



**Homelessness Australia**  
*Creating a framework for ending homelessness*

## **States of being:**

# **Exploring the links between homelessness, mental illness and psychological distress**

## **An evidence based policy paper**

**Homelessness Australia**

**November 2011**

Contact: Travis Gilbert  
[policy@homelessnessaustralia.org.au](mailto:policy@homelessnessaustralia.org.au)

## Table of Contents

1. Introduction	Page 3
2. Historical responses: demons, deviance and medicalisation	Page 4
3. Out of the asylums and onto the streets? Exploring the links between de-institutionalisation and homelessness	Page 6
4. Not quite at home: specialist homelessness services and boarding/rooming houses fill the accommodation gap	Page 9
5. The in-betweeners: too unwell for homelessness services, not unwell enough for hospital.	Page 12
6. Re-institutionalisation: prisons- the new asylums?	Page 13
7. Locked out: barriers to effective service interventions	Page 16
8. Cause and effect: what comes first? Homelessness or mental illness	Page 18
9. Emerging evidence: Linking homelessness, mental illness, exposure to trauma and violence	Page 19
10. The wrong door? Co-morbidity dual diagnoses	Page 21
11. Early intervention: getting in before things get heady	Page 22
12. Emerging needs: older Australians and veterans	Page 25
13. Home safe and well: the importance of housing to stabilising mental illness and promoting recovery.	Page 27
14. Breaking the cycle, promoting well-being: Models that work	Page 31
15. Discussion and conclusions	Page 40
16. Recommendations	Page 45

# 1. Introduction

The link between homelessness and mental illness is well established.

The experience of homelessness can have a devastating impact on individuals and families: emotionally, mentally and physically. Homelessness services provide support to large numbers of people on a daily basis who present to them in crisis, often experiencing high levels of psychological distress and often exhibiting symptoms of conditions that would meet the Diagnostic and Statistical Manual IVTR criteria for a psychiatric illness.

We know this because our members report dealing with large numbers of clients who are experiencing high levels of psychological distress and/or who are exhibiting symptoms of mental illness but who for various reasons cannot secure access to mental health services.

We know this because academic research consistently finds that high numbers of people who experience homelessness also experience symptoms of mental illness.

What we do not know is the incidence and prevalence of mental health disorders amongst people experiencing homelessness. Depending on the research paper, the client group and the sector of homelessness that they find themselves in estimates vary from 30%<sup>i</sup> to up to 85%<sup>ii</sup>.

The 2007 National Survey of Mental Health and Well-being found that the estimated prevalence of mental health 'disorders' in the general population was approximately 20% at any one time, while the incidence over the course of a life-time was 45.5%<sup>iii</sup>. It seems reasonable to conclude that the prevalence and incidence of mental illness would be higher amongst people experiencing homelessness than those who are stably housed given how distressing the experience of homelessness is for many people.

It would be interesting and beneficial to be able to generate some consistent data that can provide us with reliable estimates of the incidence and prevalence of mental illness amongst people who are experiencing homelessness. This would give us an indication of the level of need in the community for housing based solutions and service responses that take into account homelessness within the mental health sector and, mental health and psycho-social support needs within the homelessness sector. The anecdotal evidence we do have is that mental illness and high levels of psychological distress are common place for clients of homelessness services, people sleeping rough and people in boarding houses and supported residential facilities (SRFs). We need better data to help us understand the types of disorders that are most prevalent amongst people experiencing homelessness, whether or not they developed symptoms prior to or post becoming homeless, whether or not they have formal diagnoses and what events coincided to disrupt their housing stability.

Homelessness Australia presents this paper with the intention to explore what the literature and our members are telling us about the links between homelessness, mental illness and psychological distress.

The paper has been prepared at a time when a significant national mental health reform package is on the verge of being implemented and providers of homelessness services must be able to gain access to a proportion of these dollars and the expanded services they will fund over the next four years. There is a homelessness specific component of the package and a significant proposal targeting people with severe and persistent mental illness that we will provide some commentary on in the paragraphs below.

We also want to propose some recommendations that the homelessness and mental health sectors believe, if implemented, would lead to improved housing and mental health and well-being outcomes for Australians experiencing homelessness and mental illness and those who may be at risk of becoming homeless as a result of mental illness.

This paper has been prepared in consultation with Homelessness Australia's Board, Councils and members and the Mental Health Council of Australia.

## **2. Historical responses: demons, deviance and medicalisation**

The belief that people who had displayed symptoms of mental illness should be segregated from society until psychiatrists declared they had "recovered" is perhaps a continuation of the stigma attached to mental illness and neurological conditions prior to the age of 'enlightenment'. Indeed before the medicalisation of health and wellbeing, some types of mental illness were viewed as manifestations of the supernatural. In the case of epilepsy for example, grand mal seizures were believed to be indicative of demonic possession.

Similarly, people living with what we now call schizoid-type disorders were reportedly more likely to be accused of witchcraft and consorting with Satan as was allegedly evidenced by their conversations with 'beings' that others could not see (auditory hallucinations)<sup>iv</sup>. For others, what we now regard as symptoms of mental illness were once believed to be evidence of 'punishment by the Gods' or conversely in other societies, people may have interpreted symptoms as evidence that people experiencing them could receive divine messages or act as mediums between the physical world and the spiritual realm<sup>v</sup>.

The rise of 'modern medicine' resulted in the medicalisation of health and wellbeing including mental health and gradually in 'Western' societies, people exhibiting symptoms were viewed by society as 'sick' rather than possessed by demonic spirits or punished by the Gods.

This new explanation seemingly did little to reduce the stigma associated with mental illness however. The rise of psychiatry began in the late 18<sup>th</sup> Century as the period of the 'enlightenment' led people to postulate that behaviours exhibited by individuals that were previously thought to be the work of the supernatural could in fact be symptoms of afflictions and illnesses that could be treated by the medical profession.

The search for treatments/cures for various manifestations of insanity began in Germany in its centres for scientific research in the 19<sup>th</sup> Century.

Elsewhere in Europe, the dominant approach to dealing with people whose behaviour was labelled deviant was to require them to submit to 'moral therapy' which asserted that people labelled insane had lost their reason/rationality and needed to be removed from their physical environment, family and community and placed in secure care where their physical, emotional, environmental and occupational needs were supposed to be attended to<sup>vi</sup>.

While some psychiatrists were opponents of moral therapy and believed mental illnesses were conditions of the brain and central nervous system that required medical treatments and cures they became advocates of one of its central components: the need to segregate 'sick' individuals from society while they were undergoing treatment. By asserting that psychiatrists were the only people qualified to administer treatments for various forms of insanity that, thanks to German research, had been re-cast as diseases of the brain, the new discipline was seeking to establish a monopoly over both the labelling of conditions as 'mental illnesses' and the administration of treatments to remedy them.

Achieving the status of legitimacy within the medical profession that had hitherto concerned itself with treating and seeking to cure physical ailments and diseases took a great deal of time. Many psychiatrists believed that physical evidence could be found within the brains of people they labelled as mentally ill that was not identifiable in 'sane' individuals. Theories such as the presence of lesions in the brain were offered. Various attempts to determine physical characteristics present in individuals labelled by psychiatrists as mentally ill that were not present in the brains of people who were 'sane' foundered. Psychiatrists reasoned that this was not because they did not exist but offered two alternative hypotheses. Some asserted that medical dissection instruments were not yet advanced enough to detect them while others contended that physical/structural changes and characteristics were not readily identifiable in the brains of people in the 'early stages of lunacy'<sup>vii</sup>. The second proposition is interesting in that it added credence to the discourse that psychiatrists were seeking to make dominant; that the behaviours exhibited by certain individuals were symptoms of illnesses that could only be treated and 'cured' by psychiatrists, as practitioners within the medical profession. By the mid-19<sup>th</sup> Century, having incorporated aspects of moral therapy into its treatment regimen, notably the need to remove people from their living environment and place them in secure facilities to undergo treatment, the medicalisation of mental illness was complete and psychiatry gained its long sought legitimacy within the medical fraternity.

In Australia the medical diagnosis and treatment of 'insanity' first occurred in New South Wales in 1811. Governor Macquarie converted a farmhouse in Castle Hill in Sydney's west into the first public asylum known to have operated in Australia, for convicts declared insane by the colony's doctors<sup>viii</sup>. The first 'purpose built' hospital to accommodate persons deemed mentally ill on a long term basis and offer 'moral therapy' was the Callan Park hospital for the insane that commenced operation in 1884 in Sydney's inner-west<sup>ix</sup>. Later it would amalgamate with the Rozelle hospital and remain a facility providing treatment to people with mental illness until 2008 when it was closed and patients were transferred to the Concord hospital.

Long-term institutionalisation in 'hospitals for the insane' remained the dominant treatment model in Australia until the early 1970s as it was believed that sequestration in asylums was essential to protect the community from people with mental illness and people with mental illness from themselves in the name of safety<sup>x</sup>. Asylum by definition means protection from harm. Institutionalisation was also viewed in a utilitarian context as doing the greatest good for the greatest number, by segregating the few from the many for the supposed protection of all.

### **3. Out of the asylums and on to the streets? Exploring the links between de-institutionalisation and homelessness**

There is a body of evidence in literature, particularly literature from the United States that establishes a link between the policy and practice of de-institutionalisation of mental health in-patients and an increase in the number of people who are visibly homeless. The strength of the causal relationship is a subject of considerable debate however. Some of the factors that influenced the paradigm shift in mental health policy commonly referred to as de-institutionalisation are explored in this section.

The closure of asylums that offered long-term institutional treatment to people with a variety of symptoms of psychological distress, mental illness and psychiatric disturbance began in the United States in the late 1950s, in Britain and Europe in the early 1960s and in Australia in the early 1970s. The de-institutionalisation movement was influenced by the rise of universal human rights post World War II and advocates raised the spectre of institutionalisation as constituting a fundamental breach of the human rights of people diagnosed with mental illness. Sociologists point to the rise of post-modernism, feminism and 'anti-psychiatry' as theoretical influences that shaped the practice of de-institutionalisation.

In addition to changing views about the appropriateness of compulsory detention and its place in post-World War II society, two other factors were influential in foreshadowing the decline of the large scale asylum as the dominant place of 'care' for people with mental illness. Firstly, improvements in psychotropic drugs used to control/suppress symptoms of particular DSMIVTR 'disorders', in particular the discovery of the phenothiazines, the mood-stabiliser, lithium, tri-cyclic antidepressants and sedatives changed the environment within asylums and enabled people to control many of their symptoms. Secondly, in response to a growing number of reports of inhumane 'treatment options' and the use of medical techniques such as electro-convulsive therapy and solitary confinement for punitive rather than therapeutic reasons behind asylum walls, thousands of patients were discharged from asylums into the community with the promise of large scale community based outpatient services and a chance at re-integration into society.

The aims and rationale for deinstitutionalisation remain sound and there is no doubt that many people who found themselves institutionalised in secure asylums with little if any contact with the outside world were not aided greatly by their treatment regimen and were in some cases subjected to treatment we might regard as inhumane.

With sufficient support and where necessary, an appropriate regimen of psychotropic medication(s), people were to be supported to live independently in the community and to engage with clinical outpatient treatment and community mental health services.

By the 1970s the number of people in secure institutional psychiatric care (asylums) was declining significantly in all States and Territories. The paradigm shift in the treatment of mental illness saw the dominant treatment model shift from segregation in asylums to community-centred 'open door' therapy<sup>xi</sup>.

The psychiatric hospital was to be utilised for acute care only with smaller wards to provide beds on a long-term basis only to those who represented a danger to others in the community. The shift from long-term institutionalisation to short term acute care foreshadowed a transformation in the balance of patients who were held involuntarily versus those who were admitted with consent between the mid-1960s and 1980. In 1965 over 80% of patients in psychiatric facilities were there involuntarily, a decade later this had fallen to just under 50% and by 1980, less than 20% of people undergoing treatment in mental health facilities were there because of a compulsory treatment order.

It seems logical that any person or group of persons whose lives had been rigidly structured in institutional care would require fairly intensive independent living skills programs, particularly those who had been institutionalised for many years.

There is certainly evidence that community mental health services and clinical outpatient treatment providers were established and taking clients/patients who had been in institutional care in the 1970s in the UK, the USA and Australia. What is less clear is whether or not long term in-patients were afforded the opportunity for stepped-down levels of care to enable them to make the transition to independent living in the community and to what extent community mental health services were established and resourced to deal with the steady numbers of people who were exiting institutional mental health care.

There are differing views in the literature as to the extent to which these services were established and how adequately they were resourced to deliver the necessary care and support to people who had been long term residents of asylums and other secure psychiatric institutions.

Indeed by the end of the 1970s, reports were emerging that documented instances of people being discharged into substandard and/or inappropriate accommodation settings with little or no access to outpatient treatment, most commonly, sub-standard boarding houses and emerging homelessness services that were being established in the 1970s to support new client groups such as women escaping domestic violence and young people.

