Psychiatric Disability Services
of Victoria (VICSERV)

Psychiatric Disability Services of Victoria (VICSERV) welcomes the opportunity to provide feedback on the DoH (formerly DHS) ***Improving Public Housing Responses Strategic Project – New segmented waiting list proposal.***

VICSERV is the peak body for Psychiatric Disability Rehabilitation Support Services (PDRSS) in Victoria. Our members provide housing support, home-based outreach, psychosocial and pre-vocational day programs, residential rehabilitation, mutual support and self help, employment, training and support, carer education, respite and advocacy.

The project and proposed changes to the segmented waiting list has the potential to improve access to housing and support for people with a mental illness. Apart from the social and economic benefits that stable housing provides for people with a mental illness, it has also been shown to be associated with clinical improvement and reduced hospital readmissions.[1]

Overall, VICSERV supports the proposed new model.

The following feedback is offered in response to the discussion paper:

- The movement of DoH clients in disability or mental health residential facilities from Segment 2 to the new Homeless and Family Violence first priority group segment is welcome. The discussion paper makes specific mention of Secure Extended Care Units and Continuing Care Units. It is unclear whether or not clients of other mental health residential facilities such as Adult and Youth Residential Rehabilitation Units and Prevention and Recovery Care (PARC) services would be eligible to apply for the new segment. In order to prevent the revolving door of homelessness and hospitalisation experienced by so many people with a severe mental illness, all mental health residential facilities should be included in the first priority segment.

- Simplifying the application process and a greater acknowledgement of and support for service providers' professional assessment is also welcome. This will assist with a shared understanding between Housing and Community Building and support providers of tenants' support needs. Assistance to maintain tenancy can also be better coordinated. Training on mental health issues for Office of Housing workers may be useful to strengthen the relationship between support providers and tenants with a mental illness.

[1] Housing and support: a platform for recovery, VICSERV 2008 (attached)

- It is recommended that the list of mental health support programs that will be eligible to make direct applications to the Office of Housing includes the Commonwealth funded Personal Helpers and Mentors (PHaMs) program. PHaMs is an outreach program for clients both within and outside the PDRSS system.

- Families often provide accommodation for their adult sons and daughters with a mental illness. Often this is because there is no other alternative available rather than it being the choice of either party. In some circumstances, such as the case of adult children living with ageing parents, the definition of 'unsuitable housing' should apply.

- The possible further adjustment outlined in Section 3 makes clear sense and is broadly supported by VICSERV.

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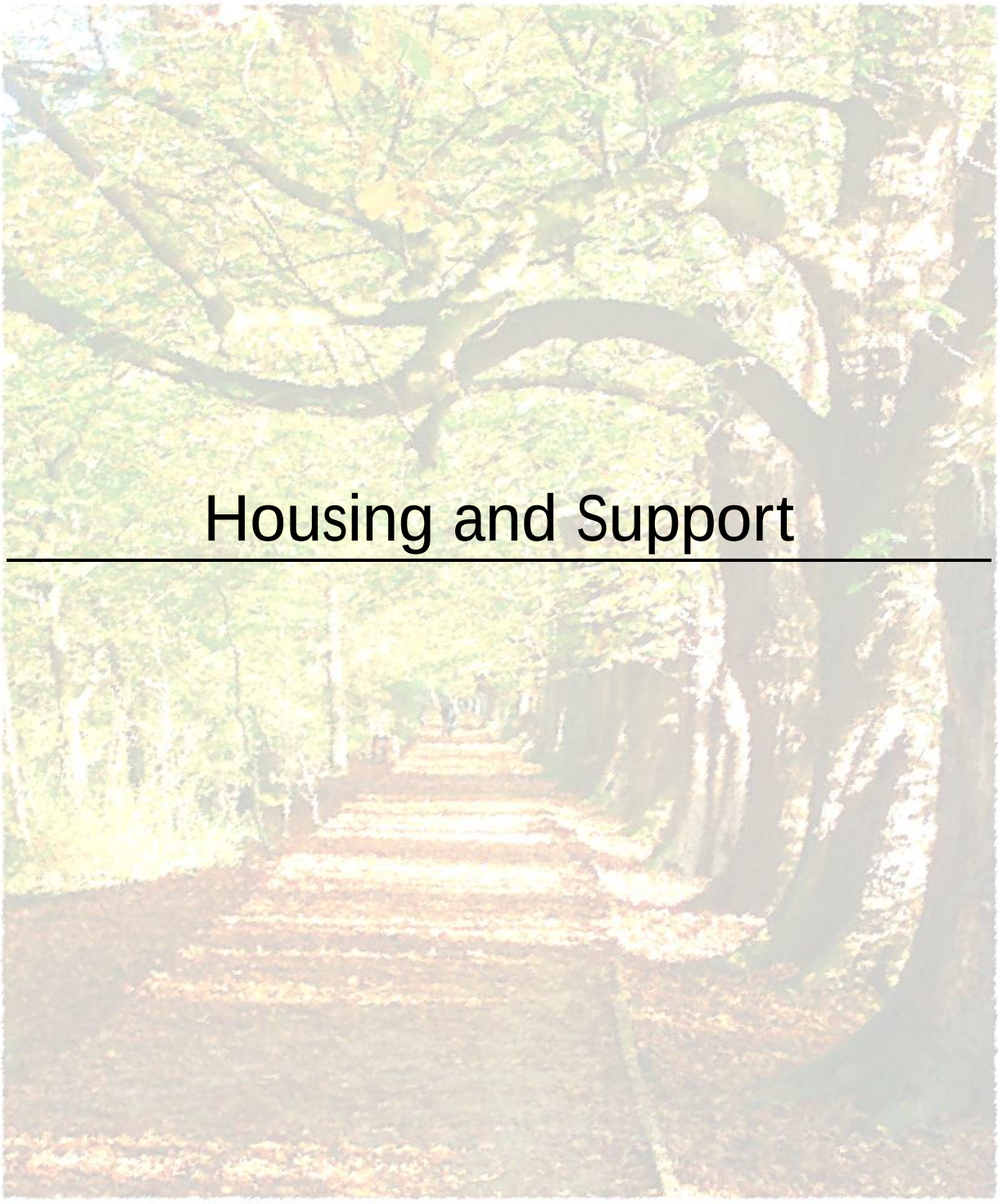

Housing and Support

DoH *Improving Public Housing Responses Strategic Project* - VICSERV Proposal 2010
and the *Housing and Support* paper from VICSERV's *Pathways to Social Inclusion*

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VICSERV Pathways to Social Inclusion

Housing and Support: a platform for recovery

Facing the facts

- At least 42% of people with severe mental illness are currently housed in tenuous forms of accommodation
- Research shows that two-thirds of consumers identify housing and housing support as the most important issues in their lives
- Only 27% of people with psychiatric disability are buying their own homes compared to 70% of the mainstream population
- Housing supply is insufficient. Private rental is becoming increasingly out of reach.

Better outcomes are possible

- Housing means affordable and appropriate accommodation, plus the supports necessary, to maintain tenure
- There is a strong association between housing and clinical improvement
- The needs of people living with severe mental illness seeking stable and appropriate 'homes' must be addressed if we are serious about supporting recovery
- We know there are cost savings to be made in a range of areas including clinical, emergency and crisis services through the provision of stable, appropriate housing.

