

# Trajectories: the interplay between housing and mental health pathways

Report for national consumer and carer consultations

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## **Related reports and documents**

Trajectories: the interplay between mental health and housing pathways. A short summary of the evidence.

Trajectories: the interplay between mental health and housing pathways. Final research report.

Trajectories: the interplay between mental health and housing pathways. Quantitative evidence on the relationship between mental health and housing.

Trajectories: the interplay between mental health and housing pathways. Report for Indigenous consultations.

Trajectories: the interplay between mental health and housing pathways. Policy options report.

Available at <https://www.ahuri.edu.au/research/trajectories>

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# Executive summary

Although mental health issues are a key risk factor for homelessness, there is very little research on the nexus between housing and mental health. Mind Australia Limited has worked in partnership with the Australian Housing and Urban Research Institute on Trajectories, a project that is focused on the interplay between housing and mental health pathways. This report concentrates on the findings from the national consumer and carer consultations that were conducted during 2019. The aim of those consultations was to contribute to understanding how people navigate their way through mental ill-health and the mental health and housing/homelessness service systems, their preferences for housing and how these influence the decisions they make about housing and/or mental health. The project also aimed to identify a typology of trajectories (typical cases) to understand the housing and mental health pathways of groups of individuals. The project's findings were intended to be used to provide guidance on effective policy and programs to support recovery for people with mental ill-health who also experience housing insecurity and/or homelessness.

## Study design

Ethics approval was obtained from the University of Wollongong (2018/402). The project used a qualitative approach that included individual interviews and focus groups. Participants included consumers (people who self-selected on the basis of having mental health and housing issues) and carers (people who care for someone who has mental health and housing issues). In some areas, recruitment was focused on Indigenous people. Participants were drawn from a range of locations in urban and regional areas throughout all eight states and territories.

Data collection combined semi-structured interviews and focus groups. Using a narrative inquiry format, the interviews focused on people's personal accounts of: their mental health and housing journeys; their housing histories and the range of factors that influenced their choices of housing. These factors included: mental ill-health/wellness status; the types of housing people live in; what

housing they can afford; what housing they would prefer to live in; and the role and appropriateness of various forms of accommodation. The focus groups aimed to stimulate discussion about the housing and mental health systems, including issues relating to those systems where it is useful for participants to be able to discuss their experiences, hear about others' experiences as a group and reflect on systemic changes that are needed. Recruitment was conducted in partnership with relevant mental health and housing services in the local area.

## Results

Overall, 16 consultations were conducted with 130 consumers and carers across 14 areas. This report focuses on the consumer and carer data but it does not include the consultations that focused specifically on Indigenous people (those consultations were based in Port Hedland, Darwin, Alice Springs and Melbourne and are presented in a separate report). This report is based on the perspectives of 86 participants. Analysis focused on exploring the interconnections between housing and mental health and interactions with services and supports, and identifying typical pathways (trajectories) through housing and mental health systems.

## Housing experiences and interconnections between housing and mental health

Housing and mental health were clearly inter-related and affected each other in a number of ways. Housing and living situation affected several major areas of the participants' lives, including their financial situation, feelings of safety, feelings of housing security, self-worth, relationships, perceived control, their environment and their employment status.

## Experiences with the housing and mental health services and systems

Participants experienced difficulties in getting access to housing and mental health supports and services. Housing services were often not known about and public housing waiting lists were very long. Access to community mental health services and clinical services was also limited, for a range of reasons.

## Trajectories and circuit breakers

Analysis demonstrated that participant experiences could be characterised by five major pathways through housing and mental health services and systems. People could move in and out of these pathways over time, and they are categorised in this report as:

- being excluded from help required
- being stuck without adequate support
- cycling
- stabilising
- being well supported.

By reflecting on these trajectories and how people move through the mental health and housing systems, a number of circuit breakers were identified. Circuit breakers are factors that enabled people to move out of their current situation and establish stability and focus on recovery.

These included:

- access to secure, affordable housing in an area where they feel safe
- support to maintain a tenancy
- connection to a trusted worker

Figure 1: Impact of housing



Source: The authors.

- help to manage distress and sort things out beyond medication
- help to deal with trauma
- social support and community connections
- early intervention when things go wrong.

## Discussion and implications

The results of this study highlight the interconnections not only between housing and mental health, but also connections with employment, trauma and substance misuse. Only once people had secure housing could they start to think about addressing their mental health, their relationships and their day-to-day activities. While housing is the foundation for mental health, it is not on its own sufficient to support recovery. Mental health supports are also necessary, including clinical and psychosocial supports. (Psychosocial supports are those that help people increase their capacity for everyday activities, including maintaining relationships, performing day-to-day tasks, maintaining health etc.) Important elements of psychosocial support include having a trusted worker for support and advocacy, as well as having connections with others, feeling understood and not judged by peers, and having a routine and meaningful activities to engage in.

Policy and service implications that emerged from these consumer consultations included:

- There is a clear need for medium-term responses that provide housing and support to enable people to stabilise. Short-term housing arrangements do not provide enough stability to enable people to focus on their mental health and start to work on their recovery. Medium-term housing arrangements would provide that stability. Support is needed in addition to housing to ensure that any changes in mental health/ challenges are recognised early and supports are put in place to protect tenancy.
- There is a need for trauma counselling for people who have experienced trauma. Participants would benefit from assistance to understand the impact the trauma has had on them and to develop methods to deal with its effects.
- Availability of rapid access to early-intervention mental health and tenancy support is required if problems emerge. Not becoming eligible for assistance until reaching crisis point means that stability and recovery become increasingly difficult and longer to achieve.
- Transition support when exiting from institutions and services requires improvement. This must include considering the best housing option for the person and their family.
- A spectrum of housing and support is required to provide greater choice and control for participants. There is no 'one size fits all' accommodation option that will provide the appropriate level of support for all participants.
- Carers require specific support to assist them in their caring responsibilities. Both housing and mental health services need to have in place policies and practices that include carers
- Both housing and mental health services need to have in place policies and practices that include carers in care and discharge planning.

# 1 Study rationale

The national and international evidence identifies mental health issues as a key risk factor for homelessness (Bleasdale 2007; Busch-Geertsema et al. 2010; Chamberlain and MacKenzie 2004; Johnson and Chamberlain 2012; Park et al. 2012). People with mental health issues are at risk of homelessness due to: uncoordinated service systems; poor support networks; social isolation; and high levels of stigmatisation, both within the service system and in society in general (Robinson 2005). People with mental ill-health also face multiple challenges in accessing housing, including economic disadvantage and discrimination in the private rental market (Beer et al. 2006; 2005; Bleasdale 2007).

There is very little research on the nexus between housing and mental health. The majority of the research is from the health perspective, with housing viewed primarily as an ancillary factor. Moreover, there is a paucity of research that explores people's experiences of their pathways through mental health and housing/homelessness, taking into account various factors such as life stage, gender and location. The Journeys Home (JH) longitudinal survey records quantitative data relating to individuals exposed to high levels of housing insecurity, but in-depth qualitative data is absent (Bevitt et al. 2015).

## 1.1 Aim of project

The main aim of this project was to contribute to knowledge on the mental health and housing/homeless pathways of people with serious mental health issues. By investigating their lived experiences as described in their own words, it was intended to contribute to understanding how people navigate their way through mental ill-health and the mental health and housing/homelessness service systems, their preferences for housing and how these influence the decisions they make about housing and/or mental health. The research also explored their ideas and views on the potential points of intervention, in order to provide guidance on effective policy and programs to support recovery for people with mental ill-health who also experience housing insecurity and/or homelessness.

The project also aimed to identify a typology of trajectories (typical cases) to understand the housing and mental health pathways of groups of individuals. Further, it aimed to identify failure points in the housing and mental health systems as service systems users experience them. Failure points represent missed opportunities for early intervention, and potential key points for system improvement.

## 2 Study design

Ethics approval was obtained from the University of Wollongong for this study (2018/402). A qualitative approach that combined individual interviews and focus groups was used. Data collection comprised 16 community consultations, held at 14 areas across Australia. The consultations included consumers (people who self-selected on the basis of having mental health and housing issues) and carers (people who care for someone who has mental health and housing issues). In some areas, recruitment was focused on Indigenous people. Participants were drawn from a range of geographic locations in urban and regional areas throughout the eight states and territories. The sample was not intended to be representative but rather to reflect a breadth of experiences. Participants were selected to represent diversity in terms of: age; gender; sexual identity; mental health condition; current living arrangement and location (urban, regional, remote).

Inclusion criteria were having experiences of mental ill-health and/or distress and difficulties with housing and/or homelessness – either directly, or as the family member or carer of someone who has had such experiences. Participants were aged over 18 and capable of providing informed consent. The only specific exclusion criterion related to the requirement to communicate in English. Those who could not do so were excluded on the grounds that provision of a translator could not be guaranteed. The exception to this was in Indigenous communities, where we partnered with Indigenous researchers who could translate as required.