Indeed in March 1979, the Member for the NSW state seat of Ashfield told parliament raised the issue of poor standards of accommodation for former psychiatric patients in the electorate noting:

*“...Spotters were said to receive fees for shepherding discharged patients towards sub-standard boarding houses... There were complaints (by neighbours) of abusive and obscene language and the smell of urine coming from the boarding houses... A women’s refuge in Blacktown in September 1978 made a plea for former women patients who, for want of accommodation, had to roam the streets at night. Some had attempted suicide, numbers had been the victims of rape and violence...”<sup>xii</sup>*

In response to the increasing volume of such reports, legislation providing for the registration and oversight of boarding houses for former psychiatric patients was enacted in 1981<sup>xiii</sup>. Reports about the inadequacy of accommodation for former in-patients were not confined to New South Wales. Reports and investigations throughout that decade emphasised the need for adequate and organised community care and housing for people diagnosed with mental illness.

By the early 1990s, congregate/semi-private accommodation settings were funded to provide accommodation with support to people living with mental illness under the name of supported residential facilities (SRFs) or supported residential care facilities. While not specifically for people with mental illness, SRFs are funded to provide accommodation and day to day support to their residents and many SRFs accommodate people with mental illness who are, for various reasons, not able to live unsupported for a period of time. The SRF sector is a mixture of private proprietors and not for profit care providers and it is probably fair to say that both the level of ‘support’ and the standard of accommodation varies markedly.

Despite the establishment and funding of SRFs, there is a reasonable body of evidence, both anecdotal and documented that demonstrates that a significant number of people with affective disorders, psychoses and schizoid-type disorders cycle between homelessness services, boarding houses, emergency rooms, acute psychiatric care and back into homelessness.

Having considered all of this, when we asked our members whether there was a causal link between de-institutionalisation and homelessness, the general consensus was that it is a myth that de-institutionalisation causes homelessness. There was a sense from a number of members that it is important that we de-bunk this myth because a logical conclusion to the view that de-institutionalisation causes homelessness is that the solution is re-institutionalisation which Homelessness Australia does not believe is the case.

Succinctly put, a housing sector leader told us:

*“...All mentally ill people do not automatically become homeless. The majority live and function in the community with family and other supports. Those that become homeless are usually poor and without family support. I am yet to discover a wealthy person with family support who has a severe mental illness homeless on the streets...”<sup>xiv</sup>*

Colleagues in Victoria told us:

*“...It is not de-institutionalisation per se; rather the under-investment in community and home based mental health services. Reports from services suggest that it can be challenging for people with severe and persistent mental health issues, who need permanent housing linked to ongoing health and wellbeing support services, to access the right type and intensity of support needed for a successful tenancy...”<sup>xv</sup>*

We know that the vast majority of people would meet DSMIVTR criteria for mental illness can, with the right support and provision of safe, secure and appropriate accommodation that meets their needs, live independently in the community.

This is demonstrated by statistics referred to earlier that indicate that as many as one in five Australians may be experiencing mental illness at any given time.

A nurse from an agency that provides support to people with mental illness in South Australia told us:

*"...De-institutionalisation is a good thing and with the improvements to meds [sic], would have happened anyway. It is the continued under-investment in and poor coordination of access to community mental health services and the lack of follow-up care that leads to people ending up on the streets where their problems only get worse... Mental health care in this state is a shambles..."<sup>xvi</sup>*

As with most issues relating to homelessness, people do not need institutions they need more affordable, accessible and safe housing options with security of tenure and access to community, health and social services that enable them to get well, stay well and live independently in communities that are inclusive.

#### **4. Not quite at home: specialist homelessness services and boarding/rooming houses fill the accommodation gap**

Specialist homelessness services account for a significant proportion of Homelessness Australia's members. Supporting large numbers of people with varying forms of mental illness as well as others who are experiencing high or very high levels of psychological distress is a key issue that is raised over and over again when we seek feedback from members about the issues that are affecting service delivery. Services that provide support to single adult men in particular, report that they are providing support to large numbers of people with complex and challenging patterns of behaviour that include manifestations of mental illness symptoms as well as psychological distress and anti-social behaviour/aggression.

It is unclear what proportion of clients of specialist homelessness services would meet the DSMIVTR criteria for a mental illness if services were able to secure a referral for a clinical psychiatric assessment but the anecdotal reports and the case notes taken by workers indicate that the proportion who identify mental health and psychiatric issues in the National Data Collection Agency data significantly understates the number of clients who are presenting to services with these issues.

There are services established specifically to provide accommodation, housing and support to people with both histories of homelessness and complex mental health needs and severe and persistent psychiatric illness. MIND Australia/The Richmond Fellowship is a well established provider of these services. Many other services are not specifically designed to accommodate and support people with complex needs and this places them under significant strain.

Later we provide examples of some of the service models and interventions that are achieving good outcomes for people experiencing homelessness as well as mental illness, psycho-social disorders, psychological distress and disorders resulting from exposure to significant trauma provided to us by both homelessness services and mental health service providers.

The feedback we have received from both sectors in the preparation of this paper is that while our members tell us that mental health issues and psycho-social disorders are common amongst clients of homelessness services, mental health services also report that homelessness and housing insecurity are common issues for many of their clients/patients.

Having reviewed some of the literature and reports on the issues of mental illness and homelessness in the course of preparing this paper we have uncovered evidence that the boarding house sector is also accommodating large numbers of people with mental health problems and who are experiencing high levels of psychological distress. Reports conducted in four jurisdictions have drawn attention to some of the less desirable features of life in some boarding houses and suggest that while they are accommodating significant numbers of people with psychological and psychiatric problems, they may not be the best settings for people seeking to stabilise their symptoms and work towards recovery from illness. Reports commissioned for the Social Inclusion Unit in SA, the Rooming House Taskforce in Victoria, the NSW Ombudsman and Baptist Community Services Wollongong/ACT have exposed the realities of life in boarding/rooming houses and highlighted the common incidence of poorly managed or untreated mental illness amongst occupants<sup>xvii</sup>.

They suggest that just as boarding houses were common sources of accommodation for people upon exiting asylums/long stay hospitals in the 1970s, they continue to be so in the present day. Estimates on exact numbers vary as they do with attempts to estimate the prevalence of mental illness amongst people experiencing homelessness generally.

A 1993 Human Rights and Equal Opportunity Commission Inquiry into Mental Health estimated that 70-80% of boarding house residents in Sydney would meet the criteria for mental illness though many may not have a formal diagnosis<sup>xviii</sup>.

An Inquiry into the psychiatric and intellectual disability support needs of boarding house occupants in metropolitan Adelaide revealed 48% met the criteria for mental illness or high levels of psychiatric distress<sup>xix</sup>.

The Victorian Government's Rooming House Standards Taskforce Report concluded that high numbers of people with histories of de-institutionalisation and severe mental illness were rooming house occupants and that this was a continuing trend with the number of Disability Support Pension recipients citing incapacity due to mental illness who were occupants of rooming houses increased by 41% between 2001 and 2006<sup>xx</sup>.

A 2011 NSW Ombudsman's report also highlighted the high prevalence of people staying in boarding houses who experience mental illness and the difficulties for many of this group in terms of the impact of the occupant mix on the severity of their illness and the challenge of managing medication and controlling symptoms.

The report also questioned both the adequacy and appropriateness of boarding house environments for people with mental illness<sup>xxi</sup>.

A 2011 report on the needs of residents in unlicensed boarding houses commissioned by Baptist Community Services in the ACT and Illawarra and funded by NSW Health and the Mental Health Coordinating Council found that one third of residents had a mental health disorder and the majority (55%) experienced high levels of psychological distress<sup>xxii</sup>.

The reports also noted that the experience of homelessness can be traumatic for a large number of people and the risk of exposure to trauma increases as the length of time experiencing homelessness increases. Recent findings from the Michael Project conducted by Mission Australia and the Journey to Social Inclusion involving clients from Sacred Heart Mission in Melbourne has also identified exposure to trauma as a common and significant issue for people who have experienced long periods of homelessness.

While boarding houses and homelessness services appear to have become default accommodation options for significant numbers of people who fifty years ago may have been institutionalised in asylums, the literature also suggests that it is families who have met the responsibilities of accommodation and care for relatives discharged from asylums. Conversely it was often family members who were the ones who referred loved ones to the care of asylums decades earlier when they were unable to cope with the burden that mental illness bestowed on them.

It could be argued that in the present day it is still families who provide accommodation and care to large numbers of people living with mental illness and psycho-social disorders in Australia.

It could also be argued that it is the people who are without strong family and social support networks more often find themselves unable to access or sustain housing and who require frequent stays in psychiatric settings before being discharged into tenuous accommodation and who end up in the homelessness service system which is often inadequately resourced to address complex psychiatric and psychological care needs.

As noted earlier, estimates of both the incidence and prevalence of mental illness and psycho-social disorders amongst people experiencing homelessness will vary depending on factors such as age, gender, reasons for homelessness, length of time spent experiencing homelessness and exposure to trauma and violence.

What a scan of some of the literature has revealed is that people with mental illness and who are experiencing high levels of psychological distress frequently present to homelessness services or reside in boarding houses while homelessness is often reported by people accessing mental health services both community-based and clinical.

The phenomenon is not new, historically, the disadvantaged, excluded and economically deprived have been overrepresented in mental health facilities since at least the 19<sup>th</sup> Century and in the present day it is not a problem unique to Australia.

Literature from Canada, the European Union, New Zealand, the United Kingdom and the United States consistently reports high rates of mental illness amongst people experiencing homelessness. What is less clear is determining the precise nature of the relationship between cause and effect.

## **5. The in-betweeners: Too unwell for homelessness services, not unwell enough for hospital**

Homelessness Australia's members often report that a proportion of their clients, often referred to in policy circles as having 'complex needs', are the most difficult to secure referrals to clinical mental health services, in particular, in-patient care. Workers from specialist homelessness services report that they often seek referrals to clinical mental health services only to be told that the client is not unwell enough for clinical care or does not meet a mental health diagnostic criteria because their condition is axis 2 (personality disorders and developmental disorders).

This is not to say that homelessness services find it easy to refer clients with axis 1 disorders (schizophrenia, Bipolar 1 & 2, Depression, anxiety disorders, or other affective states) but given the focus on mental health reform in the May Budget and recognition of the need for better coordination between service systems it is worth including here.

It is obviously preferable to have people treated in the community but homelessness services are dealing with significant numbers of people in crisis at any one time and this often means there is not the capacity for staff to deal with exacerbated symptoms of mental illness whether or not these result from so-called 'personality disorders' or whether they result from axis 1 diagnoses that are more likely to be accepted into clinical and in-patient care.

Workers from Homelessness Services in Western Australia have informed us that a major concern for them is the inability to refer people when moderate symptoms emerge. They are frequently told that their client(s) condition(s) are not serious enough to warrant clinical care but their assessment is that without intervention symptoms will worsen. They have told us that this too often happens and the person becomes agitated and distressed and the symptoms escalate to a level that may warrant in-patient care. Often by this stage the person is in need of more intensive support and on-going monitoring than can be provided in a busy homelessness service. The dilemma is obvious. Workers from homelessness services are regarded as not understanding the eligibility criteria for admission to clinical mental health services and often do not use the same clinical language/jargon that mental health specialists use when seeking to refer clients.

Workers from homelessness services feel their concerns are too easily dismissed and that they are regarded almost as 'overreacting' for seeking to refer clients early after symptoms emerge or it becomes obvious that a person may have a mental illness. This is in fact not the case and it is the intention of workers from homelessness services to seek referrals to clinical services and hospitals at the earliest opportunity. Experience tells them what is coming; they see similar cases every day.

Part of the core mandate of specialist homelessness services is to conduct an assessment of a person's health, social circumstances and well-being. Increasingly this requires people to assess a person's mental state and their level of psychological distress and its impact on social functioning.

Having done so, they are then required to seek referrals to external services that cannot be fully provided by staff on-site. Yet when they do so they find their clients are not unwell enough to be accepted by mental health services, in particular providers of in-patient care.

Workers in Western Australia, South Australia and Queensland have expressed frustration at a group of clients I have referred to in the title of this section as the 'in-betweeners'. They are too unwell to be fully supported by specialist homelessness services but are not unwell enough to be accepted for referral to specialist mental health services. Their needs may be complex or they may simply require a formal diagnosis or support to manage symptoms of a mental health disorder or support to reduce psychological distress in cases where a mental health diagnosis is not warranted. They require intensive support and this may or may not be possible for specialist homelessness services depending on the level of mental health training their staff have and the case load that they are dealing with at any given time.

## **6. Re-institutionalisation: prisons- the new asylums?**

There is a growing evidence base that indicates that a significant proportion of both men and women who end up in our prison system meet DSM criteria for mental illness. According to the Mental Health Foundation in the United Kingdom, only one in ten prisoners "have no mental disorder"<sup>xxiii</sup>. Department of Justice figures from the United States indicate a similar prevalence among those incarcerated in Federal prisons there and as many as 25% are experiencing more severe mental disorders such as schizoid-affective disorders or bipolar disorder, a rate 12 times higher than the general population<sup>xxiv</sup>.

Research conducted in Australia indicates that as many as seven out of ten female prisoners and two-thirds of male prisoners may be suffering from mental illness and one in four would meet the criteria for more severe and persistent illness such as affective and schizoid-type disorders<sup>xxv</sup>. The Australian Institute of Health and Welfare (AIHW) report *The Health of Australia's Prisoners* states that 37% of prisoners incarcerated in 2009 have been diagnosed with a mental illness.

