MENTAL HEALTH COUNCIL OF AUSTRALIA

Home Truths

Mental Health, Housing and Homelessness in Australia

March 2009

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Acronyms

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AHMAC	Australian Health Ministers' Advisory Council
AHURI	Australian Housing and Urban Research Institute
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
CEAS	Canberra Emergency Accommodation Service
CHP	Council to Homeless Persons
CMHS	Center for Mental Health Services (United States)
COAG	Council of Australian Governments
DHHS	Department of Health and Human Services (United States)
DSP	Disability Support Pension
HACC	Home and Community Care
HASI	Housing and Accommodation Support Initiative
HASP	Housing and Support Program
HPIC	Homeless Persons Information Centre
HREOC	Human Rights and Equal Opportunity Commission
ILP	Independent Living Program
ISHOPS	Inner South Homelessness Outreach Psychiatric Service
MHCA	Mental Health Council of Australia
MHCC	Mental Health Coordinating Council
MHSC	Mental Health Standing Committee
NGO	Non-government Organisation
NSW	New South Wales
PHaMs	Personal Helpers and Mentors
PILCH	Public Interest Law Clearing House
SA	South Australia
SAAP	Supported Accommodation Assistance Program
SAMHSA	Substance Abuse and Mental Health Services Administration (United States)
SHL	Supported Housing Limited
UNSW	University of New South Wales
WCYS	West Coast Youth Services

1. Foreword

Fifteen years ago, the Human Rights and Equal Opportunity Commissioner Brian Burdekin wrote that:

> One of the biggest obstacles in the lives of people with a mental illness is the absence of adequate, affordable and secure accommodation. Living with a mental illness – or recovering from it – is difficult even in the best circumstances. Without a decent place to live it is virtually impossible. [1]

In 2008, Prime Minister Kevin Rudd described homelessness in Australia as a 'national obscenity'.[2] There are currently an estimated 105,000 Australians who are homeless on any given night. We don't know exactly how many of these people have a mental illness, but the proportion is certainly high, with estimates as high as 75 per cent.

The recent Australian Bureau of Statistics (ABS) survey into Mental Health and Wellbeing revealed a further tragedy – that in the ten years since its last survey, the percentage of people with mental and substance use disorders receiving proper care actually appears to have fallen in Australia, from 38 per cent to 35 per cent. Put another way, 65 per cent of people requiring mental health care do not receive treatment.[3] These are the stark and grim parameters within which we must work to address the obscenity of homelessness.

In December 2008 the Rudd Government released a White Paper on Homelessness – *The Road Home: A National Approach to Reducing Homelessness* – which established a laudable goal of reducing the level of homelessness in Australia by 50 per cent by the year 2020.

The White Paper is a landmark document providing a vision for tackling homelessness and looking beyond housing with strategies that address the broader needs of the homeless population, including employment, education, health and social support. These plans, combined with the paper's bold targets, have the potential to make a real difference to homeless and unstably housed Australians.

The link between mental illness and homelessness is intimate and clear. Simply put, the Federal Government's ability to meet its ambitious goals in addressing homelessness depends largely on governments at all levels changing their approach to managing mental illness.

In particular, the MHCA sees the White Paper's policy of 'no exits into homelessness' from hospitals, mental health services, alcohol and drug services, and prisons as a major initiative which can make a real difference. As things stand today, discharge from these institutions into homelessness or unstable housing is not uncommon for many people with a mental illness. If ending this practice is the only goal achieved under the White Paper it will be deemed a massive success for people with a mental illness.

A home is about having more than just four walls and a roof. It should provide safety and security, and help one develop a strong sense of self. A home also helps to develop community connections. Adequate, appropriate and affordable housing is an essential part of social inclusion and participation. Having a place to call 'home' is integral to everyone's mental health, whether one has a mental illness or not. Stable and secure housing is especially critical for people with mental health problems.

Yet for many, achieving or maintaining a stable home is not that easy and too many people end up in unstable housing or become homeless. These two situations can cause a mental illness or exacerbate existing symptoms that were previously manageable. Being homeless also results in a range of complex mental and physical health problems, which are often made worse by the difficulties that many people face when trying to access good mental health care. In short, people often go untreated.

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1 Human Rights and Equal Opportunity Commission (HREOC), *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, HREOC, Canberra, 1993.

2 K. Rudd, 'Joint Press Conference with Minister Anthony Albanese, Adelaide', 22 May 2008, online at www.pm.gov.au/media/Interview/2008/interview_0262.cfm, accessed 25 September 2008.

3 ABS, *National Survey of Mental Health and Wellbeing: Summary of Results, Australia, 2007* (ABS Cat. no. 4326.0), ABS, Canberra, 2008. [NB This survey canvassed anxiety and affective disorders but excludes psychotic disorders and personality disorders. The survey also includes substance use disorders.]

The significance of housing to good mental health was recognised by the Council of Australian Governments (COAG), which agreed to measure the prevalence of mental illness among the homeless population under its National Action Plan on Mental Health 2006-11. To date unfortunately, COAG's reporting on this matter has been limited to existing, incomplete data, and Australia has not developed a consistent, national policy response to housing instability and homelessness for people with a mental illness.

For the Federal Government's policy agenda to be successful, a robust, nationwide regime of independent monitoring, accountability and evaluation is required. Whilst social inclusion and health system reform are currently at the forefront of the Australian Government's policy agenda, recognition of the complex relationships between mental health, housing and homelessness must be at the heart of this policy debate and subsequent policy development. Independent accountability and monitoring is absolutely essential to ensuring that such reforms are implemented successfully across Australia, and are assessed continually in terms of viability and value.

These issues must not slip off the national agenda, particularly now, as Australia and the world address a monumental economic crisis.

Home Truths has been prepared and published by the Mental Health Council of Australia (MHCA) after an extensive review of relevant literature and research. It probes the relationships between housing, homelessness and mental health, considers appropriate models to support and accommodate people experiencing mental illness, and contains strategies and recommendations to provide as well as support housing for these people. As is so often the case, Australia already hosts several innovative, high performing services and models of effective housing support for people with a mental illness. They are not waiting to be invented, just waiting to be supported and propagated.

Fundamentally, we must understand that unless there are significant changes to current practices in the way Australia responds to mental illness, we will not achieve the government's new policy goals of reducing homelessness by 50 per cent by 2020.

The Hon. Rob Knowles

Chair, Mental Health Council of Australia

2. Executive Summary: Ten Home Truths

[A home] represents a protected refuge from the outside world, enables the development of a sense of identify and attachment…and provides a space to be oneself.

Xavier Bonnefoy[4]

A secure home is widely recognised as providing a fundamental basis for building mental health. However, for many people with a mental illness, achieving or maintaining stable homes can prove difficult, and some slip into unstable housing or even homelessness. It is essential that mental health issues are a part of any discussion on homelessness and housing.

The importance of housing for people with mental illness has been repeatedly acknowledged at the highest levels. The Senate Community Affairs Committee Report on mental health services maintains that:

> It is clear that adequate housing for people with mental illness remains a major gap in the community-based care currently available. The effects are evident among a variety of groups: those with mental illness who are being held in hospitals because there is nowhere else for them to go; those who have no housing options and are homeless; and those that are surviving in less than therapeutic accommodation environments.[5]

This recognition has, however, yet to be reflected in policies and funding. Thus this report explores how this lack of recognition affects mental health and homelessness in Australia, and identifies what needs to be done to improve housing outcomes for those adversely affected by this glaring oversight.

Section 3 of this report identifies significant gaps in the homelessness and mental health service systems and identifies some worrying facts about mental health and homelessness. Recent data reveals that 20 per cent of the population has experienced a mental or substance use disorder in the past 12 months, but, of these, only 35 per cent accessed services for their mental health problems. While it is currently estimated that 105,000 people are homeless in Australia on any given night, despite the widespread recognition of the high proportion of people with a mental illness in the unstably housed or homeless populations, there are no definitive statistics about the number of people in the homeless population who live with a mental illness.

People with a mental illness face a number of barriers in their attempts to achieve and maintain stable housing. These include housing affordability, insecure tenure, poor housing conditions, financial difficulties, administrative issues, behavioural and social issues, stigma and discrimination, and a lack of support and treatment. Certain groups will experience additional difficulties due to their increased social isolation. Mental illness can also result from, or be exacerbated by, the experience of homelessness or unstable housing.

The Australian Government's 2008 White Paper on Homelessness sets bold targets for reducing homelessness in Australia, including a 50 per cent reduction in the number of homeless people and the availability of accommodation to all rough sleepers by 2020. The strategies presented in that document are holistic and look beyond housing as a solution to the homelessness crisis. However, to halve homelessness by 2020, there must be radical changes in mental health services in Australia well before that date.

It is time a number of 'home truths' are acknowledged – 10 to be exact – about what will happen if nothing is done about mental health and homelessness, and what governments must do if they are serious about addressing this national housing crisis. These home truths form the basis of a new strategy to improve housing outcomes for people with a mental illness, and are explored further in Section 4 of this report. A number of case studies that illustrate some of the core principles of the 'Home Truths' strategy are examined in Section 5.

4 X. Bonnefoy, 'Inadequate housing and health: an overview', *International Journal of Environment and Pollution* 30 (3/4) 2007, pp. 411-429.
5 Senate Community Affairs Committee, *Towards Recovery: Mental Health Services in Australia*, Commonwealth of Australia, Canberra, 2008, p.113.

Figure 1 explores the 10 'Home Truths', and identifies the stark reality of what will happen in Australian society if they are not addressed. These home truths include the importance of recognising the links between mental health and homelessness, new, practical strategies in the COAG National Action Plan on Mental Health that address housing for people with a mental illness, allocation of housing stock specifically for people with mental illness, zero tolerance for discharge into homelessness, and research and evaluation of homelessness and housing programs and services.

But the home truths do not just target housing policy. To reduce homelessness in Australia, there must be fundamental reforms in mental health services. Access to services must be increased. Programs must have a consumer focus, with recognition of the effectiveness of permanent supported housing programs and emphasis on the home and community based care that is known to be successful. Mainstream services and services for people with mental illness and people who are homeless must go beyond their specialisations and provide holistic support for their clients, working with other services and sectors to meet all of their clients' needs. Similarly, relevant research must address all aspects of mental health and the homelessness experience.

Some of the strategies in the 'Home Truths' are already being followed, including some of those outlined in the new White Paper on Homelessness. Others will require new innovations and initiatives combined with considerable political drive. The target to reduce homelessness in Australia by 50 per cent by 2020 can be met – but only if mental health services are reformed.

Figure 1: Ten Home Truths

Mental Health, Housing and Homelessness: Ten Home Truths	
If we do nothing…	**What must be done…**
1. The prevalence of homelessness in Australian society will continue to increase.	A national strategy on homelessness that includes due recognition of the relationships between mental health and homelessness must be developed and funded.
2. The prevalence of inadequately treated mental illness in Australian society will continue to increase.	Access to mental health care must be increased.
3. Funding will continue to be directed at existing services and people whose needs are not being met by current services will continue to fall through the cracks.	There must be immediate investment in innovative, consumer-focused programs with an emphasis on home based care.
4. COAG and other national plans, including the National Action Plan on Mental Health, will continue to include tokenistic encouragement of service coordination, but without providing the funding required for effective coordination.	Housing must remain as one of the top priorities in the COAG National Action Plan on Mental Health, but with additional funding specifically to support national coordination and action beyond a narrow focus on the existing health system.
5. Mental health care will continue to be hospital-based in spite of evidence demonstrating the benefits of community care.	Home and community must become the preferred treatment sites with the number and scope of peer, carer, allied health and community options being significantly increased.
6. Access to housing will continue to be limited for many people with a mental illness.	Thirty per cent of public and social housing stock must be set aside for people with a mental illness.
7. Access to income and other support will continue to be limited for people with a mental illness, particularly when they are homeless or unstably housed.	Services including employment, welfare, health, alcohol and drugs and many others in the community sector must have the capacity to go beyond their specialisations to respond to issues of mental illness and homelessness.
8. People will continue to be discharged from psychiatric hospitals, other health services, and institutions such as prisons with no arrangements for their housing, treatment and support in the community.	Properly resourced and monitored discharge planning must be implemented across Australia, with zero tolerance for discharge from hospitals to homelessness or unstable housing. This goal must be independently monitored and publicly reported.
9. Programs providing housing and mental health services will continue to be evaluated erratically and inconsistently, resulting in a lack of accountability.	Programs providing housing and mental health services must be regularly, independently evaluated against common criteria to allow for program comparison, with transparent assessments and reporting.
10. Our knowledge about mental health, housing and homelessness in Australia will continue to be inadequate due to a lack of data.	National research to build a greater understanding of the connections between mental illness, unstable housing and homelessness must be a priority, with appropriate funding and ongoing support for this research.

3. Mental Illness, Homelessness, and Housing: The Context

Some health problems precede and causally contribute to homelessness. Some health problems are the consequence of or are exacerbated by homelessness; and homelessness complicates the treatment of many illnesses.

Institute of Medicine[6]

3.1 Mental illness

The term 'mental illness' generally refers to illnesses that affect the mind or brain and influence the way a person thinks, acts and feels. These illnesses include bipolar disorder, depression, schizophrenia, anxiety, eating disorders and personality disorders. Mental illness is common, with almost half of all Australians aged 16 to 85 experiencing a mental disorder at some point in their lives, and 1-in-5 experiencing a mental disorder in any year.[7] Anxiety and depression are the most common mental illnesses.

Although the exact cause is unknown, it is not caused by a character fault, weakness or something inherently 'wrong' with a person. Some of the factors believed to contribute to mental illness are:

- biological factors including changes in brain structure and/or chemistry;
- environmental factors;
- abuse and other stressful life experiences;
- substance or drug abuse; and
- negative thought patterns.

The symptoms of mental illness may reduce a person's quality of life and make it more difficult to manage the demands of day-to-day life, including work, study and relationships. Of particular significance to this report are the difficulties that may arise in maintaining stable accommodation as a result of mental illness.

Stigma also has a severely negative impact on many people experiencing a mental illness, as explained in the MHCA's *Let's Get to Work* report:

> Australians know that there is stigma associated with mental illness. Perhaps it is not so well understood that this amorphous concept of 'stigma' actually manifests itself as real discrimination. The consequences of this discrimination are most acute in two areas – access to housing and access to employment.[8]

Data recently released by the ABS reveals the high levels of mental illness in Australia. The ABS found that 45 per cent of Australians aged between 16 and 85, or 7.3 million people, have experienced a mental or substance use disorder at some time in their lives, while 20 per cent (3.2 million people) had experienced a mental or substance use disorder in the past 12 months.[9] Mental illness is widely recognised as a significant health concern, and accounts for 13 per cent of the total disease burden in Australia, coming third behind cancers and cardiovascular disease.[10]

6 Institute of Medicine, *Homelessness, Health and Human Needs*, National Academy Press, Washington DC, 1988.
7 ABS (2008) *op. cit.*
8 MHCA, *Let's get to work. A National Mental Health Employment Strategy for Australia*. MHCA, Canberra, 2007.
9 ABS (2008) *op. cit*.
10 Australian Institute of Health and Welfare (AIHW), *Australia's Health 2008* (AIHW Cat. No. AUS99), AIHW, Canberra, 2008.

For mental illness, almost the entire burden of disease is due to disability, rather than premature mortality. In 2003 it was estimated that about 1-in-20 Australians had a disabling psychiatric condition, and almost half of these sometimes or always needed assistance with mobility, self-care and communication.[11] In fact, mental illness accounts for 24 per cent of the non-fatal disease burden in Australia.[12]

Australian governments have identified mental health as a priority area for health policy and funding, and have acknowledged that because of the different levels and systems providing mental health services, there is a lack of clarity about relevant responsibilities, which in turn results in fragmentation and poor connections; thus having a detrimental effect on access to services for many individuals.[13]

Of the 3.2 million Australians aged 16 to 85 who experienced a mental or substance use disorder in the past 12 months, only 35 per cent accessed services for treatment, whilst 26 per cent did not have their needs for counselling or similar services met, and another 29 per cent did not have their information needs met.[14]

3.2 Homelessness

Definitions vary: from people living on the streets to people dwelling in various forms of unstable or inadequate housing. One commonly used definition that is based on culturally defined minimum acceptable standards in the Australian community is that '…an independent person or couple should be able to expect at least a room to sleep in, a room to live in, kitchen and bathroom facilities of their own, and an element of security of tenure'.[15] This results in a multi-tiered definition of homelessness, outlined in Figure 2.

