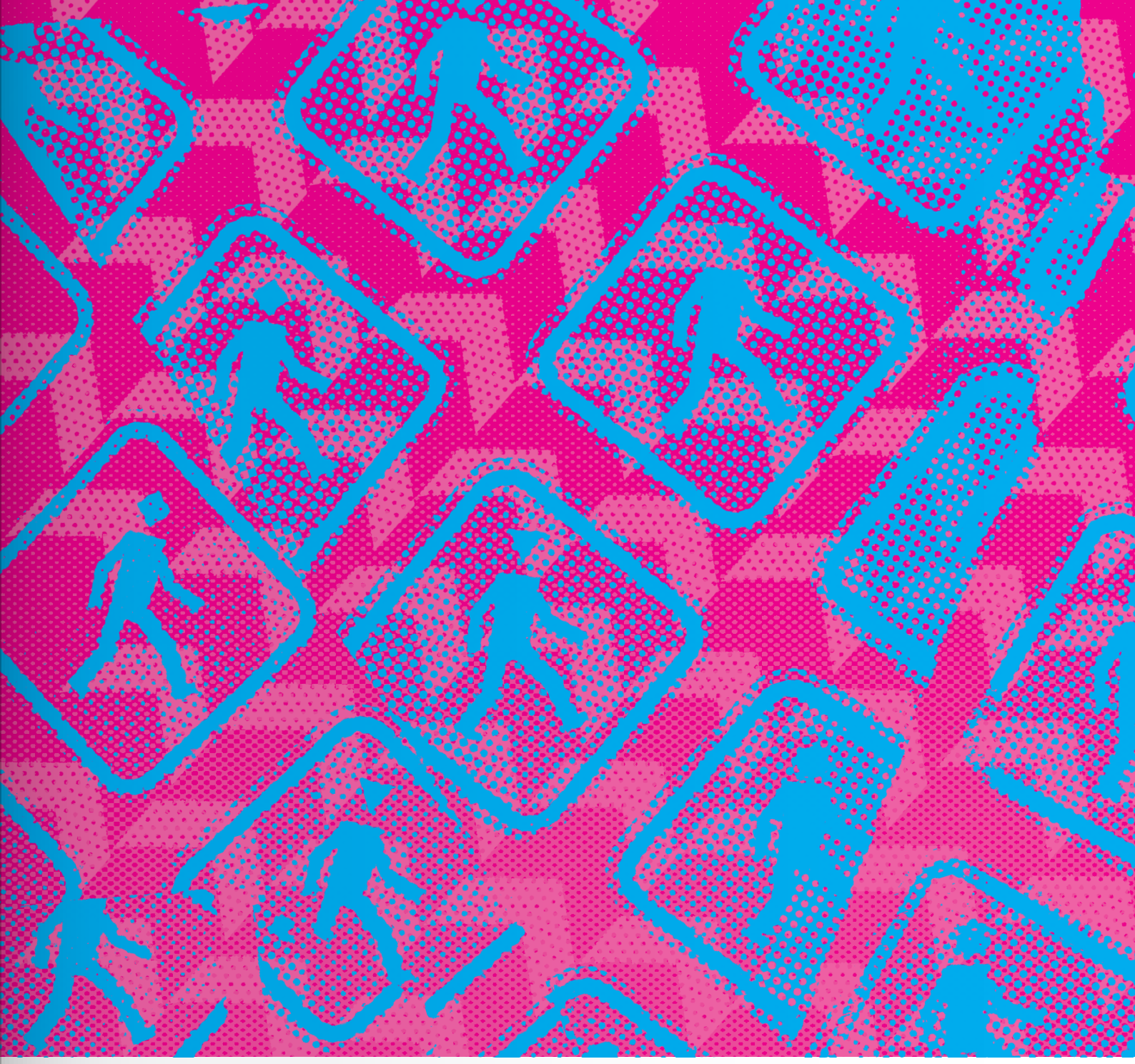


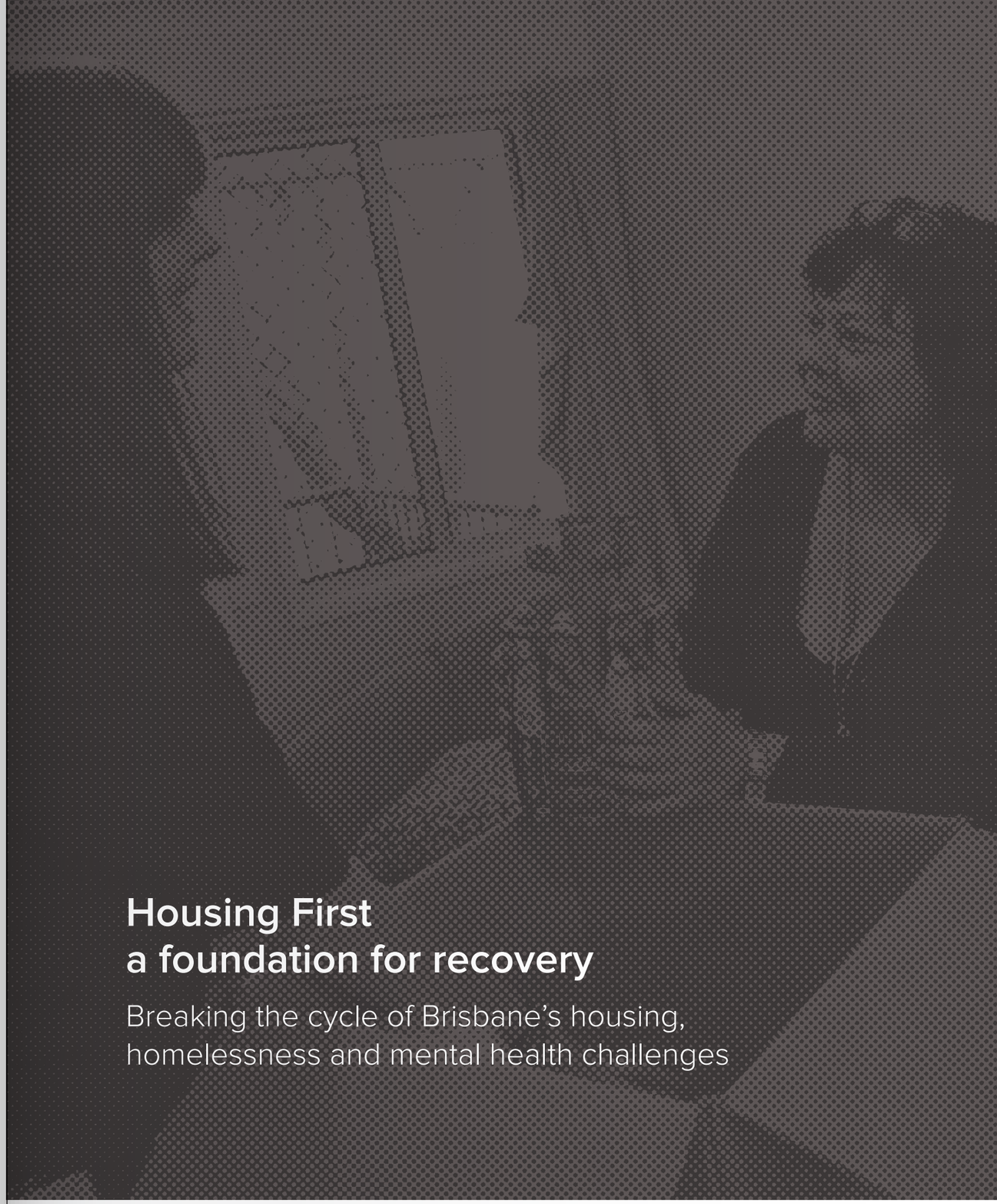
Housing First: a foundation for recovery