Our call for action

- Introduce housing policy and options with an explicit focus on people recovering from severe mental illness
- Scalable, flexible models of housing-linked support
- Economic modelling of costs/benefits of stable housing
- Address the critical issue of ageing carers and housing risks.

Housing and Support: a platform for recovery

Mental health service consumers repeatedly tell us…[2]

… That stable housing is critical to the quality of their lives, and support to retain that housing is the most important issue they are faced with.

We know the housing need; we have the evidence for practice

It is time for planned investment and action that brings together mental health and housing agendas to deliver 'homes' for people with severe mental illness.

- At least 42.0% of people with severe mental illness are currently *housed in tenuous forms of accommodation* such as hostels, boarding houses, hotel/rented rooms, emergency accommodation, shelters, no fixed address. It is likely that many are cycling through different types of tenuous housing and primary homelessness ('sleeping rough'). The movement through tenuous housing and primary homelessness—and the repeated loss of stable accommodation—is captured by the concept of *iterative homelessness*.

- Research shows that two-thirds of consumers identify *housing and housing support* as the most important issues in their lives.

- There is a strong association between housing and clinical improvement. Stable housing has been shown to be a better predictor of reduced hospital admissions than clinical interventions.

This story is not new. In 1993, the *Report of the National Inquiry into the Human Rights of People with Mental Illness*, stated:

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

We know the barriers to housing

- Public debate on affordable housing has a strong focus on home ownership and working families. The reality is that most people living with severe mental illness are far removed from the possibility of home ownership. Only 27% of people with psychiatric disability are buying their own homes compared to 70% of the mainstream population.

[2] Please refer to *Housing and Support – Policy and Practice Failure. Background Paper* for details and references.

- Housing supply is insufficient. Private rental is becoming increasingly out of reach of people living with severe mental illness. The supply of public and community housing is inadequate with successive governments over a number of years failing to properly resource the social housing sector. Between 1996 and 2005, the *Commonwealth Government stripped more than $3 billion from funding to social housing*, despite significant increases in the need for affordable rental accommodation due to upward trends in the housing market.

- There is no systematic policy or plan for developing and maintaining an adequate stock of housing or for a flexible, supported housing program with state-wide coverage that directly addresses the (changing) needs of people living with severe mental illness. We appear to be spending a disproportionate amount on 'housing' people in hospitals (or prisons).

- For people with a severe mental illness, housing means affordable and appropriate accommodation, plus the supports necessary, to maintain tenure. Yet there is no overarching and consistent approach to providing housing linked support that meets the changing needs of these consumers.

- People living with severe mental illness are often 'invisible' in 'ageing in place' policy and program initiatives.

- There is *inadequate linkage* between mental health and housing policy and planning agendas.

We know what works

Stable, affordable, (individually) appropriate housing options with flexible support. Key features are:

- Housing policy and options with an explicit focus on people recovering from severe mental illness

- The provision of secure and ongoing tenure in appropriately designed and located housing stock

- Housing options that are integrated into the community in a manner that addresses stigma

- Choice of housing based on consumer preference e.g. a 'home', over which consumer control is fostered

- Comprehensive and coordinated ongoing support tailored to individual needs as they change over time—provided in the person's home (rather than in a transitional environment)

- Eligibility for housing based on need and de-linked from compliance and wellness requirements.

We know there are *cost savings* to be made in a range of areas including clinical, emergency and crisis services through the provision of stable, appropriate housing that comes with long-term support.

Addressing housing and support needs: turning knowledge into action together

The *needs of people living with severe mental illness for stable, appropriate 'homes' must be addressed if we are serious about supporting recovery* and maximising the positive impact of Psychiatric Disability Rehabilitation and Support Services (PDRSS) and clinical interventions on that journey. To successfully meet housing needs it is necessary to:

- Respond to the diversity of the population of people living with severe mental illness, taking into account age, gender, capacity, culture, relationships, and preferences

- Remove any requirement for 'wellness' from housing eligibility requirements

- Address stigma

- Ensure the supports to maintaining housing are flexible and readily available

- Make housing and support 'everybody's business'

- Invest in the short, medium and long term.

There are important opportunities to progress a *specific housing agenda* for people living with severe mental illness at both State and Commonwealth Government levels by:

- Actively participating in and influencing affordable housing policy directions and initiatives

- Ensuring mental health policy and practice developments address the critical issues of flexible (housing) support

- Promoting strong inter-sectoral linkages and partnerships that actively promote shared approaches and joint accountability for achieving housing outcomes.

Carers as housing and support providers

Carers can spend over 100 hours a week providing care for people with mental illness.[3] Their role is hidden or underestimated in many ways, and this is largely the case when in comes to providing housing and support options for their care recipients. Carers are housing and support providers, and they provide these in the long and short term, as well as in planned and emergency contexts. The extent of the role of carers in these capacities is not well understood, and there are emerging risks and vulnerabilities as some carers age and others face their own housing affordability issues.

It is critical to build a comprehensive knowledge of the part carers play in responding to the housing needs of people with mental illness. This will enable us to better understand their risks and vulnerabilities and provide adequate and appropriate supports to ensure sustainability of this 'hidden' housing sector.

At the present time, and in this paper, VICSERV is not fully addressing the issue through the propositions offered, but does seek to ensure it is on the mental health reform 'radar'. VICSERV plans to undertake a more detailed analysis of carer contributions, roles and needs in its next phase of proposition development and invites interested stakeholders to engage in dialogue and a partnership approach to this work.

The VICSERV proposition: making housing and support 'everybody's business'

A respect for human rights and practice evidence combine to underscore the critical importance of responding to the housing and related support needs of people with severe mental illness as a matter of priority. The failure to respect these rights and meet these needs harms consumers, limits potential, and exacerbates and undermines the value of public investment in treatment and other services.

In order to effectively support recovery, VICSERV proposes a multi-faceted housing strategy that will turn knowledge into action and, ultimately, produce better life outcomes for consumers. The strategy requires a commitment to partnering across sectors and for intervening at policy, planning and service delivery levels to make housing 'everybody's business'.

[3] See *Social Inclusion – An Outcome Measure for the Mental Health Service System. Notes on Context, Definition and Evidence* for details.

There are *three strategy elements* in the VICSERV proposition. These are:

- Visibility and voice
- Planned and integrated approach
- Innovation and expansion.

1 Visibility and voice

There is a risk that the specific, yet diverse needs of people living with severe mental illness will 'get lost' and become diluted in the broader affordable housing and homelessness debates. Whilst these debates are relevant and important for mental health consumers, there is a risk of their needs being overshadowed by the needs and issues of other (more dominant) groups, or being only partially recognised and responded to.

It is therefore important to establish a specific 'mental health housing and support agenda' that is interlinked to homelessness and affordable housing policy and initiatives as well as mental health policy and service system development, at both federal and state levels.

To achieve and sustain this 'voice' and influence, VICSERV proposes series of three short to medium term initiatives aimed at quantifying and making need explicit (and at promoting) evidence-based housing and support solutions. These initiatives are:

(a) Economic modelling of costs/benefits of stable housing. It is proposed that a project is initiated to investigate economic modelling of the costs/benefits of stable housing and its relationship to recovery. This project will include a literature review and (extended) research study. The project could usefully be supported by a collaborative approach involving:

- Government as co-leader, (part) funder and partnership broker.
- VICSERV as sector agent and co-leader.
- Representation from consumer bodies, clinical mental health services, and the housing/homeless sector.

