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Connecting Housing, Health, and Social Supports for People Leaving Treatment: Housing Policy Lessons from Australia

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Abstract

This article presents housing policy and practice recommendations for enhancing the coordination of housing, health, and social care supports for individuals leaving institutional settings. Our recommendations are derived from empirical research conducted in Australia's two most populous states (Victoria and New South Wales) between October 2019 and March 2021 among people leaving residential treatment for mental health and/or alcohol and other drug (AOD) use issues. The period immediately following discharge from these settings is known to involve significant risk of housing insecurity, particularly for vulnerable individuals with complex health and social care needs. In conducting this research, our goals were to identify models of best practice in discharge and transition planning, and to propose strategies for enhancing coordination between residential treatment providers and key social and housing support services to mitigate the risk of homelessness for individuals leaving these settings. This article presents key research findings and recommendations for improving service coordination and transition planning across diverse institutional settings.

Introduction

The period immediately following discharge from residential treatment services for mental health and/or alcohol and other drug (AOD) use problems involves significant risk of housing insecurity for vulnerable individuals with complex health and social care needs (see Brackertz et al., 2020; Duff et al., 2013; Manning et al., 2017; Ritter et al., 2014). This article presents housing policy and practice recommendations to enhance the coordination of housing, health, and social care supports for individuals leaving these settings. Our recommendations are derived from empirical research conducted in Australia's two most populous states (Victoria and New South Wales) between October 2019 and March 2021 among people leaving residential treatment for mental health and/or AOD use issues. Our goals are to identify models of best practice in discharge and transition planning and to propose strategies for enhancing coordination between residential treatment providers and housing and social support services to mitigate the risk of homelessness for individuals leaving these settings.

Leaving Treatment: Housing Risks and Responses

In Australia, the primary sources of homelessness support are specialist homelessness services (SHS), which are agencies funded to deliver a range of accommodation related services and/or personal services to individuals who are homeless, or at risk of homelessness. Data from these services show that a substantial proportion of people who access these services in Australia have mental health or AOD use problems and housing insecurity. Of the 241,113 people who accessed SHS in 2017–18, one-third (81,000) reported a concurrent mental health issue, while the number of clients with a mental health issue increased by around 8 percent over the previous 5 years (AIHW, 2019c). One in 10 SHS clients were identified as having AOD use problems in 2018–19, with 55 percent of this group known to be homeless at the point of presentation to services

(AIHW, 2019c). In response to these trends, Australia's National Housing and Homelessness Agreement (2018–23) identifies individuals exiting institutional settings as a priority cohort and outlines the need for improved early intervention and prevention efforts, including more evidence-based service development.

Also relevant to the present study are the growing numbers of Australians accessing mental health care and/or AOD treatment services each year. In 2018–19, around 137,000 Australians accessed AOD treatment services, involving around 220,000 closed treatment episodes, with an average of 1.6 episodes per client (AIHW, 2019a). Of these treatment episodes, 65 percent involved non-residential treatment, 15 percent were delivered via outreach services (away from main service location), and 15 percent were delivered through residential programs. Around 260,250 individuals underwent a mental health-related hospital stay for one or more nights in 2017–18, with 63.6 percent of these admissions involving specialized psychiatric care (AIHW, 2019b). Approximately 36.3 percent of overnight stays involving specialized psychiatric care were involuntary admissions. Evidence indicates that treatment outcomes across these sectors are mixed, with more than three-quarters of Australians who exit treatment in either of the mental health and/or AOD treatment sectors returning to treatment at least once in their lifetime (Kelly et al., 2016; Nathan et al., 2016; Ritter et al., 2014).

