HOME and HEALTHY

Evalulation Final Report

YFS
BUILDING INDEPENDENCE & PARTICIPATION

IUIH institute for urban indigenous health

MICAH PROJECTS
Breaking Social Isolation
Building Community

THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

Home and Healthy

Evaluation Final Report

School of Nursing, Midwifery and Social Work
23 April 2024

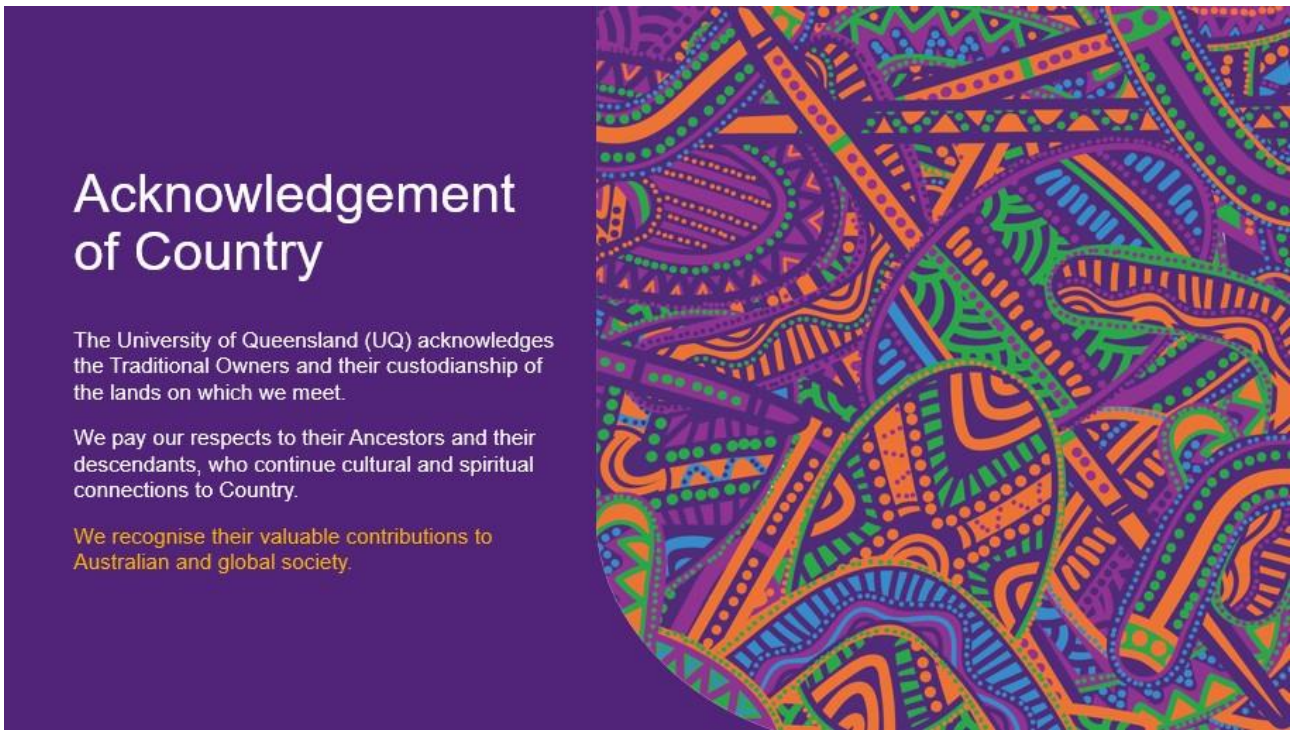
The University Of Queensland
AUSTRALIA

Acknowledgements

The Evaluation Team would like to thank the participants of Home and Healthy for sharing their time and their experiences of the Home and Healthy program with us.

We are grateful for the assistance provided by Ms Shelley Elliot and staff at Micah Projects, YFS, and IUIH throughout this evaluation. Without their assistance, particularly in contacting and transporting participants, the evaluation would not have been possible.

Thank you also to Ms Chloe Warrell, Ms Tammy Crowther, Ms Annabel Koay, and Ms Bhadra Nair for their excellent research assistance on this project.



Last saved	23 April 2024
File name	Final Report
Authors	A/Prof Maree Petersen, Dr Jemma Venables, Prof Karen Healy & Dr Caitlin Nathanson
Name of project	Evaluation of Home and Healthy
Name of organisation	Micah Projects
Project number	HABS230234

Contents

Figures

List of Acronyms

Acronym	Definition
BSPHN	Brisbane South Primary Health Network
CPSP	Commonwealth Psychosocial Support Program
GP	General Practitioner
IUIH	Institute for Urban Indigenous Health
NDIS	National Disability Insurance Scheme
SPMI	Severe and persistent mental illness

Executive Summary

1.1 What is Home and Healthy?

Home and Healthy has been operating in the Brisbane environs since 2022. Home and Healthy is a program delivered by Micah Projects, YFS (formerly Youth and Family Services), and Institute for Urban Indigenous Health (IUIH) to provide support for adults experiencing severe and persistent mental illness (SPMI) who are at risk of homelessness. The program seeks to enhance participant's wellbeing by working with them on their recovery plan and housing goals.

1.2 What did the evaluation involve?

The purpose of this evaluation as prescribed by the Brisbane South Primary Health Network (BSPHN) is to:

1. Present findings of how the **partnership between Micah Projects, YFS, and IUIH provide an integrated psychosocial support model** focused on support and system navigation for people with co-occurring mental illness and homelessness risk
2. Demonstrate how the partnership and **program model can effectively navigate across systems** such as housing, health care, drug and alcohol, mental health and homelessness and social enterprise
3. Learn how the **fundamentals of psychosocial support** for individuals to manage their recovery plan, treatment support and tenancy obligations is essential for preventing homelessness
4. Understand how the **service system navigation role is capable of enhancing support and workforce** of BSPHN CPSP commissioned providers and their ability to support people with co-occurring mental illness and homelessness risk
5. Understand how **rapid response** support contributes to strengthening the system, **averting and/or addressing immediate mental health crises** and decreasing possible hospital presentations

To address the prescribed purposes of the evaluation, we adopted a **mixed-method approach** involving:

1. **Literature review**
2. **Interviews with program participants**
3. **Focus groups with practitioners**
4. Review of **case files**

1.3 What did the evaluation find?

This evaluation drew on a range of data including a literature review, consultations to gain the perspectives of stakeholders including participants, practitioners, team leaders, as well as a sample of participant case records for the evaluation. Across the dataset, our analysis found that:

1. **People with severe and persistent mental illness and experiencing a risk of homelessness were well supported by the practice model of Home and Healthy.** The three agencies, Micah, YFS, and IUIH, partner constructively, sharing information and working in the best interests of participants. **The practice model of Home and Healthy reflects best practice in relation to service navigation and psychosocial support.** The relationship-based practice framework of the practitioners is a strength of Home and Healthy.

2. Culturally appropriate support is important in promoting recovery. **A strength of the Home and Healthy program is the option for Aboriginal and/or Torres Strait participants to connect with IUIH.** The provision of culturally appropriate services supported cultural identity for participants.

3. It is important the complex nature of recovery for people with serious and persistent mental illness is acknowledged. **By recognising participants' agency and working in non-judgemental ways, Home and Healthy was responsive to the complex and dynamic needs of participants, and their unique recovery journeys.**

4. The objective of the program to reduce hospitalisation lacks an appreciation of the serious mental and physical health issues most participants live with. The mortality rate for this group of people is very high and **hospitalisation can be evidence of timely and appropriate care**.

5. **The limited supply of social housing including supported housing, affordable private rental housing, and safe temporary accommodation in the greater Brisbane area** seriously compromises the health and wellbeing of participants.

6. The prime service objective to support participants to access long term support through the NDIS program is questioned given the shortage of support packages for people with psychosocial disabilities within that program and the design of the program. Given the under-resourced community mental health support in Queensland, **there is a paucity of long-term support services for people with severe and persistent mental illness.**

1.4 Recommendations

Reflecting on the above key findings from the Home and Healthy evaluation, five recommendations are presented. The recommendations are largely directed at the funding body and Government rather than the service delivery agencies:

1 We recommend **a longitudinal study is undertaken incorporating baseline data on participants health and health service use, that follows participant's engagement with the health system over time by matching data to ensure engagement with all health providers is included.** The rigor of the study would also be stronger with the inclusion of a larger number of interviews with participants and a larger case file review.

2 The sizes of the areas that practitioners service is large, particularly for IUIH. It is challenging for practitioners to respond in a timely manner given the distances travelled. However, the outreach model is viewed as a strength of the program and allows greater accessibility for Aboriginal and/or Torres Strait Islander participants. As such, no reduction to the geographical areas currently covered is recommended. Instead, **increasing staff levels would increase capacity and thus responsivity.**

3 The Home and Healthy program is designed to support participants for nine months. This time frame is not realistic for both participants and practitioners. It is recommended consideration is given to **extending the support timeframe for the Home and Healthy program**.

4 We recommend a review of participant admission to the NDIS as a primary objective of the Home and Healthy program. Alongside the shortage of packages for people with psychosocial disabilities, there are serious concerns about the suitability of the NDIS program for people with complex needs who are likely to require coordination of multiple health and welfare services and a rapid health intervention multiple times during their life. **Government investment in long-term, case-management and supported housing is required**, particularly for those who are ineligible for NDIS.

5 We recommend **the supply of affordable appropriate housing be increased in Queensland**. The lack of affordable housing compromises the Home and Healthy program. Housing is the platform to enable mental health and wellbeing to be stabilised let alone improved connections with family, community engagement, and independence.

2. Introduction

This report presents the findings of an evaluation study examining the Home and Healthy program. Part of the Commonwealth Psychosocial Support Program, Home and Healthy is a non-clinical program delivered by Micah Projects, YFS (formerly Youth and Family Services), and Institute for Urban Indigenous Health (IUIH) to provide psychosocial support to people aged 16-years and over, experiencing severe and/or persistent mental illness (SPMI) who are homeless or at risk of homelessness. By working with individuals and their informal support networks, the program seeks to identify and address recovery and housing goals to enhance participant's sense of wellbeing and stability (Micah Projects, 2024). This evaluation was conducted by A/Prof Maree Petersen, Dr Jemma Venables, Prof Karen Healy and Dr Caitlin Nathanson (herein the evaluation team) from The University of Queensland's School of Nursing, Midwifery and Social Work. The evaluation was conducted over the period October 2023 to March 2024.

The purpose of this report is to provide insights into the implementation and delivery of the Home and Healthy program, as well as the impact of the program on the lives of people who access the service. Aligned with the purpose, our approach aimed to maximise opportunities for stakeholders to share their perspectives on and experiences of the Home and Healthy program. As such, this report brings together the perspectives of practitioners and managers involved in delivering the Home and Healthy, as well as the views of people who have received services via the program (herein known as participants). We also draw on case file data to map psychosocial support, interventions, and outcomes for participants. The findings presented in this report focus on the operation of and practice approaches used in the program. We draw on contemporary literature as a 'benchmark' for best practice in this field, so that we can highlight both strengths and opportunities for improvement of the current Home and Healthy model.

2.1 Overview of the Home and Healthy Program

Home and Healthy, established in 2022 is part of the Commonwealth Psychosocial Support Program (CPSP) and is funded by the Australian Government Department of Health and Aged Care through the Brisbane South Primary Health Network (BSPHN) and delivered via a consortium between: (a) Micah Projects – who services the Brisbane South and Redlands sub-regions; (b) YFS – who services Logan and Beaudesert; and (c) IUIH – who provides services across the whole region to support Aboriginal and/or Torres Strait Islander participants who prefer a community-controlled service response. Individuals and other services can refer people to the program by completing a referral form (See Appendix 1) and sending it the organisation (Micah, YFS, IUIH) that services the area that is applicable to the participant.

Home and Healthy eligibility criteria:

People aged 16-years+ with severe and persistent mental illness who:

- Have an associated reduced psychosocial functional capacity, +
- Have complex housing and homelessness support needs impacting their mental health or vice versa, +
- Are able to actively engage in the community (i.e., are not in prison or long-term psychiatric facility) +
- Are not already receiving support through NDIS and/or state-funded psychosocial support programs

The Home and Healthy program is focused on a person's mental and wellbeing, homelessness risk and their social connectedness. It supports people aged 16-years and over with severe and/or persistent mental illness and who are at risk of or experiencing homelessness.

The primary service objectives are:

- Identification and process towards personal recovery goals
- Improved or stabilised mental health and wellbeing, leading to reduced need for acute mental health services.
- Improved access to, and sustainment of, stable, safe and appropriate accommodation
- Improved linkages to primary health care
- Improved access to long-term supports through NDIS if applicable
- Increased functional capacity.
- Increased connection and reduced isolation, leading to improved engagement in daily and community activities, and improved relationships.
- Increased knowledge and skills with improved self-confidence and independence.

To achieve these objectives, Home and Healthy adopts an integrated model of psychosocial support and provides (Micah Projects, nd):

One-on-one Support

This element of the program seeks to **enhance outcomes for people aged 16-years and over experiencing SPMI who are homeless** or at risk of homelessness by supporting them to **navigate across various systems to address needs**, related but not limited to, housing, physical and mental health, alcohol and drugs and social inclusion.

Service Navigation

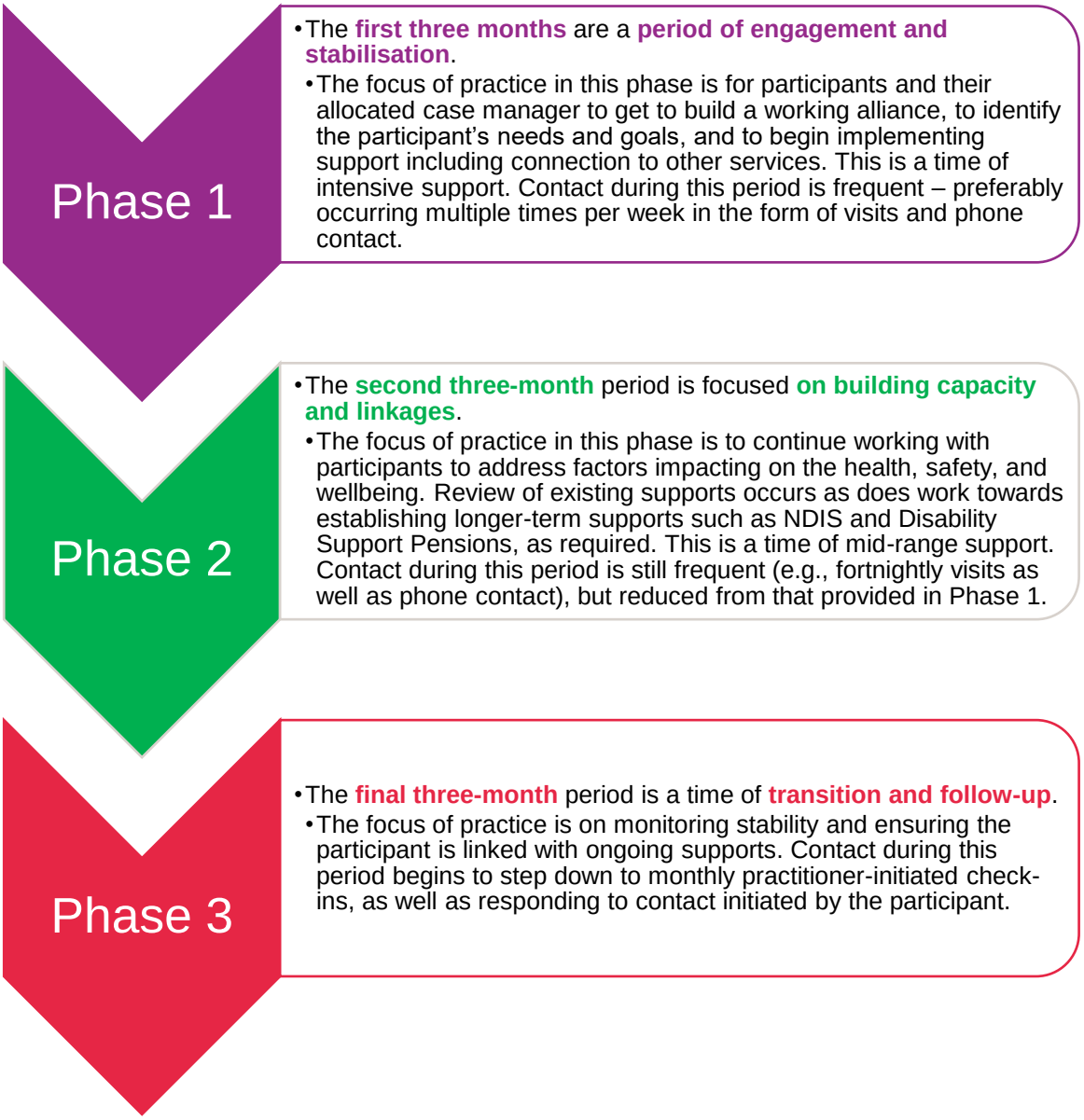
This program element aims to **build the capacity of other CPSPs by increasing their knowledge and skills in supporting participants** in navigating the housing system. The Navigator role seeks to achieve positive outcomes for participants by providing resources and direct support to these CPSPs.

NDIS & Health Integration Navigation

This element of the program is focused on **providing support to GPs who support patients attending the Inclusive Health Clinic and/or in emergency accommodation in Brisbane's inner city**. It helps connect GPs, participants, and other stakeholders to navigate NDIS and other systems (e.g., Centrelink, QCAT, MHRT).

2.2 How the program supports and engages with participants

The Home and Healthy program is intended to support participants for approximately nine months. This timeframe can be extended if people are waiting for longer-term support, such as NDIS funding, to be established. Informed by the Critical Time Intervention Model, the nine-month program comprises three main phases, decreasing in intensity overtime as people transition to accessing mainstream and/or other specialist services.



A more detailed flow chart of the way in which participants are referred into, move through and exit the Home and Healthy program is provided in Appendix 2.

2.3 Purpose of this evaluation

The purpose of this evaluation as prescribed by the Brisbane South Primary Health Network (BSPHN) is to:

1. Present findings of how the **partnership between Micah Projects, YFS, and IUIH provide an integrated psychosocial support model** focused on support and system navigation for people with co-occurring mental illness and homelessness risk

2. Demonstrate how the partnership and **program model can effectively navigate across systems** such as housing, health care, drug and alcohol, mental health and homelessness and social enterprise

3. Learn how the **fundamentals of psychosocial support** for individuals to manage their recovery plan, treatment support and tenancy obligations is essential for preventing homelessness

4. Understand how the **service system navigation role is capable of enhancing support and workforce** of BSPHN CPSP commissioned providers and their ability to support people with co-occurring mental illness and homelessness risk

5. Understand how **rapid response** support contributes to strengthening the system, **averting and/or addressing immediate mental health crises** and decreasing possible hospital presentations

Guided by the BSPHN's prescribed purpose, the evaluation team sought to address the following research questions:

1. How did Home and Healthy work with people living with SPMI and experiencing homelessness to gain housing and manage their recovery? What are the views and experiences of practitioners and team leaders.
2. What were the perceptions and experiences of participants in the Home and Healthy program?
3. How do the components of the model of practice including psychosocial support, rapid response, navigation, and interagency collaboration operate? Which aspects worked well? What are the challenges?
4. What are the practice frameworks of practitioners and team leaders?
5. What is the impact of structural factors including housing, mental health resources, disability support on the participants and the objectives of the program?

To address the aims of the evaluation, we adopted a **mixed-method approach** involving:

1. **Literature review**

2. **Interviews** with participants

3. **Focus groups** with practitioners

4. Review of **case files**

See chapter 3 for more detail.

2.4 Structure of the report

Following the Introduction, the report is structured as follows:

Chapter 3: overviews the contemporary literature and identifies key issues around preventing homeless for people with severe and or persistent mental illness. We draw on this evidence throughout the report to contextualise our findings and to provide a useful 'benchmark' of best practice from which to compare the Home and Healthy program.

Chapter 4: details the evaluation approach and outlines the methods of data collection used in conducting this evaluation.

Chapter 5: is our first findings chapter. In it, we report on the *participants*' perceptions and experiences of being supported by the Home and Healthy program. The data comes from the individual interviews with 14 of the program's participants. It shows that, overwhelmingly, participants find the Home and Healthy program accessible and an important support for helping to address the mental health and wellbeing, homelessness risk and a variety of other health and social needs. The findings presented contribute to addressing Evaluation Purposes 2, 3 and 5. The chapter concludes with a summary of the key findings discussed in relation to contemporary literature.

Chapter 6: is our second findings chapter and reports on the *practitioners*' perceptions of and practices in delivering the Home and Healthy program. The data is this chapter comes from the four focus groups conducted with 10 practitioners in both frontline and manager roles in the Home and Healthy program. Our analysis demonstrates that practitioners' share an understanding of the program purpose and goals and have a common approach to the key components of the program. The practitioners identify that a strong collaboration exists across the Home and Healthy service providers and that the service also has robust relationships across the service system including with housing, police, mental health, and health care providers. The findings presented in this chapter contribute to addressing Evaluation Purposes 1, 2,3, 4 and 5. A discussion of the findings in relation to the literature concludes the chapter.

Chapter 7: is our third findings chapter and reports on the review of 26 *case files*. Reviewing practitioners' documented accounts of working with participants helps us to understand the nature and breadth of support participants received while they were engaged with the Home and Healthy program, and their outcomes. In doing so, the chapter helps to address Evaluation Purposes 2, 3 and 5. We conclude this chapter with a discussion of the key findings with consideration of the extant literature.

Chapter 8: Conclusion. In this final chapter we reflect on key learnings and offer several recommendations for how the Home and Healthy program can sustain and build on its current strengths whilst responding to gaps and challenges.

3. Messages from the Literature

This review of the literature focuses on persons with co-occurring severe and persistent mental illness (SPMI) and homelessness risk. It sought to find best practice examples of holistic, integrated/coordinated, psychosocial outreach support provision aimed at supporting recovery. It also included literature on system navigation roles where support sought to assist persons to navigate multiple systems and/or train the sector in how to support this population.

THE SEARCH STRATEGY	
Timeframe:	• Last 20 years
Types of studies:	• International and national peer-reviewed research in journals and book chapters; as well as grey literature, with a particular focus on Australian social housing research
Key terms included:	• Mental illness; homelessness and psychosocial support. A number of search strings were used to capture the various dimensions of each key term. For example: (severe mental illness or serious mental illness or severe and enduring mental illness) AND (homelessness or homeless persons or houseless or housing) AND (navigation or access or navigation of services); (severe mental illness or serious mental illness or severe and enduring mental illness) AND (homelessness or homeless persons or houseless or housing) AND (case manager or case management or case managers)
Databases searched:	• Psychinfo; CINAHL. • Further studies were retrieved from the reference lists of key papers.

3.1 Housing for people with SPMI: The Australian context

People with SPMI and homelessness risk have multiple complex needs across several life domains that are often not being met by mainstream services (Brackertz et al., 2020). Beyond their mental health and housing needs, they may be experiencing adversities such as poverty and unemployment, substance abuse, trauma and victimisation, chronic medical conditions, care histories, offending histories, family challenges, social isolation, disability and so on (Padgett et al., 2016). They have higher rates of morbidity and mortality (Corrigan et al., 2014). These problems and disparities can be magnified for people from minority ethnic

groups such as First Nations peoples (Corrigan et al., 2014; Toombs et al., 2021) including Aboriginal and Torres Strait Islander peoples.

Safe, secure, appropriate, and affordable housing is critical for supporting recovery. Housing provides the platform for other supports to be put in place to address the complex issues this population faces (Isaacs et al., 2019). However, there is recognition within the field that even when allocated housing, the realisation of recovery for people with SPMI, who face cumulative disadvantage, is complex, and requires significant resources and skilled practitioners (Parsell et al., 2015). Ongoing psychosocial support is likely to be required to maintain housing stability and support recovery of those with co-occurring SPMI and homelessness risk (Meehan et al., 2011).

Research suggests people with SPMI rely on public housing and their housing careers are unstable and often characterised by frequent moves, insecure housing, and inadequate accommodation (Brackertz et al., 2020). There is recognition that systemic issues need to be addressed to provide more of the right type of housing and psychosocial services for people with SPMI and homelessness risk (Brackertz et al., 2018). Systemic issues include:

- a lack of affordable, safe and appropriate supported and private rental housing for people with SPMI
- discrimination in the private rental sector
- the social housing system does not adequately monitor and consider the mental health of its tenants
- while landlords and tenancy managers would be well placed to respond to emerging mental health issues, they are not skilled to do so
- there is a shortage of support packages under NDIS for persons with psychosocial disabilities
- the psychosocial support system is being broadly subsumed by the NDIS, and many who are currently receiving psychosocial support through the community mental health services will not be eligible for continued support under NDIS
- discharge from psychiatric and health institutions poses significant risks for homelessness and mental health
- housing, homelessness, and mental ill health issues are interrelated in this population but are separate policy systems with little integration and this contributes to poor housing and health outcomes for people with SPMI (Brackertz et al., 2018).

A parliamentary inquiry into the NDIS for people living with psychosocial disabilities related to a mental health condition has revealed design and implementation issues. These include that the NDIS design was heavily focused on people with physical disabilities and the needs of people with psychosocial disabilities are complex, support needs often vary over time and may be cyclic in nature and require a multi-faceted and coordinated service system response across both health and social services based on recovery-based principles (Queensland Mental Health Commission, 2017). Reviews continue into how to best increase rates

of utilisation of support packages under NDIS for persons with psychosocial disabilities in Australia (Commonwealth of Australia, 2023).

There is work at the national level to develop a shared vision to end homelessness via the Australian Alliance to End Homelessness (AAEH) (Pearson, 2020). Four evidence-based approaches to ending homelessness are proposed: (1) Housing First; (2) person-centred & strength-based; (3) systems change; and (4) place-based collaboration. Eight agreed activities are applied across these four approaches: (1) assertive outreach; (2) common assessment; (3) a real-time quality by-name list; (4) coordinated systems; (5) continuous improvement; (6) data-informed systems; (7) leadership advocacy; and (8) stronger emphasis on the right to housing and support (Pearson, 2020). This approach has been trialled in the Adelaide Zero project (see Tually et al., 2018). Early data suggests that this coordinated, integrated approach holds promise for addressing homelessness in Australia, but only if, and when, the range of systemic issues are addressed through sustained, coordinated efforts (Pearson et al., 2021).

3.1.1 Housing for people with SPMI: The Queensland context

Studies undertaken in Queensland have highlighted the lack of appropriate affordable housing to meet the needs of people with SPMI (Jones et al., 2014; Stambe et al., 2023). These issues have been problematic for a considerable period. Systemic barriers have been reported for social housing clients with complex needs in Queensland. In research by Jones and colleagues (2014), a critical problem identified was the lack of sufficient and suitable housing supply to meet the increasing demand from people with mental health issues. They noted that it was not possible to estimate the number of new and current residents with mental health and substance misuse issues, and that existing information was totally inadequate for planning purposes. They reported that workers in the Housing Service Centre had ad hoc or non-existent relations with mental health workers and found few examples of joint care coordination. They called for improved data about the mental health status of new entrants as well as existing residents of social housing, and more provision of housing models that closely integrate housing and mental health support to facilitate positive outcomes for this population (Jones et al., 2014).

A recent study of assertive outreach approaches in Brisbane found that even when identified and supported through assertive outreach, many people who were initially homeless remained so at the end of the study period (Stambe et al., 2023). While people were supported to register for social housing, very low housing stock, and unaffordable private rentals meant that assertive outreach relied on boarding houses to provide temporary housing. This solution was considered by all stakeholders as undesirable as boarding houses were characterised by instability and violence (Stambe et al., 2023).

3.2 Models of psychosocial support for people with SPMI and homelessness risk

A review of the literature identified three models of psychosocial support for persons with co-occurring severe and persistent mental illness (SPMI) and homelessness risk: (1) supported accommodation with integrated case management support; (2) collaborative outreach models; and (3) community navigation models.

