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Pathway Out of Care: A case for change

Supported accommodation for those facing homelessness and experiencing mental ill-health

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Contents

Purpose of this paper

Why do we need to do things differently?

Individuals with mental ill-health are likely to have complex needs, have difficulty accessing the private rental market and be at high risk of unstable housing. There is insufficient public and social housing to meet demand and the private rental market is increasingly unaffordable. Further, individuals discharged from institutional care are at significant risk of homelessness and further physical and mental health dangers.

Providing supported accommodation to individuals with mental ill-health who are facing or are at risk of homelessness can generate significant cost savings to government, particularly through decreased use of health and justice services in the future. In addition to these immediate savings, breaking the cycle of mental ill health exacerbated by periods of homelessness can provide a platform for vastly improved life outcomes for the individual and increased contribution within our community.

A proposed pathway out of care

Recent research from the Australian Institute of Health and Welfare (2018) indicates that the prevalence of mental health issues among clients seek specialised homelessness services has been increasing.[2] The State Government has no additional funds to meet this increased demand for services and there is much evidence that current interventions are not sufficient to provide long term improvements to outcomes.

There is an urgent need to harness the various sources of support to create innovative and sustainable systemic responses to solving this issue.

Any response must be able to deliver:

- **Improved individual outcomes**, including improved health and social inclusion
- **Financial savings to government** due to decreased service use, such as reduced emergency department and psychiatric hospital visits.
- **Additional public and social housing stock,** and continue to add capacity to the current system.

"One of the biggest obstacles in the lives of people with a mental illness is the absence of adequate, affordable and secure accommodation.

Living with a mental illness – or recovering from it – is difficult even in the best circumstances. Without a decent place to live it is virtually impossible."

(Human Rights and Equal Opportunity Commission, 1993)[1]

Sources: 1) Cited in Mental Health Council of Australia, 2009, Home Truths: Mental Health, Housing and Homelessness in Australia; 2) Australian Institute of Health and Welfare, 2018, Mental health services in Australia 2018.

Purpose of this paper

This paper is based on three core ideas:

1. **Developing a program which assists people with mental ill-health to maintain housing stability is essential.** The intersection between mental health, housing insecurity and homelessness is real, complex, and two-way.
2. **A Housing First approach is the most effective way to address chronic homelessness and support individuals with complex needs.** Everyone has the right to a home and to the support that will allow them to thrive.
3. **There is a strong business case to act now to provide accommodation and support to individuals with mental ill-health at risk of homelessness.** It is more cost effective for people to be housed than homeless, and there are programs which will deliver cost savings for government.

An illustration of change

Ending homelessness is more cost-effective than managing it; and we can act now.

This paper demonstrates two concepts for a supported accommodation project to show what is possible. Further detail is provided on the current capacity of the different components of the proposed response that are affected as well as looking at the approximate funding flows that would be associated.

This paper invites a discussion about options that:

- Are quantifiable
- Are in line with current policy
- Diversify sources of support
- Consider all stakeholders
- Model a collaborative network of community, justice, health services and housing providers

"It costs us more, on average, to leave someone homeless than to house and support them…

…Our failure to end homelessness before now is an economic failing as much as it is a social failing."

(WA Alliance to End Homelessness, 2018)[3]

Sources: 3) WA Alliance to End Homelessness (WAAEH), 2018, The Western Australian Strategy of End Homelessness

Executive Summary

While this paper identifies two conceptual models that can achieve outcomes, there are systemic barriers to putting them in place

The intersection of homelessness and mental illness are problems that must be addressed.

Homelessness is a growing problem in Western Australia, driven by a number of different underlying issues. People with severe mental illness are particularly vulnerable to homelessness. Mental ill-health and insecure housing are interlinked and must be addressed together in any sustainable solution. Homelessness and mental ill-health have significant impacts on an individuals life outcomes. These outcomes, particularly in terms of impact on the health and justice system translate to a direct cost to the State Government that will continue to grow. Solving homelessness is more cost effective than managing it.

While there are many government and non government bodies in place, the current system is not geared to address this adequately.

Through review of extensive research conducted over the last few years coupled with interviews with stakeholders in the current system,* there are clearly identified principles of appropriate responses that will promote the best outcomes for those experiencing homelessness and mental ill health. These include: "housing first" responses that have appropriate accommodation options coupled with the right level of wrap around services for trauma informed tenancy, recovery, therapeutic and psycho-social support.

These principles underpin the two conceptual models presented in this document that are focused on two cohorts of people. Funding flows were then modelled to start to understand which parts of the existing system are best placed to be able to deliver the desired results.

There are currently multiple government and non government organisations involved in the nexus of homelessness and mental ill-health through the provision of services, accommodation and funding. However, there is limited clarity over the total map of services and funding available to individuals despite the very linked nature of the services and accommodation. Further, there is no mechanism to ensure all service offerings are compatible with the latest evidence based approaches that should underpin any response.

While all organisations seek to solve homelessness and improve mental health there is often a misalignment of the principles underlying the various approaches. Examples include tenancy support that may not be trauma informed or an inability to accommodate the episodic nature of some mental illnesses in some service responses. This means the total current system isn't geared towards ensuring the current resources are used effectively and focused towards attaining the best possible outcomes for individuals.

Note: See Appendix A for full list of references and Appendix C for the list of stakeholders interviewed.

Executive Summary

While this paper identifies two conceptual models that can achieve outcomes, there are systemic barriers to putting them in place

There are significant benefits associated with addressing this issue if we can address the system itself.

There is enormous understanding by organisations of the need for new approaches to delivering diverse housing options that also support recovery from mental ill health, and a huge appetite to participate in community. In many cases, there are models in place that are achieving excellent outcomes. There is also acknowledgement within the sector that more accommodation and support services are needed which requires more funding.

The first step towards achieving this should be the optimisation of the current system, by reviewing all services and accommodation currently provided. This should be accompanied by the provision and application of a consistent evaluation framework to evaluate all service responses provided. Doing this would have three direct benefits:

- Fast remediation of any current system blockages, inconsistencies and inefficiencies to release any spare capacity in the provision of resources;
- Shared understanding of the outcomes achieved of all service responses enabling prioritisation of funding allocations within the current funding envelopes; and
- Optimisation of the current system and full evaluation of outcomes will place WA well to participate in innovative funding options such as social impact bonds when they become available.

There are some clear next steps to get any additional housing that treats the needs of those with mental illness.

To move toward creating this optimised environment requires some focused next steps:

- Build on the emergence of the Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018-2025 to align all involved organisations to an agreed set of principles underlying how support is provided (such as individual rights, continuous improvement) and what they look like in actual application;
- Undertake a system wide mapping exercise to identify all services and accommodation options available and current bottlenecks or system failures that impact capacity and efficiency in the current system;
- Design a consistent framework for evaluating all services and accommodation to help in re-directing available funding; and
- Identify alternative sources of funding (e.g. asset transfer, social impact bonds) or asset utilisation that will contribute to feasibility of new housing and better utilisation of current assets.