It is envisaged that a highly credentialed research body would be contracted to finalise a research methodology and undertake the research based on the scope identified by the stakeholder/research partnership. The initial literature review would provide information on

housing options that are appropriate and economically viable and evidence of the impact of housing on recovery goals.

Investment required: $60,000 in Year one to develop the research scope and proposal and complete the literature review. It is expected that longer-term requirements would be identified as part of the scoping work.

(b) Ageing carers and housing risk. There is an important area of 'housing risk' that is currently not quantified or managed—the risk to consumers who are living with aging carers. It is proposed that VICSERV be specifically funded to work though its member agencies to identify the extent of the risk and options for addressing it.

Investment required: once-off, specific purpose funding to VICSERV of $60,000.

(c) Discharge to where? There is a relatively cost-effective and straight-forward option for gaining a broad 'snapshot' of housing need and appropriateness of current housing options. The method uses bed-based services to administer a tight set of questions related to housing options and preferences—including the actual accommodation the consumer is discharged to. The questions would be embedded in discharge planning and discharge records for a limited time period. The 'snapshot' could be taken on a state-wide basis (preferably) or in selected local areas, potentially using Mental Health Alliances as research champions.

It is proposed that this research project be designed and implemented at the soonest possible time and be jointly developed by the Department of Human Services (DHS), VICSERV and Area Mental Health Services representatives.

It is intended that the findings from these initiatives are actively utilised by the DHS, VICSERV and its members and partners to influence and inform federal and state housing and mental health agendas to incorporate specific and explicit housing strategies for people living with severe mental illness. Findings may also inform the work of Mental Health Alliances.

Investment required: it is anticipated that this work could be resourced from within the DHS Mental Health Branch with the support of Mental Health Alliances, although there may be some cost associated with question design and collation and analysis of results.

2 Planned and integrated approach

Recognising the critical role of secure housing and support to retain housing in recovery and optimising the value of clinical interventions means taking a proactive, planned approach to ensuring that housing (and housing need) is 'everybody's business'. VICSERV is proposing multi-level strategy to achieve this. The strategy includes:

(a) Housing needs forecasting: In order to meet housing needs in the long term and move from inadequate, reactive responses, it is essential to plan to meet needs by developing a sound understanding of its parameters. The first step is to complete a 'housing needs forecasting' project that considers the immediate, medium and longer term (based on burden of disease and population projections) housing and support needs for people living with severe mental illness. It is proposed that the partnership group identified to lead and support the 'economic modelling' project (see above) be utilised to scope and initiate this work.

Investment required: $120,000.

(b) Opportunity audit: It is recognised that addressing gaps in housing stock requires long-term strategies and solutions, however, it is possible to identify immediate and medium opportunities that are worth investigating. There are properties that are land owned, utilised by, or accessible to PDRSS providers that could be converted though capital investment into housing stock in relatively short timeframes if process obstacles are addressed.

An audit of these opportunities and the barriers to converting them into innovative housing solutions provides a sound basis for short-medium term planning. It is proposed that VICSERV work with its members to compete the 'opportunity audit' in a project jointly funded by DHS Mental Health and Housing Branches. VICSERV would expect to involve a community housing provider/expert in the project planning and implementation.

Investment required: once-off, specific purpose funding of $75,000.

(c) Housing and support on Mental Health Alliance agendas. It is important that VICSERV, through its members, and DHS, through its policy and funder roles, work to ensure that Mental Health Alliances include 'housing and support' needs analysis and responses as part of their program of work directed towards improving client focus and better (clinical) outcomes.

Investment required: no additional.

3 Innovation and Expansion

(a) Scalable, flexible models of housing linked support. In order to make a difference to outcomes for mental health consumers and achieve a mental health service system that is not driven by crisis, exacerbated by housing insecurity, or blocked by housing shortage, there is no option but to invest in creating and maintaining homes for people living with severe mental illness. Homes are about both appropriate housing stock and flexible models of support.

Investment required: It is vital to radically expand the investment in home-based support options increasing the reach of these programs and increasing capacity to scale up and scale down support to individual consumers depending on their needs at different points in time.

Specifically, response capacity must be increased (in the shortest possible timeframes) to address the extent of need for housing linked support. This means meeting demand for support in terms of number of individuals requiring support and the frequency of support required. Programs must be funded to provide some level of coverage after hours (including weekends). Continuity of relationship with clients (from community to acute or other bed-based services and between community locations in agreed local areas) should also be promoted. This must be done without programs becoming crisis responses. This means substantial investment in the PDRSS sector in housing linked support initiatives using a unit price/funding model that adequately meets costs and provides for planned out-of-hours inputs.

In order to determine the quantum of the required investment over time, it is necessary to adequately assess (and forecast) the degree and nature of need and fully conceptualise the model of service. This work involves a different mindset—one which recognises that clinical outcomes will be improved as housing and housing linked support needs are met.

VICSERV proposes the initiation of a staged modelling project that initially (and in the shortest possible timeframe) uses existing understanding/evidence of unmet or inadequately met needs and good practice evidence to inform the first phase of increased investment. A long-term investment plan would then be developed built on knowledge from:

- Economic modelling of cost/benefits of stable housing (see 1(a) above).
- Housing needs forecasting (see 2(b) above).
- 'Discharge to where?' research (see 2(c) above).

The plan would be based on consideration of potential alignment between (some) State (e.g. HBOS) and Commonwealth (e.g. PHAMS) funding streams, other relevant opportunities and information. VICSERV recognises and supports the DHS role in leading this process and seeks to be an active contributor throughout both phases.

(b) Workforce needs analysis: It is critical that Victoria, as part of creating its vision for community mental health into the future, incorporates a workforce strategy that assists in rebalancing the workforce structure. This rebalancing would reflect the fact that an effective, outcome-driven mental health service system is as much about addressing social risk and protective factors (particularly those related to housing and support) as it is about clinical risk and clinical intervention.

The Ministerial Mental Health Workforce Advisory Group has an important role in conceptualising a workforce based on a different paradigm and models of community care that focus on meeting support needs in order to maximise the gain from clinical inputs. There is a risk that the workforce planning agenda could be dominated by clinical workforce shortage and a consequent need to ensure inputs (beyond representational roles) that effectively raise the broader conceptual questions and workforce issues.

VICSERV seeks the opportunity to address the Advisory Group on this matter using the evidence and propositions in this paper (and those contained in the companion papers which together form the *Pathways to Social Inclusion*). VICSERV will also further develop its own workforce needs over the upcoming 12 months.

Investment required: whilst there is a requirement for substantial investment on building the housing support workforce, there is no immediate investment required in workforce needs analysis beyond the existing commitment to the Advisory Group, providing the focus of the work undertaken through that forum has adequate breadth. VICSERV's own work will be internally resourced.

(c) Capital investment for innovation and to meet housing need: it is clear that there is requirement for large-scale investment in housing options for people living with severe mental illness. The quantum of the required investment will be determined as need and models that work are better quantified and the affordable housing agenda becomes specifically concerned with and inclusive of this client group (see propositions above).