3.2.1 Supported accommodation with integrated case management support

A number of supported accommodation models with integrated mental health support exist (see Bruce et al., 2012; Carpenter-Song, 2012; Clark et al., 2016; Dunt et al., 2017, 2022; Meehan et al., 2010, 2011; Parsell et al., 2016; Pearson et al., 2007; Smelson et al., 2013, 2018; Stregioplous et al., 2019; Toombs et al., 2021). In these models supported accommodation is primarily provided by the public housing sector (Bruce et al., 2012) or, less commonly, via private sector rentals (Dunt et al., 2017, 2022). Integrated mental health support involves both case management and non-clinical support, such as support workers, and is provided by the community sector (Bruce et al., 2012; Toombs et al., 2021). Case management support can either be located on-site or delivered via regular on-site case management visits. Some case management models are time-limited such as Critical Time Intervention (CTI) (see Clark et al., 2016) and others provide ongoing support (see Bruce et al., 2012; Pearson et al., 2007). These vary in intensity, with some people having access to 24/7 on-site support (see Pearson et al., 2007) and others receiving 20 hours a week of support work (Dunt et al., 2017). Some provide specific cultural programming including cultural mentors and curriculum such as the Housing Outreach Program Collaborative (HOP-C) North (Toombs et al., 2021). Australian examples of supported accommodation with integrated case management include Housing Accommodation and Support Initiative (HASI) (Bruce et al., 2012; Dadich et al., 2013); Housing and Support Program (HASP) (Meehan et al., 2010); Project 300 (Meehan et al., 2011); Brisbane Common Ground (Parsell et al., 2016); and the Doorway program (Dunt et al., 2017, 2022).

Key features of these combined models of support include:

- Provision of housing first, with the homeless population being identified through community outreach (Smelson et al., 2018)
- Case management and non-clinical services provided primarily on-site (Pearson et al., 2007)
- Collaboration between case managers, mental health providers and consumers to develop recovery plans (Smelson et al., 2018)
- Multiple sectors working in partnership e.g. housing, mental health and community support providers (Bruce et al., 2012)
- Wrap-around support where a wide array of services is provided to meet the multidimensional needs of consumers (Pearson et al., 2007; Smelson et al., 2018), including clinical support for mental health and co-occurring disorder symptom-management and non-clinical support provided by

support workers and peer workers to address other recovery domains (see Dadich et al., 2013; Toombs et al., 2021)

- Person-centred planning (Bruce et al., 2012).

Overall, these diverse programs in Australia and internationally report positive outcomes for people with SPMI and homelessness risk. These include improvements in tenancy stability, reduction in hospital admissions and length of hospital stay, reducing use and cost of health services (Bruce et al., 2012; Dunt et al., 2017, 2022; Smelson et al., 2018), improvements in mental health and engagement in mental health services, social connectedness, and modest improvements in involvement in education and work (Bruce et al., 2012; Toombs et al., 2021). However, most Australian models are pilot programs, are small in scale, localised, or have time limited funding and need outstrips supply (Brackertz et al., 2018). It is argued that these are effective and could be scaled-up nationally to meet current demand (Brackertz et al., 2018; Dunt et al., 2017, 2022), but this would require system level integration and coordination, a significant increase in funding and stronger partnerships with private rental providers to improve housing supply (Brackertz et al., 2018). The literature suggests that no one particular program and/or approach are suitable for all circumstances or consumers (Benston, 2015; Brackertz et al., 2018). The focus of this report is on integrated outreach approaches to supporting people with co-occurring SPMI and homelessness risk.

3.2.2 Outreach approaches – Developing collaborative partnership/coordination models in the community

The literature provides some examples of innovative place-based collaborative models focused on building partnerships across providers in community sectors to support persons with SPMI and homelessness risk. These include Inner City Health Associates (ICHA) (Stergiopoulos, 2014); St. Paul's Center (SPC) (Baker et al., 2018); Partners in Recovery (PIR) (Isaacs et al., 2019) and the Adelaide Zero Project (Tually et al., 2018). See Appendix 3 – Table 1 for a comparison of the models.

Some of these programs have similar features. For instance, a shared feature of the ICHA and Adelaide Zero Project partnership/coordination models are that they developed placed-based solutions through community consultation. They then used coordination and collaboration with the sector to develop a range of programs to address the range of the needs of the community. For example, ICHA delivered front-line services such as primary care via psychiatrists in the community, but also developed shelter and drop-in based collaborative mental health care teams; an inter-agency, multidisciplinary street outreach team (MDOT); and Coordinated Access to Care for the Homeless (CATCH) (Stergiopoulos, 2014).

Overall, the programs report positive outcomes for people with SPMI and homelessness risk. For instance, all clients who were homeless or at risk for homelessness when they came to the SPC, obtained, and remained in housing while they were followed. There were no incarcerations and seven hospitalisations, yielding a hospitalisation rate of 3% for these clients. This resulted in an estimated saving of at least $37,500 to $50,250 per year in hospitalisation costs for this group of acute patients (Baker et al., 2017). Participants

of PIR had decreases in unmet needs in relation to psychological distress, daytime activity, and company (Isaacs et al., 2019). These promising findings suggest there is a place for community outreach partnership models among the range of services for people with SPMI and homelessness risk. Part of this support can involve community navigation roles to assist this population to navigate multiple service systems and improve their outcomes.

3.2.3 Community navigation models

A third approach to support for people with SPMI and homelessness risk are community service navigation models. Those reviewed were in relation to mental health service navigation specifically and included: Opening Doors to Recovery (ODR) a team of Community Navigation Specialists (CNS) (Compton et al., 2016) and a Peer Navigator Program (PNP) (Corrigan et al., 2017; Compton et al., 2016). See Table 2 in Appendix 3 for a comparison of the models.

Both navigation programs featured a multi-stage development process. They first involved consultation with the community, including consumers themselves to identify the problems faced by the populations (Corrigan et al., 2015; Compton et al., 2014); this was followed by the development of protocols for the navigation models (Corrigan et al., 2017; Compton et al., 2014) and finally they were tested for their effectiveness with the target populations in terms of how they reduced homelessness, hospitalisations and improved mental health outcomes (Compton et al., 2016; Corrigan et al., 2017).

Positive outcomes were reported in both programs in relation to their objectives. ODR aimed to reduce recidivism in terms of hospitalisation, incarceration, and homelessness for participants with mental illness and a history of psychiatric recidivism. A significant reduction in the number of hospitalisations was reported, as was a substantial and significant reduction in the number of days hospitalised during the year of community navigation compared with the previous year. Recovery was apparent across the 12-month study period, indicating trajectories of improvement throughout the follow-up period and not just immediately following hospital discharge (Compton et al., 2016). The PNP research examined the impact of a peer navigator model used with a group of people with serious mental illness who were homeless compared with treatment as usual. It compared measures of general medical illness, psychiatric disorder, recovery, and quality of life across four time periods: baseline, four, eight, and twelve months. Both groups decreased the rate of homelessness significantly over the course of the study. Pairwise, chi-square tests showed significantly less homelessness for the intervention group from baseline (N=26, 76%) to the eight-month assessment (N=9, 26%) and from baseline to the 12-month assessment (N=3, 9%) and compared to the TAU group. All results of the 234 ANOVAs for total scores were significant, suggesting that those in the PNP showed significant improvements in health compared with the control condition across the year of assessment. Results showed significant improvement in the self-report indices measured in physical and mental health for those in the PNP program compared with treatment as usual. PNP participants showed significant improvement on seven of the eight subscales of the measure. Health improvement corresponded

to improved recovery and quality of life (Corrigan et al., 2017). These studies demonstrate the role of various community navigation models improving a range of outcomes for people with SMPI and homelessness risk.

3.2.3 Summary of models of psychosocial support for people with SPMI and homelessness risk

The literature highlights the place for a variety of psychosocial programs, including supported accommodation with integrated case management approaches, collaborative outreach approaches, and community navigation programs to address the range of needs of people with SPMI and homelessness risk. However, the complex nature of recovery for this population must be acknowledged. While people with SPMI and homelessness risk may become housed, only some may recover, particularly if recovery is narrowly defined as a reduction in mental health symptoms (Kerman et al., 2019). There is limited literature examining factors and predictors of mental health recovery for this specific group; a single study was identified by Kerman and colleagues (2019). This study used longitudinal data from a randomized controlled trial of Housing First to examine predictors of recovery among homeless people with mental illness. Participants who perceived their recovery to be greater were more likely to have: fewer chronic medical conditions, have fewer mental health symptoms, have a diagnosis of a psychotic disorder, have less substance use problems in the past month, be homeless for less time in their lives, receive case management, have a close confidante with whom to share personal information, be more involved in community activities, and feel like they belong in their communities (Kerman et al., 2019). This study highlights the importance of psychosocial support for this population, and it is argued that there is a role for integrated outreach approaches to provide such support.

3.2.4 Psychosocial support for people with SPMI: The Queensland context

The psychosocial support landscape in Queensland has evolved over the last ten years in response to the implementation of the roll-out of NDIS. There is significant unmet need for psychosocial supports outside the NDIS in Queensland. There is a critical gap in state funding for psychosocial supports for people with SPMI, particularly funding for non-government organisations in the community mental health (Queensland Alliance for Mental Health et al., 2023). Queensland invests just 4.7 per cent of its mental health funding in community managed mental health NGOs, the lowest rate of any state or territory (Productivity Commission, 2023). Queensland Health (2022) has calculated that it is meeting just 29.6 per cent of the need for NGO-delivered psychosocial supports for people with SPMI. This funding shortfall leaves Queenslanders with SPMI with few options for support other than hospital emergency departments. Accordingly, in a recent submission to the Queensland Government, the Queensland Alliance for Mental Health (QAMH), the Mental Health Lived Experience Peak Queensland (MHLEPQ) and Arafmi (2023) called for an increased investment in funding for non-government organisations in the community mental health sector. The Queensland government has also acknowledged the need to expand community-based psychosocial services (Parliament Mental Health Select Committee, 2022). This is based on the need for a full spectrum of services to meet the diverse support needs of people with SPMI.

3.3 Facilitating recovery: key considerations for the provision of integrated psychosocial outreach support

Overall, this review of the literature suggests several practice considerations for supporting people with SPMI and homelessness risk in their recovery via integrated psychosocial outreach support. These include:

- the need for assertive, persistent outreach.
- the provision of integrated case management/care coordination at the service delivery level.
- meaningful and effective interpersonal interactions between service users and service providers.
- providing rapid support to mitigate crisis events.
- providing navigation support to access psychosocial support.
- building social support.
- managing mental health and physical symptoms.
- recognising that recovery is much broader than symptom reduction.
- ensuring psychosocial supports are culturally appropriate.
- addressing the local context: using community consultation to tailor psychosocial supports to local needs.
- increasing the capacity of the sector through training: a role for integrated case management navigation teams.
- engage in advocacy to address systemic issues.

3.3.1 The need for assertive, persistent outreach

People with SPMI and homelessness risk require assertive, persistent outreach as a first step to helping to identify and then support them within the community (Pearson et al., 2021; Stambe et al., 2023). Research suggests a number of barriers prevent this population from engaging in services including: inaccessibility of service locations; limited capacity to attend services when unwell which may be particularly challenging among people with more severe and complex physical and mental health issues; reluctance to attend places where there are large numbers of other highly vulnerable people and negative past experiences may lead some people sleeping rough to stop engaging with homelessness services (Pearson et al., 2021; Stambe et al., 2023). There may be further barriers for Aboriginal and Torres Strait Islander peoples (see Corrigan et al., 2017 example) where consumers reported barriers to accessing services.

Stambe and colleagues (2023, p.3) report that persistent outreach approach provides the following benefits:

- it helps practitioners build trust and rapport, enabling them to get to know the person and build a relationship over time. This is particularly critical for helping to overcome the feelings of distrust or stigmatisation that prevent people from accessing homelessness support.
- it allows the space for people to exercise their agency and decline support until they feel ready to accept it on their own terms, without the fear that the offer of support may disappear if they take too long to accept

- this assertive, persistent outreach approach works within an integrated network of service delivery with the aim of ending homelessness However, lack of appropriate, affordable housing was a systemic barrier to achieving this.

3.3.2 The provision of integrated case management/care coordination at the service delivery level

Persons with SPMI and homelessness risk have multiple and complex needs, many of which are not health related. A fragmented service system, with services funded to address one presenting problem at a time, creates barriers to access (Padgett et al., 2016). Furthermore, mental health services are unable to address the range or complexity of needs within this population without collaboration with other agencies (Isaacs et al., 2019). Housing, mental health, health sectors and the broader community sector providing psychosocial supports need to be integrated with interagency, cross-sector collaborations and partnerships (Baker et al., 2018; Brackertz et al., 2018; Pearson et al., 2021; Stergiopolous et al., 2014). This requires a sector-wide commitment to shared language, objectives, and principles to avoid confusion, misunderstanding and inefficient use of limited resources (Keenan et al., 2021). The literature provides examples of multi-stage processes that have been used to develop a shared vision and achieve partnerships across multiple sectors to address the needs of people with SPMI and homelessness risk (See Stergiopoulos, 2014; Tually et al., 2018).

Integrated case management/care coordination models improve recovery for this population by reducing unmet needs (Clark et al., 2016; Isaacs et al., 2019; Kerman et al., 2019; Pearson et al., 2021). These include both clinical and non-clinical case management models (see Dadich et al., 2013), or those that use a combination of both. For example, in HASI case management is provided by the mental health sector and non-clinical support is provided by the community sector (Bruce et al., 2012). Non-clinical psychosocial support by community providers in HASI includes help with day-to-day tasks and facilitating social and community participation for people with SPMI and homelessness risk (see Muir et al., 2010). The evidence suggests the need is for “holistic support that meets the level of need” (Brackertz et al., 2020, p. 2). There is agreement within the literature that people with SPMI and homelessness risk require long-term supported housing (Brackertz et al., 201; Pearson et al., 2007) and that this housing should be safe, secure, affordable, and appropriate (Brackertz et al., 2020). This population have longstanding mental ill health and supporting progress towards recovery and independence may take years, is a non-linear process (Brackertz et al., 2018) but can be supported via long term integrated case management/coordination (see Muir et al., 2010; Carpenter-Song, 2012).

Coordinated efforts are required to sustain tenancy for people with SPMI and have been shown to be effective (Bruce et al., 2012). Case managers/care coordinators play a central role in working with the housing sector, with both private and public housing providers to maintain people in housing. For instance, the literature provides examples of case managers working with private landlords to improve stability of housing (see Pearson et al., 2007), or working in partnership with the housing commission such as in HASI

(Bruce et al., 2012). Common Ground has also focused on providing skills training directly to formerly homeless tenants in how to be a 'good tenant' (see Parsell et al., 2015).

Early intervention has been proposed as part of the solution to sustaining tenancy for people with SPMI and homelessness risk. Brackertz and colleagues (2018, p. 52) note that "the goal of early intervention should be to stabilise people in their existing tenancy and to avoid evictions. The evidence and the investigative panels show that early intervention is an important mechanism to prevent housing instability and homelessness and that there is considerable scope to increase and improve early intervention". This could involve integrated case management teams tailoring tenancy support programs to assist people with SPMI to maintain their existing tenancies (Brackertz et al., 2018).

3.3.3. Meaningful and effective interpersonal interactions between service users and service providers

A good connection with a trusted worker is crucial to recovery for people with SPMI and homelessness risk (Brackertz et al., 2020, Parsell et al., 2015). This involves developing rapport and trust so that a respectful ongoing relationship can be established, and workers can learn about the needs of consumers and tailor support to address these (Parsell et al., 2015). Certain approaches are reported to enable consumers to feel valued such as: an individualised, personalised approach involving treating tenants as human beings and knowing their names (Parsell et al., 2015); making compassionate gestures such as staying late to talk, offering food or a drink when meeting; seeing and commenting on strengths; using person-first language; active listening; and personal qualities such as trust, respect, fairness, honesty (Keenan et al., 2021; Kerman & Sylvestre, 2020). The need to work collaboratively to determine plans future recovery goals has also been acknowledged **(**Kerman & Sylvestre, 2020). Within this work, helping with system navigation and providing advocacy and support is also considered important to promoting recovery (Brackertz et al., 2020; Kerman & Sylvestre, 2020).

3.3.4 Providing rapid support to mitigate crisis events

A responsive psychosocial support system is necessary to mitigate negative life events and sustain tenancy for people with SPMI (Brackertz et al., 2020). Research by Brackertz and colleagues (2020) demonstrates the interplay between housing and mental health pathways over time. They reported that people who had deteriorating mental health and who did not access health services were 58% more likely to experience a forced move within the next two years and were 35% more likely to experience financial hardship within one year. Due to the complex adversity this population experiences there are likely to be intermittent disruptions/crisis periods across their trajectories due to a range of events. For example, people may experience: a rapid deterioration in mental and/or physical health requiring periods of hospitalisation (Brackertz et al., 2020); be victims of domestic violence; have involvement with the criminal justice system; or require treatment for substance abuse (Padgett et al., 2016). Practitioners in the field have expressed uncertainty about the capacity of NDIS to provide quick activation of support in response to relapses

(Brackertz et al., 2018). It has therefore suggested that there is a role for Primary Health Networks, and the community sector, to provide quick solutions (Brackertz et al., 2018).

Research indicates that case management support for intermittent crisis episodes can divert people with SPMI from psychiatric inpatient facilities or the justice system (Compton et al., 2016). A potential consideration is in what form community case management should be provided. For example, in some supported accommodation programs case management or some form of concierge support is available 24/7 (see Pearson et al., 2007). In the ODR program technology is being trialled where a text message immediately informs community navigation specialists (CNS's) if a participant of ODR comes into contact with the police, police are then informed of their participation in ODR. The CNS then receives a text message so that they can then arrange for the person to be diverted from the justice system where possible (Compton et al., 2016). Another consideration is the need to maintain the supported housing place for people with SPMI during episodic crisis periods so that they do not lose their housing and return to homelessness (Brackertz et al., 2020). This is where community case managers or navigators can play a role in communicating and advocating to the housing provider in order to sustain tenancy (Brackertz et al., 2020).

3.3.5 Providing navigation support to access psychosocial supports

Navigation support is a key part of addressing the psychosocial support needs of persons with SPMI and homeless risk (Brackertz et al., 2020). People with SPMI have complex needs, require access to multiple services and these services are known to be fragmented and complex to navigate (Brackertz et al., 2018; Padgett et al., 2016). Service navigation roles can improve integrated care by supporting consumers to access the range of supports that they need and have been shown to improve a range of outcomes for people with SPMI and homelessness risk (Compton et al., 2016; Corrigan et al., 2017).

Navigation roles may be performed by integrated teams such as in the case of CNS (Compton et al., 2016) as well peers, in the PNP program described earlier (Corrigan et al., 2017). Corrigan et al (2015) argue this will require outreach and "this typically begins where the person is at: on the streets, in the shelters, in the criminal justice system, or wherever else [people] who are homeless and with mental illnesses may be found" (p. 130). It is argued that navigator services can facilitate the needs of persons with SPMI and homelessness risk as they arise by identifying and liaising with services and supporting consumer engagement and navigation through them (Corrigan et al., 2015). Peer navigators could be considered for their unique benefits, for example their "personal experience with mental illness and homelessness brings a special intimacy. Peer navigators know useful tricks-of-the-trade to manage the challenges of living on the streets and can help the person be especially alert to problems that might imminently undermine health" (Corrigan et al, 2015, p. 268).

3.3.6 Building social support

Social support is important for finding and maintaining housing and has been found to be a protective factor in those with well-supported housing and mental health trajectories (Bracketrz et al., 2020; Gabrielian et al.,

2018). People with SPMI and homelessness risk often lack social support, experience social isolation and loneliness and transient relationships and/or social network depletion across their life course (Bracketrz et al., 2020; Kerman & Sylvestre, 2020; Muir et al., 2020; Padgett et al., 2016). This presents a risk factor for housing instability (Bracketrz et al., 2020) and physical and mental ill health (Hwang et al, 2009). Research demonstrates that even when this population have access to long-term supported housing, they may still experience a lack of social connection and loneliness (Carpenter-Song, 2012; Kerman & Sylvestre, 2020). They may lack informal supports and rely heavily on formal supports such as case managers if they are in supported accommodation (Gabrielian et al., 2018).

Improving social support and increasing community involvement promotes recovery among those with SPMI and homelessness risk (Kerman et al., 2019; Muir et al., 2020). There is a need for different types of social support such as instrumental and emotional (Hwang et al., 2009) and both formal and informal such as case managers and family and community support. This population have been found to lack social supports and case management can provide reliable support, particularly during tumultuous times and this is valued by consumers (Kerman & Sylvestre, 2020). Case management services promote a sense of connectedness and belonging for consumers (Carpenter-song, 2012; Kerman & Sylvestre, 2020).

Families and carers are an important source of support for people experiencing SPMI (Brackertz et al., 2020). Family supports may be under-utilised, and, in some cases, there may be opportunities to collaborate further with families to increase formal supports and improve longitudinal housing stability (Gabrielian et al., 2018). However, this will be dependent on individual family contexts. In some circumstances families do not provide supportive opportunities, rather they may be a destabilising force that could undermine personal recovery goals (Gabrielian et al., 2018).

Interventions that help consumers build or repair their informal support networks and differentiate between positive versus negative relationships have been recommended (Gabrielian et al., 2018). These practices include social skills training to improve social skills and functioning; social cognition training, which trains consumers to better perceive and use social information, interpret social cues, and interpret social events and family focused treatments, for example, psychotherapy or psychoeducation, which can help individuals improve relationships with family members who provide informal support (Gabrielian et al., 2018). However, equally, there is a need to improve mental health carer support services and ensure the responsibility of care is not falling entirely on carers due to gaps in mental health services (Brackertz et al., 2020).

Given the lack of provision of NDIS and community mental health providers for this population the community sector is likely to play a critical role in improving social opportunities for people with SPMI and homelessness risk. The non-clinical support provided in the HASI program provides one case example of how successful social and community participation can be facilitated for people with SPMI and homelessness risk (see Muir et al., 2010).

3.3.7 Managing mental health and physical symptoms.

The research shows that not accessing health and mental health services is a risk factor for housing instability (Brackertz et al., 2020). Managing mental and physical health symptoms promote recovery among people with SPMI and serve as a protective factor for homelessness risk (Brackertz et al., 2020; Kerman et al., 2019). In research by Kerman and colleagues (2019) consumers reported that mental health services had an important role in helping them to cope with their symptoms and living environments. Having access to medications and learning coping strategies were identified as two ways that services were helpful. Participants reported that they had learned skills in therapy and counselling that were useful for their recovery. Being able to use learned coping skills was also highlighted as facilitating a sense of control (Kerman et al., 2019). There is a need to provide education and information to increase consumers awareness of available services (Corrigan et al., 2015). Considering the range of systemic barriers to accessing health and mental health services for this population, there is an important role for integrated, holistic outreach models to provide psychosocial supports to address broader recovery domains (Muir et al., 2020). These types of models demonstrate positive outcomes for this population (Stergiopolous, 2014).

3.3.8 Recognising that recovery is much broader than symptom reduction.

This population can be better understood and responded to via a 'complex recovery' lens (Padgett et al., 2016). People with SPMI and homelessness risk have multiple complex needs across multiple life domains. Beyond their mental health and housing needs, they may be experiencing adversities such as substance abuse, trauma and victimisation, chronic medical conditions, offending histories, family challenges, social isolation, disability and so on. Often, services and interventions have been attempted, and aren't working, helping or appropriate or are not coordinating and working together; and/or consumers service experiences could be linked to multiple adversities (Padgett et al., 2016). The term complex recovery denotes the "multiple co-occurring problems in an individual's life. When viewed as the product of cumulative adversity, complex recovery is the dynamic process of overcoming multiple forms of adversity as one pursues a 'recovered life'" (Padgett et al., 2016, p. 61).

Research demonstrates that for this population, recovery is multidimensional (Bitter et al., 2020; Carpenter-song, 2012), non-linear (Brackertz et al., 2020), and a personal journey in which a recovered life is individually defined (Padgett et al., 2016). Living a full and meaningful life may or may not include an improvement in mental health symptoms (Kerman & Sylvestre, 2020; Meyers et al., 2016). A scoping review by Bitter and colleagues (2020) of research into recovery domains beside clinical for people with SPMI included societal, personal, functional, lifestyle and creative and spiritual domains. It reported that research in this area is still limited, but a number of recovery-promoting interventions in other areas than clinical recovery had been developed and evaluated, a quarter of which showed added value to recovery (Bitter et al., 2020). This reinforces the need for a multidimensional understanding of recovery and the need for holistic psychosocial supports that tap into the range of recovery domains (Carpenter-Song, 2012) and meet the level of need (Brackertz et al., 2020). Multidisciplinary, interagency responses are required for this population as "this broader framework is necessary for considering the interconnectedness of different

adversities and the multiple service systems accessed by this population in their recovery" (Kerman & Sylvestre, 2020, p. 394).

Community service providers can be instrumental in fostering hope through encouragement and an orientation toward the future and making day-to-day life meaningful (Kerman et al., 2019; Meyers et al., 2016). Research by Meyers et al (2016) describes a recovery concept of 'a meaningful day' which involved companionship and productivity. This concept is used in the ODR program and Meyers et al (2016) demonstrated in their mixed-methods study how consumers felt that having a meaningful day could help them achieve stability and autonomy in their recovery process. This recovery concept could be operationalised in community psychosocial outreach programs in Australia to promote psychosocial recovery for people with SPMI and homelessness risk.

3.3.9 Ensuring psychosocial supports are culturally appropriate.

Culturally appropriate services are considered to be part of a stabilising environment for people with SPMI and homeless risk (Brackertz et al., 2021). As Toombs and colleagues (2021) note "given that indigenous pathways to homelessness can differ from non-Indigenous youth, interventions that address homelessness must also adapt to meet diverse needs" (p. 96). Aboriginal and Torres Strait Islander people have been recognised by the Queensland housing commission as a key priority population. Therefore, integrated psychosocial programs should consider partnerships with Aboriginal led service providers to ensure cultural responsiveness. Programs such as HOP-C North provide examples of cultural programming, including embedding cultural teachings, spiritual practices, and land-based activities as part of psychosocial support provision (See Toombs et al., 2021). This kind of cultural programming could be incorporated into local psychosocial support models to promote recovery.

3.3.10 Addressing the local context: using community consultation to tailor psychosocial supports.

The literature demonstrates that how you develop and implement supported housing solutions and psychosocial supports for people with SPMI and homelessness risk will look different depending on the local context (for example, see Stergiopoulos, 2014 and Tually et al., 2018 in Appendix 3 - Table 2). Each region is likely to have unique barriers that may impede the implementation of services to address the local needs (Toombs et al., 2021). These barriers could include: the types of housing and mental health services that are available in local areas, issues with capacity such as long waiting lists and cultural barriers faced by Indigenous populations (Toombs et al., 2021). The literature provides examples of integrated outreach programs and community navigation programs that have used a multi-stage process to address the needs of people with SPMI and homelessness risk. For instance, ICHA, ODR and the Adelaide Zero Project all demonstrate how community consultation and academic partnerships can be used to firstly understand the issues of the local community, then shared principles can be developed and a range of programs developed and implemented to address the range of needs. Finally, ongoing evaluation has been used to ensure barriers to implementation across the sectors are identified and that there is continuous improvement (See

Stergiopoulos, 2014; Tually et al., 2018). These types of processes could be implemented by integrated community outreach programs to develop local solutions for people with SPMI and homelessness risk in Queensland.

3.3.11 Increasing the capacity of the sector through training: a role for integrated case management navigation teams.

Integrated case-management teams can provide training to other providers in the sector such as housing and health to increase the capacity of the whole sector (Baker et al., 2018). This involves education about the complexity of the needs of people with SPMI and homelessness risk and up-skilling the sector with the skills necessary to engage and better support this population. The literature provides examples of navigation programs where manuals with key principles of support and skill sets have been developed collaboratively with consumers with SPMI and homelessness risk. Navigation specialists and/or peers have then been trained in these key principles and skills (see Compton et al., 2016; Corrigan et al., 2017 for further description of skills) and have reported improvements in their skills (Compton et al., 2014; Corrigan et al., 2017). These have been tested for their effectiveness with the target populations and have demonstrated positive outcomes such as reduced homelessness, hospitalisations, and improved mental health outcomes (Compton et al., 2016; Corrigan et al., 2017). This type of approach could be used by local integrated case management teams.

