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Prof Stephen King  
Productivity Commission

### **AHURI submission to Productivity Commission Inquiry on Mental Health**

On behalf of the Australian Housing and Urban Research Institute (AHURI) I am pleased to make a submission responding to the Productivity Commission draft report on Mental Health.

This submission provides a commentary on the report, focusing in particular on Australian Housing and Urban Research Institute (AHURI) research relating to mental health and its relationship with homelessness and housing. The submission draws in particular on recent AHURI research for the National Mental Health Commission, as well as forthcoming research for MIND Australia to be released on 19 February 2020. AHURI research is available free from [www.ahuri.edu.au](http://www.ahuri.edu.au).

If there is any way we can be of further assistance, please contact me

Yours sincerely,

**Dr Michael Fotheringham**  
**Executive Director**



# **Submission to Productivity Commission Inquiry on Mental Health**

**Australian Housing and Urban Research Institute**

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**January 2020**

## About AHURI

As the only organisation in Australia dedicated exclusively to housing, homelessness, cities and related urban research, AHURI is a unique venture. Through our national network of university research partners, we undertake research leading to the advancement of knowledge on key policy and practice issues.

AHURI research informs the decision-making of all levels of government, non-government sectors (both private and not-for-profit), peak organisations and the community, and stimulates debate in the media and the broader Australian community.

Our mission is to inform better housing, homelessness, cities and related urban outcomes through the delivery and dissemination of relevant and authoritative research. To achieve this mission we deliver four key programs.

### National Housing Research Program

AHURI's National Housing Research Program (NHRP) invests around \$4 million each year in high quality policy-oriented housing research and associated activities. We broker engagement between policy makers, key stakeholders and researchers. This allows us to undertake research that is immediately relevant and actively contributes to national housing policy development.

Our network of university research partners conducts research on key policy issues utilising a variety of research activities. This ensures the flexibility to undertake longer-term projects when fundamental research is needed, while also responding quickly to new strategic policy issues as they arise.

### AHURI research on cities

AHURI is actively broadening its scope to consider the role, functioning and policy questions facing Australian cities. We are enhancing our significant evidence base on housing and homelessness policy and solutions, and consolidating our role in delivering integrated and robust evidence to guide policy development. AHURI is working with governments and relevant stakeholders to expand our role in delivering research that informs urban policy and the shaping of cities in Australia.

### Professional Services

AHURI Professional Services draws on our in-depth understanding of housing, homelessness, cities and urban policy and the expertise of AHURI's national network of Research Centres. We deliver evidence reviews and synthesis, policy engagement and transfer, and are experts in research management and brokerage.

### Conferences, events and engagement

Our conferences, events and communications stimulate professional and public dialogue. We disseminate research in innovative ways and engage with the government, private, not-for-profit sectors and the community.

### National Network of AHURI Research Centres

There are currently eight AHURI Research Centres across Australia:

- AHURI Research Centre—Curtin University
- AHURI Research Centre—RMIT University
- AHURI Research Centre—Swinburne University of Technology
- AHURI Research Centre—The University of Adelaide
- AHURI Research Centre—The University of South Australia
- AHURI Research Centre—The University of New South Wales
- AHURI Research Centre—The University of Sydney
- AHURI Research Centre—University of Tasmania.

# Contents

|  |           |
|--|-----------|
| <b>About AHURI</b>   | <b>ii</b> |
| <b>Executive Summary</b>   | <b>1</b>  |
| Mental ill-health interacts with housing and homelessness  | 1         |
| Housing related reforms for mental health  | 2         |
| Reform area 1: early intervention and prevention   | 2         |
| Reform area 2: close critical gaps in community based mental health care services  | 2         |
| Reform area 3: investment in services beyond health  | 2         |
| Reform area 4: assistance for people with mental illness to get into work and enable early treatment of work-related mental illness          | 3         |
| Reform area 5: fundamental reforms to care coordination, governance and funding arrangements   | 3         |
| <b>1. Evidence on the relationship between housing and mental health</b>   | <b>4</b>  |
| Terminology  | 4         |
| Mental health, housing and homelessness are inter-related  | 4         |
| Housing issues can negatively affect mental health   | 4         |
| Mental ill-health can negatively affect housing security   | 5         |
| Mental ill-health can precede homelessness or develop after becoming homeless  | 6         |
| Chronic homelessness and severe mental illness are strongly inter-related  | 6         |
| Risk factors for mental ill-health and housing insecurity  | 7         |
| Risks of mental ill-health are regionally unevenly distributed but this is explained by individual demographic rather than regional features | 7         |
| Risk factors for mental ill-health are elevated for those with other markers of disadvantage   | 7         |
| Positive housing and mental health trajectories depend on access to mental health services, adequate housing, resources and supports         | 8         |
| What is a positive housing and mental health trajectory?   | 8         |
| Diagnosis and use of mental health services help prevent entry into homelessness and accelerate exits from homelessness                      | 8         |
| Choice and control over housing and support assist recovery  | 9         |
| Affordable, secure and good quality housing and good neighbourhood amenity help those experiencing mental illness                            | 9         |
| The impact of poor mental health on housing instability is mediated by access to resources like services, social support and home ownership  | 10        |
| There are diverse mental health and housing trajectories   | 11        |
| <b>2. Evidence on housing related reforms for mental health</b>  | <b>13</b> |

|  |           |
|--|-----------|
| Reform context   | 13        |
| The NDIS is reshaping Australia’s mental health system but many who have housing issues but less severe mental illness miss out  | 13        |
| It is appropriate for mental health system frameworks to embrace a consumer centred approach   | 13        |
| Consumer centred models should consider the social and system driven dimensions of mental ill-health and early intervention and prevention approaches                                    | 14        |
| Mental health policy frameworks are based on a stepped model of care that recognises severity of mental ill-health but they should also consider the housing trajectories of individuals | 14        |
| Reform area 1: early intervention and prevention   | 14        |
| Interventions for young people   | 14        |
| Prevent housing issues from arising  | 15        |
| Reform area 2: close critical gaps in health care services   | 16        |
| Health care access - community mental health provision   | 16        |
| Reform area 3: Investment in services beyond health  | 16        |
| Improve care integration and coordination, including with housing  | 16        |
| Increase support for carers and families   | 17        |
| Support people to find and maintain housing  | 17        |
| Social housing supply  | 18        |
| Advocacy - build consensus and collaboration around housing and mental health  | 18        |
| Increase consumer choice and control in relation to housing through new housing models like Housing First  | 18        |
| Reform area 4: assistance for people with mental illness to get into work and enable early treatment of work-related mental illness  | 19        |
| Social inclusion helps recovery from mental illness  | 19        |
| Reform area 5: fundamental reforms to care coordination, governance and funding arrangements   | 19        |
| Governance changes   | 19        |
| <b>References</b>  | <b>21</b> |

## List of figures

|  |    |
|--|----|
| Figure 1: Indicative housing career for a person with a psychiatric disability       | 6  |
| Figure 2: Mental health and housing instability direct effects and mediating factors | 11 |

# Executive Summary

## Mental ill-health interacts with housing and homelessness

Mental ill-health interacts with housing and homelessness in a number of ways:

- housing issues that can negatively affect mental health include housing affordability stress (e.g. unaffordable rental), insecure, unsafe and inappropriate housing, frequent moves, forced moves (e.g. due to eviction), neighbourhood disputes and unsafe neighbourhoods
- mental ill-health can lead to behaviours that negatively affect housing stability (e.g. difficult behaviours, hoarding)
- social isolation can undermine a person's housing security, worsen mental ill-health and lengthen the duration of mental ill-health, potentially leading to homelessness
- mental ill-health can precipitate homelessness but there is also a reciprocal effect - homelessness can also contribute to the onset of mental ill-health
- there is a very high incidence of mental ill-health among those those experiencing chronic homelessness and among those seeking assistance from specialist homelessness services.

Risk factors for mental ill-health are correlated with individual characteristics such as age, physical ill-health or disability. However, the risk of housing insecurity for those with mental ill-health is linked with markers of disadvantage, such as previous experience of homelessness, unemployment or incarceration, being a victim of domestic and family violence, having complex needs, lack of social support, problematic behaviours like substance misuse, and difficult behaviours that can emerge with mental illness.

