Trajectories: the interplay between mental health and housing pathways

Policy priorities for better access to housing and mental health support for people with lived experience of mental ill health and housing insecurity

February 2021

Authored by

Nicola Brackertz
Australian Housing and Urban Research Institute

for

Mental Health Australia
Mind Australia Ltd.

Related reports

Brackertz, N., Borrowman, L., Roggenbuck, C. Pollock, S. and Davis, E. (2020) *Trajectories: the interplay between mental health and housing pathways. Final research report*, Australian Housing and Urban Research Institute Limited and Mind Australia, Melbourne, https://www.ahuri.edu.au/research/trajectories.

Pollock, S., Davis E., Cocks N., Baumgartel G., Egan, R. (2020) *Trajectories: the interplay between mental health and housing pathways. Report for national consumer and carer consultations*, Australian Housing and Urban Research Institute Limited and Mind Australia, Melbourne, https://www.ahuri.edu.au/research/trajectories.

Brackertz, N., Borrowman, L. (2020) *Trajectories: the interplay between mental health and housing pathways. Quantitative evidence on the relationship between mental health and housing*, Australian Housing and Urban Research Institute Limited and Mind Australia, Melbourne, https://www.ahuri.edu.au/research/trajectories.

Brackertz, N., Wilkinson, A., and Davison, J. (2019) *Trajectories: the interplay between mental health and housing pathways. A short summary of the evidence*, AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne, https://www.ahuri.edu.au/research/research-papers/trajectories.

Pollock, S., Davis E., Clifton, E., Davis V., Firebrace, S., Williams, G. (2020) *Trajectories: the interplay between housing and mental health pathways. Report from Aboriginal and Torres Strait Islander consultations*, Australian Housing and Urban Research Institute Limited and Mind Australia, Melbourne, https://www.ahuri.edu.au/research/research-papers/trajectories.

Brackertz, N., Wilkinson, A., and Davison, J. (2018) *Housing, homelessness and mental health: towards systems change*, AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne, https://www.ahuri.edu.au/research/research-papers/housing-homelessness -and-mental-health-towards-systems-change.

Contents

Foreword

This report identifies priority policy areas and effective interventions to enable better access to housing and mental health support for people with lived experience of mental ill health and housing insecurity. Importantly, it upholds the fundamental right that every individual deserves choice and control, safety, and a home.

As national lived experience consumer and carer advocates in mental health with a passion for wholesome sustainable change, we know that safe, secure housing is the foundation for mental health. How do you lead a contributing life if you don't have somewhere safe to live?

We know that without a safe place to call home, and without accepting and supporting social connection and community, it is difficult to have good mental health and social and emotional wellbeing, or to even access the supports you need. Unfortunately, we also know that there are too few housing options, that there is a shortage of housing stock and that housing staff lack training in how to support someone when they're unwell.

It is extremely important that people with lived experience are partners in the design of services which affect them. We have participated in this policy development process by bringing our own lived experiences, and those of our peers throughout Australia to the virtual table. We have been included throughout this entire process, with our views incorporated throughout this document.

Our expectation is that this report creates meaningful change for people like us who have experienced housing insecurity and mental ill-health. If our governments' response to COVID has shown us anything, it's that national and jurisdictional problems are solvable and that quick and effective action can be taken if there is bipartisan support and cooperation across different levels of government.

This report demonstrates that supplying housing makes good economic sense when one looks at the return on investment in all areas of a persons' life. We urge policymakers to ensure that recommendations in this solution focussed report are acted upon. Change can happen if everyone works together to deliver action that we know is achievable. And the changes included within this document will ultimately save lives.

We call on all Governments to act now.

Thank you
Evan Bichara, Eileen McDonald, Yvonne Quadros, Jan West

Acknowledgements and contributions

Executive summary

Trajectories: the interplay between mental health and housing pathways (Trajectories) policy development research was undertaken as a joint project between Mind Australia (Mind) and the Australian Housing and Urban Research Institute (AHURI). The research aimed to gather data and document the experiences of people living with mental ill health on the importance of housing to their mental health and areas for potential intervention and support. Mental Health Australia became involved once this research was completed to support the development of this paper that takes these research findings to engage with key stakeholders and find applied solutions that could become the basis for future advocacy and government investment.

66

The housing problem is possible to solve. The only thing stopping us is a failure to prioritise investment in solving the problem. (policy development participant)

Policy priority 1: Provide genuine choice and control in housing by increasing the availability of a diversity of safe, secure, appropriate and affordable housing for people with lived experience of mental ill health and housing insecurity.

1.1 Develop more public, community and affordable housing either through direct capital investment by state, territory and federal governments or by addressing the funding gap.

1.2 Close the gap in the availability of housing with integrated mental health support by expanding existing models that have shown to be effective.

1.3 Better utilise the private rental market to provide diverse housing options to suit a range of different needs, for example by expanding the use of programs that head lease properties from the private rental market.

1.4 Expand the use of Housing First models for those who are experiencing persistent homelessness.

Policy priority 2: Increase support to sustain the tenancies of people with lived experience of mental ill health who are able to live independently.

2.1 Develop tailored tenant support programs that recognise the variable capacity and care needs of people experiencing both episodic and enduring mental ill health.

2.2 Develop and deliver training and resources to grow the capacity of housing workers to sustain the tenancies of those with lived experience of mental ill health.

Policy priority 3: Strengthen early intervention and prevention.

3.1 Implement mechanisms and provide resourcing to facilitate better coordination between parts of the clinical and community mental health systems and the housing and homelessness systems.

3.2 Improve transitions out of institutional care ('no exits into homelessness').

3.3 Implement population based screening to identify those at risk.

3.4 Ensure that people have rapid access to clinical and community based mental health services when they need it (step up step down).

These policy priorities were identified following an extensive policy engagement process with key policy makers and people with lived experience, and build upon a significant body of previous research which includes:

- a review of the academic and grey literatures

- quantitative analysis of two longitudinal panel data sets

- national consultations with service providers in fields of housing and mental health

- consultations with 130 consumers and carers representing every Australian state and territory.

Overall, the research found that housing is the foundation for mental health recovery. There was strong evidence that poor mental health contributes to financial hardship and forced moves. Data showed that the experience of severe psychological distress increases the likelihood of financial hardship in the following year by 89 per cent and increases the likelihood for financial hardship within two years by 96 per cent. A diagnosed mental health condition increases the likelihood that people will be forced to move from their home within one year by 39 per cent.

The research identified five overarching trajectories experienced by people with lived experience of insecure housing and mental ill health as they navigate the housing, homelessness and mental health systems. People on the excluded trajectory lack access to the housing and mental health care they need. 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 down trajectory is marked by a downward spiral in which people enter into and drop out of supports repeatedly, which progressively erodes their resources. 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.

Findings from previous research

Trajectories: the interplay between mental health and housing pathways (Trajectories) is a collaborative research project with the Australian Housing and Urban Research Institute (AHURI), Mind Australia Ltd. (Mind) and Mental Health Australia (MHA).[1]

Trajectories aimed to develop an applied understanding of the housing and mental health pathways of people with lived experience of mental ill health, the intersection of these pathways and potential points of intervention.

This report presents the priority policy options arising from the overall research. All Trajectories research is available at https://www.ahuri.edu.au/housing/trajectories.

Key findings from the overall Trajectories research are as follows.

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.

Poor mental health contributes to financial hardship and forced moves

Quantitative analysis of longitudinal data[2] showed that poor and deteriorating mental health directly impact housing stability (as measured by forced moves and financial hardship). The experience of severe psychological distress increases the likelihood of financial hardship in the following year by 89 per cent and increases the likelihood for financial hardship within two years by 96 per cent. A diagnosed mental health condition increases the likelihood that people will be forced to move from their home within one year by 39 per cent (Brackertz et al. 2020).

Most people recover quickly but a small proportion experience persistent and recurring mental ill health

Analysis of longitudinal data showed that most people within the general population experience only relatively short periods of mental ill health: 66 per cent recovered within one year and 89 per cent recovered within three years (Brackertz et al. 2020).

Social support, accessing health and mental health services shortens spells of mental ill health

Analysis of longitudinal data shows that having good social support, good general health, and accessing mental health and other health services, can reduce the likelihood of housing instability and shortens the length of time a person experiences mental ill health. For example, social support can reduce the likelihood that a person's mental health will deteriorate to the point where they experience symptoms by 33 per cent (Brackertz et al. 2020).

