Supported Housing
What have we learned about collaborative care and where to from here?

Adjunct Associate Professor Theresa Williams
WA Centre for Mental Health Policy Research
Presentation Outline

- Supported Housing Model
- Review Findings
- Challenges in Collaborative Care Models
- Where to next?
It's More than a House….

People without homes need housing; that goes without saying…..housing is necessary but not sufficient to help individuals with serious mental illnesses and/or co-occurring substance use disorders who have been homeless regain psychiatric and residential stability…..they require unique, flexible supportive services that are not a requirement to maintain housing

[US Dept Health and Human Services, 2003] [my emphasis]
What is the WA Independent Living Program?

- Housing and Support Program
  - MOU between Health and Housing Departments
  - Houses head-leased from Department of Housing
  - Supportive Landlord (NGO/CHA – Funded by DoH)
  - Psychosocial Support (NGO – Funded by DoH)
  - Clinical Support (MHS)

- Commenced 1995

- Over 750 people in independent housing

- Grown at about 50 housing units per year

- Based on ‘Supported Housing’ model
Supported Housing Model

- Supported Housing emerged late 1980s as alternative to ‘Linear Residential Treatment Model’

- Core elements of Supported Housing Model
  - Home – not a treatment facility
  - Permanent – not transitional
  - Ordinary housing & scattered site
  - Individualized support – moves in and out
  - Fosters social integration
Principles and Operational Domains of Supported Housing

Domains Related to Housing & Tenancy

Typical & Normalized Housing

Consumer Choice

- Home in the community as a basic right
- Normal roles as regular tenants and community members
- Consumer empowerment
- Functional separation between support services and housing

Resource Accessibility

Domains Related to Mental Health Support

Individualized & Flexible Support

[Wong, Filoromo & Tennille]
What the Research Says....

- Most consumers prefer normal, independent, permanent housing with flexible supports.

- Housing with support increases residential stability & reduces homelessness & hospitalization.

- Improves quality of life and increases level of functioning.

- People with very high support needs can be managed in supported housing.

- People who don’t do well tend to be younger, more impaired & dual diagnoses.

[Culhane et al 2001; Lipton et al, 2000, Tsemberis and Eisenberg, 2000; Rosenheck et al, 1998]
Allocate 60 housing per year
Clients eligible for public housing
Health selects clients

**Supportive Landlord**
- NGO or CHA
- Houses head-leased from Dept Housing
- Funded by DoH

**Psychosocial Support**
- NGO
- Funded by DoH
- Not exclusive to ILP

**Clinical Support**
Public Mental Health Services

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**MOU**

**HEALTH DEPARTMENT** --- **HOUSING DEPARTMENT**

**SERVICE PROVIDERS**
WA Independent Living Program Model

MOU

HEALTH DEPARTMENT

Allocate 60 housing per year
Clients eligible for public housing
Health selects clients

HOUSING DEPARTMENT

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Client

Clinical Support
Public Mental Health Services

SERVICE PROVIDERS
Later Variations.....

HEALTH DEPARTMENT

HOUSING DEPARTMENT

MH Support Agencies, not CHA's
Rural and Outer Metro

Supportive Landlord
PLUS
Psychosocial Support

Client

Clinical Support
Collaboration or Integration?

Separating the landlord and support roles

Advantages:
- Efficient – share client information, coordinate services
- Align priorities - client receives required support
- Financial viability - small organisations

Disadvantages:
- Subtle pressure to accept support to keep tenancy
- Landlord + support not community norm
Review Findings

Overall a successful program....

- Independent housing for over 750 people
- Tenancies largely stable and successful

But need to....

- Separate the landlord and support roles
- Clarify roles of partners agencies eg HASI
- Build the support services
- Increase the number of houses
Review Findings: Improving Co-ordinated Care
What is the Consumer Role in Co-ordinated Care?

- Have we built coordinated care largely around agencies working together and do consumers have to ‘fit in’?

- Can consumers choose parts of the program or is it a package deal?
  - Can you have a house without support or treatment?
  - Do you have to be a client of the public mental health services?
  - What if you don’t want to give consent for information to be shared?
  - Can the support be tailor-made to match your priorities?

SO WHERE TO FROM HERE?
THE CHANGING RELATIONSHIPS BETWEEN SERVICE USER, COMMISSIONER AND PROVIDER

**TASK BASED COMMISSIONING**

- **Commissioner**
  - Commissions services to deliver tasks that address eligible needs
- **Provider**
  - Delivers commissioned tasks
- **Service user**
  - Receives commissioned tasks

**OUTCOME BASED COMMISSIONING**

- **Service user**
  - Identifies issues, outcomes and how best to achieve them
- **Provider**
  - Works with SU to agree tasks that achieve outcomes
- **Commissioner**
  - Supports SU to identify outcomes & agree resources

**Linear and hierarchical**
- Requires inflexibility

**Dynamic three way relationship**
- Requires flexibility

Self Directed Support: A National Strategy for Scotland, 2010
CHOICE, CONTROL AND RECOVERY:
A guide to Self-directed support