Return to treatment is especially common among individuals with co-occurring mental health and AOD related problems (Manning et al., 2017), while adolescents and young adults with mental health or AOD use problems have similarly mixed outcomes (Ritter et al., 2014). Housing insecurity and weak social supports are key risk factors for repeated service contacts for individuals with a history of AOD related problems (Lubman et al., 2016), with similar reports for individuals with a history of in-patient mental health treatment (Brackertz et al., 2020). These risks are compounded with each subsequent episode of treatment, with the associated disruption to housing creating challenges for individuals attempting to maintain stable housing after a period of treatment. International research evidence, including program evaluations, indicate that comprehensive transition planning, along with careful coordination between health and social services, are central to successful reintegration into stable housing for individuals leaving residential treatment for AOD and/or mental health problems (Aubry, et al., 2016; Holmes et al., 2017; HUD 2007). Coordinated transition planning may reduce the subsequent incidence of service contact for individuals with a mental health diagnosis (Brackertz et al., 2020; Xiao et al., 2019). Reports also confirm the role of discharge planning in reducing subsequent treatment presentations for individuals leaving AOD treatment (Ritter et al., 2014). There is strong evidence that effective transition support has a host of additional health and social benefits, including reduced involvement with the criminal justice system (Holmes et al., 2017), improved primary health outcomes (AIHW, 2019a), and stronger self-reported experiences of social inclusion (Duff et al., 2013).

The present study responds to recurrent concerns in housing policy debates regarding the most effective forms of housing support for individuals leaving residential treatment settings (see Brackertz et al., 2020). Little is known about the most effective models of housing support and assistance, including what services are needed alongside these supports. It is also unclear how

allied social supports are coordinated with housing assistance and how these support services may be most effectively integrated into supported accommodation programs. While support from informal caregivers is known to be critical to the maintenance of stable housing for vulnerable individuals (Duff, et al., 2013), there is little guidance on how these informal supports may be integrated into formal support efforts. These debates highlight the need for fresh insights into the most effective ways of customizing "post-exit" care planning for individuals leaving diverse residential treatment settings to address their housing needs. Effective tailoring of housing support is currently limited by the lack of data on pathways into and out of residential settings, the role of risk and protective factors, and the most effective sequencing and combination of housing supports over time.

Research Approach, Aims and Methods

This study addressed four research questions:

1. What models of best practice may be derived from the available literature to enhance transition planning and service integration for individuals leaving treatment?
2. How does residential treatment affect individual housing careers over time?
3. How can post-exit support packages be tailored and delivered to individuals leaving residential treatment who are most at risk of homelessness?
4. How effective is existing service integration between housing and other sectors in transition planning and post-exit support for individuals leaving residential treatment? What opportunities exist for service improvement and enhanced coordination?

A mixed methods study design was best suited to address these questions, involving analysis of an administrative dataset on patient outcomes and original qualitative research conducted in New South Wales and Victoria with service providers and people with lived experience of residential treatment. All research received institutional ethics approvals at the Royal Melbourne Institute of Technology (RMIT) University.

Data Sources

Mental Health Treatment Outcomes Cohort

The first study phase involved analysis of linked administrative data maintained by the Victorian Department of Health and Human Service (DHHS). Access to this dataset enabled analysis at person-level of service utilization patterns of a cohort of individuals across health and mental health services, family and justice services, and housing services (the latter from the Specialist Homeless Information Platform). The study cohort comprises 5,174 individuals aged 15–24 who were admitted to the hospital in Victoria for mental health issues and who were discharged from the hospital some time in 2013–14. The decision to focus on a population aged 15–24 years at the time of their service contact was made because, in nearly three-quarters of cases, the onset of mental health problems in Australia occurs before the age of 24 (AIHW, 2019a), suggesting

that early intervention and improvements in service accessibility for this cohort should yield the greatest individual, social, and economic benefits. Our analysis of this cohort draws on administrative data from 13 Victorian Government databases, using a unique identifier created by the Centre for Victorian Data Linkage (CVDL) within the DHHS (see Duff et al., 2021: 23–24 for more details on method and approach). These data shed important new light on pathways into and out of treatment and on how service contacts mediate housing outcomes over time. By analyzing service utilization patterns following treatment exits, we have also been able to identify risk factors for housing instability for different cohorts and then consider policy recommendations to reduce these risks.

Service Providers' Views and Experiences

Our qualitative research proceeded in two phases. The first involved interviews and focus groups with a sample of service providers in Victoria and New South Wales. Interview and focus group questions for service providers examined pathways into and out of support services, with an emphasis on housing outcomes, service availability and gaps, and on responses to individuals with complex health and social needs. During this phase we conducted 17 interviews (10 in Victoria and 7 in New South Wales) and initiated four focus groups (one in Victoria and three in New South Wales) with service providers, involving 35 participants across the two study sites. Interviews were conducted in-person or over the phone, and all focus groups were conducted in-person. Interviews and focus group discussions highlighted pathways into and out of residential settings, the types of supports available, and the significant structural barriers encountered by service providers in the provision of effective housing support. These sessions also provided an opportunity to establish relationships to help facilitate recruitment for the second phase interviews with service users.