Breaking the cycle of Brisbane's housing, homelessness and mental health challenges

partners in recovery
supporting mental health and wellbeing

phn
BRISBANE SOUTH
An Australian Government Initiative

MICAH PROJECTS INC
Breaking Social Isolation
Building Community



Housing First
a foundation for recovery

Breaking the cycle of Brisbane's housing, homelessness and mental health challenges

Funded by Brisbane South PHN PIR Consortium
An Australian Government Initiative

Photography: Craig Holmes

November 2016

Acknowledgements

We acknowledge the Australian Government's investment in the Partners in Recovery (PIR) program, Brisbane South PHN – lead agency for PIR in Brisbane South, and the 10 PIR partner organisations – Aftercare, The Benevolent Society, Brook RED, FSG Australia, Gallang Place, Harmony Place, Micah Projects, Neami National, Richmond Fellowship Queensland (RFQ) and Stepping Stone Clubhouse.

We acknowledge all stakeholders who contributed to the Mental Health, Housing and Homelessness Plan, the Southside Care Coordination Panel, the Lived Experience Advisory Group, and the *Housing First: a foundation for recovery* community action plan and associated Integrated Healthcare and Housing First Fact Sheets – specifically:

Briannon Stevens – Intuit Works

Michael Tansky, Shelley Elliot, David Meddings, John Araneda, Sarah Burns and Kayla Godwin – *Micah Projects PIR Team*

Janelle Kwong, Ross Westoby, Kim Rayner, Maria O'Connor, Jo Bennett and Maria Leebeek – *Micah Projects*

Micah Projects Backbone and Communications Team

John Mendoza – *ConNetica*
Stephen Harvey – *Harvey Risk Management Pty Ltd*
Roundtable attendees

Rod Buchner and Renee Lee – *Service Integration Coordinators, Metro South Addiction and Mental Health Services*
Panel attendees

Lyndall Baker, Wayne Jaye, Michael Nycyk, Brian Sparks, Malcolm Hull and Lesley Houston – *Lived Experience Advisory Group*

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micahprojects.org.au

Housing First: a foundation for recovery

Artwork:
Coming Together by Luke Roma, Rocky Boy, Jagalingu Man from Rockhampton Region, 2013

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

Our commitment to Reconciliation

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

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

Executive summary

As organisations that have worked with people experiencing homelessness and mental illness for over 20 years, we have witnessed people trapped in a revolving door of homelessness, hospital admissions, incarceration and housing instability. We have seen people traumatised as they attempt to meet their basic needs for food and shelter in a complex system. We have observed the multi-abuse trauma resulting from a lifetime of poverty, violence and abuse overlaid with the heavy burdens of stigma, shame and discrimination. We have witnessed people employ coping mechanisms for their trauma that both retraumatise and exacerbate stigma – such as alcohol and other drug use, self-harm and risky behaviours.

We know these issues are interconnected, and yet, we have not made inroads in connecting our fragmented systems of care which respond to substance use, homelessness, and mental illness. Our failure to respond to people trapped in this revolving door of expensive emergency services costs us all; both in the long term human cost of failing to meet people's basic rights to safety, dignity and psychological wellbeing, and the costs every year to health and social care systems.

Now is the time to take action – with a Queensland Housing Strategy, a new Housing First roadmap to ending homelessness in Brisbane, and mental health reforms driving planning and innovative investment at the local level.

The good news is that we know what works to end the cycle of homelessness and mental illness: *Housing + Supports*. Long-term housing is critical to recovery from mental illness, and community-based multidisciplinary supports are critical to staying housed and breaking the cycle of homelessness. Known as Housing First, this approach needs leadership to join up disconnected healthcare, housing, homelessness and community services. It also requires investment to deliver long-term housing to people with mental illness and embed outreach multidisciplinary clinical teams in community services.

This action plan advocates for the implementation of Housing First for mental health in Brisbane. It outlines four straightforward strategies for achieving this – **know who needs Housing First; close housing gaps; close service gaps; and implement Supportive Housing**.

Our advocacy for a Housing First approach is the result of recent work to understand what we need to do to create lasting change within a human rights framework for people who are chronically homeless and highly marginalised. We acknowledge the role of the consumers and lived experience movement, and the emerging neurodiversity movement, in advocating for non-pathologising supports, acceptance of diversity and protection of human rights. It is our hope and belief that this plan honours people's fundamental rights to housing, safety, dignity and self-determination.