### 2.1 Participant recruitment

Recruitment occurred through identified organisations that typically provide support, information and/or advice to adults living with mental health issues or who have difficulties with housing or are experiencing homelessness, in the relevant areas where the research took place. A number of organisations assisted with recruitment, including:

- EACH
- Wellways
- Flourish
- Neami National
- Helping Minds
- Danila Dilba Health Services
- Larrakia Nation
- Team Health
- Yilli Rreung Housing
- Tangentyere Council
- Mental Health Association of Central Australia
- Central Australia Affordable Housing
- Bloodwood Tree
- NT Shelter.

Some of these organisations – including Neami National, Wellways and Danila Dilba Health Services – had additional research committees whose formal approval the project sought. Organisations who assisted with recruitment were briefed about the study and, in partnership with researchers, decided the best way to distribute information about it. These included approaching potential participants, advertising in flyers or through social media, advertising in community spaces and sharing with partner services. Services obtained consent from potential participants to pass their contact details on to the researchers, who would call them and discuss their possible involvement in the study. If the person consented to being involved, a time was booked in for an interview and/or group discussion.

Interviews were conducted by all members of the research team, including researchers with lived experience of mental ill-health (i.e. peer researchers). All researchers were involved in a day of training on interviewing and the interview approach. In most areas where it was feasible, participants were offered the option of being interviewed by a researcher or by a peer researcher. Participants were also given the option of taking part in a one-on-one interview and/or a focus group. Participants were given a \$60 voucher for each part of the study to acknowledge their time and contribution. Travel costs were also covered as required. At the end of the interview, participants were asked to provide demographic information (age, gender, country of birth, Indigenous status, primary language spoken at home, sexual identity, income, employment status and psychiatric diagnoses, and whether they identified as having comorbid physical, visual, auditory or intellectual disabilities). They were also given a list of major local and national mental health services and encouraged to use their normal support networks if any issues arose as a result of participating in the study.

## 2.2 Participant involvement

The researchers obtained consent for participation from the participants prior to the commencement of the interviews and focus groups. The researchers ensured that participants were provided with information about the study, including the risks and benefits of participating. Participants were informed that they could cease the interview at any time, choose not to answer specific questions and withdraw their consent during or at the end of the interview. For the focus group, participants were informed that they could cease involvement at any time and choose not to answer specific questions however they were unable to withdraw their consent following the focus group (because it would not be possible to identify them in the focus group transcript).

One-on-one interviews focused on people's personal accounts of their mental health and housing journeys. Interviews explored people's housing histories and the range of factors that

influenced their choices of housing, including: mental ill-health/wellness status; the types of housing people live in; what housing they can afford; what housing they would prefer to live in; and the role and appropriateness of various forms of accommodation. Interviews used a narrative inquiry format. Narrative inquiry aims to elicit story-telling from the interviewees, allowing them to relate the significant events in their life and the social context in which they occurred. The interviews were effectively structured around story-telling and listening.

Focus group discussions centred on people's perspectives of the housing and mental health systems, including systemic issues where it was thought to be useful for participants to be able to discuss their experiences, hear about others' experiences as a group and reflect on systemic changes that are needed. Interviews and focus groups were audio recorded (with the participants' consent) and later transcribed. Interviews were conducted between January and December 2019.

## 2.3 Data analysis

A grounded textual analysis, which allows categories to emerge from the data, was applied to the interviews and focus groups. According to Hsieh and Shannon (2005: pp1279-1280), the advantage of this approach to content analysis is "gaining direct information from study participants without imposing preconceived categories or theoretical perspectives". Interviews were transcribed and read repeatedly by researchers to achieve immersion and obtain a sense of the key themes. Key thoughts, ideas or concepts from the manifest content were highlighted throughout the interview transcripts, with a coding scheme applied to reflect them. These codes were then used to identify a series of 'typologies' which reflect typical housing and mental health pathways, experiences of the intersection between the housing and mental health systems and the role of individual contributory factors. All interviews were read and coded at least twice by different researchers.

## 3 Results

### 3.1 Participants

Overall, 16 consultations were conducted across 14 areas with 130 consumers and carers. Thirteen of these consultations were focused on consumers; three were focused on carers, and in four areas there was a specific focus on recruiting consumers who identified as being Indigenous. This report focuses on the consumer and carer data but does not include the consultations that concentrated specifically on Indigenous people (in Port Hedland, Darwin, Alice Springs and Melbourne). As there were some differences in the themes that emerged

for those who identified as being Indigenous, a separate report has been prepared. Table 1 demonstrates the number of participants involved at each site.

Interviews were conducted at every site and focus groups were conducted when feasible. In some areas, participants were unable to return for a focus group on a second day; some participants did not want to participate in a focus group. Generally, the same participants who attended the interview also attended the focus group, but in a few cases people attended the focus group only.

**Table 1: Participant numbers**



Area	Interviews	Focus group
Melbourne (not Indigenous specific)	5	Yes – 5 participants
Melbourne (not Indigenous specific)	7	No
Wangaratta	6	Yes – 5 participants
Brisbane	6	Yes – 6 participants
Mackay (carers)	6	No
Adelaide	6	Yes – 6 participants
Berri	6	Yes – 6 participants
Hobart (consumers)	7	Yes – 7 participants
Hobart (carers)	0	Yes – 9 participants
Bathurst	6	Yes – 6 participants
Sydney	6	Yes – 6 participants
ACT	7	Yes – 7 participants
Perth (carers)	9	Yes – 8 participants
Port Hedland (Indigenous specific)	14	Yes – 8 participants
Darwin (Indigenous specific)	12	No
Alice Springs (Indigenous specific)	10	No

## 3.2 Demographics

Excluding the Indigenous-person-specific consultations (which are covered in a separate report), this report is based on the perspectives of 86 participants. Demographics were collected for 83 people, including 63 consumers and 20 carers.

### 3.2.1 Consumer demographics

#### Participant age

The average age of interviewees was 42 years (SD = 13.1). For those reporting their age, approximately one-third (34%) were 34 years or under, nearly a quarter (23%) were 35 to 44 years, just under another quarter (22%) were 45 to 54 and the remaining 20% were 55 and older. Data was missing for one participant.

#### Participant gender and sexuality

Forty-six percent of participants were female. Sixty-one percent of participants recorded their sexuality. Of these, 74% said they were heterosexual, 10% said they were bisexual, 5% said they were lesbian or gay, 2% said they were asexual, 3% were “other” (not further described) and 5% preferred not to say.

#### Country of birth, nationality and primary language

Participants were predominately Australian born (84%). Three percent were born in the UK, 4% were born in Asia and 3% were born in New Zealand. There was 1% each from the Middle East and the USA, with data missing for one participant. Ninety-seven percent spoke English as their primary language.

#### Indigenous status

Six percent of participants identified as Aboriginal Australian and 3% as Torres Strait Islander peoples.

#### Current employment

Thirty-six percent of the participants were not employed and not seeking employment. Thirty-five percent were unemployed and seeking part-time work, and 13% were unemployed and seeking full-time work. Eight percent worked part-time and 2% were self-employed or worked in the family business. One participant did volunteer work. Data was missing for three participants.

#### Income

Income data was available for 48 participants. Of these, over one-quarter (29%) had an income less than \$14,999 per year. Another half (56%) had an annual income of \$15,000 to \$29,999. Only 15% of participants had an income of \$30,000 or more.

#### Disabilities

Of those who reported their disability status, 25% stated they had physical disabilities, 11% dual disability (mental ill-health and intellectual disability), 13% intellectual disability, 4% visual disability and 4% hearing disabilities. Thirty-seven percent said they had no disability. Some people did not consider their mental ill-health as a disability.

#### Mental health

Of those who disclosed their mental health condition, 69% reported living with anxiety, 57% lived with depression, 40% with PTSD, 30% with schizophrenia or schizo-affective disorder, 22% with Bipolar Affective Disorder and 15% with Borderline Personality Disorder. Many lived with a number of diagnoses: 27% lived with two diagnoses and 27% lived with three; 17% lived with four diagnoses and 5% lived with five. Three participants chose not to disclose their mental health diagnoses.

## Current housing

When current housing could be ascertained (it was not clear for 10 participants), 34% percent of participants were currently living in transitional housing; 11% were living in private rental and 11% were home owner/mortgage payers. Only 9% were in public housing and 8% were living in the family home. A minority were living in community housing (5%), a caravan (5%), a short-term sub-acute mental health service (4%), couch surfing (2%) and boarding house (2%).