The AIHW report notes:

*"...It is well-established that people with mental illness are incarcerated at a higher rate than the general population and that prisoners have higher rates of psychological distress and mental illness than the general population..."<sup>xxvi</sup>*

The incidence of schizoid-type disorders in the general population is estimated to be just under 1%, while just over 3% of Australians have been diagnosed with affective disorders, most commonly bipolar<sup>xxvii</sup>.

This means that the proportion of persons with more severe mental disorders in the prison population is six times higher than the general population, while prisoners are twice as likely to suffer from any form of mental illness as those who are not incarcerated. In addition, there is a large body of evidence from the fields of psychiatry and psychology that demonstrates that incarceration exacerbates symptoms of mental illness and can trigger mental illness in individuals with a predisposition.

In an earlier paper on preventing exits into homelessness from statutory care, mental health facilities and correctional facilities, Homelessness Australia noted that there are links between homelessness and institutionalisation and that people are often discharged from correctional facilities into either tenuous, insecure accommodation or homelessness.

We are aware that there are a number of good housing exits programs in place that assist people exiting prison to access transitional and stable accommodation. A couple of providers have informed us that it is often prisoners with mental illness whose accommodation quickly breaks down 'on the outside' and who are need of greater support pre and post-release.

Some Homelessness Australia members commented on the links between homelessness, mental illness and incarceration, noting:

*"...The ongoing impact of de-institutionalisation for some individuals has resulted in some people with multiple and complex needs cycling in and out of homelessness, hospitalisation and the criminal justice system This highlights a need to address this service gap through Intensive supported accommodation services within normal community settings..."<sup>xviii</sup>*

Another provider noted:

*"...High numbers of people seem to transition from one form of institutionalisation to another. Through out of home care to juvenile justice to short stays in mental health hospital wards to homelessness then prison system then they're released and they're back in the homeless system having not received adequate interventions and support in any of them..."<sup>xix</sup>*

It may be important to mention at this juncture the high incidence and prevalence of incarceration rates amongst the first Australians both in juvenile justice setting and adult correctional services. We know that Aboriginal and Torres Strait Islander Australians are dramatically overrepresented in the criminal justice system and in prisons. They are also overrepresented in homelessness services data and in the homelessness count on Census night<sup>xxx</sup>.

In addition, many Indigenous people may have fundamentally different conceptions of 'mental illness' and homelessness and experience the stigma of both somewhat differently to other Australians.

Many Aboriginal people talk of the concept of 'spiritual homelessness'<sup>xxxi</sup>, where they may or may not be stably housed in a Eurocentric sense but consider themselves to be homeless because they are away from their 'country' and the cultural and spiritual connections to the land.

In conventional terms meanwhile we know from data produced by the Australian Bureau of Statistics that Indigenous people are six times more likely to live in overcrowded housing than other Australians and that this can have significant detrimental effects on mental and physical health<sup>xxxii</sup>.

There is also evidence to suggest that incarceration can have a profound deleterious effect on mental health and well-being<sup>xxxiii</sup>. Coupled with the lengthy history of dispossession and the on-going legacy of the stolen generation, this has had an enormous impact.

In some regional and rural communities, as many as four out of five young Aboriginal men have had contact with the custodial or prison system<sup>xxxiv</sup>. An article in the Medical Journal of Australia notes:

*“...The high rates of repeated short-term incarceration experienced by Aboriginal people in Australia have a multitude of negative health effects for Aboriginal communities and the wider society, while achieving little in terms of increased community safety...”<sup>xxxv</sup>*

In addition, the report cites a study of Aboriginal inmates in South Australia that found:

*“...73% of Aboriginal prisoners expected to have no or insecure housing on release corresponded with our clinical experience... Arguably most problematic of all is the lack of access to suitable housing. One of the few studies conducted on housing after release found that former prisoners who are re-incarcerated report that a lack of suitable housing is a key factor in their unsuccessful transition to outside life...”<sup>xxxvi</sup>*

Given the positive correlation between a lack of secure housing and increased rates of recidivism this is a significant cause for concern.

The article also highlighted the on-going dangers to the health and well-being of Aboriginal ex-prisoners post-release:

*“...The post-release consequences of incarceration are only just beginning to be articulated. Literature in this area is sparse. However, it is becoming evident that the first 6–12 months following release from prison is a high-risk time. Recent studies in Western Australia showed that released Aboriginal prisoners have an almost 10 times greater risk of death than the general WA population and an almost three times greater risk of death compared with their Aboriginal peers in the community. The main causes of death are suicide, drug and alcohol related events, and motor vehicle accidents...”<sup>xxxvii</sup>*

There is a need for further research on the impact of incarceration on mental health outcomes for all Australians, in particular those who identify as Aboriginal and Torres Strait Islander. As we found during the course of our research for our policy paper on preventing exits into homelessness, there is a significant intersection between homelessness, imprisonment and poor mental health outcomes.

While beyond the scope of this paper, it is noteworthy that during the past thirty-five years that de-institutionalisation has occurred in the disability and mental health arenas, the prison population has quadrupled. Indeed over the ten year period from the 1996 Census to the 2006 Census, the prison population doubled<sup>xxxviii</sup>. Given that the prison population continues to increase and the prevalence of mental illness amongst prisoners also appears to be increasing it is reasonable to ask:

Are prisons the new asylums?

## 7. Locked out: Barriers to effective service interventions

Some of the barriers to effective service interventions that we have identified include:

- A lack of 'in-reach' into homelessness services by mental health professionals and specialists such as psychiatrists. This presents enormous difficulties for workers in homelessness services who are dealing with clients exhibiting symptoms of mental illness or who are experiencing high levels of psychological distress as they are unable to secure referrals to mental health services in a timely manner, if at all.
- All too often there is an expectation that people accommodated in homelessness services must present directly to mental health services in order to be assessed as needing a referral. While we know that this is how the service system operates it could be seen as reflecting a middle-class, well-functioning service users perspective where there is an assumption that a person will either know where to go or have sufficient cognitive functioning to be comfortable seeking help from services in what are often very clinical, sterile treatment environments.
- There is evidence that there is a degree of disconnect in the discourse or jargon used by professionals in both the homelessness and health/mental health sectors. Some homelessness service providers<sup>xxxix</sup> have told us that their non-clinical workers often contact acute crisis and intervention services and clinical mental health professionals seeking referrals for their clients and find that their concerns are dismissed because they are not using clinical terminology. Some have reported feeling belittled by health professionals.
- On the other side of the coin, mental health services have told Homelessness Australia that they are sometimes contacted by workers in homelessness services (and elsewhere in the community sector) seeking immediate referrals for people who are experiencing symptoms that are not acute enough to warrant treatment or that are behavioural in manifestation rather than symptoms of mental illness.
- The lack of accommodation beyond crisis services and the problem of staying in contact with a client group that is often transient. While housing was identified by many as an important factor that can greatly improve the chances of promoting recovery and well-being, other providers stressed that effective outreach must aim to encourage people to address their situation wherever they are located.
- For some this could be in boarding houses while for others the path to accessing services that can assist in recovery and/or stabilisation could start while they are in in-patient care, accident and emergency or rough sleeping<sup>xl</sup>. In essence, the lack of housing should not be used as a barrier for facilitating a service offer.

- The stigma of both homelessness and mental illness can dissuade people from seeking assistance from either housing providers or health services. It can also make it difficult for support workers to assist people to access private rental properties and even State/Territory housing authorities.
- There are structural barriers to service access including but not limited to; lack of housing, poorly located housing, transport issues, cost-prohibitive services and the fact that both housing and homelessness and mental health care systems are difficult to navigate even for well-functioning, articulate people let alone people who have been socially excluded, are experiencing an escalation of symptoms or whose cognitive functioning is impaired. Navigating service systems is not only complex it can be both frustrating and stressful particularly when entry doors typically operate simply as gateways to lengthy waiting lists (especially in homelessness, housing and mental health).
- The link between homelessness and poorer mental health outcomes may be well established but homelessness service providers have told us that mental health services and homelessness services are not well connected in Australia. In most states and territories alignment between the policy directions and service systems is poor or non-existent and mental health services struggle to understand homelessness while workers in homelessness services usually not experts in mental health (nor are they funded to be).
- Homelessness Australia heard from a range of sources about the detrimental impact of poverty, social disadvantage and social exclusion on the lives of people with mental illness.
- Another issue that we would have liked to devote more attention to in this paper concerns cultural differences in perceptions of the causes of mental illness, stigma and shame and the deterrents this creates to seeking help. Homelessness Australia is aware of research conducted by Multicultural Mental Health Australia that has documented additional barriers to seeking help that people from some culturally and linguistically diverse backgrounds face when symptoms of mental illness emerge. An excellent summary of the barriers faced by people from CaLD communities and information about effective service models can be found in the report *Evaluating Mental Health Services for People from Non-English Speaking Background Communities* on the [Multicultural Mental Health Australia website](#).

Additional barriers can include:

- limited or no contact with family members
- limited social support networks
- poor planning and financial skills
- alcohol or other drug use
- poor acceptance of mental illness
- poor acceptance of treatment
- history of brief repeating hospitalisations

- other associated health issues
- poor discharge planning
- cost barriers to treatment access
- the lack of affordable housing
- poorly located housing that is not close to transport or support services and;
- Cultural differences in views about mental health and illness.

## **8. Cause and effect: what comes first, homelessness or mental illness?**

Like many issues of cause and effect, the answer to this question is not simple and the relationship is not necessarily linear. While the onset of mental illness can be triggered or exacerbated by the experience of homelessness, it is perhaps equally true that a cohort of people with mental illness are vulnerable to homelessness at least in part because of the way in which their illness manifests.

People with mental illness are at greater risk of homelessness due to requirements of personal care, social isolation, family breakdown, stigma, discrimination and a breakdown in housing tenure due to hospital admissions.

The experience of homelessness is stressful and even short periods of homelessness can trigger anxiety and despair. If homelessness becomes intermittent or recurrent, the likelihood that it will trigger an anxiety disorder or depression is increased.

In Australia, perhaps even more so than elsewhere, having a secure place to call home, specifically one you own or are purchasing, has been the aspirational goal and cultural expectation/norm for at least a century. This has meant that even private rental has historically been viewed as transitional accommodation, the final step before graduating to home purchase.

Having a safe and secure place to call home enables a person to establish roots in a community, connect to health and social services and a sense of belonging and protection from the elements.

People who are experiencing housing insecurity or who are living in unstable accommodation are more likely to experience higher levels of psychological distress or symptoms of anxiety and depression than people with security of tenure<sup>xii</sup>

People who have spent longer periods of time in homelessness settings, boarding houses or sleeping rough are significantly more likely to develop more severe and persistent disorders such as affective disorders and schizophrenia<sup>xiii</sup>.

Research that sought to identify pathways into homelessness found that people who experience homelessness having taken the 'mental health pathway' tend to remain

homeless for significantly longer periods than people who experience homelessness after leaving

Homelessness Australia has been made aware of instances in which people have lost their housing following short term admissions to in-patient mental health facilities. This has sometimes been because the tenant was too unwell to notify their landlord that their symptoms had worsened and they were evicted due to non-payment of rent. In other cases, notably tenants in public housing properties, also faced eviction following short-term in-patient care because public housing authorities believed they had abandoned the property.

While it is true that some people prefer to live in semi-communal accommodation settings, it is equally true that these types of accommodation settings that offer people no privacy are completely inappropriate for other people who are recovering from short or medium term stays in in-patient mental health facilities. Indeed as boarding houses are often sites of illicit drug use and violence, exposure to both of which can exacerbate symptoms of mental illness, they are in many cases the least appropriate accommodation setting into which people should be exited from mental health facilities.

Homelessness Australia is aware of cases of people being discharged from mental health in-patient settings into backpacker accommodation.

Whether or not people were connected to outpatient services is not known but arguably, backpacker hostels are inappropriate accommodation for people who have recently required in-patient care in a mental health unit.

In other jurisdictions, we have heard reports of people arriving at homelessness services having been provided with a taxi voucher upon discharge from a psychiatric facility or hospital. Due to the very short nature of acute care stays (as short as 24 hours in some cases), accommodation planning is not always possible.

The link between mental ill health and homelessness cannot be considered in isolation from other factors such as economic and social inequality, intergenerational poverty and social exclusion. Families have historically carried a significant share of the care burden for people with disabilities and mental illness and continue to do so. It is those who are without family support and who are from socio-economically disadvantaged backgrounds for whom homelessness presents itself as a very real risk.

That said, there is a strong body of evidence that demonstrates that having access to stable accommodation, preferably housing, is positively associated with longer periods of stabilisation, fewer emergency mental health admissions, greater 'compliance' with medication and improved social functioning<sup>xliii</sup>.

## **9. Emerging evidence: linking homelessness, mental illness, trauma and violence**

Recent studies by Sacred Heart Mission and Mission Australia have documented a strong correlation between exposure to trauma and long-term homelessness.

Both reports found that a majority of people who participated in the studies had been exposed to traumatic events such as witnessing a murder or attempted murder, repeated assault, regular exposure to violence and kidnapping or deprivation of liberty<sup>xliv</sup>.

Exposure to trauma, either a severe single event or recurrent exposure to violence or sexual abuse is correlated with the development of post-traumatic stress disorder, multiple-personality disorder and/or schizoid-type disorders. There can be a delay of months or even years between the exposure and the onset of symptoms but symptoms may be triggered or exacerbated by an event, place or person that results in the subconscious re-visitation of the experience<sup>xlv</sup>.