Views and Experiences of People with Lived Experience of Residential Treatment

The second phase of qualitative data collection involved interviews with a sample of individuals with lived experience of residential treatment in Victoria or New South Wales. The second phase was significantly disrupted by COVID-19-related restrictions on movement, particularly in Victoria. In consultation with the research team and key stakeholders who assisted with recruitment of service providers, it was decided to conduct the interviews with service users online or over the phone. Recruitment information was circulated via the communication channels of supporting agencies and through professional networks via social media. We also worked with advocacy organizations to recruit via lived experience advisory groups. COVID-19 lockdown restrictions meant we were unable to interview people with unstable housing, such as those in boarding houses and in supported residential services (SRS).

Guided by the models of best practice derived from the evidence review conducted earlier, interviews with service users explored ways of optimizing post-exit housing support, the availability and utility of informal social supports such as caregiver and extended social networks in maintaining stable housing, along with options for more effectively integrating formal and informal supports into transition planning and post-exit support arrangements. We conducted 25 interviews (15 in Victoria and 10 in New South Wales) with individuals who had experience of residential

treatment in order to generate first-person accounts of transition pathways and supports. There was significant diversity within the accounts of those with lived experience, with many people recounting extensive contacts with mental health, substance use treatment, and housing services. Some people spoke of experiences of homelessness, other housing difficulties, and the need for respite support to maintain their housing.

Analysis and Findings

Our linked data analysis confirms that service transitions have a significant impact on housing trajectories, particularly for younger individuals with complex health, housing, and social care needs. This relationship is complex in that frequency of service contact is obviously an indication of service demand and the complexity of individual's health care needs. Yet it is also the case that service contacts, particularly residential treatment (in mental health and/or AOD treatment settings), may disrupt housing situations. For example, entering residential care may disrupt formerly relatively stable housing arrangements, such as when individuals end a residential tenancy agreement before entering treatment. On the other hand, individuals may decide, perhaps as a result of treatment, that they wish to alter their housing post-treatment in favor of, for example, other accommodation in a different location.

We discovered a strong correlation between the volume and frequency of service contacts and periods of housing insecurity in the mental health treatment outcomes cohort. The younger the age at which first contact with health and/or social services occurs, the stronger the impacts on housing over time. Younger individuals with complex health, housing, and social care needs tended to experience significant disruptions to their housing trajectories post-care. We also found that young people with mental health issues use services at a much higher rate than the general population. For example, youth with mental health issues have more than seven times the rate of hospital admissions compared to all Victorians aged 15–24 years (140.5 admissions per 100 person year [PY] as compared to 18.6 admissions per 100 PYs); six times the rate of emergency department presentations (163.0 presentations per 100 PYs compared to 26.4 per 100 PYs); and are more likely to access AOD treatment (26.9 per 100 PYs as compared to 1.8 per 100 PYs). Similarly, 13.3 percent of young Victorians with at least one episode of hospitalization for a mental health concern accessed homelessness services between 2013–14, compared with 1.8 percent of all Victorians aged 15–24.

In the 30 days after leaving the hospital, 18 percent of people in the cohort were re-admitted into the hospital, with mental health the most common reason (9 percent). After 12 months, over one-half (55 percent) had been re-admitted to the hospital, with over one-quarter of these (29 percent) admitted for a mental health reason. Over the following 4 years, over three-quarters (78 percent) had been re-admitted to the hospital, with mental health issues being the most common reason for readmission (42 percent). A substantial minority of people, however, were readmitted for self-harm (34 percent) and/or substance use issues (28 percent). First Nations Australians accessed services at a higher rate across almost all service use types (see Duff et al., 2021: 31–32). These results are important, because frequency of hospitalization is strongly linked in the data to later contact with Specialist Homelessness Services. Our qualitative data suggest that this is likely due to disruptions

to individual housing arrangements associated with periods of either voluntary or involuntary admissions to psychiatric care. This can happen, for example, when an individual enters the hospital from private rental accommodation, which is then placed at risk if an individual stays in the hospital for longer than anticipated and cannot maintain rental payments.