## 3.2.2 Carer demographics

The average age of carers was 56 years (SD = 14.7) and ranged from 21 years to 76 years. Ninety percent were female carers. All spoke English as their primary language and none identified as Indigenous. Of those who responded about employment (four people did not), 31% were not employed and not seeking employment. Thirty-eight percent were employed part-time, 13% were employed full-time and 13% were self-employed. Income data was available for 18 participants. Of these, over one-third had an annual income of \$15,000 to \$29,999 (39%). Eleven percent had an annual income of less than \$14,000 and 38% had an income over \$50,000.



## 4 Qualitative results

Analysis focused on exploring the interconnections between housing and mental health and on interactions with mental health and housing services and supports. Major themes are presented within the following topics:

- housing experiences and interconnections between housing and mental health
- experiences with the housing and mental health services and systems
- changes needed to improve outcomes
- trajectories: pathways through mental health and housing services
- circuit breakers: breaking the cycle.

### 4.1 Housing experiences and interconnections between housing and mental health

Participants in this study experienced many forced moves, housing insecurity and short-term housing experiences. Common housing experiences included transitional housing, boarding houses, caravan parks, couch surfing, living on the streets and living with family. Private rental was less common and home ownership was rare. Most of the common housing experiences were characterised as being unsafe or stressful and not conducive to recovery and mental wellbeing. Transitional housing, although often providing people with a safe space, did not offer the stability needed to support recovery and generated much anxiety about the future.

*I've lived out of a suitcase for seven years. So I just want somewhere where I can unpack and not have to pack back up again. (consumer, Bathurst)*

A minority of participants had periods of stable housing, often through public housing or private rental. Stable housing was important for mental health and recovery and gave people the space to start to focus on other areas of their lives. Housing would be disrupted by forced moves. There were a number of reasons for these, including increasing rent or loss of income, housing not being maintained due to participant illness and distress,

housing being unsafe and relationship breakdown/changes. For people who were faced with a forced move and looking for alternatives, private rental was often unaffordable and they were driven to rely on informal supports. Living with family/friends often placed significant strain on the relationships, which had a negative effect on mental health. Participants were very aware of not wanting to be a burden on those around them and also recognised the importance of having their own space to maintain their mental health. In many cases, having to rely on informal support when relationships were strained led to permanent relationship breakdown, forcing the participant to become more socially isolated and more likely to have to use formal services once they had reached crisis point.

Housing and mental health were clearly inter-related and affected each other in a number of ways. Participants reported that their housing had a significant impact on their mental health and recovery and on their overall quality of life. Housing and living situation affected several major areas of participants' lives, including their financial situation, feelings of safety, feelings of security, self-worth, relationships, perceived control, their environment and their ability to obtain employment, study or volunteer. Participants discussed the far-reaching impacts of their housing situation on their whole lives, particularly highlighting the interconnectedness of housing, mental health and employment.

#### 4.1.1 Housing and financial situation

The cost of housing restricted options for the participants and limited their resources for other expenses, including medication and mental health care. For most participants, private rental was unaffordable. Many had tried private rental in a shared house environment to reduce costs, but this was often difficult to maintain in the long term if the person became unwell or relationship difficulties developed. Furthermore, for participants who had experienced trauma, it was difficult to find people they could trust to live alongside. Some participants were in private rental that was sub-standard. In several places, participants in private rental were being exploited by landlords because there were

simply no other options for them. One participant who had secured private rental after a long period of searching continued to face issues with her landlord yet felt trapped in her current place because of a lack of other affordable options. It is possible that landlords know that the tenants are trapped and therefore may be slower and less responsive around maintenance issues. This places significant stress on people with mental ill-health. In Bathurst, several participants talked about cameras being in their house and having no privacy.

*There was structural problems with the place that were questionable from the start... Twice within the first six months, the place was treated for white ants. She [the landlady] said the pest people were meant to be out there checking and baiting traps annually – they never did that. (consumer, Berri)*

*Fair enough having cameras outside the house to see who enters the premises... but cameras in the kitchen, cameras up the hallways... I really felt like I had next to no privacy. (consumer, Bathurst)*

Many participants spoke about the difficulties of obtaining secure housing while receiving Newstart Allowance payments. Some individuals qualified for Disability Support Pension (DSP) and found this increased income resulted in a more manageable way to live, despite the fact that their income was still below the poverty line. Other participants who received DSP were still under significant financial stress in maintaining their housing. The process of applying for and being granted access to the DSP was seen as long and arduous.

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

In some areas, such as Berri and Canberra, a few participants were able to maintain a mortgage on DSP, although they experienced significant stress in making the repayments. So, the effects of housing stability can be compromised if there is significant stress around mortgage repayments and

uncertainty about future health and opportunities for employment.

*The mortgage could go up, the interest rates could go up, and I worry all the time, thinking, if they go up heaps then how much are we going to be able to afford? (carer, Berri)*

*Because of budgeting severely, I think that's why I'm not eating properly and because I'm not eating properly, I'm not sleeping properly [and] I might be tired during the day. (consumer, ACT)*

The prohibitive costs of housing created barriers for engaging in other activities needed for a well-rounded life and basic mental health support, including medication. The decision to get mental health support needed to be weighed up against other basic living costs, and one participant referred to not wanting to wait until their situation had become one of 'therapy or die'. While they knew they could get 10 sessions of therapy through a Mental Health Care Plan, they also knew the limitations and inadequacy of 10 sessions for those with chronic and persistent mental ill-health.

*How the hell am I supposed to live, and what optimism am I living for? I am paying so much to stay alive that I have nothing left to stay alive with. (consumer, ACT)*

There was also a financial impact for carers who tried to devise their own solutions to best support their family member. For example, in Hobart and Perth, where they could, carers paid rent or a mortgage for their family member. This sometimes created other problems for the carer as their pensions would be negatively affected because the property was seen as an investment property. There were also financial problems within the family.

#### 4.1.2 Feelings of safety

Most participants referred to housing experiences where they felt unsafe. This could be due to insecure housing (for example, broken locks) or to the negative behaviour of neighbours or other people in the neighbourhood (for example,

substance misuse, violence or yelling). For individuals who have been exposed to traumatic violence in the past, this behaviour can be a trigger for anxiety, leading to self-imposed isolation in order to feel safe. Isolation can further contribute to mental ill-health.

*And so, this particular person [in a boarding house] just absolutely lost it, which was just – and I was just shaking for the rest of the day. And so today when I heard that she was up and about, I didn't even come out to rest – like, I came out of my room, heard that she was up and about, went back in my room. (consumer, Adelaide)*

Participants often referred to not 'fitting in' to public housing, especially when others who misuse substances around them. Sometimes this led participants to engage in substance misuse themselves when they were trying to avoid doing so for the sake of their mental health.

*At that time, I would have been better off on my own and seeking help. I mean, sometimes it's not good to be around people who have the same sorts of issues. People who have got issues with addiction should not be housed together, it doesn't work. I've seen it while living it. (consumer, Sydney)*

Carers also reported feeling unsafe at times when the person for whom they were caring was experiencing periods of acute illness and distress. The situation of having an unwell person in the family home and the associated lack of safety came about because of the mental health and housing systems failing to protect people when they are in greatest need. One carer talked about a time when their family member was discharged from acute care without their knowledge, and the family member returned home in a distressed and frightened state. Another carer in Perth had to go to her daughter's house in order for her daughter to feel safe enough to shower. In some cases, carers talked about being the provider of last resort – being the place someone is sent to when all service options have failed them. Consumers expressed a similar view of reliance on family as the provider

of last resort, and mentioned that this sometimes involved living in places where they had previously experienced abuse and trauma.

*... and then three days later, they [inpatient unit] threw him out on the street without telling us or giving us any information, no shoes, and he walked all the way back to this flat he was living in, on the other side of Perth, and had bleeding feet. And they didn't follow him up, which is against the law; so we were apologised to in the end. (carer, Perth)*

### 4.1.3 Feelings of security

Short-term housing and transitional housing, while providing the person with a safe place to live, also created a lot of stress and anxiety about needing to find somewhere else to live in the long term. The length of stay in transitional housing seemed to vary from three months to a few years, although many participants reported that they did not know how long they could stay in their accommodation. In no case was the length of stay in transitional housing reflective of the minimum wait time for public housing, which was often the only viable long-term housing option for participants. In contrast, a feeling of mental stability was described when finding housing, although this was the case for only a minority of participants.

*... you've had this place at the time, over three months, and they've got other people to come in there, so then you're going to be homeless. So just extra stress: oh God, I've got something else to worry about. (consumer, Sydney)*

*Lots of times I wondered, is it worth it? Is it worth waiting and trying? And I've had suicidal thoughts before. Yeah. Because of housing difficulties. (consumer, ACT)*

### 4.1.4 Self-worth

Feelings of worthlessness can come from, or be exacerbated by, a lack of secure housing and the process of getting assistance for housing. This process can make people feel inferior, which

has negative implications for their mental health. Participants spoke very negatively about their experiences with public housing staff and felt a lack of control in their interactions with them. This seems to stem from a lack of information that staff are able to disclose about the length of waiting lists. Participants also referred to having difficulty talking about housing problems with housing staff and justifying their need to move because of negative impacts on their mental health (for example, violence, not feeling safe and there being too much noise).