Background

The *Housing First: a foundation for recovery* toolkit has been developed by the **Brisbane South PHN (BSPHN) Partners in Recovery Consortium** – a group of 10 non-government organisations partnered with BSPHN and funded by the Australian Government Department of Health to support people with severe and persistent mental health issues, along with their carers and families, to address their complex care needs and improve their wellbeing.

The interconnected values informing the PIR approach to mental health care are:

- **Recovery oriented:** creating opportunities for the person to resume control of their situation
- **Culturally competent:** integrating culture to work in cross-cultural situations
- **Trauma informed:** creating opportunities for survivors to rebuild control and empowerment.

The 10 non-government PIR organisations that partnered with BSPHN are:

- Aftercare
- The Benevolent Society
- Brook RED
- FSG Australia
- Gallang Place
- Harmony Place
- Micah Projects
- Neami National
- Stepping Stone Clubhouse
- Richmond Fellowship Queensland

As organisations supporting people with severe mental illness, we observe that so many of the people we support are trapped cycling between homelessness, hospital and corrections systems. Consequently, their mental health suffers and deteriorates over time. **We have come to understand that without addressing housing as a priority, our efforts to support people with their recovery are constantly hampered.**

In 2014, BSPHN funded Micah Projects to work with stakeholders to develop shared solutions for providing better housing outcomes for people with severe mental health issues. Micah Projects conducted a literature review, and engaged mental health specialists ConNetica, to facilitate a workshop and Roundtable with Brisbane stakeholders. After comparing the evidence of different models, ConNetica concluded that the Housing First approach provides a "substantive and qualitative improvement in harm minimisation, health outcomes, material benefits, social inclusiveness and psychological wellbeing for those… provided with permanent housing."[1] ConNetica also recommended that Brisbane agencies invest in a collaborative project to build greater service integration and care coordination.

The PIR consortium have invested in a coordination project in line with the ConNetica recommendations. In 2016, BSPHN again funded Micah Projects to initiate coordinated housing solutions in partnership with Metro South Addiction and Mental Health Services, and PIR, housing and community mental health service providers. Terms of Reference, Protocols and Referral Forms were developed, the Southside Care Coordination Panel and Lived Experience Advisory Group formed, and commenced taking referrals in July 2016.

As a group of agencies, we are committed to changing our practices and the systems we work within to bring Housing First to people with severe mental illness. The culmination of our recent work is this action plan and associated fact sheets on Housing First and Integrated Healthcare models. We have worked together to understand Brisbane's housing, homelessness and mental health challenges, and map out how Housing First can be implemented for people with mental illness in our community. As organisations who are supporting people with recovery, we understand the crucial importance of getting clinical treatment services to people wherever they are. This report provides models, evidence and recommendations for how that can be achieved – primarily through embedding multidisciplinary teams in community services and integrating those services with permanent housing.

This Housing First for Mental Health plan demonstrates how a Housing First evidence-informed approach to ending homelessness assists people who are homeless and living with mental illness to move quickly into permanent housing.

1 Mendoza, J. Hervey, S. (2015) *Improved Outcomes for people with Severe Mental Illness and Housing Solutions.* Brisbane, Australia: ConNetica and Micah Projects.

Homelessness services at Turbot Street, Brisbane during 500 Lives 500 Homes Registry Fortnight 2014.

Photography: Patrick Hamilton

Understanding Brisbane's housing, homelessness and mental health challenges

What lies beneath – multi-abuse trauma

In Brisbane, there is a growing percentage of people who are cycling through our hospital, corrections, homelessness and mental health systems. People trapped in this cycle are not only experiencing mental illness, but are also often victims of multi-abuse trauma. This frequently involves sexual assault, domestic violence, and/or child abuse, layered with trauma from the coping strategies of substance misuse and self-harm. Stigma, discrimination and oppression add trauma to people who are Indigenous, sex and gender diverse, have a disability or are from other minority groups. This discrimination exists even in our service system.

Fragmented care leads people to bounce through crisis systems of care, unable to access the supports they need. The failure of our systems to provide adequate housing, income and trauma-sensitive support to people, often through generations, has led to people experiencing homelessness, incarceration, and intergenerational poverty. Our First Peoples are still experiencing racism, poor healthcare and housing, incarceration and child removal. These experiences all add layers of abuse across people's lifetimes.

Understanding Brisbane's housing and mental health challenges means understanding the complex and interconnected nature of multi-abuse trauma and the way this impacts on mental illness and homelessness. What follows are some of the key factors which intersect in people's lives to create barriers to wellness and housing stability.

Homelessness and mental illness

In 2014-15 Brisbane's homelessness services supported 2807 people (27%) who had been diagnosed with mental illness.[2]

Mental illness and homelessness are interconnected. It is becoming increasingly clear that people experiencing homelessness have higher rates of mental illness than the general population.[3] People with mental illness also have much higher rates of homelessness and housing instability.[4] The reasons are multifaceted, and include social isolation, inadequate health and social supports, insufficient affordable housing stock, poverty, challenging behaviours when unwell, stigma and discrimination.[5]

Housing insecurity and homelessness also act as a significant risk factor for poor mental health.[6] Homelessness is a traumatic event with lifelong psychological impacts on children, young people and adults.

A survey of Australians who are homeless found that 73% met diagnostic criteria for Post Traumatic Stress Disorder (PTSD).[7] Most participants were exposed to multiple traumatic events with over 97% having experienced more than four traumatic events in their lifetime. This compares with a 4% rate in the general community. These figures confirm established research showing that adverse childhood experiences predict increased odds of experiencing homelessness as an adult, as well as a higher incidence of mental and physical health problems.[8]

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2 Queensland Government. (2015). Department of Housing and Public Works Data source: 2014-15. *Confidentialised unit record files (CURF).* Brisbane, Australia: Unpublished raw data.

3 Australian Institute of health and Welfare. (2015). *Specialist Homelessness Services 2014–15*. Retrieved from http://www.aihw.gov.au/homelessness/specialist-homelessness-services-2014-15/.