(d) 'Limited life (Social Housing) Subsidy Scheme': for the medium term, until adequate levels of appropriate housing stock are achieved, it is inevitable that significant numbers of people with a mental illness who are 'Segment 1 eligible' will continue to live in tenuous accommodation types, i.e. very low-end private rental, boarding houses, pension only Supported Residential Services (SRS), caravan parks etc. This market can be termed the 'social housing market'. Whilst these options are not necessarily preferred or desirable, there is an immediate need to make them affordable and more stable in order to meet the needs of consumers. This means consideration of a 'limited life social housing subsidy scheme' with the level of subsidy potentially being higher than 50% of rental cost.

VICSERV is aware that this issue is a complex and vexed one and recognises detailed work will need to be undertaken to ensure the proposed subsidy does not result in unintended consequences (harmful practice), and is not seen to substitute for the central, longer-term goal of affordable, appropriate housing stock.

Investment required (c) and (d): the investment analysis for these propositions is beyond the scope of VICSERV. However, the key messages related to investment are:

- It needs to be planned and upfront.

- It needs to respond to the immediate crisis with shorter-term programs of investment through targeted subsidy.

- The longer-term economic gains and health outcomes will justify substantial levels of investment in housing that are required.

Summary of proposed investments

Strategy Element	Initiative	Year 1	Over 3 Years (& beyond)	Funders and Contributors	Outcomes
Visibility and Voice	Economic modelling	$60,000	To be determined	Seed funding DHS, longer term to be determined	Evidence base for investment
	Ageing carers and housing risk	$60,000	-	DHS or C'wealth	Risk identified and understood
	'Discharge to where?' snapshot	Existing	-	VICSERV/ DHS	'Quick' overview of immediate need
Planned and Integrated Approach	Housing needs forecasting	$120,000	To be determined	DHS	Knowledge of need over time. Capacity to take a planned approach
	Opportunity audit	$75,000	-	DHS	Viable opportunities identified and scoped
	Mental Health Alliances – focus on housing and support	Nil	-	Existing forum and resources	Increased awareness, local responsiveness
Innovation and Expansion	Housing linked support	To be determined	To be determined	DHS – potential C'wealth partnership	Rebalanced system – better consumer outcomes
	Workforce needs analysis	Existing	-	Ministerial Advisory Group, DHS, VICSERV	Balanced and effective approach to workforce planning
	Capital investment for innovation and to meet need	To be determined	To be determined	C'wealth, State, housing providers	Long term solution and platform for recovery in place – better outcomes
	Limited-life social housing subsidy scheme	To be determined	To be determined	DHS, C'wealth, others	Current crisis responded to in the short –medium term

Not just a house but a home

Many people living with severe mental illness experience significant socio-economic disadvantage such as financial dependency on income support and insecurity of housing tenure. This is evidenced by their demographic profile, which was captured through a census of 3,800 Australians aged 18 to 64 with psychotic disorders.[4] The research, undertaken by the Low Prevalence Study Group of the *National Survey of Mental Health and Wellbeing*, included interviews with 980 participants using a specifically designed instrument covering socio-demographic details such income and accommodation. The research found that 85.2% of those interviewed relied on a government pension or social benefit (in particular, the disability pension) as their main source of income. And whilst many lived in relatively stable forms of housing—such as public/private rental properties (31.4%), family homes (14.9%), their own homes (14.9%) or supported housing (2.6%)—a concerning proportion were housed in far more tenuous accommodation types. According to the study, 19.6% were in institutional settings, 13.6% were in hostels, and 8.8% were in other marginal forms of accommodation or were homeless.[5]

In their follow up bulletin to the census of people with low prevalence disorders, Harvey et al. suggest that special attention must be paid to those who are homeless or in marginal settings (here including hostels as well as boarding houses, hotel/rented rooms, emergency accommodation, shelters, no fixed address, etc.).[6] In the literature, the term 'iterative homelessness' has been developed to describe the repeated loss of stable accommodation and the movement through different forms of tenuous housing—a cycle that sometimes means not having a roof over one's head to sleep under at night ('sleeping rough' or primary homelessness).[7] The movement through tenuous housing may be short term (as in secondary homelessness) or ongoing and even permanent (as in tertiary homelessness). The notion of iterations of homelessness is useful because it captures the full set of homeless experiences that includes primary homelessness, but is not exclusive of secondary and tertiary contexts of being without a home.

Attention to the needs of people with severe mental illness caught in iterations of homelessness must be prioritised for at least three reasons. Firstly, consumers repeatedly identify stable housing as critical to their quality of life. In a recent survey of members conducted by the

[4] Jablensky A, McGrath J, Herrman H, Castle D, Gureje O, Morgan V and Korten A (1999) *People Living with Psychotic Illness: An Australian Study 1997-98*, National Survey of Mental Health and Wellbeing Report 4, Canberra: Mental Health Branch, Commonwealth Department of Health and Ageing. This study was part of the first National Survey of Mental Health and Wellbeing. The second National Survey of Mental Health and Wellbeing was conducted in 2007 with preliminary results available in late 2008.
[5] Ibid., p. 33.
[6] Harvey C, Evert H, Herrman H, Pinzone T and Gureje O (2002) *Disability, Homelessness and Social Relationships Among People Living with Psychosis in Australia*, National Survey of Mental Health and Wellbeing Bulletin 5, Canberra: Mental Health Branch, Commonwealth Department of Health and Ageing, p. 4 and p. 30.
[7] Robinson, C (2003) *Understanding Iterative Homelessness: The Case for People with Mental Disorders*, Melbourne: Australian Housing and Urban Research Institute.

Schizophrenia Fellowships of Australia, around two-thirds of respondents mentioned housing and housing support as the most important issues in their lives.[8]

Secondly, there is a strong association between housing stability and clinical improvement in people recovering from mental illness. The benefits of secure, safe and affordable housing for the general population are well documented. According to the World Health Organisation, these benefits go much further than merely providing a place of shelter. Not just a house, but a home, can foster a sense of belonging and self-worth. It is the place that supports participation in the social and economic life of the community.[9] For people living with severe mental illness, a home is especially important for promoting security, increasing quality of life, and reducing the risk of relapse and hospitalisation. In their paper, Meehan et al. cite several studies to support this. Some studies show that when assessed as stand-alone variables, stable housing is a better predictor of positive outcomes (i.e. not being hospitalised) than the existence of mental health services. Other studies show the negative effects of poor housing compared to appropriate housing and the improvement in overall functioning when consumers are moved from the former to the latter.[10]

Thirdly, access to adequate housing is a fundamental human right.[11] Without access to appropriate housing, people lose a base from which to build networks, hold down a job, and participate as citizens in their community.