Elements that lead to positive housing and mental health trajectories include:

- diagnosis and treatment for mental health
- choice and control over housing and support (which aids recovery)
- wrap around services including supported housing and
- getting access to affordable, secure, safe and appropriate housing.

Protective factors include: good physical health, social support, use of health services, use of mental health services, and being in home ownership. Lack of access to appropriate mental health support and health services, renting in the private market, negative life events (e.g. separation from spouse, experience of violence, serious illness, disability) are risk factors for housing instability.

Five housing and mental health trajectories are identified. Note that people can move between these trajectories, with the latter two being desired outcomes. The trajectories are:

- **excluded** from accessing services
- **stuck or trapped** in a particular part of the housing system
- **cycling** in and out of institutional, housing and mental health systems
- **stabilising** their situation after finding appropriate mental and housing support and

- **well supported** by mental health and housing support so that they are able to participate in work and the community.

## Housing related reforms for mental health

Mental health systems are presently being reformed in Australia in a number of ways, though there remain areas for improvement in relation to housing:

- the National Disability Insurance Scheme (NDIS) is reshaping Australia's mental health provision but many who have housing issues but less severe mental illness miss out on assistance.
- mental health system frameworks are rightly embracing a consumer centred approach but models need to also address social and system driven problems that contribute to mental ill-health, such as easing housing affordability pressures, and providing more early intervention and prevention approaches that can reduce the need for mental health services.
- mental health policy frameworks are underpinned by a stepped care model recognising severity of mental ill-health. However, these models should also recognise the housing trajectories of individuals and consider that neither housing nor mental health trajectories conform to the linear (or stepped) conceptualisations that underpin policy concepts.

AHURI research is broadly supportive of the reform areas recommended by the Productivity Commission and suggests additional reform areas, which are outlined below.

### Reform area 1: early intervention and prevention

- **Early interventions** around mental health for young people at school could help address youth homelessness, and programs like youth foyers can effectively assist young adults with mental illness who are disconnected from their families.
- **Homelessness prevention** could be improved through: better training and resources about mental illness for housing managers in social and private rental and workers in the homelessness sector; improved processes around anti-social behaviour, temporary absences and information sharing; improved availability of tenancy support programs; and monitoring effectiveness of recent residential tenancy reforms to improve security of tenure in private rental.
- **Policies to improved affordability** in housing could have a beneficial impact in reducing the incidence of mental illness.

### Reform area 2: close critical gaps in community based mental health care services

- **Availability of, and access to, community based mental health care** needs to improve, especially for those on the 'excluded', 'stuck' and 'cycling' trajectories. Assistance is needed in getting diagnoses and navigating the care system. There needs to be an increase in the number of community based mental health care services provided.

### Reform area 3: investment in services beyond health

- **Care integration and coordination** should be improved, including by scaling up state based housing and mental health programs like Doorways (in Victoria) and

Housing and Accommodation Support Initiative (or HASI) in New South Wales to a national level.

- **Support for carers and families** should be increased so people are able to be supported in their homes in the community.
- **People exiting institutions** with a mental illness need support to find and maintain housing (including through a national discharge policy).
- **Supply of long term accommodation** including supported housing and social housing, needs to increase for those presently stuck in transitional housing or in inappropriate living arrangements.
- **Advocacy** for better services could be ramped up by way of peak bodies building consensus and collaboration around housing and mental health.
- **Consumer choice and control** could be improved through increased provision of housing models like Housing First.

#### **Reform area 4: assistance for people with mental illness to get into work and enable early treatment of work-related mental illness**

- **Connections to work** are important for mental health and recovery
- **Housing and connection to local neighbourhoods** with suitable amenities are important elements in facilitating social inclusion and recovery from mental illness, especially for youth.

#### **Reform area 5: fundamental reforms to care coordination, governance and funding arrangements**

- **New reforms** to expand care coordination in housing and mental health need to occur as do new reforms to address exits from institutions.
- **Governance** approaches might include: a national framework and formalised inter-agency agreements for collaboration between housing and mental health providers at a local level. This might also involve new policies guaranteeing no new exits from institutions into homelessness, including clear guidelines around what constitutes an exit into homelessness.

# 1. Evidence on the relationship between housing and mental health

## Terminology

For the purposes of this submission, we refer to mental health and mental ill-health. Mental ill-health is used as an umbrella term that captures the entire range of mental health issues, and comprises:

- 'low prevalence' conditions including schizophrenia and other psychoses, schizoaffective disorders, bipolar disorder and major depression affecting less than three per cent of the adult population
- 'high prevalence' conditions, including depression and/or anxiety and affective disorders, which are the most common mental health disorders and affect approximately 14 per cent and 6 per cent of adults each year respectively (this includes post-traumatic stress disorder, obsessive compulsive disorder, depression and bipolar disorder that have different treatment requirements and outcomes).
- psychosocial disability refers to the functional restrictions associated with a mental health disorder on people's capacity to manage the social and emotional areas of their lives.

## Mental health, housing and homelessness are inter-related

### Housing issues can negatively affect mental health

AHURI research shows that housing issues can trigger mental ill-health. This includes disruptors such as 'neighbours creating problems, high cost of rental and difficulty managing finances' (O'Brien et al. 2002) and mortgage stress (Ong et al. 2019).

Studies using data from the Household Income and Labor Dynamics in Australia (HILDA) survey have shown that entering unaffordable housing (where a household is spending more than 30 per cent of income in housing costs) is detrimental to mental health of individuals residing in low to moderate income households (bottom 40% of income earners). This is not the case for higher income households. Because of this, interventions that can improve housing affordability for low income households (e.g. increased household income, reduced housing costs) would be effective in reducing inequalities in mental health (Bentley et al. 2011).

Most people living with mental ill-health rent in the private market and many struggle with discrimination, insecure tenure and housing affordability stress (Wiesel et al. 2014; Brackertz et al. forthcoming). Australian studies have shown that renters tend to have poorer mental health than home owners, but differences between tenures are due to individual household characteristics of renters, rather than causal effects of the tenure itself (Baker et al. 2013). However a study comparing mental health and housing in the UK and Australia has shown that Australian private renters whose housing became unaffordable experienced a small but significant decline in mental health, while on average the same change in affordability for home purchasers led to no change in mental health (Bentley et al. 2016). However, the reverse was found to be true for the UK (Bentley et al. 2016). The study authors speculate that more generous government support for UK private renters relative to Australian private renters may explain the difference in mental health sensitivity to housing affordability by tenure type (Bentley et

al. 2016). Declines in mental health that came about from housing becoming unaffordable were more likely amongst those also experiencing employment insecurity (Bentley et al 2016).

Because unaffordable private rental appears to have a negative impact on mental health, long term structural trends in the housing system are likely to put increased pressures on households at risk of mental ill-health. Key issues include:

- growth in number of people in private rental (Hulse et al. 2018) and the need to address the higher incidence of mental ill-health of people in the private rental market (Brackertz and Borrowman, forthcoming).
- worsening housing affordability putting stresses on households and worsening mental ill-health (Hulse et al. 2019; Bentley et al. 2016).
- lack of availability of secure tenures like social housing which is rationed, barriers to access, and mobility in and out of social housing for some groups such as Indigenous tenants (Wiesel et al. 2012).