Figure 2: Cultural definition of homelessness[16]

Culturally recognised exceptions: accommodation situations in which it is inappropriate to apply the minimum standard – e.g. jails, student residences, seminaries etc.	Marginally housed: people in housing situations close to the minimum standard
	Tertiary homelessness: people living in single rooms in private boarding houses – without their own bathroom, kitchen or security of tenure
	Secondary homelessness: people moving between various forms of temporary shelter including friends' houses, emergency accommodation, youth refuges, hostels and boarding houses
	Primary homelessness: people without conventional accommodation ('street homelessness' or 'rooflessness' – living on the streets, in deserted buildings, improvised dwellings, under bridges, in parks etc.)

In itself it provides a basic understanding of the requirements needed to give a person a roof over their head. However, other definitions include additional aspects of the homeless experience such as the lack of economic and social supports that a home normally provides,[17] and not having access to safe, secure, and adequate housing.[18]

These definitions highlight the social isolation that arises from being without a stable and secure home. A homeless person is likely to be cut off from their family, friends and other social networks; they will often have no social support, and their safety is often compromised due to their housing situation, or lack thereof.

It is important that definitions of homelessness acknowledge that many homeless people experience poverty and social exclusion, face the likelihood of multiple disadvantage, experience a lack of belonging and connection to community, have little control over the place in which they live, are stigmatised and feel a lack of acceptance from the

11 ABS *Survey of Disability, Ageing and Carers*, cited in AIHW (2008) *op. cit.*
12 AIHW (2008) *op. cit*.
13 COAG, *National Action Plan on Mental Health 2006-2011*, COAG, Canberra, 2006.
14 ABS (2008) *op. cit.*
15 C. Chamberlain, *Counting the Homeless: Implications for Policy Development* (ABS Cat. No. 2041.0), ABS, Canberra, 1999, p.9.
16 Adapted from C. Chamberlain and D. MacKenzie, 'Understanding Contemporary Homelessness: Issues of Definition and Meaning', *Australian Journal of Social Issues*, 27(4), 1992, pp. 274–297, cited in Chamberlain (1999) *op. cit.*
17 Council to Homeless Persons (CHP), *Homelessness Information Sheet Number 1: Overview of Homelessness in Victoria*, CHP, Melbourne, 2005.
18 Homelessness Australia, 'About Homelessness', 2006, online at www.homelessnessaustralia.org.au/site/about.php, accessed 24 September 2008.

wider community.[19] Homelessness definitions must also include people who are living in dangerous or inappropriate housing in order to avoid losing a roof over their head, a group that The Mental Illness Fellowship Victoria describes as the 'housed or hidden homeless'.[20]

Based on the cultural definition provided in Figure 2 above, 53 out of every 10,000 people in Australia are homeless. On Census night 2006, 27 per cent of these were in boarding houses, 13 per cent in Supported Accommodation Assistance Program (SAAP) services, 47 per cent were staying with friends or relatives, and 13 per cent were either in improvised dwellings or sleeping rough.[21]

Australia's primary response to homelessness is through SAAP, which was developed as a 'last resort safety-net' for people who are homeless or at risk of being so. Its original aim was to provide supported accommodation for people who are homeless over the long-term, but its focus has now expanded to include the resolution of housing crises, re-establishing family links where appropriate, and assisting clients to move beyond SAAP services. SAAP is viewed, however, as a 'band-aid solution' for many clients, and their service needs are not always met. Evaluation has found that, while the services currently provided are necessary, they are insufficient to address homelessness in Australia. SAAP now allocates $333 million in funding each year to 1300 agencies; this represents 58 per cent of Commonwealth and state/territory government funding for services to cope with homelessness.[22] An independent evaluation of SAAP concluded that for SAAP to be maintained and to continue in its current form a funding increase of 15 per cent would be required, and for SAAP to develop new ways of working and expand service capacity a funding increase of 35 to 40 per cent would be required.[23]

Currently there is no national policy framework to provide consistency in state and territory approaches to the provision of affordable housing, even though the availability of affordable and stable housing is an essential requirement for the prevention of homelessness. In fact, quantities of public housing stock across all states and territories have declined over the past ten years. Recent figures from the AIHW reinforce the long waiting times for public housing.[24] Commonwealth Government funding for the Commonwealth State Housing Agreements has declined in real terms by 30 per cent since 1996. Other strategies are in place to address housing affordability issues, including Commonwealth Rent Assistance, the National Rental Affordability Scheme and First Home Saver Accounts; however, these only partially address these matters.[25] States and territory governments also have their own strategies to address issues of housing affordability and homelessness, but these vary widely. A national response is what is needed, and the new agreements and strategies that appear in the White Paper on homelessness will go some way towards achieving national consistency in housing affordability programs and homelessness services provision.

3.3 Current Commonwealth Government responses to homelessness: The Homelessness White Paper

In December 2008, the Australian Government released a White Paper on Homelessness: *The Road Home: A National Approach to Reducing Homelessness*, on the heels of a Green Paper that had been released in May 2008. The White Paper aims to guide homelessness strategies in Australia to the year 2020, recognising that 'Just maintaining the current effort on homelessness will see an increase in the number of Australians who are homeless due to the growth in populations at risk of homelessness'.[26]

19 F. Reynolds, *Homelessness Strategy 2007-2012*, City of Sydney, Sydney, 2007.
20 Mental Illness Fellowship Victoria, *Which Way Home? Submission to the Australian Government Green Paper on Homelessness*, Mental Illness Fellowship Victoria, Melbourne, 2008.
21 C. Chamberlain and D. MacKenzie, *Counting the Homeless: Australia 2006* (ABS Cat. No. 2050.0), Australian Bureau of Statistics, Canberra, 2008.
22 Commonwealth of Australia, *Which Way Home? A new approach to homelessness*, Commonwealth of Australia, Canberra, 2008.
23 cited in D. Wright-Howie, *An Australian Blueprint to Reduce and Eliminate Homelessness*, CHP, Melbourne, 2007.
24 AIHW, *Public Rental Housing 2007-08: Commonwealth State Housing Agreement national data report*, AIHW, Canberra, 2009.
25 Commonwealth of Australia (2008) *Which Way Home?*
26 Commonwealth of Australia, *The Road Home: A National Approach to Reducing Homelessness*, Commonwealth of Australia, Canberra, 2008, p.viii.

The strategies presented in the White Paper target issues of homelessness and unstable housing holistically, looking beyond housing as a solution to address other needs of the homeless population, including employment, education, health and social support. These strategies, combined with the bold targets of a 50 per cent reduction in overall homelessness and the availability of accommodation to all rough sleepers by 2020, have the potential to provide real benefits to all Australians in these situations.

The White Paper divides its initiatives into three broad areas:

- 'Turning off the tap': strategies to ensure that services intervene early to stop people becoming homeless, including:
  - increasing support to assist people in rental housing to maintain their tenancies;
  - assisting young people to remain connected with their families;
  - assisting families at risk of homelessness to stay housed;
  - 'no exits into homelessness' from hospitals, prisons and statutory care;
  - assisting women and children experiencing domestic violence to remain safely in the family home;
  - additional community mental health services under the Personal Helpers and Mentors program; and
  - a network of Community Engagement Officers to improve access to Centrelink services for people who are homeless.
- 'Improving and expanding services': strategies making services more connected and responsive across a range of areas not limited to housing, such as health and economic and social participation, including:
  - a workforce development strategy for specialist homelessness services;
  - testing new funding models reflecting the complexity of client needs;
  - improving information technology systems; and
  - developing quality standards for specialist homelessness services.
- 'Breaking the cycle': strategies assisting people who become homeless to move quickly through the crisis system to stable housing, and providing the support they need so that they do not re-enter homelessness, including:
  - building additional public and community housing for low-income households and people at risk of homelessness;
  - providing specialist facilities and improving services for older people who are homeless;
  - building and upgrading houses in remote indigenous communities; and
  - assertive outreach programs for rough sleepers.

The White Paper also includes strategies for research, implementation and governance. These will be essential as the White Paper initiatives are implemented in the different states and territories, to ensure that there is consistency and that the initiatives achieve the expected results.

These new strategies have the potential to make a real difference to people who are homeless or at risk of homelessness in Australia. However, it is yet to be seen whether the allocated funding ($1.2 billion over the next four years) will be sufficient; whether the strategies will be accepted by state and territory governments; how the strategies will be implemented; and whether implementation and distribution of these new programs will be consistent on a national level.

3.4 The relationship between mental health and being homeless

Mental illness, housing instability and homelessness often share much common ground. An understanding of the relationships between these experiences is essential if accommodation problems are to be tackled.

Mental health problems are common among the homeless and those in unstable housing. How many experience mental illness is difficult to determine as estimates vary widely depending on how homelessness and mental illness are defined, although a Commonwealth Department of Health and Ageing review noted in 2005 that regardless of definition, it appeared that the homeless had a higher prevalence of severe mental disorders than the rest of the population.[27]

This trend is demonstrated in other research. A survey by SANE of people living with mental illness found that 94 per cent of respondents had been homeless or were without suitable housing at some time in their lives.[28] Recent ABS data shows that of those who had reported being homeless at least once in their lives, more than half had experienced a mental disorder in the previous 12 months, 3 times higher than among those who had never been homeless.[29] A major Australian study found that 75 per cent of their sample of homeless people in inner Sydney had at least one mental disorder, and 93 per cent reported having at least one extreme trauma.[30] A Melbourne study found similarly that 30 per cent of their homeless sample had mental health issues, while 43 per cent had substance use issues.[31] Another study took a different approach, assessing the subjective wellbeing of the homeless population, and found that homeless people in inner Sydney have a mean wellbeing score of 55.2 percentage points, well below the Australian adult normative range of between 73.4 and 76.4 percentage points.[32]

Other Australian and international studies also indicate the significant over-representation of people with mental illness in the homeless population.[33] The Royal College of Psychiatrists in the UK found that in a 2003 study of the people attending an open Christmas shelter for the homeless, 1-in-3 had a mental illness. It also emphasised that global studies repeatedly revealed that rates of depression, anxiety, substance misuse and psychosis were several times higher among the homeless.[34] In addition, survey findings suggest that people in marginal accommodation experience severe mental illness in similar proportions to people who are homeless.[35]

Without definitive statistics on the proportion of homeless or unstably housed people who experience a mental illness, it is difficult, if not impossible, to know whether these people are being reached by existing programs. We cannot assess what proportion of the homeless population requires treatment for their mental illness, whether those affected are receiving the treatment that they need, or whether this treatment is effective. Until data collection on mental illness and homelessness is improved, our picture of the homeless population in Australia will remain incomplete, and we will not know if homelessness and mental health programs are effective.

27 St Vincent's Mental Health Service and Craze Lateral Solutions, *Homelessness and Mental Health Linkages: Review of National and International Literature*, Department of Health and Ageing, Canberra, 2005.
28 SANE Australia, *Housing and mental illness (Research Bulletin 7)*, SANE Australia, Melbourne, 2008.
29 ABS (2008) *op. cit.*
30 T. Hodder, M. Teesson, and N. Buhrich, *Down and Out in Sydney: Prevalence of Mental Disorders, Disability and Health Service Use among Homeless People in Inner Sydney*, Sydney City Mission, Sydney, 1998.
31 C. Chamberlain, G. Johnson, and J. Theobald, *Homelessness in Melbourne: Confronting the Challenge*, RMIT Publishing, Melbourne, 2007.
32 Wesley Mission, *More than a bed: Sydney's homeless speak out*, Wesley Mission, Sydney, 2008.
33 St Vincent's Mental Health Service and Craze Lateral Solutions (2005) *op. cit.*
34 Royal College of Psychiatrists, Press Release, 31 August 2007, online at http://www.rcpsych.ac.uk/pressparliament/pressreleases2006/pr961.aspx, accessed 3 January 2009.
35 H. Hermann, and C. Neil, 'Homelessness and mental health: lessons from Australia', in D. Bhugra (ed), *Homelessness and Mental Health*, Cambridge University Press, Cambridge, 1996.

Additional factors can also have a bearing on mental illness and housing problems, including those set out below:

People who are not receiving treatment for a mental illness:

The treatment of mental illness becomes more difficult when a person is homeless or in unstable housing. Approximately two thirds of all people with mental illness do not receive treatment in any given year,[36] and this proportion is likely to be far higher for those experiencing homelessness, who frequently report difficulties in accessing care.[37] Obstacles that interfere with homeless people receiving adequate health care include financial barriers, a lack of transportation to treatment facilities, a lack of a Medicare card or health insurance, a lack of a fixed address or permanent contact details, a lack of insight into their illness, a lack of awareness of available services, and a reluctance to access services due to past negative experiences.[38]

When a person with mental illness is homeless or not adequately housed, inappropriate hospitalisation or unnecessarily long stays in hospital may result.[39] Outside of hospital, transient lifestyles may increase the likelihood of people not sticking to their treatment as many find it almost impossible to take medicine regularly while living on the streets.[40] Thus, regardless of whether mental illness precedes homelessness or vice versa, what is apparent is that homeless people experiencing mental illness find it extremely difficult to continue appropriate treatment.

People with co-morbid substance use disorders:

Substance use disorders very frequently coexist with mental illness, and in combination these conditions result in a particularly high risk of homelessness. People who have a mental illness and are homeless are very likely to also experience a substance use disorder.[41] When mental health and substance use issues are present, people may encounter obstacles in obtaining or retaining appropriate housing. Drug and alcohol use are known factors in increasing relationship tensions within families, between neighbours or landlords.[42] The financial costs of ongoing addiction may compete with housing costs.[43] Furthermore, it may be more difficult for people with substance abuse problems to obtain the help they need to access housing and treatment. There is anecdotal evidence that some mental health services will not provide treatment for a client who is using alcohol or drugs, while some detoxification centres refuse to treat clients experiencing mental illness,[44] as one testament revealed:

> The government departments were very cooperative when they found out you were homeless, but not so cooperative when they found out you were a homeless drug addict. I think it's a case of 'Drug addict? Too hard basket, don't worry about it'. Especially if you're a chronic drug addict, then it's 'Oh, she's never going to change'.[45]

36 ABS (2008) *op. cit.*
37 C. Robinson, *Understanding iterative homelessness: the case of people with mental disorders*, Australian Housing and Urban Research Institute (AHURI), Melbourne, 2003.
38 PILCH Homeless Persons' Legal Clinic, *Homelessness, Mental Health and Human Rights: Submission to the Senate Select Committee on Mental Health*, Public Interest Law Clearing House, Melbourne, 2005.
39 A. Freeman, G.E. Hunt, E. Evenluis, D. Smith and J. Malone, *High Support Accommodation for People with Psychiatric Disabilities – a survey of high support, very high support and residential rehabilitation services in NSW and assessment of the needs and satisfaction of consumers residing there*, Aftercare, Sydney, 2003.
40 HREOC (1993) *op. cit.*; K.R. Wireman, 'Preventing Homelessness: A Consumer Perspective', *Journal of Primary Prevention* 28, 2007, pp.205-212.
41 St Vincent's Mental Health Service and Craze Lateral Solutions (2005) *op. cit.*
42 Robinson (2003) *op. cit.*
43 David Plant and Associates, *Homelessness and Mental Health*, Prahran Mission, Melbourne, 2000.
44 S. Parker, L. Limbers and E. McKeon, *Homelessness and mental illness: mapping the way home*, Mental Health Coordinating Council (MHCC), Sydney, 2002.
45 'Sallie', quoted in A. Byrne, *Homeless: true stories of life on the streets*, New Holland, Sydney, 2005.