Current context

Mental ill-health, unstable housing and homelessness are critical 'must solve' issues for Australia

Mental ill-health affects many Australians, but not all who experience mental ill-health seek treatment

45% of Australians aged 16-85 will experience a high prevalence of mental health disorder (anxiety, depression or substance abuse) in their lifetime.[4]

However, most Australians who experience mental ill-health do not seek treatment. In 2007, only 35% of those who experienced mental ill-health in the past 12 months accessed mental health services.[4]

The Australian housing market is under stress with limited access to affordable, appropriate or social housing

Over 1 million households in Australia are paying housing costs which exceed 30% of household income.[5] Private renters experienced a 62% increase in average weekly housing costs between 1994-2014, after adjusting for inflation.[6]

Western Australians on low incomes have limited access to affordable housing: retires, single people with a disability and single parents on Newstart allowance are able to afford 1% or less of private rentals.[7]

The availability of public housing is decreasing over time. People who are at risk of homelessness are discouraged by wait times of up to 10 years to secure public housing accommodation.[8]

5.1%

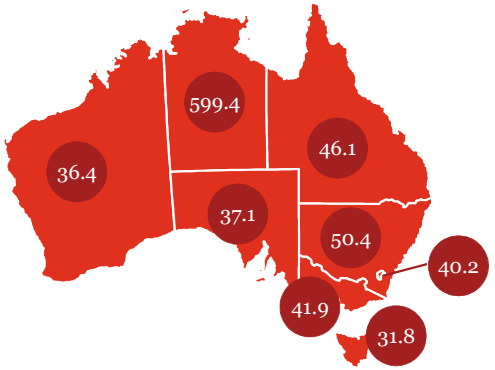
Social housing as a proportion of housing stock in 2007

Social housing as a proportion of housing stock in 2016[9]

4.7%

Homelessness in Australia has increased by 14% from 2011 to 2016

In Australia, on average 116,427 people are homeless on any given night.[10]



Rate of homeless persons per 10,000 of the population, 2016[8]

Homelessness is not just a housing problem. It has many causes, including the shortage of affordable housing, long term unemployment, substance abuse and family and relationship breakdown, and mental health issues.

People with severe mental illness who are without family, community and clinical supports are particularly vulnerable to homelessness.

Sources: 4) ABS, 2008, National Survey of Mental Health and Wellbeing; 5) ACOSS, 2018, Housing & Homelessness; 6) AIHW, 2017, Australia's welfare 2017; 7) Anglicare Australia, 2018, Rental Affordability Snapshot 2018; 8) Kaleveld et al, 2018, Homelessness in Western Australia: A review of the research and statistical evidence; 9) Bracketz et al, 2018, Housing, homelessness and mental health: towards system change (AHURI); 10) ABS, 2016, Census of Population and Housing: Estimating Homelessness 2016.

Current context

Mental health, unstable housing and homelessness are interlinked and need to be addressed together for a sustainable solution

Mental ill-health is over-represented in the homeless population and increases housing risk

Those with mental ill-health often move more frequently, have insecure housing arrangements and inadequate accommodation. Over 30% of those with a psychological disability can be categorised as being at high housing risk, compared to under 20% in the general population.[11]

16%	27%	30%	48%
Proportion of general population with a current mental ill-health issue[9]	Proportion of WA Specialist Homelessness Services clients who had a current mental health issue in 2016[2]	Proportion of rough sleepers who have been taken to hospital against their will for mental health reasons[12]	Proportion of rough sleepers who had spoken to a mental health professional in the 6 months[12]

Links between housing and mental health are two-way

An episode of mental ill-health can plunge someone into homelessness, but the isolation and trauma caused by rough-sleeping can also precipitate mental ill-health.

15% of homeless sample population had mental health issues prior to becoming homeless and 16% developed mental health issues since experiencing homelessness.[9]

Institutional discharge is a moment of significant risk

In 2016-17, more than 500 people presented at homelessness services in Victoria after leaving psychiatric services.[13]

More than one third of discharged public mental health hospital consumers who committed suicide did so within one month of discharge.[14]

There is insufficient funding and affordable housing for people with mental ill-health

People with lived experience of mental ill-health often have complex needs and require housing support. Private rental housing is the most common form of accommodation for people with mental ill-health. However, it can be difficult for people with mental ill-health to access accommodation.[9]

Public and community housing places are limited. Funding for residential facilities or group homes, alternative housing arrangements, is being disrupted by the changing funding mix available (i.e. the replacement of state government subsidies by the national NDIS packages).[15]

Sources: 2) AIHW, 2018, Specialist Homelessness Services 2016-17; 9) Bracketz et al, 2018, Housing, homelessness and mental health: towards system change (AHURI); 11) Baker, 2018, Policy Challenges from Robust Evidence, Investigative Panel on Housing, Homelessness and Mental Health; 12) Flatau et al, 2018, The State of Homelessness in Australia's Cities; 13) Perkins, 2018, 'More go straight from psychiatric hospital to homelessness' (The Age); 14) WA Government Department of Health, 2009, Western Australian Suicide Prevention Strategy 2009-2013; 15) Cited in Bracketz et al, 2018.

Current context

There are many participants and providers of support in this space but there is scope for more systemic coordination and aligned goals

Service Providers

Community Sector Organisations

The coordination of support and accommodation for people living with a mental illness who need regular aid to live independently in the community. These organisations ensure liaison with local mental health services and other community support agencies is maintained.

Department of Health

WA Health's Mental Health Unit (MHU) assists and supports Western Australia's Mental Health Services in delivering an evidence-based, patient centred, and supportive mental health system for all West Australians. The MHU is responsible for developing system-wide policies for mental health services included in the policy frameworks and has a role in the coordination, review and reform of public mental health services.

Department of Communities

Facilitate housing opportunities for people who would otherwise be unable to access housing through the private market by working in partnership with the private, government and not-for-profit sectors to deliver affordable housing in Perth, and in regional and remote locations.

Accommodation Providers

Department of Communities (Housing)

In addition to the provision of public housing in metropolitan and country areas of Western Australia, the Housing Authority provides assistance to people who need rental assistance, becoming a home owner and those facing issues related to homelessness.

Community Housing Organisations

Assists vulnerable individuals maintain their tenancies by referring them to appropriate agencies and ensuring properties are secure and maintained to the specifications set out in lease agreements, managed in accordance with the National Community Housing Standards and meet the standards for non government providers of Community Mental Health Service.

Private Rentals

A private transaction where a tenant pays a rental amount to a landlord, who is the owner of the property, under a pre-agreed lease agreement.

Funding Providers

Department of Communities

Provides annual grant funding of $30 million to more than 130 community sector organisations and local governments to deliver a range of services and programs throughout Western Australia and oversee the delivery of programs that support and strengthen the community.