### **Mental ill-health can negatively affect housing security**

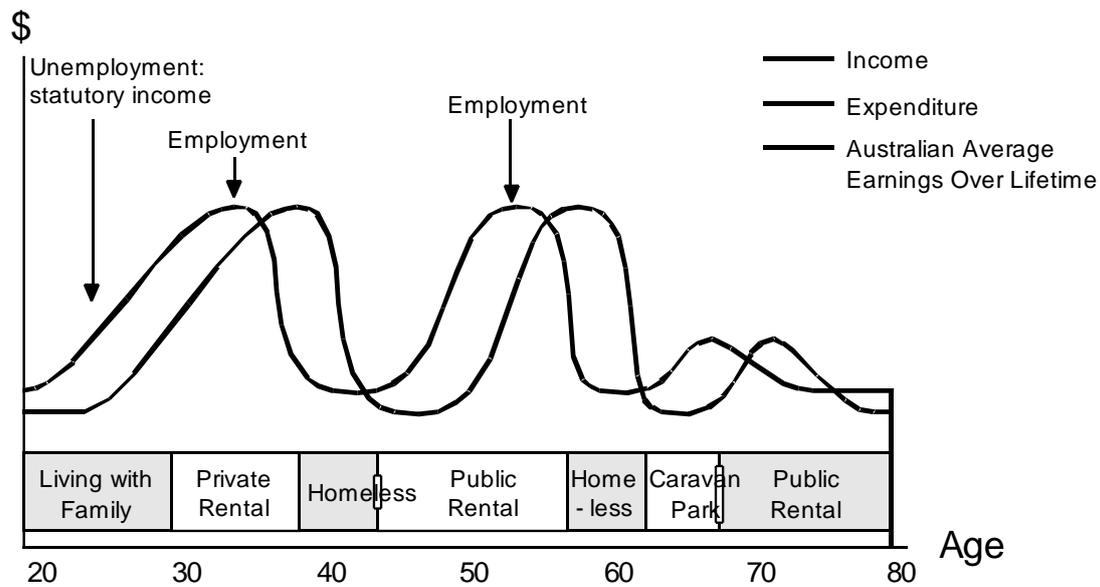
Poor mental health can negatively affect a person's housing situation. Behaviours associated with mental ill-health (e.g. antisocial behaviour, delusional thinking and inability to prioritise finances) may jeopardise housing tenures. Tenants with mental ill-health may contravene anti-social behaviour management policies in social housing, leading to eviction (Habibis et al. 2007).

Mental ill-health can lead to social isolation which can further exacerbate housing crisis by limiting access to emotional support. Poor physical health associated with mental ill-health can undermine a person's capacity to maintain their home (O'Brien et al. 2002).

Entries to homelessness are affected by both structural and individual risk factors. Structural factors include weak labour markets and constrained housing markets. Individual risk factors include serious mental illness and drug or alcohol dependency (Flatau et al. 2013; Johnson et al. 2015).

Over the longer term, people with lived experience of mental ill-health have housing careers that are unstable and often characterised by frequent moves, insecure housing and inadequate accommodation (Kroehn et al. 2008). Figure 1 shows how periods of severe mental ill-health have lag effects that flow through to an individual's housing market transitions. The research suggests that home ownership is not a likely housing outcome for this group, rather public rental housing is appropriate. People living with mental ill-health are more likely to move between the parental home, private rental, homelessness, social housing and caravan parks, due to the episodic nature of mental illness (Kroehn et al. 2008).

**Figure 1: Indicative housing career for a person with a psychiatric disability**



### Psychiatric Disability

Kroehn et al. (2008)

### Mental ill-health can precede homelessness or develop after becoming homeless

Issues around mental illness can both precede, and precipitate, homelessness. A study of homeless people in Melbourne found that 15 per cent of the sample had mental health issues prior to becoming homeless and a further 16 per cent had developed a mental illness since experiencing homelessness. The authors found that 'homelessness seems to cause mental health issues, particularly anxiety and depression' (Johnson and Chamberlain 2011:36). Homelessness is linked with trauma. Trauma can precipitate bouts of homelessness, and homelessness can precipitate trauma (Chamberlain, Johnson et al. 2014).

A study of the Journeys Home longitudinal study of people at risk of or experiencing homelessness also found that there are two distinct pathways for homelessness: those who are homeless before they develop a mental illness, and those whose mental illness is present prior to becoming homeless (Scutella et al. 2014)

- Those who develop mental illness *before* experiencing homelessness usually experience mental illness in adolescence or childhood. Then a long period of time elapses (eight years on average) before the individual experiences homelessness (Scutella et al. 2014).
- Those who develop mental illness *after* becoming homeless usually experience mental illness at a much older age than the general population - this occurs on average nine years after first experiencing homelessness. (Scutella et al. 2014). This supports the idea that environmental exposure to housing related stress can lead to mental illness.

### Chronic homelessness and severe mental illness are strongly related

Analysis of the Journeys Home data showed that mental health diagnosis and psychological distress were highest among people experiencing chronic housing instability and homelessness (Johnson et al. 2014).

Westoby (2016) identified four typical cohorts experiencing severe or chronic mental illness and who are homeless:

- 1 people who are homeless and do not receive any services to support their mental health issues.
- 2 people who are attended to and hospitalised by medical practitioners but who are not adequately supported when released back into the community.
- 3 people who are treated in a psychiatric facility in hospital and remain hospitalised without a discharge or exit strategy back into the community.
- 4 people who experience primary or secondary homelessness in substandard and insecure tenures and who struggle to manage their mental health.

## **Risk factors for mental ill-health and housing insecurity**

### **Risks of mental ill-health are unevenly distributed by region but this is explained by individual demographics rather than area effects**

The evidence suggests that mental health varies across geographic areas, but area effects (e.g. geographic location) do not appear to be significant in explaining overall levels of mental health – rather it is risk factors at the individual level that seem to most strongly and independently be associated with mental health. The uneven distribution by region is associated with clustering of individuals with particular risk factors like age, physical ill-health and financial hardship, in certain geographic locations (Butterworth et al. 2006).

### **Risk factors for mental ill-health are elevated for those with other markers of disadvantage**

Individual risk factors for housing instability and mental ill-health include:

- **Homelessness** The prevalence of severe and persistent mental illnesses is higher among people experiencing homelessness than the general population and the risk of homelessness among people with mental ill-health is significant (Lourey et al. 2012).
- **Lack of social support** People often draw on the financial and emotional support of friends and family during crises. The symptoms of mental ill-health can cause individuals to withdraw from or overtax their support networks thereby eroding the informal resources available to them in times of crisis (Gaebel et al. 2016; O'Brien et al. 2002).
- **Alcohol and other drugs** Long-term substance misuse has been linked to anxiety, depression and paranoia. Persons with bipolar, anxiety and antisocial personality disorders are more vulnerable to alcohol or other drug addiction (Shivani et al. 2002; AIHW 2016a).
- **Domestic and family violence** Domestic and family violence (DFV) is a leading cause of homelessness for parents and children. Those escaping DFV are vulnerable to mental ill-health as a result of trauma associated with violence in the family home (Gilroy et al. 2016; Rees et al. 2011; AIHW 2016b).
- **Interaction with the criminal justice system** People with mental ill-health who enter prison or forensic care are at an elevated risk of housing instability and homelessness (Baldry et al. 2012; Forensicare 2011; Johnson et al. 2015; Robinson 2003).

- **Unemployment** Employment can mitigate homelessness by facilitating greater access to longer-term accommodation options such as private rental, while also improving mental health through feelings of empowerment and self-worth (Bond et al. 2012; Caton et al. 2005, Howden-Chapman et al. 2011; Johnson et al. 2015).
- **Physical ill-health** People with physical ill-health have a higher rate of entry into homelessness and the presence of a chronic health condition predicts longer duration of, and lower rates of exit from, homelessness (Bevitt et al. 2015). People with a long term health condition are 38 per cent more likely to experience deteriorating mental health in the next year (Brackertz and Borrowman, forthcoming). Those with poorer physical health had lower levels of mental health, but people within this group experienced better mental health if they had higher levels of social capital. People with very good self-assessed general health are 80 per cent less likely to experience worsening mental health in the following year (Brackertz and Borrowman, forthcoming).
- **Disability.** Middle and lower income earners experience greater deterioration in their mental health after acquiring disabilities than those on higher incomes. The evidence shows that this deterioration occurred across all tenures but especially among private renters, people with mortgages and renters in unaffordable housing (Kavanagh et al. 2016).
- **Complex and high needs.** Persons experiencing both homelessness and mental ill-health represent a hard to reach group for service providers (Brackertz and Winter 2016). Ineffective service responses can have significant impacts given that causation flows in both directions with regard to the worsening of mental health and homelessness (Johnson and Chamberlain 2011).
- **Difficult behaviours.** Some behaviours associated with mental ill-health (e.g. anti-social behaviour, delusional thinking, inability to prioritise finances) may be detrimental to a person's housing situation. For example, difficult behaviours may trigger anti-social behaviour management policies for people living in public housing, sometimes causing eviction (Jones et al. 2014).

## **Positive housing and mental health trajectories depend on access to mental health services, adequate housing, resources and supports**

### **What is a positive housing and mental health trajectory?**

Policy makers require an understanding of how people experiencing mental ill-health are able to successfully navigate their way to stable mental health and housing outcomes.