The evidence suggests that the Australian social housing system does not adequately identify, monitor, and consider the mental health of its tenants and lacks the knowledge about what actions to take in response to early warning signs to avoid a tenancy reaching crisis point. Brackertz and colleagues (2018) have identified the need to:

- “Educate social housing providers, real estate agents and tenancy managers about how to identify early warning signs of a mental health crisis and the need for early intervention if these are detected;
- Develop materials and work with social housing providers, real estate agents and tenancy managers on how to take appropriate action to link tenants to service providers and supports to assist in sustaining their tenancy; and
- Better implement procedures in public housing authorities to identify and monitor people with lived experience of mental ill health and link them with the required supports and services when needed” (p. 53).

Local integrated case management/navigation teams are well placed to engage the housing sector and provide this education.

3.3.12 Engage in advocacy to address systemic issues

Systemic issues such as the lack of public and private sector housing stock mean that for those who are currently homeless, many will remain so without addressing these issues (Pearson et al., 2021). There is a need to advocate at the upstream level to address these and other system issues such as the need for state

and national integration of housing and mental health sectors (Pearson et al., 2021; Stambe et al., 2023; Tually et al., 2018). Local integrated case management/navigation teams could become involved in projects such as the Australian Alliance to End Homelessness which hold promise of a shared vision, and an evidence-based plan for ending homelessness in Australia.

4. Evaluation Approach and Method

The evaluation was conducted over the period October 2023 to March 2024. The study received ethical clearance from The University of Queensland's Human Research Ethics Committee in September 2023 following full review (2023/HE001460). This section outlines the evaluation approach and study design including an overview of data sources and participant characteristics. We also reflect on the limitations of the study design.

4.1 Overview of the evaluation approach

The evaluation was aimed at understanding the implementation and delivery of the Home and Healthy program, as well as the impact of the program on the lives of service users – particularly those related to housing, mental health and wellbeing, and social connection. Our approach was participatory in that we aimed to maximise opportunities for stakeholders, particularly people receiving services from the program and those who deliver it, to share their perspectives and experiences of Home and Healthy.

4.2 Study design

The study used a mixed-method design involving three main data collection methods, these are summarised below:

Interviews

We conducted **semi-structured interviews** with **14 participants** of the Home and Healthy program

Focus Groups

We conducted **focus groups with practitioners** (managers/team leaders and frontline workers). In total we held 4 focus groups involving a total of 10 practitioners.

Case file review

In order to map the needs, supports/interventions and outcomes for clients we conducted a **review of 26 case files**.

4.2.1 Overview of data sources and data collection

A brief overview of data sources, including participant characteristics, and our approach to data collection is outlined below.

Interviews with participants of the Home and Healthy program

To protect the anonymity of Home and Healthy participants, the evaluation team were not provided with a list of participants to contact for interview. Instead, practitioners drew on their knowledge of people's health and wellbeing at the time when identifying potential participants to take part in the evaluation. Recruitment materials were written in simple English and were shared with program participants by Home and Healthy practitioners. With the person's consent, practitioners then advised the research team of the person's interest in participating and scheduled a suitable time for interview. In most cases, the practitioner arranged transport for the participant to attend the interview at one of the Home and Healthy delivery organisation office locations.

The researcher conducting the interviews was a qualified social worker and an AASW Accredited Mental Health Social Worker with extensive practice experience. To respond to participants' literacy support and comprehension needs, the researcher spent time before the interview reading and explaining the participant information sheet and what was meant by informed consent. They also assessed if the person had capacity to provide informed consent before beginning the interview.

A total of 14 people consented and participated in an interview. They ranged in age from early 20s to over 50-years-old. Eight of the participants received Home and Healthy services via Micah Projects, four through YFS and two via IUIH. The majority of participants were male (n=10). At the time of interview, 12 of the participants were housed (public or social housing (n=6); private rental (n=2); emergency accommodation (n=1); with family while awaiting public housing (n=1); did not explain housing type (n=1)). Only one participant reported currently living on the streets and another did not provide an answer to this question.

As outlined in the Request for Quote and agreed to by Micah Projects, the interviews with service users focused on the following domains outlined in Figure 1 below.

All interviews were conducted on-site at the offices of one of the organisations involved in the delivery of Home and Healthy. In most cases, practitioners supported participants with transport to attend the interview. The interviews lasted between 12 and 60 minutes ($\bar{x}$ = 33mins) With the consent of participants, the interviews were audio-recorded. We note, that for the shorter interviews, the health and wellbeing of participants on the day may have made it challenging to concentrate or participate in an interview for a

longer period. Despite this, the points made by participants were insightful and provided rich insights into the elements of practice that supported their engagement in the program.

Figure 1

Topic guide for interviews with Home and Healthy program participants.

Focus groups with practitioners

A total of four focus groups were conducted, involving 10 practitioners. Two of the focus groups were held in person and two were conducted online via TEAMS. With the consent of participants, the focus groups were recorded. The focus groups lasted between 40 and 90 minutes ($\bar{x}$ = 68 mins). Due to the small number of focus group participants, we have not shared any demographic details out of concern practitioners are identifiable.

As outlined below in Figure 2, the focus groups aimed to capture practitioners' perspectives on a range of topics including:

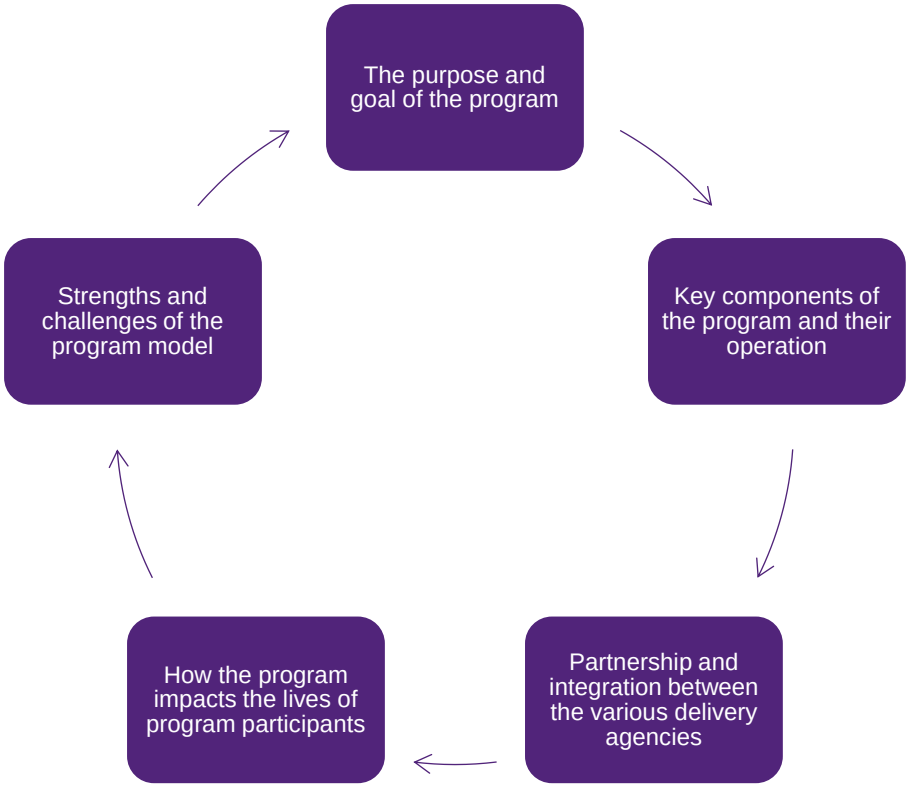


Figure 2

Topic guide for focus groups with practitioners.

Case file review

To enable the case file review a data abstraction form was designed to summarise the participant's files (see Appendix 4). Data was collected from two sources: the Efforts to Outcome database which included the participant's case notes and Redicase data base which included scores from the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS), a measure of met and unmet needs. The data abstraction form sought to understand the nature of the psychosocial support and the systems the participant accessed. It also sought to understand the nature of the contact between the worker and the participant. The data abstraction form did not include the participant's name. The form included fields of participant code that incorporated age and gender, period supported, presenting issues such as health issues, homelessness, risk of eviction; health and wellbeing profile include CANSAS score; summary of contact, reports of health and wellbeing in case files, and psychosocial domains, nature of worker's contact, and outcomes. The psychosocial domains included legal engagement, housing, counselling/therapy, finances, formal supports, informal supports, and culture. The researchers read the case files of a randomly selected number of participants within the offices of Micah with a team leader providing access to the organisation's Efforts to Outcome and Redicase databases.

The project aimed to review all Home and Healthy files, both open and closed, held at Micah Projects over the period that Home and Healthy has been operating. However, available time under the budget was limited to forty hours, enabling the abstraction of data from 26 participant files. Further, the project sought to understand changes in the health and wellbeing of participant's during their engagement with Home and Healthy. In addition to accounts of wellbeing in the case files, the project aimed to consider the participant's CANSAS score as an account of the participant's wellbeing. However, Cansas scores were missing on 12 participant files. In some cases, this was due to the file only open for a limited time (eg. one month). In other cases, the Cansas had not been completed. A literature review of CANSAS completed by a social work student as part of their placement is attached in Appendix 4 and provides a discussion of the uses and issues associated with this tool. Further, it is understood the CANSAS was completed by the Home and Healthy practitioner, a legitimate undertaking (see CANSAS specific literature review in Appendix 5). However, this resulted in the CANSAS not providing information from the participant's viewpoint of their wellbeing sought by this evaluation.

5. Participants' perceptions and experiences of the Home and Healthy program

I just think they are extremely necessary…Home and Healthy…I think they would probably be one of the most important things in Brisbane right now. Without them, yeah, shit wouldn't happen, and a lot of people would be dead… So, people like that can make a change and make it feel like someone cares…That means more to me than anything. So, Home and Healthy, thank God.

- (Participant 4)

This chapter reports on the data collected via the individual interviews with Home and Healthy participants. The interview audio was transcribed verbatim. The transcript data was analysed thematically (Braun & Clarke, 2013) in order to address the evaluation foci. The findings presented contribute to addressing points 2, 3 and 5 of the Evaluation Purpose provided by BSPHN.

1 Present findings of how the **partnership between Micah Projects, YFS, and IUIH provide an integrated psychosocial support model** focused on support and system navigation for people with co-occurring mental illness and homelessness risk

2 Demonstrate how the partnership and **program model can effectively navigate across systems** such as housing, health care, drug and alcohol, mental health and homelessness and social enterprise

3 Learn how the **fundamentals of psychosocial support** for individuals to manage their recovery plan, treatment support and tenancy obligations is essential for preventing homelessness

4 Understand how the **service system navigation role is capable of enhancing support and workforce** of BSPHN CPSP commissioned providers and their ability to support people with co-occurring mental illness and homelessness risk

5 Understand how **rapid response** support contributes to strengthening the system, **averting and/or addressing immediate mental health crises** and decreasing possible hospital presentations

In this chapter, we examine the participants' perceptions and experiences of the Home and Healthy program, particularly focusing on: (a) how and why participants entered the program; (b) the elements of service delivery and practice approach that supported their engagement in the program; (c) the impact of the service on their lives; (d) period of time supported by the program; (e) what being 'home and healthy' means to them; and (f) their recommendations for improving the program.

5.1 How and why participants enter the Home and Healthy program

All but one interview participant discussed their referral into the Home and Healthy program. The participants entered via various pathways including **self-presentation** to one of the delivery agencies for assistance (n=3), **referrals** from external stakeholders such as general practitioners (GPs)/psychologists (n=3), Department of Housing (n=1), Child Safety (n=1), case worker at emergency accommodation (n=1), in-home rehabilitation social worker (n=1), Brisbane City Council (n=1), hospital (n=1), or internal referrals from another Micah program (n=1). This suggests that there is broad sector awareness of the program.

When discussing why they were referred to the program, the participants described how their histories, punctuated by trauma, violence, drug and alcohol use, criminal legal and child protection system involvement combined with SPMI and often multiple chronic health issues (e.g., diabetes, heart conditions, pulmonary diseases, arthritis and autoimmune diseases) had contributed to their current varied, complex, and dynamic needs. They also explained how, prior to Home and Healthy, they had been unable to find support and/or how other services had been unable to adequately support them:

> I went I looking for the help first, I was trying to get help first. Then [Child Safety Officer] come from Child Safety and she got on to another place first, but they weren't – they were helpful but not the right suited person for me. Then they put me onto this one. I come out and I seen [Home and Healthy practitioner] and they did – she helped us and they listened to me, because I have got a lot of, like a lot of issues. *(Participant 12)*

Regarding housing, approximately a third of participants spoke of losing housing prior to entering the program due to eviction, natural disaster, and family conflict. Hoarding, property damage, conflict with landlords and arrears were noted as contributors to evictions or threats thereof. For example:

> Then when the kids went [into out-of-home care], I lost my place, and they downsized me to a two-room unit. I had heaps, and because my mum passed away – so I had her stuff as well and there was just so much stuff and it was just impossible to move. It has only two rooms and then my daughter moved in with me and her boyfriend, it was like… it was chaos and so I've been labelled a hoarder. *(Participant 1)*

> I ended up getting a place at [suburb] for three years and had trouble with the neighbours and people in that area. A lot of problems. I really didn't have any support then…Anyway, ended up getting kicked out. *(Participant 2)*

A smaller number of participants described having experienced multiple and lengthy periods of living on the streets prior to engaging in the program, and throughout their lives:

> I've been homeless all my life. If I'm with a woman, I'm pretty much not homeless until we have an argument and I'm on the street in a bag as it happens *(Participant 11)*

Instability and movement between housing types (couch surfing, emergency accommodation, private rental, public housing, the streets) and geographical locations were notable themes across the participants' discussion of living arrangements prior to entering the program.

5.2 Home and Healthy is accessible to participants because the practice approach is different to other services.

Many of the participants stated that they did not know what the purpose of the Home and Healthy Program was. For example, *Participant 14* shared, "I just don't know about what his [Home and Healthy practitioner] role is, apart from being awesome". However, there was one participant who discussed the importance of the program's dual focus on housing and health. They commented:

> The two [housing and health] do go together, don't they, because, basically, half mental health people's issues… and their problems are through Housing or problems with their housing, and stuff, and half their housing issues are because of mental health. Both them two go hand in hand together. There's nothing more genius than to keep them together. It's just common sense. *(Participant 1)*

What was common across the participants' accounts was distinguishing the approach of Home and Healthy from other services they had previously received support from and which they perceived to be unresponsive, judgemental, or unable to address their needs. Participants indicated that their Home and Healthy practitioners "can understand me more" *(Participant 9)*, have "actually done things for me" *(Participant 4)* and listen:

> They make the other services look shit… you need for the housing part and for that – your mental part and people to be there and to listen, they're [Home and Healthy] there, not like all these other [services]– they don't just brush you off. *(Participant 12).*

5.2.1 To participants, their primary Home and Healthy practitioner *is* the program

Participants' descriptions of the support they received from the program centred around their relationship with their primary Home and Healthy practitioner. They described a positive relationship with at least one, if not more, practitioners within the Home and Healthy service. Participants used words such as "incredible", "amazing", "dedicated", and "genuine" when referring to their primary Home and Healthy practitioner who they described having strong relationships with. Participants considered their practitioner/s to be approachable and relatable, viewing them as somebody they "can always count on" *(Participant 1)*, who "don't just brush you off" *(Participant 12)* and are "a good help for me" *(Participant 9)* due to their reliability, responsivity, and trustworthiness:

> [Home and Healthy practitioner]'s 100 per cent - I'll call him anytime. He's good as - he just does - he does extra stuff for me… stuff like that I don't even think of, he thinks of. *(Participant 5)*

> [Home and Healthy practitioner]'s been trustworthy as a person for me to go to when I'm at a crisis point and need support right then. *(Participant 14)*

Participants particularly valued being listened to, respected, and treated with a non-judgement attitude:

> I feel a lot less anxious talking to [Home and Healthy practitioner], like I can go to him in that panicked state and be like just this, blah, blah, blah. He doesn't cut you off, he doesn't doubt you. like I said, he could be thinking the opposite, but he's still respectful. *(Participant 14)*

Several of the participants reported feeling as though they would be able to raise an issue or disagree with their practitioner, without it impacting on their working relationship. As one participant shared:

> I think there's been one or two times that I haven't agreed with [Home and Healthy [practitioner] and I'll tell her, but she appreciates it… For our relationship...constructive… *(Participant 1)*

There were only two exceptions to the positive description of participants' relationships with their Home and Healthy worker. One participant *(Participant 7)* described a time when they were offended by a practitioner's mistimed joke, explaining how they felt the practitioner "was taking the piss" out of them. However, they reflected that whilst it upset them, it was probably unintentional. In contrast, the other participant spoke of being mismatched with a practitioner of the opposite gender, who they felt was "rude" and judgemental of their personal relationship. This participant advised that they had taken part in the evaluation to provide feedback because they did not "want nobody to go through what [they] did" *(Participant 13)*.

5.3 A practice approach that fosters engagement and enhances wellbeing

When discussing the support, they received from the Home and Healthy program, the participants routinely highlighted how the approach to practice adopted by their worker helped to support their engagement and enhance their wellbeing. Their comments centred around: (a) gentle and persistent outreach; (b) responsive practice; (c) participant-led support that respects agency; and (d) service system navigation and advocacy.

5.3.1 The provision of gentle and persistent outreach and offers of support

Many of the participants flagged that they had difficulty trusting services and this meant that they needed a prolonged period of engagement to feel safe. They reflected on how Home and Healthy's gentle persistence and outreach approach helped to build trusting relationships with their practitioner, and the service more broadly over time. For example:

> It took me like four months of hit and miss, me and [Home and Healthy practitioner], before I even met him… that was mostly on my part… he didn't quit though, he always kept trying, you know? *(Participant 10)*

> For the first few weeks, I was a bit standoffish… [Home and Healthy practitioner] came and picked me up and just go for a cup of coffee. We just go down to the park and sit there for a cup of coffee or a slushie, or whatever, and we didn't have to talk. We'd just sit there for an hour and start talking. But I mean, even just little things like that. She always seems to know when to ring at the right time. She says, oh, I'm coming to get you, we'll go for a coffee, and then she'll come and pick me up *(Participant 1)*

Both excerpts highlight practitioners' purposeful efforts to build rapport and to demonstrate a commitment to the participant, before trying to commence work on 'tasks'. It speaks to a recognition of the prolonged periods of persistent outreach required for participants to trust the practitioners enough to engage. The participants particularly valued that the practitioners "came to them" explaining that "the service that comes to you is the service that's going to make it easier for you to engage with" *(Participant 5)*. This participant went on to explain how outreach made them feel like they were valued and that Home and Healthy was supporting them "because I'm human, not just because I landed on their lap".

Other participants echoed this sentiment, describing how practitioners' efforts to call, and check-in between in-person visits made them feel cared for and valued by the program, particularly if they themselves had not initiated contact with Home and Healthy for a while. For example:

> I know they are there for me if I need them. They will ring me if they haven't heard from me for ages, and say, oh [Participant 8], we haven't heard from you for a while, what's happening? Do you want me to come over and we have a chat? I think they're a wonderful service. *(Participant 8)*

5.3.2 Responsive practice that meets people 'where they are at'

As well as meeting people in their geographical location via outreach, the participants reiterated that their Home and Healthy practitioner was attuned to their shifting needs and capacity and adjusted their approach accordingly. As one participant shared:

> I can say what I want to say to her. If I'm in a shitty mood, [Home and Healthy practitioner] will know not… to deal with this today, can we deal with it tomorrow? [Practitioner says] Oh, we can deal with it whenever you need. *(Participant 8)*

Other participants recounted how their Home and Healthy practitioners adapted their interaction and communication style to meet their needs. *Participant 12* described this as working at their pace by taking "little steps" so that they would not get "overwhelmed with too much and get frustrated and angry". They described feeling supported when their practitioner made the effort to:

> …just listen and the come down to my level... because I don't understand a lot of questions. Like I can't read and write…I'm very nervous. *(Participant 12)*

This practice enhanced the participants' understanding of processes and their ability to be involved in planning and decision-making about her support needs.

Participants also identified that the amount of support and contact provided by their Home and Healthy practitioner varied in accordance with their needs at the time:

> I would say at least once a week but on some hectic weeks, or if I've needed to go somewhere, I may see her two or three times a week and she'll keep in touch - communicate very well; send a text or an email or phone call. She's very, very considerate. *(Participant 6)*

> Weekly or fortnightly. But then if I was having a really bad time, she'd come out twice a week… and then it got to fortnightly. Then it got to just once a month for a couple of months there, and I sort of got bad again. She's always been in touch every week, at least. *(Participant 1)*

As illustrated in the quotes above, the participants valued this responsivity and did not experience the support intensity tapering off in an arbitrary linear step-down or time-limited manner. Furthermore, many participants also felt that they could reach out to their practitioner on an as needed basis – even if there had not been much contact prior.

5.3.3 Participant-led support provision that is non-judgemental and respects their agency

Participants described being supported by their Home and Healthy practitioner to identify individualised goals and required supports. Whilst they valued the input of the practitioner, participants reported feeling that they were always consulted and "have always got a choice" *(Participant 3)* about what support was pursued or actioned. For example:

> there's so many more things that [Home and Healthy practitioner] has offered and could have offered and given me and I could have made use of resources and things, but it's not for me. I didn't want them or need them. But it's always been there, and she's made that quite clear from the start – that anything I wanted or needed, she's got the resources there. She can make things happen for me if I want. That was really good as well. *(Participant 1)*

There was one exception to this, where a participant described one of their Home and Healthy practitioners as "pushy" and trying to impose goals. They shared:

> It's the way [Home and Healthy practitioner]'s coming across. He's a little bit forward where we're a little bit more relaxed. Don't like forward thinkers too much, but yeah, just telling [participant] what to do in the way that program, or [participant's] goals. *(Participant 13)*

Other than this example, participants felt that their choices were respected and that there was no negative judgement from their Home and Healthy worker. To illustrate this point, one participant described deciding to leave a boarding house to sleep rough and engaging in behaviours that resulted in their arrest. They were appreciative of their workers' non-judgemental response, commenting:

> Even the outcome of that, there's no judgemental – no judging at all, nothing. That's what I mean, [practitioner is] down to earth. *(Participant 10)*.

For the few participants that self-reported yelling at or "abusing" staff – this non-judgemental attitude had enabled them to remain engaged in the program, feeling supported.

5.3.4 Service system navigation and advocacy

Several of the participants distinguished Home and Healthy from other services, saying "they're not like the rest" *(Participant 10)* because of the role they played in helping to navigate systems. As one participant shared:

> Just dealing with them [Departments], I guess. Actually, anything with authority and stuff I had issues with. Just with my depression and that, I felt like they were bullying me and hassling me, and I wouldn't deal with them. I wouldn't speak to them, and that. [Home and Healthy practitioner] came along to my appointments with me and sort of I guess helped me understand – both sides

> understand each other a bit better. She made them understand and told him my side of things – like more than they would of if I hadn't have had her there… With [Home and Healthy practitioner] there backing me up and supporting me, they listened, and they took my – and went, okay. *(Participant 1)*

Like *Participant 1*, several other participants highlighted how important it was to them to have a Home and Healthy practitioner there to help explain their side and respond to questions from service providers that they did not feel capable to themselves. This support and advocacy was perceived to result in more favourable outcomes for participants, as one participant shared, if it wasn't for Home and Healthy's advocacy "I wouldn't be where I am today – I'd be homeless on the streets again… that's a fact" *(Participant 1)*.

The most discussed service systems were Department of Housing for housing applications or transfer requests, NDIS applications including undertaking required assessments to support the application, social security – particularly for DSP applications, and GPs for mental health plans. Some participants also cited examples where Home and Healthy had helped them to navigate the child protection system, probation and parole, private rental disputes and bond issues, victims of crime claims, managing debts, as well as school supports for their children. Participants valued the support in identifying and linking them with other services, transport to appointments and assistance in completing required paperwork. As *Participant 9* shared," getting my DSP claim done and filled out. Because that was a big struggle for me to get done, getting all the paperwork together and submitting it". This highlights how administrative tasks and formal paperwork can act as barriers to suitable support and resources being provided to people with SMPI and other chronic conditions.

5.4 Impact of the service on participants' lives

Overwhelmingly, participants shared positive examples of the multi-faceted ways that Home and Healthy had impacted their lives. For example:

> I'm glad that I was put on to them… I'd be lost without [Home and Healthy practitioner]. I certainly would be homeless and that's a fact. That's a guaranteed fact. I would not have my home today if it wasn't for [Home and Healthy practitioner], definitely wouldn't have my kids, I wouldn't have my cats. If I lost my place, I would probably be suicidal, just about, and back on the drugs. I really owe her a great deal – a lot when it comes down to it. I don't know if they realise the extent of how big it is – what they've done for me. (*Participant 1)*

The participants' comments about the impact of Home and Healthy on their lives centred around the dimensions of: (a) health and wellbeing; (b) housing; (c) identity; and (d) hopes for the future.

5.4.1 Health and wellbeing

Nearly all the participants indicated that the program had helped to address their mental/health needs more than they could have done on their own. For example, *Participant 1* reported "my health and my mental wellbeing – everything is 100% better". Whilst one person recounted being hospitalised for their mental health following an arrest, four of the participants advised that they had not been hospitalised since engaging with Home and Healthy. Being "more stable", having a support person, being back on appropriate medication, and having housing with access to bathrooms, laundry and a kitchen for cooking were cited as contributing factors to improved health and wellbeing.

Participants discussed how Home and Healthy helped to link them to a wide range of mental/health services and supports including, but not limited to general practitioners, psychologists, psychiatrists, alcohol and other drug services, inclusive health services, audiology services, dental care, podiatry, rheumatologist, cardiologists, and other specialists. Being connected to health services "for mob" was valued by the Aboriginal and/or Torres Strait Islander participants. Five participants briefly flagged that Home and Healthy was assisting them with NDIS applications. However, the thing that participants spoke most about was practical support centred around managing their physical and mental health needs. The importance of Home and Healthy's support in making, remembering, and transport to get to appointments was highlighted by nearly all participants. For example:

> [Home and Healthy practitioner] has been instrumental in taking me to the psychiatrist appointments, making sure I don't miss them because they're - firstly they're quite expensive and if you miss them, yes, it's very hard to get appointments there, so that's been pretty crucial as well… Perhaps without her, I might not even be at the point where I am because I might have missed appointments and been further behind. *(Participant 6)*

Several of the participants also explained how their Home and Healthy practitioner attended the appointments with them acting as emotional support and a second set of ears to hear and help process the information discussed. As one participant shared:

> They've taken me to see specialists and things which I'm really grateful for, and being there so that [Home and Healthy practitioner] can explain stuff to me, which really means the world to me, because the specialists can talk to me and then while they're talking to me my head is going, 'oh, that Jacaranda looks beautiful, I'd like to put that on a canvas' *(Participant 4)*

Support in coordinating services was also valued. For example, *Participant 10* explained how their Home and Healthy practitioner had started:

> …to work with my psychologist and my GP as well. I have those two and the three of them are kind of conjoined and started interacting. So he did that and that was really important too. *(Participant 10)*

However, one participant reiterated that despite the best efforts of their Home and Healthy practitioner, sometimes the provision of required support was contingent on external gatekeepers. They explained:

> He knows that I'm unwell, I know I'm unwell and there's only so much that he can do. So he can call mental health, but then again, it's up to mental health whether they decide to act on that. Like they said they'll [Home and Healthy] work with me in the community because they only – they don't institutionalise people. *(Participant 14)*

This highlights the systemic barriers faced by those seeking mental health services before 'crisis' point.