Mental Health Commission

Commissions more than $836 million of mental health, alcohol and other drug services in WA and are invested in a full range of services including prevention, community treatment and support, community bed-based, hospital-based and forensic services.

Commonwealth Funding

Providing various grant arrangement programs based on social policy functions, with allocations to ensure the financial support is provided to the most vulnerable Australians in areas where there is the greatest need.

Current context

Currently the majority of services are State funded and there is little scope to provide additional services or accommodation without major change

WA Department of Communities

The lead agency for homelessness. The Department will provide $63.1m[16] in funding for homelessness support services in 2018-19 (see right).

WA Mental Health Commission

Will provide $48.1m[16] for Community Support Services in 2018-19. This will include funding for:

- **Transitional Housing and Support Program:** People exiting residential AOD treatment services who require ongoing support and accommodation.
- **Independent Community Living Strategy:** People diagnosed with severe mental illness who require ongoing support and accommodation.

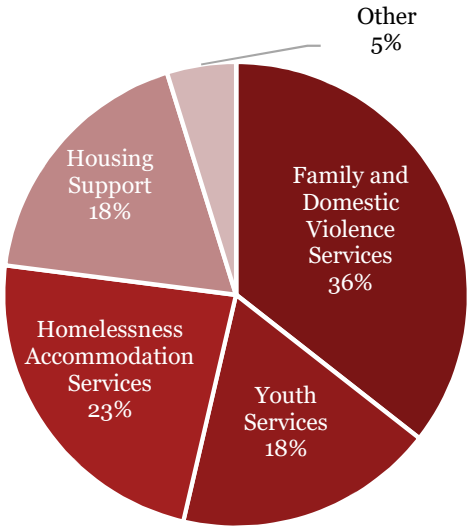
The Commonwealth Government

Negotiating the National Housing and Homelessness Agreement (NHHA), following the end of the National Partnership Agreement on Homelessness. The NHHA will provide $4.6b in funding over 3 years, including $375m in additional homelessness support funding. There will be a focus on people affected by domestic violence and youth.[17]

In Western Australia, the Department of Communities is the lead agency for homelessness.

Funding from the WA Department of Communities reflects key pathways into homelessness: family and domestic violence and youth homelessness. However, there are two notable exceptions: Indigenous-specific funding and funding that reflects the comorbidity of mental health and homelessness.

Breakdown of WA government funding of homelessness and homelessness related services[8]



Homelessness service providers are heavily reliant on government funding.

Homelessness service providers are majority government funded, supplemented by philanthropic donations and other sources. For Specialist Homelessness Services (SHS), 85% of funding was from government and 4% from philanthropy. Accommodated-based service providers internally generate a portion of their income, mostly from client rent. However, this is still a small portion of their total funding (3%).[18]

There have been recent changes to funding.

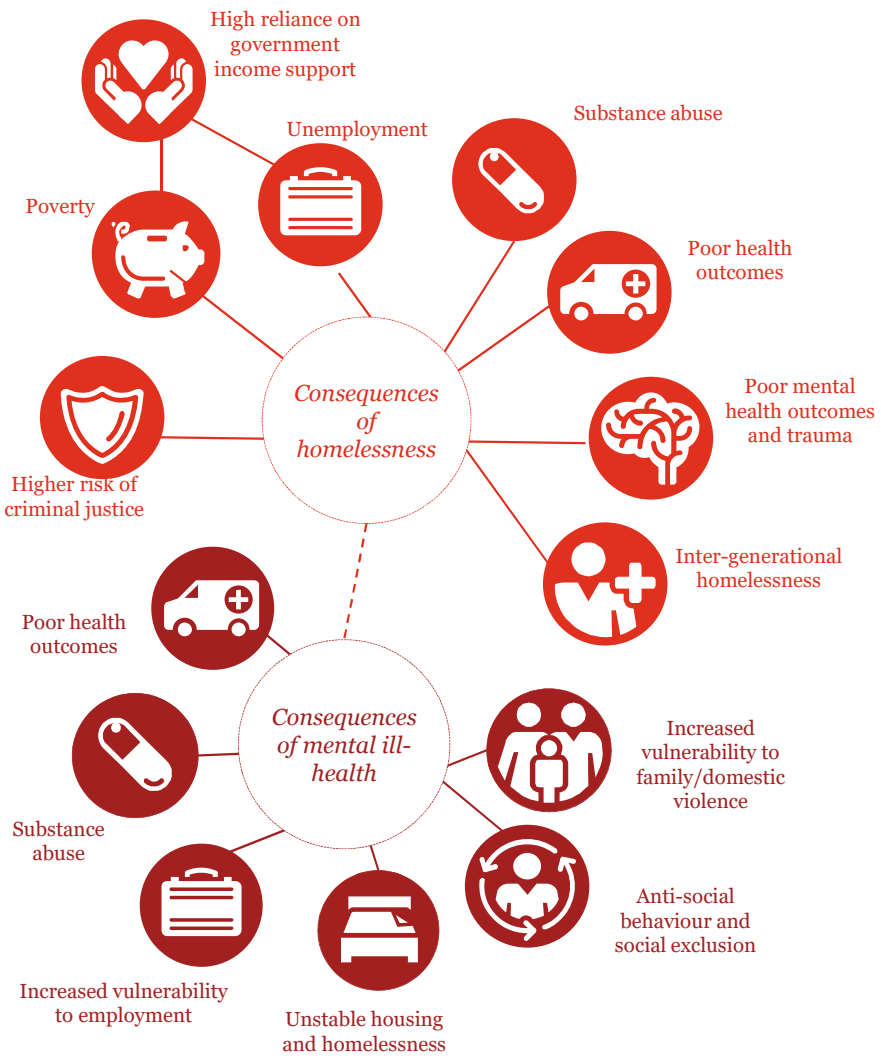
For community mental health service providers: state subsidies for supported residential facilities are being replaced by national NDIS funding. This funding change is argued to be compounding the effects of the social housing shortage.[9]

For community housing providers: earlier this year, the National Housing Finance and Investment Corporation (NHFIC) was created to establish a bond aggregator to provide loans to registered community housing providers.

Sources: 8) Kaleveld et al, 2018, Homelessness in Western Australia: A review of the research and statistical evidence; 9) Bracketz et al, 2018, Housing, homelessness and mental health: towards system change (AHURI); 16) WA Government, 2018, State Budget 2018-19; 17) Commonwealth of Australia, 2017, Reducing Pressure on Housing Affordable Factsheet; 18) Flatau et al, 2016, The financing, delivery and effectiveness of programs to reduce homelessness (AHURI no. 270)

Opportunity for change

There are numerous benefits in providing supported accommodation to people with mental ill-health, the most important of which is improved outcomes



Evidence suggests providing supported accommodation can…

Improve health and reduce health service use. Recent WA research[19] has found that the provision of public housing can significantly reduce health service use, including fewer: presentations to emergency departments, overnight stays in hospital, psychiatric hospital visits and people accessing mental health services. However, health service use may actually increase initially as previously unmet needs are addressed.