People in contact with the criminal justice system:

People who are homeless and people who have a mental illness are both more likely than the rest of the population to come into contact with the criminal justice system.[46] A project by the PILCH Homeless Persons' Legal Clinic found that at least 75 per cent of homeless participants received fines and charges in relation to behaviour directly related to their homelessness or mental illness, including begging, drinking in public, other public space offences, activities performed due to extreme poverty such as shoplifting, or drug and alcohol related offenses.[47]

The MHCA's *Not for Service* report found that homeless people with a mental illness were more than 40 times more likely to be arrested and more than 20 times more likely to be imprisoned than those with stable accommodation; and offenders without stable accommodation were more than three times more likely to offend than those with stable accommodation.[48] *Not For Service* uncovered evidence suggesting that some homeless people with a mental illness actually seek imprisonment so that they will not be living rough: 'Another consumer pleaded guilty to something they didn't do just so they could get into a "better cell" – a 14 week prison sentence was better than being sick and homeless'.[49]

Homeless young people experiencing mental illness:

Mental illness is predominantly a young person's disease and therefore it has a particular impact on education, employment, social life and development.

The facts paint a desperate picture:

- Thirty-one per cent of homeless people are between the ages of 12 and 24, with another 12 per cent under the age of 12.[50]
- People aged between 15 and 19 had the highest rate of access to SAAP services for any age group, followed by people aged between 20 and 24.[51] These are critical years for mental health.
- Research estimates that between 20 and 25 per cent of people aged between 12 and 17, and 25 to 40 per cent of people aged between 18 and 24 have mental health disorders.
- Seventy-five per cent of people with an adult-type psychiatric disorder will experience its onset by the age of 24, and 55 per cent of the disease burden in the 15 to 24 age group is because of mental illness.[52]
- Young people who are homeless are twice as likely as their peers who are in stable accommodation to have a psychiatric disorder in their lifetime.[53]
- Research in Melbourne found that 37 per cent of homeless young people surveyed had attempted suicide, with 11 per cent attempting suicide in the past three months; 36 per cent had harmed themselves in the past three months; 26 per cent reported a level of psychological distress indicative of a psychiatric disorder; 14 per cent reported clinical levels of depression; 12 per cent reported clinical levels of anxiety; and 12 per cent had clinical levels of psychosis. These figures are much higher than are seen in the general young population.[54]

46 Center for Mental Health Services (CMHS), *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-Occurring Substance Use Disorders*, Department of Health and Human Services (DHHS) (Substance Abuse and Mental Health Services Administration [SAMHSA]), Rockville, 2003.
47 PILCH Homeless Persons' Legal Clinic (2005) *op. cit.*
48 Evidence from Department of Corrective Services, NSW, cited in MHCA, *Not for Service: Experiences of injustice and despair in mental health care in Australia*, MHCA, Canberra, 2005.
49 MHCA (2005) *op. cit.*, p.483.
50 Chamberlain and Mackenzie (2008) *op. cit.*
51 AIHW, *Homeless People in SAAP: SAAP National Data Collection annual report 2005-06* (AIHW Cat. No. HOU156), AIHW, Canberra, 2007.
52 P.D. McGorry, R. Purcell, I.B. Hickie and A.F. Jorm, 'Editorial: Investing in youth mental health is a best buy', *Medical Journal of Australia* 187 (7 Suppl), 2007, S5-S7.
53 CHP, *Submission by the Council to Homeless Persons to the Senate Select Committee on Mental Health*, CHP, Melbourne, 2005.
54 B. Rossiter, S. Mallett, P. Myers, and D. Rosenthal, *Living well? Homeless young people in Melbourne*, Australian Research Centre in Sex, Health and Society (La Trobe University), Melbourne, 2003.

These statistics relate to the key years in a person's life for the completion of education, commencement in employment, and the formation of a firm financial basis for future housing stability. In a sample of homeless young people in Melbourne, only 38 per cent were attending an educational institution, and almost half of these reported that they attended school less frequently after they lost their accommodation.[55] One homeless person explained that:

> My mental health issues started when I was fourteen … My first trip to hospital was when I was seventeen. I spent three months there and that's why I didn't do my HSC.[56]

Problems completing education thus potentially lead to future unemployment, financial instability and a greater risk of homelessness. It is therefore clear that special attention needs to be paid to young people with a mental illness to prevent them from becoming homeless, and to homeless young people who already have, or are at risk of developing, a mental illness.

Homeless older people experiencing mental illness:

While many young people experience mental illness and homelessness, 17 per cent of homeless people are over 55 years of age, and of that group, 7 per cent are over 65.[57] The issues faced by older Australians are likely to be exacerbated by declining physical health and longer periods of homelessness or unstable housing. This group may also experience significant mental health issues, and these links should be investigated. This is a particularly timely issue now, as many older Australians face the loss of superannuation and retirement savings due to the world financial crisis.

Indigenous Australians experiencing homelessness and mental illness:

Aboriginal and Torres Strait Islander people are vastly over represented among both people who are homeless and people living with mental illness. While 2.4 per cent of the Australian population identify as Aboriginal or Torres Strait Islander, they represent 9 per cent of the homeless population, 16 per cent of people living in improvised dwellings, and 20 per cent of those in SAAP.[58] Indigenous Australians also experience much higher rates of mental illness: in 2003-04, Aboriginal and Torres Strait Islander people were up to twice as likely to be hospitalised for mental and behavioural disorders as other Australians.[59] The impact of poor mental health on housing for Aboriginal and Torres Strait Islanders needs to be assessed urgently, particularly when these are considered in conjunction with other barriers to social inclusion.

People with mental illness living with families and carers:

A large number of people with mental illness live either with their families or other carers.[60] The provision of accommodation and support by families and carers may be the only reason that these people are not in the homeless population. This is, however, often an unsuitable arrangement for both the consumer and the carer. There is potentially increased stress and anxiety for both parties and reduced opportunities for independence for the mental health consumer.[61] Where the home is owned by ageing parents, '…there is no "tenure" as such and future security is not assured'.[62]

Nevertheless, there can be substantial benefits arising from family support for people with mental illness: they are less likely to experience repeated episodes of homelessness, they will have more disposable income,

55 *ibid*.
56 'Jai', quoted in A. Byrne (2005) *op. cit*., pp.136-137.
57 Chamberlain and Mackenzie (2008) *op. cit*.
58 *ibid*.
59 ABS and AIHW, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* (Cat. No. 4704.0), ABS and AIHW, Canberra, 2005.
60 HREOC (1993) *op. cit.*
61 P. Cameron and J. Flanagan, *Thin ice: Living with serious mental illness and poverty in Tasmania*, Anglicare Tasmania, Hobart, 2004.
62 Mental Illness Fellowship Victoria (2008) *op. cit*., p.3.

and they will have less need to access mental health services.[63] However, carers have commented that there is often no other option than for them to provide this accommodation, and have expressed their concerns about who will care for their friend or family member when they are no longer able. Two carers described this dilemma:

> I feel that I can no longer cope with him living at home due to this illness. But there is nowhere for him to live. It's all unavailable. I would not want him locked away in an institution. But where can people with a mental illness live?[64]

> I have a son in his early 20s. He has schizophrenia and lives with me. He is unmedicated…he is impossible to live with, and only lives with me because he has nowhere else to go. There is no mental health vacancy anywhere in the ACT and he is incapable of living independently. There is just nowhere for him.[65]

The role of such carers should be recognised, and the significant contribution that they make to accommodating people with a mental illness should be supported. At the same time, alternative accommodation must be made available so that consumers have options other than living with carers if this is problematic or not the preference of the consumer or carer.

People in rural and regional areas:

People living in rural and regional areas typically experience all of the barriers described above. Additionally, there are the added barriers of geographical isolation and limitations in availability of homelessness and mental health services. There is less variety in the available services, and services are often located a significant distance away. Financial and transport barriers exacerbate the isolation experienced by people in these areas.

3.5 Barriers to achieving and maintaining stable housing

Mental illness contributes to an increased risk of homelessness, and people experiencing mental illness, particularly episodic mental illness, face a range of difficulties in maintaining stable housing. These barriers are numerous and involve many different situations, as can be seen below:

Housing affordability:

It is widely regarded that the maximum reasonable level of expenditure on housing should be 30 per cent of income. Often this figure is exceeded due to rising property costs and rental demand, which causes other needs, such as mental health, to be neglected.[66]

The health effects of housing payment problems can be significant. One recent study revealed that worrying about whether or not one can meet mortgage or rental payments has deleterious effects on wellbeing. Another study found that home owners with mortgages reported greater psychological distress than those without, while renters reported an even greater level of psychological distress. Another study indicated that problems making housing payments or going into arrears have significant psychological costs similar to those experienced as a result of marital breakdown or unemployment, and that threats to housing represent '…a

63 Cameron and Flanagan (2004) *op. cit*.
64 MHCA (2005) *op.cit.*, p.443.
65 *ibid*., p.709.
66 G. Harris, '*The right home in the right location with the right support': Submission in response to the Discussion Paper 'Accommodation and Personal Support for People with Disabilities in South Australia*', Mental Health Coalition of South Australia, Adelaide, 2006; SANE Australia (2008) *op. cit.*; J. Yates, *Housing affordability and financial stress*, AHURI, Sydney, 2007.

major life event affecting mental health'.[67] Other factors to consider are major housing events that may result from an inability to meet costs, including moving house or eviction. Both of these are recognised as major events that affect mental health.[68]

Insecurity of tenure:

Insecurity of tenure may cause significant stress and other health problems. A recent study found that people in rental accommodation were more likely to report that they were in 'fair' or 'poor' health and more likely to visit their doctor than home owners. Renters also reported a significantly higher number of serious health conditions than home owners. While this report does not posit any reason for these discrepancies, it seems probable that the greater instability in housing tenure and the lack of control in housing experienced by renters has some impact on their overall health status, including their mental health.[69]

Another study found that greater security of tenure resulted in reduced residential mobility, which in turn resulted in residents feeling more in control, more settled in their home and less stressed.[70] Reduced security of tenure and consequent moves can have a range of non-housing effects that also impact on mental health, including disruption to schooling or employment, pressure on relationships and reduced or impaired social networks.[71] A lack of stable housing due to poor security of tenure is often part of a larger picture of weak social networks, family breakdown and a lack of community participation, all of which have negative impacts on mental health.[72]

These findings are supported by a recent AHURI report, which found that housing insecurity is linked to insecurities in other aspects of life, including financial, employment, family and health. Housing insecurity appears to reflect, contribute to or exacerbate experiences of anxiety and depression, as well as being linked with other forms of insecurity, such as employment insecurity, that also contribute to feelings of stress, anxiety and depression.[73]

Housing conditions:

Housing must be of an adequate quality, as various conditions and features within a dwelling can have significant negative impacts on health. Many of these relate to physical health, such as mould, air pollution, pest infestations, temperature control and sanitation. However, other aspects of living conditions, such as low quality housing, overcrowding, noise levels, pollution, lack of daylight and inadequate privacy, are directly related to poor mental health.[74] Poor quality housing may cause people to experience anxiety, depression, insomnia, paranoid feelings, and social dysfunction.[75] This may be for the first time, or it may aggravate pre-existing psychiatric illnesses or symptoms.[76]

Safety and security:

Feelings of safety and security in a dwelling are also essential to mental health and wellbeing, but these may be affected by fear of threats and crime, as well as exposure to and fears of violence, including domestic violence. A home can be '…a physical and psychological envelope within which intimacy will appear and

67 E. Robinson and R. Adams, *Housing stress and the mental health and wellbeing of families* (Australian Family Relationships Clearinghouse Briefing No 12), Australian Institute of Family Studies, Melbourne, 2008.
68 AIHW, *Australia's welfare 2007* (AIHW Cat. No. AUS93), AIHW, Canberra, 2007.
69 A. Waters, *Do housing conditions make a difference to our health?* (AHURI Research and Policy Bulletin No. 6), AHURI, Melbourne, 2002; see also AIHW (2007) *Australia's welfare 2007*.
70 Robinson and Adams (2008) *op. cit.*
71 AIHW (2007) *Australia's welfare 2007*.
72 Mental Health Coordinating Council (MHCC), *Social Inclusion: Its importance to mental health*, MHCC, Sydney, 2007.
73 K. Hulse and L. Saugeres, *Housing insecurity and precarious living: an Australian exploration*, AHURI, Melbourne, 2008.
74 AIHW (2007) *Australia's welfare 2007*; S.A. Bashir, 'Home Is Where the Harm Is: Inadequate Housing as a Public Health Crisis', *American Journal of Public Health* 92(5), 2002, pp.733-738; Bonnefoy (2007) op. cit.; World Health Organization, *Breaking the vicious cycle between mental ill-health and poverty*, WHO, Geneva, 2007.
75 Bonnefoy (2007) *op. cit.*
76 AIHW (2007) *Australia's welfare 2007*.

develop and where each and every individual will find an opportunity to be him or herself.' For this 'envelope' to be maintained, however, the home must be free from, or the fear of, unwanted intrusions.[77] A lack of housing options to escape from an unsafe situation, including domestic violence, is likely to have a negative impact on one's mental health.

Location and environment features:

A home's location can also affect mental health. Feelings of safety and security can be affected not only by features of the dwelling, but also features of the community in which it is located. Most of us are familiar with the stigma that ghettos and poorer districts attract. Almost every Australian city and town has areas or neighbourhoods which are known by stereotype and reputation as being a home to drug and alcohol users, migrants, gangs, the undereducated, and unemployed.

Crime, vandalism, graffiti, segregation and loitering can all affect feelings of safety and security and thus also affect mental health, as can disputes over communal or shared facilities or areas. Stigma is also a factor – living in an area stigmatised by socio-economic and even racial prejudice can enforce social isolation and a sense of a lack of control over communal or shared facilities or areas. Mental health issues are further exacerbated when there are insufficient community facilities and access to services, shops and public transport.[78]

Stable and secure housing is therefore an essential prerequisite for building and maintaining mental health. Evidence suggests that homelessness can limit or even prevent recovery,[79] and that quality of life increases or declines in line with changes in adequate housing.[80] Thus, a home which provides a refuge has significant mental health benefits. However, inappropriate, unstable or insecure housing which does not meet the resident's preferences is likely to have the opposite effect.