Homelessness is therefore an elevated risk for this group, because access to social housing in Australia is difficult. Waiting lists are very long because of a lack of housing supply (see Duff et al., 2021: 60–62). Young people, in particular, appear to be insufficiently profitable for Community Housing Providers to support, due to their issues of income insecurity and generally mixed employment histories. Income support is a particularly pressing need in this respect. Changes in assessment criteria for income support payments in recent years have resulted in many people who would previously have been eligible to receive a disability support pension (DSP) instead receiving the unemployment payment Newstart, which is of demonstrated insufficiency (see Davidson et al., 2020). Equally, our interviews suggest that public housing is unattractive for some young people because it locks them into a particular public housing tenancy within a particular location, when they prefer to be more geographically mobile.

A policy option that may mitigate the risk of homelessness for this group is enhanced housing assistance to sustain individual rental arrangements by subsidizing rent payments for the duration of an individual's hospitalization. Some of the service providers we spoke to indicated that there may likely be scope to draw on existing rental assistance mechanisms, or to access discretionary funding that is often available at the psychiatric ward level (for example, through brokerage funding available through Inpatient Unit Planning support funds) to support rental payments to reduce the risk of loss of tenancy and ensure that individuals can return to their existing housing. This will require the early identification of individuals in need of housing support, involving enhanced intake and admissions procedures to identify housing risk for individuals at intake and during a hospital stay. Individuals identified at risk of housing insecurity could then be referred to SHSs and other housing providers.

Findings from Interviews

Interview participants described inconsistent and sometimes ineffective discharge planning arrangements by mental health and/or AOD treatment providers across Victoria and New South Wales. Interviews indicate a significant gap between how care and service coordination is described in relevant policy documents and what is commonly experienced by individuals exiting residential treatment settings. We identified instances of effective practice in service delivery, but also many instances of poor transition planning. Central to all discussions of effective practice among both service providers and service users was the centrality of safe and secure housing for mental health and wellbeing. For individuals with experience of mental illness or distress, and/or significant histories of AOD-related problems, safe and secure housing was seen as an indispensable condition for recovery. Equally critical to recovery is effective coordination between different service sectors, although most service providers indicated that instances of effective service integration and coordination were highly variable and relationship-dependent at best. Other service providers made reference to the impact of housing and social care policy and practice reforms over the last decade, which have tended to involve the design and delivery of carefully targeted services with

strict eligibility criteria, often in carefully designated "catchment areas." As a result, increased service specialization, combined with growing geographical fragmentation, have become hallmarks of housing, health and social care service responses around Australia.

Discussing these changes, interview respondents noted how housing services in Victoria and New South Wales have become increasingly complex in recent years, with greater service specialization involving more targeted supports, typically calibrated to address the needs of increasingly diverse groups. As such, services have become more complex, more specialized, and more difficult to navigate for many, particularly more vulnerable individuals. Service providers noted the enduring impacts of service silos and the ongoing lack of coordination between services. More critically, some service providers questioned whether services were actually capable of delivering long term, coordinated support, as one respondent noted:

> *The thing we all need to remember is that our homelessness service system, with only a few limited exceptions, is only funded for a defined period of support. Really, it's mainly only short-term support, intended to resolve a temporary crisis in someone's life. So this idea that we can overcome, in some cases, decades of accumulated disadvantage that starts in early childhood, goes all the way through school, and then any experience at work people might have had. The idea that you can somehow manage or make up for those sorts of things through a 6-week intervention, or a period of crisis accommodation, is just farcical.*
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Making similar arguments about the inadequacies of existing housing support programs, most service users we interviewed described complex histories of insecure housing, with regular changes of accommodation and multiple points of contact with housing support and service providers in diverse geographical settings. The individuals we interviewed with experiences like this spoke of the grueling impact of the conditions of doubt, fear, insecurity, and vulnerability that tends to pervade all aspects of daily life for those experiencing housing insecurity, affecting physical and mental health, employment, friendships, and the ability to plan for the future. Housing and health go "hand-in-hand" as many interviewees put it. Discussing this point, one interviewee with lived experience of treatment settings noted how:

> *If I don't have safe housing or stable housing, then I can't be mentally well and I'm going to more than likely relapse again, and I don't want that. And that's also my main reason for not wanting to go back into a privately rented room or something like that is because every time that I've lived in a shared house, they're got people on drugs [and] I just can't be around that for my recovery. That's why, honestly, I want my own place, so I can just shut the door on all the drugs and no one's in my house that's using.*
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Alluding to the broader social and structural dimensions of these experiences, including housing market conditions, other interviewees emphasized how rising housing costs, tight private rental markets, and long waiting lists for social housing shape the housing pathways of vulnerable individuals on fixed incomes. The key point is that stable, affordable housing is increasingly

difficult to access across the country, particularly in metropolitan settings, significantly impacting the housing pathways of individuals exiting treatment settings.

Addressing these challenges, service provider interviews often emphasized how effective service coordination typically requires personal relationships, informal work-arounds, creative negotiation, and compromise. Finding ways to "work the system," to make what have become highly bureaucratized service systems work for clients, have become critical on-the-job skills for the coordination of effective health, housing, and social outcomes for disadvantaged clients. In talking about these systems, service users also remarked upon what they described as inconsistent and sometimes ineffective discharge planning arrangements. Ideally, discharge planning provides an opportunity for clinical and allied health professionals to liaise with community health and housing service providers to address an individual's housing needs in more systematic and effective ways. The design of appropriate housing supports for individuals leaving treatment was a strong focus of service provider interviews, whereas service users tended to point to shortcomings and inconsistencies in this support. Some service users noted how their decision to enroll in residential AOD treatment, or to seek an admission to psychiatric inpatient care, was partially motivated by the desire to find respite from housing situations that they regarded as unsafe or unhealthy. For others, for whom their housing may be secure (insofar as they had security of tenure), this did not necessarily make their housing safe or appropriate in terms of their health or recovery (living close by to other drug users). Service users often indicated how these nuances were overlooked in care planning discussions, where their existing housing was seen as "good enough" despite their misgivings about aspects of this housing (such as drug/alcohol use in the vicinity).

Discussion and Policy Implications

Our findings offer significant new insights into effective models of post-exit support and discharge planning for individuals leaving residential settings for mental health and/or AOD use problems. This research has enabled us to identify and analyze: key barriers to successful reintegration into stable housing; relevant risk and protective factors mediating pathways into stable housing; and the role of formal service supports and informal social and family supports in retaining housing. Overwhelmingly, our research confirms that appropriate, safe, and affordable housing is crucial to support individual's mental health and wellbeing, to facilitate community participation, and to sustain recovery (Kavanagh et al., 2016; Paquette and Pannella Winn, 2016; Thornicroft, Deb, and Henderson, 2016). Despite strong evidence of the health and social benefits of housing (Xiao, Gulcur, and Nakae, 2019), housing insecurity continues to be a problem for many individuals leaving mental health inpatient services and AOD treatment in Australia. In contexts of growing service fragmentation, discharge and transition planning arrangements are becoming more complex and uncertain across the housing, mental health, and AOD treatment sectors (see also Aubry, et al., 2016; Brackertz et al., 2020). Failure to adequately plan for and support safe transitions from residential treatment into secure housing can have significant consequences for individuals leaving care, with strong impacts on their housing, their health and wellbeing, and their economic and social participation in the community.

Furthermore, we found that housing, mental health, and AOD treatments sectors in both New South Wales and Victoria remain largely separate service systems with little formal integration. There is significant scope, therefore, to enhance the integration of housing, mental health, and/or AOD treatment services, along with other health and social supports as needed, through more systemic organizational and governance arrangements. Poor integration and a lack of coordination result in suboptimal outcomes, including higher rates of inpatient care, increased need for AOD treatment, and greater pressure on SHS and other services following discharge. Indeed, individuals entering and exiting mental health and/or AOD treatment typically have complex ongoing health and social care needs, requiring significant post-care coordination between housing, health, and social care providers.

