing renters 17 per cent. Public housing renters, however, showed the greatest growth across all tenures, comprising 26 per cent of working-age DSP recipients. The percentage of DSP recipients who were outright owners increased over time, as people paid off their mortgages, especially amongst older age cohorts, which is further evidence of the 'home ownership effect' on retirement decisions—whereby

the ‘possession of a home free of mortgage I owns the income threshold at which an individual can contemplate exit from the labour market’ (Castles 1997).

Owner-purchasers on the DSP seem to be concentrated in the 45+ years age bands. Dalton and Ong (2005) proposed that the Howard-era Welfare to Work DSP changes (which tightened eligibility criteria and encouraged people with disability to work) would have the largest impact on renters, both public and private. Their modelling showed that public housing renters on the DSP would experience the greatest level of disadvantage in terms of activity limitations and education/employment restrictions imposed by the reforms. Public renters on the DSP would also experience the most severe unemployment trap, measured in terms of ratio of disposable income while unemployed versus being employed.

5.1.2 Relationship between mental health and housing instability

This part of the analysis examined the direct relationship between poor and deteriorating mental health and housing instability among the general population, using HILDA data. Housing instability comprised two variables: forced moves and financial hardship.

Our analysis showed strong evidence that deteriorating mental health and mental health diagnosis are statistically significantly related to housing instability.

People experiencing severe psychological distress, as measured by the K6 score:

- had an 89 per cent increased likelihood of experiencing financial hardship in the following year and a 96 per cent increased likelihood of experiencing financial hardship within two years (see Table 1)
- had a 28 per cent increased likelihood of experiencing a forced move in the following year and a 26 per cent increased likelihood of experiencing a forced move in the following two years (see Table 2).

People with a diagnosed mental health condition, as measured by the MHI-5 score:

- had a 44 per cent increased likelihood of financial hardship within one year and a 46 per cent increased likelihood of financial hardship within two years (see Table 1)
- had a 39 per cent increased likelihood of a forced move within one year and a 32 per cent increased likelihood of a forced move within two years (see Table 2).

Table 1: Marginal effects of mental health on financial hardship, within one and two years, HILDA

	Financial hardship			
	within 1 year	within 2 years		
K6				
Reference = no symptoms (K6 < 5)				
Mild to moderate psychological distress (K6 = 5–12)	0.425*** (0.052)	0.397*** (0.055)		
Severe psychological distress (K6 ≥ 13)	0.889*** (0.103)	0.958*** (0.115)		
MHI-5				
Reference = no symptoms or diagnosis				
Diagnosed with a mental health condition	0.435*** (0.078)	0.462*** (0.079)		
No diagnosis but has symptoms (MHI-5 > 48)	0.324*** (0.119)	0.376*** (0.121)		
<i>Number of observations</i>	36,567	9,995	32,982	9,153

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

iii) Wave dummies are also included in the list of covariates.

Table 2: Marginal effects of mental health on forced moves, within one and two years, HILDA

	Forced move		Forced move	
	within 1 year		within 2 years	
K6				
Reference = no symptoms (K6 < 5)				
Mild to moderate psychological distress (K6 = 5–12)	0.193*** (0.069)		0.218*** (0.055)	
Severe psychological distress (K6 ≥ 13)	0.282** (0.121)		0.255** (0.099)	
MHI-5				
Reference = no symptoms or diagnosis				
Diagnosed with a mental health condition		0.385*** (0.135)		0.320*** (0.105)
No diagnosis but has symptoms (MHI-5 > 48)		0.440** (0.192)		0.291* (0.155)
<i>Number of observations</i>	<i>19,116</i>	<i>48,403</i>	<i>18,298</i>	<i>46,267</i>

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

iii) Wave dummies are also included in the list of covariates.

People who experienced deteriorating mental health and who had symptoms, as measured by the MHI-5 score:

- had a 24 per cent increased likelihood of financial hardship in the following year and a 28 per cent

increased likelihood of financial hardship within the next two years (see Table 3)

- had a 30 per cent increased likelihood of a forced move in the following year and also a 30 per cent chance within two years (see Table 3).

Table 3: Marginal effects of deteriorating mental health on housing instability, within one and two years, HILDA

	Financial hardship		Forced move	
	within 1 year	within 2 years	within 1 year	within 2 years
MHI-5				
Deterioration of mental health with symptoms (MHI-5 > 48)	0.244*** (0.041)	0.288*** (0.052)	0.296*** (0.059)	0.294*** (0.056)
<i>Number of observations</i>	107,101	82,110	121,748	106,743

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

iii) Wave dummies are also included in the list of covariates.

Analysis of whether housing instability contributes to poor or deteriorating mental health found strong evidence that financial hardship in the past one to two years elevates the likelihood that a person will experience deteriorating mental health (to the point where the person experienced symptoms) by 23

per cent (past year) and 21 per cent (past two years) (see Table 4). There is some evidence (significant at the 10% level) that a forced move in the previous two years elevates the risk of a person experiencing deteriorating mental health by 14 per cent (see Table 4).

Table 4: Tenure and housing instability as predictors of deteriorating mental health, within the next one or two years, HILDA

	Deteriorating mental health with symptoms (MHI-5 > 48)
Reference = private rental	
Home owner	-0.076* (0.045)
Public housing	0.123 (0.089)
Community housing	0.234 (0.181)
Rent-free (e.g. living with family/friends)	-0.003 (0.103)
Forced move in the previous year	0.009 (0.079)
Forced move in the previous 2 years	0.139* (0.076)
Financial hardship in the previous year	0.225*** (0.042)
Financial hardship in the previous 2 years	0.214*** (0.042)
<i>Number of observations</i>	<i>85,243</i>

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

iii) Wave dummies are also included in the list of covariates.

5.1.3 Mediating factors

Mediating factors can either soften or amplify the impact of housing instability on mental health and vice versa. Understanding mediating factors is important, as they offer opportunity for policy and social interventions to provide support to people with lived experience of mental ill-health.

Tenure

Analysis of the relationship between tenure, housing stability and mental health found that home ownership provides a moderate degree of protection against deteriorating mental health, but that people with a mental health diagnosis are less likely to be home owners. People with mental ill-health are more likely to rent (whether in public, community or private rental).

- People with a mental health diagnosis were 3 per cent less likely to be home owners and 2.2 per cent more likely to be a private renter (see Table 5).
- People who had not been diagnosed with a mental health condition, but who had symptoms, were 0.9 per cent more likely to be in public housing (see Table 5).
- Individuals with mild psychological distress were 2 per cent less likely to be a home owner, 2.1 per cent more likely to be a renter, 0.5 per cent more likely to be in public housing and 0.6 per cent less likely to be rent-free (see Table 6).
- Home ownership had only a modest protective effect against deteriorating mental health, with home owners being 8 per cent less likely to experience deteriorating mental health within the next year than private renters (see Table 4).

Table 5: Marginal effects of mental health on housing tenure, HILDA

	Diagnosed with a mental health condition	No diagnosis but has symptoms (MHI-5 > 48)
MHI-5		
Reference = no symptoms or diagnosis		
Home owner	-0.030*** (0.008)	0.001 (0.011)
Private renter	0.022*** (0.008)	-0.014 (0.010)
Public housing	0.004 (0.003)	0.009** (0.004)
Community housing	0.003* (0.001)	0.002 (0.002)
Rent-free (e.g. living with family/friends)	0.002 (0.003)	0.003 (0.005)
<i>Number of observations</i>	32,092	32,092

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

iii) Wave dummies are also included in the list of covariates.

Table 6: Marginal effects of housing tenure on mental health, HILDA

Tenure	Mild to moderate psychological distress (K6 = 5–12)	Severe psychological distress (K6 ≥ 13)
Reference = no psychological distress (K6 < 5)		
Home owner	-0.020*** (0.005)	-0.040*** (0.011)
Private rental	0.021*** (0.005)	0.034*** (0.010)
Public housing	0.005** (0.002)	0.004 (0.003)
Community housing	-0.0002 (0.001)	-0.001 (0.001)
Rent-free	-0.006*** (0.002)	0.002 (0.004)
<i>Number of observations</i>	<i>62,931</i>	<i>62,931</i>

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

iii) Wave dummies are also included in the list of covariates.

Health and use of health services

Use of health services and mental health services was found to protect against housing instability for people who had poor or deteriorating mental health. Good physical health reduced the length of time a person experienced mental ill-health with symptoms, reduced the likelihood of housing instability, and offered strong protection against deteriorating mental health. Conversely, people with a long-term health condition had an elevated risk of housing instability and deteriorating mental health.

- People who had deteriorating mental health with symptoms but who did not access health services were 58 per cent more likely to experience a forced move within the next two years compared to those without deteriorating mental health (see Table 7).
- People who had deteriorating mental health with symptoms but who did not access health services or mental health services were 65 per cent and 36 per cent more likely, respectively, to experience financial hardship in the next one to two years, compared to those without deteriorating mental health (see Table 7).
- Self-assessed ‘good’ general health and ‘very good’ general health reduced the duration of a spell of mental ill-health by 5 per cent and 9 per cent, respectively (see Table 8).
- ‘Very good’ self-assessed general health reduced the likelihood of a forced move within two years by 10 per cent, and the likelihood of financial hardship within the next year and two years by 34 and 30 per cent, respectively. Importantly, it reduced the likelihood of deteriorating mental health by 80 per cent (see Table 9).
- Conversely, having a long-term health condition increased the likelihood of a forced move within one year by 15 per cent and within two years by 18 per cent. A long-term health condition increased the likelihood of financial hardship within one year by 21 per cent and within two years by 24 per cent. The likelihood of deteriorating mental health increased by 38 per cent (see Table 9).
- Serious personal injury or illness negatively impacted mental health status for up to three years (see Table 10) and increased the likelihood of a forced move in the following year by 17 per cent (see Table 12).

Table 7: Marginal effects of deteriorating mental health with symptoms and health service use on housing instability, HILDA

Effects of deteriorating mental health with symptoms (MHI-5 > 48)	Forced move within 2 years	Financial hardship within 1 year
Did not see health services	0.582** (0.279)	0.655*** (0.230)
Did see health services	0.327* (0.169)	0.184 (0.131)
Did not see mental health services	0.220 (0.184)	0.364*** (0.133)
Did see mental health services	0.394 (0.250)	-0.188 (0.225)
<i>Number of observations</i>	<i>14,240</i>	<i>8,005</i>

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

iii) Wave dummies are also included in the list of covariates.

Table 8: Marginal effects of health and social connectedness on duration of a spell of mental ill-health, HILDA

	Self-assessed variables	Duration of spell of mental ill-health
Health		
Reference = poor self-assessed general health		
	Good general health	-0.052** (0.026)
	Very good general health	-0.085*** (0.029)
Social connectedness⁷		
	Social support	-0.057*** (0.007)

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

⁷The social support index is constructed using a set of 10 questions from HILDA, which ask about people's social networks and support. The higher the value in the index, the higher the level of social support for the individual.

Table 9: Effects of health and social support on housing instability and mental health deterioration, within one and two years, HILDA

	Forced move		Financial hardship		Deteriorating mental health with symptoms (MHI-5 > 48)
	within 1 year	within 2 years	within 1 year	within 2 years	
Health					
Reference = poor self-assessed general health					
Very good general health	-0.101* (0.054)	-0.111** (0.054)	-0.343*** (0.039)	-0.302*** (0.048)	-0.807*** (0.050)
Long-term health condition	0.149*** (0.042)	0.175*** (0.042)	0.212*** (0.030)	0.242*** (0.036)	0.376*** (0.040)
Social connectedness					
Social support	-0.047*** (0.013)	-0.051*** (0.013)	-0.103*** (0.010)	-0.098*** (0.012)	-0.327*** (0.012)
<i>Number of observations</i>	<i>146,774</i>	<i>128,330</i>	<i>127,623</i>	<i>97,706</i>	<i>85,243</i>

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

iii) Wave dummies are also included in the list of covariates.

Social support

The analysis found that social support provided protection against housing instability and deteriorating mental health. A one-unit increase in self-assessed social support:

- reduced the likelihood of a forced move in the following year and within two years by 5 per cent (respectively) and reduced the likelihood of financial hardship by 10 per cent (see Table 9).
- reduced the likelihood of deteriorating mental health by 33 per cent (see Table 9)
- reduced the length of time a person experienced a spell of mental ill-health by 6 per cent (see Table 8).

Life events

We examined the impact of the following life events on mental health status and housing instability: death of a close relative or family member; death of spouse or child; serious personal injury or illness; serious injury or illness to family member; separation from spouse; being a victim of physical violence; change of employment; loss of employment; and retirement from the workforce. Most life events affected mental health status in the first year following the event, but some life events had enduring consequences.

- Being a victim of physical violence negatively affected mental health status for up to three years, increased the likelihood of a forced move within the next year by 37 per cent, and increased the likelihood of financial hardship by 5 per cent within the next year (see Table 10, Table 11 and Table 12).
- Separation from a spouse negatively affected mental health status for up to two years (see Table 10).
- A change in job in the past 12 months increased the likelihood of a forced move within the next year by 27 per cent and within the next 2 years by 29 per cent (see Table 12).

Table 10: Marginal effects of life events on mental health status, over the next three years, HILDA

Period of time after the life event	Mental health status (MHI-5)
Serious personal injury or illness	
1 to 12 months	1.998*** (0.131)
13 to 24 months	0.333* (0.131)
25 to 36 months	0.580*** (0.135)
Separated from spouse	
1 to 12 months	3.980*** (0.214)
13 to 24 months	0.714*** (0.210)
25 to 36 months	0.070 (0.211)
Victim of physical violence	
1 to 12 months	4.211*** (0.336)
13 to 24 months	1.227*** (0.326)
25 to 36 months	0.910*** (0.326)
<i>Number of observations</i>	97,830

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

iii) Wave dummies are also included in the list of covariates.

Table 11: Marginal effects of being a victim of physical violence on financial hardship, within the next 12 months, HILDA

Period of time after the event	Financial hardship
Victim of physical violence	
1 to 12 months	0.053*** (0.009)
13 to 24 months	0.032*** (0.009)
<i>Number of observations</i>	<i>91,679</i>

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

iii) Wave dummies are also included in the list of covariates.

Table 12: Marginal effects of life events on forced moves, within the next 12 months, HILDA

Period of time after the life event	Forced move
Serious personal injury or illness	
1 to 12 months	0.168** (0.069)
13 to 24 months	-0.001 (0.075)
Changed job	
1 to 12 months	0.271*** (0.055)
13 to 24 months	0.292*** (0.056)
Victim of physical violence	
1 to 12 months	0.369*** (0.117)
13 to 24 months	0.212* (0.124)
<i>Number of observations</i>	<i>104,196</i>

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

iii) Wave dummies are also included in the list of covariates.

5.1.4 Duration of mental ill-health

Using survival analysis, we found that the duration of a spell of mental ill-health within the general population was relatively short for most individuals.

- Two-thirds (66%) of people experiencing mental ill-health, as indicated by the MHI-5 score, recovered within one year and 89 per cent

recovered within three years (see Table 13, survivor function).

- Women, young people, families with multiple children, individuals who were not working, people with poor self-assessed general health, residents of Victoria, and people with poor social support all had a significant relationship with longer periods of mental ill-health (see Appendix 3).

Table 13: Recovery periods for people with mental health symptoms, HILDA

Year	Number of observations (MHI-5 > 48)	Spell of illness ended during this year	Net loss as no further information on individual	p (probability of escape in that year)	Survivor function	Standard error	Confidence intervals at 95% level
1	5,492	3,625	134	0.66	0.3399	0.0064	0.3274 - 0.3525
2	1,733	870	79	0.50	0.1693	0.0052	0.1593 - 0.1796
3	784	293	39	0.37	0.106	0.0044	0.0977- 0.1148

Source: Authors' calculations.