Improve mental health. Research on the whole of Australia has found that mental health deteriorates with the number of social housing moves, but mental health can improve if stability and quality of housing improves.[11]

Decrease jail time. Australian research suggests that there is a 'revolving door' between prison and homelessness.[18] The report on Australia's Health 2018 reported that one in four people were homeless or in insecure accommodation in the four weeks before entering prison,[20] and 31% of Australia's prisoners anticipate being homeless upon exit from prison.[18]

Improve safety. People experiencing homelessness are often victims of attack. In WA, 61% of homeless women rough sleeping have been a victim of an attack since becoming homeless, and 42% report that they have been coerced into activities they did not want to do.[19] Australian research has found that 62% of people felt safer following entry to homelessness support.[21]

Increase employment[18] Homelessness can remove an individual from opportunities to access the labour market. Further, accessing an affordable home close to employment opportunities is difficult with no income. Providing homelessness support can reduce reliance on government income and increase reliance on wage/salary income. [21]

Improve social inclusion. When interviewed, many Australian individuals who were rough sleeping commented that key factors for feeling safe and well included reuniting with family, developing a social support network and maintaining support with agency.[12]

Sources: 11) Baker, 2018, Policy Challenges from Robust Evidence, Investigative Panel on Housing, Homelessness and Mental Health; 12) Flatau et al, 2018, The State of Homelessness in Australia's Cities; 18) Flatau et al, 2016, The financing, delivery and effectiveness of programs to reduce homelessness (AHURI no. 270); 19) Wood et al, 2016, What are the health, social and economic benefits of providing public housing and support to formerly homeless people? (AHURI no. 265); 20): AIWH, 2018, Australia's health 2018; 21) Flatau et al, 2008, The cost-effectiveness of homelessness programs: a first assessment (AHURI no.119);

Opportunity for change

Associated with improved life outcomes for an individual is the cost savings to government

Evidence suggests providing supported accommodation can deliver savings to government. The amount saved depends on the profile of the individual who receives the support.

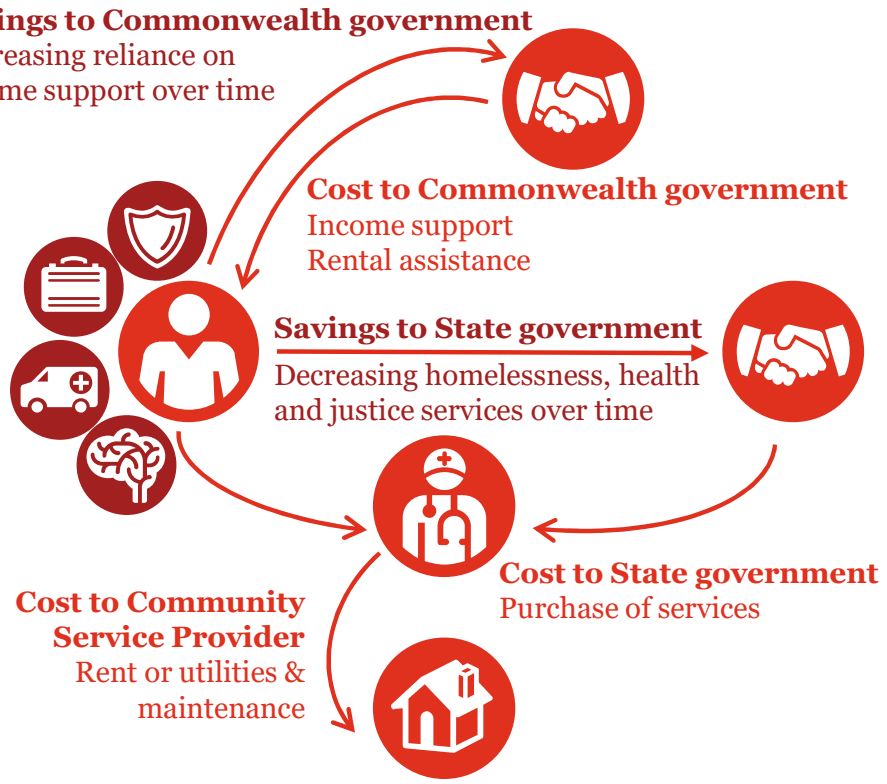
Save $1,178 - $84,135 per person per year in avoided health costs.[8,12,19,22,23,24]The high average health care costs of homeless populations tend to be driven by a small proportion of the group: those with a diagnosed mental health disorder and/or long-term physical health condition. The group with the highest health care costs are those who had spent a significant amount of time sleeping rough.

A recent WA study[19] estimated that the reduced health service use among clients of the NPAH Mental Health program was $84,135 per person per year. These were individuals with "severe and persistent mental illness who are either homeless or at risk of homelessness when discharged from a Mental Health Inpatient Unit". We consider this as an estimate of the potential health savings from providing accommodation and support to those with high needs.

As an estimate of the potential cost savings from providing accommodation and support to those with lower needs, we conservatively use a lower estimate of $1,559 per person per year.[23]

Save $1,064 - $9,363 per person per year in avoided justice costs. [8,12,19,22, 23,24] People experiencing homelessness are more likely to interact with the justice system and are often victims of attack.[8] There has been limited research into justice service use cost savings. Consequently, we take a conservative approach and suggest an average cost saving of $2,397 per person per year[23] (i.e. for justice savings we do not differentiate between high and low needs).

Cost savings can be realised by both State and Commonwealth governments.



Sources: 8) *Kaleveld et al, 2018, Homelessness in Western Australia: A review of the research and statistical evidence;* 12) *Flatau et al, 2018, The State of Homelessness in Australia's Cities;* 19) *Wood et al, 2016, What are the health, social and economic benefits of providing public housing and support to formerly homeless people? (AHURI no. 265);* 22) *MacKenzie et al, 2016, The cost of youth homelessness in Australia;* 23) *Zaretzky & Flatau, 2013, The cost of homelessness and the net benefit of homelessness programs: a national study (AHURI no. 218);* 24) *Conroy et al, 2014, The MISHA Project*

Opportunity for change

Review of research and consultation with various stakeholders has indicated a number of key principles for any potential solution