Conversely, lack of social support and not accessing support services can amplify the negative relationship between housing instability and mental ill health. People who experience deteriorating mental health to the point where they experience symptoms of anxiety, depression and mental distress, and who do not access health services are more than twice as likely (58%) to be forced to move from their home within two years,

and more than one in three (35%) are likely to experience financial hardship within one year (Brackertz et al. 2020).

Trajectories for recovery are non-linear and in many cases lack of housing and support harms recovery

> "
>
> *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)*

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.

Typical trajectories

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

Excluded from help required

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

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.

Stuck without adequate support

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.

Cycling down

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

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.

Stabilising

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.

Well supported

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.

The Trajectories research confirmed that housing, homelessness and mental health are inextricably linked. A combination of sustained access to safe, secure, affordable and appropriate housing and targeted mental health support provide the foundation to enable people to build contributing lives.

In Australia, there already exist many programs and interventions that aim to provide a level of support to enable people to get and stay well whilst living in the community. Some provide a combination of 'housing + support', whilst others 'assume' the provision of housing, and focus only on support. However, the capacity of these programs to meet need is insufficient, as they tend to be small scale, pilot programs or geographically limited. Furthermore, the Australian housing, homelessness and mental health systems are fragmented within themselves and there is limited integration across these systems. A lack of policy integration between housing, homelessness, clinical and community based mental health, as well as government silos, impede the development of national, cross sectoral, integrated and accountable policy solutions.

In addition, there is a recognised lack of affordable housing across the country, particularly for those on low incomes. The long-term structural trends in the Australian housing system (falling rates of home ownership, increase in private rental, declining stocks of social housing, lack of affordable housing for low-income households) are key factors in the housing issues facing those with mental ill health.

Method

Previous Trajectories research identified a wide range of policy options (see Appendix 1). The purpose of the Delphi process was to identify a subset of priority policy options that can be implemented to ensure access to appropriate, safe, secure, and affordable housing for people experiencing mental ill health. To do this, the research used a modified Delphi process.

Delphi is an anonymous group process that can be used to facilitate group consensus or to prioritise options. It is an iterative process where options are deliberated over consecutive rounds of engagement, with the researcher moderating feedback and findings. Anonymous sharing of group opinions allows participants to benchmark themselves against peer responses and to share opinions.

Participants in the Delphi process were provided an overview of the previous Trajectories research and potential policy options (see Appendix 1) and were asked to consider and rank the effectiveness and feasibility of each option.

The 33 participants in the Delphi process were invited to represent high level decision makers and people with policy knowledge and expertise in the fields of housing, homelessness and mental health. Participants included people with lived experience of housing insecurity and mental ill health, academics, mental health and housing peak bodies, an Aboriginal housing organisation, and representatives from state and federal governments. Participants were asked to commit to contribute to all research activities of the Delphi process, as each new stage built upon and extended the previous stages.

The Delphi process had five rounds of engagement which consisted of the following:

1   A webinar designed to acquaint participants with the findings from previous Trajectories research and to explain to them how the Delphi process would work was held on Tuesday 11 August 2020. Participants were provided with a discussion paper that outlined a broad spectrum of policy options that arose from the previous research (see Appendix 1).

2   The first online Delphi questionnaire was delivered between 18 August to 2 September 2020 and received 22 valid responses from the 33 invited participants (86% response rate). The survey asked participants to rank the spectrum of policy options in relation to:

   • how effective they are likely to be in achieving the desired outcomes (i.e. facilitating better access to housing and mental health support)

   • how feasible they are likely to be (e.g. how readily they could be implemented).

   Researchers summarised findings from the survey and provided these to Delphi participants.

3   The second Delphi questionnaire was delivered online between 22 September and 6 October 2020 and N=20 valid responses were received (61% response rate). The survey asked participants to identify which specific programs and interventions they thought would most effectively support the priority policy options identified in the first round survey. The survey also asked respondents about the impact the COVID-19 crisis was likely to have on needed housing and mental health responses. Findings from the survey were summarised and provided to participants.

4   An online workshop, to which all participants were invited, was held on 26 October 2020 from 10 am–12 noon AEST. The workshop was designed to bring together all strands of the Delphi process and provide participants with the opportunity to workshop detailed solutions for identified priority policy areas.

5   An online workshop with four people with lived experience of insecure housing and mental ill health to test and validate the identified policy priorities (19 November 2020).

Policy priorities for better access to housing and mental health support

Housing is the foundation for mental health recovery, yet many people with lived experience of mental ill health have insecure housing. Many are excluded from the supports they need, are trapped in inappropriate arrangements, or are experiencing a downward spiral that progressively erodes their resources. This negatively affects people's lives and mental wellbeing and harms their ability to recover.

The research identified three policy priority areas to address these issues:

- Increase the availability of safe, secure, appropriate and affordable housing

- Provide more and better support to sustain tenancies

- Strengthen and expand early intervention and prevention.

The following section details options for specific interventions and programs to support and implement the policy priorities.

It should be noted throughout that people with lived experience of mental ill health exist not only as individuals, rather they are part of social networks consisting of families, carers, friends and as the wider community, all of which affect their wellbeing and the choices available to them.

❝

The way our mental health system operates, it is very much focused 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)

Policy priority 1: Provide genuine choice and control in housing by increasing the availability of a diversity of safe, secure, appropriate and affordable housing for people with lived experience of mental ill health and housing insecurity

❝

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

People with lived experience of mental ill health have distinct housing pathways that are characterised by more turbulent housing careers, often moving between parental home, private rental, homelessness, social housing and caravan parks (Beer et al. 2006: 9). This variability in their housing pathways is due to the episodic nature of many mental illnesses, which results in periods in and out of employment, as well as significant transitions through the housing market.

Increasing the availability of safe, secure, appropriate and affordable housing for those with lived experience of mental ill health and housing insecurity was the top policy priority identified in all streams of the Trajectories research. The need for genuine choice and control over housing options and living arrangements was a strong theme throughout. Like the broader Australian population, people experiencing housing insecurity and mental ill health have a range of different housing needs and preferences (Owen et al. 1996), spanning those who own or are purchasing their own home, those who are renting in the private market, those who live

independently in social housing, those who require medium- or long-term housing support and those who experience intermittent or persistent homelessness.

Consequently, effective policy responses should aim to increase options across the housing spectrum, to provide public, community and affordable housing, integrated housing and support models, better utilisation of the private rental market, and Housing First models for those experiencing homelessness or at risk of homelessness. Additionally, thought needs to be given to who makes choices about housing (e.g. those with lived experience of mental ill health, their families and carers, service providers, government agencies) and the information and assistance needed to explain and navigate these options.

1.1 Develop more public, community and affordable housing either through direct capital investment by state, territory and federal governments or by addressing the funding gap

"

There is a sound economic argument in favour of developing more social and affordable housing. Social housing construction supports the building and construction industry, creates jobs, creates dwellings for those who need them, and the resulting housing helps to keep people safe and well. Evidence on the return on investment shows that in the long run it is cheaper for government to develop additional housing than allowing the present situation to continue. This can be supported by partnerships with the private sector. (policy development participant).

There is an urgent need for more social (public and community housing) and affordable housing to provide safe, secure, affordable and appropriate housing to people with lived experience of mental ill health and housing insecurity. The availability of a sufficient quantity of this type of housing is essential for the effective implementation of many of the other policy options that would contribute to ensuring that people with lived experience of mental ill health can be housed securely and commence and sustain their recovery.

"

I feel unsettled because 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, Brisbane)

Social and affordable housing provides secure long term housing. Public housing is funded by state and federal government under the National Housing and Homelessness Agreement, State and Territory Governments have primary responsibility for funding and delivering housing supports, with some funding and responsibilities shared by the Australian Government.

Community housing providers provide social housing that they have developed using private debt finance, long term loans with lower interest rates offered by the National Housing Finance and Investment Corporation, philanthropic and other sources of capital. Many community housing providers also manage social housing properties that are owned by state and territory governments.

Historically in Australia, governments built, owned and managed public housing, which was seen as the way to increase affordable housing supply (with some properties being sold to lower income tenants over time). However, this view is changing, with many governments seeing their role less as an active manager of tenants or properties, but rather as a regulator of housing supply and management, and a source of subsidy to cover the funding gap. Instead not-for-profit community housing providers are increasingly being engaged to manage and grow the supply of affordable rental housing (AHURI 2019a).

Across Australia there is a significant shortage of social housing, with almost 190,000 people on social housing waiting lists Australia wide as at 30 June 2017, many of whom have lived experience of mental ill health. For example, roughly 20 per cent of all social housing tenants reported accessing mental health services in 2016 (AIHW 2017).