5.2 Relationship between mental health and housing instability for people at risk of homelessness or homeless

Findings from the analysis on the relationship between mental ill-health and housing instability for the at-risk JH cohort (i.e. at risk of homelessness or homeless) were less conclusive and highlighted the different roles mediating factors play for this cohort. The analysis demonstrated slight protective effects of a mental health diagnosis and public housing tenure against becoming homeless.

Our analysis showed no strong statistical relationships between mental health, tenure and housing instability for the at-risk JH cohort. Diagnosis of a mental health condition appears to have a slight protective effect against homelessness but increased the risk of financial hardship.

- The analysis showed no statistically significant relationship between psychological distress and tenure (see Table 14).
- A mental health diagnosis reduced the likelihood of homelessness by 3 per cent (significant at the 5% level) (see Table 14).
- The likelihood of a forced move within the next six months was elevated by 4 per cent for people experiencing severe psychological distress (see Table 15), and by 3 per cent for those experiencing deteriorating mental health with symptoms (see Table 15) (both significant at the 5% level).
- Severe psychological distress elevated the likelihood of financial hardship within the next six months by 8 per cent (see Table 15).
- A mental health diagnosis increased the likelihood of financial hardship within the next six months by 6 per cent (see Table 15).

Table 14: Marginal effects of mental health on housing tenure, JH

	Mild to moderate psychological distress (K6 = 5–12)	Severe psychological distress (K6 ≥ 13)*	Diagnosed mental health condition	No diagnosis but has severe psychological distress (K6 ≥ 13)
Reference = no symptoms (K6 < 5)				
Private rental or home owner	0.021 (0.015)	0.027 (0.022)	0.033* (0.020)	0.015 (0.043)
Social housing	-0.016 (0.013)	-0.031 (0.020)	0.001 (0.020)	-0.066 (0.045)
Homeless	-0.005 (0.012)	0.005 (0.017)	-0.034** (0.016)	0.051 (0.032)
<i>Number of observations</i>	7,961	7,961	7,990	7,990

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

iii) Wave dummies are also included in the list of covariates.

*Could include people who have been diagnosed with a mental health condition

Table 15: Marginal effects of mental health on housing instability, within the next six months, JH

	Forced move		Financial hardship	
Reference = no symptoms (K6 < 5)				
Mild to moderate psychological distress (K6 = 5–12)	0.020 (0.012)		0.040*** (0.013)	
Severe psychological distress (K6 ≥ 13)	0.041** (0.017)		0.083*** (0.020)	
Deteriorating mental health with symptoms (K6 ≥ 13)		0.027** (0.012)		
Diagnosed with a mental health condition			0.063*** (0.018)	
<i>Number of observations</i>	6,186	4,645	6,053	4,645

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

iii) Wave dummies are also included in the list of covariates.

5.2.1 Entries into homelessness

Our analysis of mental health and entries into homelessness found no strong statistical relationships.

- People without a mental health diagnosis who experienced severe psychological distress were 6 per cent more likely to enter into homelessness compared to those without a diagnosis and without symptoms (significant at the 5% level) (see Table 16).

Table 16: Marginal effect of mental health status on entries into homelessness, within the next six months, JH

	Entries into homelessness
Reference = no diagnosed condition and K6 < 13	
Diagnosed with a mental health condition	-0.011 (0.012)
No diagnosis but has severe psychological distress (K6 ≥ 13)	0.058** (0.025)
<i>Number of observations</i>	4,948

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

iii) Wave dummies are also included in the list of covariates.

5.2.2 Mediating factors

Tenure

The analysis provided strong evidence that public housing tenants were 10 per cent less likely to enter homelessness compared to private renters (see Table 17). This points to the protective effects of public housing compared to other tenures.

Social support

There was some evidence that social support has a modest effect on the likelihood of entering homelessness, lowering the chance by 2% (significant at the 5% level) (see Table 17).

Table 17: Marginal effect of tenure and social support on entries into homelessness, within the next six months, JH

Entries into homelessness	
Tenure	
Reference = private rental	
Home owner	-0.054 (0.056)
Public housing	-0.104*** (0.017)
Community housing	-0.010 (0.016)
Other housing*	-0.002 (0.016)
Social connectedness	
Social support	-0.015** (0.007)
<i>Number of observations</i>	4,923

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

iii) Wave dummies are also included in the list of covariates.

*Other housing can include sleeping rough, transitional housing, boarding houses and living rent-free.

Risk factors

The analysis examined the relationship between risk factors—including illicit drug use, experience of violence or abuse, and having ever been in state care or detention—and housing instability.

- Illicit drug use (regular and irregular) and experience of violence or abuse (as a child or

recently) increased the likelihood of financial hardship and entry into homelessness in the following six months (see Table 18).

- Irregular illicit drug use increased the likelihood of a forced move by 4 per cent (see Table 18).
- Having been in state care increased the likelihood of entry into homelessness by 2.3 per cent (see Table 18).

Table 18: Risk factors as predictors of housing instability, within six months, JH

	Forced move	Financial hardship	Entries into homelessness
Substance use			
Reference = did not use illicit substances			
Irregular illicit drug user	0.042*** (0.012)	0.079*** (0.015)	0.025** (0.011)
Regular illicit drug user	0.030* (0.017)	0.100*** (0.023)	0.031** (0.014)
History of abuse			
Reference = did not experience abuse or violence as a child			
Experienced abuse or violence as a child	0.005 (0.014)	0.075*** (0.020)	-0.02* (0.012)
History in detention			
Reference = never in detention			
Ever in detention	0.014 (0.013)	0.009 (0.012)	0.010 (0.012)
History in state care			
Reference = never in state care			
Ever in state care	0.015 (0.013)	-0.011 (0.020)	0.023** (0.011)
<i>Number of observations</i>	<i>6,186</i>	<i>6,053</i>	<i>4,923</i>

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

iii) Wave dummies are also included in the list of covariates.

6 Mental health and housing trajectories

- The research identified five trajectories to describe the lived experience of people with mental ill-health:
 - excluded from help required
 - stuck without adequate support
 - cycling
 - stabilising
 - well supported.
- A lack of access to housing, healthcare and mental health care leads to people being excluded from required support. As a consequence, people live in inadequate housing that prevents recovery or worsens their mental health. Factors that inhibit people receiving mental health support include: long wait times, lack of assertive outreach and assistance to navigate the system, and dependence on a diagnosis.
- The mental health and housing systems are crisis-driven and have limited resources to provide people with adequate support and a clear pathway for recovery. Instead, consumers lack control and choice because they are stuck in temporary housing, cannot be discharged from institutions, and/or do not receive mental health treatment to address their multiple complex needs.
- The housing, homelessness and mental health systems are not well integrated, resulting in people entering and dropping out of support services repeatedly without recovering. Cycling between services leads to an accumulation of disadvantage and people experience a strong downward trajectory.
- Circuit breakers allow people to overcome barriers and to access the supports and housing they need, enabling them to stabilise their mental health and achieve recovery. Circuit breakers include wrap-around services, assistance to navigate the system, access to public housing, receiving a mental health diagnosis, and gaining access to integrated supported housing.
- Consumers living in a well supported environment have safe, secure, appropriate and affordable housing, and receive mental health care that addresses their needs to live their best life. In a well supported environment, people are able to focus on needs that go beyond housing and mental health recovery. Relying on their ability to access support services when needed, they are empowered to self-advocate for services.

The research identified five mental health and housing trajectories. These trajectories serve as an overarching framework for analysis. Trajectories are not mutually exclusive and within each trajectory there are multiple narratives. Trajectories may at times overlap and people may switch between trajectories.

Note that these trajectories do not relate to the severity of mental illness or the level of need.

For example, a person may have a severe mental illness, but can still be well supported if they have stable housing and appropriate mental health care. This is consistent with research that has shown that the severity of a mental health condition is not associated with housing outcomes; rather, access to appropriate and sufficient support is the determining factor for housing and mental health outcomes (Spicer, Smith et al. 2015).

Mediating factors, as outlined in Section 5.1.3, can act as triggers that contribute to a person entering or remaining within a certain trajectory, or moving between trajectories.

The five trajectories are as follows.

- **Excluded from help required.** The key characteristic of this trajectory is a lack of access to housing or mental health care. This may be because people do not meet eligibility criteria; services and/or housing are not available, inappropriate, or difficult to access; there is a lack of clarity within the system about who is responsible for providing support and services; the system is difficult to navigate; discrimination, lack of culturally appropriate services or prior negative experiences discourage access; there is a lack of system integration and coordination between services; the system is crisis-driven; or cost prevents access.
- **Stuck without adequate support** due to a lack of options or pathways. This trajectory includes people who: are trapped in inappropriate housing (e.g. crisis or transitional housing) because there are no pathways into appropriate and affordable long-term housing; are stuck in hospitals or institutions because of involuntary arrangements, because they cannot be discharged, because there is no transition support available, or due to a lack of adequate community care; are stuck financially and are unable to afford appropriate housing and/or mental health treatment and support; are stuck without help to navigate the system; have multiple complex needs and do not receive the help they need due to a lack of system integration.
- **Cycling.** This is when people enter into and drop out of the system, services and supports repeatedly. Cycling is generally characterised by a strong downward trajectory. Cycling is due to: inappropriate discharge from institutions or state care into homelessness or short-term housing; the episodic nature of mental ill-health and the lack of flexible, scalable long-term services; inadequate duration of support; symptom management rather than holistic care; people

disengaging due to bad or inappropriate services; lack of continuity between services; lack of an ongoing support worker; unresolved trauma; the need to trade-off access to one type of support against losing another type of support; the NDIS service model not being compatible with recovery-oriented care; and the crisis-driven system, in which people cannot access help until they reach crisis point.

- **Stabilising.** On this trajectory, people have access to secure, safe, appropriate and affordable housing in a location that is meaningful to them, as well as ongoing mental health support, support to facilitate meaningful social connections, and financial stability. Once these conditions are in place, people can focus on recovery and rebuilding their lives.
- **Well supported.** People on this trajectory have the type of housing and level of care that is right for them; can engage in meaningful activities and relationships; and have financial security. There is no one specific outcome that classifies as 'well supported'; rather, a well supported trajectory aligns with a person's individual capacity and their needs in terms of housing and mental health. They can navigate the system and access support when needed. It means that a person has the necessary support to develop their independence and achieve their ambitions, as they can focus on things beyond housing and mental health.

Consumers reported that the drop from being well supported to being excluded, cycling or stuck without adequate support can happen rapidly—it is not a slow or stepped progression (a result of the deficit of mid-level support or the 'missing middle'). Combined with long waiting lists for services, this means that consumers' support needs are generally not addressed until they hit rock bottom.

Overall, housing trajectories are shaped by:

- access to housing (availability, affordability, location, eligibility criteria, processes and access pathways for social housing, discrimination, types of housing available)

- living in housing (rent, use of premises by tenants, maintaining the property, moving between properties, portfolio management by landlords, stability, landlord understanding of how to work with people presenting with mental health issues, availability of tenancy support)
- leaving housing (eviction, moving out of housing by choice, transferring between tenures).

Mental health trajectories are shaped by:

- access to mental health services (availability, location, affordability, eligibility criteria, cost)
- using mental health services (duration of support, appropriateness of treatment, integration with other services, skills and continuity of workforce, flexibility of services)
- exiting or stepping down from mental health services (transition planning and support, transferring between services).

6.1 How do people with lived experience and service providers view trajectories?

It would be simplistic to assume that the five trajectories identified above are categories that neatly reflect the actuality of people's lived experience. They are not. Rather, they act as a framework to assist researchers and policy-makers to better understand the types of experiences people have.

When asked to describe a 'typical trajectory', most research participants looked confounded and replied that there was none. Nonetheless, overall analysis of qualitative data revealed common characteristics in people's trajectories and certain experiences could be grouped, and hence the five trajectories emerged.

The terms participants used to describe trajectories included: fractured, reactive, crisis-driven, risk-averse, cycling, downward spiral, unstable, lack of options, lack of continuity, and non-linear. Research participants were eager to point out that there was a diversity of people and experiences,

and that there was no typical story. They noted that people's needs were on a continuum, from those who just needed housing to those who needed ongoing support.

Comments made about people's trajectories through the housing and mental health systems include:

People create their own pathways. It is kind of almost simplistic to think, 'If we understand the system enough, we will be able to map the pathways'. But it is like desire lines, isn't it? When you see a path that is lovely and landscaped, and then all of a sudden, people are walking directly from the carpark because no one thought to put a path through where they have mulched. (service provider)

Where an individual is on their journey with their mental health in terms of accepting what their level of illness might be—their capacity to maintain, take their medication ... all that sort of stuff—also greatly impacts their pathway through the system. (service provider)

6.2 Excluded from help required trajectory

Often, individuals enter the formal housing and mental health system at a point where their need is greatest. However, given the significant level of demand and geographic variability in service provision, individuals may face long waits before they can access treatment, particularly public inpatient treatment. (service provider)

People on the excluded trajectory experience a lack of access to required housing, healthcare and mental health care. An inability to access needed housing, supports and services was by far the most common reason for exclusion mentioned by service providers, consumers and carers, and is consistent with findings from the literature (Jones, Phillips et al. 2014; NSW Ombudsman 2012).

The mental health and housing systems are both crisis-driven and operate in an environment of severe resource constraints. The resultant tightening of eligibility criteria and rationing of resources to those people who are most in need (or crisis) means that many others are precluded from receiving the housing and support they need.

6.2.1 Housing

Many consumers are excluded from access to safe, secure, appropriate and affordable housing, and consequently live in situations that prevent recovery or worsen their mental health. Their housing pathways may include frequent moves; remaining in the family home even if the situation is negative; and forms of homelessness and marginal housing such as couch surfing, living in boarding or rooming houses or other unsafe accommodation. Mental health and recovery is impacted by the housing situation. Consumers reported that inadequate housing affected their financial situation, feelings of safety and security, self-worth, relationships, perceived control of their environment, and employment status.

Consumers recognised the importance of having secure housing to maintain mental health and achieve recovery. However, in many cases, consumers reported that they were not living in stable housing, such as public housing or their own home, but rather relied on transitional housing and informal support from friends or family that could not be sustained over time.

I've lived out of a suitcase for seven years. So I just want somewhere where I can unpack and not have to pack back up again. (consumer)

Housing providers explained that, for some people, boarding houses are the accommodation of choice.

What they enjoy about lodging is that they have one room and one bill. And that's good. They've got someone to sit and watch the telly with and the football. So it builds up these little communities that you get in some of the lodging houses. For some people, lodging houses are

a point they move through until they get their housing of choice. For some people, it is their housing of choice. But it's about, 'Let's help support them and make sure it's good quality'. (housing provider)

However, boarding houses are often unsafe environments that are characterised by violence, AOD, abuse and the presence of other people with complex needs. Consequently, some consumers prefer to live on the streets rather than expose themselves to environments and behaviours that are detrimental to their mental health.

There's the lack of appropriate housing there, safe housing for people with mental health issues. A lot of people that we speak to would prefer to live on the streets than be in a rooming house. (service provider)

Barriers to access for public and community housing include onerous and lengthy application processes (forms, interviews, documentation required, keeping the application active) and long waiting lists. Meeting eligibility criteria does not guarantee a social housing tenancy, as most social housing is available only to those on the priority list—even then, waits of over five years were commonly reported—and a mental health diagnosis alone is not generally enough to be considered a priority for social housing.

Gateways into the social housing system include homelessness services, 'street to home' programs, mental health programs, and supported housing programs (e.g. HASI in NSW and the Housing and Accommodation Support Partnership Program in SA). These services assist consumers with the application process for social housing, but are available only to people who are at crisis point. Research by the Productivity Commission (2018) shows that the homelessness system is the most common entry point to social housing. This is consistent with the qualitative data from the consumer consultations: consumers consistently reported not being eligible for housing services until they became homeless, and some consumers and carers reported being actively discouraged from applying for public housing. Thus, rather than

assisting people to access and sustain appropriate housing, most housing support is only available after consumers have hit crisis point.