The correlation between exposure to trauma and the onset of mental illness and the findings of the Journeys to Social Inclusion evaluation and the Michael Project could provide additional insight into the relationship between homelessness and mental illness and high levels of psychological distress.

Furthermore, the Australian Institute of Criminology has found that people sleeping rough or staying in crisis services are three times more likely to be victims of aggravated assault or assault involving a weapon than people who were stably housed prior to arrest<sup>xlvi</sup>.

This suggests that homelessness itself, particularly rough sleeping and cycling between crisis services and rough sleeping, increases the likelihood of exposure to violence or trauma which may trigger mental illness or exacerbate an existing condition.

Turning to a different client group but one that is equally important and in need of further research it would be useful to get an Australian analysis of the impact of exposure to domestic and family violence and the trauma of repeated exposure to violence in the family home and the development of mental illness, particularly post-traumatic stress disorder.

An *Issues Paper* prepared by the Australian Domestic and Family Violence Clearinghouse reviewed some of the literature and research findings examining the link between exposure to violence and the development of mental illness with a key focus on children. It reported on the findings of a UK study of children's exposure to and/or involvement in domestic violence that found:

*"...that while only 13 per cent qualified for a full PTSD diagnosis, larger numbers suffered from traumatic symptoms which included intrusive and unwanted remembering of the traumatic events (52 per cent); traumatic avoidance (19 per cent); and traumatic arousal symptoms (42 per cent)..."*<sup>xlvii</sup>

Furthermore research from the United States has demonstrated that:

*"...Domestic violence can lead to other common emotional traumas such as depression, anxiety, panic attacks, substance abuse and posttraumatic stress disorder. Abuse can trigger suicide attempts, psychotic episodes, homelessness and slow recovery from mental illness..."*<sup>xlviii</sup>

Given what we know from mental health research more broadly this is not surprising. Exposure to trauma is a common causal factor in the development of some of the more serious axis 1 disorders such as schizophrenia.

The research also noted that children who are exposed to or experience violence in the family home can go on to experience high levels of psychological distress as a result and can also develop early onset mental illness:

*“... Children exposed to domestic violence are at risk for developmental problems, psychiatric disorders, school difficulties, aggressive behaviour, and low self-esteem. These factors can make it difficult for survivors to mobilize resources...”<sup>xlix</sup>*

In addition we know that many women who experience domestic and family violence require intensive counselling and support after leaving violence to support their transition to life without the threat of violence. This will often include the need for referral to mental health services.

We have been provided with information about a partnership between providers of domestic and family violence services and psychiatric, disability, rehabilitation and support services in Victoria that enables women to access psychiatric and psychological services as required following a period of time in refuge accommodation. It also enables specialist domestic violence workers to provide on-going support to women who require short or medium term stays in psychiatric facilities<sup>l</sup>.

Such agreements require a level of formality and cross-sector collaboration and there are no doubt many other examples of good practice in this area that are not documented in this paper. A scoping study of the partnerships that do exist between providers of domestic violence services, homelessness services and mental health services both clinical and community oriented would be a valuable resource for all three sectors.

## **10. The Wrong Door? Co-morbidity dual diagnoses**

We sought feedback for this paper from both the homelessness and mental health sectors. Two issues were mentioned as critical barriers to effective service interventions by workers from peak bodies and providers in both sectors, they are:

- The inability to secure access to stable housing with security of tenure and;
- The difficulties faced by people who had a diagnosis of mental illness with a co-occurring alcohol and/or other drug use disorder.

Leaving housing aside for the moment (its importance will be discussed in the next section), let us turn to the issue of co-morbidity dual diagnoses or tri-diagnoses (mental illness, alcohol and/or other drug use and chronic physical health problems).

Our members as well as mental health consumer networks and providers of mental health services have told us that too often people will present or will be presented (following an

admission to accident and emergency) to psychiatric services who will assess them as having a mental health diagnosis but will not admit them for in-patient treatment because they have disclosed either current or recent alcohol or illicit drug misuse.

As a consequence they may be referred to alcohol or other drug services and told that mental health services cannot and will not admit them for in-patient treatment until their substance use ceases which for many people is not a realistic goal; at least in the immediate future.

A common occurrence is that mental health assessments will not be performed if a person is under the influence and an assessment of the severity of a person's alcohol or other drug use will not be conducted if there is a concurrent mental health issue. There are often good reasons for this as the existence of both may cloud an accurate assessment of the specifics of one or the other.

The end result however is that the person receives no help or treatment for either symptoms of their mental illness or their alcohol and/or other drug use and both problems remain unaddressed.

Some providers of homelessness services have told Homelessness Australia that the majority of clients they see who have long-term histories of chronic homelessness and/or housing insecurity who present with mental health symptoms will also disclose alcohol and/or other drug use. They report frequently being unable to secure timely referrals to either alcohol and other drug services or mental health services and social workers in homelessness services often find themselves having to manage complex and challenging behaviours that manifest from co-morbidity dual diagnoses, within the confines of specialist homelessness services. This is not what these services were set up to manage and for the people experiencing co-morbidity it is not an adequate response.

Homelessness Australia recommends that the soon to be implemented National Partnership Agreement on Mental Health must strongly link to the National Partnership Agreement on Homelessness and homelessness reforms more broadly.

We believe that the \$571.3 million package over 5 years to deliver more and better coordinated services for people living with 'severe and persistent' mental illness has the potential to benefit people with co-morbidity dual diagnoses who currently present in significant numbers to homelessness services and who we are informed make up a high proportion of the 'rough sleeper' cohort. We are hopeful that the improvements in coordination and service access that will be driven through this initiative will mean that people who present to mental health OR alcohol or other drug services with co-morbidity dual diagnoses will be able to access treatment no matter which door they present to.

## **11. Early intervention: getting in before things get heady**

Mental Health researchers tell us that as many as 75% of people who go on to develop mental illness prior to the age of 25<sup>li</sup>.

As Professor McGorry has noted, the mental health of young people within developed countries is of growing concern. Despite a significant decline in the rate of youth suicide over the past fifteen years<sup>lii</sup>, rates of onset of mental illness amongst Australians aged 15-24 have increased slightly during the same period<sup>liii</sup>.

According to the Mental Health Council of Australia and the Black Dog Institute, rates of mental illness in Australia are highest amongst people aged 18-24 a problem amplified by the inclusion of substance use disorders given that the rate of drug use other than alcohol is higher for this group than most other demographics<sup>liv</sup>.

Early intervention is an often used term that can have different meanings when applied to different client groups and age demographics and different sectors. Given the high percentage of people who develop symptoms of mental illness before the age of 25 it seems logical to primarily focus on young people in this chapter but it should be noted that early intervention strategies can be employed to support recovery from illness across all demographics.

An example of this in relation to domestic and family violence might be to reduce the exposure of children to violence as we know there is a correlation between exposure to violence/trauma and the development of conditions such as post-traumatic stress disorder (PTSD) and in extreme cases multiple-personality disorder later in life<sup>lv</sup>.

Returning to young people, the importance of intervening early to prevent mental illness from becoming entrenched, severe and persistent cannot be overstated. High profile mental health sector advocates such as Professor Patrick McGorry and Professor John Mendoza have written and spoken publicly at length about the need for improved access to mental health services for young people and the expansion of successful programs such as Headspace and the Early Psychosis Prevention and Intervention Centres which has been progressed following the significant funding package for mental health in the May Budget.

Youth homelessness services frequently provide accommodation and support to young people who are exhibiting symptoms of mental illness. Sometimes workers are able to identify a need for access to youth mental services at the early onset stage, while other young people reach youth homelessness services in crisis having been dealing with mental illness with little or no support for some time.

Later in our discussion of some the models that are working to support young people experiencing both homelessness and mental illness we discuss the good work and positive outcomes that the Innovative Health Services for Homeless Youth (IHSY) program has delivered.

Homelessness Australia welcomes the significant new funding for mental health programs such as EPPIC and Headspace that was announced in the May Budget. We also welcome new funding commitments that will drive improved system access and coordination. This is a critical area of need identified over the course of researching for this paper.

Young people from supportive families that are well resourced find it difficult to access mental health services even Child and Adolescent Mental Health Services that are specifically established for them.

It is not uncommon for people to be visited by assessment teams only after a crisis or acute episode has occurred and there is a clear and present risk of self harm.

The onset of mental illness in adolescence and young adulthood can have a devastating and immensely disruptive impact on the life of the young person and their family who will usually shoulder the bulk of the care burden as is the case with people living with intellectual and physical disabilities.

For younger people the advent of mental illness early in their high school years can be incredibly disruptive to education and this can establish a trajectory of disadvantage than can result in some young people ending up in the circumstances of exclusion and economic disadvantage described elsewhere in this paper.

Young people from middle-class and advantaged backgrounds are less likely to follow this pathway. Their families are afforded sufficient material resources and social capital to ensure that their children can receive a level of care that at least in the early stages following the onset of mental illness will not result in a young person becoming homeless.

This is in no way meant to imply that the disruption to education, family life and psycho-social functioning is not acute and significant for these families.

For young people in families with less material resources and less social capital getting access to mental health services as quickly as possible after the onset of symptoms is critical to minimising the risk that a significant mental health episode and the manifestation of mental illness will lead to family breakdown in later years.

For young adults (aged 19-24) the development of mental illness can also have a profoundly disruptive and devastating impact.

They may find that continued enrolment in further education and vocational training is simply not possible in conjunction with trying to manage, stabilise and recover from mental illness.

This can have implications later in life if people are unable to return to the pursuit of higher education and vocational training and begin to enter a cycle of unemployment and exclusion from economic participation. People from families with a lower capital base both economic and social may be more at risk of family breakdown and entry into a history of housing insecurity than people from more advantaged backgrounds.

It is critical then that cost barriers to service access are as low as possible not only for young people but for all people needing access to mental health services.

Rigid, clinical models of mental health service delivery often involve financial costs that cannot be met by some young people or their families.

In addition they are often clinical, sterile environments that are not youth friendly. In recent years community based mental health models for young people have emerged in response to a recognition that more well-established models have not been accessible to young people for a variety of reasons and have not met demand for service or the needs of young people living with mental illness particularly well.

Data presented at a youth homelessness conference on 23 November indicated that just under 80% of young people experiencing homelessness who were respondents to a survey used social media sites such as Facebook, Twitter and Tumblr. Homelessness Australia therefore believes that social networking must emerge as a key vehicle for the promotion of Government services including mental health services for young people. Being able to access information about where to go to get help and support for mental illness has been a core component of the success of organisations such as Beyond Blue and SANE Australia in reaching young people. Perhaps this is due in part to the relative anonymity of accessing information about issues where there is a degree of social unacceptance and stigma on-line.

Whatever the reasons, promoting homelessness, housing and mental health services and access gateways to them on-line would appear to be the way forward if we are seeking to increase access to and knowledge of the services that are available to support young people experiencing homelessness.

## **12. Emerging Needs: Older Australians and Veterans**

Two cohorts that Homelessness Australia is aware are emerging groups with particular mental health and intellectual disability needs that we need to conduct further investigations about are older Australians and veterans (in some cases older Australians are also veterans).

Data from the United States indicates that veterans of military service and wars account for a significant component of the overall population of people experiencing homelessness, particular those experiencing primary homelessness<sup>lvi</sup>. While the proportion is likely to be lower in Australia due to the fact that a significantly lower proportion of Australians have been engaged in active military service and arguable our housing and support programs for returned service people are better targeted, we are aware that the Department of Veterans' Affairs in Australia considers the issue a significant one.

Many people who have returned from active military service are likely to have a need for some form of mental health or psycho-social support services given the relationship we described earlier between exposure to and involvement in violence and the development of mental illness, post-traumatic stress disorder and high levels of psychological distress.

The Department of Veterans affairs provides a range of housing and mental health care assistance services for returned service people and has produced a fact sheet on homelessness amongst veterans with input from Homelessness Australia<sup>lvii</sup>.

In summary:

The DVA have a budget of \$4.8bn, to holistically manage the needs of a client group numbering just under 300,000 veterans and their families (12). Of this total, some 143,000 people within the DVA treatment population have had some experience with mental illness, including people with an accepted mental health disability and others who have either received mental health care or drug treatments for mental illnesses. The most common mental illnesses affecting the DVA client group are anxiety, depression, alcohol dependence and posttraumatic stress disorder.

DVA purchase a range of services for their client group, including:

- Contracts with 443 public state, territory and private hospitals and clinics to provide services including mental health.
- Primary care services, including general practitioners and others
- Counselling services
- Chronic disease management
- Case coordination
- Rehabilitation
- Dental
- Pharmacy
- Respite Care
- Allied health
- Home Care and Community Support
- Carer and Volunteer Support
- Peer Support and Education

Source: Department of Veterans' Affairs.

Though not a high profile group in the literature, Homelessness Australia is aware that with an ageing population and in recognition that older people experiencing homelessness often present to services in crisis with high and complex needs that Australians aged 55 and over are a group that need to be afforded greater consideration by both the homelessness and mental health care sectors.

Related issues whilst not strictly mental illness such as acquired brain injury, Alzheimer's, dementia and other forms of illness that affect psycho-social functioning and behaviour can place significant workers in homelessness services under significant pressure.