The evidence shows that in order to increase the supply of social and affordable housing, federal and state governments need to address the funding gap or make direct capital investments in social housing. The funding gap is the difference between what it costs to supply, build, maintain and manage social housing and the amount low income tenants can afford to pay (including using any Commonwealth Rent Assistance or other government entitlements). Across Australia on average each social housing dwelling needs around $13,000 each year as a government subsidy to address this funding gap (Lawson et al 2018).

1.2 Close the gap in the availability of housing with integrated mental health support by expanding existing models that have shown to be effective

"

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)

Across Australia there already exist numerous models that integrate housing and mental health support. These supported housing models are primarily aimed at those with severe mental illness and integrate housing, psychosocial and mental health support services. Evaluations have shown that supported housing models are effective in assisting people to recover from mental ill health, cost effective, sustain tenancies, and decrease hospital usage (Bruce et al. 2012; Meehan et al. 2010; SA Health 2013; Smith 2015; Parsell et al. 2016). The literature identifies the following critical elements of supportive housing: affordability, permanence (secure tenure, normality, voluntary service engagement, safety, privacy, 24-hour access to crisis support) (Parsell and Moutou 2014). The evidence shows that successful models share certain factors and principles, including effective mechanisms for coordination at the state and local levels, cross sector collaboration and partnerships, immediate access to housing (social housing or private rental), and integrated person centred support (Brackertz et al. 2018).

However, existing models do not meet the demand for these services and there is a need to scale up successful models of supported housing with integrated mental health care that provide medium- and long-term housing (Brackertz et al. 2018). In 2017–18, there were only about 4,600 supported housing places across Australia to meet an estimated demand for about 14,000 to 17,000 places – a gap of about 9,000 to 12,500 places (Productivity Commission 2020b: 986).

Examples of successful supported housing models that could be expanded or replicated include government funded initiatives such as the Housing and Accommodation Support Initiative (HASI) and the Housing and Accommodation Support Partnership (HASP).

Housing and Accommodation Support Initiative (HASI) operates in NSW, Tasmania and the Northern Territory. An evaluation of NSW HASI showed it to be effective in contributing to tenancy stability, clinically significant improvements in mental health, independence in daily living, social and community participation, and improvement in education or paid and unpaid work (Bruce et al. 2012). Critical success factors include effective mechanisms for coordination at the state and local levels, cross sector collaboration and partnerships, access to secure long term affordable housing, and clinical care and rehabilitation (delivered by specialist mental health services). The remit of HASI type programs could be improved by broadening eligibility criteria and providing further opportunities for the involvement of supportive family, friends and carers.

The Housing and Accommodation Support Partnership (HASP) Program (SA Health 2013) in South Australia provides long term housing and support using a coordinated approach between consumers, carers, community housing providers, and government mental health services. It is targeted toward high needs and precariously housed individuals. HASP provides long term affordable housing, psychosocial rehabilitation and support services, clinical mental health care and rehabilitation, independent living skills, and support for improved quality of live and wellbeing (McDermott 2017; SA Health 2011). HASP has assisted people with lived experience of mental illness and significant functional impairments, homeless, and connected with community health into 84 houses. Support is also provided to participants and ranges between 24/7 to 15 hours, 2–3 days per week (McDermott 2017).

Some people living with severe and persistent mental illness need ongoing support. This may include long term housing, mental health care, tenancy support and/or support with daily living activities that is available 24/7. This specialist housing may be in the form of congregate or individual living arrangements. One example is the Haven Foundation model, which combines government grants and philanthropic funding.

The Haven Foundation model[3] model provides long term housing and associated psychosocial support for people with severe and enduring mental illness to maximise their independence and quality of life and recovery. The model provides residents with their own self-contained apartment with private kitchen and bathroom facilities, located within a block of units that also offers shared communal facilities to provide spaces for social interaction. The model has 24/7 onsite psychosocial support. Residents enter into an open-ended lease with the foundation (cost is 25% of the Disability Support Pension plus 100% of CRA). An evaluation of Haven South Yarra (a collaboration between Housing Choices Australia, Prahran Mission and overseen by the Haven Foundation) found the model improved tenancy stability, social connectedness, a sense of belonging and hope for the future and contributed to managing mental health issues. Cost was estimated to be about $100,000 per person per year (Lee et al. 2013).

1.3 Better utilise the private rental market to provide diverse housing options to suit a range of different needs, for example by expanding the use of programs that head lease properties from the private rental market

Most people with lived experience of mental ill health rent in the private market, yet many struggle with discrimination, insecure tenure and housing affordability (Brackertz et al. 2020). The federally funded Commonwealth Rent Assistance (CRA) provides financial support to rent in the private market (equal to 75% of rent above a threshold, up to a limit) to eligible renters, however, in many cases this subsidy is insufficient to afford safe, secure, appropriate and affordable housing. Over one-third (34%) of low-income CRA recipients

---

3   http://www.havenfoundation.org.au

still remain in housing affordability stress (i.e. they pay more than 30% of their income in rent) after CRA is deducted from their rents (Ong et al. 2020).

> **"**
>
> *If you're on Newstart and you're, like, I need to rent a place, there's nothing available. (consumer, Adelaide)*

Many renters with lived experience of mental ill health face discrimination from landlords, have insecure tenure, and experience unwanted moves because their lease ended or they were evicted. Forced moves incur financial and social costs and are stressful, which negatively impacts on their mental health (Brackertz et al. 2020).

Private renters often live in poor quality housing in locations not suited to them, or in housing that is not safe. High rental costs mean that some share housing with people they would otherwise not choose to live with. Being forced to move and having to accept whatever accommodation is available (including the homes of friends and family), contributes to people losing their mental health supports—and rebuilding these supports is very difficult (Brackertz et al. 2020).

> **"**
>
> *I'm just waiting for a call to say I have to move out now. (consumer, Port Hedland)*

Nevertheless, the private rental market could be utilised as a source of readily available and diverse housing options, to suit a range of different needs, provided the right supports are put into place. The evidence suggests that a combination of sufficient rental subsidy for tenants, combined with landlord education, partnerships with real estate agents, landlord incentives (including bonds and insurances), combined with a range of wrap-around supports to the person taking up this option can be successful.

For example, Doorway is a rental subsidy housing model with integrated services that targets people with mental illness.

The Doorway[4] program is a Victorian Government initiative delivered by Wellways, which provides integrated housing and recovery support designed to assist people with lived experience of persistent mental ill health who are at risk of, or are experiencing homelessness. Doorway is a collaboration between hospitals, housing and mental health service providers and landlords. The program links consumers with private rental housing and psychosocial support while providing time limited rental subsidy, brokerage and tenancy support. The model is based on Housing First principles, but is highly innovative, as it diverges from the predominant model of providing housing via social housing providers, in favour of the private rental market. Doorway supports participants to choose, access and sustain their own private rental accommodation by subsidising their rental payments where required. In addition, Doorway's housing and recovery workers support participants to develop tenancy skills and build natural support networks. Doorway creates integrated support teams for each participant.

An independent evaluation of the Doorway pilot program showed high levels of tenancy sustainment, reduced usage of bed-based clinical services, and reduced hospital admissions, totalling annual cost savings to government ranging from $1,149 to $19,837 per individual. Outcomes for participants included modest improvements in the proportion of tenants in paid or unpaid employment, taking steps to find work, seeing an employment consultant, accessing education and vocational training opportunities and receiving qualifications for their vocational training (Dunt et al. 2017).

---

4   https://www.wellways.org/our-services/doorway

Head leasing models are another way to provide access to the private rental market that offers security of tenure and affordability to renters, while providing assurance to landlords. Under head leasing arrangements, a private rental property is rented from the landlord or owner by a legal entity, such as a community housing provider or a government agency, which then on lets the property to a low income or disadvantaged tenant. Head leasing provides to landlords a guaranteed income for the length of the lease, maintenance and any damage caused by tenants is repaired by the lessor and landlords do not need to use (and pay for) the services of a real estate agent to manage the property. This means the lessor may be able to negotiate a lower rent than might otherwise be the case (AHURI 2019b).

While not targeted specifically at people with lived experience of mental ill health, several large scale head leasing models exist in Australia, including the Queensland Community Rent Scheme and the Tasmanian Private Rental Incentives Program,[5] both of which provide transitional housing for eligible tenants. Some community housing, such as Defence Housing, also makes use of head leasing. There is considerable scope to expand head leasing, for example using models where properties are rented from private landlords and then re-let at subsidised rents (e.g. capped at 30% of tenants' income). The advantages of head leasing are that it provides choice in types of housing and location; offers secure and affordable rental to tenants; avoids the need for upfront capital investment in building new homes; reduces the risk of discrimination in the private rental market.