Financial difficulties:

The slide into homelessness is often precipitated by financial crisis. A Wesley Mission report found that 71 per cent of homeless people in their Sydney-based sample became homeless following a housing crisis, and in 88 per cent of these cases such a crisis was caused by financial difficulties.[81] In another study, finances were identified by 44 per cent of the sample of homeless or unstably housed people experiencing mental illness as a barrier to achieving stable accommodation.[82]

Financial hardship can often be explained by the low workforce participation rate of people with a mental illness, which was just 29 per cent in 2003.[83] Those who are unable to work may find that the Disability Support Pension (DSP) or another Centrelink benefit is their only source of income. Such comparatively low incomes can obviously be significant barriers to obtaining and/or retaining stable housing. Opportunities to purchase property are greatly reduced and the costs of private rental or saving for a bond may also be out of reach.[84] A recent survey by SANE found that high rental costs were a major barrier for people with a mental illness in their search for a suitable place to live.[85]

77 Bonnefoy (2007) *op. cit.*
78 ACT Legislative Assembly Standing Committee on Health and Disability, *Appropriate Housing for People Living with a Mental Illness*, ACT Legislative Assembly, Canberra, 2007; AIHW (2007) *Australia's welfare 2007*; Bonnefoy (2007) *op. cit*.
79 Senate Community Affairs Committee (2008) *op. cit*., p.112.
80 AIHW (2007) *Australia's welfare 2007*.
81 Wesley Mission (2008) *op. cit*.
82 Robinson (2003) *op. cit*.
83 MHCA (2007) *op. cit*.
84 David Plant and Associates (2000) *op.cit*.; Robinson (2003) *op.cit*.; B. Robson, *Can I Call this Home? an evaluation of the Victorian Housing and Support Program for people with psychiatric disabilities*, Psychiatric Disability Services of Victoria, Melbourne, 1995.
85 SANE Australia (2008) *op. cit.*

Administrative issues:

Nearly 90 per cent of respondents to SANE's survey reported that the complexity of applying for public housing had created difficulties for them.[86] Another study found that applying for the DSP, seen by some respondents as a prerequisite for public housing, was also extremely difficult, and intensive support was often required to complete the application.[87]

Tasks such as organising and keeping appointments, completing forms and accessing telephone services when seeking housing and benefits may seem to some people with a mental illness '…at times physically and mentally impossible' due to feelings of depression, inertia and powerlessness.[88]

Behavioural and social issues:

When they are unwell, some people with a mental illness exhibit behaviours or symptoms that may threaten their housing stability, such as causing disturbances to neighbours, causing a threat to themselves or others, missing rent or utility payments, not opening mail or neglecting their housekeeping. Symptoms are known to include paranoia, intense fear, anxiety, depression, delusions, mood swings, hallucinations, memory problems, confusion, and disordered thinking. Any of these behaviours may lead to eviction or other difficulties that put their housing at risk.[89]

A mental illness can also lead to difficulties in maintaining social relationships, which may cause conflict with family, employers, landlords or neighbours. Breakdown of these relationships may jeopardise housing.[90] A lack of understanding from family members about a person's mental illness may also create issues if a person is living in the family home: in a 2003 AHURI study, family or relationship breakdown was the third most important reason why respondents had left their accommodation, while a recent Wesley Mission study identified such breakdowns as the second most frequently cited cause of homelessness.[91]

Stigma and discrimination:

This is a key factor affecting people's ability to find housing. Nearly 90 per cent of respondents in a SANE housing survey believed that they had been discriminated against at some point in their search for appropriate housing, particularly when seeking private rental accommodation.[92] People with mental illness may be stigmatised and discriminated against by their neighbours: they may '…at best be given the "cold shoulder" and at worst be victimised by other tenants'.[93]

Insufficient support and treatment:

Some people experiencing mental illness who can usually retain stable housing may find that their accommodation is put at risk due to a period of poor health or an acute episode. Eighty-seven per cent of respondents to the SANE housing survey reported that lack of support around the time that they became unwell and were hospitalised had contributed to the loss of their accommodation.[94] The episodic nature of mental illness, which may result in periods of hospitalisation or other absences from the home for treatment, can make it especially difficult for those affected to meet housing payments, thus putting them at risk of losing their accommodation.[95]

86 *ibid*.
87 Robinson (2003) *op. cit*.
88 A. Reynolds, S. Inglis and A. O'Brien, *Effective programme linkages: an examination of current knowledge with a particular emphasis on people with mental illness*, AHURI, Melbourne, 2002; Robinson (2003) *op. cit*.; L. Rosie, *Response to: Inquiry into Appropriate Housing for People Living with Mental Illness*, Mental Health Community Coalition ACT, Canberra, 2005.
89 Cameron and Flanagan (2004) *op. cit*.; Harris (2006) *op. cit*; Parker et al (2002) *op.cit*.; Reynolds et al (2002) *op. cit*.; Robinson (2003) *op. cit*.
90 CMHS (2003) *op. cit*.
91 Robinson (2003) *op. cit*.; Wesley Mission (2008) *op. cit.*
92 SANE Australia (2008) *op. cit*.
93 Rosie (2005) *op. cit*., 10.
94 SANE Australia (2008) *op. cit.*
95 Harris (2006) *op. cit.*; Robson (1995) *op. cit*.

Early intervention is needed to ensure that effective treatment and support services are readily available to assist people to retain their accommodation, particularly when they are unwell. People who are not receiving the support they need to manage their complex needs may be particularly susceptible to changes in their accommodation.[96]

3.6 Mental health problems as a consequence of homelessness

For some people mental health issues precipitate or lead to homelessness, while for others their mental illness is a result of their homelessness, or has been made worse by it.

Consequences of homelessness related to mental health may include low self-esteem, social isolation, and the exacerbation or development of specific mental health disorders including schizophrenia, depression, bipolar disorder and post-traumatic stress disorder. Low prevalence disorders are particularly common in the homeless population, and many of these conditions may become chronic.[97] Depression and distress are two to eight times more likely to occur in people who are homeless, and homelessness may exacerbate existing or underlying symptoms of mental illness.[98]

Evidence also suggests that people with psychosis who are homeless experience greater adverse effects than those with that condition who are housed.[99] The terrible experiences of many people in this population also have significant impacts on mental health; abuse and experiences of trauma and victimisation during a period of homelessness or unstable housing are likely to have very negative impacts on mental health. [100] Research reveals traumatic experiences that affect mental health being repeated throughout the lives of homeless people with mental illness, including domestic violence, relationship breakdown, deaths of friends and family members, incest, abuse, assault and accidents.[101]

A lack of appropriate support and treatment services for people experiencing homelessness also has detrimental effects on mental health. Recent research in Melbourne indicated that over half of the 30 per cent of homeless people in their sample reporting a mental illness had developed these problems after becoming homeless.[102] These findings are supported by the AIHW, which also found that unstable or unsatisfactory housing can have negative impacts on mental health.[103] Evidence also indicates that mental health worsens with longer experiences of homelessness.[104]

3.7 The impact of deinstitutionalisation

With such a large proportion of homeless people having a mental illness, one might ask why governments have moved away from the system of housing people in large institutions.

Asylums were generally regarded as an unhealthy mixture of substandard care and human rights abuses. Changes in psychiatric practice and improvements in psychoactive medications enabled a move away from these confinement models to medication-based community treatment. Unfortunately, the overwhelmingly positive move to successfully integrate people into community life has been made more difficult through failures to invest in community support. For some who left these asylums the community provided no support to house them.

A common misconception is that deinstitutionalisation resulted in people being discharged onto the streets. Inpatients of psychiatric institutions included those receiving short-term acute care, who could reintegrate

96 AIHW (2007) *Australia's welfare 2007*.
97 PILCH Homeless Persons' Legal Clinic (2005) *op. cit.*
98 Parker et al (2002) *op. cit*.
99 Australian Federation of Homelessness Organisations, *Mental Health and Alcohol and Other Drug Issues as Factors in Homelessness*, AFHO Policy Platform, Canberra, undated.
100 CMHS (2003) *op. cit*.
101 Robinson (2003) *op. cit*.
102 Chamberlain et al (2007) *op. cit*.
103 AIHW (2007) *Australia's welfare 2007*.
104 PILCH Homeless Persons' Legal Clinic (2005) *op. cit.*

into the community without difficulty. Of those who were long-term patients, many were placed in residential services in the community before wards closed. Some facilities were specially built, such as psychogeriatric facilities and residential rehabilitation units. In most states and territories, however, the closure of institutions was not balanced with the development of sufficient housing options that had adequate support for people to build community connections and focus on their psycho-social recovery.[105]

The problem with deinstitutionalisation was that it was not accompanied by any clear concept of people's housing needs as well as their needs for health care and protection within the community.[106] The subsequent establishment of services outside of asylums and institutions has been uneven, and the service system as a whole has not been evaluated.[107]

Not many professionals would advocate the return to the system of institutions; however, governments have failed to provide adequate alternatives. While it is misleading to argue that policies of deinstitutionalisation have 'caused' an increase in homelessness among people with a mental illness, what can be said is that the failure to increase community-based treatment and support services has contributed to and exacerbated difficulties for people with a mental illness in accessing the stable and appropriate housing that is an essential prerequisite for effective treatment and support.

These problems have been exacerbated by changes in the housing market over the past ten years, including the significant reduction in funding for public housing, the loss of low-cost accommodation due to inner city gentrification, the shortage of rental property and associated rent increases, and the decrease in affordable housing.

Appropriate housing is required to complement treatments that have replaced institutionalised care, or such procedures will be ineffective.

105 Parker et al (2002) *op. cit.*
106 D. Green, 'The End of Institutions, Housing and Homelessness', *Parity*, April 2003.
107 M. Carter, T. Burke, and S. Moore, *Case Studies in Deinstitutionalisation*, Institute for Social Research (Swinburne University), Hawthorn, 2008.

4. What Must Be Done: The 'Home Truths' Strategies

The number of people with a psychiatric disability who can be effectively supported to maintain stability in their housing may well be limited more by the supply of both support and housing, rather than the limitations and challenges presented by their illness and resultant disabilities.

Australian Housing and Urban Research Institute[108]

4.1 A national homelessness strategy must recognise mental illness

Home Truth No. 1:

A national strategy on homelessness that includes due recognition of the relationships between mental health and homelessness must be developed and funded.

Evidence provided in the previous sections of this report clearly identifies a link between mental illness, homelessness, and housing; thus any genuine housing strategy must address these clear relationships and ensure each issue is given adequate attention.

A Green Paper, entitled, *Which Way Home? A new approach to homelessness*, was published by the Rudd Government in May 2008, and in December of that same year it released a White Paper, entitled *The Road Home: A National Approach to Reducing Homelessness*, detailing a national strategy to reduce homelessness in Australia. The MHCA welcomes these initiatives and strongly supports many of the recommendations in the Government's new homelessness strategy.

In its submission in response to the Green Paper,[109] the MHCA argued that any homelessness strategy for Australia must go beyond simply acknowledging the large proportion of the homeless population experiencing mental illness, and that Australia's new homelessness strategy must contain measures that are specifically targeted at addressing mental health issues among this population, including:

- early intervention to prevent people with a mental illness from slipping into homelessness, such as effective discharge planning;
- mental health services aimed specifically at homeless and unstably housed populations that recognise the particular needs of this group and provide services for them in their own location;
- effective strategies for the management and treatment of co-morbid mental illness and substance use problems;
- support and rehabilitation for people with a mental illness to meet their additional needs during their transition from homelessness;
- the willingness to engage directly with consumers, their carers and their families to ensure that their needs are being met;

108 A. O'Brien, S. Inglis, T. Herbert and A. Reynolds, *Linkages between housing and support – what is important from the perspective of people living with a mental illness*, AHURI, Melbourne, 2002.

109 MHCA, *Mental Health Council of Australia Submission: Which Way Home? A new approach to homelessness*, MHCA, Canberra, 2008.

- recognition of the diverse needs and biographies of people with a mental illness and people who are homeless; and
- the need for ongoing monitoring and accountability measures.

The MHCA is particularly pleased to see that the White Paper acknowledges mental health issues, and the development or expansion of strategies aimed at improving housing outcomes for those with special needs, such as those with mental illness. A number of strategies in the document will be of particular benefit to people with a mental illness who are homeless or unstably housed: [110]

- The Australian Government's Personal Helpers and Mentors (PHaMs) program has already proven successful in assisting many people with mental illness to live in and engage with their community, by such measures as the stabilisation of housing. This program will be expanded to provide services to an additional 1000 Australians.
- New or expanded services developed under the National Partnership on Homelessness to assist people with mental illness to both maintain their housing and connect with their communities will also provide significant benefits, particularly through new or enhanced links between mainstream agencies, specialist homelessness services and specialist mental health services.
- A new 'No Wrong Door' approach should result in people who have a mental illness and are experiencing difficulties with their housing being connected to specialist homelessness services through their interactions with other services, including those pertaining to mental health. This should be of particular benefit to people with mental illness, who often experience particular difficulties navigating confusing and poorly connected service systems.
- Additional assertive outreach for rough sleepers will assist people with a mental illness who are currently sleeping rough. Again, many of these people are reluctant to interact with health services as a result of past negative experiences. Assertive outreach will assist people to obtain treatment while also connecting them with other essential services to facilitate a move off the streets and into stable housing. In addition, a national network of Community Engagement Officers, to assist homeless and disconnected people to access Centrelink services, will probably provide significant benefits to people with mental illness.
- Of particular importance in the White Paper is the new policy of 'no exits into homelessness' from either hospitals, mental health services or prisons. Currently a lack of discharge planning results in a transition to rough sleeping or unstable housing for many people with a mental illness exiting such facilities. The MHCA welcomes this new 'no tolerance' approach, and considers that the implementation of this particular new strategy, combined with the strengthening of current post-release services, will be one of the most significant outcomes of the White Paper process.

The MHCA is particularly pleased that the White Paper sets real outcome targets for matters relating to homelessness, and more specifically in relation to goals such as preventing individuals from being discharged from any health care facility into a state of homelessness.

The key to such a strategy being effective involves not only what resources are provided and actions taken, but also establishing a clear monitoring and reporting capacity to ensure that the community at large knows to what degree the goals of the strategy are or are not being achieved. Without such information, it appears probable that those policy initiatives will fail to change current practices, especially those on mental health and discharge to homelessness. This goal must be monitored actively if the number of people with a mental illness moving into homelessness is to be reduced.

110 Commonwealth of Australia (2008) *The Road Home*.

4.2 Access to mental health care must be increased

Home Truth No. 2:

Access to mental health care must be increased.

Recent ABS data on mental health and wellbeing in Australia shows that almost two thirds of people who experienced a mental health problem over the past 12 months did not receive either treatment or support for their illness, and that there is significant unmet need in mental health services. Over the past year 2.1 million adult Australians with a mental health disorder did not receive services for their mental health problems, but perceived that they had an unmet need.[111]

There is significant disparity in access to mental health services depending on where one lives in Australia. MHCA analysis of data on the new mental health Medicare item numbers through the Better Access program found that access to psychologists and clinical psychologists in rural and regional areas was far lower than in urban areas. Young people and men are also under-represented in the use of these services.[112]

It is unacceptable that large parts of Australian society cannot obtain the treatment and information required to build or maintain their mental health and wellbeing. In *Not for Service*, the MHCA called for funding for mental health services to be increased to 12 per cent of the total health budget, in line with the proportion of Australia's total disease burden that is due to mental health[113] (now 13 per cent). The most recent publicly released figures on mental health spending show that in the 2004-05 financial year, $3.9 billion was spent on services for that sector by the major funders – the Commonwealth Government, state and territory governments, and private health funds. This accounts for 6.8 per cent of all national health spending, and 7.3 per cent of government health spending – well below the 13 per cent that would reflect the disease burden of mental illness.[114]

A roundtable discussion paper from the Australian Healthcare and Hospitals Association, The Mental Health Services Conference and Pricewaterhouse Coopers identified a number of problems with the current model of mental health service provision in Australia that limit access to these services for many people. Whilst it is extremely important to emphasise that a huge funding increase is required for mental health services, another key issue is that no single agency sets national standards and monitors the state of mental health services in Australia. This essentially means that there is no common national standard for mental health care. There is also a lack of integrated funding across the whole of government, so other human services, including housing, are not factored into mental health services.

The paper also identifies other issues with current mental health services provision in Australia, supporting the need for reform, such as:

- the mainstreaming of mental health services has led to an acute and hospital centred approach;
- there has been a lack of investment in community care;
- current funding methodologies, including 'fee for service' systems, do not drive collaboration, continuity, integrity and quality;
- mental health spending does not follow health requirements of the population and varies between locations and states/territories;
- multiple agencies are involved in the provision of mental health services, but current arrangements between providers are complicated;

111 ABS (2008) *op. cit.*
112 D. Crosbie and S. Rosenberg, *COAG Mental Health Reform – Mental Health and the new Medicare Services – 2nd Report November 2006- August 2008*, MHCA, Canberra, 2008.
113 MHCA (2005) *op. cit.*
114 Department of Health and Ageing, *National Mental Health Report 2007: Summary of Twelve Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2005*, Commonwealth of Australia, Canberra, 2008.