Criteria	Comments
Tenant outcomes are improved	Homelessness is the cause of a number of significant health, social and economic costs to both the individual and society. These include: increased substance abuse, poor health and mental health outcomes, increased criminal justice interactions, unemployment, trauma and inter-generational homelessness. There is significant evidence that stable housing, particularly with wrap-around support, improves an individual's outcomes. New programs must help tenants improve their outcomes, and must be evaluated to ensure this occurs.
Housing First approach is taken	The Housing First model supports individuals with complex needs experiencing chronic homelessness; it is appropriate for individuals with mental ill-health who require support. Australian and international evidence strongly supports Housing First Programs as the most effective way of addressing chronic homelessness. When designing a support program, fidelity to the Housing First model should be considered. Questions to ask include: can the individual keep their housing if they no longer want or need support; can the individual continue to access the support if their tenancy is lost or left; does the individual have choice and control over the housing type and location, support that is provided, and the definition of and pathway to success?
Adds to public housing stock	Public housing supply is limited, and has been declining over time. Consequently, people who are homeless or at risk of homelessness can wait up to 10 years for access to public housing.[8] These individuals may not be able to access the private rental market, or the private rental market may not supply affordable and adequate accommodation. New programs should aim to increase the public housing stock, decrease wait times and support people into rapid housing.
Funding is available and diversified	Services are recognising the importance of diversifying their funding mix, in order to gain certainty on future funding, increase sustainability, and become less reliant on government grants. This may include new financing models, such as social impact investment models (social impact bonds or loans, social enterprises) or housing supply loans. A new program must consider the means of funding, and whether it can be diversified so that the program is less reliant on government grants.
Project creates substantive equality	Substantive equality recognises that policies and practices put in place to suit the majority of clients and applied equally to all clients may be indirectly discriminatory by not addressing specific needs of certain groups. This can create systemic discrimination. Examples include: Overcrowding as a reason for eviction from private rental tenancies disproportionately affects Indigenous Australians, as community core values relate to family and kinship; Anti-social behaviour policies disadvantage people with lived experience of mental ill-health, whose ill-health often causes anti-social behaviour and requires treatment support. Any proposed accommodation and support must consider substantive equality.
Trauma informed and recovery focused	Trauma-informed care is a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage. Many people experiencing homelessness and mental ill-health have also experienced trauma. Any response to this group should be trauma informed to ensure the services designed to help do not inadvertently cause more harm.

Sources: 8) *Kaleveld et al, 2018, Homelessness in Western Australia: A review of the research and statistical evidence*

Potential Concepts

These concepts are built upon the principles identified to deliver improved outcomes

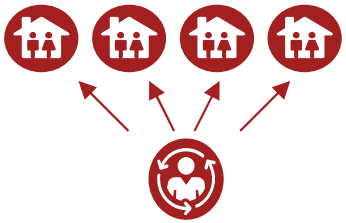
Source of Referral
Health Services
Homelessness Services

Mental Health and Homelessness Assessment Service

Typically low prevalence mental illness requiring acute care and may include people with a forensic history.

Concept one: Housing with intensive support

- Hub and spoke model
- Housing first approach
- Accommodation in Community based development
- Intensive onsite therapeutic services
- Trauma informed tenancy support



Typically high prevalence mental illness such as depression and anxiety requiring support to reach potential

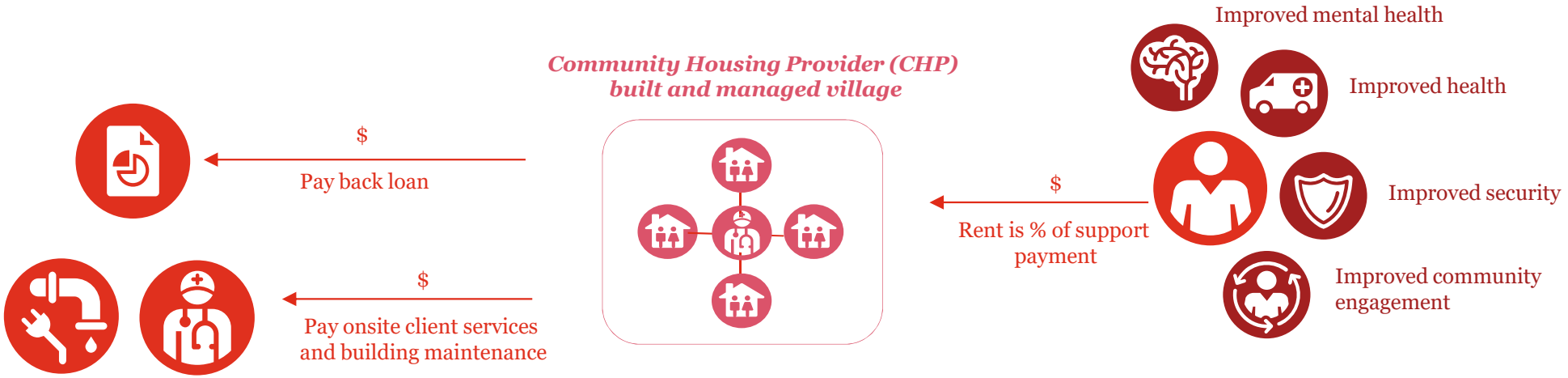
Concept two: Supported housing

- Supported accommodation in private rentals
- Housing first approach
- Trauma informed tenancy support
- Recovery support

While these options are not new concepts and are modelled in a number of programs, there is simply not enough appropriate housing for this cohort. This paper identifies possible changes that could enable access to more housing.

Potential Concepts

Concept one: How would this work?



Funding

- Land provided on long-term lease from Government in identified priority areas
- CHP applies for a loan from National Housing Finance and Investment Corporation (NHFIC) to cover capital cost
- CHP repays NHFIC loan using rental incomes
- Mental Health Commission purchase package of services for onsite delivery through CSO's

Services

- Trauma informed tenancy support services provided ongoing
- Intensive therapeutic supports onsite

Accommodation

- CHP built and managed
- Single-site, clustered accommodation
- On-site support and coordination of support services already provided
- Tenants can remain or move on to private accommodation
- Includes spaces for community use

Tenant

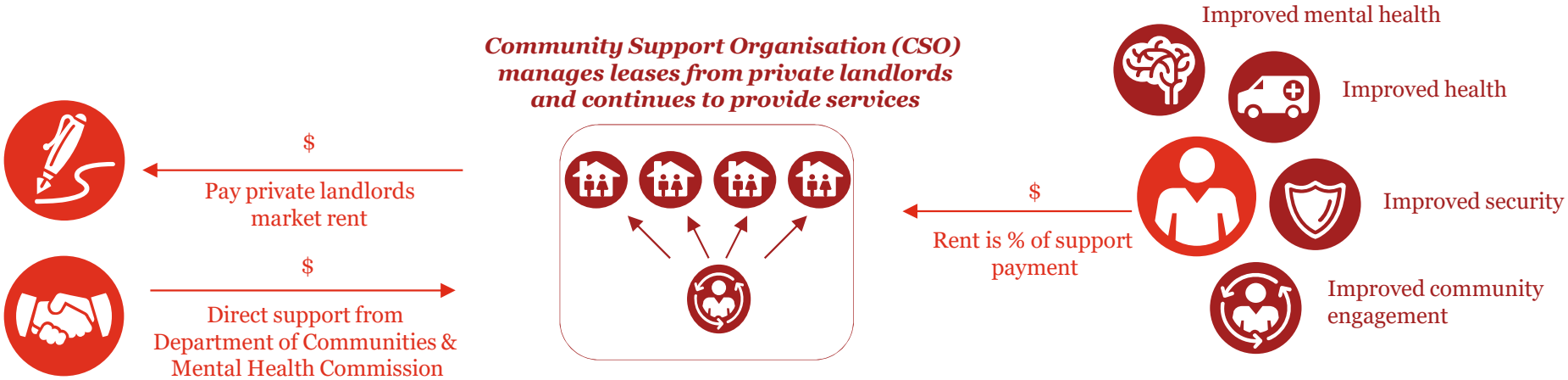
- Receives welfare support payments and Commonwealth rental assistance
- Pays a percentage of support payment, capped at 30% of income or disability support, or 100% of rental support
- Can choose how long they remain in the accommodation