The Mental Health Rapid Rehousing program is an example of a head leasing initiative designed to prevent exits from institutional care into homelessness.

Mental Health Rapid Rehousing is a housing assistance initiative funded by the Tasmanian Health Service and administered by Housing Tasmania and delivered in collaboration with registered community housing providers and Housing Connect. The initiative provides clients exiting Mental Health Services inpatient units with transitional accommodation (leases up to 12 months) at subsidised rent. The initiative targets clients who are approved for discharge but who remain as inpatients because they do not have appropriate and affordable post-discharge accommodation. Mental Health Rapid Rehousing complements the current social housing portfolio by creating a pool of five dedicated properties – either private rentals or owned by community housing providers. Clients are matched to affordable accommodation from the pool of properties. Rent payable by the occupant will not exceed 30 per cent of the income of the household plus Commonwealth Rent Assistance.[6]

1.4 Expand the use of Housing First models for those who are experiencing persistent homelessness

> 66
>
> *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, Berri)*

There is a bidirectional relationship between homelessness and mental ill health, where poor mental health is a risk factor for homelessness and the experience of being homeless can contribute to mental ill health. Unsurprisingly then, there is a high prevalence of mental illness among the homeless population.

---

5   https://www.communities.tas.gov.au/housing/tasmanian_affordable_housing_strategy/key-projects/private-rental-incentive/private-rental-incentives-program-information-for-owners-and-agent

6   https://www.communities.tas.gov.au/housing/tasmanian_affordable_housing_strategy/key-projects/rapid-rehousing/fact-sheet-mental-health-rehousing

The evidence supports that Housing First models are an effective intervention to combat homelessness and increase mental health for those experiencing persistent homelessness.

While several Housing First programs exist in Australia, and have shown to provide good outcomes, effective implementation of Housing First has been constrained by the lack of appropriate affordable housing stock necessary to quickly provide long term housing to those experiencing homelessness. Furthermore, demand for Housing First by far exceeds the capacity of existing programs. In 2018–19, about 31,000 people with mental ill health who were either homeless or at risk of homelessness had an unmet need for longterm housing across Australia (Productivity Commission 2020b:1001).

Scaling up existing Housing First programs and initiating new ones to meet the need for long term housing of people with mental ill health who are homeless is a key policy priority.

Housing First models The pioneers of Housing First describe the fundamental principles of the model as 'providing homeless individuals with immediate access to permanent, independent housing with post-housing support and without treatment contingency' (Stefancic and Tsemberis 2007). Housing First models are based on the principle that safe and permanent housing is the first priority for people experiencing homelessness. Once a person is securely housed, their support needs (e.g. mental health, drug and alcohol counselling) can be addressed and wrap around services provided. However, engagement with these services is not a condition of maintaining the housing nor is it a precondition for being eligible for housing. Housing first is most often targeted at people who are sleeping rough and who have complex support needs. Ideally, Housing First homes are dispersed throughout neighbourhoods and communities and are not identifiable as different from those around them to avoid stigmatised and vulnerable people being placed in close proximity to one another, which can lead to tenancy failures (Johnson et al. 2012).

Programs that follow Housing First principles have been shown to be effective in responding to homelessness among people with lived experience of mental ill health. Most evaluations report positive outcomes in the domains of tenancy sustainment; reduced use of government services (especially health and justice); mental health, quality of life and wellbeing, and to a lesser degree, employment (Baxter et al. 2019; Bullen et al. 2015; Conroy et al. 2014; Gulcur et al. 2003; Johnson and Chamberlain 2015; Ly and Latimer 2015; Mental Health Commission of Canada 2014; Parsell et al. 2015; Parsell, Tomaszewski and Jones 2013a, 2013b; Pleace 2016; Tsemberis 2010; Tsemberis et al. 2004; Vallesi et al. 2018; Woodhall–Melnik and Dunn 2015). An evaluation of the MISHA project by Mission Australia from 2010−2013, which used a Housing First approach, found that after two years 97 per cent of clients were still living in secure housing; and the associated cost savings to government equated to $8,002 per person per year (Conroy et al. 2014).

Common Ground models provide congregate housing based on Housing First principles, and operate across Australia. Common Ground provides permanent supportive housing and intensive and integrated support for people with complex needs; they are primarily targeted at rough sleepers. Evaluations of Common Ground in Melbourne[7], Sydney[8], and Brisbane have shown the model to be effective is sustaining tenancies and improving mental health. The evaluation of Brisbane Common Ground (BCG), which is a partnership between the Queensland Government, Commonwealth Government, Grocon Pty Ltd, Micah Projects and Common Ground Queensland Ltd., included analysis of linked administrative data. The analysis showed that as a cohort, tenants used an estimated $1,976,916 worth of services (health, criminal justice, homelessness) in the 12 months pre BCG tenancy commencement, compared to an estimated $852,314 worth of services in the 12 months post BCG tenancy commencement. Once the cost of providing BCG is factored in, this equates to a cost saving of $13,100 per tenant per year. In other words, housing a previously homeless person in BCG saves the government $13,100 per year per person in reduced service usage. A 65 per cent reduction in episodes requiring mental health services demonstrates that the model contributes to improved mental health and wellbeing (Parsell et al. 2016).

---

7   https://www.launchhousing.org.au/housingsupport/elizabeth-street-common-ground
8   https://www.missionaustralia.com.au/servicedirectory/191-housing-homelessness/camperdown-support-services-css-common-ground-sydney

Policy priority 2: Increase support to sustain the tenancies of people with lived experience of mental ill health who are able to live independently

Better support to sustain tenancies is a priority policy option that will allow more people with lived experience of mental ill health and housing insecurity to live independently. Tailored and flexible tenancy support programs that provide care coordination integrated with financial and housing support are a central strategy for this. The development and delivery of education programs for housing workers is another cornerstone of this policy priority.

2.1 Develop tailored tenant support programs that recognise the variable capacity and care needs of people experiencing both episodic and enduring mental ill health

A range of tenancy support services are already available in all Australian jurisdictions. While tenancy support services have been shown to be effective in stabilising tenancies and cost effective for government to provide (Zaretzky and Flatau 2015), these programs are not specifically designed to meet the needs of those with menta ill health, they do not have sufficient capacity to meet demand, and eligibility criteria mean that many who need this type of support cannot access it (e.g. private renters).

There is a need to develop tailored tenancy support programs that recognise the variable capacity and care needs of people experiencing both episodic and enduring mental ill health, and with eligibility criteria that are designed around people's identified support needs, rather than the type of housing they live in.

People with lived experience of mental ill health and housing insecurity require ongoing and flexible support to sustain their tenancies. Models that focus on care coordination integrated with housing, psychosocial and financial support are most likely to be successful. It is important that these programs be accessible to tenants in the social and private housing sectors alike.

Effective models need to combine:

- adequate financial support so people can afford and keep their housing
- support to manage tenancy related issues
- care coordination
- psychosocial support
- options for support from peer workers to assist with settling into a new tenancy and provide ongoing support.
- mental health training for housing workers and landlords.

Tenant support programs A range of general supports to sustain tenancies is already available. These include CRA, hardship variations on home loans and general income and employment support. More specific tenancy support services are often provided to people in social housing and a small subset of private renters. These tenancy support services help people to access housing or stabilise their tenancy to prevent homelessness.

Existing tenant support programs aimed at preventing people at risk of eviction from losing their tenancy and becoming homeless are usually short term. Private Rental Assistance programs typically provide financial relief in the form of bond loans and rental grants, subsidies and relief (Tually et al. 2015). Private Rental Brokerage Programs are tenant advice schemes that provide targeted early intervention and assistance in the form of information, advice and brokerage services designed to build tenancy capacity and establish links with the local private rental industry. They often use a case management model. The evidence shows that tenant support programs are effective and cost effective ways to assist people to maintain their tenancies and avoid homelessness (Zaretzky and Flatau 2015). However, the evidence also indicates that many repeatedly return to tenancy support programs when they encounter difficulties in sustaining their tenancies, indicating that these programs may be effective in averting an immediate housing crisis, but that they are not equally successful in facilitating long term secure tenancies (Tually et al. 2016).

Care coordination models Partners in Recovery (PiR),[9] which ceased in June 2019, was an example of a care coordination model intended to coordinate care for people with severe and complex mental ill health. It assisted people to live independently and sustain their tenancies and could be used as the basis for a model to provide coordinated and tailored tenancy support.