5.4.2 Living arrangements and housing

All but two participants (one who did not answer the question and the other who stated they had received no housing support) described Home and Healthy providing some form of assistance regarding living arrangements and housing. This included, housing applications and transfer requests, support to attend housing appointments and inspections, sourcing crisis accommodation, providing resources when sleeping on the streets, moving assistance, brokerage to furnish and set up the house, as well as getting bond back from previous properties. For example:

> I was in a tent in a park for several weeks, in the car for… weeks and I was living on park benches and [Home and Healthy practitioner] was doing everything he could. He came to application house stuff, he kept ringing on and ringing on and hit and hit, I think that's worked. So, in this housing crisis, I waited x months which is unbelievable. So, he's actually helped with that. *(Participant 10)*

A subset of participants, who indicated that hoarding and property maintenance could be an issue that placed their housing at risk, explained how valuable practical support cleaning and decluttering by "just do[ing] a box a week" or helping to arrange gardening services was to retaining their housing. *Participant 1* proudly explained the impact of this support:

> Everyone's really pleased. Housing – they want to call just to see how well we're doing because they're so – everyone's really impressed and so proud of me – how far I've come. *(Participant 1)*

Of the six participants living in public housing, half felt unsafe but described that they had no other option than to accept the property. As one participant shared:

> I didn't want to take it but I also didn't knock it back. I'd go back to the bottom of the list... if you get offered a place, you should take it. So yeah, there's that many people that want a place, so why should I knock them back and that's how I feel. If I knock that back, that's wrong because there's so many people looking for a house. *(Participant 12)*

The main concerns raised by these participants were violence as well as drug use, sale, and production in their complex or area. One of the participants *(Participant 14)* explained how their Home and Healthy practitioner was the only person that believed their concerns about their "toxic and violent" property and was helping them find alternatives. Similarly, another participant *(Participant 4)* described how, despite acknowledging the important changes to their health associated with having stable housing and access to a shower and kitchen, they had considered returning to homelessness due to their concerns about violence in their complex. However, their Home and Healthy practitioner had supported them to lodge a housing transfer request, so they were able to stay housed. They shared:

> So, they're putting me through the [Department of Housing transfer] process and they're making sure that I'm doing everything by the book so it doesn't come back and bite me on the bum. They're trying to help me get back into a home… somewhere where I deserve a bit of quality in life. *(Participant 4)*

This suggests that whilst participants may recognise the benefits of stable housing provided by public housing for their physical health, concerns about safety can make their living arrangements feel untenable. This highlights the need for greater matching and the need for holistic support so that people do not need to choose between feeling safe and being housed.

5.4.3 Sense of worth and identity

Many of the participants described how the treatment they experienced from their Home and Healthy practitioner made them feel valued, "like someone cares" *(Participant 4)* about them, and most importantly, like "a human" *(Participant 5)*.

One of the Aboriginal participants shared that being engaged with IUIH had made them feel proud to talk about their culture and identity. They shared:

> they're starting to make me feel again, in my head that it's not wrong for me to tell people that… it's not wrong for me to tell people about my culture. *(Participant 5)*

This participant highlighted how welcomed they felt at the service from the first phone call and emphasised how they "hadn't been judged by skin colour" when they first met the practitioners and that "was the best part" because they had been so concerned about not having their identity recognised. Whilst all organisations delivering the Home and Healthy program should deliver culturally responsive support, these comments reiterates the importance of having a Community Controlled Organisation involved in the delivery of Home and Healthy for Aboriginal and Torres Strait Islander participants.

Another participant *(Participant 14)* shared that they would be eligible to receive support from LGBTIQA+ services. However, they did not seek this support because of how affirming their Home and Healthy practitioner was of their identity and how responsive to their needs, including those related to their identity, that the practitioner was.

5.4.4 Goals for the future seem possible

A few participants explained how future goals seem possible now that they were housed in an affordable and safe location. For example:

> Just get a job. I have a [child]. Get set up for [them] to start staying with me. Try and do normal things, meet new people not in boarding houses, stuff like that. I want to join a [sports] team. Just meeting people in general, in social environments, who aren't on drugs. *(Participant 10)*

This indicates that the support of Home and Healthy helps to provide stability to the lives of participants, providing a foundation from which they can then pursue goals beyond housing and their health.

5.5 Period of support and thoughts about exiting the program

Seven of the participants shared how long they had been engaged in the Home and Healthy program and most (n=5) had been engaged with the program for less than four months. However, there were two participants who reported being part of the program for over 12 months. One of these participants indicated that they were scheduled to exit the program in a fortnight, sharing that they were sad about closing but felt confident that they could recontact their Home and Healthy practitioner should something go wrong in the future. The other participant reported that there had been discussion of closing their case at the nine-month mark, but the decision was to continue providing support. When asked what closing would mean for them, they shared:

> I guess it'd have to a good thing. It'd have to make me feel good, in a way. I'd be sad, I guess, to see her [Home and Healthy practitioner] go. But I guess it'd be a good thing because it means that I'm better. I've got to where I need to be at. *(Participant 1)*

Three of the participants reported that their practitioner had discussed how long the program usually lasted (responses ranged from six to 12 months) and one person indicated that timelines for case closure had not been discussed with them, commenting "I guess when I don't need it, or don't want it" *(Participant 14)*.

5.6 What being 'home and healthy' means to participants

Participants shared what being 'home and healthy' meant to them. Most participants' responses focused on having their own place to live. Somewhere that was "economical and safe" *(Participant 9)*, provided stability and security, as well as a place to cook, bathe, keep clothes clean and "do whatever I want" *(Participant 8)*. The next most cited elements were eating healthy food on a regular basis and having good mental health

which was described as “being outgoing and motivated” *(Participant 9)*, engaging in activities and having a purpose. As *Participant 6* shared:

> …healthy choices and having a bit of a purpose, being active and doing things as well, trying to just be all round balanced and healthy and have a good mental balance or focus or be - not be too negative or stressed, that sort of thing.

A small number of participants considered having a support network, “no dramas” and being able to get back to employment as key elements of being ‘home and healthy’.

5.7 Recommendations for improving the service

Eight of the participants offered suggestions for improving the program. These varied from staff having more holidays in recognition of their hard work, through to requests for support services to operate beyond 9am - 5pm and greater consideration of matching practitioners with participants. One participant *(Participant 3)* wished that their practitioners would listen a little bit more so that they did not have to repeat information they had already shared. Two participants desired access to more support and acknowledged existing constraints on practitioner’s time due to being “really busy” *(Participant 4)*. When advocating for practitioners to spend more time with people, particularly when they are on the street, *Participant 2* stated:

> Like, they're personal cases. They've got to take it - they've got to give them time. They've got to give them that time. You know what I mean? Instead of run from here to there and doing a time schedule. That's no good.

Given the importance of outreach to participants, further resourcing for additional staff may enable Home and Healthy practitioners to spend more time outreaching to participants.

One participant suggested engaging with participants to help identify locations where Home and Healthy could be advertised to others who would benefit from the program. They shared:

> more advertising… Just a little bit more branding in the places… I feel like this is why we need the homeless people's voice for this. I wish I could sit down with [Home and Healthy] representatives and just say, hey, look, listen, these are the hot spots where I know people sleep. How come we're not putting posters that say, hey, if this is you or this is you, you can actually get this help if you choose to take it. *(Participant 5)*

This suggestion implies that there may be more people in the community that could access and benefit from the program if they knew about it. It also highlights the importance of lived experience in helping to identify strategies for sharing information with other people in similar situations about the program.

5.8 Summary

This chapter has reported on the experiences of 14 participants currently engaged in the Home and Healthy program. People have a right to participate in decisions and processes that impact on their lives. As such, the inclusion of the voices of people accessing services is critical for ensuring that support provided is accessible and responsive to their needs. Overwhelmingly, the participants were positive about their experience of being supported by the program, irrespective of which of three organisations were delivering the support. As people with SPMI and homelessness risk, the participants highlighted the importance of having access to a program with a dual focus on housing and mental health and wellbeing, as well as a more holistic understanding of their complex, interrelated and multifaceted needs (Bitter at al., 2020; Carpenter-song, 2012; Padgett et al., 2016). The importance of relationship-driven practice, support navigating support systems and advocacy, as well as assertive and persistent outreach were central to participants' positive accounts of the program. As such, the participants' data predominantly makes contributions to addressing **Evaluation Purpose 3**, *regarding the* ***fundamentals of psychosocial support*** *for managing recovery and maintaining housing.*

Consistent with existing literature (Pearson et al., 2021; Stambe et al., 2023), many of the participants explained how other services were either inaccessible or unable to respond adequately and appropriately to their needs. They suggested that Home and Healthy was different to other services they had worked with in the past due to the practice model adopted and the skill and approach of the practitioners involved in service delivery. Reflecting current best-practice in enhancing outcomes for people with SPMI and homelessness risk, the participants highlighted several pillars of practice that facilitated their engagement in the Home and Healthy program. First, assertive, persistent outreach (Pearson et al., 2021; Stambe et al., 2023) that lays a foundation for engagement by demonstrates a commitment to the participant, recognises the time required to establish trust and rapport and overcomes practical barriers to participants accessing service locations. Second, the centrality of relationship-driven practice (Brackertz et al., 2020, Parsell et al., 2015) and the importance of practitioners demonstrating that they are listening, responsive, respectful, trustworthy, and genuine (Keenan et al., 2021; Kerman & Sylvestre, 2020). Participants identified that these first two pillars were critical for creating a platform of safety and trust, from which they then felt able to share their needs and goals with practitioners (Parsell et al., 2015).

From this platform, the third pillar of practice, collaboratively developing individualised plans for support (Kerman & Sylvestre, 2020; Padgett et al., 2016) in a manner that is non-judgemental and acknowledges the agency of participants can be realised. The fourth practice pillar identified by participants was the provision, coordination, and management (Clark et al., 2016; Isaacs et al., 2019; Kerman et al., 2019; Pearson et al., 2021) of holistic support that recognises the broad, dynamic and complex support needs of participants within their individual recovery journey (Bitter et al., 2020; Brackertz et al., 2020; Carpenter-song, 2012; Padgett et al., 2016). For the two participants who identified as Aboriginal, sourcing and linking them with Aboriginal Community Controlled Organisations was particularly valued (Brackertz et al, 2021; Toombs et al., 2021). Intertwined with pillar four was the final pillar of providing service navigation support (Brackertz et al., 2018; Compton et al., 2016; Corrigan et al., 2017; Padgett et al., 2016), including administrative task support

as well as individual advocacy to help educate others in cognate sectors about the participants' needs and circumstances (Baker et al., 2018). As such, the participant data indicates that, in their individual interactions with program participants, the Home and Healthy practitioners are implementing recognised best practice principles for providing psychosocial support to people with SPMI and homelessness risks. These findings add further support to the evidence-base regarding the importance of these pillars of practice for not only engaging but supporting people with SPMI and homelessness risk in, from their own perspective, a meaningful and transformative manner.

As well as speaking to the fundamentals of psychosocial support outlined above, the participants' accounts also highlighted how the Home and Healthy model appears to ***effectively navigate across systems*** *such as housing, health care, drug and alcohol, mental health and homelessness* (**Evaluation Purpose 2**). As described above, participants in the program considered system navigation to be a key pillar of practice and a factor that differentiated Home and Healthy from other services. They described how practitioners' knowledge and skilful navigation of various support sectors (e.g., social security, housing, health, alcohol and other drugs, criminal legal system, child protection) enabled the provision and, importantly, coordination and management of psychosocial support that was tailored to their individual, intertwined and multidimensional needs – all of which they saw as impacting on their recovery and housing. This reflects findings of others (Brackertz et al., 2020; Kerman & Sylvestre, 2020) regarding the importance of system navigation, support, and advocacy to promoting recovery.

However, despite the presence of psychosocial support and service navigation provided by Home and Healthy, some participants raised the issue of inappropriate housing, due to the presence of violence and drug use within public housing environments. Whilst the support provided by Home and Healthy helped to alleviate some of the participants' concerns due to support in lodging transfer requests and other supports, they still felt unsafe within their living environment with some even considering re-entering homelessness. Previous work by Parsell et al., (2015) has also highlighted the lack of safety experienced by those living outside of single-site supportive housing. This indicates that, for people with SPMI and risk of homelessness, greater access to supportive housing, including that with onsite support, is required rather than general public housing or private rental stock.

Finally, the participant data makes some contributions to **Evaluation Purpose 5** - *understand how* ***rapid response*** *support contributes to strengthening the system,* ***averting and/or addressing immediate mental health crises*** *and decreasing possible hospital presentations.* Whilst four participants indicated that they had not been hospitalised since engaging with the Home and Healthy program it is not clear from their accounts if this was due to rapid responses that averted or addressed immediate mental health crises. What is apparent from the participant data is that they attributed improvements in their mental health and wellbeing to the stability and support offered to them by having trusting, respectful and committed relationships with their primary Home and Healthy practitioner. Whilst the participants describe the frequency and intensity of support changing over time, they felt this was done in response to their own needs and circumstances, rather than an arbitrary, pre-established linear model. This suggests that whilst practitioners may be guided by the nine-month Critical Time Intervention Model which underpins the program, in practice they are

responsive to needs of participants and thus, provide support to participants for longer and at higher intensities than the model outlines. This reflects existing findings (e.g., Carpenter-Song, 2012; Muir et al., 2010), which suggest that those with SPMI and homelessness risk may require long-term integrated case management as recovery in a non-linear and protracted process (Brackertz et al., 2018). To better reflect this practice reality, it would be beneficial to extend the support timeframe outlined in the model to at least 12-months. This is important as it has implications for practitioners' expected case-load size and the capacity of the workforce to uphold the practice pillars – notably assertive outreach and relationship-driven practice in their daily work. Whilst extending the support-time frame of Home and Healthy would be beneficial, it should also be complemented by greater access for people with SPMI to long-term, supported housing (Pearson et al, 2007; Brackertz et al, 2018) that can be attuned and responsive to the changing needs of participants.

6. Practitioners' perspectives on the Home and Healthy program

This section reports on the practitioners' perceptions of the Home and Healthy program, as well as their espoused practices. The data presented in this chapter was collected via four focus groups, conducted with ten respondents who were team leaders and front-line staff delivering Home and Healthy across three agencies. The focus group involved semi-structured topic guide related to the five evaluation purposes. The focus groups were conducted in person and online. The interviews were transcribed, and the data was entered into NVivo. We conducted a thematic analysis using Braun and Clarke's (2013) staged approach. This involved first, data familiarisation through reviewing each transcript. A coding frame was then developed using the evaluation topics as a guide. Initial themes were identified and then consolidated in relation to each topic area. We compared the themes across focus groups and no substantial differences were identified among the groups. In reporting our thematic analysis, we have elected not to identify the specific focus groups for each excerpt to preserve the anonymity of the participants and because of the consistency of themes across each group.

The findings outlined below contribute to addressing points 1 to 5 of the Evaluation Purpose provided by BSPHN:

1 Present findings of how the **partnership between Micah Projects, YFS, and IUIH provide an integrated psychosocial support model** focused on support and system navigation for people with co-occurring mental illness and homelessness risk

2 Demonstrate how the partnership and **program model can effectively navigate across systems** such as housing, health care, drug and alcohol, mental health and homelessness and social enterprise

3 Learn how the **fundamentals of psychosocial support** for individuals to manage their recovery plan, treatment support and tenancy obligations is essential for preventing homelessness

4 Understand how the **service system navigation role is capable of enhancing support and workforce** of BSPHN CPSP commissioned providers and their ability to support people with co-occurring mental illness and homelessness risk

5 Understand how **rapid response** support contributes to strengthening the system, **averting and/or addressing immediate mental health crises** and decreasing possible hospital presentations

6.1 The purpose and goals of the program

The core purpose of Home and Healthy emerged as responding holistically to people who experience significant mental health and housing challenges. Team leaders and frontline practitioners identified that program participants had been inadequately served by mainstream health, human services, and housing providers. This commitment to a holistic approach is reflected in the following excerpt:

> The program's been designed to address where housing and mental health intersect. So, a lot of the people we support, it isn't just a one-off incident of housing, they tend to be that cohort that have had multiple housing placements all over. They're typically people with either poorly addressed mental health or undiagnosed mental health or incorrectly diagnosed and treated or they've been resistant to treatment.

Practitioners identified participants in Home and Healthy as those who had "fallen through cracks" in the formal system and who had also lacked informal supports. By responding holistically to this population, the program aims to improve a range of housing, health, and wellbeing outcomes. While reduced hospitalisation is a program goal, the primary purpose concerns improving people's health and wellbeing in the community through improved housing and services access. As a frontline practitioner stated:

> Home and Healthy program is trying to advocate and support them [participants] to have access to services, so that it [mental health condition] doesn't go untreated for as long and so the hospital isn't the last resort anymore and it doesn't need to be their only point of call as well, because they've already got other supports in their life that they can use, that we've helped them connect in support with.

While reduced hospitalisation through early and supportive interventions is a goal, it was also acknowledged that, in some circumstances, hospitalisation is unavoidable and is not evidence of program failure. For example, one respondent identified that it is "our duty of care" to call emergency services and encourage hospitalisation where the person unsafe to themselves or others. This respondent added that in the event of hospitalisation of a participant, Home and Healthy still maintained an important support role, "we can be beside them and support them if they did deteriorate".

Practitioners emphasised that program's holistic purpose was aligned to key principles of self-determination and relationship-based practice. Turning first to the principle of self-determination, practitioners highlighted that participants direct the goals of service provision. As one respondent stated:

> They [participants] know themselves best and we want them to be able to progress towards the things that they feel that's going to make their lives better for them, so it can be anything from helping them to apply for DSP [Disability Support Pension], to attending meetings. Like they're okay maybe making phone calls, but it's attending things on their own towards – oh God, I've

> worked on a huge amount of things. People come in and go oh my God, 'my dog's in the pound', so help me sort that out because I don't know how to do.

The holistic and participant-led nature of Home and Healthy means that "everything is in our scope". Workers seek to respond to a broad range of issues that matter to participants' goals and of the broader program goals of improving housing and mental health outcomes. This means that workers may be involved in activities that the participant identifies as important, such as rescuing their pet, through to working alongside participants to facilitate their access to health and human services.

Relationship-based engagement is also a key principle of the program. Practitioners identified that many participants had experienced relationship breakdown in both their informal (family and friendship networks) and with formal service providers. As one frontline practitioner stated, Home and Healthy is:

> really about giving an opportunity for connection to people who've burned their bridges everywhere else, who don't necessarily have insight, who can't - they haven't been able to connect with mainstream services. So, it's an opportunity for connection, I think, for them and an opportunity to start to think about what they need to feel safe and well because those two things don't often feature in the landscape of the people we support.

Home and Healthy service providers identified that program participants required more time and support to build a relationship with service provider than is usually available in mainstream health and human services. The increased support needs of participants is associated with a range of factors including prior trauma, mental health challenges and the instability associated with homelessness.

Through a relationship-based approach Home and Healthy practitioners are able to engage participants in developing and achieving health and housing goals. As a respondent stated:

> The primary relationship with that worker is really, really critical in my observation of the program and what works well. I think it's off of that relationship where we tend to really leverage it to get people to consider things that they had previously been quite adamant they would never do or revisit or a lot of what I call plant a seed, you just leave that there and we might circle back to that and that really skilful stuff around trying to convince someone that the idea was kind of theirs in the first place anyway.

A key strength of the program is the recognition of the importance of relationships for achieving program and participant outcomes. Practitioners identified that the program provided an opportunity for them to offer the time and support to needed for participants to "feel safe" and to trust them. Further, respondents highlighted their role in offering "hope and unconditional positivity" to support participants in achieving their goals.

A further goal of the program is strengthening the capacity of the health and human services sector to respond to people experiencing complex health and mental health issues and to prevent hospitalisation. As a team leader commented:

> We were funded for a system navigator position to support other PHN funded providers to develop their capacity around housing and homelessness so that they're not sending everyone to one or two agencies, they're actually working in a holistic way with their participants rather than farming them off, which is sort of what has happened.

The Home and Healthy team provides a rapid response to participants involved with PHN funded services. The Home and Healthy system navigator works intensively with a participant over a short period to prevent escalation of their housing and mental health crisis and where possible, to avert hospitalisation.

6.2 Key features of Home and Healthy

6.2.1 A tailored response

Home and Healthy offers individualised responses to participants experiencing mental health and housing challenges. Practitioners provide participants with a structured program of support for up to nine months with the first three months focused on identifying goals and developing a plan to achieve these goals. While waiting lists exist for the Home and Healthy program, there is also capacity for a rapid response. This is enacted in circumstances where the participant needs immediate attention with the rapid response focused on the alleviation of the specific issue rather than offering the full Home and Healthy program. As a respondent noted, a rapid response is enacted when there is:

> more of a situational crisis that needs a quick response, it can't wait eight weeks. That's where I might pick up the support and either triage it into the team, which I don't think has really happened that often, or link them in with services in the wider community. That's been really good. There's been situations where we've closed someone within two or three weeks, because we did that short, sharp kind of intervention. But then other times I've worked with them for six months, because it was more complicated than we thought it would be, or these things take time, so that's that aspect of it.

While Home and Healthy is not intended solely as a crisis service, the program's rapid response provides an option for engaging with participants in a timely and effective manner. However, there are challenges for practitioners being able to effectively work with participants in short time frames:

> rapid response, which is the same sort of thing but trying to keep it within a two-month timeframe, generally speaking – failing at that most of the time, but…

Another key feature of the Home and Healthy program is the outreach model. Practitioners acknowledge that having an appointment structure, in which participants are expected to attend a service does not fit with participants given they are "a hard-to-reach population". Participants often do not own mobile phones,

computers and are without stable housing. As such, outreach was viewed as being more responsive to participant needs as it meant that they could be met in their community or at home "because then they're in their safe space, we're going to be where they feel comfortable". Whilst the outreach model is flexible and appropriate, practitioners reflected on its time-consuming nature:

> most of the time outreaching and knocking on the door or trying to find them in known locations. It could be four hours or more with just one person. But…it requires that.

Another challenge associated with outreach is last minute cancellations. As one practitioner explained:

> it'll be cancels on the spot and you might have to travel all the way to, like, Cleveland or Redbank or something like that… I would be going over to Stradbroke and a client wants to cancel, you know, it is what it is…but, you know, we respect their decisions and we know that they're going through a lot, yeah, so reschedule, no problem

Despite the time intensive nature of outreach, practitioners considered to be important, particularly for enabling cultural connections. As noted by one participant:

> It's also great, like, the Home and Healthy program is also great because it gives us a bigger catchment area as well to work with more. None of our other programs in our TSS [Transitional Support Services] goes that far. So, we [usually] just go five kilometres within the city catchment. So, this [Home and Healthy program] gives us out more to work with more that can't access our services and that would like to work alongside mob as well. So, I think that's the great thing about home and healthy as well.

6.2.2 A focus on increasing stability

Home and Healthy providers work with participants to increase their stability within the community. The focus is on reducing the reliance of tertiary and crisis services by increasing participants access to housing, health services and other support within their community. As a respondent stated:

> I think a good outcome is stability, and by that I mean less instances of crises across the time and I think that's a great outcome. It really settles, someone goes from calling you multiple times a day to maybe once a fortnight. To me that's a great outcome.

Stability is achieved in several ways. This includes, firstly, working with participants to the achieve their goals. Second, by addressing housing needs. Third, by linking participants to accessible health, mental health and other support services needed to sustain their wellbeing in the community. Fourth by building participants capacity to access services and to advocate for themselves. As a frontline practitioner identified the service impacts on participants lives by improving their capacities to:

> function and achieve the things that they can do with our support, without our support. So, the things that they needed us to do, or they needed us to help them to achieve at the start, being

> able to do that without our input or our support, or our assistance. I always consider that to be an outcome, because we've helped support and advocate for them and then now, they can actually support and advocate for themselves and they don't need that.

The increased stability involved linking participants to affordable housing and practical affordable and accessible supports to sustain their health and housing in the community.

6.2.3 From vulnerability to housed and healthy

Home and Healthy aims to build connections between participants and the formal and informal systems of support needed to achieve health, safety, and wellbeing in the community. Respondents identified that many of the participants were extremely vulnerable and excluded at the initial point of contact with the program. Practitioners identified that it was essential for them to work alongside participants, at their own pace, to achieve housing stability and to improve health outcomes. A frontline practitioner offered the following example:

> He [the participant] was homeless, in his car. He told me he was shooting meth in between his toes while he was talking to me and we've just – I'd helped him do a little bit of housing here and there, but he's sort of stopped drugs, started doing community sport. He lived in temporary accommodation for a long time successfully and then has recently been housed.

Practitioners emphasised that in addition to achieving improved housing and health service access, the impact of the program on participants' quality of life is important. When discussing the outcomes, they were seeking, a respondent stated:

> For me it's someone telling me that they feel happier, safer, healthier, empowered. I never like – I get thanks a lot, but I don't want thanks. I'm doing this, you know – I say I'm just your cheerleader, you just needed someone to help cheerlead you through these processes and just to ride those speedbumps and roadblocks and yeah, keep pushing.

Team leaders and frontline practitioners emphasised that a strength of the program was the partnerships between them and participants to achieve sustainable health and housing outcomes.

6.3 Partnership and integration among service agencies

Respondents identified that the agencies delivering Home and Healthy had a positive relationship that enabled them to collaborate in supporting participants and managing challenging situations. A team leader identified that while each Home and Healthy provider served different participants,

> I think we deal with very similar challenges. I think we work together as best as possible to help each other through some of those challenges, so if we have particular complex participants in

> one area that we may seek advice from our partner organisations on how we might best deal or support that participant, if we keep I guess coming up empty with strategies or suggestions.

Respondents identified that the three service agencies collaborated in a range of ways including referring participants to the Home and Healthy program provider that best suited each individual participants' needs and by working together to address participants' needs.

Each of the Home and Healthy provider agencies is a well-established health care provider with recognised knowledge and skills in recovery-oriented mental health care in the community. Home and Healthy program providers can leverage their relationships across the sector to work collaboratively with the broader health, human services and public housing system to achieve outcomes for participants. For example, a team leader identified that they hold weekly meeting involving key housing agencies, including the Department of Housing, as well as Queensland Police Service and Probation and Parole. These meetings are:

> really focused on people rough sleeping right now and who can house them. That's been really successful at getting placements, yeah, with Department of Housing. So it's really great, but I can also raise people from the team to go rough sleeping, to the other orgs, have you seen them? The police can go yeah, we street checked them on this day, or they've come into hub, they've asked for support or whatever it might be.

As this excerpt indicates Home and Healthy providers were able to draw upon their relationships with government and non-government housing providers to improve participants' access to housing, but shortfalls in affordable housing supply continue to create challenges in achieving the program goals

6.4 Challenges

Respondents identified a range of challenges in implementing the Home and Healthy approach. The key barriers were systemic barriers related to the availability of suitable housing, gaps in health and disability services, and the timelines of Home and Healthy.

6.4.1 The housing crisis

The lack of suitable housing creates a major significant barrier to achieving a core goal of housing stability. As a respondent identified:

> The program does a really good job of being able to definitely help people achieve where they want to be, it's just for some people that end goal of that housing is a place where we're getting to the halt and that's – obviously it's because we're in a housing crisis. If we looked at this program a couple of years ago, we mightn't be in the same situation and may have been able to get those good housing outcomes a lot sooner. So yeah, that's probably the thing that's holding us back a little bit, yeah, being able to progress with some people.

Respondents emphasised that while housing is a critical component of achieving stability and independence for participants, Home and Healthy is not primarily a housing service. Home and Healthy focuses on working alongside participants to achieve community- based responses to health and housing needs and that the crisis in housing supply was a barrier to achieving sustainable change with participants.

6.4.2 Barriers in the service system

The limited availability of mental health specialists and other health care services was also identified as a significant barrier to achieving participants' goals. As a respondent reflected on their experience of working alongside a participant with complex health and disability concerns:

> Then we kind of hit a stone wall where we get no progress at all, because we're in this waiting period where we can't get in to see a therapist to get an assessment. We can't get that evidence to submit before the NDIS, or then we eventually get it and it's wrong because it's got two or three things on it that are incorrect, then we're back to the drawing board again with waiting to put it back before the [NDIA] again.

Long waiting lists to see mental health specialists has both immediate effects on participants opportunities to receive service and also to complete the assessments required to access other services such as NDIS services. There are a number of issues in relation to the appropriateness of the NDIS as support for people with a SPMI and risks of homelessness. As noted by practitioner there are continued difficulties in relation to eligibility:

> a big emerging challenge that I know I'm seeing, because I do a lot of NDIS applications, or we all do, but they're starting to reject more and more applications that are primary impairment, psychosocial… there's that plan to kind of move people away from NDIS and so we're starting to see applications that would've got through last year no problem at all, get knocked back. But there's no other services in place to direct the applicants to, so this is starting to become a big challenge and I foresee it really becoming massive and I can see the program probably having to change into the future to address that.