'Housing pathways' is a terminology that describes the experiences and mobility of households and residents within the housing system (Clapham 2002; Wiesel et al. 2012). AHURI research has recently built on this concept and broadened it to describe the experiences of housing and mental health over time – these housing and mental health pathways are termed 'trajectories' (Brackertz et al. forthcoming).

### **Diagnosis and use of mental health services help prevent entry into homelessness and accelerate exits from homelessness**

Analysis of the Journeys Home data showed that persons diagnosed with bipolar disorder or schizophrenia are 3.2 per cent less likely to enter into homelessness than those without diagnosis. This represents a 40 per cent reduction in the chance of becoming homelessness. This may reflect the impact of engagement with services in

preventing homelessness, and the fact that people with low prevalence illnesses are more likely to engage with health services (Johnson et al. 2015).

By contrast, those without a mental health diagnosis who experienced severe psychological distress were more likely to enter into homelessness compared to those without a diagnosis and without symptoms (Brackertz et al. forthcoming).

The Journeys Home data also showed that people with a recently diagnosed mental illness who experienced homelessness were also more likely to *exit* homelessness within six months compared to the broader homeless population and spent less time in primary homelessness than other respondents (Bevitt et al. 2015). The authors attribute this to that group having better access to the service system including homelessness services.

### **Choice and control over housing and support assist in recovery**

AHURI research shows that independent housing is a critical foundation that enables people with mental ill-health to manage psychiatric disability, cope day to day and it supports their wellbeing (O'Brien et al. 2002). This housing:

*...needs to be "acceptable" to the person. Even though it may not need to meet all their preferences, it must not have features that make it difficult to manage any disabilities associated with the mental illness' (O'Brien et al, 2002:ix).*

Choice and control over housing and support contribute to wellbeing and quality of life for people with mental ill-health (Nelson et al. 2007). Autonomy with respect to housing aspirations, and housing which fosters meaningful relationships in the home and the community, are associated with improved wellbeing and quality of life, and decreased symptomatology and service use (Aubry et al. 2016; Nelson et al. 2007).

Control over housing can deliver indirect positive mental health outcomes to individuals through feelings of empowerment and belonging. Empowerment and personal control are associated with greater resilience and ability to cope with stressors among people with severe mental illness (Aubry et al. 2016).

### **Affordable, secure and good quality housing and good neighbourhood amenity help those experiencing mental illness**

Public housing is found to have a protective quality in preventing entry into homelessness. Using the 'at risk' cohort from the Journeys Home data, recent AHURI research found that compared to private rental, those in public housing had a 10% decrease in the risk of entry into homelessness (Brackertz and Borrowman, forthcoming). There is evidence that safe, secure, appropriate and affordable housing allows people to focus their attention on mental health recovery (Bleasdale 2007; Honey et al. 2017).

A number of studies have shown that good quality housing (building amenity and aesthetic appearance of newer well maintained buildings) reduces mental health care costs and leads to greater wellbeing and residential stability (Harkness et al. 2004; Nelson et al. 2007). A study in Scotland showed that new and improved living conditions around housing features led to social participation and neighbourhood interaction. It also found that improvements in housing design can change residents' psycho-social processes with positive flow on effects for mental health and quality of life (Gibson et al. 2011). Neighbourhood amenity is a factor in reducing mental health care costs among those with mental ill-health and helps in maintaining usage of mental health care services (Harkness et al. 2004).

## **The impact of poor mental health on housing instability is mediated by access to resources like services, social support and home ownership**

To better understand the nature of mental health and housing trajectories, AHURI analysed two longitudinal panel data sets: HILDA, which represents the general population; and Journeys Home, which represents a vulnerable cohort who is at risk of homelessness or is homeless (Brackertz et al. forthcoming).

The analysis:

- considered the direct effects of mental health status and deteriorating mental health on tenure and housing stability (as measured by financial hardship or forced moves).
- modelled the impact of mediating factors (health and mental health services use, physical health, life events, housing and non-housing factors).
- undertook a survival analysis to determine the duration of spells people spend in mental ill-health.

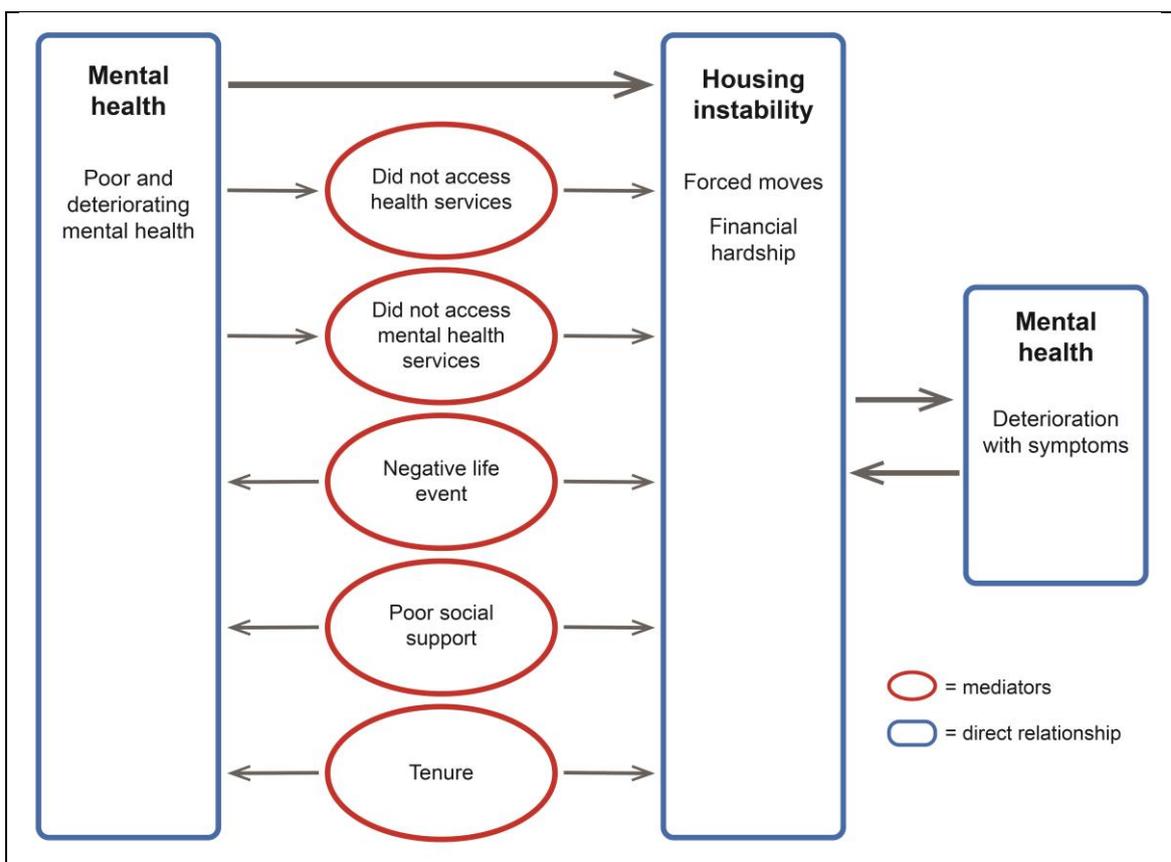
The analysis confirmed that deteriorating mental health and mental health diagnosis have a statistically significant relationship to housing instability. It also identified a number of mediating factors that helped to reduce the impact of mental ill-health on housing instability, or shortened the length of time a person experienced mental ill-health:

- tenure (home ownership provides some degree of protection against deteriorating mental health).
- good general health.
- adequate social support.
- accessing mental health and health services.

Conversely, the absence of mediators and presence of negative life events (like serious personal injury or illness or a long term health condition) increased the likelihood of housing instability and deteriorating mental health. The relationships between housing instability and mental health are illustrated in Figure 2 below.

Mediating factors largely work on an individual level and can therefore be understood as individual risk or protective factors. However, the degree of impact these mediating factors can have on a person's mental health and housing trajectory also depend on the availability and adequacy of service system.

**Figure 2: Mental health and housing instability direct effects and mediating factors**



Source: Brackertz et al. (forthcoming).