PiR was delivered by a consortia of local NGO services and Primary Health Networks; it involved a 'no closed door' approach where support facilitators connected clients to the appropriate services after learning about their needs, and was flexible in that it allowed additional funding not otherwise available in the public system to meet client needs. The flexibility of PiR considered the non-linear trajectories experienced by most people recovering from mental ill health, and the integrated and client-centred approach recognised the importance of making the mental health system navigation straight forward for clients who may be at-risk of, or experiencing crisis (Smith-Merry et al. 2016).

Other examples include My Home Living Care[10] (home care and community support services for people with a disability or who are aged); the Recovery Assistance Program[11] (psychosocial rehabilitation); and Pathways to Recovery,[12] which offers a range of disability and mental health support services in South Australia, including support coordination, outreach support provided in home to support daily living, community participation, skills development, social support, independent living support, and mental health support.

The NSW Aboriginal Housing Office's Services Our Way Program (SOW)[13] is an Aboriginal-led, trauma-informed care coordination service for vulnerable Aboriginal people and families. The program offers holistic support (not-specific to 'mental-health', or 'domestic family violence' or 'drug and alcohol' etc). It supports vulnerable Aboriginal people and families to engage effectively with supports and service providers so that they can access the right type of supports where and when they need it.

---

9   https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pir
10   https://myhomelivingcare.com/
11   https://www.shelterme.org.au/recovery-assistance-program-rap-darwin
12   http://www.pathwaystorecovery.com.au/
13   https://www.aho.nsw.gov.au/programs/services-our-way

2.2 Develop and deliver training and resources to grow the capacity of housing workers to sustain the tenancies of those with lived experience of mental ill health

"

Training should incorporate awareness about how to identify early warning signs of mental illness and the benefits of early intervention. It should also provide advice on appropriate interventions to stabilise existing tenancies for people with poor mental health, such as connecting tenants to mental health services or care coordinators. (policy development participant)

Housing workers in both the private rental market and in social housing (e.g. landlords, tenancy managers, real estate agents) have an important role to play in assisting people to maintain their tenancies. Frontline housing workers are often in a position to identify vulnerable tenants, detect when a crisis may be emerging and link tenants with the right supports to assist them to sustain their tenancy. However, due to high workloads, a lack of understanding and knowledge, and a lack of resources housing workers can struggle to identify, monitor and appropriately respond to tenancy issues among people with lived experience of mental ill health.

"

The workers need to have some understanding of the issues that we have, and it should be mandatory that they need to do some kind of classes or sessions so they have a basic understanding instead of having no concept what we're dealing with. (consumer, Sydney)

The capacity of housing workers could be extended by developing and delivering mental health training for front line workers and managers in order to increase their capability to identify and respond to potential housing issues among people with lived experience of mental ill health. The training should be backed by online resources available to workers to enable them to respond swiftly and appropriately.

"

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. (housing worker)

This training would need to expand beyond mental health first aid training[14] to incorporate elements on how to identify and respond to early warning signs of mental ill health, managing difficult behaviours and trauma informed care and practice. [15]

"

I think one of the big things … is around that psychological safety. I think that real trauma informed approach, … because people physically might feel safe, but psychologically they don't due to trauma and experience, and so on. That massively impacts people's ability to sustain tenancy … people are just moving from tenancy to tenancy, but they are never actually achieving that psychological sense of safety. We see that a lot too. (service provider)

---

[14] https://mhfa.com.au
[15] E.g. Blue Knot (https://www.blueknot.org.au); Mental Health Coordinating Council training (http://www.mhcc.org.au/ learning-development); use of Trauma-Informed Care and Practice Organisational Toolkit (TICPOT) (http://mhcc.learningcart.com/content/TICPOT.aspx).

Specifically, training will need to advise on how to link tenants with effective supports and care coordination to address both their mental health and housing issues.

Organisations such as the Community Housing Association (CHIA), in conjunction with mental health organisations and input from people with lived experience of mental ill health and housing insecurity, would be well placed to contribute to the delivery of landlord education programs and resources.[16] To be most effective, this training should be delivered to workers and landlords in both the social and private housing sectors.

Policy priority 3: Strengthen early intervention and prevention

Early intervention and prevention can avoid many issues from occurring or escalating and was identified by the research as a priority area for policy. Prevention includes initiatives that identify risk factors and aim to mitigate these, sustain existing tenancies and prevent people from becoming homeless. Early intervention initiatives offer quick responses when a person becomes unwell or first experiences housing insecurity.

3.1 Implement mechanisms and provide resourcing to facilitate better coordination between parts of the clinical and community mental health systems and the housing and homelessness systems

“

Service silos within mental health and across portfolios (e.g. housing, justice, employment) remain a large barrier to the better coordination of services. Political commitment is needed to break through these silos. (policy development participant)

Trajectories research identified that continuity of care is an important factor in recovery and in helping people to stay well. Conversely, a lack of continuity of care means that people repeatedly enter into and exit the system, which exposes them to a downward cycle that continually erodes their resources and mental health. A lack of continuity of care, insufficient duration of support and an inability to access supports and services quickly when they are needed are key system gaps, which if addressed, could prevent many crises form occurring.

“

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)

Analysis of state, territory and federal housing, homelessness and mental health policies shows that they are essentially separate policy systems with little integration. This contributes to poor housing and health outcomes for people with lived experience of mental ill health (Brackertz et al. 2018: 29).

“

… and when you're unwell, how do you navigate the system about where do you get assistance from and what's available, especially in regional areas too, and then you haven't got transport. So sometimes I think you fall through the gaps. (consumer, Berri)

---

[16] Work towards this is underway in some jurisdictions (e.g. NSW).

These gaps are due to factors such as: government silos and lack of integration across the clinical, community mental health, housing and homelessness systems; 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) (Brackertz et al. 2020).

There are many examples of service integration at the local level. However, there is a need for high level policies, guidelines and MOUs for service coordination, including joined up funding and agreed outcomes linked to KPIs. This needs to include good and genuine communications and networks across government branches. Implementation could be based on geographical areas, hospital networks, Primary Health Networks, etc.

At the service level it is necessary to properly resource support coordination via dedicated staff time, platforms and systems that support sharing of data for planning purposes (e.g. vacancies, location of stock, client information). This includes addressing issues around privacy and consent using well implemented consent to share information across care providers, explained in an accessible manner that makes sense to the consumer.

On the individual level, the relationship between the worker and the person experiencing mental ill health is important in providing high quality and effective care.

A number of Australian state and territory governments have achieved a degree of system integration in housing and mental health service provision. However, this is a recent phenomenon and has occurred in an ad hoc manner, with significant differences between states and territories in the scope of system integration. The NSW Housing and Mental Health Agreement is an example of a mechanism that facilitates service and systems coordination.

Housing and Mental Health Agreement (HMHA)

The Housing and Mental Health Agreement (HMA) commenced in 2011 and is an example of collaboration between the housing and mental health systems in Australia. It is an agreement between NSW Health and the NSW Department of Family and Community Services (now Department of Communities and Justice) encompassing all its agencies: Housing NSW; Aboriginal Housing Office; Ageing, Disability and Home Care, and Community Services. It recognises that NGOs are key providers of services to people with mental ill health and signatory departments are committed to working in partnership with NGOs, and their peak organisations to improve outcomes for this group of people.

The HMHA provides the overarching framework for planning, coordinating and delivering mental health, accommodation support and social housing services for people with mental ill health who are living in social housing or who are homeless or at risk of homelessness. It includes a high level action plan to support the implementation of the Agreement. Commitments within HMHA have enabled the implementation of programs such as HASI. A 2019 review identified generally broad support and a continued need for the HMHA and noted that importance of building a shared perspective of its purpose. I was noted the HMHA should be updated to reflect a more diverse and networked service environment and contemporary language and content, including input from those with lived experience.

The MOU between Housing SA and SA Health, Mental Health and Substance Abuse is another example of system integration in mental health and housing provision. It was established in 2007 and updated in 2012 to 'guide the coordinated delivery of mental health services, psychosocial support and general housing services' (South Australian Government 2012). The agreement provides management guidelines for information sharing; timely pro-active, early intervention and preventative approaches; sensitive tenancy monitoring approaches, and collaborative and flexible arrangements between housing agencies (South Australian Government 2012).

3.2 Improve transitions out of institutional care ('no exits into homelessness')

> **"**
>
> *'No exits into homelessness' should be a whole of government key performance indicator applied to clients of all state funded mental health services – both Government and NGO provided. Housing status should be recorded on entry, at every review and on exit. The data needs to be publicly reported and seen as a human right. Housing supply needs to match demand. (policy development participant)*

Improving transitions out of institutional care to eliminate exits into homelessness requires a consistent Australia wide formal policy of no exits into homelessness when people with mental illness are discharged from institutional care (e.g. hospitals and prisons), coupled with and supported by comprehensive and appropriately resourced discharge plans that integrate care coordination and housing support.