*You feel worthless and you feel like you don't belong anywhere. (consumer, Bathurst)*

*Nobody else [apart from the researchers] has taken the time to listen, to figure out what to do with me, so I'm just a number. (consumer, ACT)*

#### 4.1.5 Relationships

Some housing tended to have negative effects on participants' relationships, particularly shared housing or living with family. Privacy and space to be on one's own was valued highly by the participants to support their mental health and recovery. Shared housing often posed challenges for participants' mental health. Preferring to spend time by oneself rather than with housemates had an impact on relationships with housemates, potentially making them less forgiving if rent was not paid on time. Shared housing was often a more intense experience if the participant was not employed as housemates might then spend a lot of time together. Some consumer participants wanted to live in a shared-house environment, but only with someone they trusted and in a house where privacy was accessible when needed. Outside of having a private rental, which was often unaffordable, for most this was not possible to achieve within the housing/homelessness service sector.

*Like, I can't deal with living right on top of someone, or right besides someone because I don't get along with people. Like I can say 'hello' and see them every now and then, but living right on top of someone, I just can't do that. (consumer, Bathurst)*

Participants living with family also reported that the living situation placed significant stress on the family relationship. It was not always best for the person who was being cared for to stay in, or return to, the family home, particularly if there was a lack of understanding about mental ill-health, or if they felt like they were a burden on the family. At the point of discharge from hospital, there was often little consideration of whether living with family was the best option for the person or their family.

One carer talked about her parents not providing care for her sibling who struggled with mental ill-health. Due to their religious beliefs, they did not support her and further contributed to her poor mental health. One carer also reported feeling unsafe with her son when he changed medications and his behaviour changed. Even when the family relationship was positive, living with family still placed significant pressure on both the familial relationship and the carer, and in some cases contributed to a permanent relationship breakdown.

*Our parents are emotionally and physically abusive; they don't believe that mental ill-health is a real thing. They think they she's just on purpose behaving badly, or she's been possessed by demons, due to their own personal beliefs. (carer, Mackay)*

*Being put on the ward for a week or two and then trying to find somewhere to stay at that time – if anything, those guys [hospital staff] will lean on family and they'll say, 'Go live with family', but I pretty much burnt through all my family. (consumer, Brisbane)*

While privacy and space were valued by many participants, isolation was often a result of the move to secure independent housing. For some participants, the process of gaining secure housing meant losing connections and living in isolation. This was seen as a difficult transition period where it was not uncommon to consider moving back into homelessness and/or a boarding house in order to be around a known community. This process was seen to take time and would be a period where added mental health support and support with community engagement could be of benefit.

*I feel like I'm in a house, no-one talks to me. I've not made a single friend. I have no friends in Berri or anywhere. (consumer, Berri)*

Housing played an important role for participants who were parents who may have lost access to their children. If they could secure housing, they could spend more time with their children, which gave them purpose and helped with recovery.

*I've got a four-year-old son. I'd like at least a two-bedroom place so when I do have him unsupervised if he stays overnight, he's got a room. I get laughed at. (consumer, Bathurst)*

#### 4.1.6 Perceived control

Participants reported a lack of control and choice around their housing, in terms of both applying for housing and then maintaining the house. One participant became increasingly frustrated about maintenance issues not being addressed by the Department of Housing. In the absence of any action from them, and in an attempt to control the situation, he stopped paying his rent. As a result, he was evicted.

*So it got to the point where they weren't doing what I was asking them to do, so I stopped paying rent, and then, you know, a few months down the track, they said 'You're evicted.' The only places I could stay were hotels or boarding houses, because you didn't need a full bond or anything like that. (consumer, Sydney)*

In public housing and private rental, participants felt significant pressure to maintain the house to someone else's standard. Additionally, they felt stress around keeping people out of their house who may potentially jeopardise their housing. They felt there was some hypocrisy as public housing organisations could choose when they responded to a tenant but there was no leniency or flexibility for tenants when they struggled to respond in time.

*Make sure that it's well looked after. It's up to the people who are letting you rent, their perspective [on] how good they want it, how clean they want*

*it. So, you're running around with your head cut off your shoulders and you're spring cleaning and making sure everything's done and no marks on the wall or doors or anything like that... (consumer, Berri)*

*If you owe them money, they really want it back, but if they owe you money, it takes you years to get it back. Yeah, so really, they treat all of us like a number. (consumer, ACT)*

#### 4.1.7 Environment

After experiencing mental health issues, participants reported that they wanted peace and stability: peace from trauma, stability in their relationships and peace in their environment. They wanted largely to be left alone in peaceful, safe and secure housing. Participants had mostly had a lack of choice about their housing, which often led to them being placed in housing environments that were not conducive to recovery. For several participants, the physical environment was part of what distinguished some of their best housing experiences. Participants also talked about the importance of being close to services and supports. Many expressed a desire for their housing to enable them to connect to nature more, whether this was through having a garden, getting some sunlight or having access to nature in their neighbourhood.

*It was bliss. It was so peaceful there. I didn't have any mental health dramas at all... You get home at the end of the day, and it was just like walking into a slice of paradise. It was so nice. It's in a quiet and cosy place and it's surrounded all by nature. (consumer, Brisbane)*

### 4.1.8 Employment

Some participants were too unwell to work, but even if they were able to work, the interdependency between housing and employment made securing either difficult. One participant was not able to secure private rental because he was not working and was not able to get a job because he had no fixed address. This was not an isolated experience. It was sometimes difficult to maintain employment when people became unwell. Work was often overwhelming and negatively affected their mental health. There were a number of participants who were on Newstart Allowance (they should have been on DSP) and the process of applying for jobs was very stressful. Without employment and income, housing options were limited. Furthermore, without employment or income, the prospects of improving their financial situation were limited.

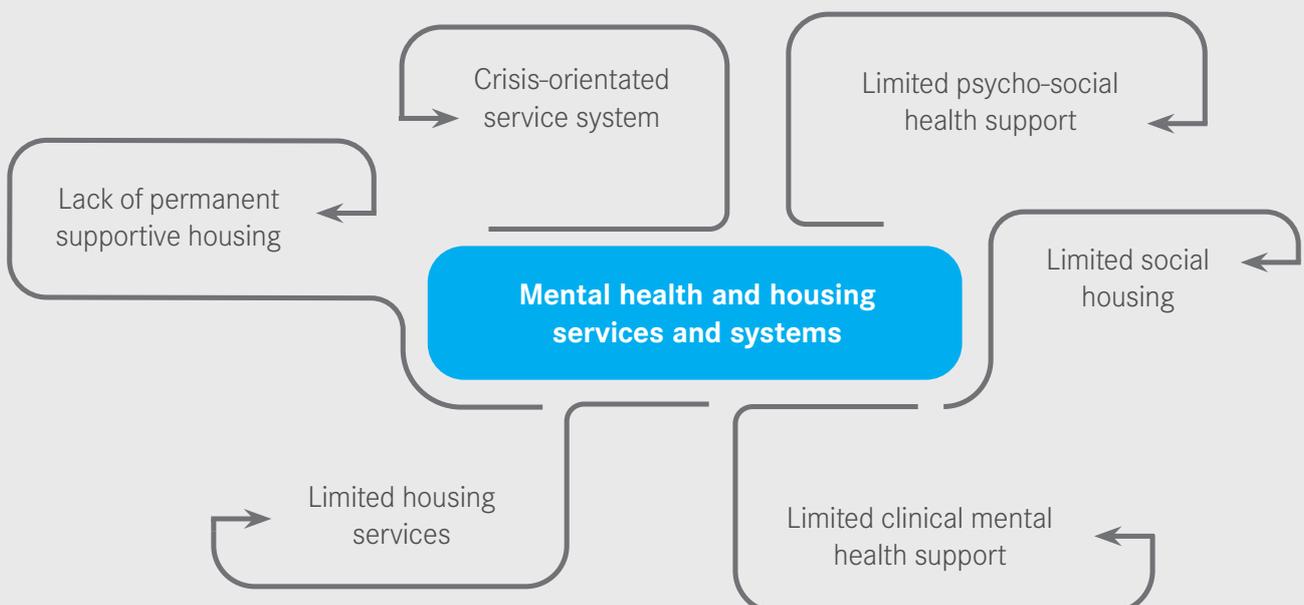
*I've rung countless places [for housing] and they will not even give you their address if you're not working... For a job they want to know, where do you live? How long have you been there? I don't want to lie yet I want to protect my chances of getting a job as well. It's sort of two dogs eating each other. (consumer, Sydney)*

### 4.2 Mental health and housing services and systems

Participants experienced difficulties in getting access to housing and mental health supports and services. Housing services were often unknown and public housing waiting lists were very long. For people who were unwell, there were often few supported accommodation options. Access to community mental health services and clinical services was also limited for a range of reasons. When people are unwell, it is very difficult for them to navigate both the housing and the mental health systems without support. Often participants had to balance meeting their housing and mental health needs due to the incompatibility of the two service systems and the lack of communication between them.