4 SANE Australia. (2008). *SANE research bulletin 7: Housing and mental illness.* Retrieved from https://www.sane.org/images/PDFs/0807_info_rb7_housing.pdf

5 Mental Health Council of Australia. (2009). *Home Truths, Mental Health, Housing and Homelessness in Australia*. Retrieved from https://mhaustralia.org/sites/default/files/imported/component/rsfiles/publications/MHCA_Home_Truths_Layout_FINAL.pdf

6 Baker, E., Mason, K., Bentley, R. & Mallett, S. (2014). Exploring the Bi-directional Relationship between Health and Housing in Australia. *Urban Policy and Research, 32*(1), 71-84.

7 O'Donnell, M., Varker, T., Cash, R., Armstrong, R., Di Censo, L., Zanatta, P., Murnane, A., Brophy, L., & Phelps, A. (2014). The trauma and homelessness initiative. *Report prepared by the Australian Centre for Posttraumatic Mental Health in collaboration with Sacred Heart Mission, Mind Australia, Inner SouthCommunity Health and VincentCare Victoria.* Retrieved from https://www.sacredheartmission.org/sites/default/files/publication-documents/THI_Report_research%20findings.pdf

8 Montgomery, A. E., Cutuli, J. J., Evans-Chase, M., Treglia, D., & Culhane, D. P. (2013). Relationship Among Adverse Childhood Experiences, History of Active Military Service, and Adult Outcomes: Homelessness, Mental Health, and Physical Health. *American Journal of Public Health*, *103*(Suppl 2), 262–268.

Jessica and Charlotte in their home.

Photography: Katie Bennett

"I've got bipolar and get depressed without a cat. Charlotte loves it here. She's still in a kitten stage and runs around the flat. The room is excellent and you get the city lights." *Jessica*

Psychosocial disability and deinstitutionalisation

As institutions for people with disability closed in Queensland, we have seen some Queenslanders experience opportunities to live in the community with choice and control over housing, supports and friendships.

However, these choices and opportunities have not been afforded to all. Many people continue to miss out due to a lack of the housing, healthcare and personal supports needed to buffer against the ongoing effects of ableism and multi-abuse trauma. The consequence of these systems failures is that many people with psychosocial disability are trapped in cycles of insecure housing, homelessness, acute psychiatric care, alcohol and other drug treatment, and hospital admissions.

In Brisbane, 5.5% of people accessing homelessness services, stated they were in a psychiatric hospital unit in the previous 12 months. 5% had been in a corrections facility, and 2% had been in rehabilitation.

A total of 19.6% of people accessing Brisbane's homelessness services are known to have been in an institutional setting in the year beforehand.[9]

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9 Queensland Government. (2015). Department of Housing and Public Works Data source: 2014-15. *Confidentialised unit record files (CURF).* Brisbane, Australia: Unpublished raw data.

Substance use and physical health conditions

In 2014-15 Brisbane's homelessness services supported 2046 people seeking assistance with mental health issues, drug/substance use and alcohol use.[10]

Mental illness and substance use occur together very frequently, and are deeply interconnected challenges, often precipitating and interacting negatively with one another. Alcohol and other drug use are coping mechanisms for dealing with the trauma of homelessness, the distress of mental illness and their associated challenges. Both mental illness and substance use are barriers to accessing housing. Stigma and discrimination are exacerbated for people who are homeless when they have addictions or mental illness.

People with mental illness have poor physical health, with high rates of co-existing medical conditions and shortened life expectancies:[11]

60% have a co-existing physical illness (12% in general population)

- 6x more likely to have dental problems
- 3x more likely to have cardio-vascular disease
- 2x more likely to have respiratory disease
- 2x more likely to have diabetes

-20 years
Likely to die 20 years earlier

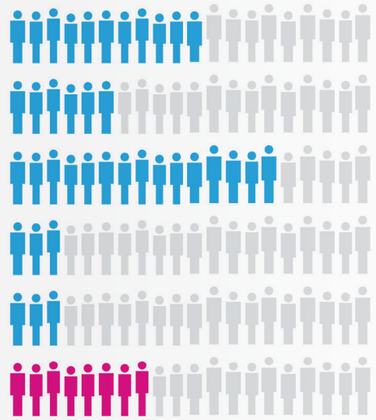
constitute approximately **one third** of all avoidable deaths

There is a growing body of evidence that Australians experiencing homelessness also have high rates of co-existing physical health conditions, such as infectious diseases, skin and respiratory conditions, and cardiovascular diseases.[12] In addition, people experiencing homelessness have a pattern of accessing high cost emergency care and poor engagement in primary healthcare programs. In our services, we are seeing people who present with a familiar pattern of these interrelated issues.

10 Queensland Government. (2015). Department of Housing and Public Works Data source: 2014-15. *Confidentialised unit record files (CURF).* Brisbane, Australia: Unpublished raw data.
11 Australian Government. (2015). Equally well: Quality of life; equality in life. *The Australian national consensus statement on the physical health of people with a mental illness.* Retrieved from https://consultations.health.gov.au/national-mental-health-commission/594530eb/user_uploads/national-consensus-statement---online-consultation-draft.pdf
12 Wood, L., Flatau, P., Zaretzky, K., Foster, S., Vallesi, S. and Miscenko, D. (2016) *What are the health, social and economic benefits of providing public housing and support to formerly homeless people?*, AHURI Final Report No. 265, Australian Housing and Urban Research Institute Limited, Melbourne.

Health needs of people homeless or at risk of homelessness in Brisbane

People homeless or vulnerably housed experiencing mental illness



- 56% Physical health condition — 9.95% unknown
- 32% Psychotic symptoms — 30.6% unknown (likely under-reported)
- 74% Psychological distress — 9.2% unknown
- 15% Alcohol use — 21.7% unknown (likely under-reported)
- 15% Substance use — 23% unknown (likely under-reported)
- 3+ 35% Three or more conditions (likely under-reported)

Partners in Recovery Service data[13]

People experiencing homelessness

Families with a parent 25 yrs or over

- 40% Mental health condition
- 16% Physical disability
- 45% Asthma
- 37% Substance use
- 14% Heart disease

Individuals 25 yrs or over

- 56% Mental health condition
- 25% Physical disability
- 25% Asthma
- 67% Substance use
- 55% Dental condition
- 28% Heat exhaustion