For older Australians whose psycho-social functioning is such that they remain competent to live in to live independently, domiciliary care and assistance with medication management may be sufficient. We also need to see increased access to the aged care system for older Australians with limited means.

The housing and mental health care needs of older Australians are an emerging issue not only for homelessness services but also for our aged care system and the Australian Government as a whole. The needs of older Australians experiencing homelessness, housing insecurity, degenerative diseases of the mind and mental illness warrant further exploration and research.

### **13. Home safe and well: the importance of housing to stabilising mental illness and promoting recovery**

The importance of accessible, affordable, safe housing with security of tenure to health and well-being cannot and should not be discounted or underestimated. Having a place to call home with security of tenure is the first step in the process of civic participation and access to community, health and social services.

The lack of affordable housing in 21<sup>st</sup> Century Australia is well-documented and does not require much in the way of re-stating in this paper.

That said the trajectory from homelessness to stable housing in Australia frequently requires people to navigate their way through a complex social service system which promises the hope of acquiring housing at the end of the journey. This is difficult enough for people who may be functioning fairly well in spite of their homelessness let alone for people whose homelessness has exacerbated symptoms of mental illness to the point where they are not well enough to access accommodation and or support services.

The importance of housing to community and social inclusion, health and well-being and economic participation has been emphasised repeatedly by Homelessness Australia members and was again re-iterated in our consultations with our membership while preparing this paper.

Given that as many as one in five Australians are living with mental illness at any one time and over 45% will experience symptoms of mental illness over the course of their lifetime<sup>lviii</sup>, we know that with adequate resources and support services people living with mental illness can maintain housing and participate fully in community life as well as economically.

What follows is a snapshot of some models of housing and support that we are aware are achieving good outcomes for people living with mental illness. It is by no means exhaustive.

#### **Step up, Step down continuum of care models**

Housing models that enable people to access higher and more intensive levels of support as their symptoms worsen or conversely as they enter into the recovery phase from mental illness have been demonstrated to prevent homelessness and reduce the incidence of hospitalisation amongst people living with more severe mental illness particular axis 1 disorders such as bi-polar and schizophrenia<sup>lix</sup>.

There are variations of these models of accommodation and support operating in a number of jurisdictions, some of which are specifically targeted at people experiencing homelessness, some of which are not. We are aware of good models operating in Queensland, South Australia, Victoria and Western Australia that provide flexibility in both security of tenure and intensity of support as needed.

The models may vary at an operational level and differ for locational reasons (some may be located on the sites of psychiatric campuses, others may be set up as scatter-site housing with clinical services and mental health professionals on-site in more intensive settings and 'on-call' as people transition to accommodation and housing during stages where less-intensive support is needed.

Broadly speaking we have identified some common elements to a stepped continuum care model of accommodation, housing and support:

- Secure care. When symptoms are most acute and severe such as in situations following a psychotic episode or breakdown, more intensive care is required either in a hospital or dedicated mental health facility. This is particularly essential in situations where there is a risk of self-harm.
- Acute in-patient beds.
- Intermediate models. These can provide clustered accommodation adjoining or close to clinical mental health services. The focus may be on transitioning people to independent living or connecting them to community based mental health services and outpatient care.
- 24 hour supported accommodation (clinical).
- Medium term accommodation with support.
- Supportive housing. Can be high density, medium density or scatter site and may or may not include on-site supports but usually requires that a person is connected to support workers and mental health specialists.
- Independent living. The ultimate goal in the recovery process.

Step-up, step down models of care enable people to have some continuum of care when symptoms increase or decrease and are advantageous as they can support people across all age cohorts and life stages with right tenancy mix in place.

### **Permanent Supportive Housing**

The 'Housing First' model which is employed by supportive housing organisations such as Common Ground has yielded some very encouraging results for people with lengthy histories of homelessness who are living with severe and persistent mental illness.

Housing first advocates correctly point out that poverty and socio-economic disadvantage combined with mental illness are the key reason for the high incidence of mental illness amongst people who have experienced recurrent homelessness. They have told Homelessness Australia that the 'myth of deinstitutionalisation' ignores the very real experience of significant hardships, poverty and social exclusion amongst people with severe and persistent mental illness and have pointed out that affordable housing with on-going support services is a more cost-effective and socially inclusive solution to the problem of chronic homelessness amongst this group than institutions.

The principles of the Housing First approach are:

- 1) Move people into housing directly from streets and shelters without preconditions of treatment acceptance or compliance;
- 2) The provider is obligated to bring robust support services to the housing. These services are predicated on assertive engagement, not coercion;
- 3) Continued tenancy is not dependent on participation in services;
- 4) Units targeted to most disabled and vulnerable homeless members of the community;
- 5) Embraces harm-reduction approach to addictions rather than mandating abstinence. At the same time, the provider must be prepared to support resident commitments to recovery;
- 6) Residents must have leases and tenant protections under the law;
- 7) Can be implemented as either a project-based or scattered site model.

The work of Sam Tsemberis and others in the United States and Canada has illustrated that permanent supportive housing and assertive community treatment that actively encourages people who are not housed to access supportive housing has been successful in assisting hundreds of people to stabilise their symptoms, remain housed for long periods and improve their likelihood of sustained recovery from mental illness<sup>ix</sup>.

One of the most important benefits of permanent supportive housing adopting a 'housing first' approach is that while support workers encourage people to engage with health and social services once they have been provided with housing that meets their needs, it is not compulsory and the models offer substantive 'consumer choice'.

The 'harm reduction' approach to alcohol and other drug use adopted by supportive housing that follows a 'housing first' approach makes permanent supportive housing an excellent model of housing and support for people with co-morbidity dual diagnoses who are still in the pre-contemplative or contemplative stages of addressing their alcohol and other drug use and for whom abstinence is not a realistic short-term goal. Given that Australia's drug policy is coordinated within a 'harm reduction' framework, permanent supportive housing that adopts this principal is entirely appropriate for this client group.

While specialist homelessness services data does not indicate that problematic substance use is offered by clients as a main reason for seeking assistance, academic research and anecdotal reports from service providers suggest that alcohol and other drug use and co-occurring mental health diagnoses are common amongst people experiencing homelessness.

Research from overseas indicates that permanent supportive housing is also appropriate for people who have experienced significant episodes of trauma and are exhibiting high levels of psychological distress.

This is because the experience of homelessness exacerbates trauma and psychological distress and once housed, people can begin to address serious issues that have contributed to their homelessness and/or been exacerbated by it such as post-traumatic stress disorder and high levels of psychological distress.

The approach differs markedly from so-called 'treatment first' models of accommodation and support that require people to stabilise their symptoms and address any alcohol and other drug use that so often goes hand in hand with severe and persistent episodes of mental illness.

A number of our members have told Homelessness Australia that co-morbidity (mental illness co-occurring with alcohol and/or other drug use) and tri-morbidity (mental illness co-occurring with significant physical health problems as well as alcohol and/or other drug use) is common place amongst clients of homelessness services, particularly male clients aged 35 and over. This assertion is in part supported by specialist homelessness services data that shows that males aged 35 and over report mental health and substance use as main reasons for seeking assistance more frequently than any other client group<sup>lxi</sup>.

For this group, Homelessness Australia believes the provision of permanent supportive housing following 'housing first' principles is entirely appropriate. There is strong evidence that while not requiring people to immediately address mental health and substance use issues in return for housing, permanent supportive housing models actually deliver more sustained outcomes in terms of people accessing treatment and reducing or ceasing alcohol and other drug use. In many ways it is a simple equation, when the anxiety and stress of not knowing where you will spend the night or where you will be beyond the next few weeks of crisis accommodation is removed, it becomes easier to address other factors that may have contributed to homelessness such as mental illness and alcohol and/or other drug use.

In addition, the Mental Health Council of Australia's *Home Truths* report released in 2009 stated that there is a strong evidence base that clearly demonstrates the importance of stable housing with security of tenure to the promotion of recovery and improved social functioning for people with mental illness, in particular people with schizoid-type disorders and affective states such as bi-polar. It placed housing front and centre on the list of priorities for the mental health reform agenda it proposed and warned that the failure to address the inability of people with mental illness, particularly severe and persistent mental illnesses to access and sustain housing would lead to both an increase in homelessness and an increase in the severity of mental health disorders amongst people experiencing homelessness<sup>lxii</sup>.

While many people will need intensive support and assistance to transition to independent living and sustain their tenancies others will quickly be able to stabilise their symptoms once provided with a safe place to call home and placed on appropriate medication regimens.

Homelessness Australia heard about the importance of housing and the provision of support packages and support workers from members in the domestic violence, family homelessness, generalist and youth sectors. It is also well documented by research from the mental health sector and journals of psychiatry that were canvassed for this paper.

Given the lack of affordable housing in Australia at the present time (as evidenced by the National Housing Supply Council Report that projects a current housing shortage of 493,000 rental properties that are affordable and available to the bottom 40% of income earners) , a key recommendation of this paper is that there is a clear and pressing need for significant

reform to the provision of housing in Australia to ensure that more affordable housing is constructed and allocated rapidly over the next decade.

Homelessness Australia supports a target of an additional 220,000 affordable rental dwellings (including public and community housing) to be constructed and allocated over the next decade with the Government to establish a percentage target for their allocation to persons with histories of housing instability and mental illness.

We believe there is a good evidence base to support increasing funding for the provision of more permanent supportive housing models for middle-aged and older people with long histories of homelessness and higher support needs.

For younger people experiencing homelessness, permanent housing may not necessarily be appropriate as they do not launch into permanent tenure early in their lives but like other young people go through multiple stages of 'moving around' before settling. As many parents of young people with a stable housing history will note they often take many turns at becoming independent living and may return home multiple times as economic resources deplete and circumstances change.

#### **14. Breaking the cycle, Promoting well-being: Models that are working to prevent homelessness provide stable housing and improve the well being of people who have experienced homelessness, mental illness and psycho-social disorders.**

There are a number of organisations that are funded to provide both housing and on-going support to people with mental illness. Mind Australia is a Homelessness Australia member that has been providing stable housing with on-going support services for people living with mental illness who would otherwise be experiencing homelessness for over thirty years in Victoria where it commenced operation as the Richmond Fellowship and more than seven years in South Australia.

*"...Mind's approach to homelessness is not just about putting a roof over people's heads. By addressing homelessness issues Mind opens up possibilities for homeless people to access vital mental health, housing and other support services. Ultimately Mind hopes that through its work it is able to help break the cycle of homelessness for its clients..."<sup>xiii</sup>*

Mind Australia manages a number of properties for people with histories of homelessness who are experiencing either mental illness or who are living with high levels of psychological distress. The level and intensity of support provided to people is tailored to their needs and varies according to the severity of symptoms and whether or not assistance is required with day to day activities such as shopping and medication management.

*"...Mind's programs include; residential rehabilitation, outreach services, transition to independent living, transition to stable and secure accommodation, respite for carers, volunteer and mentor programs, individual service packages and programs that foster healthy living, creative expression and participation in employment..."<sup>xiv</sup>*

A support worker from South Australia has told Homelessness Australia that one of the biggest difficulties is finding appropriate houses for Mind clients that are located in proximity to mental health services. Mind provides in home support services for clients who have been providing with housing to assist them to sustain their tenancies and participate in the community when their symptoms have stabilised. One of the benefits of the organisation is that its workforce includes who are experts in homelessness as well as mental health professionals. Many clients of the organisation exhibit challenging behaviours and other housing providers may have found them 'too difficult to house' or find that they do not match their tenant mix. People with co-morbidity dual diagnoses of mental illness/psychological distress and alcohol and other drug use disorders are often referred to Mind Australia for support.

Mind Australia often works with clients that have been barred from other services or who other providers have found too difficult to 'manage' or whose behaviours are such that they are not able to mix with others supported by the homelessness service. Mind Australia is unique in that it the only large scale provider of homelessness and specialist mental health services in Australia.

Mind provides assertive outreach and long-term support directly to people experiencing homelessness wherever they are staying, often in boarding houses and sleeping rough. Mind believes that there is a need to support people to stabilise their mental illness begin the process of recovery and encourage them to believe that transitioning to stable accommodation with security of tenure is of paramount importance.

The provision of holistic support that initially meets basic needs and then enables the person to improve cognitive and social functioning to a level that enables them to address other more ingrained issues in their lives is an important hallmark of the success of their model.

Mind Australia has told Homelessness Australia that there is insufficient in-reach into Homelessness services and there is a need for much greater coordination between the homelessness and mental health sectors to increase understanding of the role of workers in each sector and the importance of working together to improve outcomes for clients with histories of homelessness and housing insecurity who are also living with mental illness and/or high levels of psychological distress and associated impaired cognitive and psycho-social functioning.

### **The Housing, Accommodation and Support Initiative (HASI) (NSW)**

The Housing and Accommodation Support Initiative (HASI) is an innovative partnership program between NSW Health, Housing NSW and the non-government organisation (NGO) sector that provides housing linked to clinical and psychosocial rehabilitation services for people with a range of levels of psychiatric disability.

HASI is designed to assist people with mental health problems and disorders requiring accommodation support to participate in the community, maintain successful tenancies,

improve their quality of life and most importantly to assist in their recovery from mental illness.