- funding methods do not support workforce reform;
- the consumer and carer voice and ability to exercise choice in choosing services is limited; and
- the separation of Commonwealth and state/territory mental health responsibilities is problematic.[115]

These are major concerns, and substantial restructuring in mental health services will be required to address them. It will not be sufficient to continue to tinker with existing services. Radical reform is required to ensure that quality mental health services are available to all Australians, regardless of their location, gender, age, ethnic background, socio-economic status or housing situation.

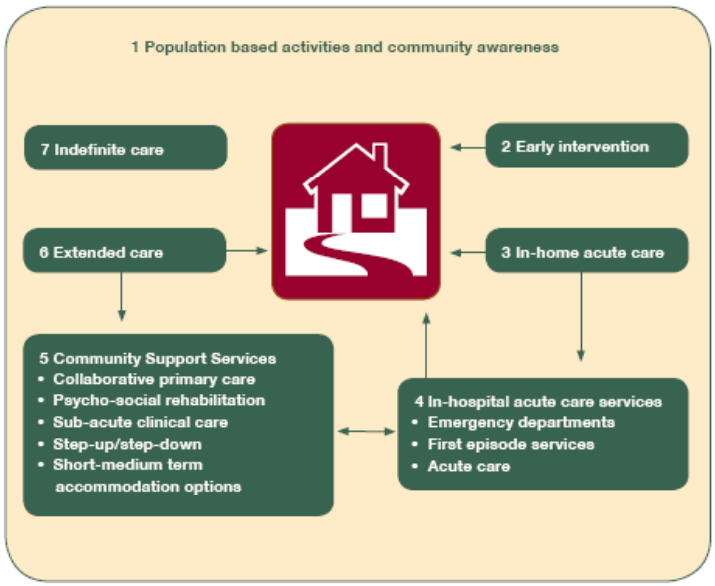
4.3 There must be investment in innovative, home-based programs

Home Truth No. 3:

There must be immediate investment in innovative, consumer-focused programs with an emphasis on home-based care.

Mental health service provision in Australia is usually hospital-based, when ideally treatment and support should be in the home or community. Permanent supported housing models should play a central role in mental health service provision, as these models allow for continuity of treatment, and are highly effective in preventing and ending homelessness for people with a mental illness.[116] The MHCA's *Time for Service* promoted a community-based model, as shown in Figure 3. The central principle of this model was that home is the place that most people prefer to live and receive care, and that the current construction of the mental health system means that it is not possible to receive acute care at home and is also extremely difficult to access any other form of care at home. Figure 3 provides one possible model that would remove these difficulties.

Figure 3: A New Mental Health System for Australia
Key components to enable independent living at home[117]



Services should be designed to maximise independent living, be flexible and responsive to individual needs, and accessible when needed. Critically, these services must be made available close to where people live or provided in conjunction with housing through supported housing programs.[118]

The additional PHaMs places proposed in the White Paper will provide services that fit into this community/home-based framework, and will be of significant benefit to those who access them. However, research shows that support is most

115 Australian Healthcare and Hospitals Association, The Mental Health Services Conference and Pricewaterhouse Coopers, *Mental Health Funding Methodologies: Roundtable Discussion Paper*, AHHA, Canberra, 2008.
116 D.J. Rog, 'The Evidence on Supported Housing', *Psychiatric Rehabilitation Journal* 27(4), 2004, pp.334-344.
117 From MHCA, *Time for Service: Solving Australia's mental health crisis*, MHCA, Canberra, 2006. See the *Time for Service* report for more information on this model.
118 CMHS (2003) *op. cit*.

effective when it is linked with housing, though housing and support should not necessarily be provided by the same organisation. Also, the availability of housing should not be contingent on a person's willingness to receive treatment or support.[119] Separating the management of housing and support minimises conflict and ensures the integrity of landlord and support functions, whether these functions are provided by separate organisations or by separate areas within the same organisation.[120]

The support needs of people with mental illness will vary widely at different stages of their illness and their recovery, ranging from 24 hour to weekly care, or as needed. Service systems should be flexible enough to accommodate these variances.[121] These varying levels should not be viewed as a hierarchy of support ranging from high support to low support, with the expectation that people will 'progress' through the levels until they require little or no support. Flexibility to move through the different levels as needs change is required. It is unlikely that a single service or program could manage the full range of support needs, but recognition that these requirements will change is required and should be combined with awareness of and links with other services that can fill the service gaps. Services must be available that can meet all levels of service need.

Effective support services should include a number of key elements:

- capacity for assertive outreach;
- sufficient time to nurture and build relationships with each service user;
- ability to manage fluctuations in health and support needs without putting housing or support at risk;
- consistency in the support provided;
- capacity to undertake case management or service coordination if the service user is unable to manage their diverse support needs;
- development of crisis management plans in collaboration with the service user; and
- effective approaches to managing issues around client confidentiality while releasing information to other services.[122]

Multifaceted support may be required. This may include practical assistance with areas such as obtaining treatment for mental illness, money management, cleaning and daily living, accessing social activities and outlets, accessing opportunities for skill development and meaningful activity, building connections to other services, or simply having someone to talk to.[123]

The ability for consumers to exercise choice in their support services is important. One study found that having control over professional support played an important role in providing consumers with positive outcomes, including adapting better to community living.[124] Recognising and accepting consumer choice may mean that housing risks are balanced with the consumer's right to make decisions about the type and amount of support that they receive.[125] The consumer's right to make their own decisions about support is a key element of supported housing models; unlike some other models, receiving treatment and other support services is not a compulsory prerequisite to receive housing. This approach has been identified as a key source of empowerment for consumers.[126]

An example of how consumer choice should be valued can be seen in the case studies below in section 5. In

119 O'Brien et al. (2002) *op. cit.*
120 UNSW Consortium, *Principles for effective housing and support policy for people with a mental illness*, UNSW, Sydney, 2008.
121 MHCC (2007) *op. cit.*
122 Reynolds et al (2002) *op. cit*.
123 O'Brien et al (2002) *op. cit*.
124 G. Nelson, J. Sylvestre, T. Aubry, L. George and J. Trainor, 'Housing Choice and Control, Housing Quality, and Control over Professional Support as Contributors to the Subjective Quality of Life and Community Adaptation of People with Severe Mental Illness', *Administration and Policy in Mental Health and Mental Health Services Research* 34, 2007, pp.89-100.
125 O'Brien et al (2002) *op. cit*.
126 S.D. Parkinson and G. Nelson, 'Consumer/Survivor Stories of Empowerment and Recovery in the Context of Supported Housing', *International Journal of Psychosocial Rehabilitation* 7, 2003, online at www.pscyhosocial.com/IJPR_7/survivor.html.

Neami's Community Housing Program, for example, clients are given the choice to maintain their homes in a state in which they feel comfortable. In relation to the issue of cleanliness of client properties, Neami support workers provide advice and prompts if squalor becomes a risk to a client's health or tenancy; however, if house cleaning does not appear to be a priority for the client, the decision '…to live in mess is their privilege', as it would be for anyone else living in the community.[127]

In addition to the successful Australian examples detailed in the case studies in section 5, supported housing is a model that has proven to be successful overseas. The Pathways to Housing Program in New York is one well known example. It is a housing-first model that allocates people with a psychiatric disability their own apartments, and then offers intensive and individualised clinical and social support services aimed at addressing clients' '…emotional, psychiatric, medical, and human needs'. A key element of the program's success is its emphasis on long-term housing solutions.[128] Another successful overseas model, which is currently being implemented in various locations in Australia, is the Common Ground model, also developed in New York. Common Ground projects involve building specific accommodation or redeveloping existing buildings and providing low cost accommodation to homeless people. Twenty-four-hour support services are provided on site. Tenants pay 30 per cent of their income towards their rent, and on average remain as tenants for 4.8 years.[129] The program is not targeted specifically at people with a mental illness, but the large proportion of the homeless population experiencing mental illness is mirrored in Common Ground residents.

Supported housing models have been highly successful in providing treatment and support in a person's own home within the community, rather than in a hospital setting. They are also extremely effective in assisting people to obtain and maintain stable housing, which is essential for mental health. The success of these models, including the viable alternative that they provide to hospital-based treatment, should be recognised through ongoing funding and support.

4.4 Housing must remain a mental health priority for COAG

Home Truth No. 4

Housing must remain as one of the top priorities in the COAG National Action Plan on Mental Health, but with additional funding specifically to support national coordination and action beyond a narrow focus on the existing health system.

The importance of housing, including supported accommodation, for building mental health is recognised in the COAG National Action Plan for Mental Health 2006-2011. One of its four outcomes is:

> …increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation.[130]

However, the initiatives within the plan do not reflect this recognition as they contain no strategies for housing people with a mental illness. While one strategy does aim to help consumers improve their independent living skills, none look at ensuring that people with a mental illness obtain appropriate accommodation. There is a

127 M. Carter, *From Psychiatric Hospital to Supported Housing: The Neami Community Housing Program*, Melbourne, Australia, 1995-2008, Institute for Social Research (Swinburne University of Technology), Hawthorn, 2008, p. 28.

128 A. Stefancic and S. Tsemberis, 'Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: Four-Year Study of Housing Access and Retention', *Journal of Primary Prevention* 28(3-4), 2007, pp.265-279; S. Tsemberis and R.F. Eisenberg, 'Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals With Psychiatric Disabilities', *Psychiatric Services* 51(4), 200, pp.487-493; see also Pathways to Housing Inc, 'Pathways to Housing', 2008, online at www.pathwaystohousing.org, accessed 15 September 2008.

129 Common Ground, 'Common Ground', undated, online at www.commonground.org, accessed 15 October 2008; F. Reynolds, *Churchill Fellowship Report: To Examine Programs that Assist Vulnerable and Complex Chronically Homeless People*, Winston Churchill Memorial Trust of Australia, 2008; more information on Australian examples is available at Common Ground Adelaide 'Common Ground: Whatever it Takes', undated online at www.commongroundadelaide.org.au, accessed 15 October 2008; HomeGround Services 'HomeGround Services: We're Housing People', undated online at www.homeground.org.au, accessed 15 October 2008; A. Horin, 'Homeless will get a place to call their own', *Sydney Morning Herald* 10 September 2008.

130 COAG 2006 *op. cit*.

separate COAG housing plan, with associated programs and targets; however, none of its initiatives relate to mental health.

Obviously, strategies that are effective in providing housing and support for people with mental illness may cost a lot of money; however, research indicates that this expenditure will be offset, if not matched completely, by reductions in service use in other areas.

A review of Australian and international studies found that providing stable housing for homeless people generated cost savings in a range of areas, and in some cases paid for most of the housing expenditure, while in others savings exceeded the required housing budget. Access to stable housing also significantly increases the likelihood of employment, thus reducing costs through unemployment benefits.[131] Research in inner Sydney found that the costs associated with reactive, crisis-based care are greater than those associated with engagement and early intervention with the homeless population.[132] Western Australian research found that reductions in the use of the health care and justice systems have the potential to save the annual cost of delivering effective homelessness programs.[133]

International research also suggests similar cost benefits. For example, studies on the New York/New York housing program for people with a mental illness found that those placed in these programs spent less time in shelters, hospitals and prisons.[134] Other research found that providing higher quality housing in better neighbourhoods led to better outcomes for people with mental illness, with the savings in mental health care costs outweighing those of property.[135]

The individual implementation plans of the states and territories that form part of the COAG National Action Plan on Mental Health include varying amounts of funding for initiatives relating to accommodating people with a mental illness or assisting homeless people with mental illness, although there are significant differences between these initiatives, including the allocated funding, the types of initiatives, and the number of places available:

- NSW: individual implementation plan includes $58.8 million for the HASI initiative.
- Victoria: $40.4 million to improve pension-level Supported Residential Services to upgrade accommodation and support for residents with psychiatric disability, with another $8 million for 'proactive tenancy support' to '…create stable and affordable housing pathways' following discharge from inpatient facilities.
- Queensland: $20 million for the procurement of a mix of accommodation for approximately 80 consumers (subsequently expanded with the commitment of $40 million capital expenditure and $22.45 million operating expenditure over 4 years, to allow for a total of 240 supported housing places), as well as $19.7 million to establish homeless health outreach teams and additional transitional housing places.
- Western Australia: $10 million to expand the Independent Living Program (ILP) and increased non-clinical psychosocial services assisting people to remain in their homes and another $27.2 million for the establishment of Community Supported Residential Units (with an additional $12.47 million subsequently allocated to further expand mental health specific accommodation over the period of the National Action Plan), as well as $1 million for Homeless Clinical Services providing transitional supported accommodation services.

131 M. Berry, C. Chamberlain, T. Dalton, M. Horn, and G. Berman, *Counting the Cost of Homelessness: A Systematic Review of Cost Effectiveness and Cost Benefit Studies of Homelessness*, AHURI, Melbourne, 2003. (Report prepared for the Commonwealth National Homelessness Strategy).

132 L. Giles, F. Reynolds, J. O'Mahony and P. McGeorge, 'Help the Homeless (Spend Less, Spend Wisely)', presentation to the *NSW NGO Mental Health Conference: 'Count-Me-In'*, Sydney, 2007.

133 P. Flatau, K. Zaretzky, M. Brady, Y. Haigh and R. Martin, *The cost-effectiveness of homelessness programs* (AHURI Research and Policy Bulletin No. 104), AHURI, Melbourne, 2008.

134 D.P. Culhane, S. Metraux and T. Hadley, 'Public Service Reductions Associated with Placement of Homeless Persons in Supportive Housing', *Housing Policy Debate* 13(1), 2002, pp.107-163.

135 J. Harkness, S.J. Newman and D. Salkever, 'The Cost-Effectiveness of Independent Housing for the Chronically Mentally Ill: Do Housing and Neighborhood Features Matter?' *Health Services Research* 39(5), 2004, pp.1341-1360.

- Tasmania: $5.3 million for additional supported accommodation.
- ACT: $2.8 million for Youth Supported Accommodation.
- South Australia: no accommodation-specific initiatives as part of the National Action Plan, but $20.46 million subsequently allocated for an extra 73 supported accommodation beds across Adelaide.
- Northern Territory: no accommodation-specific initiatives as part of the National Action Plan.[136]

Far greater consistency is needed between the states and territories, and to achieve this, significant funding is required from the Commonwealth. It is not sufficient to merely identify stable accommodation as a 'key outcome' without ensuring that the achievement of this is made possible through consistent initiatives across the state and territories and at a national level.

When the potential cost benefits of supported housing for people with mental illness are considered, there is no good reason for COAG not to include significant new initiatives and investments targeting housing for such individuals in the National Action Plan for Mental Health.

4.5 Treatment must be available in the community and at home

Home Truth No. 5

Home and community must become the preferred treatment sites with the number and scope of peer, carer, allied health and community options being significantly increased.

For people who are socially isolated due to mental illness, homelessness or unstable housing, hospital-based services are unlikely to meet their needs. Unfortunately this is where most services are available, limiting the access of these groups to the treatment and support that they require. Services must be taken to the location of the people that need them, whether they are housed or homeless.

A particularly effective model for providing services is known as 'assertive outreach'. This model works on the principle that many people who are homeless, or are at risk of losing their homes may be unable to seek the services that they require, or may not wish to do so because of previous negative experiences, so the services must be taken to them instead. Assertive outreach is 'designed to operate out of the office base and on the client's own 'territory' in the community'.[137] The goal is to identify and manage the full range of a person's needs, and manage these needs through the resources of a multidisciplinary treatment team.

Assertive outreach has been found to be an effective model in reaching homeless people experiencing mental illness, with improvement in housing stability and reductions in symptoms, and, according to some studies, reductions in the rate and duration of hospitalisations.[138] The value of assertive outreach is recognised in the White Paper with the inclusion of strategies providing additional assertive outreach programs to rough sleepers, aimed at connecting rough sleepers to sustainable housing and health services.

As well as being an effective model in targeting people who are homeless, outreach is also important to people who are housed but require support to either retain their housing or to obtain treatment for a mental illness. For a number of reasons, these people may be unwilling to access support in conventional areas, and support which is provided in their own setting is likely to be far more effective.