There is a lack of specialist workers employed by housing providers who understand mental health, mental health services and how to work with people presenting with mental health issues at housing access points or in housing assessment teams. This presents another barrier to entry into social housing. Housing and tenancy managers are constrained in their capacity to offer mental health support due to their workload; staff are not trained to handle mental health issues; providing mental health support is outside the scope of responsibility of housing providers; and it would be hard to upskill staff.

A lot of the time, housing is their primary issue, and once they are housed then the other providers will leave it for us to deal with. But we are not mental health workers. We are a housing provider and we don't have the staff to provide that support that they need. Whilst we try as best as we can, we just don't have that capacity. (service provider)

The fact that there is not enough housing that meets the physical and mental health requirements of consumers represents another barrier to access. Most housing available is either highly congregate living (e.g. supported residential facilities) or individual housing in the community. Many people with lived experience of mental ill-health struggle to live with too many other people, in share housing or in loud environments. Certain modifications to the physical characteristics of a dwelling can make housing more suitable for people with mental health issues—for example, a high level of soundproofing, or walls that are resistant to impact (so that the property does not get damaged when the tenant becomes angry or aggressive). Share housing can be designed with a mix of private and common spaces, allowing people who are not related and who did not choose to live together to cohabit.

The cost of housing is a key issue for exclusion. People on Newstart Allowance cannot afford the cost of most private rental properties; if they do

rent, they are usually required to make trade-offs between paying the rent and spending on medications, doctors, food and utilities. Even when receiving free or subsidised housing or services, many people struggle financially due to the low levels of Newstart income support. Participants also reported financial impacts for carers trying to develop their own solutions to best support their family member. For example, helping to pay the rent or mortgage of the care recipient could create other issues for the carer—their pensions could be penalised because the property was seen as an investment property, or problems could arise within the family about finances.

Many housing providers have eligibility criteria that exclude people with AOD issues; even when AOD issues are not an explicitly stated reason for excluding someone from housing, providers often choose tenants without AOD issues over those with such issues.

6.2.2 Mental health support

Access to the mental health system can be via referral from a GP, emergency department, mental health crisis team, or through interaction with the justice system. However, access to mental health support is uneven and depends on the level of mental health support required and the availability of services in a location.

Consumers and service providers reported that there were long waits and significant barriers to accessing the mental health system. Often, individuals enter the mental health system at a point when their need is greatest. However, given the significant level of demand for and geographic variability in service provision, individuals may face long waits before they can access treatment, particularly public inpatient treatment. There is a lack of mental health services in regional areas throughout Australia and services appropriate to the level of distress experienced often do not exist.

This feedback is consistent with findings from the Productivity Commission (2018). For example, low-intensity care is generally readily available through a mental health care plan and referral from

a GP (though cost may still represent a barrier). Moderate-intensity care, though, is often not available (the ‘missing middle’). High-intensity and complex care are highly rationed and are generally only accessible to people in crisis. Consumers frequently reported that they could not access mental health services until they were suicidal. Participants in the service provider focus groups expressed frustration at their inability to access mental health support for their clients unless they were in severe crisis, often requiring hospitalisation. The result of this was that by the time clients could access mental health support they had often lost their housing.

It's not necessarily just the housing support, it's more general, unless they're in acute care. People have to actually get to a point of being very unwell, where they can go to a hospital admission, to get any care. That's a really scary situation, particularly for our support workers because they can't get the support to prevent [the client] becoming acute. (service provider)

The lack of bulk billing doctors prevents many people from seeing a GP, which can affect their ability to maintain their medication and lead to them becoming non-compliant with their medication. In some instances, people replace their medication with illicit drugs.

Clients have said to us that the cost of going to a GP in order to maintain their medication becomes an issue. It's easier for them at times to become non-compliant with their medication or to replace their medication with drugs. (service provider)

Similarly, cost can preclude people from seeing a psychiatrist, psychologist and counsellors until they reach crisis point. Young psychiatrists are disinclined to work in the public health system and there are too few psychologists that charge only the cost rebated by the MBS. Consequently, even those individuals with a mental health care plan can be excluded from support due to cost.

I can't afford to go, so I don't go. You know, 24 years of battling it and I don't know where to find free services for someone my age. (consumer)

Carers are particularly excluded from mental health support as services often focus on the individual with the mental ill-health. Carers not only need help to continue to support their family member but also to maintain their own mental health.

The way our mental health system operates, it is very much focussed on the individual who's ill. My experience has shown me that the services and supports are needed for family members, carers, partners. Those services are so important because you're the one who kind of keeps the whole operation together. (carer)

Lack of assertive outreach

Lack of assertive outreach excludes consumers from access to mental health and housing services. Service providers gave many examples of how this negatively affected people. This was especially pronounced for the homeless cohort; people who were experiencing mental ill-health but did not have a diagnosis; and those who had limited insight into their mental health.

A female client in her fifties has undiagnosed mental health issues. She is estranged from her family due to her behaviour and her children have AVOs against her. So she's been transient for many years, and every now and again she ends up in Gateways [boarding house]. The client denies having any mental health issues and all her housing options have broken down due to her paranoia around her property ... causing her to become physically unwell. That's her experience.

Every time she turns up at Gateways it's also difficult to find a bed that is suitable—sometimes she'll feel that it's poisoned and she needs to be moved around. Every time Gateways have tried to contact psychiatric triage for consultation and assessment, due to the client's denial that she's got mental health issues, they haven't been able to do anything. It's not unique, because there's many examples of this. It's quite specific in terms of, 'How do we work with people that experience a lot of housing issues as a consequence of what we perceive being their mental health issues, but they just don't agree with that?' (service provider)

6.2.3 Diagnosis

Many consumers living with significant mental health issues do not engage with mental health services, either by choice, due to a lack of services in their location, or due to the stigma attached. Being homeless or living in unstable housing can be a barrier to getting mental health support. As a result, these people do not have a mental health diagnosis and do not receive any support.

Consumers reported that a major reason for not receiving support was that they did not meet eligibility criteria until they hit rock bottom, such as if they became homeless or attempted suicide. This was despite them recognising the early signs of deteriorating mental health and reaching out for assistance.

I went to places like [community mental health provider] and they interviewed me. They would say, 'I don't think you need a referral here. You are doing quite well. Just keep your chin up and you will get through it.' Things just got worse and worse. (consumer)

Public housing has said to me, 'Come back when you're homeless.' That's their rule. 'We can't help you.' (consumer)

Having a diagnosis can be a circuit breaker that facilitates access to housing and mental health services. For example, a mental health diagnosis is needed to apply for support through the NDIS. However, a mental health diagnosis alone is generally not sufficient to gain priority status for social housing.

A mental diagnosis can be a double-edged sword. The type of diagnosis can affect the services for which a person becomes eligible; there is discrimination against particular diagnoses (i.e. particular diagnoses are not 'helpful' for accessing the system); and diagnosis can lead to stigmatisation and discrimination in the community and amongst family and friends.

Most psychiatrists won't diagnose somebody with a mental illness under a certain age. But many

people don't get help unless they have a formal mental health diagnosis. So there's a bit of a catch-22 there too. (service provider)

Some people love a formal diagnosis because they realise then, 'That's what's been ... going wrong the whole of my life'. Some people find it very labelling and restrictive and comes with a stigma. (service provider)

6.2.4 Lack of assistance to navigate the system

The mental health and housing systems are fragmented and difficult to navigate. Consumers can be excluded from housing and mental health supports because they do not know what services exist, how they operate or how they can be accessed.

Many consumers reported not knowing if or what housing services exist and some did not understand that housing support consists of public housing, community housing and rent support. Consumers knew about clinical mental health services and mental health plans but were less knowledgeable about community mental health services.

Misinformation or conflicting information, sometimes between organisations and sometimes within the same organisation, hindered consumers' access to housing and services.

Consumers reported that they were required to tell their story repeatedly when trying to access services, which was challenging and could be traumatising for them, especially if it did not facilitate access housing or services. Consequently, some consumers were reluctant to engage with services.

6.2.5 System integration

The housing and mental health systems are characterised by silos and a lack of integration, which creates significant barriers to access in terms of communication, consent and referrals, and a lack of clarity about which parts of the system are responsible for providing services and support. Divisions between the federal, state and territory governments can lead to disconnected planning and can result in a combination of services that are not well integrated, and which have uncertain and variable durations of funding. Service providers identified the need for coordinating bodies within the system to organise access and share information.

The lack of system integration is particularly apparent where it excludes people from services—these are often people with multiple complex needs who are most in need of support. For example, a combination of mental ill-health, substance misuse and housing instability is common. However, because there are no clear lines of responsibility and no ‘service of last resort’, a person with complex needs may miss out on services altogether.

Rough sleepers, for example, are difficult to house. Housing providers refuse to take on the client unless mental health has stepped in. Mental health is reluctant to become involved as they have a history with that person and they have been particularly problematic and have exhibited challenging behaviours, and it is therefore the responsibility of AOD services. Housing providers consider this person to be high risk and want a baseline assessment of what’s going on with this person. But a baseline assessment for someone with AOD withdrawal, to understand their mental health, is not feasible with a person who is living on the street. In essence, this means that the person cannot be housed. The next thing is, that person ends up in corrections. This could have been an opportunity to do the baseline assessment, but this didn’t happen. Instead, the person was discharged [from corrections] without letting the service providers know they were being discharged and the person ended up back on the street. (service provider)

Consent

Lack of shared consent across services can be a barrier to early intervention and effective referrals. Shared consent also ensures that clients are not re-traumatised by having to retell their stories multiple times. While shared consent between health and housing services is practised by some agencies, its effective implementation can be difficult and requires good communication between consumers, mental health practitioners and housing workers, as well as appropriate policies and procedures to facilitate this.

In many instances, mental health services cannot be provided without the individual’s consent. Sometimes consent is withheld by the agency, rather than by the consumer.

I worked with the youth population in the last program I was a part of. In order to engage in the program, you had to have consent to talk to between six and eight agencies. [I] didn’t have a single person who declined consent over five years, but I can tell you, out of those agencies, every single time we tried to communicate between the agencies, it was actually an issue on the ground between the workforce that actually restricted access. It wasn’t the service user. It was from the agencies’ point of view. And it wasn’t even [at] the high level in the agencies. It is going down through all the different levels. It is the understanding of it in the workforce on the ground that is the issue. (service provider)

Housing workers expressed concerns around their inability to access mental health support for their tenants when they were unwell, especially if the worker did not have the tenant’s consent to do so.

Our biggest blockage from a department point of view is usually consent. Often, when the support drops off, the department is the only one working with the client. We know they are unwell, but no one will go and see them. They are not unwell enough, for example, for me to ring the police and say, ‘Can you go out and do an assessment? They are out of control.’ I think Micah⁹ is the only

support agency that will just go out and have a conversation with someone without getting any formal consent beforehand. (service provider)

Clinical practitioners noted that the way in which consent was discussed with an individual was important. For example, while it may be important to inform the housing provider that the tenant has a mental illness, the details of the client's medical history or what medications they are on should not be shared.

Lack of shared consent meant that consumers were sometimes required to refer themselves to services, even if they did not have the capacity to do so, which further excluded them from support.

NDIS

The NDIS is a significant disruptor to the mental health system and is changing the way people can access mental health services, how services are provided, what services are available, and how funding is made available to service providers and consumers.

Access to the NDIS is a significant barrier for people living with mental health issues. This is because the NDIS was not designed with consideration of the complex and differing needs of people with psychosocial disability. To access the NDIS, a person must 'have a permanent and significant disability that affects [their] ability to take part in everyday activities' (DSS 2019). However, the NDIS definition of a 'permanent and significant disability' is at odds with a recovery-oriented approach and does not accord with the episodic nature of mental illness.⁹ This creates barriers to access in the application process as it makes it challenging for people to meet eligibility criteria. In 2019, the National Disability Insurance Agency (NDIA) reported that one-third of the applications by people with a primary psychological disability did not satisfy access requirements, mostly because of not meeting disability criteria.

The complexity and length of the application process and the amount of documentation required excludes many people from the NDIS. Consumers and service providers reported that it can take many months to complete the application process and then many more months before a decision about the application is made.

We've had quite a few clients that have been knocked back many times for applications for NDIS. Because they struggle to get the documentation together. But also about actually being able to prove—there's that sort of tension between the idea that you have to prove a chronic and forever illness and trying to actually work within the concept of recovering. (service provider)

While some agencies assist clients to apply for the NDIS, most are not funded to provide the intensive one-on-one support needed to lead applicants through every step of the application process. Many applicants do not receive help to apply. Applicants face additional barriers if they are homeless, as they generally do not have the required medical and other documentation, have no address at which to receive communication about the status of their application, and face barriers in accessing the application documents.

Diagnosis is a prerequisite for the NDIS application. It is possible to qualify for 'early intervention' support, which is intended 'to alleviate the impact of a person's impairment upon their functional capacity by providing support at the earliest possible stage' and 'to benefit a person by reducing their future needs for supports' (NDIS 2019a). However, most people with a primary psychological disability receiving NDIS support qualify because they are in the 'disability' cohort (i.e. they have a diagnosed psychological disability); only 2 per cent are in the 'early intervention' cohort (NDIA 2019). Eligibility for early intervention depends on the type of mental health diagnosis: for example, it is easier for people on the autism spectrum to successfully apply, but more difficult for those with

⁸ Micah Projects is a Brisbane-based non-profit organisation that supports people experiencing mental health, housing or domestic violence issues.

⁹ According to the NDIS website (<https://www.ndis.gov.au/understanding/what-ndis>): 'A permanent disability means your disability is likely to be lifelong. A significant disability has a substantial impact on your ability to complete everyday activities.'

a diagnosis of borderline personality disorder. The cost of providing the medical reports (e.g. from a psychiatrist) to support the application is a further barrier that contributes to exclusion.

Many consumers who participated in the research did not fully understand how the NDIS operates. For example, some were assessed as eligible for the NDIS but did not know what to do once they were accepted, while others were rejected and did not understand why. Consumers and service providers were unclear on how decisions about NDIS eligibility are made, as in some instances people with similar needs were judged eligible and ineligible for the NDIS.

The ways in which the NDIS is reshaping the service system also contributes to the exclusion of some people from services. Many community-based and psychosocial support services are being subsumed into the NDIS, which changes the access pathways to these services, their funding base, and the ways in which they deliver services. To build capacity among providers and deliver more consistent support services for people with a disability, initiatives such as those delivered by the Pathways Program and the Disability Reform Council, are aiming to improve the NDIS (NDIS 2018).

The NDIS is also impacting the way support coordination is carried out, which particularly affects people with high and complex needs who need specialist programs. For example, the support coordination function under the NDIS differs from the case management support that was previously provided by Mind's Partners in Recovery (PIR) program. Local Area Coordinators (LACs) for the NDIS are supposed to help people navigate and connect with the system. However, LACs have limited capacity to do so and often do not have the skills, expertise or training to address the needs of people with very complex needs, who require an assertive approach to service engagement (in the way PIRs did).

Housing and support are not well integrated under the NDIS. This creates challenges in terms of providing support for a client in a way that respects their ability to choose what they want to disclose

to their housing provider. It also makes it difficult to put arrangements in place so supports can be accessed if the person's mental health deteriorates.

Service providers reported that they struggled to engage with and keep abreast of the many changes introduced by the NDIS, and many had difficulties obtaining information and advice from the NDIS.

... the NDIS is an impenetrable force not to be dealt with. You can't get to the inside to talk to anybody. (service provider)

Housing providers reported that a lack of responsiveness and a lack of coordinating capacity from the NDIS can lead to dwellings remaining unoccupied for long periods.