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

Figure 2: Experiences with mental health and housing services



Source: The authors.

## 4.2.1 Public housing

In all areas, public housing had extremely long waiting lists (between two and seven years), and participants had no sense of how long the waiting list would be. They referred to being the lowest priority for public housing, particularly those who are single and have a pet. Many participants were shuffled between different priorities on the list as their being in severe distress or homeless did not necessarily result in being seen as high priority. In addition, the paperwork required to access public housing is particularly difficult for someone to pull together on their own while they are unwell. Tackling the paperwork to change priorities was also difficult, especially when it needed to be done during times of low capacity. Participants felt frustrated that they needed to ‘hit rock bottom’ before services would kick in. This had a negative effect on their mental health and made the recovery process very slow.

*I am signed up for public housing. Apparently, it's up to a six-year wait, if not longer. (consumer, Brisbane)*

*In either Housing SA or looking for a private rental through real estate agents, priority goes to people with families; in a private thing, people with employment. And most people with mental illnesses that I know are alone, single, and often their only company is a pet they have to take into consideration too. (consumer, Berri)*

The process of applying for and securing public housing is marred by a lack of control and choice, particularly regarding the location of the house. The participants knew what type of housing environment would work best for them – such as not being around substance misuse and being close to support services, amenities and social support (family and friends) – or how many people they could live around. But this was not taken into consideration in their initial housing assignment or seen as a valid reason for needing a transfer to another property. Participants often said that they were made to feel as if they were being picky, when in fact their request was necessary for them to remain well. One participant had been robbed, threatened and surrounded by substance misuse when he was attempting to remain sober. The response from the Housing Commission was inadequate, so he had gone back to living on the streets as it felt safer. This had been going on for almost a decade.

*They give you two choices, and if you knock them back because they could be in really bad areas... like, I don't want to take that place because three months later I might be dead because of the area... and if you don't like any of these, you can go back on the waiting list and wait another 18 years. (consumer, Sydney)*

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

Participants spoke very negatively about their experiences with public housing staff and felt a lack of control in their interactions with them. This seemed to stem from the lack of information that staff were able to disclose about the length of waiting lists. Being forced to apply for private rental properties outside a reasonable price range to prove that you cannot find private rental can also be disheartening and humiliating.

*For the application, they want us to fill out a rental diary, meaning that we've got to go and look at all these houses that are definitely out of our budget, and it feels humiliating... we've got to be rejected from every single one of them and then take*

*them back into Housing to show them that we've been rejected for them to actually do something. (consumer, Bathurst)*

Adequate housing was not seen as a human right by many participants, and in the absence of housing solutions, they reported identifying what the bare minimum would be for them to survive. Their expectations for housing were often very low and there was little discussion about the adequacy of the house, in terms of number of rooms or its age or quality. In the Sydney focus group, there was a discussion about how all people needed was some land so they could put up tents and live in 'tent city.'

*A secure place for people to park or camp in each regional area would be a really good idea. Could be the council carpark and they clear out in the morning. (consumer, Sydney)*

One participant in Brisbane recounted his time at a refuge where he had experienced significant difficulties due to drug misuse by other residents, as well as violence and threats. But, still, he said it was:

*... better than some of the other places I had stayed. [At other places] I was paying \$200 to \$300 a week, sort of thing, but at [refuge] I was paying \$60 or \$70 a week. I was having hot showers, and wash your clothes, and I had a bed. I had people to talk to. (consumer, Brisbane)*

#### 4.2.2 Housing services

Many participants reported that they did not know whether housing services existed in their area or how to find out about them. In some places, participants reported that there were simply no services. One carer in Mackay reported that the men's shelter was the only option when it became too difficult to stay in the family home and his mental ill-health deteriorated when he was there. If services did exist, interactions with them were not always positive. Some participants reported that they felt there was stigma associated with mental ill-health and that they felt judged by housing services and real estate agents. Some participants

were excluded from housing services because of their symptoms of mental ill-health but were not supported to find a suitable alternative.

*You get depicted – they just pigeonhole you and stereotype you and you come in and they sort of give you that look like 'Oh geez, you're back here again.' It's like you feel like you're constantly judged. (consumer, Bathurst)*

*... well, there was a government house in refuge that I stayed at that I tried to commit suicide and spent three days in hospital and then when I got back to the refuge all my stuff was packed up in black bags out the front... they don't know how to deal with young distraught teenagers, even though they're a refuge for young distraught teenagers. (consumer, ACT)*

That last consumer ended up on the streets as a minor, and later became a victim of international human trafficking for over a decade. This was one of the most egregious failures in duty of care encountered in the study.

#### 4.2.3 Lack of permanent supportive housing

Some participants need more than just the provision of housing; they need support and accommodation on an ongoing basis. This may include additional help with their daily tasks, help maintaining a house and support for their mental health and managing day-to-day problems. For example, in Mackay, carers continued to care for their family member, not only because there was no other housing available but also because they needed to provide additional support for them for their mental health and/or to help them live independently.

*If he had to go and do it on his own, he can't coordinate everything that you have to do to live independently... to coordinate having a job, budgeting, go and get your groceries, meal planning, everything you have to do. That would stress him out. (carer, Mackay)*

#### 4.2.4 Limited psychosocial mental health support

In some areas, participants were connected with community mental health services that provided psychosocial support. Psychosocial supports are those that help people increase their capacity for everyday activities, including maintaining relationships, doing day-to-day tasks, maintaining health etc. Important elements of psychosocial support include having a trusted worker for support and advocacy, and also having connections with others, feeling understood and not judged by peers and having a routine and meaningful activities to engage in.

While participants felt positive about these services, they sometimes reported that they were not able to get as much support from them as they needed. For example, a local community mental health service was running support groups. For some people, these groups were the only regular activity that they were involved in, and they enabled them to connect with other people. Limitations on group numbers were seen as an issue. Some people only became connected with community mental health services after hitting rock bottom and felt disappointed that they had never previously realised that the services existed.

*If someone will listen to your story, it just gets it off your chest, as they say. And sometimes that's all you need is someone that'll listen to what you're doing and pull you out of the issue that you have at that moment. (consumer, Berri)*

*They've got a couple of groups there. They've got a music group, cooking group, art group, bowling group. It's pretty – yeah, but only a certain amount of people can go on them. (consumer, Adelaide)*

Sometimes the issue was that, even if the groups and activities were affordable and available, severe financial hardship prevented consumers from accessing them.

*I wish I could get around more and do more things, but you can't because you don't have enough money to do stuff... they've got a program that they run and they do different activities most days of the week. I try to attend as much as I can but there are some days where I can't afford to attend because it costs you a couple of dollars to attend and you might not have that money a day before payday or something. (consumer, Brisbane)*

Carers also talked about the impact of not getting help until hitting rock bottom. This included damage to family relationships, property and wellbeing during the months and years they were left without adequate support.

#### 4.2.5 Limited clinical mental health support

Participants reported that clinical mental health services offered them limited support. A number felt that psychologists/psychiatrists only focus on medication, which plays a limited role in recovery. In most areas, and particularly in regional areas, access to private psychiatrists was limited and they were in any case unaffordable. Participants reported that they need understanding, help with coping strategies and help with daily life skills.

*They're [psychologists/psychiatrists] just like, every single time I went there, 'Have you been taking your medication, have you been on this medication? Try this medication, try this one, try this one.' I'm just like, it's not what I want, it's not what I need. I need coping mechanisms, I need you to teach me how to deal with it without medication, kind of thing. (consumer, Bathurst)*

*People who understand, less medication. More vindication, help us cope, access a place where you feel safe and comfortable. No judgment, help in a timely manner. To be given a fair go, more duty of care. (consumer, Bathurst)*

There were many negative experiences with discharge from inpatient units, including a need to move people quickly through the system and discharge them into homelessness. Carers reported

that they felt excluded from care planning and discharge, at a cost to everyone's safety. There was a sense that clinical mental health services do not understand or appreciate the role that families and carers play in achieving improved mental health and outcomes for their family member. As a result, decisions were made that placed the family in danger, or slowed down the process of recovery.