Not just a house, but a home, for those with severe mental illness: this remains a significant challenge for governments at all levels as well as organisations supporting consumers and their carers/families. As noted in the groundbreaking report arising from a national inquiry into the human rights of Australians with mental illness:

> *One of the biggest obstacles in the lives of people with mental illness is the absence of adequate affordable and secure accommodation. Living with a mental illness—or recovering from it—is difficult even the best circumstances. Without a decent place to live it is virtually impossible.*[12]

Barriers to achieving housing

The high proportion of people living with severe mental illness and experiencing iterations of homelessness is well documented. Equally well documented is what appropriate housing looks like. Put simply, appropriate housing is housing that meets needs. It is stable and long term (not time limited), safe, affordable, chosen by the consumer, integrated into local communities,

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[8] As cited in Mental Illness Fellowship Victoria (2008) *Mental Illness and Housing*, Preliminary Discussion Paper for Schizophrenia Awareness Week, Fairfield: Mental Illness Fellowship Victoria, p. 5.
[9] World Health Organisation (2004) *Review of Evidence on Housing and Health*, Background Document, Budapest: Fourth Ministerial Conference on Environment and Health, as cited in Mental Illness Fellowship Victoria, op. cit., p. 8.
[10] Meehan T, Stedman T and Robertson S (2007) 'The importance of housing for people with serious mental illness' in *Parity/New Paradigm*, Special Issue, Mental Health, Housing and Homelessness, p. 54.
[11] Harvey et al. op cit., p. 29.
[12] Burdekin B (1993) *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, Canberra: Australian Government Publishing Service, as cited in Harvey et al. op.cit., p. 29.

and ideally comes with supports. Though it may sound like we have the answers to housing, numerous barriers exist that prevent it from being realised for many consumers.

The 'housing affordability' crisis

Broader economic and social changes in recent years have seen the gentrification of older working class suburbs and a rapid decline of decent, affordable rental accommodation in inner city private rental markets. For those on lower incomes, the competition for affordable rental properties (especially single accommodation i.e. one bedroom) is intense. This poses particular challenges for people living with severe mental illness, often on lower incomes, looking for single accommodation, and needing to be near services and good public transport (i.e. in the inner city).[13] There is currently a very real danger of this group being further disadvantaged as they are squeezed out of the private rental market and forced to rely on other forms of accommodation. Included here are public and community housing as well as rooming houses and boarding houses, none of which are without issues for consumers.

The recently established National Affordable Rental Incentive (NARI) Scheme is intended to ease the pressure of rental costs by increasing the supply of affordable rental housing for low- and middle-income households. The scheme packages together a range of incentives (e.g. tax relief, planning concessions, financial subsidies) to encourage developers, investors and landlords to build and provide affordable rental properties. Whilst the scheme would make affordable housing achievable for many low- and middle-income households, complementary assistance—such as the Commonwealth Rent Assistance scheme or state-funded subsidies—would still be required for those who are very disadvantaged. Even with such assistance, there remain concerns that the NARI scheme won't make a difference to those experiencing extreme socio-economic disadvantage looking for housing in the private rental market, such as people living with severe mental illness.[14]

Just as worrying is the 'invisibilising' of this vulnerable group by the current public discourse on housing affordability with its focus on 'working families' in Australia's mortgage belts. The reality is that most people living with severe mental illness are far removed from this culturally dominant ideal of home ownership. A study by Lambert et al. shows that people with psychiatric disability are much less likely to own or be buying their home than the mainstream population (27% compared to 70% respectively).[15] The current climate therefore poses specific challenges for people living with severe mental illness. As noted by the Mental Illness Fellowship Victoria:

> *For those with responsibility for people with mental illness and their families, the challenge is to effectively advocate for the specific housing needs of this very*

[13] Ilsley B (2007) 'Mental health, housing and the problem of supply', in *Parity/New Paradigm*, Special Issue, Mental Health, Housing and Homelessness, p. 70.
[14] Consultation with VICSERV Reference Group.
[15] Lambert G, Ricci P, Harris R and Deane F (2000) 'Housing needs of consumers of mental health services in rural Australia' in *International Journal of Social Psychiatry*, 46 (1): 57-66 as cited in Chesters J, Fletcher M and Jones R (2005) 'Mental illness recovery and place' in *Australian e-Journal for the Advancement of Mental Health*, 4:2, p. 2.

disadvantaged group in the clamour of an urgent, dynamic and complex mix of needs.[16]

Insufficient supply of appropriate housing

At the core of the failure to achieve housing for people living with severe mental illness is an insufficient supply of a range of appropriate housing types to meet demand. As discussed, the private rental market is becoming increasingly out of reach for many on low incomes, people with mental illness amongst them. But the public housing sector is equally incapable of responding to emerging needs with long waiting lists and depleted stock. Community housing managed by not-for-profit housing organisations is another option but is similarly in limited supply.[17] Successive governments have failed to adequately finance these social housing options with expenditure reduced every year since 1986. According to the Tenants Union NSW, in the ten years from 1996 the Commonwealth Government stripped more than $3 billion from funding to social housing, despite significant increases in the need for affordable rental accommodation due to upward trends in the housing market (such as gentrification).[18] Indeed, we have a situation today where the Commonwealth's rental assistance scheme is greater than its contribution to public housing.[19] Whilst rental assistance provides important relief to low income households in the private rental market, it is a 'demand side' response to that particular market, which sidesteps the core issue of the public housing supply.

Whilst supported housing has been shown to be very successful in providing an effective housing option for consumers, the fact is that there are not enough of these around. As revealed by the Low Prevalence Study Group research, supported housing was an accommodation type for only 2.6% of people with psychotic disorders participating in the study. Moreover, the supported housing that does exit tends to be program based within individual jurisdictions (e.g. the Housing and Support Initiative in NSW or the Housing and Support Program in Victoria—see 'Selected Models' below for more) rather than driven by systemic policy reform and funding across all jurisdictions within a coherent national framework for housing and mental illness.[20]

In Victoria, Supported Residential Services (SRS) offer accommodation to people experiencing disadvantage and requiring support with activities of daily living.[21] SRS can be described as a 'generic' approach to supported housing that includes people with mental illness in the client group. SRS are privately operated and regulated under the *Health Services Act 1988* and the *Health Services (Supported Residential Services) Regulations 2001*. They represent an important accommodation option for people living with severe mental illness—particularly through the recently introduced Supporting Accommodation for Vulnerable Victorians (SAVVI)

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16 Mental Illness Fellowship Victoria, op. cit., p. 5.
17 Ilsley, op. cit., p. 70. See also Smith A and Stylli T 'Where do you go when your last resort has closed?' in *Parity/New Paradigm*, Special Issue, Mental Health, Housing and Homelessness, pp. 59-60. It is noted that community housing offering shared or group accommodation for people with severe mental illness is not always an effective option, given specific needs related to a range of behavioural and cognitive deficit symptoms that would not be met by such arrangements.
18 Tenants Union NSW available at http://www.tenants.org.au/publish/social-housing/index.php and accessed 21/07/08.
19 Commonwealth of Australia (2008) *Which Way Home? A New Approach to Homelessness*, Green Paper, Canberra: Commonwealth Government Department of Families, Housing, Community Services and Indigenous Affairs, p. 41.
20 Wilson, J (2007) 'Towards inter-sectoral support models in mental health' in *Parity/New Paradigm*, Special Issue, Mental Health, Housing and Homelessness, pp. 22-3.
21 State Government of Victoria (2008) *Review of the Regulation of Supported Residential Services in Victoria*, Discussion Paper, Melbourne: Victorian Government Department of Human Services.

Initiative (since 2006). Funded through the Department of Human Services (DHS), SAVVI seeks to assist pension-level SRS to improve their financial viability and capacity to meet the support needs of residents. Facility cost relief for proprietors and coordination of support services for residents are amongst the key features of SAVVI.