Transitions from institutional care, such as hospitals or prisons, are points at which people are at high risk of 'falling through the cracks' in the system and pose significant risks for housing and mental health (Brackertz et al. 2018). People may become either stuck within the system; be discharged into homelessness; or lack adequate intensity and continuity of supports, leading them to experience a relapse.

> **"**
>
> *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 … they were like, 'These are the homeless numbers you can call'. That is absolute crap. (consumer, Brisbane)*

Hospital and mental health institution discharge processes can significantly impact prospects for mental health recovery and wellbeing. People generally exit mental health institutions and hospital settings into community mental health care, and while some enter into housing and support programs, others exit into unstable housing and inconsistent supports (Bryant Stokes 2012). Reasons for discharge into unstable housing and homelessness include: difficulty identifying people who are homeless or at risk of homelessness; constraints on hospital capacity and time pressures can affect discharge assessments and lead to patients being discharged too quickly; delays or lack of follow up after discharge; follow up is also only possible if the consumer has been discharged to a stable address; difficulty accessing housing and community mental health services after discharge; and lack of coordination across sectors (Brackertz et al. 2018).

> **"**
>
> *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. (service provider)*

Addressing these issues will require a suite of interventions including a commitment to a nationally consistent formal policy of no exits into homelessness from institutional care. This will need to be backed by adequate availability of social housing and supported housing, resourcing to develop comprehensive mental health discharge plans that are supported by adequate availability of supports in the community to meet the needs identified in the plans.

There is scope to expand existing effective programs that provide housing support to those exiting institutions, such as those that provide time limited transitional housing (e.g. Transitional Housing Teams), and programs that provide discharge planning and support (e.g. Royal Perth Hospital Homelessness Team).

Treating mental illness in people who are homeless helps them maintain housing. For example, in Victoria, there are specific Homeless Outreach Psychiatric Services (HOPS) operated by Alfred Health,[17] Royal Melbourne Hospital, St Vincent's Health, and soon by Eastern Health. GreenLight[18] is a partnership between Sacred Heart Mission, VincentCare and the Salvation Army assisting people sleeping rough across inner Melbourne to settle into their new home and community and stay housed.

Transitional Housing Teams (THT), Queensland Transitional housing programs aim to improve living skills and housing stability for tenuously housed patients with mental illness. Queensland established a Transitional Housing Team in 2005 as part of a government response to homelessness among people with mental illness. The team provided time limited housing and intensive living skills training and support to clinically case managed patients. A 2014 Australian study of mental health hospital discharge compared the outcomes of consumers participating in a transitional housing treatment program (THT) to a control group drawn from neighbouring hospital district mental health services without a THT. Consumers from both groups received similar clinical care in terms of length of hospital stay and intensity of treatment and were discharged between 2006 and 2009. The study measured total acute psychiatric inpatient days, problems with living conditions, illness acuity and emergency department presentations for a year before entry and a year after exit from THT (Siskind et al. 2014).

In this sample, the THT averted 22.42 psychiatric inpatient bed-days per THT participant after adjustment for age and Health of the Nation Outcome Scales (HoNOS) score, while the program also resulted in a greater improvement in living conditions. The costs saved on bed-days-averted more than eclipsed the cost of the THT in this case (Siskind et al. 2014). This suggests that post-discharge integrated mental health and housing supports can significantly improve outcomes for people with lived experience of mental ill health and produce downstream savings for government. Examples of THT currently operating in Australia include the Housing and Mental Health Pathway Program delivered by HomeGround and St Vincent's Inpatient Mental Health Service in Victoria. This program targets consumers at St Vincent's and The Alfred Hospital psychiatric wards who are not currently case managed, and are experiencing or at risk of homelessness after being discharged (Launch Housing 2018)

The Royal Perth Hospital Homeless Team (RPH HT), Western Australia commenced in July 2016 as a collaboration between Royal Perth Hospital and the Homeless Healthcare General Practice; the aim is to improve outcomes for homeless patients by supporting them through their time in hospital, improving discharge planning and continuity of care and linking them with community-based services to address their underlying health and psychosocial needs. RPH HT is modelled on the evidence-based UK Pathway model of hospital homeless healthcare, adapted to the Perth homelessness and health sector context. It provides GP care, care coordination and discharge planning for patients who are homeless. The team is made up of a clinical lead, administration assistants, GPs, nurses and a caseworker. An evaluation showed that contact with the team reduced emergency department presentations and mental health inpatient care and fewer patients discharged themselves against medical advice. These improvements were

---

17   https://www.alfredhealth.org.au/services/homeless-outreach-psychiatric-service
18   https://www.sacredheartmission.org/seek-help/housing-support/greenlight-supportive-housing

estimated to reduce hospital use by about $7,900 per patient. Given the average cost of the program was about $850 per patient, this represented a return on investment of about 9:1 (Gazey et al. 2019).

3.3 Implement population based screening to identify those at risk

Trajectories research identified that the housing, homelessness and mental health systems are crisis driven. Consequently, many opportunities for early intervention are missed and people are often only able to access help when they are experiencing a severe crisis.

Population based initiatives and broad based screening to identify risk factors that may contribute to mental ill health and services and supports that are accessible before a severe crisis occurs are key initiatives for early intervention and prevention.

Examples of initiatives that could be delivered in collaboration with schools include social and emotional wellbeing checks, initiatives to identify families at risk, and capacity building resources and training for parents and teachers. Generalist health services, such as GP clinics, are also sites where risk identification and education initiatives could be implemented.

Effective initiatives for early intervention and prevention will require a coalition of service and support providers. While not specifically targeted at people with lived experience of mental ill health, the Coalition of Schools and Services model is an example of a successful model to prevent homelessness in school children.

The Coalitions of schools and services model (COSS) is a model for the identification of at-risk children, young people and families and early intervention. The model aims to create place-based collective impact in order to identify young people at risk of homelessness and disengagement in school and intervene quickly to divert them from those journeys. The Geelong Project in Victoria (MacKenzie and Thielking 2013) is an ongoing collaboration between a number of secondary schools and support services in Geelong that are directed towards preventing and responding early to youth homelessness. It uses 'population screening' to identify high risk young people so as to enable early and targeted intervention. Key transition points (e.g. leaving school) are recognised as intervention triggers and the project 'places students at the centre of a web of service provision'. Three tiers of support are assigned: active monitoring; casework and counselling; and wrap-around case management.

The outcomes achieved by The Geelong Project (TGP) of a 40 per cent reduction in adolescent homelessness and a 20 per cent reduction in early school leaving has demonstrated what a place-based approach is capable of achieving. The COSS model of early intervention is an exemplar of 'collective impact'. It involves collaborative decision-making at executive and worker levels within a community collective of agencies and schools, under a formal memorandum of understanding. The success factors of the COSS model include local community leadership as a participating key stakeholder, ideally the lead agency responsible for the early intervention support work; the construction of a formalised community collective through a community development process; a population-screening methodology that can proactively identify vulnerable youth and families before the onset of crises; a flexible practice framework that can efficiently manage proactive support to at-risk youth and their families, while still able to be reactivated when crises occur; a single-entry point into the support system for young people in need; and a data-intensive approach to risk identification, monitoring and outcomes measurement (McKenzie et al. 2020).

3.4 Ensure that people have rapid access to clinical and community based mental health services when they need it (step up step down)

66

I went to places like [community mental health provider] and they interviewed me … [t]hey 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, Brisbane)

Trajectories research found that transition from being well supported to being excluded, cycling or stuck without adequate support can happen rapidly–it is not a slow or stepped progression and is often 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 (Brackertz et al. 2020). Step up step down support is an important component of early intervention and prevention. The ability to rapidly access treatment and supports when a person becomes unwell can in many instances avert a major crisis.

66

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)

The stepped care model is central to the Australian Government's mental health reform agenda and guides the mental health activities of Primary Health Networks (PHNs) (Department of Health 2017). 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. The other pole represents services for people requiring specialist treatment and often hospitalisation. There is a large service gap between these two poles, sometimes referred to as the 'missing middle' (Productivity Commission 2020a: 529).

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 (Brackertz et al. 2020). The 'missing middle' reflects the failure of clarity and coordination where primary and acute mental health care meet (Productivity Commission 2020a: 529).