We have specialist disability accommodation. [One share house] sat empty for over 12 months, and we were after the NDIS, and basically got a very curt email saying, 'We are not a referral service.' So, they process the people who need the housing. We have the housing, but they won't connect us together. So, people who need the housing don't know that it exists for them. It is not working. (service provider)

Housing providers also reported that the increased number of access points for support created by the NDIS made it more difficult for them to get help for their tenants.

Employment

Many consumers reported being currently unemployed but seeking either part-time or full-time work. However, even if they were able to work, the interdependency between housing and employment makes securing either employment or housing difficult. One consumer interviewed was not able to secure a private rental because he was not working and was not able to get a job because he had no fixed address. For consumers with deteriorating mental health, it was sometimes difficult to maintain employment. Work was often overwhelming and negatively impacted on their mental health. Without employment and income, their housing options were limited.

I've rung countless places [for housing] and they will not even give you their address if you're not working. For a job they want to know, 'Where do you live? How long have you been there?' I don't want to lie, yet I want to protect my chances of getting a job as well. It's sort of two dogs eating each other. (consumer)

6.3 Stuck without adequate support trajectory

I always think of this woman, who sleeps rough and she has a lived experience of a psychotic illness, and she actually sets up strategically [at] the office at [the Department of Health and Human Services]—that's where she spends most of her days. I was talking to her one day and I said, 'Are you involved in any services?' and she said, 'Yes, I have seven case workers and I'm still sleeping rough,' because her touch point and the ability for each of those services to provide the service under the constraints that they're operating in is so limited that it still doesn't deliver an outcome for her. (service provider)

The stuck trajectory encompasses people who are stuck within the system without adequate supports and with a lack of options or pathways. The primary reason for people being stuck is because the housing and mental health systems are crisis-driven and do not have adequate resources to provide appropriate supports. For example, people may be inappropriately housed in short-term or transitional accommodation because of a lack of long-term housing options, or they may be stuck in institutions because adequate community care is lacking.

The corollary of being 'stuck' is that consumers are unable to move on with their lives, recover and focus on things beyond housing and mental health. Instead they remain in limbo, whether in regard to their housing, mental health or both.

6.3.1 Choice and control

A lack of choice and control emerged as the main theme for the stuck cohort. Lack of choice and control can be because of a lack of housing options or services; lack of financial resources needed to take up alternative options; or lack of choice over services and the type of support that is provided.

Stuck without adequate mental health and psychosocial support

Consumers frequently reported that they experienced a lack of choice and control over their mental health support, or that required support options were not available, which hindered their recovery.

In most cases, clinical mental health services do not provide non-clinical support. Some consumers require psychosocial support and community-based mental health care in order to step down from hospital care and rebuild their lives in the community, but these supports are not available to them. Consequently, their mental health treatment consists of medication only, they are forced to remain in hospitals or institutions due to lack of adequate community care, or they are stuck in various involuntary arrangements.

Consumers reported that clinical mental health services offered them limited support. A number of participants felt that psychologists/psychiatrists only focus on medication, which plays a limited role in recovery. In most areas, and particularly in regional areas, private psychiatrists are limited and unaffordable. Consumers reported that they need understanding, help with coping strategies, and help with daily life skills.

[Psychologists and psychiatrists always ask], 'Have you been taking your medication? Have you been on this medication? Try this medication. Try this one. Try this one.' I'm just, like, it's not what I want, it's not what I need. I need coping mechanisms, I need you to teach me how to deal with it without medication. (consumer)

[What we need is:] people who understand, less medication, more vindication, help [to] cope, access [to] a place where you feel safe and comfortable, no judgement, help in a timely manner, to be given a fair go, more duty of care, mental health, help getting [through] life—less so to a mental health appointment. (consumer)

Consumers described that the more unwell they were, the less choice they had over what services they received and who their individual workers were. Many consumers reported seeing a GP and being on ongoing medications, but not having ongoing psychosocial support to help them with recovery. They also lacked access to sufficient psychological support. Frequently they were unable to choose to change medication type or dosage despite negative effects, or were forced to have depots¹⁰ even if the medication was too strong and affected their functioning.

Some consumers lived in stable housing but were stuck without adequate mental health support and so were not able to build on the housing foundation to facilitate recovery and increase their social participation. Consumers reported that housing without adequate support did not improve their mental health.

I've never been in a situation that I've actually had to live on the street. But I don't think the housing is mentally a saviour at all. Just one of those things. It's like putting on clothes in the morning; you just happen to have them and you use them. But having the house hasn't helped me mentally at all. (consumer)

Consumers reported that they put up with poor services because they feared they would otherwise be labelled 'difficult' and would have services withdrawn.

Consumers also reported that while there was some support for the milder symptoms of mental ill-health—for example, the 10 MBS rebated sessions with a psychologist available under the Better Access plan—this offered only limited support, and

many psychologists charge fees that are above the MBS rebated amount, which creates barriers. Similarly, consumers reported being unable to afford psychosocial support if they were not eligible under the NDIS.

Some providers are using SIL funding to purchase bricks and mortar properties. This is problematic as it ties the client to the service provider agency as their funding is tied up in the accommodation. It is a safe option for the provider, but is risky for the client, who could lose their accommodation if they wish to change providers. (service provider)

Stuck without options for appropriate and safe housing

Consumers may be stuck in inappropriate housing without options or pathways to move to more appropriate housing. For example, they may be stuck in transitional housing for a long period of time, with no pathways to transition to long-term appropriate housing. They may be required to live in shared accommodation or congregate settings that do not meet their needs.

Due to resource constraints in the social housing system, people are sometimes placed in the wrong type of housing for them (e.g. boarding or rooming houses, or transitional housing), which can be deleterious to their mental health.

We are looking at what is the quick fix, without appropriate supports ... Especially for our clients with mental health issues ... if we put them into a mishmash of just general accommodation, the risks of them getting unwell are increased. The [chances] of engaging them around recovery are decreased. The risks of putting them into an environment where they are exposed to AOD, inappropriate behaviours, etc. are escalated. (service provider)

Consumers reported living in insecure housing in which they were unable to lock their doors, or were exposed to antisocial behaviour by other residents

¹⁰ A depot injection is a slow-release, slow-acting form of medication.

or people living in the neighbourhood. Consumers often referred to not 'fitting in' to public housing, especially when there were people around them with substance misuse. Being exposed to others with substance misuse often led consumers to engage in substance misuse themselves when they were trying to avoid using for the sake of their mental health.

At that time, I would have been better off on my own and seeking help. I mean, sometimes it's not good to be around people who have the same sorts of issues. People who have got issues with addiction should not be housed together, it doesn't work. I've seen it while living it. (consumer)

Consumers reported being dependent on accepting the housing assigned to them by housing providers. In several cases, consumers deemed the housing unsuitable for their needs because of services not being close by or other residents having AOD issues. However, their preference was not taken into consideration by housing providers or not seen as a valid reason for needing a transfer to another property.

They give you two choices and if you knock them back, because they could be in really bad area-like, I don't want to take that place because three months later I might be dead because of the area. If you don't like any of these, you can go back on the waiting list and wait another 18 years. (consumer)

It's like, beggars can't be choosers. (consumer)

In some regional areas, where housing was more affordable, consumers reported being stuck with a mortgage that they could not pay when they were unwell or had only limited income.

Some consumers struggled to navigate the housing system, as they did not understand that it consists of public housing, social housing and rent assistance. Others reported that transitioning between parts of the housing system was difficult because of a lack of options and pathways—for example, consumers reported being stuck in

transitional housing for long periods of time due to a lack of options and pathways into longer-term housing options. Consumers reported being trapped in transitional housing with no sense of how long they would be able to stay there and no sense of how long it would take for them to be allocated a public housing property.

I feel unsettled ... knowing it's only a temporary place. I want to get a place long term where I can call home and feel comfortable and feel at ease and that I don't have to stress about things. (consumer)

Cost was a key factor in people remaining trapped in inappropriate housing. Consumers commonly reported being stuck in private rentals, refuges, family homes, hospitals, and other accommodation that was unsafe or not well maintained, because they could not afford other options.

Brown water through the taps. The electricity was stuffed. The water, the plumbing was bad. There were holes throughout the house and most of the windows were either locked shut or couldn't shut. (consumer)

The lack of prevention and early intervention drove many consumers out of private rental or home ownership after their first mental health crisis. Once they had lost their tenure, they found it difficult to re-enter independent housing in the private market and they then became reliant on the service system.

Consumers reported having negative experiences with housing staff and felt a lack of control in their interactions with them. This seems to stem from the lack of information staff are able to disclose to clients about the length of waiting lists. Consumers also referred to having difficulty talking about housing problems with housing staff and having to justify that they needed to move because of negative impacts on their mental health (i.e. due to violence, not feeling safe, noise being too loud).

You feel worthless and you feel like you don't belong anywhere. (consumer)

Trauma

Many consumers reported experiencing trauma as a child and acknowledged that this trauma had an ongoing impact on their relationships and behaviour. A lack of trauma-informed services and access to trauma counselling meant that consumers did not receive support to overcome their trauma, which meant they remained stuck in a cycle of mental ill-health and behaviours that prevented them from moving forward with their lives.

Many consumers reported that they experienced trauma within services. Violence or threats of violence within public housing, emergency shelters and hostels were commonly reported. These incidents were often inadequately addressed by providers, which caused consumers to be traumatised or re-traumatised. Consumers reported that this was an issue in public housing in particular, as being a victim of violence was not necessarily viewed as reason enough to be transferred to another tenancy, and therefore tenants were stuck in their existing accommodation and continued to experience violence or remained at risk of violence. Similarly, consumers reported that accessing mental health services could be a traumatising experience. Hospital emergency departments and inpatient units were seen to be particularly controlling and traumatising.

NDIS

Consumer choice is a key principle underpinning the NDIS (NDIS 2019b). However, consumers reported that their choice was constrained by the limited availability of services in some locations—for example, regional and remote locations may have only one service provider agency in the area. This led to consumers being stuck with a particular service provider organisation or worker because alternatives were not available.

There is always pragmatics and logistics which also apply. Particularly Tasmania has got a very dispersed population. If you want to have your

service up in the north-west coast, you may not get, realistically, choice of provider or housing provider. (service provider)

Service providers noted that there was a tension within the NDIS when housing providers were also providers of support services, as this limited client choice and effectively bound clients to the one service provider because they are housed by them. If the client chose to discontinue using the service, this meant their housing would also be discontinued, effectively making them homeless.

... some providers of supported residential facilities have become NDIS providers. So, of course, they're saying to their clients, 'We are your preferred provider.' They're getting a bunch of the housing money and who is going into these establishments to check that people are getting what they need? Nobody. We're going to have a situation there where the managers and owners are also providing a support, and it is problematic because if people want another support provider, they're being asked to leave their housing. (service provider)

Stuck without help to navigate the system

System navigation is resource-intensive and time-consuming work. Traditionally, system navigation was the role of social work, and social workers were trained in that skillset. Consumers and service providers interviewed pointed to a lack of clear structures or guidelines for system navigation. Service providers reported that increasing specialisation and the rapid changes engendered by the introduction of the NDIS made it difficult for them to keep abreast of changes in terms of what services were available and who was providing them. Service providers frequently relied on personal relationships and networks to refer clients, as formal structures for doing so were often non-existent.

It's a resource implication because system navigation is time-consuming work. Traditionally, it was always the realm of social work really. They were trained in that particular skillset but the

system is changing so rapidly at the moment that it's a big investment for an organisation to have tenancy officers or skilled staff that can keep abreast of the massive changes that are occurring in terms of who's providing what in what area, what pilot program. (service provider)

Service providers were frustrated by the lack of clarity about which parts of the system were responsible for clients with multiple complex issues, as this made it difficult to effectively refer clients and get them the help they needed. In addition, communication with various parts of the system was difficult due to different terminology and language used to describe issues.

Carers reported having difficulties finding adequate mental health support to facilitate recovery and feeling burnt out from navigating a constantly changing system. For carers, providing support long term can become problematic, affecting their own ability to assist the person in need.

I'm very isolated. I'm at the point where I'm so burnt out that to pick up the phone and ask for Commonwealth [respite care] to come and do a quick clean around my house is a huge task. I can't bear to do it. I come home and I don't do much. That's not really a life. (carer)

Service providers described the issues that can arise due to the lack of clarity around which services are responsible for providing support. For example, tenancy officers may struggle to get mental health services involved with a client who also has AOD issues, as mental health sees this as AOD's responsibility, and vice versa. This leads to people remaining stuck in their current situation, unable to access appropriate supports.

Consumers sometimes struggled to navigate the housing system because they did not understand that it consists of public housing, social housing and rent assistance. Similarly, referral processes could work against consumers—for example, when they were required to refer themselves to a service but did not have the capacity to do so. Many consumers reported that they did not know how

to find mental health or housing services. Applying for services and filling out the required paperwork, without support, is particularly challenging for people experiencing periods of severe mental ill-health. In cases where consumers were receiving services, they often did not know who was providing the service (i.e. whether through a mental health or housing service provider). Accessing the DSP, the NDIS and public housing without support was a major barrier for people, and support in accessing these was often patchy. This contributed to clients remaining stuck in their current situation, unable to access appropriate supports.

When you're unwell, how do you navigate the system? [How do you find out] about where ... you get assistance from and what's available? Especially in regional areas too, and then you haven't got transport. So you fall through the gaps. (consumer)

6.4 Cycling

The constant churn of people going into housing, not sustaining their tenancy, becoming homeless, back in. The constant churning because the services aren't there for long enough in order to help people build capacity and to be able to sustain their tenancy, which takes a lot of time. (service provider)

People who are cycling enter and drop out of the housing, homelessness and mental health systems repeatedly. Cycling is characterised by a strong downward trajectory. This means that each time a person enters and drops out of the system their resources (e.g. housing, social relationships, financial resources) are further eroded, with detrimental effects for their housing stability and mental health. In the most severe cases, prison becomes the final destination.

You can't get back what you lost on the way down. (consumer)

Consumers in many cases reported suffering trauma and other negative experiences in childhood and becoming homeless early in life. Interpersonal trauma usually began at a young age (prior to 18) and continued into adulthood. These traumas included: domestic violence, emotional abuse, parental abandonment, assault, a dysfunctional family situation, and death of a loved one.

Probably about a year ago I was living with mum and stepdad. They had grown to pick on me because I've got a mental health condition, so I got into a big fight with mum and dad and they were prepared to just kick me out onto the street. They literally called the cops on me. (consumer)

Cycling leads to an accumulation of disadvantage.

There are all sorts of other things that happen to people along the way. If they end up in jail, they very often end up with acquired brain injury—there's quite a lot of brain injury anyway amongst people who are homeless because they've had all sorts of levels of trauma in the community, they've been homeless. But all sorts of things happen to people when they're unwell and you see this accumulation of disadvantage, that even people who come from supportive families, over a period of time, it becomes impossible for families to continue supporting. Because somebody is paranoid and they think the very people who might be able to help them are calling the police—even when there are people that care there, it can be very, very problematic. (service provider)

Underlying these factors is the crisis-driven nature of the housing and mental health systems, which means that access to supports is rationed and support ends prematurely, leading to eventual relapse and the cycle beginning anew. Systemic triggers and decision points cause cycling. Because most of the systems' limited resources are focussed on people in crisis or with acute mental health need, preventative and follow-up care are lacking. A lack of continuity of support, due to gaps in system integration and service integration, exacerbates these issues.

They get excluded from private rentals. If someone's on Newstart, they can't really afford rent. So sometimes they'll go from different zones, different mental health clinics, then they fall through the gaps. They go from prison to community mental health—it's just really hard for them. Then their GP changes along the way. So there's not much continuity there. (service provider)

6.4.1 Housing and housing support

Housing in the cycling trajectory is characterised by insecure tenure, unaffordable rents, unsafe environments, and lack of support to sustain tenancies. Consumers may be living in private rental, social housing, supported accommodation not suited to their needs, boarding houses, crisis housing, hospitals or other institutions, or with friends and family where this is not sustainable.