136 Australian Health Ministers' Advisory Council (AHMAC) Mental Health Standing Committee (MHSC) *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2006-07*, COAG, Canberra, 2008; COAG (2006) op. cit.
137 P. Ryan and S. Morgan, *Assertive Outreach: A Strengths Approach to Policy and Practice*, Churchill Livingstone, Edinburgh, 2004.
138 C.M. Coldwell and W.S. Bender, 'The Effectiveness of Assertive Community Treatment for Homeless Populations With Severe Mental Illness: A Meta-Analysis', *American Journal of Psychiatry* 164(3), 2007, pp.393-399.

4.6 Housing must be set aside for people with mental illness

Home Truth No. 6

Thirty per cent of public and social housing stock must be set aside for people with a mental illness.

Considerable 'catching-up' needs to take place for people with a mental illness to be housed on a level that is comparable with the rest of Australian society, and housing stock and funding allocations should reflect this. In many areas, availability of public and other affordable and low cost housing – regardless of its suitability – has become the primary issue for people with a mental illness due to rising house prices and rents, the tight rental market and reductions in public housing stock. For people who are on low incomes or pensions, or who are already socially isolated, these issues are even more significant. Even where initiatives are in place to provide housing for people with mental illness, unfortunately more housing is required to meet demand.[139]

For this reason, 30 per cent of public and social housing stock, including new stock made available through the White Paper strategies, must be set aside for people with mental illness. The White Paper is an overarching strategy targeted at reducing homelessness throughout the Australian population, and does not provide for this level of housing to be specifically allocated for people with a mental illness, though it does include new and expanded services to assist people with a mental illness to maintain their housing and connect with their communities. However, given the high proportion of people with a mental illness in the homeless and unstably housed population and the difficulties in providing treatment and support in the absence of stable housing, it is essential that the housing needs of homeless people with a mental illness become a priority when housing is allocated.

Strategies for increased housing supply

An AHURI report suggests a number of strategies to increase housing supplies for people experiencing mental illness, including:

- increasing the allocation of housing to supported housing programs such as HASI;
- reviewing public housing stock configuration to increase the availability of housing that is suitable for people experiencing mental illness – for example, more individual dwellings rather than high-density developments;
- acknowledging, and accommodating, the risks associated with some housing for people with mental illness, such as stresses that may arise from having to share facilities;
- diversifying the management and supply of social housing, with tailored approaches for different regions;
- creating a brokerage service for private rental to assist people with mental illness and other complex needs;
- assisting consumers who are unable to access appropriate public housing to access private rental;
- providing incentives, such as low interest loans or tax offsets, to families who purchase properties to accommodate a relative with mental illness; and/or
- providing private rental assistance to enable people with mental illness or complex needs to stay housed in specific locations or dwellings.[140]

139 Senate Community Affairs Committee (2008) *op. cit.*
140 O'Brien et al (2002) *op. cit.*

To this comprehensive list, the MHCA adds the development of strategies to assist people with mental illness who wish to purchase their own home, such as tailored housing finance, deposit assistance and equity contribution initiatives. One study found that people with a psychiatric disability are much less likely to own or be buying their own home - 27 per cent, compared to 70 per cent of the Australian population.[141] Many people with a mental illness experience significant financial disadvantage, due to the timing or duration of their illness, which often commences in the late teens or early twenties when most people are completing their education or establishing a career. Consequently, saving sufficient funds for a deposit or displaying an employment history that is acceptable to lenders may prove difficult. Shared equity and other arrangements would mitigate this financial disadvantage. The cost of entering the market would be reduced as the main share of the deposit could come from the equity partner (in this situation, likely to be the Australian Government), ongoing mortgage costs could be reduced, and the full benefits of home ownership could be enjoyed.[142] Other strategies to be considered could involve flexibility in levels and timing of housing repayments, so that fluctuations in income or gaps in employment are managed more responsively by financial providers.

Similar schemes should be considered for families and carers who own their own property but wish to purchase a property for their loved one to reside in. Carers also may experience significant financial disadvantage or disruption to their own housing as a result of their caring responsibilities; as noted by Anglicare Tasmania, 'The dollar cost of care is no measure of the real price of anxiety and grief expressed by carers, yet it is a significant and largely unmeasured impost on families'.[143]

The value of community housing must also be emphasised. For a range of reasons, public housing may be unsuitable for people with a mental illness, and community housing is an alternative that has proved successful for a range of special needs groups. The security of tenure offered by community housing, combined with its affordability, strong relationship building between tenants and housing providers, greater access to local support networks, and supportive models of tenancy management, are all likely to be of significant value in assisting people with a mental illness to retain their homes.[144] Community housing providers specialising in providing housing for people with a mental illness should therefore be supported through continued recognition in Commonwealth State Housing Agreements and through programs to encourage funding or support from the private sector. Recently announced transitional safety net arrangements permitting charities to participate in the National Rental Affordability Scheme without risking their charitable status provide an example of how this sector can be supported.[145]

These strategies require resourcing from different levels of government, and no single approach can be identified as the solution to the issue of the availability of appropriate housing stock for people with mental illness. It will be necessary to apply diverse strategies in different areas, depending on the quantity and quality of various forms of housing stock, the availability and affordability of private rental, and the funds available. A number of strategies for increasing housing stock are proposed in the White Paper, and these are likely to alleviate the lack of affordable housing to some extent. However, it is clear that more housing is required for people with a mental illness, and a range of strategies must be adopted to provide this, including setting aside housing stock specifically for mental health consumers.

141 J. Chesters, M. Fletcher and R. Jones, 'Mental illness recovery and place', *Australian e-Journal for the Advancement of Mental Health*, 4(2), 2005, www.auseinet.com/journal/vol4iss2/chesters.pdf.

142 S. Pinnegar, V. Milligan, D. Quintal, B. Randolph, P. Williams and J. Yates, *Innovative financing for home ownership: the potential for shared equity initiatives in Australia*, AHURI, Melbourne, 2008.

143 Cameron and Flanagan (2004) *op. cit*., p. 2.

144 Community Housing Federation of Australia, *Community Housing: building on success*, CHFA, Canberra, 2001; National Community Housing Forum *Strategic Framework for Community Housing in Australia 2004-2007*, NCHF, Canberra, 2004.

145 U. Stephens, *Media Release: Rudd Government Enables Charities to Participate in National Rental Affordability Scheme*, Department of Education, Employment and Workplace Relations, Canberra, 2008.

Recognition of consumer preferences and choice

Research confirms – what is perhaps obvious – that people who have a choice about where they live are more likely to be satisfied in their housing than those who do not.[146] Many options for people with mental illness involve clustered or shared housing arrangements with other consumers. A number of Australian studies indicate, however, that the least preferred housing options for people with a mental illness are living in group settings or in housing that lacks privacy, such as boarding houses. These studies show that living independently in private houses or flats is the preferred option.[147] In a study in Melbourne, 77 per cent of consumers surveyed maintained that they wanted private housing, and only 15 per cent would choose to live in communal or shared settings.[148] Of those living with other consumers, 60 per cent of respondents in the Melbourne study said that this was not their preferred living situation.[149] One consumer emphasised that what is desired by consumers is '…housing that's integrated into the community, that is not little enclaves, not mini institutions or anything else'.[150]

A number of housing characteristics have been identified as important for people experiencing mental illness. These are very similar to housing characteristics desired by the general population. Key characteristics are independence, choice in housing, convenient location, safety, comfort, affordability, privacy, and providing social opportunity.[151] While some people with mental illness will require support services to live independently and retain their housing, this support needs to be as flexible and responsive to individual needs as possible. Very few people with a mental illness want live-in support staff.[152]

Consumer preferences for housing are summarised in Figure 4.

Figure 4: Consumer housing preferences[153]

It is important to note that unfortunately no single housing model can meet all consumer needs and preferences. Thus a range of housing options and models must be available.

However, the lack of public housing stock, highlighted above, reduces the possibility of consumer choice, as often a range of housing options that are suitable for individual needs will be unavailable. Choice in housing is further limited by financial issues and a shortage of low-cost housing.[154]

Consumer preferences can be further recognised if services draw on the expertise of mental health consumers, particularly those who have experienced homelessness or housing instability, and their carers. Consumers can make extremely valuable contributions to services, as peer support workers, staff members and positive role models; they can assist in the elimination of stigma and discrimination; and, due to their shared experiences with current service users, may make the service more 'user-friendly'.[155] The views of consumers should be sought when services and programs are being developed; as it would be ridiculous to develop something specifically for them without first finding out if they would use it.[156]

146 Nelson et al (2007) *op. cit.*; O'Brien et al (2002) *op. cit*.
147 O'Brien et al (2002) *op. cit.*
148 D. Juriansz, *My Own Space! What Mental Health Consumers in Melbourne's Inner South Have to Say about their Needs for Housing and Support*, Inner South Community Health Service, Melbourne, 1994.
149 *ibid*.
150 Robinson (2003) *op. cit*., p. 40.
151 O'Brien et al (2002) *op. cit*.
152 Juriansz (1994) *op. cit*.
153 From *ibid*.
154 O'Brien et al (2002) *op. cit*.
155 CMHS (2003) *op. cit*.
156 Wireman (2007) *op. cit*.

4.7 Community services must respond to mental illness and homelessness

Home Truth No. 7

Services including employment, welfare, health, alcohol and drugs and many others in the community sector must have the capacity to go beyond their specialisations to respond to issues of mental illness and homelessness.

People living with mental illness who are homeless, in unstable housing or have difficulty keeping their homes are likely to experience a broad range of issues in addition to housing and mental health. These may include physical health issues, comorbid substance use, income support requirements, and difficulties accessing education and employment. Services required may include primary health care, alcohol and drug services, mental health and counselling services, assistance with medication, income support and assistance with entitlements, support accessing education, employment and training, assistance with daily living activities, transportation, social networks, crisis services, family assistance and advocacy, and assistance and advocacy on legal matters. Such services are often provided by different agencies that have little or no interaction with one another, and users must navigate the system single handedly and coordinate their own care. In supported housing models, service providers assist clients to navigate the maze of different providers. For people not in these programs, the situation can be more difficult. Ideally, services targeting this population need to operate in a coordinated manner, and all services available to this population within a local area should be identified and included in coordination efforts.

Service linkages may take a number of forms, and may involve:

- housing formally linked to off-site support services;
- interdepartmental agreements or protocols;
- support packages targeted to particular tenants;
- rights to nominate housing allocation in return for guaranteed support of tenants;
- coordination of support and housing through general case management programs;
- provision of on-site support; and
- coordination of services in local networks.

Relationships between housing and support providers may also take a number of forms, such as:

- formal partnerships between services, with written agreements, memoranda of understanding or protocols for working together;
- informal relationships between individual workers or services, without documented practices, procedure or protocols;
- sharing of information about services, including modes of operation and how to initiate contact; and
- provision of a single point for referrals, such as a central coordinating agency.[157]

Disparate models will be effective in different areas, for various service providers and for different service users. Diverse approaches to service linkages and service delivery are required, to ensure that all service users' needs are met.

The White Paper recognises the importance of service integration, and promotes the development of connections between mainstream services, such as health services, and specialist homelessness services,

[157] O'Brien et al (2002) *op. cit*.

including through cross-agency case assessments, case management and case planning, mainstream services assessing the housing needs of their clients, strong service agreements and networks, and information sharing. This integration should mean that there is 'no wrong door' for entry into homelessness services, ensuring that: '…any entry point will be the right entry point for people who are homeless to be assessed and receive appropriate assistance'.[158] At the same time, specialist homelessness services should also be more holistic, assessing their clients' other needs, such as employment, education and health, and 'wrapping services' around their clients to address their various needs, brokering required services and coordinating their delivery.

An important issue in relation to service integration is that '…the capacity to achieve effective coordination requires sufficient supply of the services that need to be coordinated'.[159] Supporting a person to effectively manage a mental illness is made more difficult when appropriate and affordable housing is unavailable, and housing can be jeopardised if the right support is not forthcoming, or if the caseloads of workers providing this support are too large.

Levels of service integration

Integration of services is a major factor in these models. Five levels at which service integration may take place have been identified:[160]

1. **Arrangements between Commonwealth and state/territory governments**
   These are already in place for a range of programs, such as SAAP and HACC. There is scope within the negotiation and wording of these agreements to identify that service users will often utilise more than one such service, and to formally set out expectations that coordination between services and program areas should occur.

2. **Governments coordinating their own services**
   Federal, state/territory and local governments can all contribute to coordination of their various services, through strategies such as developing policies supporting coordinated activities, co-locating linked services and developing inter-departmental task groups to identify shared concerns and strategies for resolving these. The NSW Government's Accord between NSW Housing and Human Services and the Joint Guarantee of Service between NSW Health and Housing NSW are examples of how this coordination may work.[161] The White Paper has identified that the Australian Government will improve collaboration in areas where it funds mainstream services, and will work with State and Territory Governments to improve collaboration between mainstream and homelessness services.[162]

3. **Governments designing and funding services provided by others**
   In the design, development and funding of services offered by external providers, governments have the capacity to enable or obstruct coordination through the requirements put in place for delivery of the service. Where possible, governments should ensure that service agreements encourage and reward the creation of effective service linkages.

4. **Local service networks**
   Coordination between local services can have significant and valuable impacts on service users through the achievement of coordinated support approaches for shared clients.

5. **Individual services**
   Individual services can seek opportunities for coordination with other services, for example by developing operating practices requiring cooperative approaches with other agencies.

158 Commonwealth of Australia (2008) *The Road Home*, p. 39.
159 Reynolds et al (2002) *op. cit.*
160 *ibid*.
161 Housing NSW, 'Joint Guarantee of Service (JGOS)', 2008, online at http://www.housing.nsw.gov.au/About+Us/Partnerships/JGOS.htm, accessed 27 October 2008; NSW Government *NSW Housing and Human Services Accord (the Accord) Between the Department of Housing and NSW Human Services Agencies*, NSW Government, Sydney, undated.
162 Commonwealth of Australia (2008) *The Road Home*.

Identifying and overcoming barriers to service integration

A number of barriers to integration between different services may exist. These include:

- the existence of well-established programs offered by the different services;
- specialised work forces in each service, and inter-professional distrust;
- funding limitations;
- competition for resources and leadership;
- a reluctance to share information;
- concerns about client privacy
- a lack of technology and resources to support information sharing needs;
- a lack of required services;
- the size and complexity of the service system and the target population; and
- a lack of political will to promote coordination.[163]

However, it is possible to overcome these barriers. In its *Blueprint for Change*, the US Center for Mental Health Services identifies a number of steps that will assist services to integrate. Not all are relevant to the Australian context, but many of them could be either imported directly or adapted by Australian services, and versions of some are already in place. Implementation strategies suggested in the *Blueprint* include:

- co-locating services;
- providing training to staff from other agencies, to build a shared understanding of services provided;
- creating interagency agreements and memoranda of understanding to support formal relationships;
- implementing interagency information-sharing systems;
- pooling funding;
- developing uniform applications, intake assessments and eligibility criteria;
- using interagency service delivery teams;
- making flexible funding or brokerage funds available to fill service gaps; and
- consolidating the administration of different programs and agencies.[164]

These strategies may not be easy to implement, and administrative and funding constraints may still prove to be significant barriers. However, service users will experience enormous benefits from the effective integration of services.

163 S.J. Battens, *Housing for people with a psychiatric disability: community empowerment, partnerships and politics*, PhD. Thesis, Flinders University, Adelaide, 2008; CMHS (2003) *op. cit*.

164 CMHS (2003) *op. cit*.

4.8 Properly resourced and monitored discharge planning must be implemented

Home Truth No. 8

Properly resourced and monitored discharge planning must be implemented across Australia, with zero tolerance for discharge from hospitals to homelessness or unstable housing. This goal must be independently monitored and publicly reported.