### There are diverse mental health and housing trajectories

AHURI research (Brackertz et al. forthcoming) identified five typical mental health and housing trajectories. Trajectories can be non-linear, circuitous or interrupted and people can move between them. These trajectories do not relate to the severity of mental illness or level of need (for example, a person may have a severe mental illness, but can still be well supported if they have stable housing and appropriate mental health). Rather they show people's transitions through the housing and mental health systems. In this sense, mediating factors (as outlined above) can act as triggers that contribute to a person entering or remaining within a certain trajectory, or moving between trajectories. A successful trajectory depends on whether it is aligned with people's individual capacity and their needs in terms of housing and mental health.

The trajectories are as follows:

- **Excluded from help required** They key characteristic of this trajectory is a lack of access to housing or mental health support. This may be because: people do not meet eligibility criteria; services and/or housing are not available, inappropriate, or difficult to access; there is a lack of clarity within the system about who is responsible for providing support and services; the system is difficult to navigate; discrimination, lack of culturally appropriate services or prior negative experiences discourage access; there is a lack of system integration and coordination between services; the system is crisis driven; high cost prevents access.

- **Stuck/trapped without adequate support** due to a lack of options or pathways. This trajectory includes people who are: trapped in inappropriate housing (e.g. crisis or transitional housing) because there are no pathways into appropriate and affordable long term housing; stuck in hospitals or institutions because of involuntary arrangements, because they cannot be discharged, or because there is no transition support available or due to a lack of adequate community care; stuck financially and are unable to afford appropriate housing and/or mental health treatment and support; stuck without help to navigate the system; have multiple complex needs and do not receive the help they need due to a lack of system integration.
- **Cycling** means that people enter into and drop out of the system, services and supports repeatedly. Cycling is generally characterised by a strong downward trajectory. Cycling can be due to: inappropriate discharge from institutions or state care into homelessness or short term housing; the episodic nature of mental health and the lack of flexible, scalable long term services; inadequate duration of support; symptom management rather than holistic care; people disengaging due to bad or inappropriate services; lack of continuity between services; lack of an ongoing support worker; unresolved trauma; the need to trade off access to one type of support against losing another type of support; the NDIS service model not being compatible with recovery oriented care; and a system in which people cannot access help until they reach crisis point.
- **Stabilising** means that people have access to secure, safe, appropriate and affordable housing in a location that is meaningful to them, as well as ongoing mental health support, support to facilitate meaningful social connection, and financial stability. Once these conditions are in place, people can focus on recovery and rebuilding their lives.
- **Well supported** means that people: have the type of housing and level of care that is right for them, and engage in meaningful activities and relationships; have financial security. There is no one specific outcome that classifies a person as well supported, rather it aligns with people's individual capacity and housing and mental health needs. Well supported people can navigate the system. This means that a person has the support to develop their own independence and achieve their ambitions as they are able to focus on things beyond housing and mental health.

## 2. Evidence on housing related reforms for mental health

The Productivity Commission draft report argues for a substantial improvement in treatment of mental ill-health, and suggests the following reforms:

- Reform area 1: prevention and early intervention for mental illness and suicide attempts
- Reform area 2: closing critical gaps in health care services
- Reform area 3: investing in services beyond health
- Reform area 4: assisting people with mental illness to get into work and enable early treatment of work-related mental illness (especially for young people)
- Reform area 5: fundamental reforms to care coordination, governance and funding arrangements.

Most matters relating to the intersection of housing and mental health are in reform area 3. In this chapter, the suggestions made by the Productivity Commission are considered, and additional reform suggestions are made in turn, citing relevant AHURI research evidence.

### Reform context

#### **The NDIS is reshaping Australia's mental health system, but many with housing issues but less severe mental illness, miss out**

Australia's mental health system has two principal components—the clinical mental health sector, which is functionally separate from the NDIS, and community mental health services, which focus on on psycho-social wellbeing and participation in home and community life. The NDIS is reshaping the mental health service landscape and many community mental health services are being subsumed into the NDIS (the NDIS mental health component mainly consists of funding for psycho-social support services). While the NDIS is providing good outcomes for some people, people on the 'excluded', 'stuck' and 'cycling' trajectories are missing out.

#### **It is appropriate for mental health system frameworks to embrace a consumer centred approach**

The Productivity Commission report adopts a consumer centred approach that conceptualises people who experience mental ill-health as individuals who are potentially service *consumers*, and assumes that the services available and provided will usually be appropriate to their needs. AHURI research affirms the importance of choice and control as principles of service provision to people living with mental ill-health (see section 1).

Consumer centred welfare service reforms (e.g. in relation to the NDIS) aim to:

- give people greater control over their own lives.
- promote personal responsibility.
- develop a diverse range of services which can meet needs in a more customised way.
- diversify service provision through the involvement of a range of private and not-for-profit providers.

→ make government assistance more cost-effective (Jacobs et al. 2015).

### **Consumer centred models should consider the social and system driven dimensions of mental ill-health and early intervention and prevention approaches**

There are limitations to consumer centred models based on choice. AHURI research suggests that consumers may not always be aware of what they need (e.g. they may require medical and other help to make good choices) (Jacobs et al. 2015). Services that can be purchased may not always be appropriate, or the best way to achieve mental health (e.g. social connection may be better pursued through informal resources rather than formal supports) (Duff et al. 2013) and in some cases services may not be available at all (e.g. in some regional areas).

The proposed Productivity Commission reforms focus on the economic model of service provision and include some elements that consider social dimensions of mental ill-health and prevention and early intervention. It has four main elements (reorienting health services to consumers, reorienting surrounding services to people, early intervention and prevention, and governance and evaluation).

While provision of adequate housing might be considered a service that can be incorporated into a person's consumption 'budget', the housing market is part of a wider social and economic system. Consequently, effective solutions for people with mental ill-health will need to take into account systemic and structural problems in the housing system and mechanisms for prevention and early intervention of housing instability and homelessness, which may ease emerging mental health issues.

### **Mental health policy frameworks are based on a stepped model of care that recognises the severity of mental ill-health, but should also consider the housing trajectories of individuals**

The stepped care model is central to Australia's mental health care provision and reforms and guides the activities of Primary Health Networks. This model assumes that people can be easily placed in one of the categories according to the level of severity of their mental illness. However, people don't step up or down, but rapidly go from 'stable' to 'severe' conditions. Also, the model treats mental health as an ongoing linear progression, whereas illness can be episodic. Not all steps along the model are equally well resourced and accessible (e.g. those between GPs and clinical mental health facilities, called the 'missing middle'). For example, a person living with a severe mental illness who is stably housed may receive high levels of support, while a person who is homeless but with less severe mental illness may struggle to get the support they need, and their circumstances could change rapidly. For this reason, policy frameworks should calibrate assistance according to people's housing and mental health trajectory rather than just severity of their mental illness.

## **Reform area 1: early intervention and prevention**

### **Interventions for young people**

The Productivity Commission recommends a range of early interventions for youth, including that all schools provide educational support for children with mental illness and wellbeing leaders in schools. They also recommend reforms to encourage environments in which young adults can remain engaged and mentally well— most of these initiatives focus on greater use of online services and training and focus on strategies for tertiary institutions.

People with complex needs find it difficult to obtain housing and access to housing and homelessness support often occurs only after hospital admission for mental ill-health or when they are already homeless (Brackertz et al. forthcoming). There is evidence to support approaches that involve intervention at schools including case management of people with mental illness to address risks around youth homelessness (McKenzie 2018; Chamberlain and McKenzie 2004).

Family conflict and trauma are key causes of homelessness among children and young people (Chamberlain and McKenzie, 2004, Chamberlain et al. 2014) and many mental illnesses first emerge in teenage and young adulthood (Scutella et al. 2014).

AHURI research supports the importance of assisting young people who are disconnected from home and their families, as well as those leaving state care (Johnson et al. 2010), as this cohort is at high risk of homelessness and poor mental health. Youth foyers which provide education, employment and other support and housing in a group setting have been proven to be a successful model to address the needs of this cohort. They have been successful in regional and rural areas especially for gay and lesbian young people (Randolph and Wood 2005; Beer et al. 2006).