500 Lives 500 Homes Families Data[14] | *500 Lives 500 Homes Individuals* data[15]

13 Brisbane South PHN (2016), Partners in Recovery Service Data Source 2013 – 2016. *Unmet psychological and physical health needs of people who are homeless and accessing*, Oct 2013 – June 2016 (n=764). Brisbane, Australia: Unpublished raw data.
14 500 Lives 500 Homes. (2014). *Emerging trends VI-SPDAT adult families fact sheet*. Retrieved from http://micahprojects.org.au/assets/docs/Factsheets/2014-500-Lives-Adult-Families-factsheet.pdf
15 500 Lives 500 Homes. (2014). *Emerging trends VI-SPDAT adult individuals fact sheet*. Retrieved from http://www.500lives500homes.org.au/resource_files/500lives/2014-500-Lives-Adult-Individuals-factsheet.pdf

Service system failures

The experience of being homeless with mental illness increases the likelihood that people will interact with multiple parts of the housing, health, corrections and social services systems. However these systems are characterised by fragmentation and a lack of planning and coordination at a local level.[16]

We must also acknowledge that discrimination exists in our services. There are barriers to accessing support if you are homeless, have a disability, transient, poor, Indigenous, LGBTI and/or marginalised in other ways. In Brisbane, our healthcare services actively discriminate against people with addictions, turning people away from services if they are affected by alcohol and other drugs or failing to identify and treat co-occurring mental and physical health conditions. We have an underfunded Alcohol and Other Drug Service system which cannot meet people's mental health needs, and so people with substance use issues are suffering from both discrimination and a lack of services.

When housing and healthcare services are also poorly coordinated, getting housed and recovering from homelessness and mental illness can be an insurmountable challenge. People in Brisbane are experiencing trauma from the very systems that were designed to help them. ***We have to do better***.

16 Australian Government, Department of Health. (2015).'Response to Contributing Lives, Thriving Communities', *Review of Mental Health Programmes and Service*. Canberra, Australia; Commonwealth of Australia. Retrieved https://www.health.gov.au/internet/main/publishing.nsf/content/0DBEF2D78F7CB9E7CA257F07001ACC6D/$File/response.pdf.

Chrissy (right) moving into her new home assisted by PIR worker Sarah.

Photography: Craig Holmes

Housing First for mental health

Our commitment to implementing Housing First underpins this plan.

What is Housing First?

Housing First is a recovery-oriented approach to ending homelessness that assists people experiencing homelessness to quickly move into independent and permanent housing. For too long, people who are homeless with mental illness have been forced to jump through hoops, such as accessing psychiatric or case management services, and demonstrating personal change before being deemed 'housing ready'.

Housing First means there are no conditions that have to be met before the person moves in. They do not need to agree to psychiatric or substance use treatment. Services offered are voluntary, with the responsibility for engagement resting with the service provider, not the tenant.

Recovery, consumer choice and self-determination

Housing First considers people who are homeless with mental illness to be full citizens with rights to housing and self-determination over whether they access treatment and other support services. Housing First recognises that it is the role of professionals to be proactive in engaging people in services that assist them to stay housed, and fulfil their role as tenants, neighbours and citizens.

Housing First is a recovery oriented model, having features that are critical to people's recovery journey:[17]

- Housing is a choice; not a placement and not an institution
- Housing is low-barrier (sobriety is not a precondition to accessing housing)
- Housing is physically and emotionally safe and stable
- Housing First tenants have the same rights and responsibilities to be good neighbours and tenants as any other tenant, and are supported to meet these responsibilities
- Stability is a priority. If tenants move out (by choice or through not meeting tenancy agreements), every effort is made to connect them to safe housing and recovery supports.

Stephen on his balcony at Brisbane Common Ground.

Photography: Katie Bennett

"I'm sick a lot of the time and have to do something about the drinking. I can't keep putting myself through this. Micah has offered to help but I want to do it myself. Now I'm in a relaxed place it should be a lot easier for me." *Stephen*

Supportive Housing

A Housing First model for Brisbane

Supportive Housing is a Housing First model that involves the intentional and long-term connection of secure and affordable housing with support. Services coordinated with supportive housing are focused on tenancy sustainment and coordinated access to other specialised and community-based services. Supportive Housing is effective for people who need safe housing that is closely integrated with support services – typically, people who have been chronically homeless and/or people with complex or high support needs, including people with mental illness. One of the critical components to supportive housing for

17 National Council for Behavioural Health, *Options, Not opponents: Housing First and Recovery Housing,* http://www.thenationalcouncil.org/BH365/2016/08/23/options-not-opponents-housing-first-recovery-housing/, 2016

people with mental illness is the coordination with multidisciplinary healthcare teams as a strategy to sustain tenancy and reduce crisis hospital presentations and care. This coordination enables early identification and proactive support to people whose mental states are impacting on their wellbeing, ability to be good neighbours and to stay housed.

Supportive housing does not mean institutional care or supported accommodation. People have their own leases and access to supports is voluntary. **Supportive housing is still a recovery-oriented approach**, but is offered to people who have a long-term need for support to stay housed. Supportive housing can be delivered via onsite support, or via outreach services coordinated with tenancy management.

Integrating healthcare

Multidisciplinary healthcare supports integrated with housing, community and clinical services are needed in Brisbane. People who are homeless, tenants of boarding houses, share housing and social housing have inadequate access to clinical and community services. This is due to the complex nature of people's physical and mental health needs, the impacts of these overlapping issues on their housing, and the barriers to accessing mainstream healthcare supports.

Assertive Community Treatment (ACT) is an evidence-informed, community-based model for delivering specialist assertive outreach to people with mental illnesses. The teams include members from the fields of psychology, nursing, substance abuse and vocational rehabilitation. Multidisciplinary teams provide proactive and intensive support with a focus on housing, daily living and quality of life (rather than symptoms). ACT teams use assertive outreach to proactively engage individuals in treatment, including people with mental illness who don't meet eligibility thresholds for public mental health services. This could include people living with depression, anxiety, complex trauma, addictions, or with emotion regulation or executive functioning challenges.