The lack of proper discharge planning is another area that urgently needs addressing. Few places effectively manage discharge from hospitals to community – and the result is that people simply disappear. In the United States the Massachusetts Housing and Shelter Alliance describes this process as people without housing options coming straight from the back door of state systems and institutions to the front door of shelters:

> young people 18-24 years old who have aged out of state services; ex-offenders released from state or county facilities with no place to go; people from detox at the beginning of their recovery; and people with mental illness released directly from a hospital.[165]

This issue is also significant in Australia.

A key homelessness prevention strategy is to develop a discharge plan well before a person's exit from hospital, jail, residential treatment facilities, state care or other institutional arrangements. Inadequate discharge planning arrangements can increase the risk of homelessness among people experiencing mental illness or related issues.[166] However, in one study, over 50 per cent of respondents who had been hospitalised due to illness reported that, during their last stay in hospital, staff there did not talk to them about where they would be staying on discharge, and 13 per cent went straight onto the streets. Similarly, of respondents who had been in prison, 62 per cent reported that prison staff did not talk to them about where they would be staying on release, and 20 per cent went straight onto the streets.[167] The White Paper reports that specialist homelessness service providers find that many people come to them soon after leaving hospital, and in some cases were discharged straight to homelessness services. Others were discharged to stay with family or friends when this would not be a suitable long-term housing solution.[168] Properly executed discharge planning would reduce these issues.

The White Paper recognises the importance of discharge planning, and argues for a policy of 'no exits into homelessness' from statutory custodial care, hospital, and mental health and drug and alcohol services. As well as connecting people to long-term housing, this policy would involve assisting them to access education, training and employment, and, if appropriate, family counselling. The MHCA considers that, if it is successfully implemented, this policy will probably become one of the most significant outcomes of the White Paper process. However, there has already been criticism of the proposed policy, with the Australian Medical Association (AMA) arguing that if there are insufficient housing places into which patients can be discharged, they will continue to take up hospital beds and exacerbate existing bed shortages.[169] A recent case in the Northern Territory involved a man with a mental illness having to remain in jail for an additional 12 months simply because there were no safe housing facilities available to him.[170] As argued below, sufficient appropriate housing stock is an essential component of any discharge planning strategy.

165 P.F. Mangano and M.E. Hombs, *Introduction and Overview: Preventing Homelessness: Tools and Resources for Discharge Planning*, Massachusetts Housing and Shelter Alliance, Boston, undated.
166 Working Conference on Discharge Planning, *Exemplary Practices in Discharge Planning*, DHHS (SAMHSA), Rockville, 1997.
167 Robinson (2003) *op. cit*.
168 Commonwealth of Australia (2008) *The Road Home*.
169 E. Kretowicz, 'AMA says homeless strategy can't work', *The Canberra Times* 23 December 2008.
170 ABC Online, 'Judge 'forced' to keep mentally ill man in jail', 22 December 2008, online at www.abc.net.au/new/stories/2008/12/22/2453306.htm, accessed 23 December 2008.

What should effective discharge planning look like?

Many Australian state and territory health departments have developed discharge planning guidelines for public hospitals and health facilities.[171] While these plans often represent very well structured strategies for planned discharge, they are not always implemented effectively or consistently. More disturbing is that the use of plans is not monitored.

Discharge planning should begin when someone enters hospital, jail or other institutional settings. It should recognise that people at risk of homelessness are likely to have multiple problems, and it should therefore be broad-ranging, considering issues such as housing, health care, medication, income and finances, employment, entitlements, personal support and life skills.[172]

One way of looking at discharge planning is to understand it as 'community re-entry', and recognise that active partnerships should be developed between discharging institutions, which should have the primary responsibility for connecting consumers in their care to the community, and the agencies that will provide support and services to the consumer after discharge.[173]

NSW Health identifies several key principles for discharge planning:

- admission and discharge are part of a continuum;
- consumers, family and carers are partners in care;
- discharge criteria are based on a comprehensive assessment of the consumer's medical and psychosocial needs;
- effective discharge planning incorporates monitoring and evaluation components;
- clear and timely communication between the consumer, primary carer and all clinicians and other health professionals is essential;
- a comprehensive discharge care plan should be developed before discharge;
- provision of consumer and primary carer information and education is essential prior to discharge; and
- standardised and monitored discharge processes support continuous system-wide improvement.[174]

Arrangements for housing after discharge must be in place before community reintegration can occur successfully. The Working Conference on Discharge Planning's key points on the facilitation of housing in discharge planning are that:

- Exemplary discharge plans identify and secure a variety of housing options, recognising that the needs and preferences of consumers vary and change over time as conditions and interests evolve.
- Exemplary discharge plans stem from an assessment of a community's housing stock and partnerships between housing and service providers. Given these resources, under no circumstances should a consumer be discharged onto the streets.
- In many communities, a significant increase in the stock of affordable, supportive housing is necessary for successful community re-entry.[175]

The final point illustrates again the importance of adequate quantities of appropriate and affordable housing. Ensuring adequate housing may involve taking precautions against eviction while a person is in hospital or

171 For example, ACT Health, *ACT Health Discharge Planning Policy*, ACT Government, Canberra, 2006; NSW Health, *Policy Directive: Discharge Planning for Adult Mental Health Inpatient Services*, NSW Department of Health, Sydney, 2008; Office of the Chief Psychiatrist, *Chief Psychiatrist's Guideline: Discharge Planning for Adult Community Mental Health Services*, State Government of Victoria, Melbourne, 2002; Queensland Health, *Guidelines for Pre-admission processes, Discharge planning, Transitional care*, Queensland Government, Brisbane, 1998.

172 T.E. Backer, E.A. Howard and G.E. Moran, 'The Role of Effective Discharge Planning in Preventing Homelessness', *Journal of Primary Prevention* 28, 2007, pp.229-243; CMHS (2003) *op. cit.*

173 Working Conference on Discharge Planning (1997) *op. cit.*

174 NSW Health (2008) *op. cit.*

175 Working Conference on Discharge Planning (1997) *op. cit.*

prison, or organising appropriate housing for that person's discharge or release. A range of other factors must also be assessed to gain a full understanding of a person's home and social circumstances. These include a person's capacity to perform day-to-day living activities, what community services a person used before their admission and are therefore likely to need after their discharge, the availability of family or other carers to assist a person after they leave hospital, and any special cultural or linguistic needs.[176]

In terms of prevention of homelessness for people with a mental illness, discharge planning illustrates the importance of focusing on transition points in people's lives. The American Academy of Community Psychiatrists have proposed the term 'transition planning' as an alternative to discharge planning, as it captures the concept of continuing care, and the idea of moving from one level of service to another.[177] The Victorian Department of Human Services also uses the concept of transition to describe '…the continuity of care as the patient moves from hospital to the community', distinct from discharge which is used only to refer to specific processes relating to a patient leaving hospital.[178] Regardless of the terminology used, the importance of planning for these transitions is a key part of preventing homelessness.

As noted above, some Australian states and territories have discharge planning guidelines in place for public health services. It is essential that these are properly implemented, with monitoring in place to ensure compliance and consistency across all areas. The new policy of 'no exits into homelessness' under the White Paper must similarly be implemented properly and monitored if it is to be successful.

4.9 Housing and mental health programs must be regularly evaluated

Home Truth No. 9

Programs providing housing and mental health services must be regularly, independently evaluated against common criteria to allow for program comparison, with transparent assessments and reporting.

Programs delivering housing and homelessness services for people with a mental illness are extremely diverse, making it difficult to assess their comparative success and viability. Evaluation is often minimal, and up-to-date evaluations may not be available publicly. For example, various programs were considered as case studies for this report, but were rejected when research revealed that the most recent publicly available evaluations in some cases were more than ten years old. This is not sufficient.

An evaluation and data collection framework should be developed and implemented for government funded programs providing housing and support for people with mental illness, incorporating details of costs, reductions or increases in service use, success in retaining housing, objective and subjective measures of consumer experiences and program sustainability. Common evaluation criteria should be developed across states and territories to allow for program comparisons.

The White Paper identifies the importance of program evaluations and comparisons of this kind, and the need for multi-site and cross-jurisdictional studies, longitudinal research and comparative evaluations. The MHCA agrees that such evaluation is essential, and argues that its importance must also be reflected in funding allocation and service agreements. Service providers cannot be expected to complete or contract for evaluations if funding is not provided for this important aspect of program delivery. Evaluation requirements must be written into service agreements, ideally with specified evaluation criteria for consistent reporting.

176 Victorian Government Department of Human Services *Improving patient transition from hospital to community: A good practice guide for hospitals*, State Government of Victoria, Melbourne, 2003.
177 Backer et al (2007) *op. cit*.
178 Victorian Government Department of Human Services (2003) *op cit*, p. 1.

4.10 Research must be a priority

Home Truth No. 10

National research to build a greater understanding of the connections between mental illness, unstable housing and homelessness must be a priority, with appropriate funding and ongoing support for this research.

Research and data collection on the links between mental health, homelessness and unstable housing in Australia is patchy. The wide disparities in estimates of the proportion of the homeless and unstably housed population experiencing mental illness have already been noted in this report. One of the indicators of progress in the COAG National Action Plan is the prevalence of mental illness among homeless populations, but reliable figures are simply unavailable. The 2006-07 Progress Report acknowledges that '…getting a true picture of the homeless population is difficult', but does not promote more research in this area.[179] Reliance on SAAP figures about clients is not an adequate way to establish how many homeless people have a mental illness.

National research in this area must continue, with appropriate funding and support. Research areas could include more data on levels and types of mental illness in the homeless population across Australia, identifying effective pathways out of homelessness for people experiencing mental illness, and strategies to assist them to achieve stable accommodation. Findings from this research should continue to shape policies. Importantly, this research should be independent, and should provide an unbiased perspective on Australian Government policies and strategies targeted at reducing homelessness.

The MHCA welcomes the national homelessness research strategy proposed in the White Paper. The proposed long-term research agenda and improved data collection on homelessness will assist governments to assess the effectiveness of new initiatives, and to identify areas for further work. The importance of such a research agenda cannot be underestimated. There is considerable catching up to do in homelessness research in Australia, and research and evaluation is essential to build on the strategies in the White Paper and assess their effectiveness. The MHCA considers that, of the initial $1.2 billion allocation over the next four years to implement the White Paper's reform agenda, five per cent should be devoted to research into homelessness and evaluation of both new and existing programs.

It is also essential that research and data collection on homelessness includes investigation of the impact of mental health issues on homeless populations. Of the funding allotted to research, evaluation and data collection, a significant proportion should be devoted to research related to mental illness and homelessness. Apart from the most fundamental question on the proportion of the homeless population nationally that experiences a mental illness, research should address pathways into homelessness, including the role of mental illness, treatment rates for people who are experiencing mental illness in combination with homelessness or unstable housing, and the numbers of people discharged from mental health treatment into unstable housing. Such research is imperative to ensure that Australia's understanding of mental illness and homelessness is holistic and rigorous, so that programs can be targeted properly and real changes made to improve housing outcomes for people with a mental illness in Australia.

179 AHMAC MHSC (2008), *op. cit*.

5. Case Studies: Examples of Good Practice

There are numerous services throughout Australia that demonstrate good practice in their provision of services to people with a mental illness who are homeless or experiencing unstable housing. This section does not attempt to provide a comprehensive overview of the services available; rather, it examines in detail selected case study organisations that illustrate some of the principles discussed above.

5.1 Integrated levels of support

The Whirrakee Program – St Luke's Anglicare[180]

St Luke's Anglicare is an agency providing a range of social services throughout north central Victoria and parts of southern NSW. In Bendigo, it offers a housing and support program called Whirrakee, which provides a psychiatric disability-specific SAAP service to clients with serious mental illness.

Whirrakee operates using an integrated service delivery model, which means that staff work across all Whirrakee programs. These include home-based outreach, intensive home-based outreach, SAAP, assertive outreach, and day programs. Clients can move through the programs according to their current support needs. Importantly, clients have an allocated key worker, so even if their changing service needs require them to move to a different program, there is continuity of support.

Whirrakee also offers a discharge planning program, known as the Mental Health Pathways Program. This involves a partnership between St Luke's, Bendigo Health Psychiatric Services, and SAAP. There is a focus on earlier intervention and the identification of clear pathways after a person is discharged, while support is offered to assist clients to negotiate the mental health and housing sectors.

There are a number of benefits arising from the use of the integrated model. There is a single intake system, which is of significant benefit to clients. Unlike in mainstream SAAP services, clients have immediate access to mental health rehabilitation services. Clients have access to a range of resources, with flexible support according to their needs. If a client is no longer eligible for a particular program offered through Whirrakee, an alternative will be found, and the client will not be 'cast adrift'. Workers benefit through their awareness of all the service levels, and their involvement in the housing and mental health sectors. The integrated model also provides pathways to social and community linkages, and links to a variety of other services.

The integrated multi-level support system offered through Whirrakee provides significant benefits to clients, and allows for smoother transitions between different levels of care.

5.2 Supported Housing

Supported housing models recently have had increasing support, as research has indicated success with housing retention and community engagement, as well as cost-effectiveness.

Key principles of this model are that:

- consumers are assisted with locating, choosing and maintaining their housing;
- there are no time restrictions on the length of their stay;

180 Information in this case study is from S. Bennett, 'Mental Health and Substance Use: An Integrated Approach', presentation to the *Fifth National Homelessness Conference: New Horizons: Practice, Research and Emerging Issues*, Adelaide, 2008; S. Bennett, 'The Experience of a Psychiatric Disability Specific Housing Service', *Parity/New Paradigm joint issue: Mental Health, Housing and Homelessness*, 2007, 45-48; Y. Jaczina, research interview conducted by telephone, Canberra 19 September 2008; MHCA, *Smart Services: Innovative Models of Mental Health Care in Australia and Overseas*, MHCA, Canberra, 2006.

- participation in support, treatment and other program activities are not requirements for housing;
- support services are provided flexibly to allow for changes in level of need; and
- services are available to help to prevent the loss of housing during hospitalisation.

Other key characteristics are that:

- the model offers a home, rather than a residential treatment service;
- consumers are seen as residents of the community, rather than participants in a program;
- there is a shift in the locus of control from staff to the consumer; and
- there is a goal of social integration rather than grouping by disability.[181]

These models are often costly; however, when reduced hospitalisation and service use is considered, there are substantial cost benefits.

Housing and Accommodation Support Initiative (HASI)[182]

HASI, which operates in NSW, is one of several state government supported housing programs that operate across Australia. Others include the Housing and Accommodation Support Program (HASP) in Victoria, Project 300 in Queensland, the Returning Home program in South Australia and the Independent Living Program (ILP) in Western Australia. HASI has been selected for examination due to the comprehensive evaluation that has been undertaken.

HASI involves a partnership between NSW Health, the NSW Department of Housing and the NGO sector, and provides housing linked with clinical and psychosocial rehabilitation services for people experiencing psychiatric disability. Rehabilitation and support for accommodation is provided by NGOs, with funding from NSW Health; clinical care and support is provided by specialist mental health services in Area Health Services; and housing, property and tenancy management services are provided by public and community housing, funded by the Department of Housing. Its objectives are:

> …to assist people with mental health problems and disorders requiring accommodation (disability) support to participate in the community, maintain successful tenancies, improve quality of life and most importantly to assist in the recovery from mental illness.[183]

There are a number of stages of HASI, offering different levels of support:

- HASI One - High Support.
- HASI Two - lower levels of outreach accommodation support.
- HASI Three A - High Support.
- HASI Three B - Very High Support.
- HASI Four A - High Support.
- HASI Four B - also known as HASI in the Home, offering support to people who do not necessarily live in social housing.

181 P. Ridgeway and A. Zipple, 'Challenges and Strategies for Implementing Supported Housing', *Psychosocial Rehabilitation Journal* 13(4), 1990, pp.115-120, cited in Robson (1995) *op. cit*.