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. Trajectories research found that 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 (Brackertz et al. 2020). Consumers and service providers reported that there were long waits and significant barriers to accessing the mental health system. 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.

High-intensity and complex care are highly rationed and are generally only accessible to people in crisis. Consumers who participated in Trajectories research 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.

Expanding the availability of stepped care would address a major gap in early intervention and prevention, by bridging the gap between low intensity and acute care supports. This requires addressing gaps in the availability of specialist community mental health services.

How can we make this happen?

Research participants in the policy development process identified the need to combine advocacy with sound evidence on the economic and social benefits (e.g. Social Return on Investment, social determinants of health) generated by additional social housing development.

Respondents specifically identified the need for an advocacy coalition between mental health advocates (consumers, carers, families, services and peak bodies), housing and homelessness peaks, housing providers, and homelessness service providers.

"

Since policy decisions are not purely driven by data, along with the provision of information, there should be a strong campaign telling individual stories of people who are suffering by being homeless and also stories of recovery to demonstrate the value of housing. This would require engagement with the media sector to tell these stories, and also finding individuals and families who are prepared to have their stories told and speak publicly. No individual organization has the capacity to run such a campaign, so it would require a broad coalition of organizations across the housing, social welfare and mental health sector to collectively develop a strategy and lobby for change. (policy development participant)

Several respondents highlighted the need for long term and bipartisan political commitment to developing more housing. Specifically, they highlighted that the COVID-19 response shows that fast action on difficult issues is possible if there is a political will to do so.

"

Government has demonstrated their ability to act quickly, bipartisan and proactively during COVID, despite the expense, recognising the mental health/wellbeing, as well as [the] physical health needs of the whole population. (policy development participant)

Several participants noted the need for a whole of government response (spanning housing, health and treasury), including the need for the Australian Government to lead by providing funding to the states and a state commissioning framework that identifies the expressed need for housing for people experiencing mental ill health. Several respondents highlighted the need to reframe the understanding of the problem and broaden evidence away from models that overemphasise medical evidence and costs over evidence on social benefits, human rights emphasis, and housing as a social determinant of health. Housing policy would be better to cease narrowing access to housing by particular cohorts, in favour of recognising that all people have a right to housing. There is a need to recognise that providing housing and mental health care is a social investment, not an expense.

"

Whole of government responses are important and a human rights emphasis is helpful. Current thinking within health and mental health does not prioritise human rights and continues to overemphasise medical models and evidence relative to social models and evidence. (policy development participant)

Appendix 1: Policy options matrix

This table shows the full range of policy options identified by the Trajectories research prior to the Delphi process

	Policy interventions for people experiencing mental ill-health who				
	Can sustain independent housing in the private rental market/home ownership	Can sustain independent housing in social housing	Require a medium-term housing and support response	Require ongoing housing with support	Experience persistent homelessness
Sustain tenancies	• Support to sustain tenancies at risk, including short-term financial assistance • Ongoing support to sustain tenancies (if needed) • Programs to develop tenancy skills		• Increase accessibility and availability of psycho-social support	• Provide onsite 24-hour psychosocial support	
Availability of safe, secure, appropriate, and affordable housing	• Increase affordability in the private rental market (PRM), e.g. by providing ongoing and adequate rental assistance (currently available: private rental assistance, Commonwealth Rent Assistance) • Address discrimination in the PRM • Provide assistance to find and access private rental housing	Increase accessibility of social housing by: • Developing more affordable housing • Building more public housing • Head leasing • Choice based letting	Increase accessibility of supported housing by: • Addressing the lack of supported housing with integrated mental health support • Providing medium-term responses that integrate accommodation and support	• Expand integrated housing and support models that work well	Provide better housing options /housing pathways by: • Expanding 'Housing First' approaches • Meeting the gap in availability of long- and medium-term housing options • Improving effectiveness of Specialist Homelessness Services in terms of providing housing outcomes for people experiencing mental ill health • Improving service coordination • Developing more long-term supported accommodation with 24/7 support

Policy interventions for people experiencing mental ill-health who

	Can sustain independent housing in the private rental market/home ownership	Can sustain independent housing in social housing	Require a medium-term housing and support response	Require ongoing housing with support	Experience persistent homelessness
Housing laws and policies	• Tenancy laws to provide better security, protection, and control over living environment (e.g. no ground evictions, longer term leases, pets)	• Anti-social behaviour policies • Temporary absences • Information sharing	• Enable people to stay in same house, with support that fluctuates as required	• Flexible arrangements that enable a choice in the number of residents and shared living spaces	
Workforce capacity	• Landlord and real estate agent training and education programs to address discrimination and identify, monitor and respond appropriately to tenants with mental illness	• Train housing workers to work with people experiencing mental ill health to identify, monitor and respond appropriately to deterioration in mental health (i.e. appropriate referrals)	• Train mental health workers to understand the housing needs of people with severe and enduring mental health needs		• Assertive street outreach
Early intervention and prevention	• Early intervention and prevention tenancy support programs tailored to people experiencing mental ill health		• Better transitions and discharge planning from institutions • No exits into homelessness		• Rapid rehousing • Rapid access to clinical mental health support when unwell • Continuity of care between acute episodes
Physical environments that enable recovery		• Housing located in welcoming communities	• Location that maximises social inclusion • Design features such as soundproofing, private and secure entrances, sensory rooms and gardens • Space for support networks (family and friends) to visit and stay • Women only properties		

Trajectories: the interplay between mental health and housing pathways
Policy priorities for better access to housing and mental health support for people with lived experience of mental ill health and housing insecurity

28

Policy interventions for people experiencing mental ill-health who

	Can sustain independent housing in the private rental market/home ownership	Can sustain independent housing in social housing	Require a medium-term housing and support response	Require ongoing housing with support	Experience persistent homelessness
Better coordination of services		• Better referrals to and between housing providers • Person centred support • Improve coordination of services • Better continuity of care			• Improved data collection (e.g. by name lists)
Better service models			• Step up / step down support • Ensure continuity of care • Culturally appropriate services • Holistic support that meets level of need • Connection to a trusted worker • Trauma counselling • Critical time intervention models • Targeted interventions for vulnerable cohorts (youth, LGBTIQ+, CALD, Aboriginal and Torres Strait Islander people)		
System integration		• Implement interventions for better system integration, clear lines of responsibility, service integration and continuity of service • Identify service / housing of last resort			

References

AHURI (2019a) *Understanding the funding gap for social housing and different ways to fund it*, AHURI Brief, Australian Housing and Urban Research Institute, Melbourne, https://www.ahuri.edu.au/research/ahuri-briefs/understanding-the-funding-gap-for-social-housing-and-different-ways-to-fund-it.

AHURI (2019b) *What is head leasing?*, AHURI Brief, Australian Housing and Urban Research Institute, Melbourne, https://www.ahuri.edu.au/research/ahuri-briefs/what-is-head-leasing.

Australian Institute Health and Welfare [AIHW] (2017) *National Social Housing Survey 2016 online and supplementary data tables*, August.

Baxter, A.J., Tweed, E.J., Katikireddi, S.V. and Thomson, H. (2019) 'Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials', *Epidemiology and Community Health*, vol. 73, no. 5, pp. 379-387.

Beer, A., Faulkner, D. and Gabriel, M. (2006) *21st century housing careers and Australia's housing future: literature review*, AHURI Research Paper No. NRV2-1, Australian Housing and Urban Research Institute Limited, Melbourne, https://www.ahuri.edu.au/research/nrv-research-papers/nrv2-1.

Brackertz, N., Borrowman, L., Roggenbuck, C., Pollock, S. and Davis, E. (2020) *Trajectories: the interplay between housing and mental health pathways*. Final research report, AHURI Professional Services, Australian Housing and Urban Research Institute, Melbourne, https://www.ahuri.edu.au/research/research-papers/trajectories-report.

Brackertz, N., Wilkinson, A. and Davison, J. (2018) *Housing, homelessness and mental health: towards systems change*, AHURI Professional Services, Australian Housing and Urban Research Institute, Melbourne, https://www.ahuri.edu.au/research/research-papers/housing-homelessness-and-mental-health-towards-systems-change.

Bruce, J., McDermott, S., Ramia, I., Bullen, J. and Fisher, K. (2012) *Evaluation of the Housing and Accommodation Support Initiative (HASI),* Social Policy Research Centre, Sydney.

Bryant Stokes, A. (2012) *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, WA Mental Health Commission, Perth.

Bullen, J., Whittaker, E., Schollar-Root, O., Burns, L. and Zmudzki, F. (2015) *In-depth evaluation of Camperdown Common Ground: Permanent housing for vulnerable long-term homeless people*, Final Report, December, Social Policy Research Centre, University of New South Wales.