*They just want to dope you up and then no plan upon discharge. They just want to get you out so they can get someone else. (consumer, Bathurst)*

*Then I was homeless. I sat in a room in the hospital and had a lady explain to me about homelessness. I was freaked out. I was like, 'I'm living on the street'. Literally it was, if anything that whole area where they're like, 'These are the homeless numbers you can call'. That is absolute crap. (consumer, Brisbane)*

#### 4.2.6 Crisis-oriented service systems

The majority of participants were aware of the under-resourcing of the mental health and housing systems, and that services would likely be severely rationed to those who were deemed most in need. Many participants had sought help as they had started to become unwell and been refused access to services until they had then reached crisis point. But being in crisis did not guarantee access to help for many participants, and it was often incredibly distressing for them to have their needs dismissed. At times, this would drive participants towards self-harm or suicide attempts in order to become visible to service systems.

*I told them my full plan to kill myself and that I was like put into hospital and they were going to discharge me 24 hours later... So instead... I swallowed approximately 30 objects. (consumer, ACT)*

*It wasn't until something serious had happened with my mental health, like, I crashed my car into a tree. [...] It wasn't until I did something serious like that, that the government stepped in. (consumer, Adelaide)*

Participants were also concerned that if they complained about inadequate services they would be labelled as troublesome and be denied service access in the future. The crisis-driven nature of service systems not only left many participants with no support and a failure of early-intervention policies, but also itself caused participants harm as asking for help takes great courage; and rejection leads to a diminished sense of self-worth, feelings of isolation from society and makes it more difficult to envision a future where they would be well.

*And I've been screwed my whole life. I just want one place. That's it... no matter how much I wail and scream, my arms up in the air, and scream as loud as I can... It's not enough. So that makes me feel that I'm not enough... (consumer, ACT)*

### 4.3 Improving outcomes: what participants want

Participants discussed a number of changes that they would like to see in both housing and mental health services and systems. For housing, at a very basic level, many simply wanted a safe place to live in. Others referred to the need for public housing to offer a safe, secure environment and neighbourhood.

*There is a problem with people with mental illness being in public housing where there's drug use, criminal activity, domestic violence etc. Everybody deserves to have a roof over their head; you can't just lump people like that all into one type of housing. (consumer, Berri)*

Housing support must be provided early, and not only when a person becomes homeless. People can identify when things are getting out of control, and a little support at that stage may enable them to keep their home, particularly when people are still in private housing and could potentially avoid entering the homelessness system altogether. Given that for the majority of participants, social housing was seen as their only option for secure, long-term housing, this would have marked benefits for the overwhelmed public housing system.

Having supportive and empathetic housing staff was important for the participants. Staff with lived experience were particularly sought after. Furthermore, while the mental health of clients may not be the focus for housing staff, they are in a good position to identify when people need assistance and need to connect with other support services.

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

Having a pet in the home can provide significant support to a person with mental ill-health. Participants talked about the positive influence

of their pets and the fact that they are sometimes only still alive because of their pets. They help them to get out of the house, go for a walk and engage with the community. Many were unable to get the pets they dearly wanted for companionship because their housing was so insecure, or because there were many restrictions in the housing/homelessness system on owning a pet.

*My dog is very important to me... the dog is often the one think that keeps me out of hospital in the end. (consumer, Berri)*

In terms of changes around mental health services, participants wanted ongoing access to psychosocial support and affordable clinical mental health support. They do not want to have to wait until they reach crisis point to be eligible for services. Access to both clinical support and support to manage their day-to-day lives was seen as essential, as a lack of holistic focus on their lives impeded long-term recovery.

Carers also needed support for their own health and wellbeing to enable them to continue to support their family member. They can face significant stress in supporting their family member, and this is heightened if they are living together in the knowledge that there are no other housing options. They also need access to mental health services for themselves, in terms of understanding how best to support the person they care for and maintaining their own health and wellbeing.

There needs to be a systematic process for discharge from hospital, transitional accommodation and sub-acute services that supports housing and recovery. It is important that there are some housing arrangements that are medium-term rather than short-term solutions, and that medium-term arrangements are designed with the realities of the overall system in mind. Transitional housing with tenancies of one-to-two years was thought insufficient to bridge the gap of a five-year average wait time for public housing, which was often the only viable long-term option. Some participants referred to a good transition into public housing and mental health support after

prison (although this was not always the case and seemed to be less common for those with shorter sentences).

*There is a system in place for people out of prison in Berri. They come out of prison, they go into a housing service, they're there for a few months and they are reallocated somewhere... well, there is nothing like that for anyone coming out of a mental health hospital where they've had a breakdown, their family's left them, they're completely homeless. (consumer, Berri)*

## 4.4 Trajectories

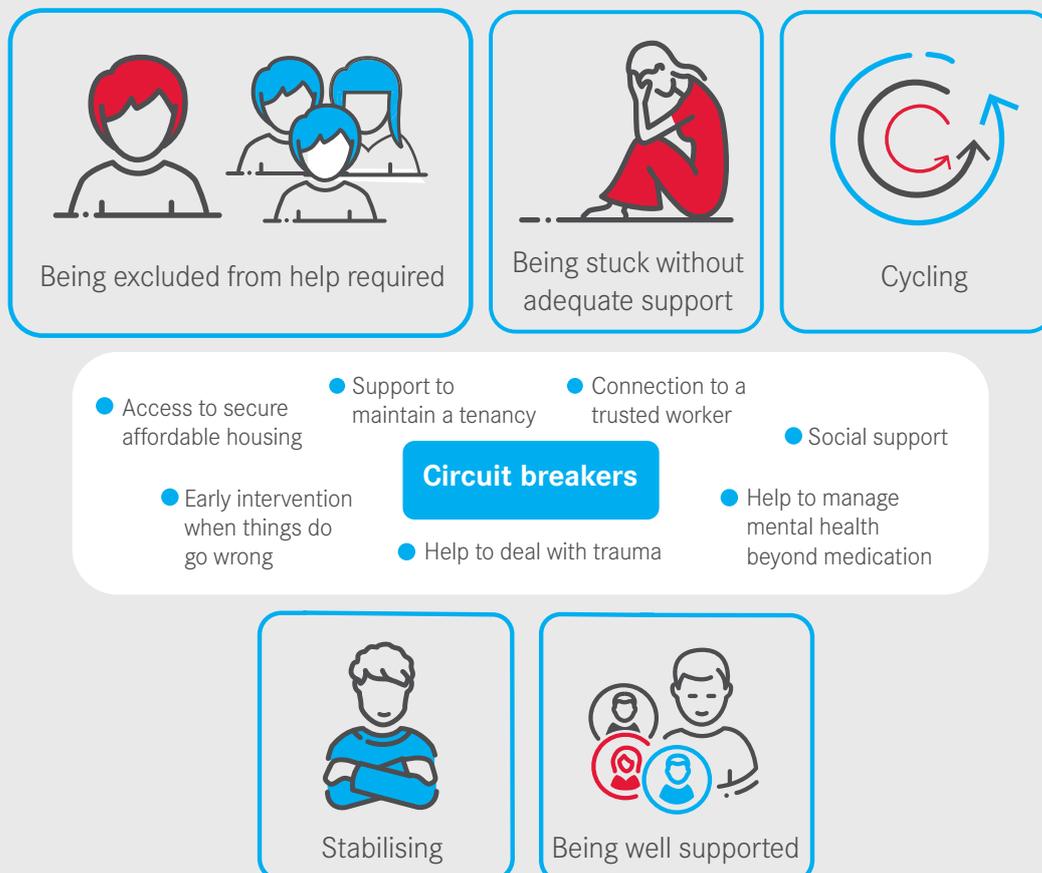
In addition to exploring how mental health and housing affect each other, the aim of this study was to identify a typology of trajectories to understand the housing and mental health pathways of groups of individuals. Trajectories were identified by examining engagement and interactions with

mental health and housing services and reflecting on housing and mental health outcomes. These analyses demonstrated that experiences could be characterised by five major pathways through housing and mental health services and systems. People could have experienced a number of these trajectories throughout their life. They include:

- being excluded from help required
- being stuck without adequate support
- cycling
- stabilising
- being well supported

In addition, circuit breakers were identified through participants reflecting on their past experiences and current situation. Circuit breakers are factors that enabled people to move out of their current situation and establish stability and focus on recovery. These trajectories and circuit breakers are presented below.

**Figure 3: Trajectories and circuit breakers**



#### 4.4.1 Being excluded from help required

Many participants were excluded from housing and/or mental health services. These participants were struggling with their housing and mental health and were trying to develop their own solutions and supports. For example, in a rural area a couple was living in a caravan with no electricity, and they had been there for four years.