In the USA and Canada, ACT has been shown to substantially reduce inpatient and emergency hospital visits and is more satisfactory to consumers than other types of community-based care. When integrated with safe long-term housing, such as in the Pathways to Housing approach, ACT teams have been demonstrated to achieve excellent housing retention outcomes. In a longitudinal study[18], 80% of the participants assigned to Pathways to Housing were in stable housing after 12 months, compared with 24% in the alternative continuum of care approach.

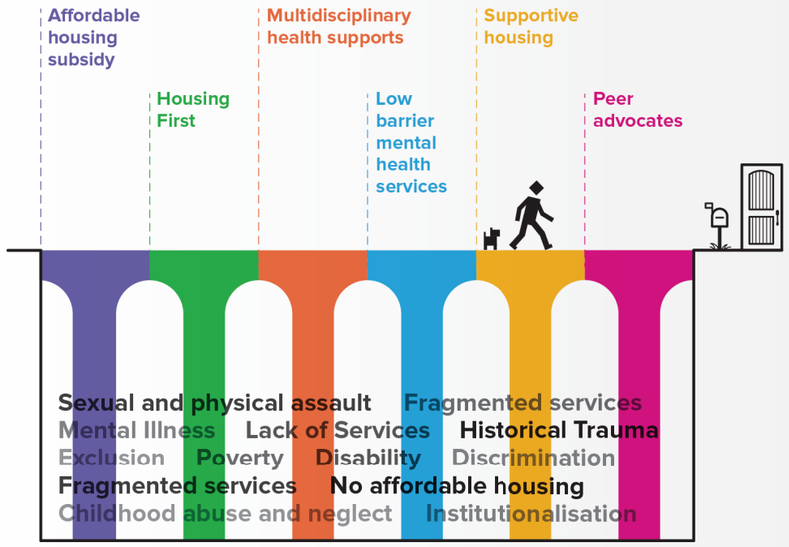
18 Tsemberis, S., Gulcur, L. & Nakae, M. (2004). Housing first, consumer choice and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94*(4), 651-656.

Housing First works

There is strong evidence that:

- We can house people with complex mental and physical health challenges, without first addressing health challenges
- Providing housing integrated with support services is a highly effective solution to ending homelessness and improving people's physical and mental health
- Coordinating Housing First approaches with multidisciplinary healthcare teams is critical to this success.

Recent research across Brisbane, Sydney and Melbourne,[19] has found that people who have been homeless with multiple social and health challenges can successfully exit homelessness and stay housed using a Housing First approach. Furthermore, in Brisbane they reported that time spent in secure housing was associated with reduced symptoms of psychological distress and improvement in measures of quality of life (using validated measures). This research reflects a body of international evidence for the successful outcomes and cost effectiveness of Housing First approaches. In a 2000 participant trial of Housing First in Canada, they reported that Housing First delivers a "large and significant impact on housing stability" and "clear and immediate improvements" to quality of life.[20]



19 Parsell, C., Johnson, G., & Button, E. (2013). *Street to home: a national comparative analysis*. St Lucia, Australia: Homelessness Research Partnership with the Department of Families, Housing, Community Services and Indigenous Affairs, Institute for Social Science Research.

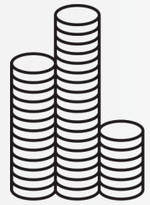
20 Goering, P., Veldhuizen, S., Watson, A., Adair, C., Kopp, B., Latimer, E., Nelson, G., MacNaughton, E., Streiner, D., & Aubry, T. (2014). *National at home/Chez soi final report.* Calgary, AB: Mental Health Commission of Canada.

Housing First is cost effective for Brisbane

A 2013 research project into the cost effectiveness of Housing First in Brisbane found the overall cost to the health, justice and community service systems reduced substantially as individuals transitioned from homelessness to housing. This was due largely to the reduction in use of justice services, with the cost to police and courts dropping from an average of $8,719 per person per annum to just $2,172.[21]

In Brisbane, Micah Projects evaluated the Homeless to Home Healthcare after-hours service in which nurses worked with an outreach team of housing-focused community workers where the Housing First approach was embedded to get people housed. The evaluation estimated an avoidance of $6.9M in hospital and emergency department costs for an investment of $500,000.[22]

By comparing pre and post utilisation data at a point in time with 41 tenants, the Hope St Brisbane Common Ground Supportive Housing Evaluation found that $1.12M less was spent across health, corrections and specialist homelessness services compared to when tenants were homeless.[23]



$2.14M

cost avoidance after 12 months of the Pathways Pilot Program

by reducing ED presentations and hospitalisations

$13,100*

saving per tenant at Brisbane Common Ground

Comparing service utilisation costs between when a person is homeless and when they are housed with support.

Pathways Hospital Admission and Discharge data[24] | *Brisbane Common Ground data*[23]

* Cost saving was calculated at a fixed point in time.

21 Mason, C., & Grimbeek, P. A. (2013). *Housing First approach to homelessness in Brisbane, Sustaining tenancies and the cost effectiveness of support services*. Brisbane, Australia: Micah Projects. Retrieved http://micahprojects.org.au/assets/docs/Publications/IR_127_A-Housing-First-Approach-to-Homelessness.pdf.

22 Connelly, L. (2015).*An Economic Evaluation of the Homeless to Home After Hours service*. Brisbane, Australia; Micah Projects. Retrieved http://micahprojects.org.au/assets/docs/Publications/IR_130_An-Economic-Evaluation-of-the-Homeless-to-Home-Healthcare-After-Hours-Service.pdf

23 Micah Projects (2015). *Brisbane Common Ground Evaluation snapshot.* Retrieved http://micahprojects.org.au/assets/docs/Publications/2016-BCG-Snapshot-for-Screen.pdf.

24 Rayner, K., & Westoby, R. (2015). *Pathways Hospital Admission and Discharge Pilot Project: Twelve Month Evaluation Report January 2015 – December 2015*. Brisbane, Australia: Micah Projects. Retrieved http://micahprojects.org.au/assets/docs/Factsheets/2016-IH-Pathways-Summary-for-web.pdf

Lotus, a Micah Projects Support and Advocacy Worker and Sue, an Inclusive Health Pathways Clinical Nurse, providing an integrated health and housing response to Tammy as she settles into her new home.