Economics to deliver

Annual cost of finance	$325,000 (average)
Annual cost of tenant support	$395,800
Annual cost of therapeutic services	$167,442
Annual cost of referral path*	
*Assumed already included in existing programs	
# People housed	50
Annual savings from housing	$3.96m

Potential Concepts

Concept two: How would this work?



Funding

- Department of Communities funds the CSO
- CSO pays private landlord the market rent, using support from Department of Communities and supplemented by rental income

Tenant

- Receives welfare support payments and Commonwealth rental assistance
- Rents a private rental house
- Pays a percentage of support payment, capped at 30% of income or disability support, or 100% of rental support
- Can choose how long they remain in the accommodation

Accommodation

- Private rental
- Scattered site, using existing private rental housing stock
- CSO managed by contract
- Provision of support to tenants
- Decentralised outreach and top up of private rental payment

Services

- Trauma informed tenancy support services provided ongoing
- Decentralised outreach provided to support recovery

Economics to deliver

Annual cost of rent subsidy	$257,500
Annual cost of tenant support	$189,900
Annual cost of therapeutic services	$167,442
Annual cost of referral path*	
*Assumed already included in existing programs	
# People housed	50
Annual savings from housing	$105,058

Potential Concepts

For these concepts to be delivered, a number of elements need to be in place

Element	Current observation	Potential for change
Alignment of goals between Government, CHP's, CSO's and Individuals	Currently, all bodies have aligned goals to improve mental illness and reduce homelessness but individual organisational structures, underlying principles and systems are not aligned.	There is potential for all involved organisations to align to a set of outcomes and the individual and community level. This would improve the efficiency of the total system as there are many silos currently that contribute to increased rates of homelessness and stress on service provision.
Evaluation of effectiveness	Some programs (e.g. ICLS, 50 Homes 50 lives) undergo formal evaluation but this is not standardised or carried out broadly across all funded services or programs.	Design an evaluation framework that aligns with the principles that can be used for consistent assessment of expenditure in this area.
Access to NIHFC funds	The newly established National Housing Finance and Investment Corporation will provide discounted funds to Community Housing Providers which will lower the cost of finance.	Current eligibility is for any registered Community Housing provider.
Provision of Commonwealth Rent Assistance	The Commonwealth currently provides rent assistance to eligible people who live in social or community housing. This is not payable to someone in Government provided housing.	Continue to access this Commonwealth resource with helping tenants to access and maintain their CRA to be part of tenancy services.
Provision of Support Payment to individual	Most tenants will be on Commonwealth funded support payments – this will be their primary source of income and they will pay rent as a proportion of this payment.	Continue to access this Commonwealth resource with helping tenants to access and maintain their support payments to be part of tenancy services.
Access to private rentals	Many people experiencing homelessness and mental ill health experience difficulty in accessing and maintaining private rentals for a variety of reasons associated with the episodic nature of their illness or a negative rental history.	Accessing suitable private rentals will be a core service of the support provider with wrap around services continuing beyond any acute phase of illness to ensure the longevity of a placement can be maintained. ***(concept two only)***

Potential Concepts

For these concepts to be delivered, a number of elements need to be in place

Element	Current observation	Potential for change
Referral and assessment capability in place	Entry point currently provide a free service for people experiencing or at risk of homelessness. In addition, there are a number of other referral points such as health and other homelessness service providers.	Health and homelessness services will need to be briefed on the particular types of accommodation provided so they can be aware of the options. In addition, an assessment service for appropriateness of accommodation and service provision would need to be provided either as an add on service of the newly established programs or through current service provision channels.
State funding for therapeutic services	Mental Health Commission currently purchases these services from Community and other providers. There is significant support for providing more therapeutic services, particularly in relation to Alcohol and Other Drugs support services.	While it is acknowledged that there is limited availability of funding, there is potential to review the currently programs being delivered to evaluate effectiveness and ensure that funds can be directed to the areas of greatest's need and optimising the balance between prevention and treatment to reduce expenditure in this area over the longer term. This also needs to be examined in the context of availability of such services and potentially addressing market failure.
State funding for support services.	There are a range of different programs delivering tenancy support, peer support and other psychosocial supports for people experiencing and recovering from mental ill health. In most instances, this support is stepped down when the individual becomes well which is not consistent with the episodic nature of mental illness.	Defined and ongoing tenancy, peer support and psychosocial services will be part of the proposed concepts in line with an individuals needs. This will require different funding structures for packages of support to allow for a different mix of intensity of support over time. This can then be applied whether in the onsite setting of concept one or more fluid outreach support under concept two.

Potential Concepts

For these concepts to be delivered, a number of elements need to be in place

Element	Current observation	Potential for change
Provision of land	The State Government has previously undertaken asset transfer programs with the CHP's. This has been a credible means of partnering to provide improved outcomes by allowing CHP's to offset provision of subsidised housing through transfer of assets that can generate a more commercial return.	Any new development in WA by a CHP will require land or the redevelopment of currently held land. There is opportunity to replicate previous transfers that allowed development of a social site through cross subsidisation. ***(concept one only)***
Funding for shortfall between rent received and interest payment (CHP)	In any development, individuals pay rent at a capped proportion of their income. This is insufficient to cover financing and operational costs of the accommodation.	This funding shortfall may need to be managed through cross subsidisation of assets or potentially through use of social impact bonds linked to improved community outcomes. ***(concept one only)***
Access to private rentals	Many people experiencing homelessness and mental ill health experience difficulty in accessing and maintaining private rentals for a variety of reasons associated with the episodic nature of their illness or a negative rental history.	Accessing suitable private rentals will be a core service of the support provider with wrap around services continuing beyond any acute phase of illness to ensure the longevity of a placement can be maintained. ***(concept two only)***