In addition, there are also issues in relation to the nature of the support:

> if they go to NDIS it's just such a thin market, you know, there's no reason a support coordinator will work with our participants and get paid the same to work with someone a whole lot less complex, so we can get them on to NDIS, but the support they receive there isn't going to be great and outside NDIS there's not really anywhere that we can refer them on to.

The lack of referral pathways including community mental health support and appropriate support through the NDIS are important challenges for the Home and Healthy program but for the health and wellbeing of participants.

6.4.3 Home and Healthy timelines

The time constraints of the Home and Healthy program were also experienced a barrier to achieving participants' goals. The range of challenges in the participants' lives fits uneasily with program logic expectations around time limits. As one practitioner stated "everything takes longer" because of the challenges in the participants' lives. As another practitioner elaborated:

> I think it's not as linear as the program sets it out to be. We technically do have these time constraints of being nine to 12 months we're meant to work with people. I've been working with someone, or a couple of people, for two years and that's appropriate. It's not because we've been slacking off, it's that's the length of time they've needed, if not more.

Further, the participants' circumstances can contribute to difficulties in accessing community- based health services and this can impact the effectiveness Home and Healthy in achieving participants' goals. Workers reported that participants may disengage for a period due a range of factors from their phone being disconnected through to deterioration of their mental health condition so that "all of a sudden you can't get in touch with them, so then everything comes to a standstill in terms of them progressing." In the context of program timelines, the impact of disengagement or a missed appointment can have a disproportionate impact on the Home and Healthy service delivery. As a practitioner noted: "Then they [the participant] miss the appointment and it's three months 'til the next psychiatrist appointment, so already that's, I mean that's half the program."

6.5 Summary

This chapter reported on the perspectives of ten team leaders and frontline practitioners delivering the Home and Healthy program across three agencies. Respondents identified that a key purpose of Home and Healthy is to build capacity in the sector to respond to people experiencing chronic mental health and housing needs. One way this is achieved is through robust partnerships between Home and Healthy agencies and other health, housing and human services agencies. Respondents identified that Home and Healthy providers collaborated to refer participants to the most appropriate provider, to review complex case matters, and to build networks across the health, housing, and human services system to better respond to participant needs. Respondents' insights addressed **Evaluation Purpose 1** of how the partnership between Micah Projects, YFS, and IUIH provide an integrated psychosocial support model focused on support and system navigation for people with co-occurring mental illness and homelessness risk. Our findings also address **Evaluation Purpose 2** concerning evidence of how the partnership and program model can effectively navigate across systems such as housing, health care, drug and alcohol, mental health and

homelessness and enterprise services. We identified that Home and Healthy led the development of networks across diverse health, housing and human service providers extending also to engaging police and probation and parole services in regular meetings to better understand, engage with, and respond to program participants.

Respondents described the program as providing holistic, relationship-based and participant-led responses with people experiencing challenges associated with homelessness and SPMI. Respondents identified that the key components of the Home and Healthy approach as working collaboratively with participants to achieve housing stability and quality of life in the community. These findings confirm prior research highlighting the value of relationship-based practice for creating sustainable change with people experiencing homelessness and SPMI (Brackertz et al., 2020; Parsell et al., 2015). Respondents' insights into Home and Healthy approach addresses **Evaluation Purpose 3** concerning the fundamentals of psychosocial support for individuals to manage their recovery plan, treatment support and tenancy obligations is essential for preventing homelessness.

Respondents identified that despite the strengths of the program in engaging participants, significant structural barriers exist to achieving program and participant goals of achieving stable housing and wellbeing in the community. Consistent with prior research risk (Brackertz et al., 2018; Jones et al, 2014), the lack of affordable and suitable housing was identified as a major barrier to achieving housing stability. This barrier contributed to challenges in achieving other goals such as engaging with community based mental health and general health services. Practitioners also highlighted how the critical undersupply of community-based mental health and general health services (Productivity Commission, 2023) impacted service participants capacity to both engage with Home and Healthy and with formal supports in their community. For example, the limited availability of mental health personnel in the public and community sector results in significant delays in access to formal assessments needed to access NDIS. Participants circumstances associated with poverty and unstable housing also impacted their ability to engage the bureaucratic processes involved in accessing mental health, health, and disability services. These findings support for the call by the Parliament Mental Health Select Committee (2022) for the expansion of community-based psychosocial services to meet the needs of people living with SPMI. These insights address **Evaluation Purpose 4** regarding understanding how the service system navigation role enhances support and workforce development of BSPHN CPSP commissioned providers and the broader human services workforce and their ability to support people with co-occurring mental illness and homelessness risk. The findings also demonstrate the limitations of service navigation in the context of under-resourcing of community-based mental health services and of the need for increased accessibility and availability of mental and general health services for people experiencing SPMI and homelessness.

Respondents identified that the inclusion of a rapid response option within the model was important to timely intervention and the prevention of hospitalisation. Respondents noted that Home and Healthy is not a crisis program and further that waiting lists exist for the program. Maintaining an option for rapid response enabled the program providers respond to individuals in "short, sharp kind of intervention" to prevent the escalation of the crisis. Further, while respondents were generally satisfied that the combination of the rapid response

and the structured program of support prevent hospitalisation, in some instances escalation to tertiary treatment was unavoidable. Yet even in those instances, the relationship-based approach of Home and Healthy enabled workers to partner with participants during hospitalisation with the goal of a more rapid and sustained return to their community. Respondents' insights on this matter contributed to **Evaluation Purpose 5** of understanding how rapid response support contributes to strengthening the system, averting and/or addressing immediate mental health crises and decreasing possible hospital presentations.

7. Case file Review

This chapter outlines the findings from the case file review of Home and Healthy participants. The findings outlined below are seeking to address points 2, 3 and 5 of the evaluation purpose provided by BSPHN.

1 Present findings of how the **partnership between Micah Projects, YFS, and IUIH provide an integrated psychosocial support model** focused on support and system navigation for people with co-occurring mental illness and homelessness risk

2 Demonstrate how the partnership and **program model can effectively navigate across systems** such as housing, health care, drug and alcohol, mental health and homelessness and social enterprise

3 Learn how the **fundamentals of psychosocial support** for individuals to manage their recovery plan, treatment support and tenancy obligations is essential for preventing homelessness

4 Understand how the **service system navigation role is capable of enhancing support and workforce** of BSPHN CPSP commissioned providers and their ability to support people with co-occurring mental illness and homelessness risk

5 Understand how **rapid response** support contributes to strengthening the system, **averting and/or addressing immediate mental health crises** and decreasing possible hospital presentations

7.1 Overview of the case files reviewed

The total of 26 case files reviewed included 14 women, 10 men, and two others. Their ages ranged from 22 years to 69 years with most participants in their twenties and thirties. Within this sample, four identified as Aboriginal and/or Torres Strait Islander peoples. There was limited information on 11 participants as their cases were closed after a short period. They appeared to be appropriate referrals as the participants experienced SPMI, chronic illness, substance misuse, backgrounds of trauma, and homelessness including sleeping rough, sleeping in cars, or facing eviction. In nine of the cases, practitioners were unable to contact the program participants; four of these attempts to contact were rapid responses. The rapid responses were linked to participant needs including participants referred for suicidal thoughts (from a psychologist), a woman heavily pregnant sleeping rough, and a woman with severe mental health issues. One person had died prior to contact and one person was hospitalised. In a number of cases, despite not being able to

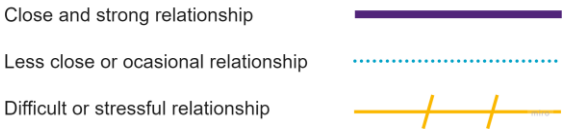
contact the participant, the Home and Healthy practitioner undertook significant work advocating for extension to eviction notices, seeking accommodation, securing a bond loan, liaising with domestic violence services, liaising with Child Safety, setting up visits by after-hours nursing, and organising online mental health support. These responses reflected the needs of the program participants as presented on referral. In another case the problems with a neighbour had been resolved. The referral came from the Department of Housing. A further case, referred by a GP, was closed promptly as information was given to the participant of what was needed for a DSP application. Whilst the participant had serious health issues it was unclear if there was a housing issue or risk of homeless and what the referral issue was.

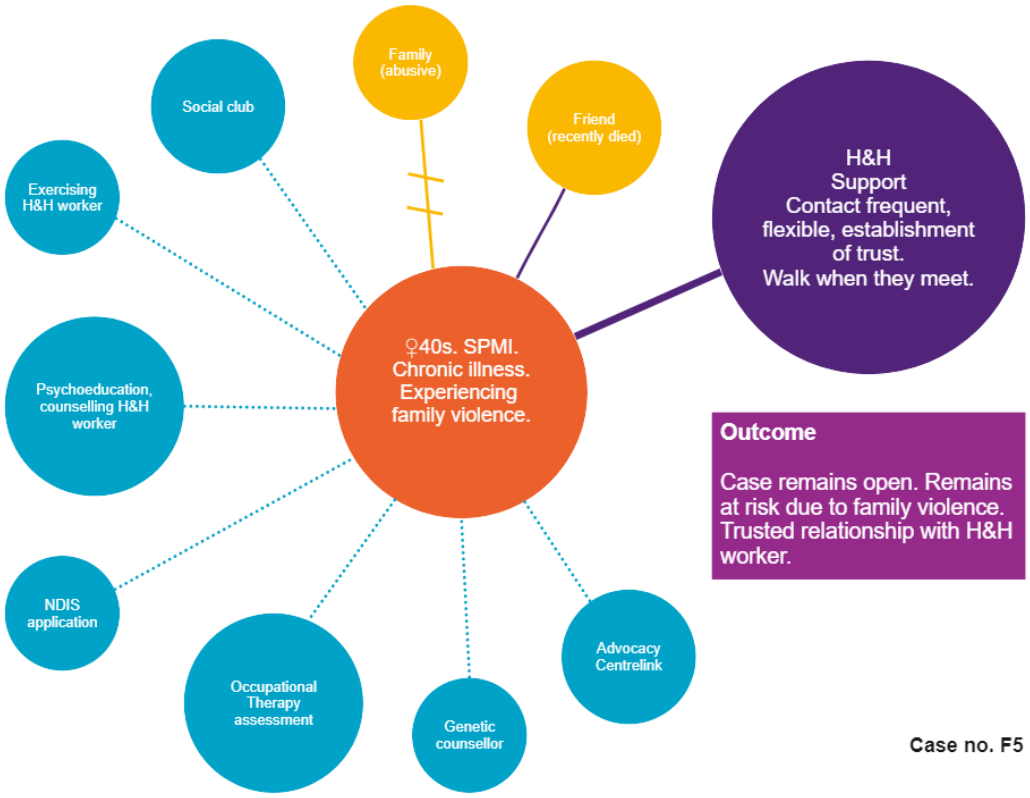
Four other cases were closed after a short period as it appears the referral may not have been appropriate, or the issue had been resolved. In one case the participant stated they did not require assistance as they were housed and accessing mental health support. This case was referred by a GP. Two participants, referred by the Department of Housing, stated they did not have a housing issue and did not wish to undertake mental health support; or the neighbourhood issue had settled down. A fourth participant was referred for a NDIS plan whereas the participant already had a NDIS plan. This referral was from a health provider. The remainder of the cases, 11 participants, were intensively supported by Home and Healthy. These are analysed in more detail in the section below.

7.2 Mapping the support provided to participants of Home and Healthy

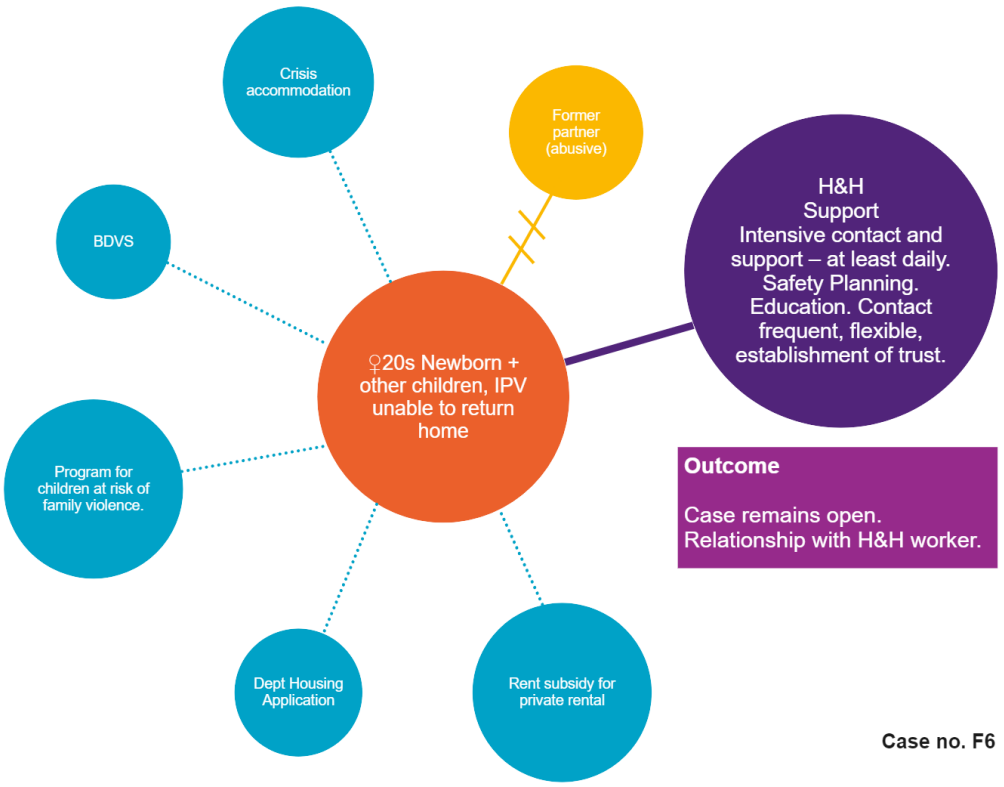
Eleven of the case files reviewed documented intensive and multi-faceted support provided by Home and Healthy. The figures below represent an ecomap of each of the 11 participants. The ecomaps provide an understanding of the service navigation and psychosocial support provided by Home and Healthy. The yellow circles surrounding the participant (the middle circle) represent existing relationships including family and formal services. The blue circles represent the services organised by Home and Healthy and include the approach of the Home and Healthy practitioner in the purple circle. The pink box includes the outcomes as detailed on the case file.

Key:



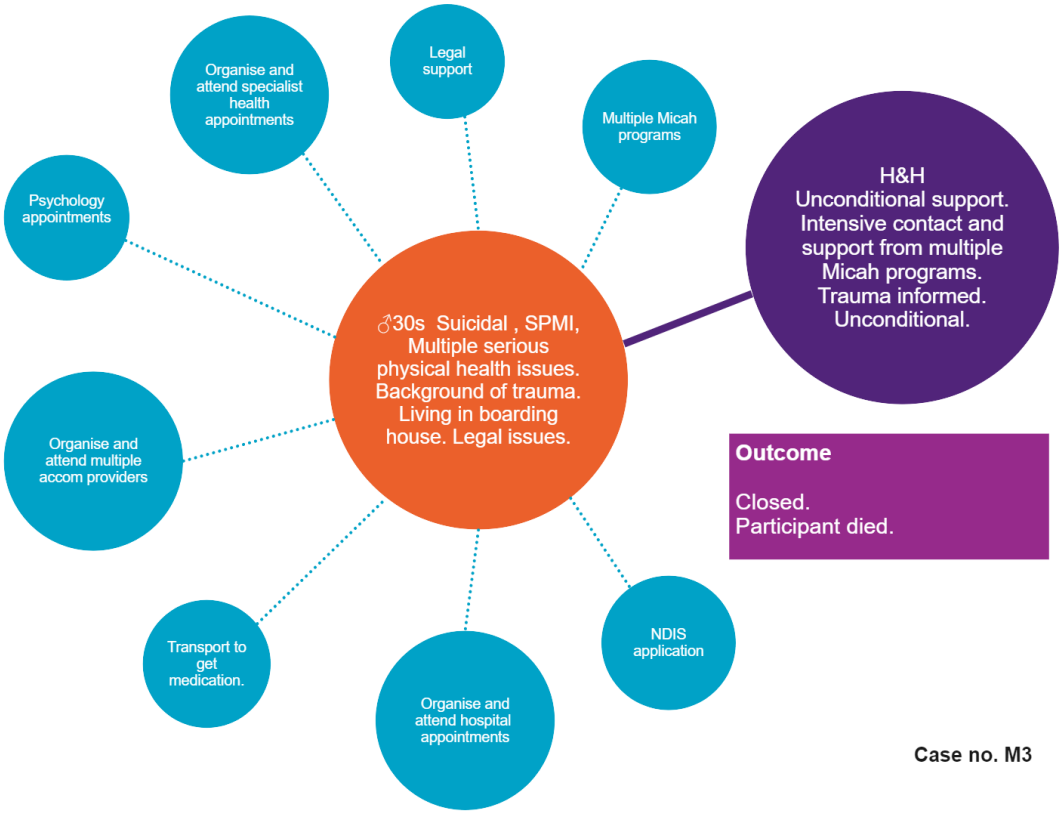


Case no. F5

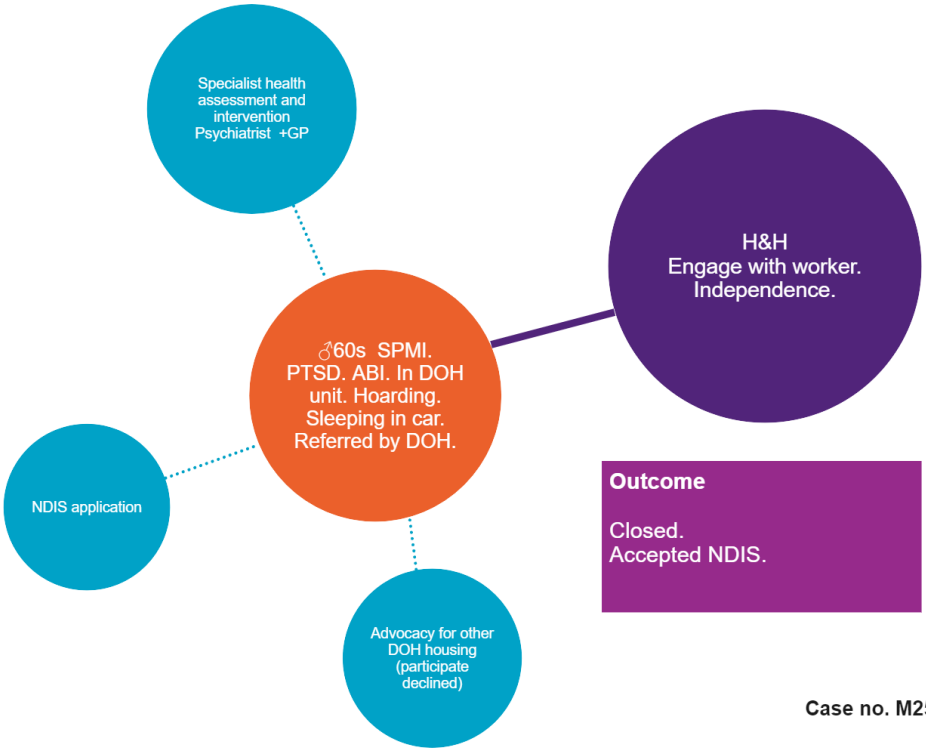


Case no. F6

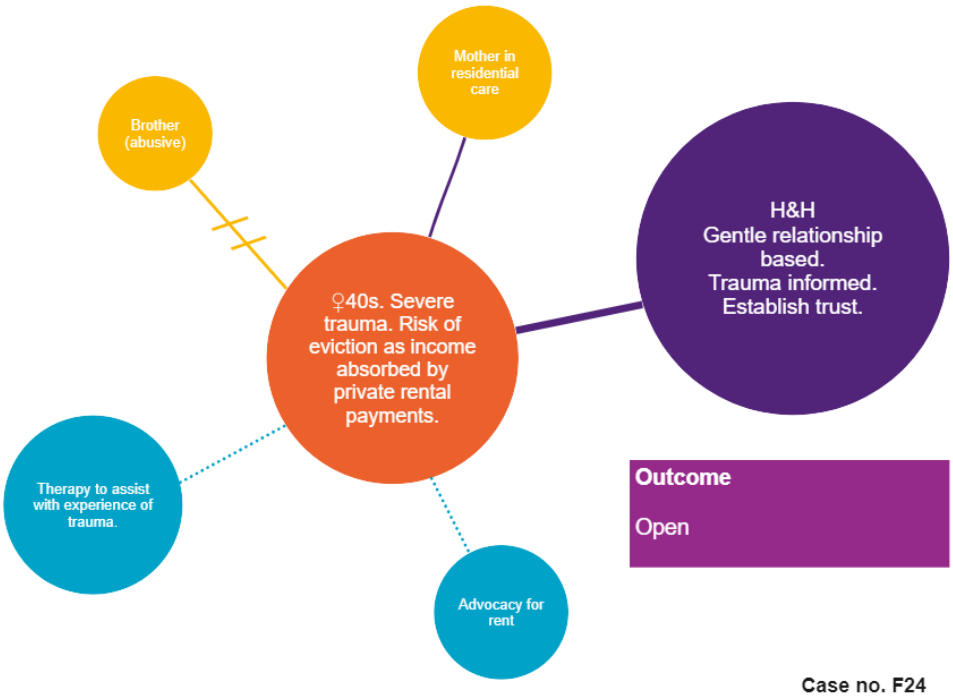
Case no. F2



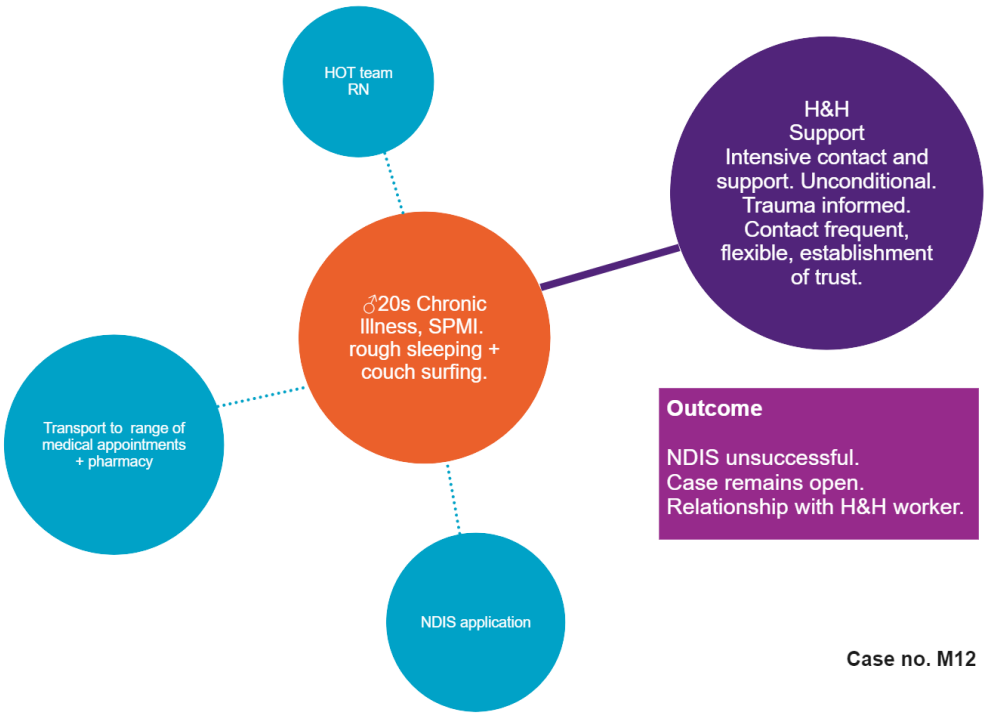
Case no. M3



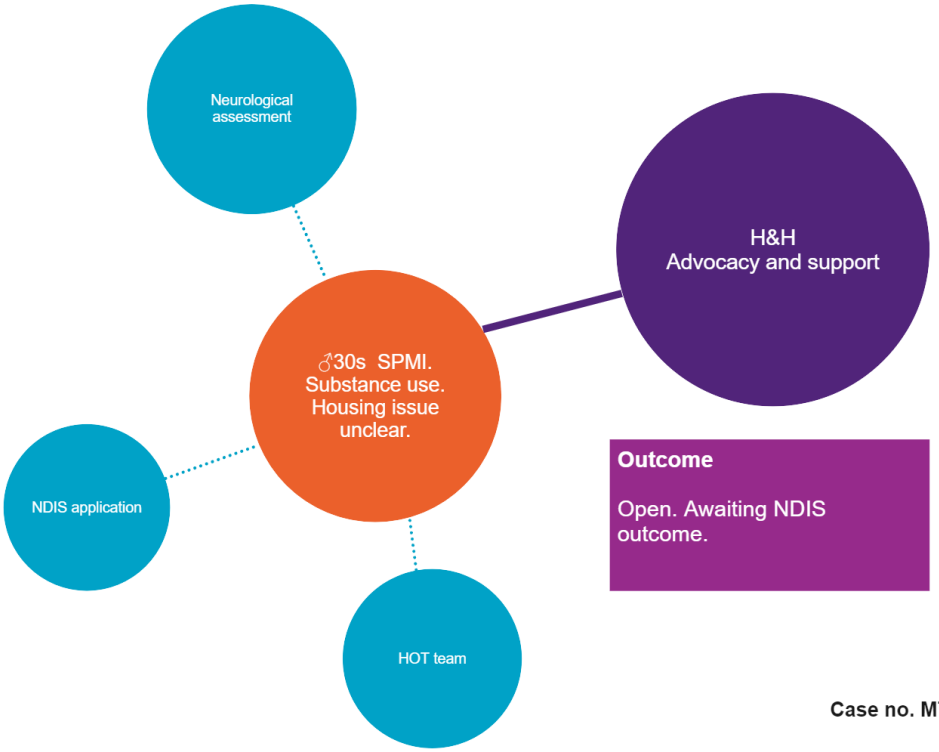
Case no. M25



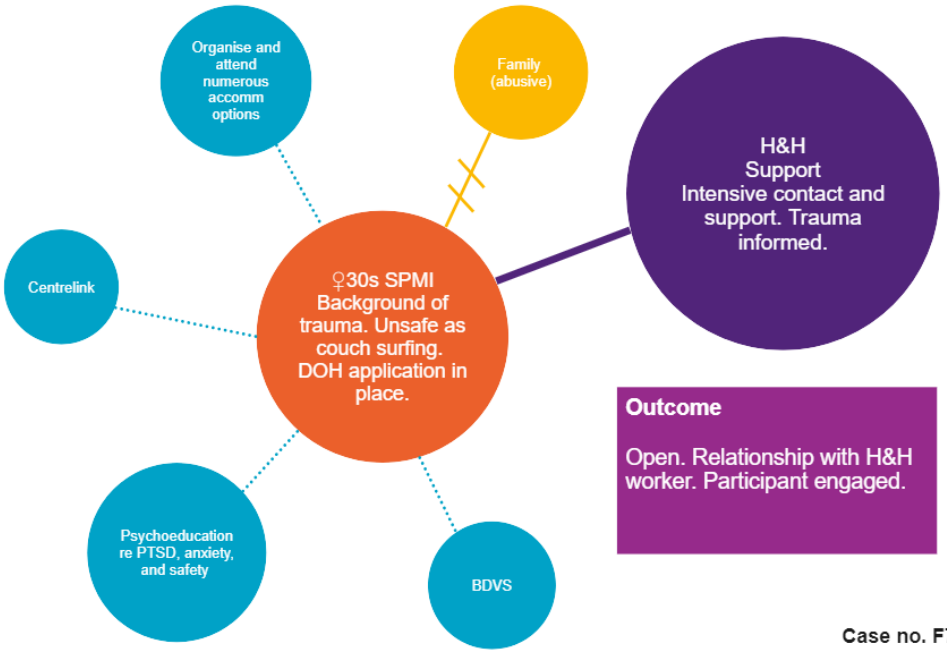
Case no. F24



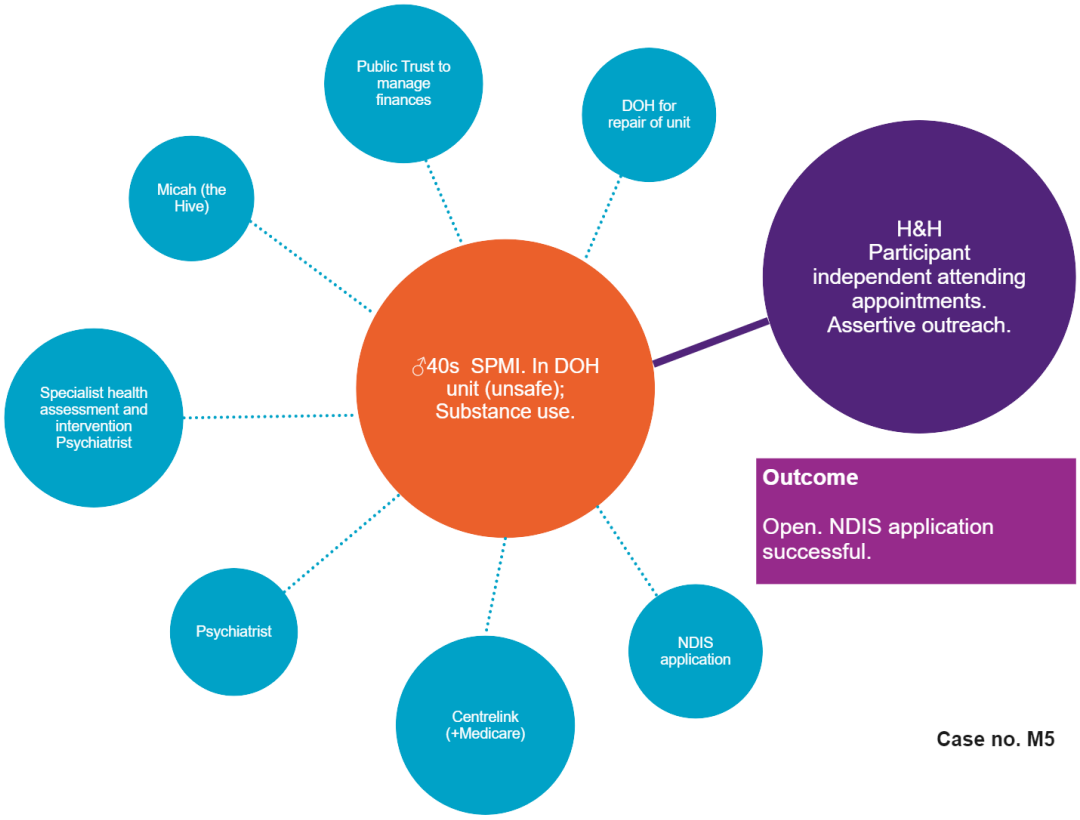
Case no. M12



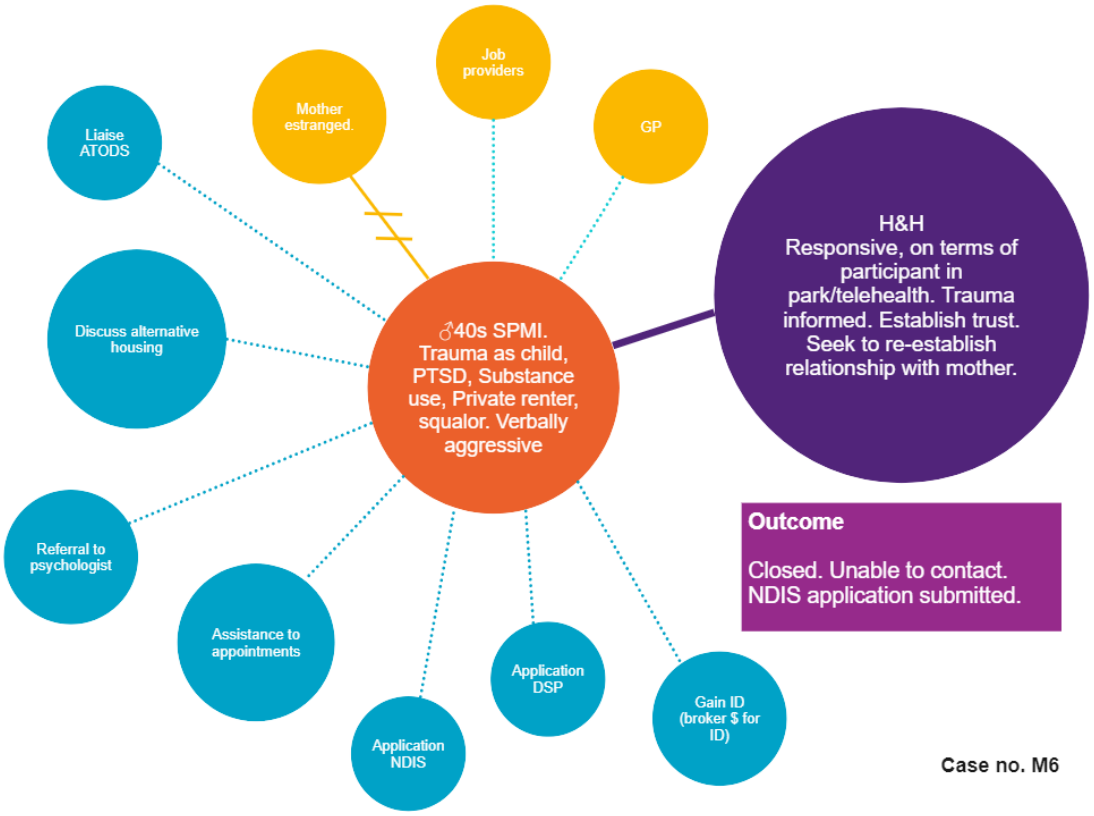
Case no. M7



Case no. F7



Case no. M5



7.2.1 Analysis of Ecomaps

The ecomaps of participants in the Home and Healthy program provide an understanding of the deep disadvantage and adversity the participants have experienced throughout their lives and at the time of referral to the program. Most participants live with SPMI and homelessness or risk of homelessness. A small number of referrals did not appear to meet the eligibility criteria (participants had existing NDIS plan, information on payments was sought) but this seems to be a lack of understanding by the referrer. The complex needs of the participants in Home and Healthy program evident in the case files included poverty, trauma as children, recent and ongoing intimate partner violence, recent and ongoing family violence, recent and continuing threat of assault (including sexual assault) in temporary accommodation, chronic medical conditions, and living with disability (Padgett et al., 2016). A number of participants were very vulnerable with an ever-present risk of violence and trauma during the time their file was open.

This group of people living with homelessness (or risk of homelessness), SPMI and other complex needs are not well supported by mainstream services (Brackertz et al., 2020, Padgett et al., 2016). Without support, the fragmented health and welfare services within the greater Brisbane area would force this group of people to navigate elaborate service systems on their own. Alongside homelessness and managing the symptoms of their mental illness the participants face chronic illness and substance use as well as barriers of health

literacy, managing forms including eligibility criteria, communication challenges, lack of transportation, and poor coordination between agencies. As such it is overwhelmingly to manage the navigation of the many systems (often interconnected) and many people give up (Rae & Rees 2015, Teggart et al., 2023). Many people with SPMI have past negative experiences with the service sector and require support to engage with services (Pearson et al., 2012, Stambe et al., 2023). Further, many people experiencing deep disadvantage do not have family or friends to assist them navigate care and support (Gabrielian et al., 2018). It is evident from the ecomaps detailed above, participants have few relationships with family and friends. In most cases the links with family and friends were characterised by a history of abuse and trauma, and for some ongoing abuse. This vulnerability of this group and their higher rate of mortality (Corrigan et al., 2014) is evident with the premature death of two participants in the file case review.

The ecomaps of a sample of Home and Healthy participants provide an understanding of how practitioners seek to address the housing and health needs of participants alongside eliminating potential barriers such as a lack of identification papers, and in receipt of inappropriate social security payments. Importantly the practitioners link participants with health care including specialists, counselling and therapy services, and drug and alcohol services. A strength of the program is the role it plays in keeping in touch with participants (sometimes daily) and transporting people to ensure they attend medical appointments and receive their medication is a timely way. This assertive outreach, going to participants in their homes or seeking them out if sleeping rough to transport the participants assists with the ongoing management of participant's health. Further, it is evident the practice of the practitioners is trauma informed with the practitioner working at the pace of the participant. In a couple of cases the gentle approach of the practitioners and establishing a trusting relationship in the first place ensured appropriate health care could be organised for very vulnerable people. The skills of the practitioners in managing verbally abusive behaviour of some participants, alongside the program's ethos to continue working with people who are angry and abusive is in contrast to many human service organisations who 'ban' angry clients. This feature of the program is a strength as it facilitates participants being able to continually receive health treatment. The structural issues in Australia's mental health system is well documented with people with severe mental health issues unable to receive appropriate and timely care (Brackertz et al., 2018) The ability to link participants with psychiatric health care, specialist assessment and treatment, and counselling to assist with the effects of trauma is a strength of the Home and Healthy program.

Alongside health care it is evident a core focus of the practitioners is addressing the participants housing needs. Both safe, secure, appropriate, and affordable housing alongside psychosocial support is critical in supporting recovery (Isaacs et al., 2019, Parsell et al., 2015). However, the complex lives of the participants is set within larger structural constraints in particular the difficulty of securing affordable housing.

Reviewing the case files of a sample of Home and Healthy participants it was evident that some participants were at risk of homelessness whilst others were homeless. For participants that are housed albeit at risk of eviction, practitioners provide advocacy and support to maintain the tenancy. Advocacy and coordinated efforts by practitioners to work with the housing sector, both private and public housing, to sustain tenancy

for people with SPMI was effectively carried out by Home and Healthy. Advocacy to sustain the tenancy of at risk clients is considered an effective intervention (Bruce et al., 2012, Pearson et al., 2007). Practitioners work to prevent eviction by early intervention was also assisted by practitioners accessing brokerage for rental payments and repairs to the participant's housing. A large number of these referrals came from social housing providers highlighting they do not provide welfare services. These referrals largely related to tenants who were at risk of eviction due to squalor, hoarding, or were subject to abuse from others. The role of the practitioners assisting people living homeless, on the streets or in unsafe boarding houses, is subject to the structural issue of a lack of affordable appropriate housing. The housing crisis with low social housing stock, unaffordable private rentals, and unsafe boarding houses makes it virtually impossible for practitioners to source housing for participants. The lack of housing in turn hampers the provision of health, legal, income security, and psychosocial services for participants (Brackertz et al., 2018). It is evident from the case file review practitioners spend considerable effort trying to source permanent (through Department of Housing) or temporary accommodation for participants. Many of the participants remain homeless after many months in the Home and Healthy program due in large part to these structural issues. The Home and Healthy program and the practitioners will continue to be constrained in supporting people into housing whilst housing stocks are inadequate and unaffordable.

An outcome sought by Home and Healthy for many participants is to be supported by NDIS. Access to long term support through the NDIS if one of the primary service objectives of the Home and Healthy program. Of those participants that engage well with Home and Healthy many exit with inclusion in the NDIS. The practitioners spend considerable time and effort organising and gaining evidence including from psychiatrists, occupational therapy, and neurological services to support the participants application for NDIS support.

7.3 Summary

In summary, the Home and Healthy program provides a holistic view of the participant in contrast to a fragmented service system which is funded to address one presenting issue (Padgett et al., 2016). Given the complexity of needs of the participants Home and Healthy's collaboration across agencies and service navigation is evident, thereby addressing **Evaluation Purpose 2, regarding service navigation**. Indeed, as noted by Issacs et al (2019) collaboration is a necessity to assist people living with homelessness and complex need.

It is apparent from the ecomaps of participants that the program integrated securing housing and healthcare with a range of other psychosocial domains to assist people. Inclusive to healthcare is supporting participants to manage drug and alcohol addictions, and counselling for participants (and their children) for experiences of trauma. In addition to the intensive support relating the housing and health, other services organised for participants included appropriate income support, legal support, organisation of administration of money by the Public Trustee, ensuring safety including intervention and support from domestic violence

services, linking with social groups, and for some reconnecting with family. To assist people who secured housing brokerage for furniture was also undertaken; an important intervention to assist people building a home. It was also evident from the ecomaps that psychosocial services were individual and tailored to the participant's circumstances and goals.

The complex nature of recovery for people living with SPMI is an important consideration in relation to psychosocial support. With the attainment of housing, it is not realistic to expect people living with SPMI to have a reduction in mental health symptoms (Kerman et al., 2019). Many participants in this case file review not only live with SPMI but substance use, chronic medical conditions, experiences of past and current trauma, and few or no informal support networks. The expectation that the program work with people for nine months (in some cases longer) does not permit the evaluation team being able to gauge from case records whether participants can manage their recovery plan. Supporting progress towards recovery may not be realistic or may take many years (with multiple episodes of ill health) for people with longstanding mental illness. Recovery frequently includes achievements and setbacks. However, this evaluation has evidence that **psychosocial support, Evaluation Purpose 3,** is provided to participants to assist them manage their daily life, and as set out in the section above on system navigation connects people with health and community services to assist their wellbeing. In one case support was provided to reconnect a participant with family.

A key strength of the program is the centrality of relationship-based practice with practitioners creating meaningful and effective relationships with participants. It is evident the practitioners establish rapport and trust with participants, considered imperative for engaging with vulnerable program participants (Keenan et al., 2021). Further the practitioners are reliable and responsive to participant's needs (Parsell et al., 2015). Practitioners undertake persistent outreach and regular phone contact with participants many of whom are very difficult to contact. There is a recognition that people with SPMI and past negative experiences with the service sector require assistance to engage with services (Pearson et al., 2012, Stambe et al., 2023). At times assertive outreach is required. Respectful and trauma informed communication is also evident and appreciated by participants. There are examples in the case files of gentle and patient communication with severely traumatised participants. Practitioner's also present as being skilled in working with verbally abusive participants providing unconditional support alongside assertive outreach.

The amount of information relating to **rapid response, Evaluation Purpose 5**, was limited in the case files included in this evaluation. This was largely due to Home and Healthy being unable to make contact with the participant. Some participants in the case files were discharged from hospital into homelessness with a referral to Home and Healthy. Practitioners worked to advocate to stop an eviction, liaised with boarding houses to find alternative accommodation, and linked participants with online mental health support. For one participant hospitalisation was appropriate given her pregnancy was near term. It was clear from the case files that Home and Healthy practitioners enacted a rapid response to referrals where the vulnerability and complex needs of the participants were apparent.

8. Conclusion

I went through a really down time in my life, and [Home and Healthy] supported me through that and helped me keep my head above the water, just. Without [Home and Healthy practitioner], I wouldn't have come halfway as I have just having the support there… putting me onto the services that they've put me on to and helping me with Housing, and stuff. It's been absolutely brilliant

(Participant 1)

We [normally] don't get listened to. That's the difference, [Home and Healthy] will always listen to what we've got to say and try to understand what we're trying to say.

(Participant 14)

8.1 Key findings

This evaluation drew on a range of data including a literature review, consultations to gain the perspectives of stakeholders including participants, practitioners, team leaders, as well as a sample of participant case records for the evaluation. Across the dataset, our analysis found that:

1. **People with severe and persistent mental illness and experiencing a risk of homelessness were well supported by the practice model of Home and Healthy.** The three agencies, Micah, YFS, and IUIH, partner constructively, sharing information and working in the best interests of participants. The practice model of Home and Healthy reflects best practice in relation to service navigation and psychosocial support. The data demonstrates the program provided timely, tailored support drawing on a range of health and support services which resulted in improved health wellbeing for participants. The respectful responsive manner of workers was appreciated by participants and in contrast to previous interaction they had with the welfare and health sector. The relationship-based practice framework of the practitioners is a strength of Home and Healthy.

2. Culturally appropriate support is important in promoting recovery. **A strength of the Home and Healthy program is the option for Aboriginal and or Torres Strait participants to connect with IUIH.** The provision of culturally appropriate services supported cultural identity for participants.

3. It is important the complex nature of recovery for people with serious and persistent mental illness is acknowledged. For example, personal recovery for some participants will be, at best, increased stability in their home rather than an absence of mental health and related symptoms. **By recognising participants' agency and working in non-judgemental ways, Home and**

Healthy was found to be responsive to the complex and dynamic needs of participants, and their unique recovery journeys.

4. The objective of the program to reduce hospitalisation lacks an appreciation of the serious mental and physical health issues most participants live with. The mortality rate for this group of people is very high and **hospitalisation can be evidence of timely and appropriate care**.

5. **Housing options for participants are very limited**. The limited supply of social housing, affordable private rental housing, and safe temporary accommodation in the greater Brisbane area seriously compromises the health and wellbeing of participants. Many participants remain homeless during their time with Home and Healthy. It is not realistic in the current housing context for Home and Healthy to be able to secure permanent safe and affordable housing for participants.

6. The prime service objective to support participants to access long term support through the NDIS program is questioned given the shortage of support packages for people with psychosocial disabilities within that program. There are also questions about the appropriateness of NDIS in supporting people with complex support needs that will vary over time and will require the coordination of multiple health and welfare services. In addition, there is uncertainty about the capacity of the NDIS to provide a rapid response when people become seriously unwell. It is acknowledged that community mental health support in also under resourced in Queensland. Overall, **there is a paucity of long-term support services for people with severe and persistent mental illness.**

8.2 Recommendations

Reflecting on the above key findings from the Home and Healthy evaluation, five recommendations are presented. The recommendations are largely directed at the funding body and Government, rather than the agencies delivering the program:

1. Understanding how responding rapidly assists the health and wellbeing and possible hospitalisations for people with severe mental illness and homelessness risk is important. However, it is beyond the scope and budget of this evaluation. We recommend a separate study is undertaken if the consortium wish to understand the impact of rapid response support on the health of people and their use of health systems. **We recommend a longitudinal study is undertaken incorporating baseline data on participants health and health service use, that follows participant's engagement with the health system over time by matching data to ensure engagement with all health providers is included.** The rigor of the study would also be stronger with the inclusion of a larger number of interviews with participants and a larger case file review.

2. The sizes of the areas that practitioners service is large, particularly for IUIH. It is challenging for practitioners to respond in a timely manner given the distances travelled. However, the outreach model is viewed as a strength of the program and also allows greater accessibility for Aboriginal and/or Torres Strait Islander participants. As such, the geographical areas covered by the program should not be decreased. Instead, **resourcing to increase staff levels to enhance responsivity is recommended.**

3. The Home and Healthy program is designed to support participants for nine months. The interviews with participants and practitioners, as well as the case file review highlights that support is responsive to the participant's needs and does not fit a linear path to participants' independence from the program within nine months for many. The complexity of participants' health, homelessness risk, lack of informal support, alongside a myriad of complex needs will often require intensive support over the long term. The model of nine months is not realistic for both participants and practitioners. It is recommended consideration if given to **extending the support timeframe for the Home and Healthy program.**

4. We recommend a review of participant admission to the NDIS as a primary objective of the Home and Healthy program. Alongside the shortage of packages for people with psychosocial disabilities. there are serious concerns about the suitability of the NDIS program for people with complex needs who are likely to require coordination of multiple health and welfare services and a rapid health intervention multiple times during their life. **Government investment in long-term, case-management and supported housing is required**, particularly for those who are ineligible for NDIS.

5. We recommend **the supply of affordable appropriate housing be increased in Queensland**. The lack of affordable housing compromises the Home and Healthy program. A lack of supportive housing, appropriate for people with severe mental illness and other complex needs, does not permit personal recovery. Housing is the platform to enable mental health and wellbeing to be stabilised let alone improved connections with family, community engagement, and independence.

References

Baker, J., Travers, J.l., Buschman, P. and Merrill, J.A. (2018). Efficient Nurse Practitioner–Led Community-Based Service Model for Delivering Coordinated Care to Persons With Serious Mental Illness at Risk for Homelessness, *Journal of the American Psychiatric Nurses Association, 24*(2), pp. 101–108.

Benston, E. A. (2015). Housing Programs for Homeless Individuals with Mental Illness: Effects on Housing and Mental Health Outcomes. *Psychiatric Services, 66*(8), 806-816. https://doi.org/10.1176/appi.ps.201400294

Bitter, N. A., Roeg, D. P. K., van Nieuwenhuizen, C., & van Weeghel, J. (2020). Recovery in supported accommodations: A scoping review and synthesis of interventions for people with severe mental illness. *Community Mental Health Journal, 56*(6), 1053-1076. https://doi.org/10.1007/s10597-020-00561-3

Brackertz, N., Borrowman, L., Roggenbuck, C., Pollock, S., & Davis, E. (2020). *Trajectories: the interplay between mental health and housing pathways. Final Research Report.* Australian Housing and Urban Research Institute Limited. https://www.ahuri.edu.au/housing/trajectories

Brackertz, N., Wilkinson, A., & Davison, J. (2018). *Housing, homelessness and mental health. Towards systems change*. Australian Housing and Urban Research Institute Limited. https://www.mentalhealthcommission.gov.au/getmedia/e1395547-292e-4236-be86-eaff9a4f1e92/Housing-homelessness-and-mental-health-towards-systems-change

Braun, V., & Clarke, V. (2013). *Successful qualitative research: a practical guide for beginners*. Sage.

Bruce, J., McDermott, S., Ramia, I., Bullen, J., Fisher, K.R., ARTD Consultants. (2012). Evaluation of the Housing and Accomodation Suuport Initiative, Social Policy Research Centre, Sydney.

Carpenter-Song, J. (2012). “Right Here Is an Oasis”: How “Recovery Communities” Contribute to Recovery for People with Serious Mental Illnesses, *Psychiatric Rehabilitation Journal*, Vol. 35(6), pp. 435–440.

Clark, C., Guenther, C. C. & Mitchell, J.N. (2016) Case Management Models in Permanent Supported Housing Programs for People with Complex Behavioral Issues Who Are Homeless, *Journal of Dual Diagnosis*, *12*(2), pp. 185-192, DOI: 10.1080/15504263.2016.1176852

Commonwealth of Australia (2023). Working together to deliver the NDIS. Independent Review into the National Disability Insurance Scheme. Final Report. Retrieved from: https://www.ndisreview.gov.au/resources/reports/working-together-deliver-ndis

Compton, M.T.., Kelley, M.E., Pope, A., Smith, K., Broussard, B., Reed, T.A., DiPolito, J.A., Druss, B.G., Li, C., Haynes, N.L. (2016). Opening Doors to Recovery: Recidivism and Recovery Among Persons with Serious Mental Illnesses and Repeated Hospitalizations, *Psychiatric Services, 67*(2), pp. 169-175.

Compton, M.T., Reed, T., Broussard, B., Powell, I., Thomas, G.V., Moore, A., Cito, K., & Haynes, N. (2014). Development, Implementation, and Preliminary Evaluation of a Recovery-Based Curriculum for Community Navigation Specialists Working with Individuals with Serious Mental Illnesses and Repeated Hospitalizations, *Community Mental Health Journal*, *50*, pp. 383–387. DOI 10.1007/s10597-013-9598-2

Corrigan, P.W., Pickett, S., Batia, K., & Michaels, P.J. (2014). Peer navigators and integrated care to address ethnic health disparities of people with serious mental illness. *Social Work in Public Health, 29*, pp. 581–593. DOI: 10.1080/19371918.2014.893854

Corrigan, P.W., Pickett, S., Kraus, D., Burks, R. & Schmidt, A. (2015). Community-based participatory research examining the health care needs of African Americans who are homeless with mental illness. *Journal of Health Care for the Poor and Underserved, 26*, pp. 119–133.

Corrigan, P.W., Kraus, D.J., Pickett, S.A., Schmidt, A., Stellon, E., Hanlte, E. & Lorena, J. (2017). Using Peer Navigators to Address the Integrated Health Care Needs of Homeless African Americans with Serious Mental Illness, *Psychiatric Services*, *68*(3), pp. 264-270.

Dadich, A., Fisher, K.R. & Muir, K. (2013). How can non-clinical case management complement clinical support for people with chronic mental illness residing in the community? *Psychology, Health & Medicine*, *18*(4), pp. 482-489. DOI: 10.1080/13548506.2012.748207

Davies, A., & Wood, L. J. (2018). Homeless health care: meeting the challenges of providing primary care. *Medical Journal of Australia, 209*(5), 230-234. https://doi.org/10.5694/mja17.01264

Dunt, D.R., Benoy, A.W., Phillipou, A., Collister, L.L., Crowther, E.M., Freidin, J. & Castle, D.J. (2017). Evaluation of an integrated housing and recovery model for people with severe and persistent mental illnesses: the Doorway program, *Australian Health Review*, *41*, pp. 573–581. http://dx.doi.org/10.1071/AH16055

Dunt, D.R., Day, S.E., Collister, L., Fogerty, B., Frankish, R., Castle, D.J., Hoppner, C., Stafrace, S., Sherwood, S., Newton, J.R. & Redston, S. (2022). Evaluation of a Housing First programme for people from the public mental health sector with severe and persistent mental illnesses and precarious housing: Housing, health and service use outcomes. *Australian & New Zealand Journal of Psychiatry, 56*(3), pp. 281–291. Doi:10.1177/0004867421101702

Gabrielian, S., Young, A. S., Greenberg, J. M., & Bromley, E. (2018). Social Support and Housing Transitions Among Homeless Adults with Serious Mental Illness and Substance Use Disorders, *Psychiatric Rehabilitation Journal*, *41*(3), pp. 208–215.

Isaacs, A., Beauchamp, A., Sutton, K., and Kocaali, N. (2019). Care Coordination Can Reduce Unmet Needs of Persons with Severe and Persistent Mental Illness, *Frontiers in Psychiatry*, *10*, doi: 10.3389/fpsyt.2019.00563

Jones, A., Phillips, R., Parsell, C. and Dingle, G. (2014). *Review of systemic issues for social housing clients with complex needs*. Institute for Social Science Research, The University of Queensland, Brisbane, https://espace.library.uq.edu.au/view/UQ:346765.

Keenan, C., Miller, S., Hanratty, J., Piggot, T., Hamilton, J., Coughlan, C., Mackie, P., Fitzpatrick, S., & Cowman, J. (2021). Accommodation-based interventions for individuals experiencing, or at risk of experiencing, homelessness. *Campbell Systematic Reviews*, *17*(2), https://doi.org/10.1002/cl2.1165

Kerman, N. & Sylvestre, J. Aubry, T., Distasio, J. & Schutz, C.G. (2019). Predictors of Mental Health Recovery in Homeless Adults with Mental Illness, *Community Mental Health Journal*, *55*, pp. 631–640. https://doi.org/10.1007/s10597-018-0356-3

Kerman, N. & Sylvestre, J. (2020). Service use and recovery among currently and formerly homeless adults with mental illness, *International Journal of Social Psychiatry, 66*(4), pp. 389–396. DO:I/:/d1o0i.o.1rg1/1707.1/10707/20027067464002091133234 24

Meehan, T., Stedman, T., Robertson, S., Drake, S. & King, R. (2011). Does supported accommodation improve the clinical and social outcomes for people with severe psychiatric disability? The Project 300 experience, *Australian and New Zealand Journal of Psychiatry, 45*, pp. 586–592. DOI: 10.3109/00048674.2011.559634

Muir, K., Fisher, K.R., Abello, D., & Dadich, A. (2010), 'I didn't like just sittin' around all day': Facilitating social and community participation among people with mental illness and high levels of psychiatric disability. Journal of Social Policy, *39*, pp. 375-91. Doi:10.1017/S0047279410000073

Meyers, N.A., Alolayan, Y., Smith, K., Pope, S.A., Broussard, B., Haynes, N. & Compton, M.D. (2015). A Potential Role for Family Members in Mental Health Care Delivery: The Family Community Navigation Specialist. *Psychiatric Services, 66*(6), pp. 653-655.

Padgett, D. K., Tiderington, E., Tran Smith, B., Derejko, K.-S., & Henwood, B. F. (2016). Complex recovery: Understanding the lives of formerly homeless adults with complex needs. *Journal of Social Distress and Homelessness, 25*(2), pp. 60-70. https://doi.org/10.1080/10530789.2016.1173817

Parliamentary Mental Health Select Committee. (2022). 'Inquiry into the opportunities to improve mental health outcomes for Queenslanders'. Retrieved from: https://documents.parliament.qld.gov.au/tableoffice/tabledpapers/2022/5722T743-64F1.pdf

Parsell, C., Moutou, O., Lucio, E., & Parkinson, S. (2015). *Supported housing to address homelessness.* AHURI Final Report No.240. Melbourne: Australian Housing and Urban Research Institute. Available from: <http://www.ahuri.edu.au/publications/projects/21024

Pearson, D. (2020). Homelessness is solvable – How we can end it in Australia, Australian Alliance to End Homelessness, retrieved from: https://aaeh.org.au/assets/images/Full-Churchill-Report-Homelessness-is-Solvable-With-Appendices-Compressed_compressed.pdf

Pearson, C.L., Locke, G., McDonald, W.R., (2007). *The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness.* US Department of Housing and Urban Development Office of Policy Development and Research.