A lack of affordable, secure, safe and appropriate housing drives the cycling trajectory. It is difficult for consumers to access mental health support without accommodation, but there is a shortage of suitable accommodation. This creates a cycle of crisis, in which people cannot maintain housing due to their mental health problems but without housing cannot get treatment. This circuit carries a high risk of homelessness, admission to hospital and, in extreme cases, prison.

Consumers described how they had to make trade-offs between accepting one type of support and losing eligibility for another. For example, the lack of medium-term housing solutions (i.e. one to five years) with integrated housing support meant that in order to access a longer-term tenancy, consumers had to forfeit mental health support as mental health support was tied to short-term housing and homelessness services. Similarly, long stays in transitional housing could mean that consumers lost their place on the public housing waiting list; accepting a SIL package and moving into private rental also meant they lost their place on the public housing waiting list. The cost of housing meant that consumers traded one need for another, most commonly forgoing recreation and a quality diet in order to maintain housing.

Service providers described a common cycle as alternating between homelessness, hospital, short-term accommodation and prison.

We commonly have people in a cycle between hospital, the streets, short-term accommodation, prison, so round and round. We find some of the options—such as Elizabeth Street Common Ground, for example—those work really well for a lot of people. They provide the benefit of long-term accommodation and a reasonable level of support, plus a mental health service that can assist as well. We've had a number of people there that were in that cycle who have gone out of that cycle because of it. There are very few other options like that. (service provider)

Private rental

Consumers related that access to the private rental market was difficult, as private rental was not affordable to them and they faced discrimination from private landlords. If they lived in private rental, their tenure was often insecure, and they could experience unwanted moves because their lease ended or they were evicted. Forced moves incurred financial and social costs and were stressful, which negatively impacted on their mental health. This link between forced moves, financial hardship and deteriorating mental health supports the findings of the quantitative analysis of the HILDA dataset.

Within private rental, consumers often lived in housing that was of poor quality, in locations not suited to them, or that was not safe. High rental costs meant that some consumers shared housing with people they would otherwise not choose to live with. Consumers recounted how the many forced moves, and the need to move to whatever accommodation was available (including the homes of friends and family), led to them losing their mental health supports—and how difficult it was to rebuild these. All of this contributed to mental stress and impeded recovery.

Social housing

Consumers reported that they had difficulties accessing social housing and housing support

until they were in severe crisis or were homeless. Within social housing, time-limited tenures (e.g. transitional housing), and the changing nature of support available as consumers transitioned from one type of tenure to another, created issues that could be destabilising and contributed to cycling. Consumers identified a lack of ongoing support within social housing. For example, mental health supports for consumers while they were homeless were no longer available to them after they became housed (or only for a short period of time), as their status within the system changed from 'homeless' to 'housed', and supports are tied to a person's status within the system, rather than their manifest need. Often, transitional housing or mental health services stopped before long-term security and recovery had been achieved.

You've had this place, at the time, over three months, and they've got other people to come in there. Then you're going to be homeless. Just extra stress: 'Oh God, I've got something else to worry about.' (consumer)

While transitional housing offered consumers relief from housing affordability stress, the time-limited nature of the tenure meant that they remained anxious about their longer-term housing prospects. Consumers reported that exit from transitional housing could be destabilising for their mental health, disrupted their established community connections and support networks, and interrupted children's schooling and friendships. Moving from transitional housing into private rental often meant that established supports were no longer available to consumers, which was a risk factor for tenancy failure and homelessness. Whilst privacy and space were valued by many participants, for some consumers a move to independent housing meant losing social connections and living in isolation. During the difficult transition period, it was not uncommon for consumers to consider moving back into homelessness and/or a boarding house in order to be around established connections.

I feel like I'm in a house. No one talks to me. I've not made a single friend. I have no friends in Berri or anywhere. (consumer)

If consumers were unable to keep their social housing due to a mental health crisis and/or a lack of ongoing support, they were at high risk of homelessness—and if that occurred, the cycle of seeking secure, safe and appropriate housing, either in the private rental market or in social housing, would start again.

Service providers identified that key drivers for eviction from public or community housing included deterioration of relations between clients and providers (often a result of smaller technicalities, such as missing documents) and a lack of specialised support staff.

Some housing providers offered a degree of case management and service coordination, though this was not their key role. Sometimes this resulted in the housing provider becoming the lead agency, which they found frustrating as they did not know how to refer tenants on for the support they needed in order to sustain their tenancies.

These reports are consistent with recent findings by Bentley, Baker et al. (2018), who followed social housing tenants and their entry and exit pathways over 13 HILDA waves to estimate the cumulative health effect of years in social housing, and the effect of tenure stability in social housing, compared with similar cohorts in other tenures. Their work showed that, over and above the effect of individual characteristics and circumstances, there was evidence of a cumulative negative mental health effect of each year spent in social housing. Importantly, the worst mental health outcomes were observed for people who made multiple transitions into and out of social housing. This finding suggests that stability in social housing is protective, and that a key positive outcome for people who need social housing is tenure security within the sector.

Service providers reported that both social housing tenants and private renters could only access tenancy support services in crisis situations, and that prevention and early intervention supports for tenancy sustainment were lacking. While private landlords and social housing providers may be

able to pick up problems early (e.g. unpaid rent, property not maintained, tenant avoiding calls from the service provider), they often did not know how to intervene or who to approach for support. They identified a tension between tenants' rights and early intervention, and reported that landlords and social housing providers were sometimes unable to refer tenants to needed support due to privacy legislation and lack of consent.

There is a risk of disengagement because people are shamed sometimes ... they don't really want everybody to know that. (service provider)

Social housing providers explained that they aimed to sustain tenancies, but that they faced challenges when encountering difficult behaviours, as they did not have the skills to work with people living with mental ill-health. They called for better coordination between different service providers. Some service providers found it difficult to identify the right kind of supports for the tenant once a need was identified because they did not know what support services were available. Social housing providers felt constrained in their capacity to deal with neighbourly conflicts. High demand for social housing meant that providers struggled to rehouse tenants when tenancies broke down.

Housing providers struggled to give tenancy support to people who lacked insight into their own condition.

There is a tenant who lives with chronic mental illness. She is supported by community mental health [and] has her caseworker. [She] has some really disturbing issues happening, or family issues happening, with her daughter, that mean that she is up and down and things are going really tough for her. She is actually really easy to talk to. She comes across as somebody who really makes sense, and talks that she is going to do things, but then just doesn't. She is quiet at times, easy to work with, and other times she will be quite aggressive and violent. But she sees all these issues with her property, that are things like someone has come in and unbricked the chimney and rebricked it during the night. Those sorts

of things. So, one of the things I do—it is about building a relationship with her so that I can have conversations with her because, another thing is, she will stop paying her rent, which is what is definitely putting her housing at risk. She will start disconnecting electrical things in the house and doing things that are a safety issue, and things like that as well.

When she rings to say that someone has been doing things to her property, I partner up with the maintenance chap and we go and visit. We listen and work through what her issues are and be pretty straight about what can and can't be done. Address anything that can be done.

I also try to work with her [case] worker. If it is about her tenancy, I don't have consent to be able to share or get any information, so I don't know anything about her illness, other than what she presents. She hasn't given consent for her mental health workers to share with me, but I can ring them and pass on observations and pass on concerns around her tenancy. Just try to get that kind of framework in place. And they will go and speak to her at times when there is a notice to vacate pending, for example. They want to keep her housed, so they will work with her in that space. We have managed to sustain the tenancy to this stage but it is tenuous. (service provider)

Boarding and rooming houses

Due to the difficulties involved in accessing social and private rental housing, many consumers with mental health issues end up in unstable, unsafe rooming house environments that are inappropriate for them and which contribute to cycling. Section 6.2.1 details some of the issues associated with boarding houses, such as lack of privacy, risk of violence, exposure to AOD, insecure tenure, poor building quality and presence of other people with high and complex needs. Boarding houses do not provide support or wrap-around services.

Consumers we spoke with related how living in boarding houses negatively affected their mental health. Some people chose to live on the streets rather than subjecting themselves to boarding

house environments. Consumers and service providers were clear that boarding houses and other inappropriate housing could work against recovery from mental health.

If you put someone into a rooming house ... It's often the people with personality disorders that end up in that type of accommodation, but the fact that they've got a personality disorder means that their interpersonal skills are not really as sophisticated as they should be. So you're really putting a person with poor interpersonal skills in a high-density environment and then expecting them to succeed. It's nonsense. There's just no possibility of it succeeding there ... At least when you're in jail or you're in hospital, you've got rights: you're a client, you're a prisoner, you're a patient. But out in these places, you really don't—you have legally but you can't access them. (service provider)

When using short-term housing options such as boarding houses, consumers reported being with other people with drug and alcohol issues, which further exacerbated their mental illness.

Institutions

Exits from hospitals, prisons and out-of-home care are points of high risk for housing instability and mental health deterioration, and are often transition points at which people fall through the cracks in the system.

Discharge from a hospital inpatient unit was identified by service providers as a key risk point for people falling through the cracks. Discharge processes varied between hospitals and jurisdictions, and depended on the type of admission.

Well, at least with the psychiatric facilities, you can often arrange a trial leave, which gives the person themselves time to come and look at the [new accommodation] and like it or not. The trial leave can be up to six months sometimes.

It depends on the severity of their mental illness. If they're a forensic patient then they have very, very structured frameworks and lots and lots of support. At the other end of the continuum: nothing ... The social workers there are overworked and under-resourced. They might get very little notice that someone is being discharged tomorrow. (service provider)

Most often, patient discharge was characterised by: the hospital's need to discharge patients as quickly as possible to free up beds for new admissions; lack of planning that takes account of patients' medium- and long-term housing situation after discharge; lack of integration between the clinical and housing/homelessness sectors; and a lack of community-based mental health supports that would allow patients to gradually step down from hospital care to independent living. As a result, patients were often discharged too early and were discharged into homelessness, into short-term or crisis accommodation, or to family where this was inappropriate.

The number of people that are exited from inpatient units into tenuous and the wrong accommodation is very high, and it is not the fault of health [services], as such. There is nothing available. It is that availability of housing for people with mental illness, one-bedroom apartments, are not always available. High density is, for some, not an option. [It is the issue of] having different types of housing available and affordable. You only have to look at what people are paying. If you are paying upwards of 75 per cent of your income on just your basic living expenses, then it doesn't leave a lot for medication, and those things fall off. The first things that people don't pay for is their medication and that drops off, and then the housing providers are left with a hole. So, I think it is actually affordable, accessible housing [that is needed]. (service provider)

The need to discharge people from hospital often led to patients being discharged into temporary accommodation (boarding houses, caravan parks),

to their families (even if this was not appropriate), or into overcrowded housing. In other cases, the lack of housing options led to patients remaining in hospital longer than needed. This reliance on mostly temporary housing solutions meant that clients could not recover, could not stabilise their housing situation, and thus continued to return to hospitals. Some consumers reported being discharged from hospitals into homelessness, often leading to long-term rough sleeping, crisis or violence.

[It's] like a spiral, where intervention and support are completely inaccessible until someone is so unwell that they require hospitalisation (and have probably lost their housing in the process); then they are discharged too early, with no discharge planning and no attention to their housing, and non-existent follow-up care. Oftentimes they are discharged from an inpatient ward to Launch Housing¹¹ or other entry point (an entry point is not accommodation) that is unable to respond to roughly half of the individuals that present on any given day, where if they are lucky they get a night in a dirty and dangerous motel and if they are less lucky they get a couple of weeks in a dirty and even more dangerous private rooming house in the outer suburbs. Once they are in a rooming house there is zero housing follow-up and they are forgotten. (service provider)

An inability to access safe, secure and appropriate housing and mental health supports within the community meant that some consumers reached a point of crisis that led to admission to an inpatient unit in a hospital. Sometimes admission to hospital occurred for non-medical reasons, such as AOD, homelessness or housing crisis, due to a lack of accommodation and support options in the community. These 'social admissions' are very expensive for hospitals and are discouraged. In SA, the Crisis Respite program filled this gap.

There were models that were funded that actually were there to provide that stopgap measure. It was called Crisis Respite. It was a great model

¹¹ A Melbourne-based homelessness service provider.

and it was a model where people could step down from hospitals and get the additional support they needed whilst you worked on what the stressors were before they stepped back into their accommodation. (service provider)

Service providers described the process of discharge from prisons and the judicial system as ‘a mess’ that had no staged process. People were discharged without consideration of their future housing situation and without communicating to service providers and families that discharge had occurred.

If a tenant goes into prison short term, the property is held for them. However, housing providers don't receive any communication from justice and therefore don't know when a tenant returns. This prevents them from monitoring the tenancy (mental health, behaviour, etc.), especially because mental health [services] close the file once a person goes into corrections. (service provider)

They're thrown out [of prison], often with no ID, often with cognitive impairments and not able to navigate systems, etc. There's a whole long list of barriers and challenges for people. Add co-morbidity or mental health on top of that, then it's a mess. (service provider)

Similarly, consumers reported negative experiences of discharge from inpatient units, including seeing people being moved quickly through the system and discharged into homelessness. Carers reported that they felt excluded from care planning and discharge—at a cost to everyone’s safety. There was a sense that clinical mental health services do not understand or appreciate the role that families and carers play in achieving improved mental health and outcomes for people with mental ill-health. As a result, decisions were made that placed the family in danger, or slowed down the process of recovery.

They just want to dope you up and then [there's] no plan upon discharge. They just want to get you out so they can get someone else [in]. (consumer)

Then I was homeless. I sat in a room in the hospital and had a lady explain to me about homelessness. I was freaked out. I was like, 'I'm living on the street.' Literally, it was, if anything, that whole area where they're like, 'These are the homeless numbers you can call.' That is absolute crap. (consumer)

Family home

Consumers often reported moving in and out of the family home because they needed support and accommodation, which was not always a positive experience for the consumer or the family. Negative experiences of living with family had implications for family connections, sometimes leading to complete estrangement, meaning that consumers were then forced to completely rely on support services, which further limited their options.

Carers reported feeling unsafe at times when the person whom they were caring for was experiencing periods of acute illness and distress, because of the mental health and housing systems failing to protect people when they are in greatest need. Carers referred to an example of a family member being discharged from acute care without their knowledge, only to return home in a distressed and frightened state. In some cases, carers talked about being the ‘provider of last resort’—the place where someone is sent when all other service options have failed them.

Three days later they [the inpatient unit] threw him out on the street without telling us or giving us any information. [He had] no shoes. He walked all the way back to this flat he was living in, on the other side of Perth, and had bleeding feet. They didn't follow him up, which is against the law; so we were apologised to in the end. (carer)

Consumers living with family reported that living with family placed significant stress on their relationships, particularly if there was a lack of understanding about mental ill-health. Upon discharge from hospital there was often little consideration of whether living with family was the best option for the person and their family. Carers reported feeling unsafe when medications, and

subsequently behaviours, changed. Even when the family relationship was positive, living with family still placed significant pressure on the relationship and the carer, in some cases contributing to a permanent relationship breakdown.

Our parents are emotionally and physically abusive; they don't believe that mental ill-health is a real thing. They think that she's just on purpose behaving badly, or she's been possessed by demons, due to their own personal beliefs. (carer)

Homelessness

The lack of affordable, secure, safe and appropriate housing meant that homelessness in its many forms (e.g. marginal housing, couch surfing, rough sleeping) was a typical stage in the cycling trajectory.

Service providers reported that consumers usually only accessed homelessness services as a last resort, after all other options were exhausted.

6.4.2 Mental health support

It's a cycle when people's wellness disintegrates. (service provider)

Mental health support for people on the cycling trajectory is characterised by: a lack of preventative and follow-up care; insufficient community-based mental health support; access to acute mental health support only in instances of severe crisis; support that is too short term, lacks choice of treatment options (focusses on medication) and doesn't provide ongoing support workers; and a changing service landscape due to the introduction of the NDIS.