HASI operates as a three-way partnership in service delivery:

- Accommodation support and rehabilitation associated with disability is provided by Non-Government Organisations (funded by NSW Health).
- Clinical care and rehabilitation is provided by specialist mental health services.
- Long-term, secure, and affordable housing and property and tenancy management services are provided by public and community housing (funded by Housing NSW).

HASI builds upon the Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing (JGOS) and provides a funding base to strengthen partnerships and protocols already established between the agencies. The HASI model is based on the 2002 NSW Health, *Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders*.

HASI has been identified as a key program under the *New South Wales Interagency Action Plan for Better Mental Health*. The Plan identifies the NSW Government's commitment to a collaborative approach to the provision of mental health services, including health, education, housing, police, justice, community and disability services. The Plan sets out a coordinated approach to managing the needs of people with mental health issues, including prevention and early intervention; community support; and coordination of emergency responses.

NSW Health and Housing NSW jointly won the 2006 NSW Premier's Public Sector Gold Award in the Service Delivery category for the implementation of the HASI program.

The Stage 1 Evaluation Report (September 2007) noted some significant outcomes for tenants, including that:

- 70% stayed in the same home for 12 months or longer and that 85% of all participants remained with the same housing provider ensuring that they maintained secure and affordable housing.
- 84% of participants experienced reduced rates, frequency and duration of hospitalisation. The time spent in hospital emergency departments decreased by 81%.
- 94% of participants had established friendships and 43% were working or studying.

In essence, the HASI is a simple program that offers the provision of housing with security of tenure and access to mental health support services. A number of providers have told Homelessness Australia that they have seen the HASI benefit their clients but that the program needs to be expanded so that it can expand its coverage across the state.

Other providers in the youth sector have told Homelessness Australia previously that the program needs to be expanded as they have seen less evidence of such high levels of success for younger people.

The Victorian Mental Health Consumer's Network has told Homelessness Australia:

*“...The evidence from HASI and Project 300 is very clear - that housing with support works and that these are the crucial components and principles for success:*

- *stable housing with a benevolent landlord, separate from support provider*
- *clinical support*
- *psychosocial support from recovery-orientated (and trained) workforce...”*

They also stated that the coordination of all of these elements is very difficult to coordinate.

Our consultations have revealed that there are mixed views about the effectiveness of the Housing and Support Initiative. We have received much positive feedback about the successful outcomes that the program has achieved. This has been balanced by feedback that suggests HASI has an ‘under-capacity’ issue and that the numbers of people eligible for the program needs more resources and may not necessarily be the best practice approach for young people.

### **The Housing and Support Program (Queensland)**

The Housing and Support Program (HASP) is an initiative under the Council of Australian Governments' (COAG) *National Action Plan on Mental Health 2006-2011*.

The Queensland Plan for Mental Health 2007-2017 identifies as a key action area, access to supported housing and accommodation services for people with a mental illness.

In Queensland, the Housing and Support Program initiative has involved the collaboration of two government agencies: Queensland Health and the Department of Communities, which includes Housing and Homelessness Services and Disability and Community Care Services.

Access into the Housing and Support Program is lead through Queensland Health, which nominates and prioritises eligible people. Department of Communities Housing and Homelessness Services match people who enter the program to appropriate social housing. Department of Communities Disability and Community Care Services provide funding to approved non-government organisations that provide support services to people in the program who have transitioned into the community.

In 2010, the Queensland Government commissioned an external evaluation of the delivery and outcomes through its Housing and Support Program, and to identify and recommend opportunities for its future management. The evaluation report was produced by the University of Queensland’s Department of Psychiatry in conjunction with the Queensland Centre for Mental Health Research (known as *The Park*).

Results of the evaluation demonstrate that given adequate community support, stable housing and good clinical case management, people with psychiatric disability and mental illness are able to successfully participate and live in their community of choice.

The Housing and Support Program aims to create a recovery orientated environment by providing:

- social housing through the Department of Communities Housing and Homelessness Services
- clinical support through Queensland Health mental health services
- community support through non-government organisations providing services funded by the Department of Communities Disability and Community Care Services.

Since commencement in 2006, the Housing and Support Program has proved to be an excellent example of how government agencies, the non-government sector, and the private sector can work together to improve the well-being of people with psychiatric disabilities and promote social inclusion. Those involved in the planning of future community integration programs for people with mental illness are encouraged to consider the Housing and Support Program model.

### **Project 300 (Queensland)**

Project 300 is a Queensland Government initiative that aims to provide comprehensive supports to assist people with a psychiatric disability to move from Queensland Health extended treatment facilities and to sustain community living.

Project 300 is a collaborative interagency model involving approved non-government service providers, Queensland Health and the Department of Communities (Disability and Community Care Services) which brings together clinical and non-clinical supports to improve the quality of life of people eligible for Project 300. Since its inception in 1995 the program has supported over 300 individuals with a psychiatric disability to move from Queensland Health extended care facilities to living in the community.

Entry to P300 is via Queensland Health. Queensland Health identifies, prioritises and nominates people who are residing in extended treatment mental health facilities.

Disability and Community Care Services provides funding to non-government service providers to enable them to support people who have transitioned into the community.

One of the only problems with Project 300 is that is small in scale.

### **Victoria's Psychiatric, Disability, Rehabilitation and Support Services (PDRSS model)**

While not specifically for people experiencing homelessness, Victoria's non-clinical psychiatric services have demonstrated that good outcomes can be achieved when community based mental health services work closely with housing providers.

### **Psychiatric disability rehabilitation and support services (PDRSS)**

The non-government psychiatric disability rehabilitation and support services sector is a core component of specialist mental health services complementing clinical mental health services. PDRSS are managed by non-government organisations and focus on addressing the impact of mental illness on a person's daily activities and the social disadvantage resulting

from illness. They work within a recovery and empowerment model to maximise people's opportunities to live successfully in the community.

### **Target group**

Psychiatric disability support services are aimed at people with serious mental illness and associated significant psychiatric disability. Services cater primarily for people aged between 16 and 64 years. The precise eligibility criteria will depend on the type of service or program being offered. Consumers receiving case management services from the public mental health service who are referred by the service are automatically eligible for support from the PDRSS.

### **PDRSS disability support services (outreach/day program/social support)**

Rehabilitation day programs assist people with severe psychiatric disabilities to improve their quality of life, participate in everyday living activities, and function as independently as possible in the community. This may involve the development of social and living skills in a group context, through centre-based and community access programs. Home based outreach services provide support to consumers living in their own homes, or other community residential settings. Training in social and living skills is provided in the resident's home, with a focus on the activities and interactions of everyday life.

### **PDRSS residential disability support services**

Residential rehabilitation services provide intensive psychosocial rehabilitation and support in group accommodation preparatory to residents living independently in their own setting. Emphasis is on developing or regaining skills to enable each resident to deal with daily living activities, developing confidence to commence or continue schooling, training or employment, as well as supporting positive contact with their family and friends.

### **Planned respite**

These services provide a short-term change in environment for a consumer and a break for carers, and include both formal and informal psychosocial rehabilitation components. Planned respite services may involve social and recreational day activities, including in-home support, holiday and adventure activities, and residential components.

### **Mutual support and self help**

These services provide information and peer support to people with a mental illness and/or their carers. This can involve the sharing of experiences and coping strategies, the provision of information and referral services, and the promotion of community awareness.

### **Innovative Health Services for Homeless Youth (IHSY) Program**

The IHSY program has been operating for some time in a number of jurisdictions across Australia. State and Territory level evaluations have documented the program's success in

reaching young people who are experiencing homelessness who face additional cost and inclusion barriers to accessing mainstream health services including General Practitioners.

The Innovative Health Services for Homeless Youth (IHSY) program is a State/Commonwealth funded program that promotes health care for homeless and at risk young people. Funds are provided for health promotion and service delivery that responds to the health needs of young people and improves their access to mainstream health services. There are eighteen providers of IHSY services in Victoria, a number of which are either auspiced by or work in partnership with youth specialist homelessness services<sup>lxv</sup>

A number of specialist homelessness services are funded to either provide IHSY services or work in partnership with primary and mental health providers who service young people who are experiencing homelessness in the locality in which the homelessness service is based. A number of specialist homelessness services in inner-city Adelaide work closely with and refer clients to Streetlink health service for support. Streetlink was funded to deliver IHSY services. Similarly, Southern Youth and Family Services in Wollongong is funded to deliver the [CHAIN Program](#) funded through IHSY.

Homelessness Australia received good reports about the work being done to support these programs and the youth homelessness sector has recommended increasing funding for IHSY services and an expansion of the program.

### **The Personal Helpers and Mentors Program**

The Department is no doubt aware of the components and specifics of the Personal Helpers and Mentors Program (PHaMs). According to FaHCSIA's March 2011 evaluation of the FaHCSIA funded community care mental health initiatives:

*"...aims to foster an individual's sense of whole and dignity and capacity for resilience through stages of recovery, it aims to underpin three key outcomes:*

- *Increase access to appropriate support services at the right time.*
- *Increased personal capacity and self-resilience.*
- *Increased community participation...*<sup>lxvi</sup>

Homelessness Australia has received mixed reports about the in-reach of the Personal Helpers and Mentors Program into homelessness services. Feedback from providers in the Northern Territory, Queensland and Tasmania has been extremely positive while providers in Western Australia have been less successful in securing access to PHaMs providers for their clients. Some services in NSW have informed us that they feel the program is 'too conservative' in its approach.

### **Community Supported Residential Units (CSRU)**

#### **Background to the program**

Formed part of a number of accommodation strategies announced as part of the Western Australian (WA) Mental Health Strategy 2004-07.

CSRUs to be located in both metropolitan and country areas.

In 2008 St Bart's was awarded the contract by the Mental Health Division of the Department of Health (now the WA Mental Health Commission) to manage four metropolitan CSRUs, located at Bentley, Kelmscott, Stirling and Middle Swan.

In total providing accommodation for 97 adults living with mental illness, with 24/7 staffing.

All sites are Licensed Private Psychiatric Hostels with the Department of Health.

### Aim of program

The WA CSRU program fosters partnerships between the public mental health service (MHS), the Department of Housing (DoH) and the chosen Non Government Organisation (in this case St Bart's).

The main aim of the program is to provide adults living with a mental illness who have low to medium support needs access to medium to long term home-like accommodation that is safe, stable and secure.

The housing was built by the DoH

The local MHS provides the clinical care and back-up that each resident needs.

The St Bart's staff support the residents with their activities of daily living in order to aid a meaningful life that will equip them to live and participate in the community.

### Partnerships

Each CSRU site is head-leased by St Bart's from DoH and houses between 22-25 people in a mix of one, two and three bedroomed units. There is a separate unit that is the staff office and communal activities unit.

The local MHS provides the clinical care and back-up that each resident needs.

There is a specific Liaison Officer at each local MHS who is the main interface between the local MHS and St Bart's and who oversees the referral process.

Lotterywest granted funding to furnish the 60 houses in the St Bart's program.

The WA Mental Health Commission provides funding to St Bart's on a bed-occupancy basis.

### Implementation of program

St Bart's opened Bentley Villas in Bentley in December 2008, followed by Arnott Villas, Kelmscott in June 2009. In February 2010 Sunflower Villas at Stirling and Swan Villas in Middle Swan were opened.

All referrals are channelled through the local MHS via an agreed process. This includes a comprehensive application form establishing that the person concerned meets the criteria for the program, visits to the accommodation and an interview with the site Supervisor. A three person selection panel consisting of a local MHS representative, a St Bart's representative and an independent community representative make the final decision as to whether the person is suitable for the program.

Each site is run independently within an overall St Bart's strategy, policies and procedure. A Supervisor oversees the day-to-day running of the site and there are St Bart's support staff on site 24/7.

Each CSRU has a service level agreement with their local mental health service that sets out the roles and responsibilities of all parties in the support of the resident.

Regular meetings are held between St Bart's and the local MHS to discuss the partnership interface.

Residents are encouraged to take ownership of their support plans, to set their goals and the steps needed to achieve those goals. St Bart's use the Outcome Star measurement tool, the local MHS use PSOLIS and there is a joint support plan that brings both together.

### Challenges for St Bart's

Some referrals by case managers are quite inaccurate which can lead to an inappropriate person moving to the CSRU. This can lead to disappointment and failure for that person as their support needs cannot be met and often they have to leave the accommodation after a short time.

The interaction between local MHS case managers and St Bart's staff is variable. The majority of case managers are very cooperative over joint support plans and encourage notification of early signs of relapse. Others are dismissive and rarely visit their clients.

Motivating residents to engage in the program activities is very challenging. On the whole most residents engage willingly. Others are very difficult to motivate to set goals, let alone put the actions in place in order to work towards those goals.

### Successes for St Bart's

A number of residents have improved their daily living skills sufficiently to be able to move to less or unsupported accommodation.

For some residents, maintaining their current accommodation is an achievement.

Some residents now have part time employment.

Some residents are enrolled in further education courses.

Some residents have re-engaged with their families.

### Resident feedback

Some key findings from the 2010-11 CSRU resident feedback survey (response rate 44%, n=39):

78% of respondents either strongly agreed or agreed that their daily living skills had improved

95% of respondents either strongly agreed or agreed that they were satisfied with living at the CSRUs.

89% of respondents either strongly agreed or agreed that their wellbeing had improved since moving to the CSRU.

82% of respondents either strongly agreed or agreed that the CSRU program had contributed to their recovery and hope for the future.