… And the increasing use of inappropriate housing by default

Rooming house accommodation involves residents renting bedrooms with access to shared common facilities such as bathrooms, kitchens and laundries. Rooming houses do not provide meals to tenants whereas boarding houses (which, like private rentals, are becoming increasingly rare due to inner city gentrification) include at least one meal a day. Rooming houses can be privately owned (sometimes called 'private hotels') or publicly owned and managed through community organisations. In Victoria, for example, DHS funds a Rooming House Program.

Rooming houses were never intended to be used as emergency or supported accommodation but are rather an option for single people (traditionally older males) seeking long-term housing options. Recent studies, however, show that rooming houses are today being used in much more complex ways by people with very high needs, including those with severe mental illness. A recent report on rooming houses in the City of Yarra, reveals that agencies in the area actually view rooming houses as a form of crisis or transitional housing for their clients. The report goes on to suggest that rooming houses are increasingly becoming part of the homelessness service system even though they are not resourced to provide adequate levels of support; nor can they 'fill the gaps' in the crisis and transitional housing system.[22]

In Victoria, time limited transitional and emergency housing is available for those who find themselves homeless (or at risk of becoming homeless) through the Transitional Housing Management Program and Supported Accommodation and Assistance Program. Because of an acute shortage, transitional and emergency accommodation can serve only a fraction of the homeless population at any given time. To address the shortfall, some housing workers have no choice but to draw on other forms of accommodation for their clients, such as rooming and boarding houses. There is evidence to suggest that for people living with severe mental illness, this form of accommodation is highly inappropriate (even traumatising). Chesters et al. note that boarding houses are often associated with increased use of alcohol and other drugs by occupants and increased exposure to violence.[23] Other research shows that the longer one stays in these types of marginal accommodation, the more 'acculturated' one becomes to the environment and the slimmer the prospects for regaining housing (and all the benefits this brings).[24] Yet, marginal accommodation is the main housing experience of many living with severe mental illness. And this situation is often enduring with only a small number ever achieving an improvement in their housing security.[25]

With so little on offer in terms of appropriate housing for this client group, many find themselves living with their parents for extended periods of time. This adds another level of

[22] Yarra Community Housing (2002) *No Place Like Home: Issues and Challenges for Community Managed Rooming Houses in the City of Yarra*, Fitzroy: Yarra Community Housing.
[23] Chesters et al., op. cit., p. 2.
[24] Chamberlain C, Johnson G and Theobald J (2007) *Homelessness in Melbourne: Confronting the Challenge*, Melbourne: Centre for Applied Social Research, RMIT University, p. 11.
[25] Mental Illness Fellowship Victoria, op. cit., pp. 14-15.

concern: that of ageing parents who provide huge amounts of care to their adult children and the options that are left for consumers when inevitably (and sadly) these supports are gone.

The important point that must be made about the use of any or all of these accommodation types is that they are not really appropriate housing options for people with severe mental illness. As stated previously, what consumers need most of all is housing that meets their needs, that is, housing that is stable, long term, chosen by them, safe, affordable, and with access to supports. Indeed, an argument can be made that as long as these housing types are considered 'options' for consumers, attention to the real issue—that of providing appropriate housing to a vulnerable group in our community—is conveniently avoided.

System failure

Insufficient supply contributes to system failure, that is, the failure on the part of the service system to find timely appropriate housing for those in need and intervene early before an episode of homelessness becomes the start of a repeating cycle. Take, for example, a person who is hospitalised because of their mental illness. This person may fall behind on rent and may lose their private rental property as a result. They might remain 'stuck' in the acute system for longer than necessary because supported housing cannot be found (or isn't available) thereby contributing to the problem of 'blocked beds'.[26] There is currently an estimated 40% or more of acute mental health patients who could be discharged if there existed appropriate housing and supports.[27] Or, they might be discharged into marginal accommodation with the prospect of dealing with their ongoing housing needs later on.[28] This unblocks the beds and relieves some of the pressure experienced by an over-burdened acute system, but doesn't address the consumer's needs for housing and can inadvertently contribute to the cycle of homelessness. This consumer can find themselves back in the acute system because their resulting homelessness has exacerbated their mental health problems or there is nowhere else to go—or both. As noted by a mental health clinician:

> *There's a real revolving door syndrome – people get admitted, they get treatment and then they get discharged but because there's no supported accommodation for them they keep coming back into hospital.*[29]

There are serious economic consequences of this 'revolving door' syndrome. The estimated average recurrent cost of providing one mental health hospital bed is around $150,000 per year (2002-2003 figure) compared to one unit of public housing at $5,990 per year (2006-2007 figure).[30] Carr et al., in their cost-of-illness study of psychosis, conclude that we appear

[26] Ilsley, op. cit., p. 71.
[27] Commonwealth of Australia, op. cit., p. 42.
[28] Henderson S (2003) 'Mental illness and the criminal justice system', Rozelle: Mental Health Coordinating Council available at http://www.mhcc.org.au/projects/Criminal_Justice/ and accessed 04/07/08.
[29] Mental Health Council of Australia (2005) *Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia*, Canberra: Mental Health Council of Australia, p. 179.
[30] Mental Health Coalition of South Australia (2008) *Housing for Mental Health: 2008-2012*, Adelaide: Mental Health Coalition of South Australia, as cited in Commonwealth of Australia, op. cit., p. 42.

to be spending a disproportionate amount on 'housing' people in hospitals (or prisons, see below) without sufficient investment in appropriate (supported) housing options in the community.[31]

System failure is also the direct result of sector isolation and a lack of integration between mental health policy and housing policy. Currently in Victoria, an estimated 10% of Psychiatric Disability Rehabilitation and Support Services (PDRSS) clients (around 1,200 people) are recorded as living in unstable or transitional housing. An estimated 5% of clinical mental health services clients (around 3,000 people) are homeless or at risk of homelessness. An estimated 25% of clinical mental health services clients (around 9,600 people) have identified unmet needs for more stable forms of accommodation.[32] These people require immediate assessment and assistance to determine their level of need and provide referrals. The reality is that this does not always happen, and mental health and housing services do not always work in partnership to share resources, skills and knowledge in order to respond expeditiously to the needs of their consumers. As Harvey et al. note, even the best clinical services will fail to meet the needs of those with the most complex needs unless there is close cooperation with housing and other services (welfare, disability support, and vocational) to provide support and assistance to each individual.[33]

Further sector isolation exists between mental health, housing services and the criminal justice system adding to system failure. What is needed is sound collaboration between these sectors so that police have different alternatives to hospitalisation or arrest. Instead, police are often called in to manage a mental illness crisis and required to make an assessment of a person's mental health status before referring them to hospital… or remand. When faced with a critical shortage of facilities for treating people with mental illness in the acute setting, police have little choice. As noted by the President of the Police Association of New South Wales:

> *Where do we take people? Where do we put people? How do we care for them in some real way so that they are not out in the streets? The reality is that people are getting charged with criminal offences where really we should be applying another section to take the opportunity to deal with psychiatric illness.*[34]

It is a sad truth that prison is 'home' for increasing numbers of people with severe mental illness who find themselves incarcerated for criminal behaviour as a consequence of a range of interlocking factors. These include poverty, marginalisation, homelessness, and substance use issues co-occurring with their mental illness, but perhaps most of all, a service system that has failed them.