Insufficient service integration makes it difficult for consumers to navigate entry into services and transitions between services, especially between state/territory jurisdictions and PHNs.

Access to mental health support

Section 4.2.2 outlined the stepped model of care and noted that the way the system currently operates in Australia means that there are limited support options for people needing moderate-intensity care. Qualitative research showed that even in cases where there is acute need, consumers and service providers both struggled to access mental health support unless the person was in severe need (e.g. were at the point of attempting suicide). This means that opportunities for early intervention and preventative care were forgone and access to needed services was only available once people were already in a cycle of mental health and housing instability. Lack of early intervention meant that people received mental health support only when their health was severely impacted, and long waiting times resulted in their condition deteriorating.

Carers described the impact of not receiving help until hitting rock bottom, including the damage done to family relationships, property and wellbeing in the months and years they were left without adequate support. Service providers noted that for some clients a formal mental health diagnosis was a tool that helped them to access support services.

Hospitals and emergency departments

Hospital emergency departments are an important access point for consumers in crisis. However, emergency departments are not designed for people with mental health issues and consumers must usually wait for long periods of time in a noisy and busy environment, which is particularly challenging when they are experiencing an acute episode of mental ill-health.

Service providers reported that resource constraints in emergency departments meant that clients were sometimes turned away even if they were experiencing an acute mental health crisis. At the same time, the medical team in the emergency department is under pressure to find a bed for the person experiencing the current crisis. As there is acute pressure on hospital beds, this

frequently means that patients in existing wards are discharged earlier than appropriate due to the need to free up beds for new emergencies.

Discharge planning is often problematic, and people are discharged without the needed support and sometimes without appropriate and stable housing (i.e. they are discharged into temporary solutions with family or friends, or into short-term crisis accommodation) and without appropriate follow-up after discharge. These processes are not conducive to recovery and lead to people being re-admitted because they lacked the necessary recovery support. This creates a cycle of deteriorating mental health and housing instability.

Consumers reported that hospitals focussed on stabilising patients with medication, but that there was a lack of psychological therapy within hospitals and after discharge. Limited coordination between hospitals and other service providers meant that patients found it difficult to re-establish their lives and mental health after they returned to the community.

Duration and continuity of support

Service providers and consumers reported that the duration of support was often not long enough to allow for recovery and people consequently struggled to get better or relapsed. Support that was too short or inappropriate meant that consumers had negative experiences, which in some instances made them reluctant to engage with services in the future.

Service providers reported that assisting rough sleepers was problematic, as they were often non-compliant with their medication, did not want to access services, and had complex needs.

We're working with people experiencing long-term and chronic homelessness, with significant complex needs and mental health [issues], and also significant traumas. And it may take somebody six to 12 months to even start to begin to talk about some of the traumas they've experienced, and maybe potentially wanting to

address [that]. Programs need to be that real ongoing long-term support. (service provider)

Many services do not provide ongoing support after a person has recovered. Providers argued that there is a need for more flexibility and responsiveness in allowing people to re-access services in the event of a relapse. Consumers reported that they could maintain their housing while they were well, but this became difficult when they became unwell.

Clients have long-term housing and have been living there for five, 10, 15 years. Support drops off after a while, and it is not until they become unwell that things become unstuck. It is hard to move between services that offer varying levels of support as needed; most individual services are not set up to vary support depending on need. (service provider)

Choice of support and treatment

Many consumers reported taking medications and seeing a GP but not having the psychological and psychosocial support they needed. Consumers also related that medication was usually the main treatment option, they felt they had little choice over the type and dosage of medication, and they were unable to access other supports (e.g. psychologists) that would aid their recovery.

Unresolved trauma was commonly reported, yet very few consumers reported having talked about their trauma or understood its impacts. Unresolved trauma impacted negatively on all areas of consumers' lives. Interviewees reported having difficulties with trust and relationships, using alcohol and drugs to manage their negative feelings, and struggling with self-harm and suicidal thoughts.

Service integration

Mental health service providers faced challenges in providing integrated and wrap-around services due to variation in service models and the episodic nature of mental illness.

Trying to pull together all the different treatment streams is quite difficult, as there are a lot of systems blocks that stop true integration. Even when you fund it together, if you put an AOD model service against a community mental health, against the public health service, there is enough variation between them that it is actually incredibly difficult to wrap services around on an ongoing basis, given the fact that mental health is an episodic illness and needs go up and down.

For instance, the community services we fund in the mental health space have a six-month tenure of care attached to that service. So, once you get to the end of that, who is providing the services? And, if you happen to get unwell at nine months, you have got to enter back into the service, and it is no different than if you get discharged from Queensland Health Service, you have got to re-enter the service. (service provider)

Housing providers faced challenges in providing wrap-around services because they were often not provided with complete information about the prospective tenant's needs, which meant they could not plan appropriately.

The majority of our referrals come from the department's wait list. We will do an interview with them [the tenant] before we do an allocation. If they disclose then that they have some issues, we will try and link them with support services, or we do a tenancy plan with them if they are coming into transitional housing. Our crisis houses already have supports that wrap around them to deal with those issues. But if they don't disclose any of that, then we may allocate them to housing and they have no support around them until something starts to go wrong, and then we find out what is really going on with them. [There's a need to share] that information that other services might know, that this person has some mental health issues, but it doesn't necessarily get disclosed to the housing provider. (service provider)

NDIS reforms

In most states and territories, funds that were previously allocated to community-based mental health services are now being funnelled into the NDIS. This is reducing the capacity of services that were traditionally funded to provide these supports, and in many instances this threatens the viability of those services.

Service providers reported that they were struggling to keep up with the rate of change to the NDIS, which affected their ability to do long-term planning and to work proactively (rather than reactively). Housing providers were also affected, as tenants often did not receive housing support as part of their NDIS package, which could put their tenancies at risk.

With the introduction of the NDIS, a lot of the mental health funding has now ceased. For us as a housing provider, we're in a predicament of having properties and putting people in it that are unsupported, which makes it difficult to sustain their tenancies. So that's a really big challenge for us as a housing organisation ... and changes the way we work. We obviously want our residents to be supported through housing, but because they've got the NDIS and the choice of what they choose in the package, they often don't get the support for housing. (service provider)

Attracting and retaining skilled workers under the NDIS emerged as a challenge for mental health providers.

Scheduled rates of pay under the NDIS are insufficient to retain and attract skilled workers (e.g. Certificate IV) to deliver the needed services. This is contributing to a deskilling of the workforce. Some organisations are retaining skilled staff by subsidising salaries from other sources. Some government departments have recognised this gap and funded providers to offer free training in areas such as trauma. (service provider)

The ongoing ‘churn and burn’ of support staff meant that consumers lacked continuity of care and had to spend time establishing rapport with new workers and retelling their story, which had an emotional impact. Consumers reported that they were often not told when their worker would change, which led to distress.

That is why it is important to have support workers or someone who is travelling with them who has a continuous relationship. (service provider)

Service providers were critical of the transaction-oriented model of service delivery used by the NDIS, and felt that this was inconsistent with the relational approach needed for mental health recovery. Some support providers indicated that the NDIS model could work against consumers learning independent living skills, which could be disempowering for the people workers were trying to empower.

We have had support workers working really hard with young people to teach them to become independent and empowered, and cook. Then all of a sudden, they get this NDIS package from this service, and in comes someone who is cleaning for them and doing this, and they [the young people] just sit back. (service provider)

Some service providers reported that the NDIS did not sufficiently support people with high and complex needs, which could result in homelessness.

That’s an emerging issue ... impacting on people who were housed ... people with the most high and complex needs who didn’t fit neatly into one sector or another who are now all being transitioned into the NDIS ... The way that supports are delivered and the types of supports delivered to those individuals have had some impacts in people becoming homeless as a result, because they can’t maintain their community tenure because they’re not getting the amount of support and the right type of support in order to maintain that. (service provider)

Some NDIS-funded services were unable or unwilling to support clients with high and complex needs and were shifting the responsibility for their care to the hospital sector.

... a number of NDIS-provided facilities are picking up the chronically unwell and they’re putting them in hospital and saying they don’t want them. The responsibility then falls to the hospital of trying to find other accommodation services and that. So the NDIS was meant to create a system where consumers had choice. It’s actually the agencies having choice, because of the shortage in placements and the difficulty with accessing funding and everything. (service provider)

However, the NDIS was reported to work well in instances where there was a dedicated resource for support coordination.

I am going to be the single voice that says that the NDIS has been quite positive in our experience ... We have ... people who have had specific funding to help them find new tenancies, and helped them set up a new tenancy, so we have been able to help them use that. But we do support coordination for 110 people, currently, with NDIS. It comes down to [whether] you have got support. If you have not got a support coordinator, that is when it is tricky. (service provider)

6.5 Stabilising trajectory

Recovery is a non-linear process. It's a process of two steps forward, one step back. But to my clients, I describe recovery as living the best life you possibly can despite what your issues are. (service provider)

People on the stabilising trajectory have experienced a mental health or housing crisis, but have achieved stable, secure and appropriate housing, and ongoing and scalable mental health support, which is allowing them to commence recovery. They are on the path to recovery but may still need help to sustain their tenancy and ongoing mental health support.

Some consumers reported that they had stabilised their housing and mental health trajectory. Public housing often provided a sense of stability for consumers and gave them space to focus on their mental health and other aspects of their lives. Other consumers found stability by living with supportive family. Stable and safe housing was important for families, particularly for allowing children to be able to stay with their parents. Most often, participants who had housing stability were on the DSP, and so could cover their rent and basic costs.

It was a new house, that's the house I felt more comfortable in. That's when I resigned myself to my illness. I stopped hiding it from myself. (consumer)

Housing was the biggest issue for DHS to [let me] have the kids back. Having secure housing has meant that I have had them returned. (consumer)

In addition to stable housing, consumers needed ongoing support for their mental health and the knowledge to tackle new issues as they arose. Consumers referred to having some trauma counselling and being able to identify early signs of mental ill-health. Further important factors consumers reported included having a

good support worker, continuity of support, and involvement in activities. Consumers referred to wanting ongoing access to community mental health services and affordable clinical mental health support. They reported not wanting to have to wait until crisis point to be eligible for services.

I just highly recommend [this worker]. He's never judged me. I can talk to him about anything. I don't even look at him as a worker. I look at him as a friend, I guess, because he's always been there for me and always listened and given me good advice. He gets me, he understands me. (consumer)

Whereas before I wouldn't talk and I wasn't doing anything. [Now I have access to this community mental health service.] It makes me feel like a sense of achievement after I've done something there. (consumer)

Carers reported needing support for their own health and wellbeing, and to enable them to continue to support their family member. They faced significant stress in supporting their family member and this was heightened if they were living together, with no other housing options.

Circuit breakers

Generally, people who were stabilising had benefitted from a 'circuit breaker'. Circuit breakers are events or supports that allow consumers to overcome the barriers they face and to access the supports and housing they need. Circuit breakers reported by consumers and service providers included the following.

- Receiving a SIL package under the NDIS. SIL packages can be quite substantial and therefore provided people with the choice and financial resources to access the services they needed.
- Assistance and advocacy to navigate the system. Consumers who had someone to support them to navigate the system reported feeling like they had more choice about where they lived and what supports they accessed. However, very few people reported this.

- Receiving public housing. Having a stable and secure place to live was reported as a way to break the cycle of crisis. However, many consumers reported that they only managed to access public housing after having experienced a severe crisis.
- Receiving a mental health diagnosis. Having a mental health diagnosis in some instances made people eligible for the services and supports they needed (which had previously been unavailable to them).
- Gaining access to integrated supported housing. For some people, gaining access to specialist programs that provided integrated supported housing for people with mental ill-health acted as a circuit breaker that allowed them to stabilise.

Characteristics of a stabilising environment

People who are stabilising may be living: in their own home or in social housing, where this is a safe environment and appropriate to their needs; in private rental, where this is affordable and they receive assistance to maintain their tenancy when they are unwell; in supported accommodation that is appropriate to their needs; or with family or carers where this is sustainable, appropriate and safe, and there is adequate support for the carer.

People who are stabilising have access to mental health support that provides an appropriate level and duration of care, and they have choice of treatment.

Characteristics of an environment that allows people to stabilise are as follows.

- **Stable and secure housing.** Consumers consistently reported that having stable and secure housing allowed them space for recovery, as they were no longer lurching from crisis to crisis. Frequently, public housing provided this stable housing, but many people only achieved public housing after having weathered severe crises, such as exiting prison or experiencing a serious health crisis.
- **Financial security.** Consumers needed to receive an adequate income either through employment or the DSP in order to stabilise. Consumers reported that being on the DSP allowed them to cover basic costs and not worry about whether they could pay the rent. If they additionally had part-time work, this could assist them to save. No one who participated in the research who was on Newstart could afford private rental, and most struggled to afford even transitional housing. Consumers were concerned that if they worked too much, they would risk losing their housing or mental health supports, and would be vulnerable if their mental health deteriorated.
- **Appropriate and safe neighbourhoods with meaningful connections.** Consumers reported positive outcomes when they lived in a safe neighbourhood, close to family/friends, public transport, services, and opportunities for work, volunteering or study. This included having good relationship with neighbours. Some service providers highlighted the importance of building community capacity to accept people with mental health issues.
- **Control of space.** Consumers highlighted the benefits for their wellbeing and mental health of being able to choose who they lived with (if anyone), having maintenance and other issues addressed in a timely manner, being able to afford furniture, and having access to space away from neighbours or housemates if they desired.
- **Feeling safe.** Feeling safe was an important precondition for recovery. This included not being forced to live in a place where trauma occurred or that triggered mental distress, assurance that support would be forthcoming if crisis occurred, and having a well-functioning informal support network of friends and family.
- **Social support and connection.** Consumers identified social support and reciprocal supportive relationships as crucial ingredients for recovery. This was often only possible once appropriate housing and mental health supports were in place. Having adequate support through the formal system meant consumers no longer had to burn through social relationships, which gave their relationships room to breathe.

Engagement in work, study or volunteering made them feel like part of the community and helped combat isolation. Availability of recreation (supported or mainstream) also helped.

- **Support that meets level of need.** Consumers highlighted the importance of support that met their level of need (too much can be as bad as too little). Once they were stabilising, consumers reported needing minimal ongoing clinical support, psychosocial support and assistance to participate in daily life.
- **Holistic support.** Consumers who received support that addressed all their co morbidities and circumstances at once (in time, not necessarily within the same service) reported that this assisted them to stabilise.
- **Continuous and trusting relationship with support worker.** A trusted worker who was available to support them instilled in consumers a level of self-confidence and self-efficacy, and a belief that solutions could be found for ongoing problems. A good relationship with a worker could be the catalyst for obtaining more support (NDIS, DSP, public housing, other services), and could be the difference between hope and hopelessness, even if overall the situation was quite bad.
- **Trauma counselling.** While only very few consumers reported receiving trauma counselling, those who had received counselling reported that this had positively impacted their behaviours and they were now better able to deal with the ongoing effects of the trauma.
- **Culturally appropriate services.** Consumers highlighted the benefits of services that were culturally appropriate.¹²

Risk factors

Risk factors that could compromise people on the stabilising trajectory included:

- low income, due to low workforce participation rates or low levels of income support with higher risk of financial hardship
- lack of secure and affordable occupancy, housing that was not appropriate to consumers' needs, or tenancies that were insecure (e.g. in private rental)
- fragmented access to and delivery of support (formal and informal) to assist recovery
- lack of support to maintain tenancy (formal or informal)
- lack or inadequacy of state/territory government private rental support programs
- risk assessments and discrimination by private landlords
- added costs and disruptions due to frequent housing moves
- periods of deterioration and improvement—these can last for several months, either side of an episode of acute illness, which is not consistent with short-term support programs
- stigma around mental health, which reduces willingness to access services.

¹² A separate report details the findings of consultations with Indigenous research participants and will be available in mid-2020 at <http://www.ahuri.edu.au/research/trajectories>.