Although 22% of respondents stated that they either strongly disagreed or disagreed that their participation in study, leisure, volunteer or paid work had improved, 55% of respondents either strongly agreed or agreed that these areas had improved.

The above example provided by St Bartholomew's House is just one example of this model of accommodation and support operating that was provided to Homelessness Australia. We are aware of similar models operating in other jurisdictions by providers such as Mind Australia and Supported Housing Limited in South Australia and Victoria. There are no doubt many others.

### **Place based services**

Place based services that reach people experiencing homelessness have been demonstrated to achieve good outcomes across the service system. Some of these were documented in the homelessness green and white paper and the Department is no doubt aware of the importance of these in terms of delivering assertive outreach and opportunities for access to housing and support services to people currently not in any form of stable accommodation.

## **15. Discussion and conclusion**

Homelessness Australia has assessed some of the literature documenting the relationship between homelessness, mental health and psychological distress. We have consulted with our members and providers of mental health services both clinical and community-based.

We have determined that there is indeed a strong relationship between homelessness and mental illness and homelessness and housing insecurity and/or medium to high levels of psychological distress. Like many factors that contribute to homelessness and are exacerbated by homelessness the relationship is complex, partly causal and often complex.

We found that there were mixed views offered by Homelessness Australia members about the impact of de-institutionalisation on the overall level of homelessness in Australia. Some providers told us they believe it is a myth and a dangerous one because the obvious and (wrong) solution is re-institutionalisation which Homelessness Australia does not support.

Other service providers believe it has contributed to an increase in overall homelessness and continues to do so, in the absence of community accommodation for people with mental illness and the decline in the availability of affordable housing in Australia over the past two decades.

We know that many people develop symptoms of anxiety and depression following the loss of housing and during and after the experience of becoming homeless. We have also heard evidence from both homelessness and mental health services of people becoming homeless following an increase in the severity of symptoms of mental illnesses that emerged prior to

experiencing housing insecurity. In these situations we can ascertain that mental illness was a contributing, if not causal factor that led to the loss of housing and contact with the homelessness service system.

We have been provided with evidence of people who have been evicted from their housing because their symptoms worsened to the point that they required short to medium term stays in psychiatric facilities or hospital wards. No contact was made with landlords or property managers, rent was not paid and it may have been assumed that the person(s) had abandoned the property. We are informed that this is a common occurrence for tenants in public housing where arguably property abandonment is more common than in private rental dwellings.

We have heard from mental health providers and consumer/carer networks that families are bearing a heavy burden of the cost both personal and economic of mental health care in this country. We have heard that mental illness, in particular caring for people with more serious axis 1 diagnoses such as bi-polar affective disorder, schizophrenia and major depressive disorders often leads to family breakdown which we know is a common trigger of homelessness particular for young people. We are told that early intervention could have prevented family breakdown in many cases if families, carers and people living with mental illness had been provided with support in the early stages after the onset of mental illness and quite simply, if they had known where to go to get help.

We learned that like homelessness, there is an urgent and pressing need for an expansion of early intervention services for young people experiencing the onset of the first wave of symptoms of mental illness. Whether this is an episode of depression or the first episode of psychosis or whether they have been exposed to a significant instance or repeated instances of trauma in the past and this has triggered post-traumatic stress disorder, it is vital that young people are connected to appropriate support services and community mental health services before their symptoms are unmanageable. We know that the clinical evidence tells us that the majority of people who experience mental illness as an on-going condition first experience symptoms before the age of 25. We also know that a significant proportion of people experiencing homelessness in Australia are aged 12-24. There is likely to be significant cross-over between these two groups and we are aware that specialist homelessness services are engaged in collaborations and partnerships with area mental health services, headspace centres and community mental health services for young people at a local service area level. We welcome the significant increase in funding for headspace and EPPIC (early psychosis prevention and intervention centres) that was announced in the May budget. The mental health reform package is very welcome and we need to ensure that there are strong linkages between the National Partnership Agreement on Homelessness and the forthcoming National Partnership Agreement on Mental Health. We heard about the good work that is being done by Innovative Health Services for Homeless Youth (IHSHY). We think there is scope to expand these services and increase funding to service providers given the emphasis on joined-up service delivery in the White Paper and the good collaborative partnerships that these services have with local area mental and primary health care networks, Medicare Locals and specialist homelessness services.

For those without family support networks, there is a compelling evidence base from both Government reports and service providers that indicates that all too frequently, this cohort end up in tenuous, unstable accommodation settings such as boarding houses often discharged there from mental health facilities with a cab voucher and a prescription for psychotropic medication.

We dared to ask the question of whether or not there is a pattern of re-institutionalisation occurring within our prison system pondering whether or not prisons are in fact the new asylums.

We have heard about the dual stigma of homelessness and mental illness and the lack of access to mental health services both community and clinical, for people who are both economically and socially excluded. Their situation is worsened if they have a co or tri-morbidity where alcohol and other drug misuse and physical health problems are also present. For this group, too often, every door is a wrong door and without family support and stable housing, they find themselves in the homelessness service system where attempts to gain access to alcohol and other drug or mental health services, or both, are again thwarted.

We learned of a group who are deemed by workers in homelessness services to be too unwell to be accommodated in homelessness services because of the high caseload of workers trained in case management or because their symptoms are such that they may present a risk to themselves or other clients or staff or because workers notice their symptoms progressively escalating. Like those in stable housing, clients frequently follow a well worn trajectory from well-being to mounting agitation/tension to psychiatric crisis. Workers from homelessness services are desperate to seek referrals to specialist mental health services before clients reach the point of psychiatric crisis.

They do this with varying degrees of success and are often frustrated by the lack of access to mental health care for their clients.

What has come through strongly in our consultations with providers of both homelessness and mental health services is the need for better coordination between homelessness services, housing providers and the community and clinical mental health service delivery system. We believe that the significant reforms proposed in the mental health package in the May Budget and the extra dollars that accompanies them provide an opportunity to improve system access and coordination between these service systems. We know that it is urgently needed.

We believe that workers in the homelessness, housing and mental health sectors would derive significant benefit from cross-sectoral training and partnerships that will increase the shared understanding of the language/jargon used by workers in each sector. A strong emphasis on collaborative training would be mutually beneficial and we believe would improve outcomes for people experiencing homelessness and mental illness who find accessing different components of each service system incredibly challenging. We suspect that Homelessness Australia and the Mental Health Council of Australia could play an important role in bringing both sectors together.

There are a group within the population of people experiencing homelessness who have been there for the long haul. They have minimal histories of successful tenancies; they have lengthy histories of housing insecurity and social exclusion. They are often experiencing high levels of psychological distress. Within this group, many have severe and persistent axis 1 mental health disorders, some diagnosed, and some without formal diagnosis. Many are rough sleeping; many have spent significant periods of time cycling between crisis accommodation, emergency departments, boarding houses, rough sleeping and back again.

It is this group that Homelessness Australia believes will benefit from the expansion of permanent supportive housing models based on housing first principles with one caveat, these models have demonstrated efficacy when targeted at older cohorts with longer histories of homelessness who may be resistant to service level interventions based on what could be described as a middle-class model of service delivery that assumes that people will access services, make and keep appointments and not be averse to environments that are often clinical, sterile and unfriendly.

We conclude that while there is a strong evidence base for the efficacy of permanent supportive housing for people experiencing severe and persistent mental illness and particularly those with co and tri-morbidity diagnoses, there are many 'home-grown' models that are also delivering excellent models of service delivery that are helping to break the cycles of homelessness and mental illness and reducing high levels of psychological distress.

Mind Australia is an example of a service provider that has successfully provided housing and support as well as assertive outreach for decades beginning as the Richmond Fellowship in Victoria.

Their focus of combining a workforce of homelessness and mental health specialists and supporting people through a continuum of care for the duration of need has achieved positive housing, support and community participation and inclusion outcomes for people living with mental illness who have often experienced long periods of housing instability and homelessness. They have also successfully transitioned people from long term institutionalisation in psychiatric hospitals into community living settings and have much to offer both the homelessness and mental health sectors in terms of expertise in both homelessness and mental health and combining a skilled workforce of practitioners from both sectors.

We heard about the importance of housing to adjustment following psychiatric crisis and in the promotion of stabilisation, recovery and well-being. Successful models that combine long-term housing and support are a key component of the long-term solution that will break the cycle of housing insecurity, homelessness, mental ill-health and psychological distress.

Without wishing to sound like a broken record, the inability to access stable housing in conjunction with support services necessary to sustain tenancies and participate in the life

of communities has again emerged as a major component of the solution to the problems explored in this paper.

The trajectory of mental illness itself, most often emerging in adolescence and young adulthood can establish a devastating pattern for some people who find their education, vocational training or University career is cut short by the often catastrophic interruption of the onset of mental illness.

For young people from middle-class and advantaged backgrounds whose families have the economic and social capital to provide support to help their children cope with the impact that mental illness can have on health, well-being and psycho-social functioning, homelessness is unlikely to result from the onset of mental illness early in adulthood.

For people with more limited means however the onset of mental illness combined with insufficient economic resources and social capital can establish a pathway that leads to family breakdown, housing insecurity, exclusion and homelessness which may precipitate exacerbated symptoms of mental illness and very high levels of psychological distress and impaired social functioning. This group is at risk of poverty, significant hardship, social exclusion and chronic homelessness.

We can and must do better for people living with mental illness and those who are at risk of and experiencing homelessness. We know that poverty and economic and social deprivation intersect with mental illness and can exacerbate the risk of long term homelessness and poorly or unmanaged mental illness. We need to ensure system access and housing supply with appropriate support services across the continuum of care to break this cycle and promote and support recovery, housing security, health and well-being and community participation. We hope that the recommendations that follow go some way towards commencing this process.

## 16. Recommendations

### 1. Housing and support

- 1.1 There is an urgent and pressing need for increased flexible, affordable and secure housing opportunities. We need to see a dramatic increase in the provision of more affordable housing in Australia to meet the needs of all low income Australians including people living with mental illness.
- 1.2 This needs to be matched with funding for tailored support packages for people experiencing homelessness and mental illness across all access, treatment and support stages of the continuum of care. Homelessness Australia believes there is scope for a significant proportion of new mental health funding to be allocated for this purpose.
- 1.3 Assertive outreach to people sleeping rough and staying in boarding houses to encourage them to access stable housing has been proven to be effective. The outreach must be geared towards supporting people to access permanent housing.
- 1.4 That more funding is provided in the next National Partnership Agreement on Homelessness for the provision of permanent supportive housing models for people experiencing homelessness, mental illness and with co-morbidity dual diagnosis.
- 1.5 Clustered housing should be promoted as a way of reducing the impact of social isolation/exclusion.
- 1.6 That the Australian Government, in consultation with Homelessness Australia and the Mental Health Council of Australia establishes a target for the proportion of public and community housing stock that is set aside for people who have experienced homelessness with a co-occurring mental illness.
- 1.7 That the Australian Government notes that both homelessness and mental health services providers have stressed the important role that the provision of affordable, safe and secure housing can play in the transition to stabilisation and recovery from mental illness.
- 1.8 The importance of **NOT** exiting people from mental health facilities into unstable, tenuous or inappropriate accommodation settings needs to be given heightened publicity.
- 1.9 There is a need to increase funding for boarding house outreach support programs given what Homelessness Australia has learned about the high numbers of people living with mental illnesses in the boarding house sector.

### 2. National Funding Instruments and Plans

- 2.1 That the Australian Government specifically links the next National Partnership Agreement on Homelessness to the soon to be implemented National Partnership Agreement on Mental Health.

- 2.2 A national strategy that articulates the recognition of the relationships between homelessness and mental health in Australia should be developed and funded.
- 2.3 That the National Plan to reduce violence against women and their children is linked to the National Partnership Agreement on Homelessness and the National Partnership Agreement on Mental Health.
- 2.4 Housing with dedicated needs-related support packages/workers must be one of the top priorities of the policy and program specifications for the mental health reform package and the National Partnership on Mental Health.
- 2.5 Rigidity in funding programs and the tendency to seek innovation through short term pilots is unacceptable. When pilot programs work they should be re-funded.
- 2.6 That specialist homelessness services receive growth funding to expand successful programs that are working well to prevent homelessness for people with mental illness.
- 2.7 That the National Partnership Agreement on Homelessness be re-funded for a further four years with a minimum of \$850 million and a further \$350 million for A Place to Call Home.

### 3. Service system access and coordination

- 3.1 Improved availability, coordination and linkages with respect to support services that assist people to maintain housing. This could include linking tenancy support programs with mental health services. Progress is being made in this aware but there is more work to do.
- 3.2 That FaHCSIA work with the Department of Health and Ageing to drive improved coordination between the homelessness, housing and mental health systems.
- 3.3 Homelessness Australia endorses the need for an annual report card on the state of the mental health system in Australia as flagged in the May Budget.
- 3.4 That homelessness services are granted improved access to clinical and community mental health care services.
- 3.5 That mental health and alcohol and other drug services are funded to devise improvements to system access that ensures that people with co-morbidity dual diagnoses are given access to treatment by both sectors where necessary.
- 3.6 There needs to be improved availability, coordination and linkages with respect to support services that assist people to maintain housing. This could include linking tenancy support programs with mental health services. Progress is being made in this aware but there is more work to do.
- 3.7 There is a need for funding and support to improve access and referral processes between homelessness, housing and mental health services. High numbers of people in the homelessness service system need referrals to specialist mental health services but cannot secure them.