The result is an over-representation of people with severe mental illness in the prison population. In their study on the prevalence of mental illness in the New South Wales prison population, Butler and Allnutt found a 12-month prevalence rate of 74% for 'any psychiatric

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[31] Carr V, Neil A, Halpin S and Holmes S (2002) *Costs of Psychosis in Urban Australia*, National Survey of Mental Health and Wellbeing Bulletin 2, Canberra: Mental Health Branch, Commonwealth Department of Health and Ageing, p. 35.
[32] State Government of Victoria (2008) *Because Mental Health Matters: A New Focus for Mental Health and Wellbeing in Victoria*, Consultation Paper, Melbourne: Victorian Government Department of Human Services, p. 32.
[33] Harvey et al., op. cit., p. 54.
[34] As cited in Henderson, op. cit.

disorder' e.g. psychosis, anxiety disorder, affective disorder, substance use disorder, personality disorder, or neurasthenia. The 12-month prevalence rate for these disorders in the non-prison population is around 22%. The authors also found a higher prevalence of psychiatric disorders amongst female prisoners compared to their male counterparts. And whist the most common group of mental disorders in the prison population was anxiety disorders, the study revealed a 12-month prevalence rate of psychosis at 9%—a figure that is 30 times higher than the non-prison population.[35]

Limited or no support

For those who do achieve stable housing, a range of issues around referrals needs to be addressed such as links to a general practitioner, chemist and mental health service. Then there are general issues like finding the local supermarket or nearest bank and working out the public transport system. There is time limited support for people in transitional housing moving into public housing, and of course ongoing support is a feature of the small numbers of supported housing that exist. But otherwise ongoing support for consumers is non-existent. Without support, many people living with severe mental illness can find themselves not able to maintain their housing and back into iterations of homelessness. As Chamberlain et al. write:

> *Homelessness cannot be resolved without housing, but on its own housing is insufficient to prevent the reoccurrence of homelessness for some people. […] A more realistic approach to the provision of long-term support is necessary. This has to recognise that most people take time to rebuild their lives after returning to stable housing.'*[36]

Stigma

People living with severe mental illness feel the effects of stigma a daily basis. With respect housing, they are frequently exposed to discrimination from landlords, neighbours and the wider community making stable housing not only difficult to achieve but hard to maintain.

Effective housing: what works?

What are the factors that contribute to effective housing for people with severe mental illness? The availability of supports is critical e.g. informal networks, appropriate clinical treatment, psychosocial rehabilitation, disability support etc. These supports are flexible and individualised, given at the outset of tenancy, and ongoing (time unlimited) after housing is established. Having a key worker or case manager to coordinate supports is also important.[37] These

[35] Butler T and Allnutt S (2003) *Mental Illness Among New South Wales' Prisoners*, Matraville, NSW: NSW Corrections Health Service, pp. 2-3.
[36] Chamberlain et al., op. cit., p. 36 and p. 44.
[37] Mental Illness Fellowship Victoria, op. cit., p. 11.

ingredients combine into what is known as supported housing. The fundamental premise of supported housing is that people living with severe mental illness are no different to everyone else in their needs for secure housing, it is just the level of support that is different.

There is evidence internationally and in Australia of a range of supported housing models that work. There is also evidence that shows significant cost savings as consumers who are securely housed with access to supports and services that they need are less likely to repeatedly return to hospital emergency departments for crisis care.[38] These models may have different stakeholders, partnerships and tenure arrangements, but they do share in common the following key elements:[39]

- An explicit focus on people recovering from severe mental illness.
- An orientation towards the whole person in all their complexity.
- The provision of secure and ongoing tenure in appropriately designed and located housing stock.
- Comprehensive and coordinated ongoing support tailored to individual needs.

Meehan et al. write that the provision of supported housing represents a new way of thinking about housing with wrap around supports, and includes several core requirements.[40] These requirements were first outlined by Ridgeway and Carling but have been developed by many contributors over time.[41]

- The house must be a home (not a 'residential treatment setting').
- Housing must be stable and long term (not time limited) to break into iterations of homelessness.
- Choice of housing must be based on consumer preference.
- Consumers must be housed as members of the community, not residents of a program.

[38] HomeGround Services (2008) 'HomeGround supportive housing: Ending homelessness in Melbourne', Collingwood: HomeGround Services, p. 5.
[39] See for example Mental Illness Fellowship Victoria op. cit.
[40] Meehan et al. op. cit., p. 56.
[41] Ridgeway P and Carling P (1987) *Strategic Planning in Housing and Mental Health*, Boston: Centre for Community Change through Housing and Support.

- Housing should foster consumer control of their environment.

- Housing that keeps levels of stress manageable should be selected.

- Housing should be located in neighbourhoods with a mix of residents (consistent with community norms) to minimise stigma.

- Housing must have an appearance consistent with the neighbourhood.

- There must be support available that is individualised and flexible.

- The levels of support required at any given time must be defined by consumers.

- Support must occur in the person's home (rather than in a transitional environment).

The UNSW Consortium has recently developed a paper for the Queensland Government to guide future policy directions for people with psychiatric disabilities. To the above requirements can be added the following:[42]

- Services must be responsive to the needs of different population groups e.g. indigenous communities, culturally and linguistically diverse communities, younger people, older people, people with complex co-morbidities including dual diagnosis and substance use disorders.

- There should be a separation of housing and support services either by different providers or different functions within the one organisation to minimise conflict and ensure integrity of service delivery.

- There must be interagency collaboration between housing providers, support providers, clinical services, government and other services relevant to the client group.

- There must be ongoing advocacy to address stigma and discrimination experienced by people living with severe mental illness in their neighbourhoods and communities.

[42] UNSW Consortium (2008) 'Principles for effective housing and associated support for people with mental illness or psychiatric disability' available at http://www.sprc.unsw.edu.au/SummaryEffectivenessFactors11March.doc and accessed 04/07/08.

Selected models

The following programs reflect successful models of supported housing. They each meet many of the requirements identified above.

Housing and support program (HASP) Vic

HASP, established in the early 1990s, saw two areas of the Department of Human Service—the Mental Health Branch and the Office of Housing—working alongside the emerging PDRSS sector to deliver housing and support programs to people with psychiatric disabilities across Victoria.[43] There are currently around 1,200 public housing properties allocated to HASP with psychosocial rehabilitation and support provided through PDRSS.

Evaluations of the program in its early days showed that residents enjoyed 'increased wellness, characterised by such measures as reduced hospital stays'.[44] Chesters et al. have more recently evaluated a housing and support provider responsible for 23 HASP properties in regional Victoria—SNAP Gippsland Inc.—with similar positive results. They write that for the residents of SNAP, 'there is a home and even if they need to go to hospital for a time, there will be a place to return to when things are better.'[45] Despite its success, HASP (according to some) has largely lost its identity and has not been sustained because housing stock has not been replaced. The program is currently in need of a re-energised policy and funding effort.[46]

Whirrakee Housing and Support Service 'Mental Health Pathways' Vic

The Whirrakee Housing and Support Service in Bendigo provides a range of housing and support services including a 'Mental Health Pathways' program.[47] This program, which was piloted through the Victorian Homelessness Strategy and has since been rolled out to other areas in Victoria, engages consumers at the point of discharge from hospital to prevent them from entering homelessness.