Potential Concepts

Both options have had a high level evaluation against the principles

Criteria	Option 1	Option 2	Comments
Tenant outcomes are improved			Both proposed options have the opportunity to improve life outcomes to tenants with different needs by providing supported accommodation options. Concept One may suit higher needs individuals more (i.e. those with acute needs), while Option 2 may be better suited for individuals who would normally enter the private rental market.
Housing First approach is taken			Both concepts can be implemented using a Housing First approach. Concept One presents a difficulty in that the individual may not have a choice of housing. Concept Two presents a different difficulty in that CSOs would need to agree to continue to provide rental subsidies regardless of whether the tenant chooses to continue support.
Adds to public housing stock			Concept One will add to the public housing stock. However, Concept Two, in which individuals are assisted by a CSO to enter the private rental market, does not immediately add to the public housing stock. We note though, that engagement with private sector landlords may lead to an increase in built-to-rent.
Funding is available and diversified			CHP can access debt through the bond aggregator, managed by NHFIC, to build community and public housing. In Option 1, CHP can use this to finance the project, and may not need any additional government grant support. This funding is not available for Option 2 as there is no new construction; in Option 2 CSOs may continue to operate using government support.
Project creates substantive equality			Both projects must be designed with a substantive equality framework in mind. The program funding and construction does not guarantee that support and tenancy are offered to create substantive equality. This requires further consideration.
Trauma informed and recovery focused			Both Concepts have been designed with a specific goal of providing trauma-informed and recovery-focused support. The two Concepts target different populations, with different needs, and therefore will provide different support arrangements in order to best address these needs.

Potential Concepts

In addition to the preliminary evaluation, these concepts have a number of other benefits and challenges to consider

Other key benefits

A Housing First approach

As the homes are an addition to the public housing stock, individuals will be able to choose to stay in the houses, regardless of whether they continue to need or use support. In this sense, the project will follow the Housing First principles that people have a right to a home, that support will be provided as long as needed, and housing and support are separate.

Improving tenant outcomes

Research shows that providing safe, secure, stable and quality housing can improve mental health. Research also shows that providing housing can reduce social isolation. Supported accommodation programs can assist tenants to manage their physical health, mental health and substance abuse issues, and improve financial management.

Substantive equality

Research has found there is a lack of integration between mental health and homelessness services.[9,25] It is essential that there is alignment between the Mental Health and Community portfolios in providing targeted support. This proposal puts this integration at the forefront.

Further, homelessness disproportionately affects Indigenous people, young people, and those suffering mental ill-health. Our proposal takes a Housing First approach that distances accommodation provision from behavioural change. In this sense, the proposed project should avoid some of the systemic barriers to substantive equality, such as the ability for private rental landlords to evict people for over-crowding and anti-social behaviour.

Potential challenges to consider

Employment outcomes

Previous projects and research, including the evaluation of the MISHA project, have found that housing program do not improve employment outcomes for individuals who are facing or at risk of homelessness.[23] A key challenge will be to support individuals to achieve employment, if possible.

Local response

Preliminary research has found that there is an inconsistent attitude to homelessness in local councils. In particular, local government homelessness strategies can focus on 'anti-social behaviour', the role of police and crime prevention.[8] Shelter WA has developed a 'Local Government Homelessness Tooklkit' to support local governments' agendas to homelessness. A key challenge will be to engage the local community on the importance of providing accommodation and support services, and the benefits to the local and greater community.

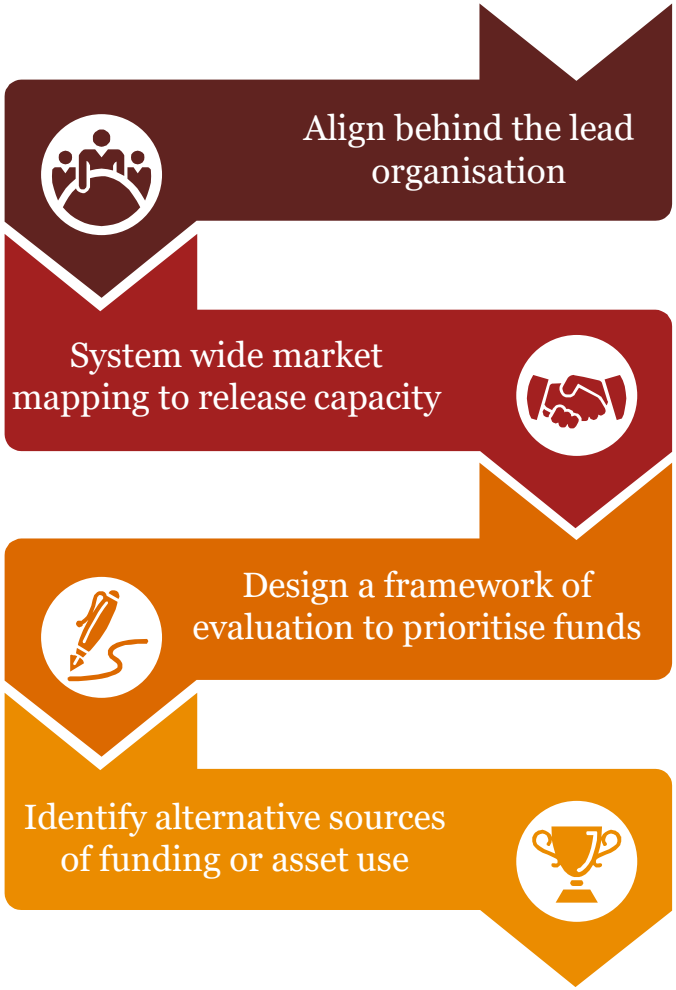
Evaluation

Evaluating a program's process and outcomes enhances its effectiveness. It allows a program to pivot earlier in the process to ensure that the needs of clients are being met. It is important that evaluation designs are developed at the start of a program before implementation, and should be open and transparent. To improve our understanding of homelessness and how best to tackle it, the proposed project should consider follow-up evaluation on clients after housing or support ends and include a qualitative evaluation component to understand impact or most significant change from the perspective of the client.

Sources: 8) Kaleveld et al, 2018, Homelessness in Western Australia: A review of the research and statistical evidence; 9) Bracketz et al, 2018, Housing, homelessness and mental health: towards system change (AHURI); 23) Zaretzky & Flatau, 2013, The cost of homelessness and the net benefit of homelessness programs: a national study (AHURI no. 218); 25) Flatau et al, 2013, How integrated are homelessness, mental health and drug and alcohol services in Australia? (AHURI no. 206)

Next steps

For new sustainable models of housing to be established will require a number of critical steps. New concepts that increase housing stock and improve mental health won't be achievable until a number of steps are taken



At present there are a number of organisations involved in substantial ways but there isn't complete alignment of principles. The Mental Health Commission has issued a draft accommodation for mental health but this doesn't translate to leadership in delivering the identified outcomes, rather inviting other organisations to use it as a guide to their own activities. To better align all resources in the space will require clear agreed principles and priorities between organisations.