*We live in a caravan beside the river... yeah, so we have got no, like, running water or a toilet or a shower or anything like that... and we have to go into town every second day and we have no fridge, so that means every second day we have to go out and get meat and whatever else because nothing lasts for more than a day or two... (consumer, rural area)*

A major reason for being excluded from the system was that people did not become eligible for services until they hit rock bottom, such as experiencing homelessness or making a suicide attempt. This was despite people recognising early signs of deterioration and reaching out for assistance. Hitting rock bottom obviously has consequences for the person and their family and can mean that recovery takes longer. This assumes that people recover everything they have lost until they get to this point, things such as housing, income, employment, relationships and a sense of being part of their communities. Consumers said that it was not the case that they do this.

*I went to places like [community mental health provider] and they interviewed me... [t]hey would say, 'I don't think you need a referral here. You are doing quite well. Just keep your chin up and you will get through it'. Things just got worse and worse. (consumer, Brisbane)*

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

In terms of housing, many participants reported that they were not flagged as being high priority

for public housing, which means they faced very long waiting lists. In the meantime, forced moves, negative short-term housing experiences and transition in and out of services had an impact on their mental health and increased exposure to trauma, making recovery more difficult, even when supports kicked in. Sometimes, there were simply no other housing options.

Some participants had never engaged with mental health services, and as a result they did not have a diagnosis and therefore were not eligible for services. Often these participants did not know that mental health services existed in their area; sometimes such services actually did not exist in the area. Many participants who connected with community mental health services for the first time did not know the services existed and had only engaged with clinical services. Others chose not to connect with mental health services because of a previous negative experience with the system. Cost was also a major barrier to accessing mental health services, particularly the costs of counselling or psychiatrists, and, as a consequence, people went without mental health support.

*I can't afford to go, so I don't go. You know 24 years of battling it, and I don't know where to find free services for someone my age. (consumer, Sydney)*

Carers are particularly excluded from mental health support as services often focus on the person with the mental ill-health. Carers not only need help to continue to support their family member but also to maintain their own mental health.

*The way our mental health system operates, it is very much focussed on the individual who's ill. My experience has shown me that the services and supports are needed for family members, carers, partners. Those services are so important because you're the one who kind of keeps the whole operation together. (carer, Berri)*

Participants were often excluded from other supports that could assist with managing their housing and mental health, such as obtaining Disability Support Payment or NDIS packages.

## 4.4.2 Being stuck without adequate support

A lot of the participants were stuck without adequate support, for housing or mental health or both. These participants were not excluded from support altogether but did not currently have the right support to progress in their recovery. In terms of housing, many participants were currently (or had been) stuck in private rentals that were unsafe or not well maintained, and were unable to afford to move.

*Brown water through the taps. The electricity was stuffed. The water, the plumbing, was bad. There were holes throughout the house and most of the windows were either locked shut or couldn't shut. (consumer, Sydney)*

A few participants, primarily in regional areas, could afford to buy a house rather than rent but were stuck with a mortgage that they could not pay when they were unwell or were under such severe mortgage stress that they had little remaining funds to live on. Others felt stuck in transitional housing. Although they had a roof over their head, they often had little understanding of how long they could be there and when they would become eligible for public housing, and where they would live if they had to leave transitional housing before public housing was available. They felt insecure and were unable to start to work on other areas of their lives until their housing was secure.

*I feel unsettled because knowing it's only a temporary place. I want to get a place long term where I can call home and feel comfortable and feel at ease and that I don't have to stress about things. (consumer, Brisbane)*

Some participants had secure housing yet were stuck without any (or only limited) mental health support. They wanted a routine and meaningful activities and connections. They spoke positively about the styles of support that community mental health services offered.

*I mean, I've never been in a situation that I've actually had to live on the streets... but I don't think the housing is mentally a saviour at all. Just*

*one of those things. It's like putting on clothes in the morning; you just happen to have them and you use them. But having the house hasn't helped me mentally at all. (consumer, Berri)*

*It's just a place to live, I guess. My life is full of could of, would of and should of. (consumer, Sydney)*

Some participants were restricted from being able to participate in social/recreational activities by financial constraints. They would struggle financially to cover rent and basic expenses, so funding socialising or recreational activities was not possible.

*I get boredom and that. I try to keep busy with appointments and that, but outside those appointments is where the boredom and the loneliness and the depression kicks in... I wish I could get around more and do more things but you can't because you don't have enough money to do stuff. By the time you pay your rent and electricity and food and petrol and smokes and food and your telephone bill and medication bill... (consumer, Brisbane)*

In some areas, participants did not seek mental health support because of the stigma that surrounds mental ill-health. As a result, they were stuck without adequate support for their mental health.

*She's very conscious of stigma when it comes to her particular diagnosis. She's happy to speak about depression, anxiety, but any further than that with her hallucinations or delusions, she's not really wanting to get into it with other people. (carer, Mackay)*

In terms of carers, many were stuck without adequate mental health support and too burnt out to navigate the system to get it. This often resulted from being a carer for many years with limited support.

*See, I'm very isolated... I'm at the point where I'm so burnt out that to pick up the phone and ask for Commonwealth Care Respite to come and do a quick clean around my house is a huge task. I can't bear to do it... I come home and I don't do much. That's not really a life. (carer, Mackay)*

### 4.4.3 Cycling

Many of the participants were cycling in and out of the housing and mental health systems. Often, these participants had experienced trauma and instability in childhood as well as homelessness or housing insecurity from a young age. Interpersonal trauma usually began at a young age (prior to 18) and continued into adulthood (often caused by multiple perpetrators and in multiple contexts). These included traumas as domestic violence, emotional abuse, parental abandonment, assault, dysfunctional family situations and death of a loved one.

*I got kicked out of home when I was 16 for being violent to my dad. He was a particularly strict father anyway, so he just wouldn't have it. (consumer, Adelaide)*

*Probably about a year ago, I was living with mum and stepdad. They had grown to pick on me because I've got a mental health condition, so I got into a big fight with mum and dad and they were prepared to just kick me out onto the street... they literally called the cops on me. (consumer, Brisbane)*

Some participants experienced trauma and discrimination from within the service system, from both other residents or service users and from staff. Of her experience in youth crisis accommodation run by a religious charity, on participant recalled:

*... being LGBTI... [was] something classed to be kicked out, if they realised. (consumer, Brisbane)*

Some participants talked about being thrown out of home or leaving home at age 14 or 15. Participants experienced many different living situations, including couch surfing, shared houses, private rental, caravans, living with family and periods of living on the streets. Some had periods where they had public housing but either lost it for being unable to maintain it or pay rent or chose to give it up due to relationship changes or the public housing being inappropriate to their needs and their being unable to transfer elsewhere.

*Even with the Department of Housing, I choose not to live there, and the transfers take you so long that I put myself out on the streets deliberately... It's more safe for me to do that than to live there. (consumer, ACT)*

Participants also cycled in and out of getting mental health support, with frequent moves making it difficult to access and/or maintain supports. It was often through hitting rock bottom, either through homelessness, severe exacerbation of mental ill-health symptoms or a suicide attempt, that they became (re)connected with services. By then, the impact of their previous experiences and unresolved traumas made recovery more challenging than it might have been if their issues had been addressed at an earlier point.

Moving from one mental health service area to another, especially across states, could also be difficult for participants as they were required to start from scratch in order to obtain services and build relationships with workers. This was a particular risk for those in the ACT as, due to the small size of the territory, it was remarkably easy to cross the border to obtain temporary housing and thereby lose their mental health services, even if they still considered the ACT to be their permanent place of residence.

Substance misuse was widespread among those who had experienced trauma and was often used to self-medicate in the absence of appropriate formal supports. In accommodation such as boarding houses and some public housing, consumers reported that being with other people who misuse substances further exacerbated their mental ill-health. Substance misuse, combined with symptoms of mental ill-health, was also commonly a trigger for interactions with the justice system. A number of participants had experienced time in prison or on remand. Even when extended contact with the justice system did not result, restraining orders stopping participants from contacting family or friends due to a severe episode also had long-term negative effects on their life stability.

Cycling in and of support has far-reaching impacts not only on the participant, but also on their family. A number of participants had had their children taken away from them, and not being with them had a continuing negative impact on their mental health and recovery. They also spoke about the impact of this on their children: mental health and substance misuse issues were emerging among their children, and parents often felt an element of personal responsibility for this that caused them significant pain.

#### 4.4.4 Stabilising

Some participants had some stability in their lives, housing and mental health. Public housing sometimes provided that sense of stability and gave participants space to focus on their mental health and other aspects of their lives. Others found it living with supportive family. To provide that stability, the housing was not only secure but also perceived to be in a safe and welcoming neighbourhood. Stable housing was important for families and for children to be able to stay with their parents. Most often, participants who had this stability in their lives were on DSP so they could also cover their rent and basic costs.