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[43] Chesters et al. op. cit., p. 3.
[44] Robson, B (1995) *Can I call this home? An evaluation of the Victorian Housing and Support Program for People with Psychiatric Disabilities*, Melbourne: VICSERV as cited in Chesters et al. op. cit., p. 3.
[45] Chesters et al., op. cit., p. 8.
[46] Ilsley, op. cit., p. 71.
[47] Bennett S (2007) 'The experience of a psychiatric disability specific housing service' in *Parity/New Paradigm*, Special Issue, Mental Health, Housing and Homelessness, pp. 45-7.

Consumers assessed as at risk of homelessness are moved into a crisis unit. They are provided with support through a worker who explores housing pathways, assists in navigating the system, and works with them on securing long-term housing and other aspects of recovery. In addition to the crisis unit, Whirrakee has nine transitional properties attached to the program and nomination rights on a number of Office of Housing properties through HASP. Importantly, there is ongoing outreach into community properties once residents have moved into long-term housing.

NEAMI/Supported Housing Ltd Initiative Vic

NEAMI and Supported Housing Ltd have partnered since 1995 to deliver long-term housing and support to people with a history of institutionalisation in Melbourne's northern suburbs.[48] Secure and affordable housing is provided by the Office of Housing with tenancy managed by Supported Housing Ltd. Psychosocial rehabilitation support is provided through NEAMI as a specialist PDRSS. Clinical support is provided by community-based mental health services.

Key factors of success include the location and type of properties, management of issues around sharing and living alone, a commitment to ongoing tenure, and practices around tenancy management. A recent evaluation of this initiative showed many people successfully housed in their communities with ongoing support after years spent in psychiatric hospitals.

Housing and Support Initiative (HASI) NSW

HASI is a partnership between the Department of Health, the Department of Housing, and non-government organisations (e.g. community housing providers, area mental health services and providers of psychosocial rehabilitation).[49] The model operates within a recovery framework to assist people with psychiatric disabilities to participate in the community, maintain successful tenancies, and improve their quality of life. HASI was established in 2002-2003 and currently supports more than 100 consumers with complex mental heath needs.

A recent two-year evaluation of HASI undertaken by the Social Policy Research Centre, UNSW, found that with appropriate support consumers 'can live independently in stable, safe, affordable homes.'[50] HASI has also demonstrated improvements in mental health (e.g. fewer rates of psychiatric and emergency admissions or shorter durations of such admissions) and increased social and economic outcomes (e.g. participation in paid employment and other vocational activities). According to the evaluators, these benefits well and truly offset the recurrent annual cost of the program of around $58k per person.[51]

[48] Carter M (2007) 'After the institution: What next?' in *Parity/New Paradigm*, Special Issue, Mental Health, Housing and Homelessness, pp. 57-8.
[49] Muir K and Fisher K (2007) 'Stable housing: The foundation of improved mental health' in *Parity/New Paradigm*, Special Issue, Mental Health, Housing and Homelessness, pp. 50-3.
[50] Ibid.
[51] Muir K (2008) 'Housing support for people with mental illness', in *Social Policy Research Centre Newsletter* (March) as cited in Mental Illness Fellowship Victoria op. cit., p. 19.

Project 300 Qld

Project 300 was an initiative that commenced in 1995 to assist 300 people with psychiatric disability to move from institutional care into housing of their choice in the community. The project involved a partnership between three government departments (Public Works and Housing, Family Services, and Health). Each client on discharge was provided with a 'package' of services including accommodation, disability support, and mental health. Each package was tailored to the specific needs of individual consumers and the emphasis was on consumer involvement in selecting the housing that was right for them in properties that were indistinguishable from others in the neighbourhood.

Meehan et al., in their paper on Project 300, write that consumers appreciated the opportunity to be involved in the selection of their accommodation and that it reduced the stress of leaving hospital. The establishment grant of $5,000 that came with the package increased consumers' sense of control over their environment. The support provided by mental health professionals and disability support workers was also viewed as appropriate to meeting their needs.[52]

HomeGround Supportive Housing Initiative Vic

This initiative is being implemented in Melbourne during 2008 and is targeted to the primary homeless population, people with severe mental illness amongst them. The initiative will offer safe, permanent and affordable housing and onsite support services to help tenants settle into and maintain their housing, and will ensure a mix of tenants to enable a thriving and diverse community within a single site development at 660 Elizabeth Street in Melbourne.

The HomeGround Supportive Housing Initiative model consists of five interdependent elements: property management, tenancy management, onsite support, safety (controlled access), and community integration. HomeGround has developed (or is developing) partnerships with a number of agencies in the homelessness service sector, mental health service sector, and corporate and philanthropic sectors. Strong partnerships have already been formed with the Office of Housing, Yarra Community Housing, City of Melbourne and Grocon to progress the initiative thus far.[53] HomeGround will deliver onsite support services and work in partnership with key agencies to broker provision of other services across the different elements.

The initiative is based on internationally proven and recognised approaches that address the complex needs of the primary homeless population, such as *Housing First* in New York City. The *Housing First* model prioritises consumer choice for housing first, not after, or as a condition of, treatment. Once housed, consumers continue to choose the supports and services they need. There is a clear separation of housing and treatment elements: tenants must pay rent and observe the rules of a standard lease and relapse does not mean housing loss. There is an emphasis in recovery with secure housing and individualised and flexible services/supports as critical to this process.

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[52] Meehan et al., op. cit. pp. 54-6.

[53] Grocon has agreed to build the facility at cost, representing a corporate donation of around $15 million. See Commonwealth of Australia, op. cit., p. 60.

The *Housing First* model has been replicated across North America resulting in tens of thousands of supportive housing units developed and operated by non-profit organisations. As noted by HomeGround, the *Housing First* model:

> *… has evolved significantly over the past 20 years into a dynamic, flexible and robust model, which meets the unique needs and characteristics of specifically marginalised homeless populations. While cost-effective, the greatest outcome has been in human terms for individuals, families and the communities in which they live.*[54]

Clearly, various models of supported housing can be drawn upon nationally and internationally that have successfully helped consumers to achieve and maintain secure and affordable accommodation. The issue as far as housing is concerned is not so much about which model to choose, but rather the policies and level of funding required to increase and sustain supported housing options. With only 2.6% of consumers living in supported housing and a much higher proportion trapped in iterations of homelessness and 'revolving' through the mental health, crisis accommodation and criminal justice systems, there is an urgent call to governments across all jurisdictions and organisations across several sectors to respond to the specific housing needs of this marginalised and disadvantaged group.

There is currently a significant process in place for tackling homelessness under the banner of the Federal Government's new social inclusion agenda. *Which Way Home? A New Approach to Homelessness* is a green paper that puts forward options for responses to homelessness including a greater focus on prevention and early intervention for population groups at risk.[55] The white paper to follow will include a national action plan to reduce homelessness in the lead up to 2020. It is critical that this national action plan includes options to progress a specific housing and supports agenda for people living with severe mental illness, lest they become further 'invisibilised' by mainstream discourses on affordable housing and homelessness.

[54] HomeGround, op. cit., p. 6.
[55] Commonwealth of Australia, op. cit.