With these housing needs in mind, our findings suggest grounds for enhancing the design of post-exit support packages to address the health and social care needs of individuals exiting institutional settings more effectively. Transition packages ought to be designed and delivered on the basis of what they enable individuals to do in their everyday lives following their exit from care. Transitional services and supports ought to be tailored to individual needs in relation to housing, employment, education, and financial needs and aspirations, as well as community integration and belonging, social inclusion, and hopes for the future (see also Duff et al., 2013). Furnishing the supports needed for a more "liveable life" (see Alam and Houston, 2020; Amin, 2014; Berlant, 2016) ought to be the focus of transition planning for individuals exiting mental health or AOD treatment settings, taking their formal and informal housing, health, and social care needs into account. Such a focus shifts the design of transition planning beyond the immediate goals of a specific organization to emphasize an individual's unique support needs in the coordination of services (see Batterham, 2019). Likewise, effective and safe transition planning depends on strong local relationships between diverse service providers, with a strong grounding in relations of trust and reciprocity, transparency, and accountability, where the client's needs are central to all service and transition planning.

Our research provides further endorsement of the housing first model—whereby long-term, permanent housing is provided without conditions—as a guide to enhance the integration of housing, health, and social care supports for individuals leaving residential treatment settings for mental health and/or AOD problems. Despite the influence of housing first models in Australian housing and social policy debates, housing readiness approaches have been more common (see Clarke, Parsell, and Vorsina, 2020). Housing readiness approaches provide supported housing arrangements according to a so-called staircase model based on assessments of an individual's capacity (or readiness) to maintain stable housing. In contrast, housing first emphasizes the provision of stable housing without conditions for individuals living with complex and persistent mental health and/or AOD use problems (see Tsemberis et al., 2004). In the latter approach, there are no behavioral or treatment prerequisites that must be met before an individual is provided with accommodation. Despite these differences, both approaches suggest that housing is an indispensable condition of effective post-exit care support for individuals leaving residential treatment settings.

Our linked data analysis indicates a strong correlation between the volume and frequency of service usage across mental health and AOD treatment settings and the risk of housing insecurity among service users. This finding is consistent with national and international research which has consistently found that frequency and volume of service usage, particularly for mental health, housing, and/or AOD services, strongly predicts housing insecurity over the life-course (see Duff et al., 2021 for a detailed review). Our analysis suggests the need for enhanced measures to identify high-volume service users and to more explicitly tailor housing and social support responses to their needs. This further suggests the need for site-specific policy development and service design efforts to facilitate the delivery of more effective transition planning supports for individuals leaving mental health and/or AOD treatment settings. In particular, we would recommend more effective integration of housing supports within the delivery of mental health care, particularly in inpatient psychiatric care, and in the delivery of community-based AOD treatment, particularly residential rehabilitation services. Interviews with service providers in each of these settings revealed significant discrepancies in the delivery of community-based mental health services, and considerable strain upon psychiatric services in hospital settings, particularly in Melbourne and Sydney's largest hospitals. We also identified significant gaps and problems in the integration of housing supports into mental health care, despite the obvious need for such coordination, particularly among more vulnerable cohorts. A similar picture emerges in our analysis of AOD treatment services in New South Wales and Victoria, with a mix of public and private care provision, and a great diversity of treatment models and pathways. Here too, the level of integration of housing supports into the delivery of treatment services is variable.

On the basis of analysis presented in this article, we identify the following key policy issues:

- Housing affordability, social housing shortages, and lack of supported housing remain key challenges for individuals experiencing mental health and/or AOD issues.
- Housing/homelessness, mental health, and AOD treatment remain separate systems across New South Wales and Victoria, with only partial systems coordination.
- Within these systems, there is significant unmet demand for housing support, as well as resource gaps and constraints on coordination between health and social supports.
- Housing supports ought to be integrated more effectively into discharge planning in psychiatric inpatient care for individuals at risk of (or experiencing) housing insecurity.
- There is scope to enhance the role of allied health staff and external community service providers in care coordination in psychiatric inpatient care to improve the integration of housing support for individuals at risk of (or experiencing) housing insecurity.
- Individuals exiting mental health and/or AOD treatment express strong preferences for greater choice and control over their housing transitions post-care.