Pearson, D., Faulkner, D., Tually, S. and Goodwin-Smith, I. (2021). *Ending homelessness in the inner city through service coordination: feasibility study: Final report*, The Australian Alliance for Social Enterprise: University of South Australia.

Productivity Commission. (2023). *Report on Government Services, Part E Section 13 Services for Mental Health*. https://www.pc.gov.au/ongoing/report-on-government-services/2023/health/services-for-mental-health

Queensland Alliance for Mental Health (QAMH), Arafmi, Mental Health Lived Experience Peak Queensland (MHLEPQ) (2023), 2024-2025 Queensland Budget Submission. Retrieved from: https://www.qamh.org.au/wp-content/uploads/2024-2025-Queensland-Budget-QAMH-Arafmi-MHLEPQ-Submission.pdf

Queensland Health. (2022). *Submission: Inquiry into the Opportunities to Improve the Mental Health Outcomes for Queenslanders.* 150_Queensland Health.pdf (parliament.qld.gov.au)

Queensland Mental Health Commission. (2017). Submission: The provision of services under the NDIS for people with a psychosocial disability related to a mental health condition
Joint Standing Committee on the National Disability Insurance Scheme. Retrieved from: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme/MentalHealth/Report

Rae, B., & Rees S., (2015) The perceptions of homeless people regarding their healthcare needs and experiences of receiving healthcare, *Journal of Advanced Nursing,* 71, 9, 2096-107.

Richter, D., & Hoffman, H. (2017). Independent housing and support for people with severe mental illness: systematic review. *Acta Psychiatrica Scandinavica*, *136*, 269-279.

Reed, T.A., Broussard, B., Moore, A., Smith, K. J., & Compton, M. T. (2014). Community Navigation to Reduce Institutional Recidivism and Promote Recovery: Initial Evaluation of Opening Doors to Recovery in Southeast Georgia, *Psychiatric Quarterly, 85*, 25–33.

Singh, S., Fitzpatrick, S., Lakshminarayanan, M., Saran, A., Wood, J., Yang, T., & White, H. (2023). PROTOCOL: An evidence and gap map of studies of implementation issues for interventions for those affected by and at risk of homelessness in high-income countries. *Campbell Systematic Reviews, 19*, e1305. https://doi.org/10.1002/cl2.1305

Smelson, D.A., Perez, C.K., Farquhar, I., Byrne, T., & Colegrove A. (2018). Permanent Supportive Housing and Specialized Co-Occurring Disorders Wraparound Services for Homeless Individuals, *Journal of Dual Diagnosis*, *14*(4), pp. 247-256, DOI: 10.1080/15504263.2018.1506195

Smelson, D.A., Zaykowski, H., Guevermont, N., Siegfriedt, J., Sawh, L., Modzelewski, D., Tsemberis, S., & Kane, V. (2016). Integrating Permanent Supportive Housing and Co-Occurring Disorders Treatment for Individuals Who Are Homeless, *Journal of Dual Diagnosis*, *12* (2), pp. 193-201, DOI: 10.1080/15504263.2016.1174010

Stambe, R., Kuskoff, E., Parsell, C., Plage, S., Ablaza, C., & Perales, F. (2023). Seeing, Sharing and Supporting: Assertive Outreach as a Partial Solution to Rough Sleeping, *British Journal of Social Work*, 00, pp. 1–18. https://doi.org/10.1093/bjsw/bcad251

Stregiopolous, V. (2014). 'Collaborative Approaches to Community-Based Mental Health Care for Homeless People: Toronto's Inner City Health Associates'. In M. Guirguis-Younger, R. McNeil, & S. W. Hwang (Eds.), *Homelessness and health in Canada*, University of Ottawa Press.

Teggart, K., Neil-Sztramko, S E., Nadarajah A., Wang A., Moore C., Carter N., Adams J., Jain K., Petrie P., Alshaikhahmed A., Yegendranag, S., Gannan R. (2023) Effectiveness of system navigation programs linking primary care with community based health and social services: a systematic review, *BMC Health Services Research*, 23, 450.

Toombs, E., Musquash, C.J., Toneguzzi, K., Bobinski, T., Frederick, T., Lund, J., Pitura, V.A., Vitopoulos, N. & Kidd, S. (2021). Adaption and Implementation of the Housing Outreach Program Collaborative (HOP-

C) North for Indigenous Youth, *American Journal of Orthopsychiatry, 91*(1), pp. 96–108. http://dx.doi.org/10.1037/ort0000520

Tually, S., Skinner, V., Faulkner, D. & Goodwin-Smith, I. (2018). Ending Street Homelessness in the inner city: Adelaide Zero Project, Don Dunstan Foundation. Retrieved from: https://www.dunstan.org.au/adelaide-zero-project/resources-azp/

Appendix 1 - Home and Healthy Referral Form Questions

Available from: [20230829-home-and-healthy-referral-form.docx (live.com)]

Participant Details

Name			
Address			
Referral Date		**Phone**	
Date of Birth		**Email**	
Gender	☐ Male ☐ Female ☐ Intersex ☐ Non-binary ☐ Other Click or tap here to enter text.		
Do you identify with any of the following?	☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ Neither Aboriginal nor Torres Strait Islander ☐ Not stated/unknown		
	☐ Culturally or Linguistically Diverse Country of Birth:		
	☐ Is an interpreter required? If yes, what language?		

Referrer Details

All details must be completed.

Source of Referral			
Name			
Organisation			
Relationship			
	Will relationship continue after referral? ☐ Yes ☐ No		
Phone		**Email**	
Is the person aware of the referral to the Home and Healthy Team	☐ Yes ☐ No		
Do they consent to being contacted by Home and Healthy Team?	☐ Yes ☐ No		

Eligibility

Are you aged 16+ and experience mental health symptoms that impact on your wellbeing and stop you doing things you want or need to do?	☐ Yes ☐ No
Are you homeless, or having problems with your current accommodation?	☐ Yes ☐ No
Have you received a Breach or Eviction Notice or is that likely?	☐ Yes ☐ No
Do you need support to connect with other services?	☐ Yes ☐ No

Support

Please complete for participants who receive support through the National Disability Insurance Scheme OR similar psychosocial supports through a state or territory program are not eligible for the Commonwealth Psychosocial Support Program

Do you currently receive support through the NDIS?	☐ Yes ☐ No
Have you applied for NDIS and/or are you awaiting a decision?	☐ Yes ☐ No
Do you receive other community-based mental health support?	☐ Yes ☐ No If yes, please give details:

Mental Health and Wellbeing

Have you ever been given a mental health diagnosis (even if you don't agree)?	☐ Yes ☐ No If yes, please give details:
Does someone currently support you to manage your mental health (ie GP, Psychiatrist)?	☐ Yes ☐ No If yes, please give details:
Do you have a case manager through Queensland Health's mental health service?	☐ Yes ☐ No If yes, please give details:

Support Needs

What assistance would you like from the *Home & Healthy Team*?

If yes, please give details:

Do you have a disability or physical health concerns? ☐ Yes ☐ No

If yes, please give details:

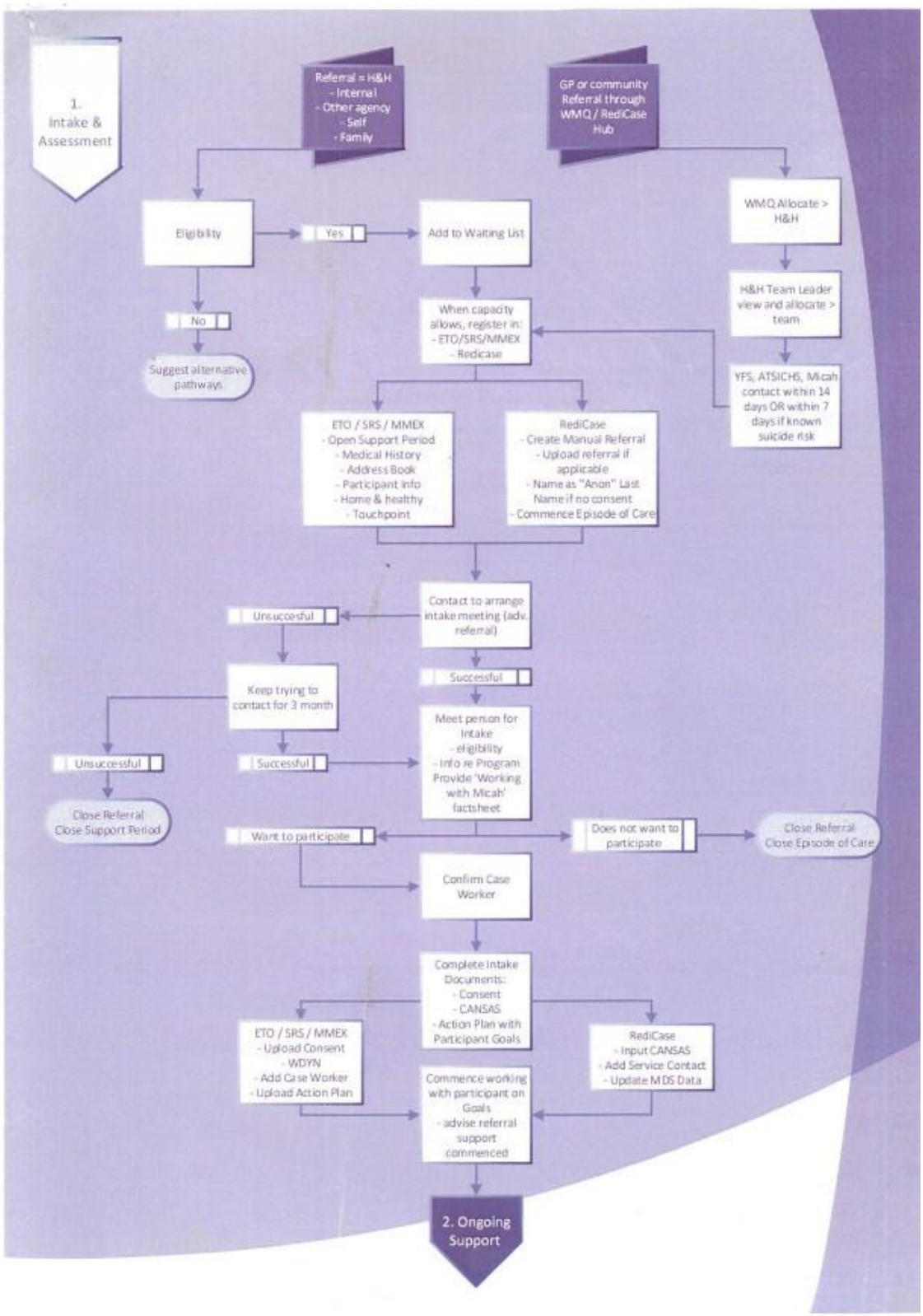
Are there any safety concerns or other issues we should be aware of?

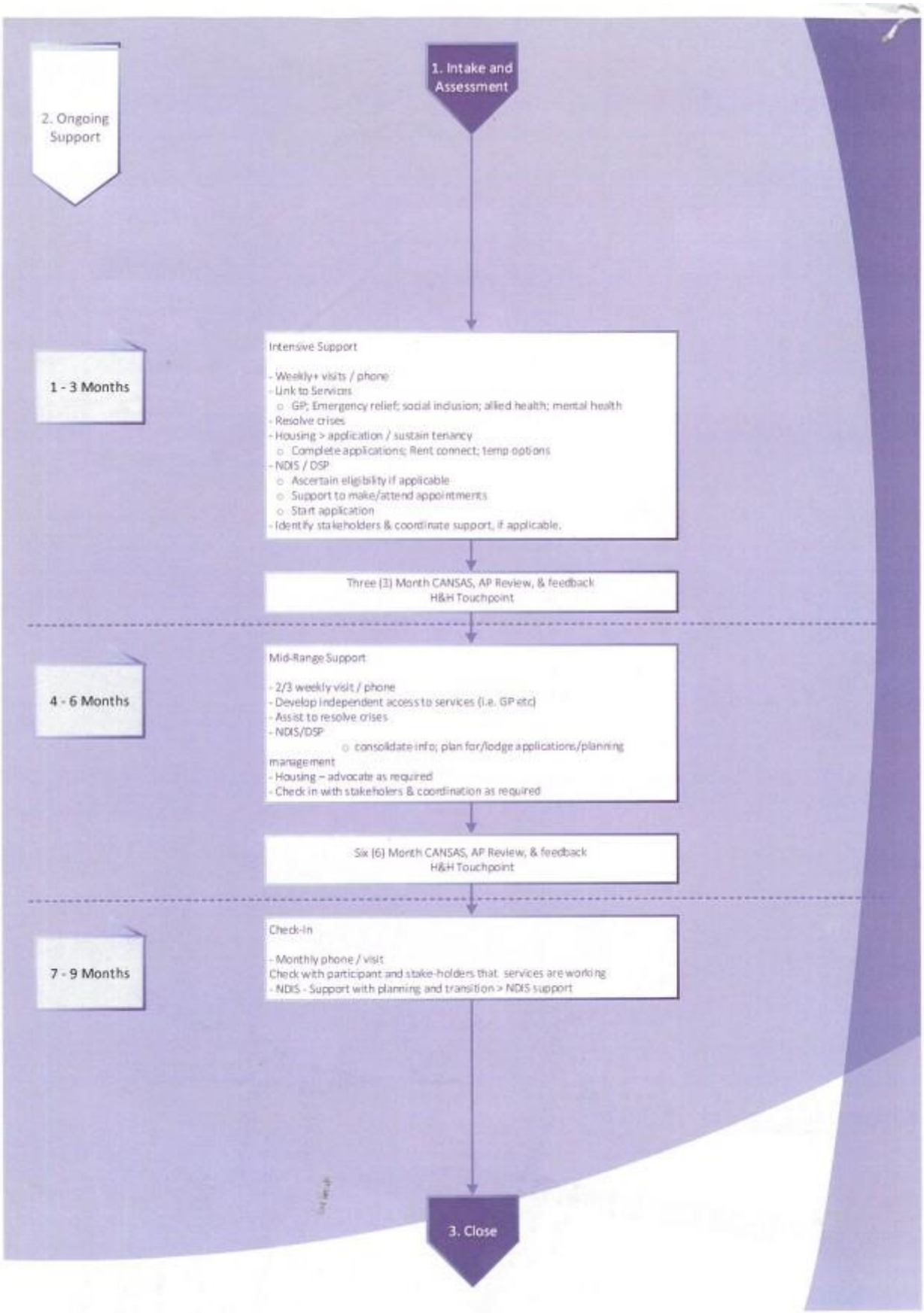
If yes, please give details:

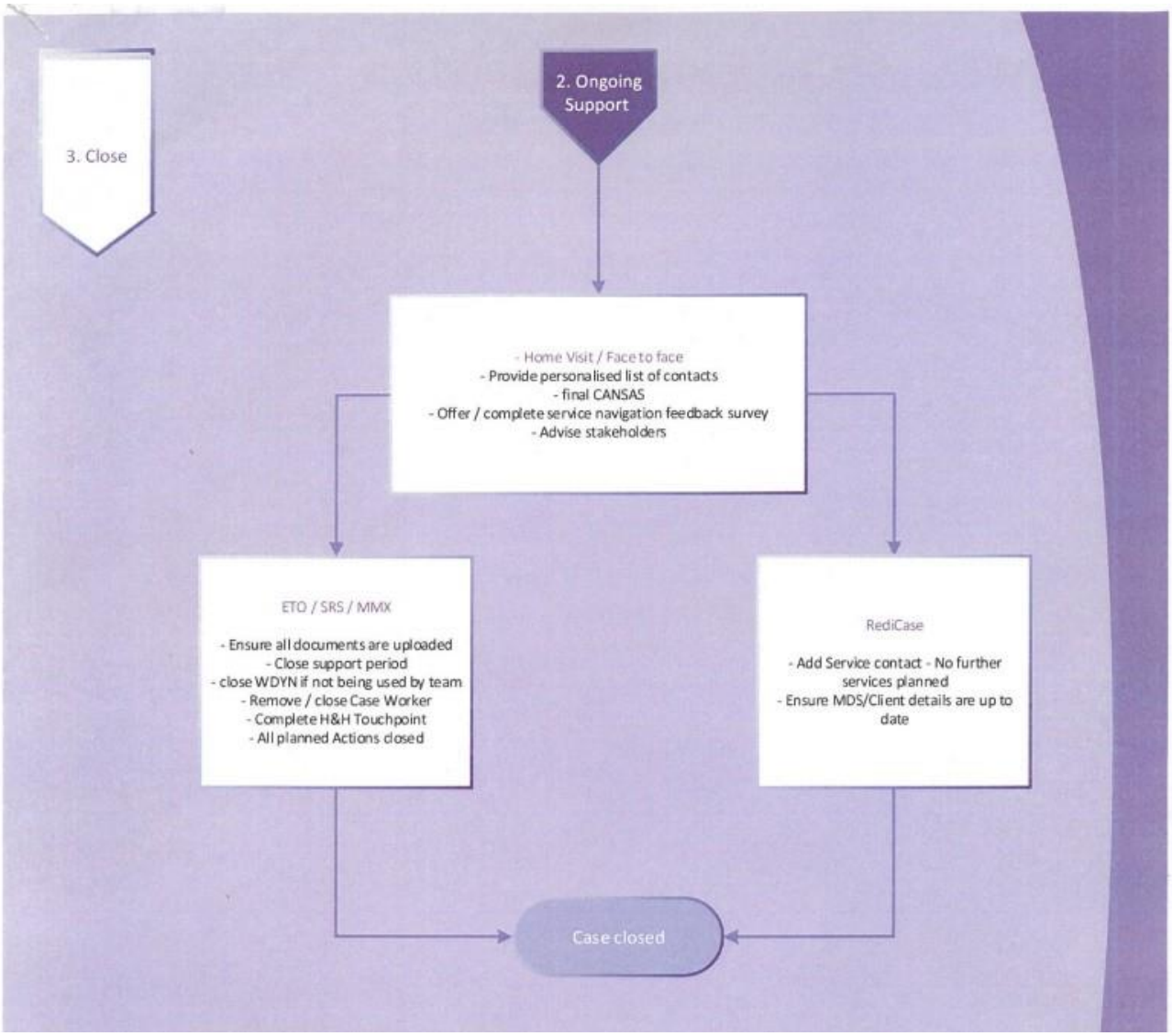
Is there any other information you would like to provide?

If yes, please give details:

Appendix 2 – Overview of Home and Healthy program from referral to case closure




1. Intake and Assessment
2. Ongoing Support
1 - 3 Months
Intensive Support
- Weekly+ visits / phone
- Link to Services
o GP; Emergency relief; social inclusion; allied health; mental health
- Resolve crises
- Housing > application / sustain tenancy
o Complete applications; Rent connect; temp options
- NDIS / DSP
o Ascertain eligibility if applicable
o Support to make/attend appointments
o Start application
- Identify stakeholders & coordinate support, if applicable.
Three (3) Month CANSAS, AP Review, & feedback
H&H Touchpoint
4 - 6 Months
Mid-Range Support
- 2/3 weekly visit / phone
- Develop independent access to services (i.e. GP etc)
- Assist to resolve crises
- NDIS/DSP
o consolidate info; plan for/lodge applications/planning management
- Housing – advocate as required
- Check in with stakeholers & coordination as required
Six (6) Month CANSAS, AP Review, & feedback
H&H Touchpoint
7 - 9 Months
Check-In
- Monthly phone / visit
Check with participant and stake-holders that services are working
- NDIS - Support with planning and transition > NDIS support
3. Close


3. Close
2. Ongoing Support
- Home Visit / Face to face
- Provide personalised list of contacts
- final CANSAS
- Offer / complete service navigation feedback survey
- Advise stakeholders
ETO / SRS / MMX
- Ensure all documents are uploaded
- Close support period
- close WDYN if not being used by team
- Remove / close Case Worker
- Complete H&H Touchpoint
- All planned Actions closed
RediCase
- Add Service contact - No further services planned
- Ensure MDS/Client details are up to date
Case closed

Appendix 3 - Literature review: Psychosocial support model comparison tables

Table 1: Community partnership collaborative outreach models

Authors	Program name	Participants	Program objectives	Program features	Measures	Results
Stergiopoulos, 2014	ICHA		ICHA aimed to set the stage for planned local system change through three broad approaches: (1) developing partnerships with local stakeholders, (2) collaborative planning and program development and (3) collaborative organizational program structures. Planning had a focus on addressing access to health care for homeless people and frontline social service providers	targeted placement of physicians in frontline homeless ser- vice settings and through the development of innovative collaborative models of service delivery in partnership with frontline health and social service providers. planned local system change through three broad approaches: (1) developing partnerships with local stakeholders, (2) collaborative planning and program development and (3) collaborative organizational program structures. ICHA identified two key domains upon which to focus initial change efforts: (1) community engagement and (2) care coordination/service integration. ICHA program planning began with extensive consultations with the City of Toronto's Shelter,	Description of programs developed through partnerships and collaborations over the past seven years.	The group served more than 1,700 people in 2010, providing approximately 5,700 hours of primary care and 8,700 hours of psychiatric care. ICHA physicians provide direct and indirect care, advise frontline staff on service and case management plans, and teach on selected topics in efforts to build community capacity. They also advocate to different service sectors to help coordinate care and ultimately connect homeless people to mainstream services and supports. ICHA physicians are recruited to provide recovery-oriented care from a harm reduction framework, focusing on the determinants of community health. They prioritize housing, income, and social support in their treatment plan. In addition to direct and indirect care to homeless people with complex health needs and development of community capacity, ICHA has identified student and resident education as a priority Programs developed through partnerships and collaborations over the past seven years: ***Shelter and Drop-in Based Collaborative Mental Health Care Teams*** Enable rapid evaluation and treatment of patients with a wide range of mental health problems, improve the ability of shelter and drop- in staff to manage them, improve the education of shelter staff and trainees on the needs of homeless persons and reduce reliance on emergency department visits and hospitalizations for unmet mental health needs.

				Support and Housing Administration Division, the Toronto Drop-In Network and several local health and social services planning groups to ensure homeless health care needs were addressed across geographical areas and service- and population-specific sectors. ICHa embarked on further extensive local needs assessments, including individual and focus group interviews of program planners, service providers and people with lived experience of homelessness, to identify perceived. strengths, weaknesses, and opportunities in each geographic area within the city, service priorities and needs of clients and service providers and directions for effective and inclusive planning and communication, including the principles upon which to base partnership development, planning and collaboration. Different models of frontline health care provision were devel- oped, depending on client needs and resources available at each service		Fusion of Care, developed at Seaton House, one of Canada's largest shelters for homeless men, is an integrated collaborative care model with on-site medical support and a flexible referral process. In this model, shelter staff and ICHA physicians work as a single team. Consultative rather than integrative collaborative care models have been developed in other settings not resourced to support integrated teams. For example, at Agincourt Community Services, a community centre serving homeless and under-housed people at the city's east end, a psychiatrist provides consultation services to the agency's housing and outreach programs, working closely with drop-in staff. Agency case managers frequently attend appointments to ensure care is seamless and coordinated. ***Multidisciplinary Outreach Team (MDOT)*** An inter-agency, multidisciplinary street outreach team—the first such team in Canada—was designed in 2007 to enable rapid evaluation and treatment of street homeless clients with a wide range of disorders, to improve the ability of street outreach staff to manage these disorders and to contribute towards ending street homelessness related to illness and disability by streamlining access to housing, entitlements and health care. MDOT consists of two part-time psychiatrists, one full-time nurse case manager, one full-time housing case manager, one full-time street outreach case manager and one part-time concurrent disorders specialist. Additional program partners include a community health centre that offers comprehensive primary care services and the provincially funded Ontario Disability Support Program that provides priority access to adjudication for income supports. MDOT follows a Housing First philosophy, developed to meet the housing and treatment needs of the chronically homeless population.

				site. Models ranging from integrative and consultative collaborative care models (Stergiopoulos, Rouleau and Yoder 2007; Tam 2010) to intensive case management and assertive community treatment team models (Stergiopoulos et al. 2010a) were developed to facilitate access to the different levels of care that homeless clients with complex health needs require. 65 physicians, including 32 psychiatrists, 29 family physicians and 4 other specialists, and provides medical and psychiatric care to more than 40 frontline homeless service agencies, including men, women, family and youth shelters, drop-ins, street outreach teams and select supportive housing agencies serving homeless persons with complex health needs.		***Coordinated Access to Care for the Homeless (***catch***)*** coordinated access to care for the homeless program (catch). The program offers a centralized referral process for community-based health services for home- less persons presenting to hospital who are not able to access other services. catch aims to improve access to medical care, psychiatric care, peer support and case management and facilitate appropriate discharge planning of homeless persons with complex health needs. An additional program goal is to relieve pressure from emergency departments and in-patient units by coordinating hospital-based care with community-based homeless clinical and social services. The program, in addition to streamlining access to primary and psychiatric care, offers access to nursing, personal, peer support and transitional case management in partnership with other agencies, including a large community mental health agency, a homeless shelter and a consumer-driven community centre. It also leverages partnerships to offer facilitated access to disability income support to hospitalized homeless persons and a discharge planning checklist as a guide to hospital-based discharge planners. The program improves service coordination and hospital com- munity integration and provides assertive outreach, transitional case management and linkage to the appropriate level of needed support. Program participants are supported in navigating the complex system of services and supports already available to them and are linked to additional needed services as soon as it is feasible. catch clinicians provide transitional supports over a period of four to six months in most cases. The project team includes four full-time staff: an ICHA administrative coordinator/agency liaison, who processes referrals to the team members, and three transitional case managers, who pro- vide outreach to three emergency department and in-patient units in downtown Toronto and the team physicians. The program enjoys the support of peer

						support workers, who accompany clients to appointments as needed.
Baker et al., 2017	SPC	212 clients who were persons With Serious Mental Illness at Risk for Homeless ness in New York	To address the needs of individuals suffering with chronic SMI and at risk for homelessness, incarceration, and unnecessary hospitalizations. As an independent community mental health center it was established on the belief that PMH NPs can deliver high-quality services in an efficient manner and provide a model for systemic change in caring for homeless and disenfranchised mentally ill people.	Nurse-practitioner led community service: full range of psychiatric services including: assessment and referral with intensive follow-up for comorbid illnesses related to chronic mental illness; individual, group, and family therapies; medication management; counselling and education; and crisis services. Community collaboration: The SPC also **w**orked closely with the larger mental health community. The New York City Department of Homeless Services assisted in identifying and contacting the shelters and drop-in centers who referred the SPC's first patients. The staff identified and systematically contacted every agency and community organization that served our target population, including Covenant House, a shelter	During a 2-year time period, the census data collected for 212 clients	All clients who were homeless or at risk for homelessness when they came to the SPC, obtained and remained in housing while they were followed. There were 0 incarcerations and 7 hospitalizations, yielding a hospitalization rate of 3% for these clients. To approximate the **cost savings** of the SPC, we reviewed records from a subgroup of 100 patients who used the Center's services for 6 months or more, represented an acute client profile based on symptoms, and had extant hospitalization histories. We documented 334 hospitalizations for these individuals, over a period of years, some with hospitalizations ranging from 1 to 30 hospitalizations. The estimated cost of a psychiatric hospitalization around this time was between $5,000 (Stensland, 2012) and $6,700 (Heslin, Elixhauser, & Steiner, 2015). Therefore, the SPC may have avoided at least $37,500 to $50,250 per year in hospitalization costs for this group of acute patients. *Community Collaboration* The contractual arrangements with Covenant House and Community Access endured for all 9 years of the SPC operations. At Covenant house, the SPC staff conducted 2,200 intake psychiatric assessments for adolescents aged 18 years and older, who were linked to community ser- vices by Covenant House staff. At Community Access, the SPC staff assisted an additional 1,500

				offering beds and services for runaway youth and Community Access, an organization managing transitional housing programs.		individuals to obtain or remain in housing through psychiatric evaluation clearances, referral for supportive housing, or by filing State Office of Mental Health housing applications.
Isaacs et al, 2019.	PIR	337	The PIR initiative of the Australian Government was set up to facilitate better coordination between clinical and other supports, to strengthen partnerships, to improve referral pathways, and to promote a community-based recovery model for persons with SPMI.	Care coordination involved working with persons with SPMI. The PIR model involved a regional lead organization that guided and supported implementing organizations. Each implementing organization had a team of care coordinators who worked with clients to develop a care plan based on their needs. Once a care plan was developed, the care coordinator (referred to as a support facilitator in the PIR program) brokered services from relevant agencies in accordance with the plan. The PIR initiative primarily aimed to reduce unmet needs of clients. Met and unmet needs were documented and monitored regularly during client-care coordinator meetings. Clients exited the program when they chose to or once most of their needs were met.	Data on clients who enrolled for the PIR initiative in Gippsland are stored by Gippsland PHN on an online purpose-built client information management system called Fixus (43). The Fixus database contains demographic data and scores from CANSAS. The CANSAS is the most commonly used instrument for needs assessment in mental health	In total, 337 clients (66% of 508 clients) had both baseline and follow-up data and were seen within the time frame of 14 to 101 weeks. At baseline, the most frequently reported unmet needs were psychological distress, daytime activity, and company (89%, 72%, and 67%, respectively). At follow-up, these had decreased to 27%, 22%, and 22%, respectively. The proportions of clients with an unmet need at baseline who subsequently progressed to having that need met at follow-up ranged between 62% and over 90%. Change in accommodation needs from unmet to met was associated with changes in monetary needs and needs related to childcare, food, safety to self, education, and access to other services, with the greatest change seen for monetary needs (adjusted OR 2.87, 95% CI 1.76, 4.69).