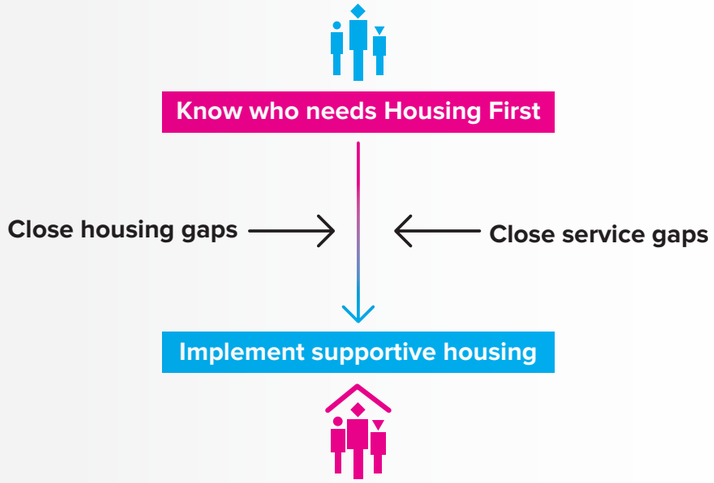
Photography: Lachie Douglas

Strategies for change

A Housing First approach underpins each of our strategies for addressing Brisbane's mental health and homelessness challenges.

Housing First:

- is an evidence based solution to end homelessness for people with complex mental health challenges
- addresses current unmet needs for housing and support in a way that reduces fragmentation and (with appropriate investment) can increase access to multidisciplinary healthcare supports embedded in community services
- employs values that align with consumers and psychiatric survivors' advocacy for self-determination and choice to access non-pathologising supports
- is recovery oriented, giving people the best chance of recovery from homelessness and multi-abuse trauma.



Strategy 1: Know who needs Housing First

If we want to end homelessness for people with mental illness, we have to know each person by name, and understand their health and housing needs. We need a picture of individual need, as well as unmet need across the system. Right now, we have a broad idea of the number of people with mental health challenges accessing homelessness services, as well as the number of people accessing PHNs who are homeless or vulnerably housed. We do not know the overlap between these sources of data, nor the very different housing and support needs of each person.

To achieve this, we will implement a **Brisbane Mental Health and Housing First Action Group**, which will include representation from across health, housing, corrections, community services and peer advisors. This group will:

1. Develop a by-name register of people who are homeless with mental illness, which is a subset of Brisbane's Register of people who are homeless
2. Establish shared screening and assessment tools, in line with Queensland's new Mental Health Act and work undertaken as part of our national mental health reforms
3. Establish coordinated entry across mental health, housing and homelessness systems leveraging existing reform efforts in these separate systems – e.g., implementation of a stepped care approach (mental health), the work of 500 Lives 500 Homes (homelessness).

Care Coordination Panels

The Southside Care Coordination Panel (The Panel) was recommended as a solution to mental ill-health and homelessness in the *Final Report: Improved Outcomes for people with Severe Mental Illness and Housing Solutions, ConNetica, August 2015*[25]. The Panel commenced in May 2016 – bringing together government and community services to provide a coordinated approach to assessing and planning responses to the needs of people living with severe and persistent mental illness who are frequently presenting at Emergency Departments, have multiple admissions to inpatient units, and have long stays in hospital. Some people with multiple diagnoses do not think they are unwell and refuse to take medication after discharge from hospital, avoid follow-up contact with mental health services, have no or few referral pathways, have difficulty finding safe housing and risk eviction due to complaints about their behaviour, experience persisting chronic dental and chronic health problems, and have regular contact with police, courts and prisons.

The Panel addresses identified issues and barriers through planning, implementing and reviewing strategies and interventions required to support people whose needs cannot be resolved by the person, one organisation alone or by working in isolation. The Panel does not replace existing service delivery models. It provides a means for closer working partnerships, improved communication and monitoring to evaluate the effectiveness of collaboration.

Strategy 2: Close housing gaps

We cannot end homelessness while the supply of housing does not match demand. We know that there is under-utilised stock in Brisbane; however, we also know that demand currently far exceeds supply. We need to work together to create more housing that matches what is needed, and engage the whole community in innovative solutions to our supply problem.

What do we know about the housing gap?

- 2807 people with mental illness access Brisbane's homelessness system over a 12 month period
- 769 people with unmet accommodation needs and mental illness access Brisbane South PHN over a three year period
- $134,506.68 was spent on accommodation by Partners in Recovery (mental health supports) in one year, more flexible funding spent on accommodation than on any other item (36% of total flexible funds).

25 Mendoza, J. Hervey, S. (2015) *Improved Outcomes for people with Severe Mental Illness and Housing Solutions.* Brisbane, Australia: ConNetica and Micah Projects.

Housing First: A Roadmap to Ending Homelessness in Brisbane recommends that the Queensland Government **establish a Social and Affordable Housing Trust fund** to increase the supply of affordable and social housing. Any efforts to implement concrete action to increase demand must ensure an **allocation of affordable housing for people with mental illness** which matches the proportion of homeless people with mental illness and psychosocial disability in Brisbane – 25-30%. A proportion of this affordable housing should be allocated to **Supportive Housing** and this is outlined more in Strategy 4.

Further, given that housing is a known crucial element to recovery from mental illness, Governments and their commissioning bodies should **allocate funds for housing rent subsidies** for people with mental illness. In implementing mental health reforms, PHNs have been tasked with developing innovative, coordinated services for people with severe and complex mental illness. Rent subsidies are one such innovation with proven outcomes for people with complex mental health and substance use challenges.

Strategy 3: Close service gaps

It is unacceptable that those people in Brisbane who have the most need for support to recover from multi-abuse trauma are the most impacted by obstacles such as underfunded services, fragmented systems of care, discrimination and other barriers to the services they do access. If we want to enable recovery from homelessness and mental illness, we need to address these gaps. Provision of adequate clinical and community services to people in the community is not only critical for the people's wellbeing but also for neighbourhood and community safety.