182 Information in this case study is from F. Kong, research interview conducted at Richmond Fellowship of NSW, Sydney, 16 September 2008; K. Muir, K. Fisher, A. Dadich, D. Abello and M. Bleasdale, *Stage 1 Evaluation Report: Housing and Accommodation Support Initiative (HASI)*, Social Policy Research Centre (University of NSW), Sydney, 2007, (report prepared for the NSW Department of Health) (see also other reports relating to this evaluation, available at www.sprc.unsw.edu.au); NSW Health, *Housing and Accommodation Support Initiative (HASI) for people with mental illness*, NSW Department of Health, Sydney, 2006; A. Papakotsias, research interview conducted at Neami, Melbourne, 18 September 2008; Richmond Fellowship NSW, 'HASI Information: Support provided', 2008, online at www.rfnsw.org.au/index.php?option=com_content&view=article&id=76&Itemid=86, accessed 22 September 2008.

183 NSW Health (2006) *op. cit*., p. 2.

HASI Stage One

High Support HASI is targeted at people on low incomes who experience mental illness and high levels of psychiatric disability who reside in a hospital bed because they have been unable to access the required level of accommodation support, or who are homeless, at risk of homelessness or inappropriately housed, and who have the ability and desire to live in the community, and have the capacity to maintain a mainstream tenancy agreement.

Community housing providers allocate accommodation, either through the private rental market or housing properties owned by the Department of Housing, and manage the tenancy, engaging with the client in a 'sensitive and responsive way'. Participants in HASI are required to sign Residential Tenancy Agreements with their housing provider. Acceptance of support and adherence to Support Contracts or Mental Health Care Plans are not legally enforceable as conditions of tenancy.

The NGO is the Support Coordinator, addressing the consumer's needs. Support is provided in line with a recovery philosophy, and may involve assistance in daily living activities, including domestic chores such as shopping, cooking and cleaning; personal care tasks such as showering and taking medication as prescribed; health care, including general and mental health treatment; productivity needs such as education, employment or other activities; financial issues such as finding a source of income, maintaining a budget, and paying rent; and leisure or community needs, including participating in social and recreational activities. The Support Coordinator may provide services directly, or liaise with other providers. On-call, 24-hour non-clinical support must be available. Each client has a Support Contract detailing the level and type of support, future planning for support needs, the provider's expectations, and client needs.

Clinical Support is provided by the Mental Health Service within the local Area Health Service of NSW Health. HASI clients each have a Mental Health Care Plan, which coordinates the client's care, contains risk management and relapse prevention strategies, and a Mental Health Recovery Plan, which assists the client in setting and monitoring their recovery goals.

HASI's objectives are to engage with clients, enabling tenancies to be maintained successfully with appropriate support, maximising participation in the community, improving mental health, and increasing access to community services. Evaluation of HASI One has shown 'remarkable outcomes', including assisting 85 per cent of participants to remain with the same housing provider, increases in community participation, improved psychological wellness and physical health, reduced frequency and duration of hospitalisation, increased connection with community mental health services, and improved connections with families.

However there are still some areas that need development. While the quality of the service is excellent, there are not enough places in the program to meet existing needs, and the cost is high at $57,000 per participant per annum. There are also problems with some aspects of the partnership arrangements, including the requirement for more flexibility with Area Health Services and housing providers, and clarification of the functions of each member of the partnership. A further issue was for HASI funding to keep up with the Consumer Price Index – funding per client has not increased since the commencement of the program.

One problem, in particular, is the availability of suitable housing stock. Available housing is not always appropriate to the needs of a person with a mental illness; for example, not in a location close to services or transport. One service provider has noted that the one or two-bedroom units required by HASI were often unavailable in rural or remote areas. Despite this, the success of HASI is clear from its evaluations, as it has been highlighted internationally as a best practice example in mental health services provision.[184]

184 Asia Australia Mental Health, *Summary Report: Asia-Pacific Community Mental Health Development Project*, AAMH, Melbourne, 2008.

Neami Community Housing Program[185]

The Neami Community Housing Program has been in operation in Melbourne since 1995. It was established with the goal of providing housing with support to people leaving psychiatric hospitals. It was funded by the Commonwealth Community Housing initiative, which committed funding for the purchase of properties; the Victorian Mental Health Branch, which provided funding for support workers; and North Eastern Metropolitan Psychiatric Services, which provided funding for additional clinical staff for the local Mobile Support and Treatment Team. Housing and support functions were separated, with tenancy management responsibilities handed over to the Supported Housing Development Foundation (later known as Supported Housing Limited [SHL]), a community housing organisation. Office of Housing funds were used to purchase appropriate properties, which were dispersed rather than clustered, while costs relating to property management, maintenance and tenancy management were to be covered from rent collected from service users.

The design of the Community Housing Program grew out of the HASP supported housing model.[186] Tenants lease their properties from SHL, with standard conditions under the Residential Tenancies Act, and rent is set at 25 per cent of the DSP. Engaging with treatment or support services is not a condition of tenancy.

Initially, clients shared housing in groups of two or three. As would occur in any share house, some difficulties occurred with this system, and Neami now has no more than two tenants per property. Most properties are now single person dwellings, which has proved much more successful.

The support offered is 'client-directed', with workers encouraging clients to create goals, and then assisting them to identify steps through which the goal can be met. As one objective is met, others are formed; and, as clients' support needs change, the nature of the support also evolves. Each client is assigned a key worker, but also has contact with the whole team for alternative contacts if their key worker is unavailable. Clients view their relationships with Neami staff as very important to them.

All clients have regular contact with clinical services. There is generally a clear division between the support provided by Neami and clinical support services, with the latter providing support in relation to medication and mental health, and Neami workers addressing other areas. For some clients, these boundaries are blurred, but this can be due to the client's own treatment and support preferences.

The Community Housing Program has enabled a number of people with psychiatric disability to sustain their tenancies and engage successfully with the community. Of critical importance to the program's success are access to affordable, well located housing that clients know is long-term and secure, and the flexibility and duration of the support offered by Neami, directed by the client's own goals. The success of the program demonstrates that, with appropriate support, people who have previously been long-term residents in psychiatric hospitals can successfully maintain tenancies in the community.

5.3 Assertive outreach to homeless populations

Queensland Health Homeless Initiative[187]

The Queensland Health Homeless Initiative is offered across Queensland by numerous District Health services, focusing primarily on mental health and alcohol and other drugs. Part of the initiative has involved the funding of Homeless Health Outreach Teams, specialist mental health teams that provide case management, assessment and intervention for homeless people with mental illness. Drug, alcohol, and dual diagnosis services are also available.

The service uses assertive outreach to access its clients, and is '…focused around people and not places'.

185 Information is this case study is from Carter (2008) *op. cit.*; Papakotsias (2008) *op. cit.*
186 See Robson (1995) *op. cit.* for more information on HASP.
187 Information in this case study is from Queensland Health, *Queensland Health Homeless Initiative: Statewide Guidelines, Processes and Protocols*, Queensland Health, Brisbane, 2008.

The use of this strategy is considered essential to successfully engage with homeless people, as they often will not readily use mainstream or clinic-based services but may be in need of health intervention or assistance. The service is offered wherever homeless people are, and may occur on the streets or at other communal places for homeless people, such as shelters or food vans. A holistic service delivery approach is adopted, and may include support with medication, housing, finances and everyday living. The initiative also aims for a collaborative response, and coordinates with other service providers, such as Housing and Centrelink, to reduce barriers to accessing services.

Inner South Homeless Outreach Psychiatric Service (ISHOPS)[188]

ISHOPS is part of the Alfred Hospital Department of Psychiatry community program, providing intensive outreach psychiatric services in Melbourne's inner southeast. Most of the individuals targeted through the service have long-term psychotic illnesses, and the majority have a comorbid substance use disorder. Most will not engage with mainstream health services, and helping them with treatment is an intensive process.

Like the Queensland Health Homeless Initiative, the clinical intervention model used involves engaging with the individual in their own environment. The focus is on mental illness, which is addressed through prolonged engagement and simultaneous assistance with a person's social issues. Initially physical health needs, accommodation and the development of social networks are addressed, while psychiatric symptoms and risk are assessed. An individual may move in and out of the catchment area repeatedly, increasing treatment difficulties.

5.4 Home-based outreach

Prahran Mission Mother Support Program[189]

Prahran Mission is a non-profit community organisation providing support and practical assistance to people experiencing social and economic disadvantage and mental illness. They offer programs across four key service areas: day rehabilitation, education, employment and training, community services, and home-based outreach support.

One of the home-based outreach programs, The Mother Support Program, aims to support women living with mental illness who have children in their care to parent as effectively as possible. It involves home-based outreach support and case management. In some cases transitional housing may be provided if required.

The program is voluntary, and participants need to apply to be part of the scheme. Services are provided in the client's own home, and flexible support is offered depending on need. Workers can assist clients to navigate through the complex processes of the mental health and housing sectors. The program works with other services including clinical mental health services.

It has been successful in assisting mothers with mental illness to access and retain appropriate housing, build resilience and coping skills, improve their parenting and enhance their capacity to live independently in the community. The outreach model of the program is especially effective in reaching mothers who are socially isolated by their mental illness.

188 Information in this case study is from J. Freidin, 'The Inner South Homeless Outreach Psychiatric Service', email to MHCA, 2008; J. Freidin, 'A Psychiatrist's View on Working with Homeless People Suffering Mental Illness', presentation to the *World Psychiatric Association International Congress: Working Together for Mental Health: Partnerships for Policy and Practice*, Melbourne, 2007.

189 Information in this case study is from J. Charalambakis, 'Prahran Mission Mother Support Program', email to MHCA, 2008.

5.5 Supporting private rental through partnerships

On Track Community Programs Alternative Outreach Program[190]

On Track was established twenty years ago in regional NSW by carers, health professionals and other people out of concern for the lack of supported housing for people with a mental illness.

In that region public housing waiting time can be up to eighteen years and programs such as HASI are not keeping up with the housing demand. Consumers who access the Alternative Outreach Program may have been evicted by Department of Housing or community housing providers and are ineligible for public housing, or they prefer to remain in the private market. In response to this, On Track approached numerous private investors to lease properties to On Track consumers via a three way partnership. The Program attracted the attention of community minded investors and property owners who lease to consumers at a reduced market rent. On Track manages all aspects of property and tenancy management and charges the investor a fee comparable to or less than that charged by real estate agents. Case management support is provided by the On Track community outreach team.

The Outreach Program has demonstrated effectively that, through careful relationship building with investors, close monitoring of risks, active case management in high risk tenancies, and remedial interventions with specific consumers, mutual benefits can be achieved for both property owners and On Track tenants. Once the tenancy has been successfully maintained for twelve to eighteen months the support can be gradually withdrawn. However, the consumer can re-enter the program at any time. The tenancy remains in place and On Track property management continues.

On Track advocates that by ensuring a strong tenancy relationship with its clients, issues around asset and property management (including maintenance) can be resolved. When risks of tenancy failure are assessed clearly at the commencement of the tenancy, the need for eviction planning and reactive remedial interventions is reduced. Instead of punitive practices to manage breaches of tenancy, matters of rental arrears, neighbourhood disputes and failure to maintain premises, On Track's preferred model is the supportive case management approach.

The On Track model has proven to be very successful in assisting consumers to access and manage their tenancies in the private market, and in assisting investors and property owners to see the benefits of building strong partnerships with NGOs. This successful model has increased housing options for people with a mental illness.

5.6 Connecting homeless people to services

Homeless Persons Information Centre (HPIC)[191]

HPIC is a service provided by the City of Sydney although it covers all of NSW. It is a telephone information and referral service for people who are homeless or at risk of homelessness, assisting them to access appropriate accommodation and services. It is available from 9.00am to 10.00pm, 7 days a week. Trained staff provide telephone assessments and can make direct referrals to a range of homelessness services including crisis accommodation. HPIC can also assist people who are intoxicated to access appropriate crisis accommodation, although some services will not assist a person who is intoxicated. Other services to which HPIC can provide referrals include legal advice, storage, hair cuts and shower facilities. It can also provide

190 Information in this case study is from L. Crayden, 'On Track Community Program Inc Alternative Outreach Programs History', email to MHCA, 2008.

191 Information in this case study is from City of Sydney, 'Homeless Persons Information Centre', 2006, online at www.cityofsydney.nsw.gov.au/Community/HomelessnessServices/HomelessPersonsInformationCentre.asp; accessed 26 September 2008; City of Sydney undated 'Homelessness Information Kit for Volunteers: Module 2: 2. Homeless Persons Information Centre (HPIC)', online at www.cityofsydney.nsw.gov.au/Community/HomelessnessServices/InformationKitForVolunteers/Module2/HPIC.asp, accessed 29 September 2008.

information about accessing affordable housing, and can arrange transport to assist a person to access accommodation services.

Canberra Emergency Accommodation Service (CEAS)[192]

CEAS is a phone service operated by Lifeline Canberra that combines accommodation assistance, counselling and referral. CEAS liaises daily with crisis accommodation services to find out about the availability of beds, and provides a central reference point for people requiring crisis accommodation to find out about availability on a particular night. If no accommodation is available for a person, the telephone counsellor will assist them to think about their resources and other options for keeping safe for the night and to manage their future accommodation needs. CEAS can also provide information about longer-term supported accommodation and other services.

CEAS also offers an extensive referral system, and can provide callers with information and contact details for a range of services that might be required by people who are homeless or unstably housed, including those relating to men, women and youth, health, pregnancy support, financial counselling, legal services and food. Phone numbers for longer-term accommodation services and ACT Housing may also be provided.

CEAS calls are answered by volunteer Lifeline counsellors, who are highly trained in providing assistance on a range of issues that may or may not be related to their homelessness, such as relationships, family and finance.

Services such as CEAS and HPIC, which provide a central reference point to access information about housing and other services, are invaluable to homeless people attempting to navigate these service sectors. The referral services provided by HPIC have significant additional benefits.

5.7 Building service links

West Coast Youth Services (WCYS)[193]

WCYS, located in Port Lincoln, South Australia, is a SAAP-funded service that provides a range of accommodation and support services to people aged under 25 and their families living on the Eyre Peninsula. While it is not specifically targeted at young people experiencing a mental illness, the high levels of mental illness in this age group mean that a large proportion of WCYS clients are experiencing some form of mental illness.

WCYS has 14 properties, half of which are transitional and half permanent, with a mix between public housing and private ownership. Properties are offered on three month leases with case management, including regular inspections, and leases are continued if all is going well with the property.

WCYS recognises the diverse needs of the under-25 age group, and has built excellent links with local services and organisations. One strategy that has contributed to these strong relationships is that WCYS's board has members from Centrelink, the police, Housing SA, the SA Department of Education and Children's Services, and Families SA. WCYS has a good relationship with the local Child and Adolescent Mental Health Service, which values its judgments on the mental health of its clients and responds quickly when assistance is required. When clients experience difficulties with the justice system, WCYS can use its strong links with the police and its relationship with a local solicitor, and can often arrange for clients sentenced to community service to serve this on a WCYS leadership camp. WYCS's relationship with Centrelink allows it to assist clients to access payments and financial counselling. Importantly, WCYS has a 'magic' relationship

192 Information in this case study is from Lifeline Canberra, 'Canberra Emergency Accommodation Service', 2005, online at www.act.lifeline.org.au/ceas.htm, accessed 25 September 2008.

193 Information in this case study is from S. Tyndale, research interview conducted at WCYS, Port Lincoln, 26 August 2008; WCYS *Vision and Strategic Plan 2008-2013*, WYCS, Port Lincoln, 2008; WCYS, 'West Coast Youth Services Inc', 2007, online at www.wycs.com.au, accessed 23 September 2008.

with Housing SA, which is valuable when assisting clients to find accommodation and when providing case management services. WCYS also has strong relationships with local schools, which allow them to intervene early when problems are arising for young people.

WCYS's strong relationships with other service providers allow them to provide stronger support to clients by connecting them with the services of other providers.

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