6.6 Well supported trajectory

There is no perfect journey or path. A typical pathway involves supporting the capacity of the individual to work with and use the system to address and meet their needs. Knowing or having knowledge of what to do and how to do it is all part of the pathway of getting the system to work for each person. Often, the individual's past experiences of the system pose a challenge that can be hard to overcome. Sometimes past experiences of the system have been traumatic. Many individuals harbour doubt and many have strong feelings of anxiety and guilt. It is important to recognise that the pathway is not what we think is viable or relevant, but is based on the individual's circumstances, their perspective and what they can cope with at a specific point in time, and/or what has priority or is relevant, despite any apparent or existing urgencies. (support worker, paraphrased)

Consumers who were on the well supported trajectory had housing and a level of mental health care that were right for them, according to their own needs and perceptions. Like the stabilising cohort, this group had benefitted from a circuit breaker.

The key difference between the stabilising and well supported cohorts was that the well supported cohort felt empowered to focus on aspects of their life beyond housing and mental health recovery. They had the ability to make choices that fitted with their needs and felt empowered to live their best life. Not many research participants reported being well supported. Consequently, the key features of the well supported trajectory outlined in this section are based on consumer views of what they *would* need to be well supported, rather than their actual experiences of being well supported.

There is no one specific outcome that classifies as 'well supported'; rather, a well supported trajectory aligns with a person's individual capacity and their needs in terms of housing and mental health. It means that a person has the necessary support to develop their independence and achieve their ambitions. This could mean support in housing, to have a stable place to live; support in education or employment, to be able to realise ambitions and participate economically; and, more broadly, support around physical health and socialisation, so that life can be participated in fully and loneliness can be minimised (i.e. allowing the achievement of functional recovery).

As I'm getting older, because I had schizophrenia, where they've placed me now and the support programs they have around, I'm finding life a bit more enjoyable. I have the doctors, my depo. I have the housing, I have counselling. (consumer)
Housing that would facilitate a well supported trajectory is affordable, safe and secure, and appropriate to the person's needs. This could be home ownership or social housing, or it could be living with family or carers where this was sustainable, appropriate and safe and there was support for the carer. Mental health support would be appropriate to the person's level of need and provide choice and flexibility to 'step up' or 'step down' as their needs change.

Key elements of being well supported are as follows.

- **Ability to navigate the system**, whether independently, with low-level support, with informal support (in a way that does not negatively affect their relationships in the long term), or with long-term support. The consumer knows what services are available and how to access them, and supports are continuously available to the person.
- **Feeling empowered to self-advocate to services**, to engage with the community as equals, to complain if there has been injustice, and to take risks. (Few consumers currently felt empowered to do these things, but many wished they were able to do so.)

- **Being financially secure, able to pay rent and bills,** and feeling in control of finances. The consumer feels comfortable that they could survive financially even if they experienced a long period of ill-health. They have enough financial support to socialise and for recreation.
- **Having appropriate, secure, safe and affordable housing** in the right location. The consumer has appropriate housing with secure tenure, regardless of how long they may be absent from their tenancy due to mental health related issues (such as hospitalisation). This enables service providers to work with the client and allows clients to focus on other aspects of their lives. (Public housing was seen to be a very secure tenure, especially for people with complex needs. Community housing was seen as a less secure tenure, as community housing providers are not able to guarantee indefinite housing if the tenant is not able to stay in the housing for a period of time.)
- **Participating in meaningful activities.** The consumer is involved in activities that are meaningful to them (e.g. volunteering, employment or social activities), which provides a feeling that there is structure and purpose in their life. They have adequate formal support to maintain existing social relationships and build on them if needed. Having adequate support gives the consumer the confidence to take risks, such as getting back into the community, looking for volunteering positions or work, or forming new relationships. (Many things that would not be considered a risk by 'normal' people were seen as catastrophically risky for consumers without support, but those who had support felt better about themselves and their place in society.)
- **Having an ongoing and appropriate level of support.** The consumer has crisis support available if needed and their basic needs are being met (not at the absolute minimum level, but at a level to maintain wellbeing in the long term). They receive ongoing support from mental health services, including clinical and psychosocial support. These services are able to adjust to changing needs as the consumer's mental health improves or deteriorates. (For consumers, having trust that services would

help them and be maintained was key to long-term wellness, as was having trust in neighbours to not cause them harm. Very few consumers interviewed were at this point, or even most of the way there, but almost all described this as the ideal situation.)

- **Ability to focus on things beyond housing and mental health.** The consumer's goal changes from survival to growing. (A few consumers who had housing and mental health support in place talked about returning to the workforce, studying or volunteering, or rebuilding relationships with friends or family.)

7 Trajectories for young people

A young person who has psychosis might be picked up then at 16 and then start working with or [sometimes] against the system ... That's when [it will] first be recognised that they need support. And they would be hospitalised normally, if they're suicidal or they're a harm to themselves or others, or [end up in] the prison system if they actually don't get caught by the mental health system. Often if they're not supported by the mental health system, they will self-medicate. That then leads to co-morbidity, mental illness, and alcohol and drug issues. Trauma is a big part of people's lives. When somebody starts off like that, unless they have privileges, and even sometimes when they do and they're educated and from wealthy families, it's always still problematic. But then often they'll cycle through hospital, housing and the other supports that are there. (service provider)

Young people may experience any of the five trajectories detailed above. However, young people experience a unique set of circumstances related to their developmental life stage. The factors that lead to youth homelessness differ from those for adults, and many serious mental illnesses first emerge when people are in their mid-teens to mid-twenties. Young people often have not yet developed the life skills to access and successfully maintain a tenancy without help, and tend to have fewer financial resources, which limits their options. In addition, the service system is designed such that age limitations and age transitions impact on young people's ability to access and sustain services. This places young people at a particular risk.

The evidence supports the assumption that if youth homelessness is not prevented or effectively addressed early on, this can lead to a life of insecure housing and homelessness. The evidence shows that if a first episode of psychosis

is effectively addressed, chances of functional recovery are high; however, if it is not addressed, the person may not achieve functional recovery even over the long term.

Family conflict is one of the most common pathways to youth homelessness (Chamberlain and Johnson 2011).

It is different for different young people. Many come at the crisis point, when it has become untenable to stay at home any longer. Their mental health or that of their parents can be the causal factor in them needing to leave home. (service provider)

Many young people only seek formal support when all other avenues have been exhausted, at which time their resources and social supports are depleted, and their mental health is poor, which makes it difficult for them to access and sustain housing.

Others come when they have already left home for some time, have been couch surfing amongst family or friends, and this then becomes unsustainable. Often, their mental health needs have gone undiagnosed, or ill-managed, and this becomes a compounding factor in their challenge to obtain shelter or a tenancy, as well as a factor that conspires against their capacity to maintain a tenancy longer term. (service provider)

Young people with complex needs often find it difficult to successfully access to housing. The idea of 'housing readiness' is particularly challenging for young people, as they often have not yet developed the necessary skills to maintain a tenancy.

Young people access the housing and homelessness systems from a number of points. Some seek support to navigate their way into housing prior to reaching a crisis point; some are discharged direct from hospital into the homelessness system following an admission for mental health; some enter the homelessness system upon the expiry of their out-of-home care order, with the department of child protection contacting the support service directly as a

viable exit-from-care pathway; others enter the homelessness system after exiting from youth justice detention or correctional institutions.

Young people's ability to access social housing depends on various eligibility criteria related to age—for example, the legal age at which they are eligible for support, the legal age at which they can have their own public housing tenancy, and the age at which they are no longer eligible for services targeting youth and therefore have to transition to the adult service system.

Service providers stressed the importance of effective early intervention for young people, including addressing trauma, to prevent them from accumulating disadvantage and cycling through the service system on a downward spiral.

The key research finding for youth trajectories is that effective early interventions coupled with social inclusion supports housing security for youth in mental health recovery by opening up access to a raft of informal community resources. Indeed, we conclude that access to informal community resources is the primary mechanism by which social inclusion bolsters housing security for youth recovering from mental illness (as argued by Duff, Murray et al. 2013). In summary:

- housing security is an 'anchor' for recovery
- feelings of housing security grow with community attachment
- formal supports can help young people access informal resources
- coordination of formal and informal resources is important.

8 Conclusion and policy implications

This chapter synthesises the findings from the *Trajectories* research project and considers the policy implications for systems and services that will facilitate access to secure, safe, appropriate and affordable housing and mental health recovery.

Previous research has shown that the housing, homelessness and mental health systems are fragmented within themselves and that there is limited integration across these systems (Brackertz, Wilkinson et al. 2018). The evidence demonstrates that interventions that can successfully address housing instability and mental ill-health do operate in Australia, but that the capacity of these programs to meet need is insufficient as they tend to be small in scale, pilot programs or geographically limited (see Brackertz, Wilkinson et al. 2018). A lack of policy integration between housing, homelessness and mental health systems, which are characterised by silos, impedes the development of national, cross-sectoral and integrated policy solutions for housing and mental health that are underpinned by cross-sector accountability mechanisms (Brackertz, Wilkinson et al. 2018).

The *Trajectories* research shows that there is a direct relationship between housing instability and mental ill-health, and that this relationship can be softened or amplified by a range of mediating factors, including social support, critical life events, and whether or not mental health and health services are accessed.

The research identified five ‘typical trajectories’, which demonstrate that the reality of people’s mental health and housing experiences are inconsistent with the linear conceptual models that currently underpin policy formation in Australia, such as the stepped care model for mental health care provision and the housing continuum. It is therefore necessary to reframe policy approaches to better reflect the lived experiences and needs of people experiencing mental ill-health and housing instability, and to address mediating factors.

- The **excluded from help required trajectory** is characterised by a lack of access to housing or mental health care. People may be excluded

from housing and mental health care because: they do not meet eligibility criteria; they lack financial resources; housing and supports are not available, inappropriate or difficult to access; the system is crisis-driven, fragmented and difficult to navigate.

- People on the **stuck without adequate support trajectory** are trapped in inappropriate housing, institutions or services due to a lack of options, choice and/or long-term pathways.
- The **cycling trajectory** is marked by a downward spiral in which people enter into and drop out of supports repeatedly, which progressively erodes their resources. Cycling is due to: inadequate transitions between services and different parts of the system; lack of clarity about which services or parts of the system are responsible for providing support; the episodic nature of mental ill-health; lack of continuity; and the preponderance of short-term supports.
- People on the **stabilising trajectory** have access to secure, safe, appropriate and affordable housing, ongoing mental health support, help to facilitate meaningful social connections, and financial stability, which allow them to focus on recovery and rebuild their lives.
- People on the **well supported trajectory** have the type of housing and level of care that aligns with their individual capacity and needs, and which allows them to develop their independence and achieve their ambitions beyond housing and mental health.

Each of these trajectories carries particular risks and provides unique opportunities for intervention. A summary of characteristics and risk factors is provided in Appendix 2.

The stabilising and well-supported trajectories demonstrate the elements that need to be supported by policy to enable people to get well and stay well.

Consultations with consumers, carers and service providers identified the following characteristics of an environment that allows people to stabilise.

- **Access to safe, secure, affordable and appropriate housing** that allows for control of space; is located in safe neighbourhoods with meaningful social support and connections (close to family and friends, good relationships with neighbours); and provides access to public transport, services, and opportunities for work, volunteering or study.
- **Connection to a trusted worker** with whom a respectful ongoing relationship can be established—someone who has the skills to assist in navigating services and who can provide advocacy and support when challenges arise.
- **Support coordination, and assistance and advocacy to navigate the system.**
- **Access to psychosocial support** to help with day-to-day tasks; maintaining tenancies, relationships and health; establishing and maintaining a routine; and undertaking meaningful activities.
- **Financial security**, either through employment or the DSP.
- **Holistic support that meets the level of need.**
- **Timely access to support** when needed.
- **Trauma counselling** to enable people to better deal with the ongoing effects of trauma.
- **Culturally appropriate services.**¹³

The analysis of quantitative longitudinal data from the HILDA and JH datasets offers further evidence of the importance of holistic approaches that integrate housing and mental health support with social support, healthcare and financial support, and effective early intervention.

The key finding of the quantitative analysis is that there is a direct relationship between mental ill-health and housing instability, and that this relationship is affected by a range of mediators (risk and protective factors). Mediating factors, such as social support, good general health, and accessing

mental health and other health services, can act as circuit breakers that reduce the likelihood of housing instability and shorten the length of time a person experiences mental ill-health. Conversely, an absence of mediating factors and experience of negative life events can amplify the relationship between housing instability and mental ill-health.

The findings suggest that to be effective, policy responses must address housing and mental health issues as well as mediating factors, and highlight the importance of holistic person-centred approaches that offer support coordination. Policy responses should aim to achieve the following.

- **Improve the level of integration across service systems and between services.** There is a significant bidirectional relationship between mental health and housing instability (particularly as measured by financial hardship), which underscores the importance of addressing housing and mental ill-health issues at the same time. For this to occur effectively, greater integration across and within service systems is required. Support to prevent financial hardship among people with mental ill-health is key to protecting them from housing instability.
- **Increase the use of health and mental health services by people experiencing mental ill-health.** The research shows that not accessing health and mental health services is a risk factor for housing instability for people experiencing mental ill-health. It is therefore essential to increase the proportion of people in this group who access mental health and health services. This will involve lowering barriers to access to health and mental health services, as well as providing education and information to increase awareness of available services.
- **Develop person-centred approaches that integrate mental health, physical health and social support.** The research shows that good physical health protects against mental ill-health and housing instability, and reduces the amount of time a person spends in mental

¹³ A separate report details the findings from the research project's consultations with Indigenous participants and will be available in mid-2020 at <http://www.ahuri.edu.au/research/trajectories>.

ill-health. The research identified that social support is an important protective factor for mental ill-health and can also shorten the amount of time a person spends in mental ill-health. This highlights the importance of support coordination and integrated treatment plans.

- **Ensure support is immediately available to mitigate negative life events.** Negative life events, such as serious personal injury or illness, experience of physical violence, or separation from a spouse, increase the risk of mental ill-health and housing instability for up to three years. This finding shows that there are opportunities to provide rapid access to support to mitigate against the negative effects of these life events in order to prevent mental ill-health and housing instability.

The well supported trajectory evidences the elements of policies that would enable people to remain well and focus on aspects of their lives beyond housing and mental health recovery. There is no one specific outcome that classifies as ‘well supported’; rather, a well supported trajectory aligns with a person’s individual capacity and their needs in terms of housing and mental health. It means that a person has the support to develop their independence and achieve their ambitions.

Housing that facilitates a well supported trajectory is affordable, safe and secure and appropriate to the person’s needs. This could be home ownership or social housing, or it could be living with family or carers where this is sustainable, appropriate and safe and there is support for the carer. Mental health support needs to be appropriate to the person’s level of need and offer choice and flexibility to step up or down as their needs change.

Key elements of being well supported include the following.

- **Ability to navigate the system**, whether independently, with low-level support, with informal support (in a way that does not negatively affect relationships in the long term), or with long-term support. Consumers know what services are available and how to access

them, and supports are continuously available to the person.

- **Feeling empowered to self-advocate to services**, to engage with the community as equals, to complain if there has been injustice, and to take risks.
- **Being financially secure**, able to pay rent and bills, and feeling in control of finances. The consumer has enough financial support to socialise and for recreation. They feel comfortable that they could survive financially even if they experienced a long period of ill-health.
- **Having appropriate, secure, safe and affordable housing** in the right location. Tenure is secure, regardless of how long the consumer may be absent from their tenancy due to mental health related issues (such as hospitalisation).
- **Participating in meaningful activities**, such as volunteering, employment or social activities, which provides a feeling that there is structure and purpose in life. The consumer has adequate formal support to maintain existing social relationships and build on them if needed.
- **Having an ongoing and appropriate level of support** that meets basic needs at a level to maintain wellness in the long term, and having access to crisis support if needed.
- **Ability to focus on things beyond housing and mental health**—for example, returning to the workforce, studying, volunteering, or rebuilding relationships with friends or family.