A comprehensive market map of broader mental health services and supports as well as homelessness services and accommodations should be undertaken to understand the flow of the population through these channels. This would enable identification of system bottlenecks and breakdown in process that would enable modifying the current system to increase capacity and efficiency within the current resource allocation.

An evaluation framework based on the agreed principles and targeted outcomes should be developed and used to evaluate current services offered to ensure delivery of outcomes and direct current available funding where there are proven outcomes.

There will continue to be a subsidy shortfall when providing subsidised housing. Where annual State funding is not going to be increased other avenues should be examined such as asset transfers from government, use of social investment bonds or accessing other sources of Commonwealth funding. This can also include innovative use of current assets to provide a diversity of options and unlock capacity.

Appendices

Appendix A

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Appendix A

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Appendix B

Case studies - international

At home/Chez soi, Canada[26]

At Home/Chez Soi was an experiment in which five cities in Canada compared the results of a Housing First intervention against the results of existing approaches in each city.

Over four years (2009-13), 2148 individuals participated, in which 1158 received HF intervention. All participants were either sleeping rough or in emergency accommodation, and all had one or more serious mental illness. Those receiving the HF intervention were housed in private rental units, and received support.

The HF intervention was extremely successful, and had better housing outcomes than existing interventions. In last 6 months of study, 62% of HR participants were housed all of the time, compared to 31% of Treatment As Usual group.

The landlords also expressed a positive relationship with the housing and clinical teams and the tenants.

The HF also generated cost savings for government. Every $10 invested in HR resulted in $3.42 - $9.60 savings in other services (mostly decreased psychiatric hospital, ED visits, emergency accommodation stays and jail stays).

In particular, the HF intervention was most successful for extremely high needs individuals. For every $10 invested in HF for the 10% of individuals with the highest service use costs at the start of the study, $21.72 of savings was generated from decreased psychiatric hospital stays and decreased ED visits.

National Strategy, Finland[27]

Finland implemented a National Strategy to reduce long-term homelessness between 2008-2011 and 2012-2015. The National Strategy was based on a Housing First approach.

In the period 2008 - 2015, 2500 new dwellings were constructed and acquired for the homeless, and approximately 350 new professionals in housing social work were hired to work on homelessness. Shelters were replaced with modern housing units and the quality of housing was improved, i.e. new dwellings were built, existing social housing was rented, and emergency accommodation was altered to become housing units.

The Strategy was successful. From 2008 to 2014, long-term homelessness fell by 1,200 people. In 2008, 2.931 people were long-term homelessness in the nation's ten biggest cities. By late 2013, this had dropped to 2,192, a reduction of 25%.

The evaluation notes that the committed cooperation and visible decrease in the number of individuals experiencing homelessness created an "atmosphere of positive change" which "reinforces itself".

The evaluation also notes that when presented with control about the support they want to receive and where they want to live, "a clear majority of homeless people with high needs and sustained or repeated experience of homelessness do *not* make choices that cause further deterioration in their well-being".

Sources: 26) Goering et al, 2014, National At Home/Chez Soi Final Report; 27) Pleace et al, 2015, The Finnish Homelessness Strategy: An International Review

Appendix B

Case studies - Australia

HASI, NSW[28]

Clients: People with severe mental illness; can accommodate 1,135 people

Accommodation: Permanent social housing

Approach: Collaborative approach between NSW Health, Housing NSW and non-overnment organisations

Outcomes:
- Reduction in hospital admissions and length of hospital stay

HASP, QLD[29]

Clients: People with severe mental illness in tenuous housing or homeless, i.e. those who require intensive psychiatric care

Approach: Collaborative approach between Queensland Health and Department of Communities

Outcomes:
- 82% of HASP clients agreed that involvement in HASP had helped them achieve their goal

Cost savings:
- $74,000 per individual for those who would have been in a community care unit without HASP
- $178,000 per individual fro those who would have been in acute inpatient units

Doorway, VIC[30]

Clients: People with severe mental illness

Approach: Participants choose private housing and the program offers rental assistance (e.g. subsidies and brokerage)

Accommodation: Private rental

Outcomes:
- 50 of 59 individuals sustained their tenancy
- Improvement in the proportion of tenants in paid or unpaid employment
- Significant reduction in bed-based clinical service use and hospital admissions

Cost savings: $1,149 - $19,837 per individual

50 Lives 50 Homes, Perth[8]

Clients: Individuals in WA who are rough sleeping.

Approach: Underpinned by Housing First principles; cross-sector collaboration between 27 agencies including Royral Perth Hospital.

Outcomes:
- 85% of tenancies were sustained
- For the clients who had been housed by 50 Lives by six months or more, there was a 31% decrease in total emergency department presentations and a 16% decrease in total inpatient admissions.

Mission Australia's Common Ground, VIC[31,32]

Clients: Long-term homeless people

Accommodation: Purpose-built community housing (104 affordable units in a 6-storey development).

Approach: Based on the New York Breaking Ground program; offers three types of housing:
- 52 units allocated for long-term homeless people
- Affordable housing program in which rent of some units is set at 75% of market rate
- General housing to those who have received priority approval for social housing

Outcomes
- 93% of tenants have sustained tenancies longer than 12 months

MISHA project, NSW[24]

Clients: Individuals supported by local housing and homelessness services and rough sleepers in Sydney

Accommodation: Sites leased from social housing providers

Approach: ACT and Housing First

Outcomes:
- 90% of participants sustained their tenancies for the entire two-year follow-up
- Mental health was poor at entry, did not improve over the two-year period, but remained stable

Cost savings: $8,002 per participant per year

Sources: 7) Kaleveld et al, 2018, Homelessness in Western Australia: A review of the research and statistical evidence; 24) Conroy et al, 2014, The MISHA Project; 28) Cited in Bracketz et al, 2018; 29) Cited in Bracketz et al, 2018; 30) Cited in Bracketz et al, 2018; 31) Mission Australia, 2017, What we do: Common Ground; 32) Mission Australia, 2017, Annual Report

Appendix C

Stakeholders interviewed

Name	Organisation	Date
Stuart Clarke, Julia Prior, Andrea Knox-Lyttle, Dannielle Pender, Rebecca Kafetzis, Mark Goerke, Michelle Draper	Department of Communities, Western Australian Government	22 August 2018
Joe Calleja	Calleja Consulting	27 August 2018
Kathleen Gregory	Foundation Housing	27 August 2018
Margaret Doherty	Mental Health Matters 2	3 September 2018
Alison Paterson, Kathryn Moorey	Access Housing	28 August 2018
Jennie Vartan	Community Housing	28 August 2018
Rhianwen Beresford	Consumers of Mental Health WA	11 September 2018
Taryn Harvey, Colin Penter, Michael Jones	WA Association for Mental Health	12 September 2018
Jeff Logan	Foundation Housing	18 September 2018

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