*It was a new house, that's the house I felt more comfortable in. That's when I resigned myself to my illness. I stopped hiding it from myself. (consumer, Berri)*

*Housing was the biggest issue for DHS to have the kids back. Having secure housing has meant that I have had them returned. (consumer, Melbourne)*

In addition to stable housing, these participants also had some ongoing support for their mental health and had developed coping strategies to manage, as well as knowledge of where to go if they needed more support. They may have had some trauma-informed counselling and knew how to identify early signs of struggling mental health. A good, stable worker, often a psychosocial support worker or clinical case manager, was key to maintaining mental wellness, as was involvement in recreation and socialising.

*I just highly recommend [worker]. He's never judged me. I can talk to him about anything... I don't even look at him as a worker. I look at him as a friend, I guess because he's always been there for me and always listened and given me good advice... he gets me, he understands me. (consumer, Hobart)*

*Whereas before I wouldn't talk and I wasn't doing anything. It makes me feel like a sense of achievement after I've done something there. (consumer, Berri)*

#### 4.4.5 Being well supported

A small minority of participants had stable, long-term housing and ongoing appropriate mental health support and were able to find wider enjoyment in their lives and participate in meaningful activities. This provided some structure and routine in their lives and enabled them to build regular social connections. They were also able to feel they were contributing through part-time employment or volunteering activities that gave their life some meaning. Generally, they had been through a lot of negative experiences and trauma to get to that point, but they had mechanisms in place to maximise their stability. They had established mental health support and knew where to go and what to do if they needed help.

*As I've gotten older, because I had schizophrenia, where they've placed me now and the support programs they have around, I'm finding life a bit more enjoyable. I have the doctors, my depot. I have the housing, I have counselling. (consumer, Sydney)*

#### 4.4.6 Circuit breakers

Through reflecting on these trajectories and how people move through the mental health and housing system, a number of circuit breakers have been identified. A circuit breaker can be defined as an intervention in someone's life that breaks their housing and mental health trajectory. These circuit breakers include:

- Access to secure affordable housing in an area where they feel safe. The housing needs to be well maintained and the landlords/property managers need to be responsive when issues arise. The housing and neighbourhood need to be safe and secure. The person also needs to feel connected and safe in the community. The person needs to be able to pay their rent and have sufficient funds for other expenses and medical needs.
- Support to maintain a tenancy. This means that when issues arise or mental health starts to decline, supports are put in place early to ensure the person can maintain their tenancy, whether in the private or public systems.
- Connection to a trusted worker who can help people navigate services, advocate with them and for them, and support them when they face challenges. This worker understands them and they feel accepted and not judged. The worker can identify when someone is struggling with their mental health and ensure that mental health and tenancy supports are put in place early. Knowing that there is a trusted worker who can be called on when needed is empowering and reassuring.
- Help to manage distress and mental illness symptoms and sort things out beyond medication. In addition to having access to medication and clinical care, it is also important to have psychosocial support.
- Help to deal with trauma. Trauma-informed support or specialised trauma counselling to help understand the impacts of trauma on mental health, relationships and behaviour, including substance misuse. Understanding from all supports of the effect of trauma on mental health and life.
- Social support and connections with others are extremely important to maintain mental health. Both housing insecurity and mental ill-health are often extremely socially isolating, so support to re-engage after times of struggle will likely be necessary for many.
- Early intervention when things go wrong: access to mental health supports when a person has early signs of deterioration rather than waiting until crisis before supports kick in.

One of these supports on their own is not enough to break the cycle. It is the combination that enables people to maintain stability, even when new challenges arise. Once stability has been achieved, some of these supports may be able to be reduced, although there needs to be the flexibility and option of drawing on them when needed.

## 5 Discussion

The results of this study demonstrated the interconnections not only between housing and mental health, but also the interconnections with employment and income, trauma and substance misuse. While these relationships are very complex, the participants in this study were able to clearly articulate how their housing affects their mental health and vice versa, as well as their feelings of safety and stability, their relationships and their environment.

The results also demonstrated that stable housing is necessary for mental health. It was only once people had secure housing that they could start to think beyond their short-term mental health needs, their relationships, day-to-day activities and longer-term pathways. While housing is the foundation for mental health, it is not sufficient for recovery. Some participants did have secure housing but were struggling with their mental health and having a meaningful life due to lack of support in those areas.

A constant theme throughout the interviews was the experience of past and current trauma. Many participants referred to early trauma and the impacts of this throughout their lives. A number of participants disclosed that they had not spoken to anyone about their trauma. Others referred to telling their story over and over without results. The impact of telling their story repeatedly took a toll on their mental health, and after each time of sharing their story they needed time to recover from this experience, especially if their disclosure had been dismissed or minimised. It was apparent from the interviews that very few people had received support to address their trauma and the interconnections between past trauma and substance misuse and their current housing and mental ill-health.

Experiences with public housing and private arrangements were often not positive for the participants. The impact of not knowing when public housing would become available (if ever) has a negative impact on mental health. Even in transitional housing, participants felt like their life was on hold until they knew what would happen to them in the long term. They held off taking next steps in their recovery such as employment, study, volunteering or trying to find or reconnect with family,

friends or a partner until they had some stability and some sense of what their future would hold.

Many people only received limited support from mental health services. Clinical support was seen to be necessary for some people, but the available support was not sufficient. Community mental health services were seen to be important for helping people with their everyday lives and navigating the service systems as well as facilitating connection to others with mental ill-health and within the communities where participants lived.

Inclusion in the housing and mental health service systems is important to stabilise mental health. People who were excluded from help from either of these systems were often left stuck and unable to move forward in their recovery. Those who cycled in and out of the system were also unable to move forward, and often declined with each successive trip through the system. In general, supports kicked in at crisis time – homelessness, suicide attempts, psychotic episodes – but this was not always the case.

### 5.1 Reflections on the interviews

Participants generally enjoyed participating in the interviews, and although they were often talking about negative experiences and deeply personal stories, they felt listened to and respected. They wanted to see the housing and mental health situation change and were strongly motivated to speak out for the sake of others so they would not have the same experiences as themselves. They shared their stories and allowed the researchers to have their insight into their lives and their views on what needs to be done to improve the situation. This may have occurred because most of the interviews were conducted in a service that we partnered with and the person had some connection to, therefore providing a safe comfortable space, and because being listened to was itself a novel and cathartic experience.

It was interesting that people who have been let down by the system repeatedly and who did not have secure housing found the time and space

to share their experiences with us. They were motivated to ensure that the system is improved. Many still maintained hope for a better future, even after repeatedly being failed by those they went to for support.

Interviews with those who had less contact with the mental health system were more emotional. For some participants, it was the first time they had spoken about the trauma they had experienced, and although they did not go into details [interviewers did not push this line of questioning], often just acknowledging that it had happened by saying it out loud was upsetting for the participants. However, these participants also appreciated the opportunity to be listened to without judgment.

Having peer researchers (i.e. those with lived experience) was an important component of this study. Overall, participants did not express a preference for a peer researcher or a non-peer researcher, but it became obvious that when peer researchers were involved, rapport was established quickly and participants felt free to share and connect. For the team overall, peer researchers were very valuable, not only in debriefing after the interviews but also in discussing and interpreting data.

## 5.2 Limitations

While the sample size for this qualitative study is large overall, participants were recruited from many diverse areas and represented across genders, ages, sexualities and mental ill-health diagnoses. When the analyses were considered as whole, theme saturation was achieved, although not necessarily within each site.

Recruitment occurred through our partnerships with other mental health and housing service providers, and thus it is possible that our sample was more connected with services than the general population of people with mental ill-health. That said, a number of people were excluded from services or were not receiving a lot of support from services. Furthermore, even if participants had current stability in their housing, they were able to reflect on their prior experiences. It is worth noting

that participants were not always aware if they were in public housing or community housing so it was difficult to disentangle these experiences.

## 5.3 Implications

Key policy and service implications that emerge from these consumer consultations include:

- **There is a clear need for medium-term responses that provide housing and support to enable people to stabilise.** Short-term housing arrangements do not provide enough stability to enable people to focus on their mental health and start to work on their recovery. Medium-term housing arrangements would provide that stability. Support is needed in addition to housing to ensure that any changes in mental health/challenges are recognised early and supports are put in place to protect tenancy.
- **There is a need for trauma counselling for people who have experienced trauma.** Participants would benefit from assistance to understand the impact the trauma has had on them and to develop methods to deal with trauma.
- **Availability of rapid access to early-intervention mental health and tenancy support if problems emerge.** Not becoming eligible for assistance until reaching crisis point means that stability and recovery become increasingly difficult and take longer to achieve.
- **Transition support when exiting from institutions and services requires improvement.** This must include considering the best housing option for the person and their family after discharge.
- **A spectrum of housing and support is required to provide greater choice and control for participants.** There is no 'one size fits all' accommodation option that will provide the appropriate level of support for all participants.
- **Carers require specific support to assist them in their caring responsibilities.** Both housing and mental health services need policies and practices in place to include carers.

## 6 Acknowledgements

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