Further research is currently underway to develop viable policy options based on the research findings and it is expected that these reports will be available in mid-2020. All *Trajectories* research reports are available at <http://www.ahuri.edu.au/research/trajectories>.

Appendix 1: Mental health policy in Australia

Integrated service delivery and coordinated access

All state and territory policies accord with the key priorities of *The Fifth National Mental Health and Suicide Prevention Plan* (the Fifth Plan) (Department of Health 2017) in aiming for an integrated, holistic and coordinated mental health service delivery system that is tailored to the needs of consumers and carers and designed to improve mental health outcomes. At the regional level, responsibility for realising this goal is assigned to state-managed Local Hospital Networks (LHNs) at the regional level, who deliver clinical and non-NGO community-based health services. At the local level, responsibility is with the PHNs. PHNs are contracted by the Commonwealth to localise the stepped care approach—an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the mental health needs of consumers (Department of Health 2017).

Person-centred planning and recovery approaches

Person-centred approaches and recovery-orientated practice are highlighted in policy across all jurisdictions, with some state plans outlining specific strategies and actions at the implementation level. Described as ‘treatment, care and support that places the person at the centre of their own care’, the Fifth Plan argues that person-centred service delivery will be enhanced if mental health staff in all service settings are trained in the delivery of recovery-oriented and trauma-informed care (Department of Health 2017). To support the achievement of this goal, the Fifth Plan recommends the implementation of the *National framework for recovery-oriented mental health services: guide for practitioners and providers* (Department of Health 2013). The National framework is also endorsed in NSW, Queensland, SA and Tasmanian policies.

Although Victorian policy does not specifically mention the national recovery framework guide, it advocates for the *Equally well in Victoria: physical*

health framework partnership—a collaborative initiative between service providers, consumers and carers that promotes the consideration of physical health in a person’s recovery (DHHS 2019).

Suicide prevention

Whilst government recognises that not all individuals who die by suicide or experience suicidal ideation have co-occurring mental illness (Department of Health 2017), the Fifth Plan calls for an integrated approach to suicide prevention that is consistent with the coordinated service delivery and support intent outlined in mental health policy (see ‘Integrated service delivery and coordinated access’ above). Commonwealth policy claims that it will support PHNs and LHNs to develop integrated, whole-of-community approaches to suicide prevention. The Federal Government also promotes engagement with local communities to develop suicide prevention actions as part of a joint regional mental health and suicide prevention plan. As such, all states/territories (except ACT) have a separate suicide prevention plan/framework, designed to integrate with mental health policy at the local and regional levels.

Aboriginal and Torres Strait Islander mental health

With the aim of closing the health gap between individuals from the Aboriginal and Torres Strait Islander communities and the general population—attributable to suicide, mental illness and psychological distress—a variety of interventions are promoted in Commonwealth and state policies. These include health promotion, treatment and support that is culturally safe and responsive.

Some policies have clearly defined strategies/ actions to address individual and community need. For example, SA plans to develop a new clinical model: the Aboriginal Mental Health and Wellbeing Centre of Excellence (SA Health 2019). Meanwhile, the Victorian Government claims to have reduced the health gap for Indigenous Victorians. When reporting on their progress toward implementing Victoria’s 10-year mental health plan, the

government suggested that programs such as the Balit Murrup initiative (which focusses on holistic understanding of mental health, Aboriginal social and emotional wellbeing, and the need for healing and trauma-informed care), have contributed to improving aboriginal mental health outcomes (DHHS 2019).

Workforce capability, community education and stigma reduction

Most state and territory policies focus on stigma reduction as a priority area to improve mental health and wellbeing. They also recognise that stigma is compounded for people who identify as Aboriginal or Torres Strait Islander; people from culturally and linguistically diverse backgrounds; people with co-morbid intellectual and physical disability; people identifying as lesbian, gay, bisexual, transgender, intersex or queer; and people in contact with the criminal justice system. As a result, several policies highlight the need for action that focusses on diversity and inclusion. These policies also call for better community information and education to increase mental health knowledge and reduce stigma (NT, ACT, Queensland, SA, Tasmania).

Policies also aim to reduce stigma in the health workforce by implementing staff training programs that build awareness and knowledge of the impact of stigma and discrimination, as well as through the development of the Peer Workforce (Fifth Plan).

Social determinants of health

The social determinants of health are recognised in several state/territory policies (ACT, NT, Queensland, SA, WA) as contributing risk factors to poorer mental health outcomes and health inequities. The Western Australian Mental Health, Alcohol and Other Drug Services Plan details several actions to address the social determinants of health, including: socio-economic positioning; safe and secure housing; accessible education and training; employment; and physical health (WA Mental Health Commission 2018). Other state policies detail similar strategies. However, the

described approaches are limited to promoting the determinants at a theoretical level (as a guiding principle) rather than offering any concrete and targeted actions.

Employment and housing

The Fifth Plan recognises employment and stable housing as effective ways to help people achieve a meaningful and contributing life. Although most state policies briefly mention housing and employment, and then only in the context of the social health determinants, some provide detail about strategies, actions or programs. For example, ACT, Victoria and Queensland offer the ‘step up, step down’ approach to accommodation support, whereby individuals in need ‘step up’ from the community into a supportive environment (e.g. clinical care). They then ‘step down’ from the hospital setting into a supported transition back to their home.

Appendix 2: Risk factors for housing and mental health

Table 19: Housing and mental health risk analysis

Where are they living?	What mental health support are they receiving?	What are the risk factors?	What are the policy interventions?
<p>Well supported (very low risk) Can sustain the tenancy and is in recovery from mental ill-health, has the support to develop their independence and achieve ambitions beyond housing and mental health</p>			
<ul style="list-style-type: none"> • Home ownership or social housing with safe environment and which is appropriate to support needs • With family or carer where this is sustainable, appropriate and safe, and with adequate support for carer • Private rental which is affordable and appropriate 	<ul style="list-style-type: none"> • Similar to ‘stabilising’ but may have stepped down level of care required • Appropriate level of care with choice and flexibility (clinical/ psychological/ psychosocial) • Supports available when required • Trusted worker • Continuity of care 	<ul style="list-style-type: none"> • Low income, including due to low workforce participation rates and low levels of income support • Being caught in the gaps during the transition to the NDIS • Lack of family and community attachments/support • Fragmented access to and delivery of support (formal and informal) to sustain recovery • Changes in social housing policy • Household breakdown due to separation or illness • Living with carer no longer viable 	<ul style="list-style-type: none"> • Develop early intervention and prevention tenancy support programs tailored to people with mental ill-health • Provide ongoing and adequate rental assistance • Address housing workforce capacity issues • Address mental health workforce issues (availability of MBS-rebated specialists, case coordination, trusted workers) • Increase availability of ‘step up, step down’ mental health support • Provide access to financial hardship programs • Improve service integration • Improve system integration • Landlord training and education programs

Where are they living?	What mental health support are they receiving?	What are the risk factors?	What are the policy interventions?
<p>Stabilising (moderate risk) On the path to recovery, but may still need help to sustain the tenancy and require ongoing mental health support</p>			
<ul style="list-style-type: none"> • Home ownership or social housing with safe environment and which is appropriate to support needs • Private rental • Housed, with assistance to maintain tenancy when unwell • Supported accommodation • With family or carer where this is sustainable, appropriate and safe, and with adequate support for carer 	<ul style="list-style-type: none"> • Appropriate level of care with choice and flexibility • Clinical support • Psychological support • Trusted worker • Continuity of care 	<ul style="list-style-type: none"> • Low income, including due to low workforce participation rates and low levels of income support with higher risk of financial hardship • Available housing is not appropriate to support needs • Fragmented access to and delivery of support (formal and informal) to assist recovery • Lack of support to maintain the tenancy (formal or informal) • Lack of secure, safe, affordable and appropriate housing • Risk assessment and discrimination by private landlords limits options • Added cost and disruption due to frequent moves • Periods of deterioration and improvement can last for several months either side of an episode of acute illness, which is not consistent with short-term programs • Stigma around mental health reduces willingness to access services 	<ul style="list-style-type: none"> • Develop early intervention and prevention tenancy support programs tailored to people with mental ill-health • Provide ongoing and adequate rental assistance • Address housing workforce capacity issues • Address mental health workforce issues (availability of MBS-rebated specialists, case coordination, trusted workers) • Increase availability of ‘step up, step down’ mental health support • Provide access to financial hardship programs • Improve service integration • Improve system integration • Landlord training and education programs

Where are they living?	What mental health support are they receiving?	What are the risk factors?	What are the policy interventions?
<p>Cycling (very high risk) Repeatedly entering and dropping out of the system (mental health and housing) with detrimental effects on mental health and housing stability; characterised by a strong downwards trajectory</p>			
<ul style="list-style-type: none"> • Private rental that is unaffordable, with insecure tenure, unsafe environment and lack of support to sustain the tenancy • Social housing with unsafe environment and support not appropriate to needs • Supported accommodation not appropriate to needs • Hospital, prison or other institution • Crisis housing • Boarding house • Living with friends and family when this is not sustainable • Living with ‘wrong’ or unsafe people (e.g. with others with high and complex needs, AOD) 	<ul style="list-style-type: none"> • Inappropriate level or type of support • Involuntary Treatment Order • Clinical support only (e.g. no psychosocial support, medication only) • Support is not coordinated • Short-term support to address crisis only 	<ul style="list-style-type: none"> • No mental health or housing support until severe crisis • No ongoing support worker • Unsafe, unsupported housing environments, leading to victimisation and mental distress • Unable to access social housing • Stable housed but no/not enough/not the right mental health support • Unaffordable private rental market • Risk assessment and discrimination by private landlords limits options • Lack of control over who they are living with • Rationing of MBS support • Unable to access NDIS • Mental health support not coordinated/bad transitions between mental health services • Lack of adequate transitions between systems • No diagnosis • Lack of family and community attachments/supports 	<ul style="list-style-type: none"> • Provide medium-term intensive housing responses that combine accommodation and support • Provide more specialised long-term housing with integrated support • Develop early-intervention and prevention tenancy support programs tailored to people with mental ill-health • Better system integration • Provide more and better access to affordable, safe, appropriate and sustainable housing • Develop service models that provide long-term support according to need • Provide more and better support to apply for the NDIS • Transitional supported housing (e.g. Common Ground and housing first models) • Better referrals to housing providers to allow for support planning • Provide adequate income support

Where are they living?	What mental health support are they receiving?	What are the risk factors?	What are the policy interventions?
Cycling - <i>continued</i>			
		<ul style="list-style-type: none"> • Low income, including due to low workforce participation rates and low levels of income support with higher risk of financial hardship • Added cost and disruption due to frequent moves, evictions or forced moves • Depletion of resources and supports over time • Lack of access to healthcare • High mental health workforce turnover and low capability • Support periods are too short and not aligned with need • Support stops once people are housed • Mental health support stops once minimum improvement in clinical symptoms is achieved • Lack of housing makes it difficult to access mental health care • Multiple/complex needs prevent access to appropriate care • Support is tied to housing or mental health status rather than need • No service of last resort 	<ul style="list-style-type: none"> • Address housing and mental health workforce capacity issues • Identify and resource service of last resort • Provide more and better preventative and follow-up mental health care • Better planning for exits from institutional care • Better transitions between systems • Support coordination and wrap-around support to help people access services (e.g. PIR)

Where are they living?	What mental health support are they receiving?	What are the risk factors?	What are the policy interventions?
<p>Stuck (very high risk) Trapped in inappropriate housing and/or services without choice and long-term pathways</p>			
<ul style="list-style-type: none"> • Homeless • Unable to exit institutions • Crisis/transitional housing • Boarding houses • Private rental that is unaffordable or insecure and not appropriate to needs • Inappropriate share housing • Living with friends and family when this is not appropriate/due to a lack of other options 	<ul style="list-style-type: none"> • Mental health inpatient unable to be discharged • Inappropriate mental health care due to lack of options or access • Stuck in a service that is doing them harm 	<ul style="list-style-type: none"> • Lack of options or pathways to long-term stable housing and mental health recovery • Lack of choice in services or housing • Lack of assistance to navigate the system • Risk assessment practices and discrimination by private landlords prevents access to private rental • Cost of housing and support prevents access • No choice over who they are living with • Unable to access mental health care unless in crisis • Unable to transition within the system from short/medium-term to long-term sustainable housing and supports • Lack of housing appropriate to support needs • Difficulty keeping social housing application active • Eligibility for support may end abruptly when their status changes from 'homeless' to 'housed' within the service system 	<ul style="list-style-type: none"> • Provide more transitional supported housing (e.g. Common Ground or Foyer models) • Provide assistance to navigate the system

Where are they living?	What mental health support are they receiving?	What are the risk factors?	What are the policy interventions?
<p>Excluded (in crisis) Cannot access needed housing and mental health care</p>			
<ul style="list-style-type: none"> • Homeless: living on the street • Living with friends and family where this is unsafe and unsustainable due to a lack of other options • Staying with/couch surfing with friends or relatives • Various forms of marginal housing (e.g. caravan parks, boarding houses) 	<ul style="list-style-type: none"> • Cannot access/is ineligible for mental health care • Not able to access MBS 	<ul style="list-style-type: none"> • Needed housing and services are not available or individual cannot access them • Uneven access to services/services do not exist, especially in rural and regional areas • Not enough bulk billing psychologists and psychiatrists • Lack of support/ options for those living with psychosocial disability • Cultural and language barriers • Lack of assertive outreach • Unable to provide documentation needed to access NDIS • Not eligible for DSP • Does not understand how the service system works and has no assistance navigating the system • Undiagnosed or unaddressed trauma and related antisocial behaviours • Alcohol and drug abuse, self-medication 	<ul style="list-style-type: none"> • Culturally appropriate systems and services • Housing first approaches (e.g. Micah Projects, Street to Home) • Specialised long-term housing and support with 24-hour psychosocial support • ‘Step up, step down’ support • Specific packages designed to respond to the needs of people with high-level housing and mental health needs • Provide assertive outreach • Follow up people assessed as not eligible for NDIS and make sure they don’t fall through the cracks • Provide assistance to apply for NDIS • Provide assistance to navigate the system • Develop protocols for shared consent

Where are they living?	What mental health support are they receiving?	What are the risk factors?	What are the policy interventions?
Excluded (in crisis) - <i>continued</i>			
		<ul style="list-style-type: none"> • Lack of capacity within homelessness services to respond to needs of people living with mental illness • Increased vulnerability to homelessness due to mental illness • Homelessness worsens mental ill-health • No diagnosis 	

Appendix 3: Personal risk factors and duration of mental ill health

Table 20: Marginal effects of the log-logistic model for survival with mental health symptoms (MHI-5>48) concerning individual characteristics, HILDA

Variables		Estimates
Gender	Female	0.051 ** (0.022)
Age		
(Reference = 15–24 years of age)	25–44 years	-0.071 ** (0.031)
	45–64 years	-0.100 *** (0.032)
	65+ years	-0.206 *** (0.044)
Dependent children	Number of dependent children	0.026 ** (0.011)
Indigenous	Indigenous	0.005 (0.057)
Social connectedness	Social support	-0.057 *** (0.007)
Labour force status		
Reference = employed	Not in labour force	0.097 *** (0.027)
State of residence		
Reference = NSW	Victoria	0.088 *** (0.028)
	WA	0.072 * (0.041)
Health		
Reference = poor self-assessed general health	Good general health	-0.052 ** (0.026)
	Very good general health	-0.085 *** (0.029)
	(Reference = no long term health condition)	
	Long term health condition	0.007 (0.024)

Notes:

i) Standard errors are in parentheses.

ii) *** p<0.01, ** p<0.05, * p<0.1

iii) Wave dummies are also included in the list of covariates.

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