### **Prevent housing issues from arising**

The Productivity Commission make a recommendations around improving housing security for those with a mental ill-health and recommends that in the medium term state and territory governments (sometimes with support of the Australian Government) should:

- offer and encourage use of mental health training and resources for social housing workers
- review policies relating to anti-social behaviour, temporary absences and information sharing to provide consideration of people with mental illness to reduce risks of eviction
- ensure tenants with a mental illness who live in the private sector have the same ready access to tenancy support services as those in social housing by meeting demand for those services.

In the long term, the Productivity Commission recommend:

- Monitoring the effects of recent reforms to residential tenancy legislation aimed at increasing security of tenure and their impacts on people with mental illness.

AHURI research broadly supports these recommendations:

- Addressing mental illness is important to addressing anti-social behaviour (Martin et al. 2019). Resources already exists to assist public housing providers in sustaining tenancies for those with demanding behaviours that may be affected by mental illness (Habibis et al. 2007).
- Tenancy support programs have been shown to be cost effective in managing short term crises, sustaining tenancies and preventing homelessness (Zaretzky and Flatau 2015). There is scope to expand the use of, and tailor, existing tenancy support programs to be more accessible to people with housing instability due to mental ill-health (Brackertz et al. 2018).
- AHURI research identifies the importance of working with private rental sector landlords, real estate agents and peak organisations to inform and educate them about the housing needs of people with mental ill-health and to minimise discrimination in the private rental market (Brackertz et al. 2018).

- Tailored education and resources and workforce training could build the capacity of the specialised homelessness sector (which has high staff turnover) to recognise issues in relation to: trauma and mental health, children's homelessness, complex needs, hoarding and squalor and gender identity (Spinney 2018).

AHURI research also supports the recommendation that governments improve affordability of housing as a means of preventing the incidence of mental illness (Bentley et al. 2011).

## **Reform area 2: close critical gaps in health care services**

### **Health care access - community mental health provision**

The Productivity Commission recommend ensuring access to the right level of care, assessment, referral and matching practices in line with consumer treatment needs. The Productivity Commission also support the Medicare Benefit Schedule (MBS) rebated psychological therapy.

AHURI evidence identified that there are barriers to accessing mental health care, especially for the 'excluded' group (described in Section 1.4). Barriers include difficulties in getting a diagnosis (especially for people experiencing homelessness) and a lack of support and guidance to navigate the complex and fragmented care system for those on the 'excluded', 'cycling' and 'stuck' trajectories) (Brackertz et al. forthcoming). People with diagnosed low prevalence mental illnesses (such as bipolar disorder and schizophrenia) are more likely to be able to access services, but those without diagnosis often struggle to get sufficient assistance. There are also issues around duration of care, which is often not aligned with the duration of need, causing people to cycle in and out of housing, homelessness, mental health and health supports, to the detriment of their recovery (Brackertz et al. forthcoming).

AHURI found that a key issue is gaining client consent to ensure effective referrals between services. The lack of shared consent between services can be an impediment to effective support coordination and can be a barrier to effective early intervention and prevention. Although there is generally a sufficient supply of clinical and GP services, there is also a need to invest more in community based mental health support ('the missing middle'). These services are important as they can be provided to people in their homes. This is a cost effective means of ensuring people can live in the community while also receiving appropriate care (Brackertz et al. forthcoming).

## **Reform area 3: Investment in services beyond health**

### **Improve care integration and coordination, including with housing**

The Productivity Commission makes recommendations for improved care pathways for people using the mental health system.

AHURI research confirms that many people struggle to navigate the mental health care and housing systems, especially those on the 'cycling', 'excluded' or 'stuck' trajectories and shows that:

- there is a strong association between mental ill-health and homelessness but the mental health, housing and homelessness systems are not well integrated (e.g. Flatau et al. 2013; Brackertz et al. 2018)
- there are failure points in the housing, homelessness and mental health systems (Brackertz et al. 2019).

- effective models that provide integrated housing, mental health and homelessness support already exist, but they do not meet demand (Brackertz et al. 2018).

This could be supported by: greater cross system integration; models for shared consent between services; and programs that integrate and coordinate housing, homelessness, mental health and other supports. A number of successful programs already exist in Australia that integrate housing and mental illness programs, such as:

- NSW Housing and Accommodation Support Initiative (HASI).
- Doorway program (Victoria).
- Queensland Housing and Support Program (HASP).

These programs have been shown to be successful in generating government cost savings, improving tenancy stability and improving consumer mental health and wellbeing (Brackertz et al. 2018).

There is scope to scale up these programs nationally to meet demand in other states and territories, and extend to new cohorts. This could occur through national frameworks and inter-agency agreements with clear guarantees given by parties around outcomes. This could already leverage off the reform frameworks already utilising a person centred approach, and perhaps integrate housing through the Primary Health Networks (Brackertz et al. 2018). To be successful this would require:

- rapid access to appropriate, affordable and stable housing (either public, community or private rental housing)
- policy and stakeholder coordination and
- integrated, person centred support (Brackertz et al. 2018).

### **Increase support for carers and families**

The Productivity Commission recommend increased support for carers and families of people with mental ill-health. AHURI research supports this recommendation.

AHURI research finds that in psycho-social rehabilitation, a specialist key worker or case manager and the supportive role of family and friends were central to recovery, and enabled people to live independently (O'Brien et al. 2002). AHURI research finds that families and carers form a significant, though largely unacknowledged component of the mental health system and helpful for enabling many people to remain in their housing in the community (Brackertz et al. 2019).

### **Support people to find and maintain housing**

The Productivity Commission make a number of recommendations for supporting people to find and maintain housing. These include:

- national discharge policy - federal and all state and territory governments commit to a nationally consistent formal policy of no exits into homelessness for people with a mental illness who are in discharged from institutional care, including hospitals and prisons.
- individuals discharged from hospitals and prisons should receive a comprehensive mental health discharge plan and services have the capacity to meet their needs.
- the NDIS should review its Specialist Disability Accommodation strategy to encourage long-term supported accommodation for NDIS recipients with severe and persistent mental illness.

- each state and territory government should work towards meeting the gap in the number of supported housing places (including long term housing options)
- each state and territory should work towards meeting the gap for homelessness services among people with mental illness

AHURI research supports these these recommendations and identifies transitions between different parts of the system and between services as key risk points for becoming homeless (Brackertz et al forthcoming).

AHURI evidence demonstrates that supported housing is an important component of addressing the needs of people with mental ill-health and disability and in reducing homelessness, including in the context of the programs integrating housing and mental illness (mentioned above) (Parsell et al. 2015).

### **Social housing supply**

AHURI research finds that increasing social housing should be a key area of intervention to address the needs of people requiring longer term accommodation. Living in social housing is a strong protective factor against homelessness (Brackertz and Borrowman, forthcoming).

### **Advocacy - build consensus and collaboration around housing and mental health**

The Productivity Commission makes recommendations around ensuring advocacy for people scheduled under Mental Health Acts.

AHURI research finds that getting policy traction and system change in relation to housing and mental health will require a clearly articulated position, sustained advocacy and leadership (Brackertz et al. 2018). Effective mechanisms to gain cross-sectoral support could be to:

- convene a national roundtable of peak bodies for mental health and housing organisations and consumers, carers and tenants to develop an integrated advocacy position
- develop a consensus statement on housing and mental health
- involve the private sector stakeholders to generate innovative solutions, access funding and raise awareness of housing and mental health in the private sector.

### **Increase consumer choice and control in relation to housing through models like Housing First**

AHURI research shows that choice and control over housing and services contributes to wellbeing and quality of life for people with lived experience of mental ill-health (Brackertz et al. 2019). People with lived experience of mental ill-health need appropriate treatment, tailored to the needs of the individual (O'Brien et al. 2002). This is especially relevant to people in the 'stuck' cohort who are trapped in transitional or other temporary housing or who are chronically 'cycling' in and out of homelessness, (as described in section 1.4).

- A continuum of care model links consumers to housing and clinical and psychosocial support services (sometimes it is called a treatment first, step-wise approach, linear, or staircase transition model) and is usually targeted to people experiencing homelessness. A critical feature of these models is that the provision of housing is conditional upon the consumer accepting and engaging with support services, and in some cases the consumer must have addressed their problems

before moving into a tenancy. However this model has been criticised for not adequately addressing rough sleeping, and for undermining an individual's capacity to achieve independence.