Conroy, E., Bower, M., Flatau, P. and Zaretzky, K. (2014) *The MISHA Project: From Homelessness to Sustained Housing 2010-2013*, Research Report, Centre for Social Impact, University of Western Australia, University of Western Sydney, University of NSW, Sydney, https://www.missionaustralia.com.au/documents/279-from-homelessness-to-sustained-housing-2010-2013-misha-research-report-2014/file.

Department of Health (2017) *PHN primary mental health care flexible funding pool implementation guidance: stepped care*, Australian Government, Canberra.

Dunt, D.R., Benoy, A.W., Phillipou, A., Collister, L., Crowther, E.M., Freidin, J. and Castle, D.J. (2017) 'Evaluation of an integrated housing and recovery model for people with severe and persistent mental illnesses: the Doorway program', *Australian Health Review*, 41(5):573-581.

Gazey, A., Vallesi, S., Cumming, C. and Wood, L. (2018) *Royal Perth Hospital Homeless Team: A report on the first 18 months of operation*, School of Population and Global Health, UWA, http://homelesshealthcare.org.au/wp-content/uploads/2018/07/Royal-Perth-Hospital-Homeless-Team-FINAL-report-June-2018.pdf.

Greenwood, R. M., Schaefer-McDaniel, N. J., Winkel, G. and Tsemberis, S. J. (2005) 'Decreasing psychiatric symptoms by increasing choice in services for adults with histories of homelessness', *American Journal of Community Psychology*, 36(3): 223–238.

Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S. and Fischer, S.N. (2003) 'Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and housing first programmes', J*ournal of Community and Applied Social Psychology*, vol. 13, no. 2, pp. 171-186.

Johnson, G. and Chamberlain, C. (2015) *Evaluation of the Melbourne Street to Home Program*, Final Report, March, Centre for Applied Social Research, RMIT University.

Johnson, G., Parkinson, S. and Parsell, C. (2012) *Policy shift or program drift? Implementing Housing First in Australia*, AHURI Final Report No. 184, Australian Housing and Urban Research Institute Limited, Melbourne, https://www.ahuri.edu.au/research/final-reports/184.

Launch Housing (2018) *Housing Mental Health Pathways Program, Launch Housing*, Melbourne, accessed 7 March 2018, https://www.launchhousing.org.au/service/housing-mental-health-pathways-program/.

Lawson, J., Pawson, H., Troy, L., van den Nouwelant, R. and Hamilton, C. (2018) *Social housing as infrastructure: an investment pathway*, AHURI Final Report No. 306, Australian Housing and Urban Research Institute Limited, Melbourne, https://www.ahuri.edu.au/research/final-reports/306, doi:10.18408/ahuri-5314301.

Lee, S., Giling, J., Kulur, B. and Duff, C. (2013) *Exploring the impact of housing security on recovery in people with severe mental illness*. Summary Report, The Haven Foundation, https://www.mindaustralia.org.au/sites/default/files/Exploring_the_impact_summary_report.pdf

Ly, A. and Latimer, E. (2015) 'Housing first impact on costs and associated cost offsets: a review of the literature', *The Canadian Journal of Psychiatry*, vol. 60, no. 11, pp. 475–487.

Mackenzie, D. and Thielking, M. (2013) *The Geelong Project: A community of schools and youth services model for early intervention*, in National Homelessness Research Agenda 2009-2013, Swinburne Institute for Social Research, Swinburne University, Melbourne.

MacKenzie, D., Hand, T., Zufferey, C., McNelis, S., Spinney, A. and Tedmanson, D. (2020) *Redesign of a homelessness service system for young people*, AHURI Final Report No. 327, Australian Housing and Urban Research Institute Limited, Melbourne, https://www.ahuri.edu.au/research/final-reports/327, doi:10.18408/ahuri-5119101.

McDermott, S. (2017) 'Housing for Australians with serious mental illness', in J. Sylvestre, G. Nelson and T. Aubrey, *Housing, Citizenship, and Communities for People with Serious Mental Illness: Theory, Research, Practice, and Policy Perspectives*, Oxford University Press, New York: 300–329.

Meehan, T., Siskind, D., Madson, K. and Shepherd, N. (2010) *Final Evaluation Report of the Queensland Government's Housing and Support Program*, November, The University of Queensland, Department of Psychiatry and Service Evaluation and Research Unit The Park, Centre for Mental Health.

Mental Health Commission of Canada (2014) *National Final Report Cross-Site at Home/Chez Soi Project*.

Ong, R., Pawson, H., Singh, R. and Martin, C. (2020) *Demand-side assistance in Australia's rental housing market: exploring reform options*, AHURI Final Report No. 342, Australian Housing and Urban Research Institute Limited, Melbourne, https://www.ahuri.edu.au/research/final-reports/342, doi:10.18408/ahuri8120801.

Parsell, C. and Moutou, O. (2014) *An evaluation of the nature and effectiveness of models of supportive housing*, AHURI Positioning Paper No.158, Australian Housing and Urban Research Institute, Melbourne, http://www.ahuri.edu.au/publications/projects/p21024.

Parsell, C., Petersen, M., Moutou, O., Culhane, D., Lucio, E. and Dick, A. (2016) *Brisbane Common Ground evaluation*, University of Queensland, Brisbane.

Parsell, C., Tomaszewski, W. and Jones, A. (2013a) *An Evaluation of Brisbane Street to Home*, Final Report, March, Institute for Social Science Research, The University of Queensland.

Parsell, C., Tomaszewski, W. and Jones, A. (2013b) *An Evaluation of Sydney Way2Home*, Final Report, May, Institute for Social Science Research, The University of Queensland.

Pleace, N. (2016) *Housing First Guide: Europe*, February.

Productivity Commission (2020a) *Mental Health: Productivity Commission Inquiry Report Volume 2*, No. 95, Australian Government, Canberra, https://www.pc.gov.au/inquiries/completed/mental-health/report.

Productivity Commission (2020b) *Mental Health: Productivity Commission Inquiry Report Volume 3*, No. 95, Australian Government, Canberra, https://www.pc.gov.au/inquiries/completed/mental-health/report.

SA Health (2011) *Housing and Accommodation Support Partnership (HASP) Program*, Government of South Australia, Adelaide, https://www.sahealth.sa.gov.au/wps/wcm/connect/a15d58804b491c08aabcfaca9225b431/HASP+brochure-MH-12042011.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-a15d58804b491c08aabcfaca9225b431-niPTH2K.

SA Health (2013) *Evaluation of the Housing and Accommodation Support Partnership*, Government of South Australia, Adelaide.

Siskind, D., Harris, M., Kisely, S., Siskind, V., Brogan, J., Pirkis, J., Crompton, D. and Whiteford, H. (2014) 'A retrospective quasi-experimental study of a transitional housing program for patients with severe and persistent mental illness', *Community Mental Health Journal*, vol. 50, no. 5, pp. 538–547.

Smith, P. 2015, *Evaluation of the Individualised Community Living Strategy (ICLS)*, May.

Smith-Merry, J., Mellifont, D., Gillespie, J. and Salvador-Carulla, L. (2016) *Evidence check: recovery-oriented mental health models*, Sax Institute, https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0019/395002/Recovery-oriented-community-mental-health-models-SAX-REPORT.pdf.

South Australian Government (2012) *Memorandum of Understanding between the Minister for Social Housing and Minister for Mental Health and Substance Abuse*, Government of South Australia, Adelaide.

Stefancic, A. and Tsemberis, S. (2007) 'Housing First for long-term shelter dwellers with psychiatric disabilities in a suburban county: a four-year study of housing access and retention', *Journal of Primary Prevention*, vol. 28, pp. 265-279.

Tsemberis, S. and Asmussen, S. (1999) 'From streets to homes: pathways to housing consumer preference supported housing model', *Alcoholism Treatment Quarterly*, vol.17, pp. 113–131.

Mind Connect
1300 286 463

Carer Helpline
1300 554 660

mindconnect@mindaustralia.org.au

mindaustralia.org.au

Mind acknowledges that Aboriginal and Torres Strait Islander peoples are the Traditional Custodians of the lands on which we work and we pay our respects to Elders past, present and emerging. We recognise the intergenerational impact of the history of invasion, dispossession and colonisation and are committed to the recognition, respect, inclusion and wellbeing of Australia's First Peoples.

Mind values the experience and contribution of people from all cultures, genders, sexualities, bodies, abilities, spiritualities, ages and backgrounds. We are committed to inclusion for all our clients, families and carers, employees and volunteers.