					services (44–46). For the PIR initiative, three additional social and health domains, namely, employment and volunteering, cultural and spiritual, and other services, were added to the original 22 domains (47). Support facilitators verbally obtained and documented client responses on the Fixus database. Aimed to ascertain whether a care coordination model adopted in Australia's Partners in Recovery [PIR]	

					initiative was able to reduce unmet needs in such persons and also if meeting accommodation needs were associated with meeting other needs. longitudinal study where met and unmet needs of clients measured using the Camberwell Assessment of Needs Short Appraisal Schedule (CANSAS) were compared at enrolment and exit from the PIR initiative. Logistic regression was used to examine the association between	

					change in accommodation needs and change in other CANSAS variables.	
Tually et al, 2018	Adelaide Zero Project	All homeless people in the Adelaide inner city	An initiative to end street homelessness in the Adelaide inner city area end of 2020, ensuring that all rough sleepers in the inner city who want a place to call home have one. The initiative aims to achieve this end by application of the Functional Zero approach, a model for ending homelessness developed by Community Solutions in the US (Community Solutions 2016, 2018).	a Collective Impact-informed initiative benefitting from the commitment and energy of 35 partner agencies from the public, private, community, philanthropic and university sectors. In line with the five core conditions of the Collective Impact[3] framework (Tamarack 2018; Kania and Kramer 2011), the Project has developed and is constantly working to ensure it has: a common agenda; shared measurement systems; mutually reinforcing activities; continuous communication between partner organisations (and beyond); and, a backbone support organisation to move the work forward. The Project is founded on five principles: Person-centred planning; housing first; no wrong door;	A progress update as at June 30 2018.	Aligned housing: Evaluation Framework in planning phase Business Alliance to end homelessness: Numerous governance groups established and operating including Strategic Advisory Group and Project Steering Group By-name list: Continued engagement with IGH, including 4 people from Adelaide Zero Project attending vanguard event in May 2018. Plans afoot to engage Community Solutions to assist with Implementation/Achieve phases of Project Charter: Plans to secure data officer/s to assist in trend analysis using By-Name List Identifying roles and engaging members to establish Strategic Data working group Common assessment tool: Three Solutions Labs planned to explore solutions for aligned housing, coordinated care and support for Indigenous mobility and homelessness Connections week:

				continuous improvement and collective action. It has been designed around four largely sequential phases of activity: establish; implement; sustain; expand. Implementation involved: Step 1: Assemble a committed group of people to lead the Adelaide Zero Project; Step 2: Know the name and needs of every person sleeping rough in the Adelaide inner city; Step 3: Rapidly assist the most vulnerable people sleeping rough with housing and support; Step 4: Consistently track progress towards achieving Functional Zero homelessness; Step 5: Continually improve responses for people sleeping rough in the inner city; Step 6: Achieve and sustain Functional Zero; and, Step 7: Expand the Adelaide Zero Project.		Preparation of data & website for Dashboard version 1.0 launched August Plans to engage Strategic Data Working Group to monitor & analyse ongoing Coordinated Care: Public and stakeholder Communications strategy and materials being finalised Brand guidelines and media policies being developed Further resources secured see Tually et al. (2018, p. 21)

Table 2: Community Navigation models

Authors	Program name	Participants	Program objectives	Program features	Measures	Results
Compton et al, 2016	ODR	72 enrolled participants with mental illness and a history of psychiatric recidivism	Reducing recidivism in terms of hospitalization, incarceration, and homeless-ness.	Five key components: 1: a mobile team of nontraditional community navigation specialists (CNSs) provides case management and recovery support. The team comprises a professional CNS, who is a licensed mental health professional (for example, a social worker); a peer CNS, who is a certified peer specialist; and a family CNS (4), who is a family member of someone with a serious mental illness with lived experience navigating the complex mental health system. CNSs are able to engage participants on a personal, nonclinical level; meet the participant in a home, community, or other nonclinical settings; share their own lived experience; and provide concrete assistance as part of navigation, for example, by transporting participants to ser- vices. The intensity of CNSs' involvement with a participant and his or her circles of support varies by need, but at least one CNS meets weekly with the	The number of hospitalisations, days hospitalised and arrests in the year before enrolment and during the first 12 months of enrolment in the program were compared. Longitudinal trajectories of recovery (using three self-report and five clinician-rated measures were examined.	Significant reduction in the number of hospitalisations and a substantial, clinically meaningful, and significant reduction in the number of days hospitalized during the year of community navigation compared with the previous year. No significant difference in the number of arrests. Recovery was apparent across the 12 months, indicating trajectories of improvement throughout the follow-up period and not just immediately following hospital dis- charge.

				participant during face- to-face visits. 2: the three CNSs provide community navigation, striving to become intimately embedded in the community through relationships with myriad service providers and community leaders and constantly “mapping” all local ser- vices and facilities that might be useful to a client’s recovery. In this way, CNSs serve as a catalyst for engaging, educating, and energizing the community to accept shared responsibility for supporting recovery. Community navigators assess participants’ strengths and needs, facilitate collaboration be- tween participants and care providers, identify supports in the community, and engage in service planning. Facilitating an understanding of available resources and how to access them empowers persons with disabilities, including mental disabilities (13). 3: CNSs continuously focus on four recovery domains: ensuring adequate treatment, finding safe housing, developing a meaningful day, and using technology to sup- port recovery. Fourth,		

				relationships with local partners underpin the ODR model. This “collaborative fusion” process engages diverse agencies and organizations that commit to support ODR, assist CNSs, and aid participants in their recovery. A meeting of these local partners takes place bi-monthly. Collaboration among these partners is not just necessary to initially implement ODR—it is part of the ODR model per se. 5: linkage between local police officers and CNSs that aims to prevent incarceration through prebooking jail diversion when ap- propriate. The linkage consists of four steps. First, upon enrolment, participants give special consent for including a very brief disclosure that they are in the ODR program in a registry in the state’s criminal justice information system. Second, if an officer conducts a routine background check during an encounter with a participant, the officer receives an automated electronic message identifying the person as part of ODR and is asked to call a toll-free number that connects to the local mental health system. Third, the call taker immediately contacts one of		

				the participant's CNSs (whoever is on call). Fourth, CNSs work with the officer on the phone or at the scene to resolve the situation without arrest when possible and appropriate.		
Corrigan et al, 2017	PNP	67	To examine the impact of a peer navigator model used with a group of people with serious mental illness who were homeless.	PNs used the skills of peer navigator manual in face-to-face meetings with ser- vice recipients in places and at times that were convenient to the recipient. Goals of the meetings were to review all health concerns and actions to address these concerns. Goals and actions could include activity related to alleviating home- lessness, improving diet, and reducing criminal justice involvement because each of these factors will influence health. PNs were expected to contact participants at least once a week. However, frequency was as high as five times a week, depending on participants' needs. Three PNs were fully trained on the program: a full-time PNP director and two halftime PNs. All three were African Americans who were homeless during their adult	African Americans with serious mental illness who were homeless were recruited for and randomly assigned to a one- year trial of the PNP compared with treatment as usual in November 2014 until completion in February 2016. Research participants completed measures of general medical illness, psychiatric disorder, recovery, and quality of life at baseline and again at four, eight, and 12	Both groups decreased the rate of homelessness significantly over the course of the study. Pairwise chi-square tests showed significantly less homelessness for the intervention group from baseline (N=26, 76%) to the eight-month assessment (N=9, 26%) and from baseline to the 12-month assessment (N=3, 9%) and for the control group from baseline (N=24, 73%) to the four-month (N=11, 33%), eight- month (N=3, 9%), and 12-month (N=5, 15%) assessments. All results of the 234 ANOVAs for total scores were significant, suggesting that those in the PNP showed significant improvements in health compared with the control condition across the year of assessment. Effect sizes for change in SF-36 and RAS were in the moderate range (.3–.5) and those for changes in TCU-HF and QLS were small but not trivial (.1–.3) (30). Results showed significant improvement in the self-report indices on the TCU-HF in physical and mental health for those in the PNP program compared with treatment as usual. PNP participants showed significant improvement on seven of the eight subscales of the SF-36. Health improvement corresponded to improved recovery and quality of life. Effect sizes of the omnibus analyses were small to moder- ate. Both groups improved their domicile and insurance coverage over the course of the study. This finding suggests that PNs had a positive impact on the

				life and in recovery from serious mental illness. The team shared responsibilities for all participants assigned to the PNP. Research assistants (RAs) shadowed PNs one on one for six hours quarterly to collect fidelity data. Fidelity data consisted of two parts. First, RAs documented the nature of interactions between PNs and service recipients (on the phone, in the office, at a health appointment, or on the streets). Second, during these interactions, RAs coded presence or absence of "skills to work with the person" (such as reflective listening or goal setting, which we expected to observe at each engagement regardless of task) and skills to work with a person's concerns (for example, interpersonal problem solving, relapse management, and harm reduction). Treatment as usual may have included services provided by the Together for Health system (T4H), a coordinated care entity funded by the Illinois Medicaid Authority to engage and manage care for individuals with multiple chronic illnesses. T4H was a network of more than 30 mental and other health care	months. We started with the Texas Christian University Health Form (TCU-HF) as a parsimonious measure of health status, including mental health (21). Research participants were asked the frequency with which they experienced in the past 30 days 14 general health problems (for example, stomach problems or ulcers, bone joint problems, and bladder infections) and ten mental health problems (such as tired for no good reason, nervous, hopeless, or depressed) on a 5-point Likert scale, with 5 indicating all the time. Items are averaged to yield a physical health and a mental health factor. Higher scores represent greater	health of program participants beyond results from improved housing and insurance.

				programs in Chicago to provide integrated care to people with serious mental illness.	experience of problems with health. Recovery was assessed with the five factors of the short form of the Recovery Assessment Scale (RAS) (26). Research participants completed 24 items (for example, “I’m hopeful about the future”), rated on a 5-point agreement scale, where 5 indicates strongly agree. Factors include personal confidence and hope, willingness to ask for help, goal orientation and success, reliance on others, and not being dominated by symptoms.	

Appendix 4 – Case file review data extraction template

Mapping Psychosocial Support: Home & Healthy Program
Data Collection Tool

Sources of data (Shelley or Danny need to give you access)

1. ETO Efforts to Outcomes
   Search with client name (randomly selected from list of current and past clients of H&H).
   As random this will include short term, long term, closed and current clients.
   Go to Tab
   Reports ⟹ Services and Activities (will give **case notes)**
2. Redicase
   Search with client name
   Click on details
   Go to Tab: Service Contacts ⟹ **CANSAS score** evident on RH side (usually collected every 3 months).

Research Questions informing mapping psychosocial support.

1. What is the nature of the psychosocial support? (include concepts of responsiveness, relationship based practice, feedback given by clients). If file closed why? (enrolled with NDIS, client not engaged with goals (?addiction. ?health issues, ?client moved)
2. What systems (including NDIS, Dept of Housing, Hospital/Medical, Alcohol and Drug Services, Centrelink, Counselling/Therapy services) are accessed for clients?

Code of client (Number, gender, age)	

Period supported:
Month/year case opened:
Month/year case closed:

Health and Wellbeing Profile include culture First Nations, Maori, African etc.
Presenting Issues

CANSAS Score

Date	Met needs Score	Unmet needs score

Summary of H&H contact
What did H&H do?
What for? Who with (identify so we know if other Micah team or external provider)

Consider identifying by psychosocial domains below (not all domains may be needed; short notes no need to extensive description; examples are not exhaustive).

Health and Wellbeing: eg link with health practitioners, assessing health needs, hospitalisations(number of inpatient stays) **.**

Legal: eg Murri Court, DV court, negotiate payment of fines

Housing: eg. list/advocate with Dept of Housing, Community Housing, crisis accommodation; advocate waive of rent arrears; Periods of homelessness

Counselling/Therapy: eg. referrals

Finances: eg Centrelink – advocate for appropriate benefit; broker monies

Formal Supports: eg HOT team, Nursing support for wounds/medication.

Informal supports/ Family: eg reconnect with family/friends; connections with wider community

Culture

Consider nature of contact: how responsive was H&H practitioner? nature of work by H&H practitioner? any client feedback? (if possible consider practice principles – relationship based practice, persistent outreach, harm minimisation, advocacy)

Outcomes: Enrolled in NDIS? Client moved? Client disengaged? Client remains open.

Appendix 5 - CANSAS literature review and references

The Camberwell Assessment of Need (CAN) was developed in 1995 by Professor Michael Phelan for routine clinical use to assess the needs of individuals with severe mental health concerns (Phelan et al., 1995., Slade et al., 1999; Trauer et al., 2007). It was later adapted into numerous forms including the Short Appraisal Schedule (CANSAS) in 1999 by Professor Mike Slade of Nottingham university and Professor Graham Thornicroft of Kings College London, all of which consists of 22 structured interview questions intended to explore 22 different domains: accommodation, food, looking after the home, self-care, daytime activities, physical health, psychotic symptoms, Information on condition and treatment, Psychological distress, safety to self, safety to others, alcohol, drugs, company, intimate relationships, sexual expression, dependents, basic education, digital communication, transport, money and benefits (Trauer et al., 2007).

Description

The CANSAS is generally utilised to understand the perceptive differences between service providers and recipients and to explore the relationship between quality of life and level of unmet needs (Trauer et al., 2007; Wiersma, 2006). It is also used to evaluate service provision and policies (Arvidsson, 2003).

CANSAS assessment can be a self-report (CANSAS -P) or a clinician's version (CANSAS -C) (Slade et al., 1999). In CANSAS-C, the interviewer elicits the patient for their opinions and documents them based on their understanding of the patient's needs (Trauer et al., 2007). There are numerous shortcomings regarding this method as it might involve the interviewer filtering the patient's viewpoint, thus affecting the authenticity of the assessment. Moreover, patients are likely to be unable to successfully answer questions based on all the domains (Trauer et al., 2007; Phelan et al., 1995).

CANSAS is scored using a Likert scale that ranges from 0, 1, 2, and 9 where 0 implies that the no need for concern, 1 implies that there the need is being met temporarily due to some extent of help being provided, 2 implies that the need is not being met and required extensive assistance to be provided for it to be fulfilled a point of 9 indicates that the need for that domain is not known (Slade et al., 1999; Phelan et al., 1995). The overall score of the needs is the sum of met and unmet needs (1 and 2). The scores of 0 and 9 are not considered to evaluate the needs. The higher an individual scores out of 22, the more need there is for an intervention as their needs are not being met. There is a general class of nonresponses on the CAN and CANSAS that can be considered as missed ratings or unrated needs; these include "don't know" responses as well as non-responses in which an item is left blank, which could mean that the respondent is unwilling to answer the question (Slade et al., 1999; Trauer et al., 2007). Answering "don't know" and giving no response are coded the same.

CANSAS-P was created to allow patients to rate their needs without the assistance of a staff member and to better understand what non-response signifies (Trauer et al., 2007). The response format has been modified

to include a fourth option, "I do not want to answer this question," in addition to the three standard choices as per the CANSAS.

CANSAS is acceptable across numerous geographical areas and cultures as the domains are applicable globally (Slade et al., 1999). CANSAS is also available in over 20 languages which makes it easier to adapt to numerous linguistic backgrounds. While there were no studies discovered which discussed any limitations based on age group, it is assumed that it can be administered to anyone experiencing an array of mental health condition. It is however argued that individuals experiencing severe cognitive disabilities and a lack of insight would be unable to successfully complete the CANSAS (Slade et al., 1999).

Literature Review

This literature review seeks to examine the development and evaluation of CANVAS along with the contexts in which it is most effectively used. Embase, PsychInfo, google scholar and PubMed were utilised to identify relevant literature between the years 1990 to 2023..

While there were thousands of articles which utilised CANVAS to understand the needs of patients living with serious mental health conditions, there were only 12 relevant articles which were found. Eight articles evaluated the efficiency of CANSAS as a tool and four studies utilised CANSAS to evaluate the needs of participants with numerous mental health concerns. Out of the studies, three were based in Australia, three studies were based in the UK, two studies each were based in Netherlands and Israel, and one each were based in Nigeria and Turkey respectively.

While reviewing the studies based in Australia, one was administered on patients that were admitted in an inpatient mental health facility (Andersen et al., 2000). The other two studies were administered on patients that were attending public mental health facilities or non-profit organisations that catered to mental health concerns (Kelly & Deane, 2009; Trauer et al., 2007).

The study by Kelly and Deane aimed to explore the forms of homework assignments utilised in a recovery-oriented case management method. It also investigates the connection between the types of assignments allocated and the CANSAS ratings of the clients' areas of need (Kelly & Deane, 2009). While this study did not evaluate CANSAS as a tool, it was able to demonstrate how the tool can be incorporated in a mental health setting to train the service providers in assessing the needs of their clients.

The study by Trauer et al., was conducted in 2007 in Australia, including a sample size of 180 participants from a non-profit organisation, which yielded several interesting findings. It is unclear if the study was administered in the community or in a clinical setting. The findings revealed that questions that explore the domains such as food, physical health, sexual expression, psychotic symptoms, and psychological distress were omitted by patients completing the CANSAS- C scales, presumably as they were classified as being invasive and did not wish to discuss (Trauer et al., 2007). They also discovered that when the CANSAS and

the CANSAS-P were compared, the same numbers of met and unmet needs were found in both forms, but the CANSAS-P generated more "I don't want to answer this question" responses than the CANSAS did "don't know" responses. This study also implies that the layout of the questionnaire can be confusing and may result in certain questions being incorrectly answered or omitted.

The third study was conducted in New South Wales, Australia. Three pairs of interviewers/ researchers, and observers evaluated the requirements of eighteen-day patients and fourteen inpatients at a psychiatric rehabilitation centre in the year 2000. This study aimed to evaluate the CANSAS tool as a reliable measure that can be successfully utilised across multiple disciplines (Andersen et al., 2000). The results concluded that there was strong consensus regarding the identification of a need. On the other hand, there was more agreement on patient ratings than staff ratings. There may be differences in how staff members rate the degree of need, as indicated by the moderate correlations on staff ratings of met needs. This contradicts the findings of Trauer et al (2007) who had previously concluded that the overall reliability of the tool was acceptable. This paper also recognises that the conceptual definition of need is imprecise, which negatively impacts the interrater reliability of the CANSAS. The definition must be appropriate for the assessment's goals and broadly applicable for comparison's sake. Thus, it is necessary to find a clear definition that also meets clinical requirements.

While evaluating the studies based in the UK, all the three studies collected their samples from community mental health centres, but do not specify whether the tool was administered in the community or in a clinical setting. The 1995 study by Phelan et al., and the 1999 study by Slade et al evaluated CANSAS as a tool intended to be utilised in a clinical setting (Phelan et al., 1995., Slade et al., 1999). They define CAN and CANSAS as thorough and somewhat quick needs assessment instruments that are simple to use and understand for a variety of staff members. Slade et al stated that CANSAS measures both met and unmet needs and considers the opinions of both staff and patients. The investigations certify that CAN and CANSAS as instruments with sufficient reliability when used in clinical settings.

The third study in the UK, conducted in 2013 by Reininghaus et al., did not evaluate CANSAS as a tool, but rather utilises it as a tool to evaluate the validity of needs assessments completed by patients and clinicians, as well as the therapeutic alliance in psychosis (Reininghaus et al., 2013). The study's conclusions suggested that the CANSAS be used in treatment evaluations where the needs assessed by patients and physicians are conceptualised as belonging to the same underlying notion. According to the study, if assessments of needs by doctors and patients comprise a negotiation process and joint decision making, biases to consistently score outcomes more positively or negatively may occur in clinical consultations with the use of CANSAS.

One of the two studies conducted in the Netherlands briefly explored the psychometric properties of the CANSAS which was deemed as acceptable (Fassaert et al., 2013). Further review into the matter within the study was not explored as the study primarily focused on the Dutch version of the Self Sufficiency Matrix

(SSM- D) as compared to the CANSAS. The second study evaluated CANSAS as a tool to present statistics on the prevalence, correlates, and implications for mental health care of individuals with severe mental illness and discuss conceptual and methodological challenges related to their needs for care (Wiersma, 2006). The study was able to able to successfully measure the met and unmet needs of the participants with acceptable reliability and validity. The studies were based on the reviews of service providers and existing patient records, and hence did not involve the administration of the tool to a sample patient population.

The study from Turkey evaluated the reliability and validity Turkish translation of CANSAS and Self-Rated Version for Individuals with Severe Mental Disorders (Tuncer, 2019). The sample comprised 111 patients with serious mental illnesses who were being treated at five different Izmir Community Mental Health Centres. Based on the findings, this study shows that CANSAS and CANSAS-P are appropriate for forming a cooperative service attitude in treatment and care planning and are valid and trustworthy instruments for conducting assessments of people with severe mental disorders in Turkey.

The studies from Nigeria and Israel focused on the use of CANSAS as a tool to evaluate the needs of patients with bipolar disorder (Esan & Medubi, 2018) schizophrenia (Ritsner et al., 2012; Ponizovsky et al., 2013) and schizoaffective disorder (Ponizovsky et al., 2013). All the three studies focused on the administration of CANSAS to patients in a clinical setting, either as an inpatient (Esan & Medubi, 2018) or returning outpatients (Ritsner et al., 2012; Ponizovsky et al., 2013). While the papers conducted in Israel concluded CANSAS as a viable option to measure the needs of patients with schizophrenia and schizoaffective disorder, the Nigerian study disagreed by stating that CANSAS is unable to accurately predict the needs of patients in an acute clinical setting.

Conclusion

In summary, the literature review suggests that CANSAS can be a useful instrument for assessing an individual's requirements in 22 distinct domains, specifically within a mental health context. For those with low insight or cognitive limitations, it might not be practical. As of right now, its only application is in the clinical mental health setting as no evidence has been found to support its applicability in a multidisciplinary setting, the community or to evaluate the requirements of those who are experiencing homelessness. The tool's sufficient test-retest reliability and low inter-rater reliability are found to be contradicting the evidence supporting its reliability. Despite being time-bound and simple to use, CANSAS has also been criticised for having rather ambiguously defined domains examined to determine needs, which makes it difficult to determine whether an intervention is necessary. The review can be concluded by stating that while certain studies did not seem to attest to the utilisation of the tool, there were numerous studies that defined the tool as being reliable and valid to be administered in a clinical setting.

References

Andersen, R., Caputi, P., & Oades, L. G. (2000). Interrater reliability of the Camberwell Assessment of Need Short Appraisal Schedule. *Australian and New Zealand Journal of Psychiatry*, *34*(5), 856–861. https://doi.org/https://doi.org/10.1046/j.1440-1614.2000.00814.x

Arvidsson, H. (2003). Met and unmet needs of severely mentally ill persons. *Social Psychiatry and Psychiatric Epidemiology*, *38*(7), 373–379. https://doi.org/10.1007/s00127-003-0643-2

Esan, O., & Medubi, A. (2018). The self-perceived healthcare needs of patients with bipolar disorder in Nigeria. *Journal of Psychosocial Rehabilitation and Mental Health*, *5*(2), 159–168. https://doi.org/10.1007/s40737-018-0120-6

Fassaert, T., Lauriks, S., van de Weerd, S., Theunissen, J., Kikkert, M., Dekker, J., Buster, M., & de Wit, M. (2013). Psychometric Properties of the Dutch version of the self-sufficiency matrix (SSM-D). *Community Mental Health Journal*. https://doi.org/10.1007/s10597-013-9683-6

Kelly, P. J., & Deane, F. P. (2009). Do therapeutic homework assignments address areas of need for individuals with severe mental illness? *Community Mental Health Journal*, *47*(2), 194–200. https://doi.org/10.1007/s10597-009-9217-4

Phelan, M., Slade, M., Thornicroft, G., Dunn, G., Holloway, F., Wykes, T., Strathdee, G., Loftus, L., McCrone, P., & Hayward, P. (1995). The Camberwell Assessment of need: The validity and reliability of an instrument to assess the needs of people with severe mental illness. *British Journal of Psychiatry*, *167*(5), 589–595. https://doi.org/10.1192/bjp.167.5.589

Ponizovsky, A. M., Rothstein, I., & Grinshpoon, A. (2013). The CANSAS self-report for screening of needs in outpatients with schizophrenia and schizoaffective disorders. *Community Mental Health Journal*, *50*(3), 343–347. https://doi.org/10.1007/s10597-013-9677-4

Reininghaus, U., McCabe, R., Slade, M., Burns, T., Croudace, T., & Priebe, S. (2013). The validity of patient- and clinician-rated measures of needs and the therapeutic relationship in psychosis: A pooled analysis. *Psychiatry Research*, *209*(3), 711–720. https://doi.org/10.1016/j.psychres.2013.01.013

Ritsner, M. S., Lisker, A., Arbitman, M., & Grinshpoon, A. (2012). Factor structure in the Camberwell Assessment of need-patient version: The correlations with dimensions of illness, personality and quality of life of schizophrenia patients. *Psychiatry and Clinical Neurosciences*, *66*(6), 499–507. https://doi.org/10.1111/j.1440-1819.2012.02383.x

Slade, M., Beck, A., Bindman, J., Thornicroft, G., & Wright, S. (1999). Routine clinical outcome measures for patients with severe mental illness: CANSAS and Honos. *British Journal of Psychiatry*, *174*(5), 404–408. https://doi.org/10.1192/bjp.174.5.404

Trauer, T., Tobias, G., & Slade, M. (2007). Development and evaluation of a patient-rated version of the Camberwell Assessment of need short appraisal schedule (CANSAS-P). *Community Mental Health Journal*, *44*(2), 113–124. https://doi.org/10.1007/s10597-007-9101-z

Tuncer, G. Z. (2019). Investigation of psychometric properties to Camberwell Assessment of need short apprasial schedule and self-rated version Camberwell Assessment of need short apprasial schedule to Turkish in individuals with severe mental disorder. *Journal of Psychiatric Nursing*, 234–240. https://doi.org/10.14744/phd.2019.50490

Wiersma, D. (2006). Needs of people with severe mental illness. *Acta Psychiatrica Scandinavica*, *113*(s429), 115–119. https://doi.org/10.1111/j.1600-0447.2005.00728.x

THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

CREATE CHANGE

Contact details

Maree Petersen
T +61 7 **33467314**
E m.petersen@uq.edu.au
W uq.edu.au

CRICOS Provider 00025B • TEQSA PRV12080