- Housing First differs from a continuum of care model as it is a philosophy of support provision based on the notion that secure and appropriate housing is fundamental to recovery and should be provided unconditionally to consumers. Access to housing is made with no readiness conditions. The model has been successful in the United States and Canada in combatting homelessness, but there are few Australian Housing First programs practicing all principles, although many are operating under programs that align with the majority of Housing First principles.

## **Reform area 4: assistance for people with mental illness to get into work and enable early treatment of work-related mental illness**

### **Social inclusion helps recovery from mental illness**

The Productivity Commission recommends active and strong leadership to reduce the social exclusion and stigma that can be associated with mental illness.

Connections to work are important. Recent research by AHURI shows that the loss of a job or redundancy is significantly related to lower self-assessed mental health in the following year. Furthermore, not being in the labour force increases the length of time that mental ill-health is experienced by 10 per cent compared to those who are working (Brackertz and Borrowman forthcoming).

Social support decreases the likelihood of mental health deteriorating to the point that symptoms are experienced. It also is important in recovering from mental ill-health – modelling shows that individuals with social support are less likely to become homeless (Johnson et al, 2015) and are likely to experience 5 per cent shorter spells in mental ill-health (Brackertz and Borrowman forthcoming).

Housing security is an important anchor for the recovery of people with mental illness and feelings of security are linked with community attachment. AHURI research also supports the role of informal resources in fostering social inclusion, which is often an important stepping stone to engaging or re-engaging with work. Location affected access to informal supports: AHURI research found that clients liked being located close to shops and public transport (O'Brien et al, 2002). Informal resources such as cafes were also an important part of helping recovery for young people (Duff et al. 2013).

## **Reform area 5: fundamental reforms to care coordination, governance and funding arrangements**

### **Governance changes**

The Productivity Commission recommend the creation of a new national mental health and suicide prevention agreement, a whole of government mental health strategy, and improved measures for consumer and carer participation in system planning.

AHURI research identifies that there are currently barriers to scaling up successful housing and mental health programs at the national level and that there is a need to develop:

- a national framework for interagency collaboration, including formalised agreements for collaboration between housing and mental health providers at the state and local levels
- a national discharge policy
- commitment to innovative funding models
- building the organisational capacity in the housing sector around mental illness and mental health provision (Brackertz et al. 2018)
- consistent, measurable indicators and outcomes for both mental health and housing (Brackertz et al. forthcoming).
- high level discussions about the need for integrated housing and mental health policies and integrated services provision (Brackertz et al. 2018)

## References

- Aubry, T., Duhoux, A., Klodawsky, F., Ecker, J. and Hay, E. (2016) 'A longitudinal study of predictors of housing stability, housing quality, and mental health functioning among single homeless individuals staying in emergency shelters', *American Journal of Community Psychology*, vol. 58, no. 1-2, pp.123-135.
- Australian Institute of Health and Welfare (2016a) *Exploring drug treatment and homelessness in Australia: 1 July 2011 to 30 June 2014*, Cat. no. CSI 23, AIHW, Canberra.
- Australian Institute of Health and Welfare (2016b) *Vulnerable young people: interactions across homelessness, youth justice and child protection—1 July 2011 to 30 June 2015*, Cat. no. HOU 279, AIHW, Canberra.
- Baldry, E., Dowse, L., McCausland, R. and Clarence, M. (2012) *Lifecourse institutional costs of homelessness for vulnerable groups*, National Homelessness Research Agenda 2009-2013, School of Social Sciences: University of New South Wales.
- Baker, E., Bentley, R. and Mason, K. (2013) 'The mental health effects of housing tenure: causal or compositional?', *Urban Studies*, vol. 50, no. 2, pp.426-442.
- Baker, E., Mason, K., Bentley, R. and Mallett, S. (2014) 'Exploring the bi-directional relationship between health and housing in Australia', *Urban Policy and Research*, vol. 32, no. 1, 71-84.
- Beer, A., Delfabbro, P., Natalier, K., Oakley, S., Verity, F., Packer, J., Bass, A. (2005) *Developing models of good practice in meeting the needs of homeless young people in rural areas*, AHURI Final Report No. 83, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/83>.
- Bentley, R., Baker, E., Mason, K., Subramanian, S. and Kavanagh, A. M. (2011) 'Association between housing affordability and mental health: a longitudinal analysis of a nationally representative household survey in Australia', *American Journal of Epidemiology*, vol. 174, no. 7, pp.753-760.
- Bentley, R. J., Pevalin, D., Baker, E., Mason, K., Reeves, A. and Beer, A. (2016a) 'Housing affordability, tenure and mental health in Australia and the United Kingdom: a comparative panel analysis', *Housing Studies*, vol. 31, no. 2, pp.208-222.
- Berry, H. L. and Welsh, J. A. (2009) 'Social capital and health in Australia: an overview from the household, income and labour dynamics in Australia survey', *Social science & medicine*, vol. 70, no. 4, pp.588-596.
- Bevitt, A., Chigavazira, A., Heralut, N., Johnson, G., Moschion, J., Scutella, R., Tseng, Y.-P., Wooden, M. and Kalb, G. (2015) *Journeys home research report no. 6*, University of Melbourne, Melbourne.
- Bleasdale, M. (2007) *Supporting the housing of people with complex needs*, AHURI Final Report No. 104, Australian Housing and Urban Research Institute,, Melbourne, <https://www.ahuri.edu.au/research/final-reports/104>.
- Bond, L., Kearns, A., Mason, P., Tannahill, C., Egan, M. and Whitely, E. (2012) 'Exploring the relationships between housing, neighbourhoods and mental wellbeing for residents of deprived areas', *BMC Public Health*, vol. 12, no. 1, pp.48

- Brackertz, N. and Winter, I. (2016) *Effectiveness of the homelessness service system*, report prepared by AHURI Professional Services for the Housing and Homelessness Senior Officers Network, Melbourne.
- Brackertz, N. and Borrowman, L. with Scutella, R. (forthcoming) *Trajectories: the interplay between mental health and housing pathways: analysis of mental health and housing instability using the HILDA and Journeys Home surveys* AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne
- Brackertz, N., Borrowman, L. and Roggenbuck, C. (forthcoming) *Mental health and housing trajectories* AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne
- Brackertz, N., Wilkinson, A., and Davison, J. (2019) *Trajectories: the interplay between mental health and housing pathways. A short summary of the evidence.*, AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/research-papers/trajectories-the-interplay-between-mental-health-and-housing-pathways>.
- Brackertz, N., Wilkinson, A., and Davison, J. (2018) *Housing, homelessness and mental health: towards systems change*, AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/research-papers/housing-homelessness-and-mental-health-towards-systems-change>.
- Butterworth, P., Rodgers, B. and Jorm, A. F. (2006) 'Examining geographical and household variation in mental health in Australia', *Australian and New Zealand Journal of Psychiatry*, vol. 40, no. 5, pp.491-497.
- Caton, C. L., Dominguez, B., Schanzer, B., Hasin, D. S., Shrout, P. E., Felix, A., McQuiston, H., Opler, L. A. and Hsu, E. (2005) 'Risk factors for long term homelessness: findings from a longitudinal study of first-time homeless single adults', *American Journal of Public Health*, vol. 95, no. 10, pp.1753-1759.
- Chamberlain, C., Johnson, G., and Robinson, C. (2014) *Homelessness in Australia: an introduction* UNSW Press Sydney.
- Chamberlain, C., MacKenzie, D. (2004) *Youth homelessness: four policy proposals*, AHURI Final Report No. 69, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/69> .
- Clapham, D. (2002) 'Housing pathways: a post-modern analytical framework', *Housing Theory and Society*, vol.19, pp.57-68.
- Duff, C., Jacobs, K., Loo, S. and Murray, S. (2013) *The role of informal community resources in supporting stable housing for young people recovering from mental illness: key issues for housing policy-makers and practitioners*, AHURI Final Report No. 199, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/199>.
- Flatau, P., Conroy, E., Thielking, M., Clear, A., Hall, S., Bauskis, A. and Farrugia, M. (2013) *How integrated are homelessness, mental health and drug and alcohol services in Australia?*, AHURI Final Report No. 206, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/206> , doi:10.18408/ahuri-8201301.