Ending a fragmented system of care requires bringing together primary healthcare, mental health care, alcohol and other drug treatment, and social supports. We call on the Queensland Government to **invest in multidisciplinary health supports embedded in community care services**, where there are fewer barriers to access and engagement. These health supports can be provided through outreach, such as with **Assertive Community Treatment teams based in community organisations**, and in community-based clinics, like the proposed for Brisbane. A Housing First approach intentionally connects these multidisciplinary supports with housing, by ensuring that:

- people who are homeless or at risk are prioritised for supports
- multidisciplinary healthcare teams outreach to people's homes
- homelessness services, and health clinics are co-located with housing services
- housing access and retention is an outcome for supports.

We know that people in the community who are survivors of psychiatric care can be strong advocates for their peers, and recommend that a **network of peer**

advocates are supported to provide information, education and advocacy as people access and engage with the service system.

We must invest in **services to sustain tenancy for people who are at high risk of becoming homeless** due to mental illness, and co-occurring substance misuse, disability, and health conditions.

We need to proactively **plan for the loss of services to high need and vulnerable populations** as Queensland Government funding transitions to the National Disability Insurance Scheme. An investment in community care is needed to respond to people who might not meet NDIS eligibility and/or have needs beyond the scope of NDIS, which have previously been met by these services.

Strategy 4: Implement Supportive Housing

Supportive Housing involves the intentional and long-term connection of secure and affordable housing with support that is focused on tenancy sustainment and coordinated access to other specialised and community-based services. It is an evidence based solution for people with multiple, complex barriers to ending homelessness and high support needs (due to psychosocial disability, multi-abuse trauma and/or multiple co-occurring physical and mental health, and addiction challenges).

We recommend that the Queensland Government, in partnership with PHNs and non-government organisations, **establish a Supportive Housing Taskforce for Brisbane** to focus on unmet need in supply of housing and supports to sustain tenancy. This taskforce will look at how we can access and bring together resources from the Queensland Government, PHNs, and the National Disability Insurance Scheme to help us to **create a mix of single and scattered site permanent Supportive Housing for people with mental illness.**

Darren with Social Inclusion worker Emma on a boat trip with 'The Hive'.

Concluding statements

People with mental illness in Brisbane face huge challenges as they struggle to recover from the interconnected and devastating impacts of homelessness, addiction, and multi-abuse trauma, and the stigma, discrimination and retraumatisation they face in a fragmented system.

These challenges have impacts on people's health, with so many developing life-threatening physical health conditions, substance use disorders, and severe mental illness. As service providers, we have witnessed lives being cut short by untreated physical health conditions and suicide.

We want to do better.

We know what works. Housing First is already ending homelessness in Brisbane, changing lives and saving money across service systems. Integrating supports with housing, including multidisciplinary healthcare supports, and giving people choice to voluntarily access supports, restores dignity and enables people to start the process of recovery.

However, it will take **commitment from Government and community leaders** working together to address critical gaps in housing, healthcare and supports. It will take bold steps, and new approaches to funding and partnerships, to embed multidisciplinary healthcare in community services and to implement Housing First innovations such as Supportive Housing.

We can no longer afford to work alone, watching people struggle with their own complex trauma in a complex system. Every child and adult who is suffering now is one too many. It is time to work together to implement what we know works to restore dignity and wellbeing – Housing First for mental health.

Glossary

Addiction
A physical or psychological need for a habit-forming substance, such as a drug or alcohol

Assertive Community Treatment
An Evidence-Based Practice Model designed to provide treatment, rehabilitation and support services to individuals who are diagnosed with a severe mental illness and whose needs have not been met by more traditional mental health services

Co-existing / Co-occurring Conditions
People who have substance use disorders and/or mental health conditions existing simultaneously

Homelessness
The experience of living without conventional accommodation (sleeping rough or in improvised dwellings), frequently moving from one temporary shelter to the next or staying in accommodation that falls below minimum community standards

Housing First
A recovery-oriented approach to ending homelessness that assists people experiencing homelessness to quickly move into independent and permanent housing

LGBTI
Lesbian, Gay, Bisexual, Transgender and Intersex peoples

Marginalised
To be placed in a position of marginal importance, influence or power

Mental Health
A state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community

Mental Illness
A health condition that changes a person's thinking, feelings, or behaviour (or all three) and that causes the person distress and difficulty in functioning

Substance Use
Any time someone consumes alcohol or other drugs

Multi-Abuse Trauma
When an individual is impacted by multiple co-occurring issues that negatively affect safety, health or wellbeing. Examples of co-occurring issues include: childhood abuse or neglect, domestic violence, societal oppression, intergenerational grief, homelessness and incarceration

Multidisciplinary Healthcare
Healthcare that occurs when professionals from a range of disciplines, but with complementary skills, knowledge and experience, work together to provide the best possible outcome for the physical and psychosocial needs of a patient

National Disability Insurance Scheme (NDIS)
A social reform in Australia initiated by the Australian government for Australians with a disability

Neurodiversity Movement
A social justice movement that seeks civil rights, equality, respect, and full societal inclusion for individuals who have a brain that functions in ways that diverge significantly from the dominant societal standards of “normal”

Primary Healthcare
The first level of contact individuals, families and communities have with the health care system

Psychiatric Survivors Movement
A diverse association of individuals who either currently access mental health services or who are survivors of interventions by psychiatry, or who are ex-patients of mental health services

Psychosocial Disability
The experience of people with impairments and participation restrictions related to mental health conditions

Recovery Paradigm
An approach to mental illness or substance dependence that emphasises and supports a person’s potential for developing new meaning and purpose in their lives as they grow beyond the effects of their illness

Supportive Housing
A housing intervention that combines non-time-limited affordable housing assistance with wrap-around supportive services for people experiencing homelessness, as well as other people with disabilities

Supportive Housing Scattered-Site Model
Units in apartment buildings spread throughout a neighbourhood or community that are designated for specific populations, accompanied by supportive services, with individual leases and a separation between tenancy management and support

Units within a single property or building providing housing for a range of supportive housing populations, with individual leases and a separation between tenancy management and support

partners in recovery
supporting mental health and wellbeing

The document
Housing First: a foundation for recovery
was produced by the
Brisbane South PHN Partners in
Recovery Consortium (Nov 2016)

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