### 4. Workforce development, collaboration and partnerships

- 4.1 That the Australian Government provides funding for the development and implementation of a strategic workforce strategy that includes joint training for

mainstream workers, mental health workers (clinical and community) and workers from homelessness services that may lead to joint qualifications.

- 4.2 That homelessness services be funded to provide training to workers in the mental health sector to increase the level of understanding of the homelessness sector and the support that can and cannot be provided.
- 4.3 That the above training be expanded to include mainstream services.

## 5. Early intervention

- 5.1 There is a need for early intervention mental health services that target young adults to have greater in-reach to and linkages with youth homelessness services.
- 5.2 Early intervention services with proven efficacy should be expanded in both reach and accessibility.

## 6. Documenting what works

- 6.1 That the Australian Government provide funding to evaluate the efficacy of housing and mental health support programs with a view to determining and articulating what aspects of successful programs and service models are working well and replicating these in other service models across Australia.
- 6.2 Organisations, particularly those with good practice examples of local area level partnerships between homelessness services, housing and mental health providers must be supported with funding to document examples of best practice that are achieving good outcomes. The need for more information is urgent.
- 6.3 That the Australian Government provide funding to enable housing, support, homelessness and mental health organisations to identify and document examples of best practice and housing and support models that have worked to prevent homelessness and support recovery.

## 7. Service System Expansion

- 7.1 There is a need for more access to after-hours mental health services that are accessible to workers in domestic violence services and homelessness services.
- 7.2 Best practice models should be documented, replicated and expanded.
- 7.3 The IHSY program should be expanded and additional funding should be provided to enable this good practice program to reach more young people in need.

## 8. Stabilisation and Recovery

- 8.1 There is an urgent need for improved responsiveness to consumer and carer requirements. Announcements in the May Budget should help drive this.

8.2 Step, up step down continuum of care accommodation and supported housing models should be endorsed by FaHCSIA and expanded.

## 9. Improved information provision

9.1 The Australian Government should provide funding for the development of more on-line resources that can be promoted through new forms of social media such as social networking sites as a means of increasing the availability of information about homelessness, housing and mental health services and how to access them to young people.

Homelessness Australia also acknowledges other contributors to this paper...

- Anglicare, Tasmania.
- The Australian Common Ground Alliance.
- Centacare, South Australia.
- Centrelink (social work services).
- The Council to Homeless Persons (Victoria)
- The Emergency Accommodation and Support Enterprise.
- The Mental Health Council of Australia.
- The Mental Health Carers and Consumers Network of Victoria.
- The Mental Health Consumer Coalition (ACT).
- The Mental Health Law Centre of Western Australia.
- The Mercy Foundation.
- Mind Australia (South Australia).
- Mission Australia.
- Sacred Heart Mission.
- St. Bartholomew's House.
- St. Luke's Anglicare (Bendigo).
- Southern Youth and Family Services.
- Streetlink Youth Service.
- The Youth Network of Tasmania (YNOT).
- Additional contributions by Homelessness Australia's councils and members.

## End notes

---

- <sup>i</sup> United States Conference of Mayors study of homeless populations in 23 US cities, 2007.
- <sup>ii</sup> Mental Health Council of Australia. Facts on Mental Health.  
<http://www.mhca.org.au/documents/AboutMentalHealth/FactsonMentalHealth.pdf>
- <sup>iii</sup> 2007 National Survey of Mental Health and Well-being,  
<http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4326.0Main%20Features32007?opendocument&tabname=Summary&prodno=4326.0&issue=2007&num=&view=>
- <sup>iv</sup> Porter, Roy The Greatest Benefit to Mankind: A Medical History of Humanity, Norton publishers, New York, 1998, pp.22-25.
- <sup>v</sup> Porter Roy, op cit, p.24.
- <sup>vi</sup> Shorter, Edward A History of Psychiatry, Wiley publications, New York, 1997, pp.192-93.
- <sup>vii</sup> Scull, Andrew The Most Solitary of Afflictions, Yale University Press, New Haven, US, 1993, p.224.
- <sup>viii</sup> A short historical survey of the relationship between Government and the medical profession in Australia 1788-1900  
[http://www.aams.org.au/contents.php?subdir=library/history/funding\\_prof\\_med\\_au/&filename=1788to1900](http://www.aams.org.au/contents.php?subdir=library/history/funding_prof_med_au/&filename=1788to1900)
- <sup>ix</sup> [http://www.dictionarvofsydney.org/entry/callan\\_park\\_mental\\_hospital](http://www.dictionarvofsydney.org/entry/callan_park_mental_hospital)
- <sup>x</sup> O'Sullivan, John Mental Health and the Law, Sydney Law-Book Company, 1981, pp.14-15.
- <sup>xi</sup> Caplan Gerald, Support systems and community mental health. New York: Behavioural Publications, 1983, p.146. O'Sullivan, *ibid*, p.11.
- <sup>xii</sup> O'Sullivan, op cit, p.16.
- <sup>xiii</sup> O'Sullivan, op cit, p.18.
- <sup>xiv</sup> Comment from Felicity Reynolds, CEO, Mercy Foundation, October 2011.
- <sup>xv</sup> Council to Homeless Persons, Feedback to Homelessness Australia, November 2011.
- <sup>xvi</sup> Psychiatric nurse from South Australian provider who preferred anonymity.
- <sup>xvii</sup> [http://www.socialinclusion.sa.gov.au/files/Homelessness\\_ItsNoPalace.pdf](http://www.socialinclusion.sa.gov.au/files/Homelessness_ItsNoPalace.pdf),  
<http://www.bcs.org.au/site/DefaultSite/filesystem/documents/About%20BCS/Research/BCS%20Boarding%20House%20Research%20Full%20Report.pdf>, [http://www.chp.org.au/public\\_news/items/2009/11/00269-upload-00002.pdf](http://www.chp.org.au/public_news/items/2009/11/00269-upload-00002.pdf),  
<http://www.ombo.nsw.gov.au/publication/PDF/specialreport/SR%20Boarding%20Houses.pdf>
- <sup>xviii</sup> Human Rights and Equal Opportunity Commission, Report of the National Inquiry into the Human Rights of People with a Mental Illness, AGPS, 1993, p.7.
- <sup>xix</sup> Anderson, Peter; Hume, Arthur, Rogers, Nancy, Stephenson, Tracey It's no palace: Boarding houses- the sector, its clientele and its future, Department of Human Services, SA Government, 2003, p.17.
- <sup>xx</sup> Department of Human Services, Rooming House Standards Taskforce: Chairperson's Report, Government of Victoria, September 2009, p.13.
- <sup>xxi</sup> NSW Ombudsman, More than a board and lodging: The need for boarding house reform, Special report to Parliament under s.31 of the *Ombudsman's Act 1974*, August 2011, pp.8-10.
- <sup>xxii</sup> Baptist Community Services Lifecare & University of Wollongong, Needs of Residents in Unlicensed Boarding Houses, University of Wollongong, 2011, pp.7-9.
- <sup>xxiii</sup> <http://www.mentalhealth.org.uk/help-information/mental-health-statistics/>
- <sup>xxiv</sup> <http://ackermangruber.com/trapped/text/>; <http://www.justice.gov/>
- <sup>xxv</sup> <http://www.hrc.org.au/files/FZEAUHUITS/Factsheet%20-%20Prisons.pdf>
- <sup>xxvi</sup> Australian Institute of Health and Welfare, The Health of Australia's Prisoners, 2009, AIHW, Canberra, 2010, p.26.
- <sup>xxvii</sup> [www.mhca.org.au](http://www.mhca.org.au)
- <sup>xxviii</sup> Submission from St Luke's Anglicare Bendigo Service, October 2011.
- <sup>xxix</sup> Ex-worker from a service provider from South Australia working with offenders, October 2011.
- <sup>xxx</sup> Chamberlain, Chris, MacKenzie, David Counting the Homeless 2006, ABS cat. No. 2050.0, 2008; ABS Methodological Review of Counting the Homeless 2006, AIHW, The Use of Government Funded Specialist Homelessness Services 2009/10, p.33; AIHW, The Health of Australia's Prisoners 2009/10, pp.9-11, 2011.
- <sup>xxxi</sup> Keys Young, Homelessness in the Aboriginal and Torres Strait Islander context and its possible implications for Supported Accommodation Assistance Program, 1998, Sydney, NSW, p.3.
- <sup>xxxii</sup> <http://www.abs.gov.au/ausstats/abs@.nsf/0/F4302CEC55D5B8EECA2574390014A785?opendocument>
- <sup>xxxiii</sup> [http://melbourneinstitute.com/downloads/hilda/conf-papers/Velamuri\\_ESAM.pdf](http://melbourneinstitute.com/downloads/hilda/conf-papers/Velamuri_ESAM.pdf)
- <sup>xxxiv</sup> <http://www.creativespirits.info/aboriginalculture/law/aboriginal-prison-rates.html>
- <sup>xxxv</sup> Krieg, Anthea S. Aboriginal Incarceration: Health and Social Impacts, Medical Journal of Australia, 2006 (184), p.534.
- <sup>xxxvi</sup> Krieg, *ibid*, p.534.
- <sup>xxxvii</sup> Krieg, *ibid*, p.535.
- <sup>xxxviii</sup> <http://www.prisonfellowship.org.au/>
- <sup>xxxix</sup> St Bartholomew's House in Western Australia has raised this as an issue with Homelessness Australia and it has come up again in generic feedback from peak bodies in Victoria and Queensland while researching for this paper.
- <sup>xl</sup> Feedback from Mind Australia, November 2011.
- <sup>xli</sup> <http://www.mhca.org.au/>

- 
- xlii <http://www.mhca.org.au/>
- xliii Stefancic, Ann; Tsemberis, Sam Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: A Four Year Study, Department of Socio-Medical Studies, Columbia University, New York, 2007, pp.6-7.
- xliv Mission Australia, Preliminary Analysis of Findings from the Michael Project, 2010, pp.5-6. Journey to Social Inclusion, outcome evaluation, 2011, p.9.
- xlv American Psychiatry Association, Diagnostical and Statistical Manual IVR, 2008, John Hopkins, p.774-776.
- xlvi <http://www.aic.gov.au/publications/current%20series/tandi/381-400/tandi384.aspx>
- xlvii Laing, Lesley Dr Children, Young People and Domestic Violence, Australian Domestic and Family Violence Clearinghouse Issues Paper, 2009, p.10.
- xlviii American Psychiatric Association <http://www.healthyminds.org/Main-Topic/Domestic-Violence.aspx>
- xlix American Psychiatric Association, *ibid*.
- <sup>1</sup> Details provided by the EASE and Annie North services in Bendigo.
- <sup>ii</sup> McGorry, Patrick, Professor [http://www.psychology.org.au/publications/inpsych/youth\\_mental\\_health/](http://www.psychology.org.au/publications/inpsych/youth_mental_health/)
- <sup>iii</sup> [http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1370.0~2010~Chapter~Suicide%20\(4.5.4\)](http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1370.0~2010~Chapter~Suicide%20(4.5.4))
- <sup>iiii</sup> <http://www.blackdoginstitute.org.au/docs/FactsandFiguresfactsheet.pdf>
- <sup>lv</sup> <http://www.blackdoginstitute.org.au/docs/FactsandFiguresfactsheet.pdf>; <http://www.aihw.gov.au/publication-detail/?id=32212254712&tab=2>
- <sup>lvi</sup> <http://www.austdvclearinghouse.unsw.edu.au/PDF%20files/issuespaper2.pdf>
- <sup>lvii</sup> <http://www.va.gov/HOMELESS/treatment.asp>
- <sup>lviii</sup> [http://www.dva.gov.au/health\\_and\\_wellbeing/mental\\_health/Pages/index.aspx](http://www.dva.gov.au/health_and_wellbeing/mental_health/Pages/index.aspx)
- <sup>lix</sup> <http://www.mhca.org.au/>
- <sup>lx</sup> See the Stepping Up report by the Social Inclusion Unit of the Department of Premier and Cabinet for more information on these models.
- <sup>lxi</sup> Stefancic, Ann; Tsemberis, Sam, op cit, Tsemmeris, Sam From Streets to Homes: An Innovative Approach to Supported Housing for Homeless Adults with Psychiatric Disabilities, Pathways to Housing, New York, 1999; Tsemberis, Sam Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction, Columbia, New York, 2010. <http://www.abgheadinghome.org/housing-first-outcomes-vs-treatment-based-housing-outcomes/>
- <sup>lxii</sup> Australian Institute of Health and Welfare The Use of Government Funded Specialist Homelessness Services 2009/10: Appendix, AIHW Canberra, 2011, pp.17-18.
- <sup>lxiii</sup> Mental Health Council of Australia, Home Truths: Mental Health, Housing and Homelessness in Australia, report, 2009, p.9.
- <sup>lxiiii</sup> Mind Australia, feedback provided to Homelessness Australia, October 2011.
- Mind Australia, *ibid*.
- <sup>lxv</sup> <http://www.health.vic.gov.au/pch/cyf/ihshy.htm>
- <sup>lxvi</sup> FaHCSIA, Evaluation of the FaHCSIA Targeted Community Care Mental Health Initiatives, 2011, p.9.