Addressing these outstanding policy and service design challenges will require significant service reforms. It further suggests the need for service design reforms to drive enhanced housing service delivery in key points of interception within and across mental health and/or AOD

treatment services, and more specialized housing support services, where care coordination can be significantly improved. Focusing attention and effort at these points can improve health and housing outcomes for individuals and reduce costs over time. In particular, widespread emphasis across the mental health and AOD treatment sectors on bureaucratic and administrative processes over and above an individual's care needs must be reversed. All discharge planning must begin from the point of view of the individual in care, in keeping with, for example, person-centered approaches to care coordination and service delivery that are increasingly common across these sectors (see Duff et al., 2021). Of added importance is the need to ensure that mental health, AOD treatment, and specialized housing supports are formally integrated through service and system design innovations. At a practical level, this could include the introduction of housing risk assessment tools at admission and during stays in both psychiatric inpatient and residential AOD treatment settings. Improved screening and assessment protocols are a critical means of ensuring that individuals in need of housing support are identified in these settings and to inform discharge planning to provide for more effective after care and transition supports on exit. Peer workers and lived experience advisory groups in housing, mental health, and/or AOD treatment spaces are a key source of expertise that could be drawn on in the development of novel screening and assessment instruments and in discharge planning.

The formal integration of housing risk assessments into screening protocols in each sector would facilitate formal assessment of individuals' existing housing status, as well as their housing preferences upon discharge, along with their risk of housing insecurity. On this basis, specialized housing services could then be more formally integrated into discharge planning arrangements in both psychiatric inpatient care and residential AOD treatment services to reduce experiences of housing insecurity and/or homelessness for individuals on exit. Housing services representatives could then work more closely with clinical and allied health teams (particularly social workers) to enhance discharge and transition planning processes in psychiatric inpatient settings. Within residential AOD treatment settings, housing needs ought to be formally integrated into transition planning arrangements from the point of intake. Our findings further suggest that post-exit assertive case management is an effective means of supporting vulnerable individuals with complex care needs to access and maintain stable housing while also reducing costs in the longer term.

Conclusion

Our research makes a compelling case for more formal integration of specialist housing services into both inpatient psychiatric and AOD treatment settings in Australia, given the significant risks of housing insecurity that many individuals experience after leaving these settings, including experiences of homelessness. There are several instances of good practices to guide these service enhancements, such as innovative housing and social justice programs like Journeys to Social Inclusion and Green Light in Victoria and the Housing and Accommodation Support Initiative (HASI) in New South Wales (see Duff et al., 2021 for details). These programs, which combine housing and mental health/psychosocial support, indicate the benefits of the integration of housing, health, and social supports, demonstrating that long term stable housing can be sustained for individuals regardless of the complexity of their health, housing, and social support needs. In this respect, we already have clear models of effective care coordination and successful service integration

to guide the provision of stable housing for all Australians. The task is to scale up these endeavors to ensure that all Australians who need such supports receive it, regardless of circumstance. Equally critical is the need to increase funding for the provision of new social housing to guarantee access to affordable, safe, and secure housing for all Australians who require it.

Our research also has important implications for the organization of social care services and supports—for example, in terms of work design issues, leadership and governance approaches, role descriptions, and task allocations— across and between specialist housing services, mental health, and AOD treatment services in Australia. Successive waves of policy reform involving changes to funding arrangements, performance indicators, work design, and organizational structures across the broad community health and social care sectors have had enormous impacts on the everyday work of delivering care in specialist housing services, mental health, and AOD treatment in Victoria and New South Wales. In each jurisdiction, the housing services landscape is becoming more complex, more fragmented, more competitive, and more focused on delivering short term outcomes for vulnerable individuals. As a result, service pathways are becoming more complex with significant impacts on individual care trajectories within and across specialist housing services, mental health, and AOD treatment. Finding ways to assist vulnerable individuals to navigate these systems of care, perhaps via expanded support and way-finding roles for peer workers in each sector, are recommended. Above all else though, our findings confirm that access to secure housing must remain the foundation of efforts to enhance the coordination of health and social supports for vulnerable individuals across the health and social care sectors in Australia. After all, enhanced care coordination and improved service integration are not, on their own, solutions to the housing insecurities that many Australians experience. The only long-term solution is stable and secure housing.

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