- Forensicare (2011) *The public housing needs of offenders with a mental illness*  
Submission to Family and Community Development Committee – Inquiry into the adequacy and future directions of public housing in Victoria, Forensicare, Victorian Institute of Forensic Mental Health, Melbourne
- Gaebel, W., Rössler, W. and Sartorius, N. (2016) *The Stigma of Mental Illness-End of the Story?*, Springer.
- Gibson, M., Thomson, H., Kearns, A. and Petticrew, M. (2011) 'Understanding the psychosocial impacts of housing type: qualitative evidence from a housing and regeneration intervention' *Housing Studies*, vol. 26, no. 4, pp.555-573.
- Gilroy, H., McFarlane, J., Maddoux, J. and Sullivan, C. (2016) 'Homelessness, housing instability, intimate partner violence, mental health, and functioning: A multi-year cohort study of IPV survivors and their children', *Journal of Social Distress and the Homeless*, vol. 25, no. 2, pp.86-94.
- Habis, D., Atkinson, R., Dunbar, T., Goss, D., Easthope, H., Maginn, P. (2007) *A sustaining tenancies approach to managing demanding behaviour in public housing: a good practice guide*, AHURI Final Report No. 103, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/103>.
- Harkness, J., Newman, S. J. and Salkever, D. (2004) 'The cost-effectiveness of independent housing for the chronically mentally ill: do housing and neighbourhood matter?' *Health Services Research*, vol. 39, no.5 pp.1341-1360.
- Honey, A., Nugent, A., Hancock, N. and Scanlan, J. (2017) "'It's hard work, believe me!": Active efforts to optimise housing by people who live with mental illness and access housing assistance', *Australian Journal of Social Issues*, vol. 52, no. 4, pp.347-366.
- Howden-Chapman, P. L., Chandola, T., Stafford, M. and Marmot, M. (2011) 'The effect of housing on the mental health of older people: the impact of lifetime housing history in Whitehall II', *BMC Public Health*, vol. 11, no. 1, pp.682.
- Hulse, K., Reynolds, M., Nygaard, C., Parkinson, S. and Yates, J. (2019) *The supply of affordable private rental housing in Australian cities: short-term and longer-term changes*, AHURI Final Report No. 323, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/323> , doi:10.18408/ahuri-5120101.
- Hulse, K., Martin, C., James, A. and Stone, W. (2018) *Private rental in transition: institutional change, technology and innovation in Australia*, AHURI Final Report No. 296, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/296> , doi:10.18408/ahuri-5112101.
- Jacobs, K., Lawson, J., Gabriel, M., Hulse, K. (2015) *Individualised and market-based housing assistance: evidence and policy options*, AHURI Final Report No. 253, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/253>.
- Johnson, G. and Chamberlain, C. (2011) 'Are the homeless mentally ill?', *Australian Journal of Social Issues*, vol. 46, no. 1, pp.29-48.
- Johnson, G., Natalier, K., Mendes, P., Liddiard, M., Thoresen, S., Hollows, A., Bailey, N. (2010) , *Pathways from out of home care* AHURI Final Report No. 147, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/147>.

- Johnson, G., Parkinson, S. and Parsell, C. (2012) *Policy shift or program drift? Implementing Housing First in Australia*, AHURI Final Report No. 184, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/184>.
- Johnson, G., Kuehnle, D., Parkinson, S., Sesa, S. and Tseng, Y.-P. (2014) *Resolving long-term homelessness: a randomised controlled trial examining the 36 month costs, benefits and social outcomes from the journey to social inclusion pilot program*, Sacred Heart Mission, Melbourne.
- Johnson, G., Scutella, R., Tseng, Y., Wood, G. (2015) *Entries and exits from homelessness: a dynamic analysis of the relationship between structural conditions and individual characteristics*, AHURI Final Report No. 248, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/248>.
- Jones, A., Phillips, R., Parsell, C. and Dingle, G. (2014) *Review of systemic issues for social housing clients with complex needs*, Institute for Social Science Research, The University of Queensland, Brisbane, <https://espace.library.uq.edu.au/view/UQ:346765>.
- Kavanagh, A. M., Aitken, Z., Baker, E., LaMontagne, A. D., Milner, A. and Bentley, R. (2016) 'Housing tenure and affordability and mental health following disability acquisition in adulthood', *Social Science & Medicine*, vol. 151, pp.225-232.
- Kroehn, M., Hutson, K., Faulkner, D., Beer, A. (2008) *The housing careers of persons with a disability and family members with care responsibilities for persons with a disability*, AHURI Research Paper No. NRV2, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/nrv-research-papers/nrv2> .
- Lourey, C., Holland, C. and Green, R. (2012) *A contributing life: the 2012 national report card on mental health and suicide prevention*, National Mental Health Commission, Sydney.
- McKenzie, D. (2018) *Interim Report The Geelong Project 2016-17* Barwon Child Youth and Family, February. <https://apo.org.au/node/133006>
- Martin, C., Habibis, D., Burns, L. and Pawson, H. (2019) *Social housing legal responses to crime and anti-social behaviour: impacts on vulnerable families*, AHURI Final Report No. 314, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/314> , doi:10.18408/ahuri-7116301.
- Nelson, G., Sylvestre, J., Aubry, T., George, L. and Trainor, J. (2007) 'Housing choice and control, housing quality, and control over professional support as contributors to the subjective quality of life and community adaptation of people with severe mental illness', *Administration and Policy in Mental Health and Mental Health Services Research*, vol. 34, no. 2, pp.89-100.
- O'Brien, A., Inglis, S., Herbert, T., Reynolds, A. (2002) *Linkages between housing and support—what is important from the perspective of people living with a mental illness*, AHURI Final Report No. 25, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/25>.
- Ong, R., Wood, G., Cigdem-Bayram, M. and Salazar, S. (2019) *Mortgage stress and precarious home ownership: implications for older Australians*, AHURI Final Report

- No. 319, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/319>, doi:10.18408/ahuri-8118901.
- Parsell, C., Moutou, O., Lucio, E. and Parkinson, S. (2015) *Supportive housing to address homelessness*, AHURI Final Report No. 240, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/240>.
- Phillips, R. and Parsell, C. (2012) *The role of assertive outreach in ending 'rough sleeping'*, AHURI Final Report No. 179, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/179>.
- Randolph, B., Wood, H. (2005) *An interim evaluation of the Miller Live 'N' Learn Campus*, AHURI Final Report No. 84, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/84>.
- Rees, S., Silove, D., Chey, T., Ivancic, L., Steel, Z., Creamer, M., Teesson, M., Bryant, R., McFarlane, A. C. and Mills, K. L. (2011) 'Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function', *Jama*, vol. 306, no. 5, pp.513-521.
- Robinson, C. (2003) *Understanding iterative homelessness: the case of people with mental disorders*, AHURI Final Report No. 45, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/45>.
- Scutella, R., Chigavazira, A., Killackey, E., Herault, N., Johnson, G., Moschion, J. and Wooden, M. (2014) *Research report no. 4. Findings from waves 1 to 4: special topics*, Journeys home, University of Melbourne, Melbourne.
- Shivani, R., Goldsmith, R. J. and Anthenelli, R. M. (2002) 'Alcoholism and psychiatric disorders: diagnostic challenges', *Alcohol Research and Health*, vol. 26, no. 2, pp.90-98.
- Spinney, A. (2018) 'Workforce Development in the Homelessness sector' *Parity*, Vol. 31, No.5, pp. 15-16
- Westoby, R. (2016) *Mental health, housing and homelessness: a review of issues and current practices*, Micah Projects Inc., Brisbane.
- Wiesel, I., Easthope, H., Liu, E., Judd, B. and Hunter, E. (2012) *Pathways into and within social housing*, AHURI Final Report No. 186, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/186>.
- Wiesel, I., Pawson, H., Stone, W., Herath, S. and McNelis, S. (2014) *Social housing exits: incidence, motivations and consequences*, AHURI Final Report No.229, Australian Housing and Urban Research Institute Limited, Melbourne.
- Zaretzky, K., Flatau, P. (2015) *The cost effectiveness of Australian tenancy support programs for formerly homeless people*, AHURI Final Report No. 252, Australian Housing and Urban Research Institute Limited, Melbourne, <https://www.ahuri.edu.au/research/final-reports/252>.

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