Submission to
NSW Homelessness Strategic Framework: Stage 1 Draft Consultation Paper

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About MHCC

MHCC is the state peak body for non-government organisations (NGOs) working for mental health throughout NSW. We represent the views and interests of over 200 NGOs. Our member organisations specialise in the provision of a diversity of support services for people with a disability due to mental illness. MHCC provides leadership and representation to its membership and seeks to improve, promote and develop quality mental health services to the community. Facilitating effective linkages between government, non-government and private sectors, MHCC participate extensively in public policy development.

The organisation regularly consults broadly across all sectors in order to respond to legislative reform and sits on National, State (NSW) and State Government Department (NSW) committees and boards in order to affect systemic change. MHCC manages and conducts research projects and develops collaborative programs on behalf of the sector. MHCC also provides accredited mental health workforce development training through its Learning and Development Unit (LDU).

MHCC thank Housing NSW, the NSW Department of Premier and Cabinet, Treasury, other partners and the inter-departmental Working Group, chaired by the Department of Premier and Cabinet for inviting us to attend the consultation in Sydney on 3 September 2008, and for providing us the opportunity to input into the development of the Homelessness Strategic Framework for NSW.

We have consulted the sector for the purposes of this submission in which we focus specifically on the experiences of people with mental illness in danger of becoming homeless; who are already either temporarily or chronically homeless; have a mental illness or are at risk of mental illness as a consequence of homelessness; and the consequential impact of homelessness on the potential for recovery and maintenance of stable mental health.

To achieve the desired outcomes at various stages of homelessness - risk/prevention; early intervention/crisis and chronically acute homelessness, MHCC propose some concrete proposals to explore that if put into practice will provide some ‘stepping stones’ towards meeting the strategic directions outlined in the discussion paper.

A Strategic Framework

Leadership Role

It is widely supported as evidenced during the consultation in Sydney, that to ensure success, a strategic framework needs to have a connecting mechanism that provides strong leadership. We propose that this must come directly from the Department of Premier and Cabinet, coordinating the will of the various departments to develop across departmental working relationships and establish meaningful partnerships with NGOs across the sector.

Strategic Directions

Whilst MHCC have no problem with the three strategic directions identified in the draft consultation paper, we suggest that it is now time to drill down below generalist statements to identified actions.

We recommend that a vision or goals for Homelessness can only be achieved through the development of key stages undertaken to enable a strategic framework to be formulated with outcomes that are quantifiable.

Activity might be directed in for example, the following areas:

1. A shift to case management model that enables homeless clients to access a broad spectrum of services including secure housing, including via non-clinical services;

2. Holistic service provision that will enable sustainable independence e.g. education, employment and other meaningful activity;

3. Increase provision of specialist supported accommodation to meet the various levels of housing need;

4. Maximise current assets, invest to improve quality or replace, or remodelling/reconfigure to meet changing and local need;

5. Accommodation to meet standards, located in the right environment to support independence e.g. close to amenities;

6. Support services to all households, regardless of tenure;

7. Build on existing efforts that support a stable, high quality and responsive provider market that provides positive outcomes for people;

8. Increase understanding of the diversity and complexity of need of particular individual and household groups, e.g. mental illness; adult and youth co-morbid mental illness and substance abuse; young people who have experienced family breakdown, conflict and abuse; women and children escaping domestic violence; survivors of trauma and violence; households experiencing financial hardship; people newly released from goal or detention; Indigenous people and other culturally marginalised groups; people with physical or developmental disability or people without stable accommodation etc.

Long term strategies

Part of any vision for homelessness needs:

1. To have clear procedures for information sharing and data monitoring as a tool for homelessness prevention

2. To ensure the availability of appropriate accommodation in line with current and future levels of demand

3. To promote the provision, development and review of support services and advice to ensure that it is accessible and fit for purpose

4. To prevent homelessness and reduce levels of homelessness against the main causes for presentations through evidence based research and resource allocation

5. To increase the proportion of homeless households who have access to health related services and those services which provide living skills and promote good physical as well as mental health

6. To increase the proportion of homeless households who have access to education, training, and provide entry into supported and mainstream employment opportunities

7. To improve access to a wide variety of tailored options that meet with changing needs.

Recommendations

1. A leadership role to be taken by the Department of Premier and Cabinet in addressing the problems of Homelessness

2. A core focus of a Homelessness Strategy must be the development of services that address the needs of people with mental illness or at risk of mental illness

3. A national commitment to increase funding to support the growth of quality housing stock providing a range of housing type, easily accessible to essential services

4. The framework must develop services that are flexibly responsive to individual needs taking into account ongoing and changing priorities, and consumer preferences whilst ensuring secure tenure

5. The framework must promote pathways for transitioning at various levels of need; prevention; crisis and long-term housing

6. The framework must include increased availability of outreach clinical services

7. The framework must embed partnerships and collaboration between community-based organisations and clinical mental health services

8. Government needs to acknowledge local expertise and a diverse skill base and establish a strong directive to work collaboratively with community-based organisations to provide appropriate responses

9. Development of MOUs between Government, across and between community organisations

10. Multi-dimensional support and treatment services must include a strong focus on co-morbid mental health and substance abuse problems, and co-morbid intellectual disability

11. The framework must include ongoing accountability. Initiate outcome evaluation from the perspective of consumers as well as service deliverers, and must include longitudinal studies

12. Evaluation of programs for cost effectiveness must also include dollar evaluation of cost to the community of homelessness in the broadest sense: social and financial impact

13. Funding of practical research for sustainable models of service delivery

14. Commitment to capacity building through workforce development, education and training

15. Homeless programs must be willing to connect with respect with homeless people at all levels of need, acknowledge the cultural, ethnic and educational diversity of people with mental illness ensuring that their individualised needs are met

16. No person who is homeless who has attempted to access services should be denied support

Context

MHCC has long been an advocate for improved services for the homeless utilising an approach that highlights the complex and wide-ranging needs of the homeless; that emphasises homelessness's close inter-relationship with mental health problems and the necessity to provide a diversity of options that enable solutions to be tailored to individual needs. These issues were addressed in our submission to the Commonwealth Homeless Green Paper in June 2008.

We reiterate that what must be emphasised is the necessity for an across government approach that firmly embeds issues of homelessness into the health agenda.

The relationship between mental health and homelessness is multifaceted. The evidence is one of multi-dimensional problems - structural, economic, systemic and clinical.[1] MHCC's platform document *Social Inclusion: Its importance to Mental Health* (2007), stresses the importance of secure housing referred to as follows:

> *Housing is one of the critical factors in a person's recovery process. A wealth of empirical evidence now attests to the fact that poor, unsuitable, substandard, and /or unaffordable housing has a direct impact on the emotional and social wellbeing of mental health consumers. Simply put, good mental health requires good housing.*[2]

It has long been established in public health literature, that appropriate, stable and secure shelter is fundamental to health and wellbeing. More recently this has been extended to those living with mental illness. Stable housing provides a *"base from which a person can focus on their recovery"*, [3] and effectively operates as a foundation upon which improved determinants of mental health become more accessible.[4]

People with mental illness need a variety of levels of support. An additional range of support is necessary for those with co-existing alcohol or other drug problems and co-morbid intellectual disability.[5] [6]

1 Parker S, Limbers L, & McKeon. (2002). *Homelessness and mental illness: Mapping the way home.* The Mental Health Coordinating Council. Sydney, Australia, p.1.
2 Office of the Public Advocate, Queensland. (2005).*Submission to the Senate Select Committee Inquiry into Australian Mental Health Services,* p. 11.
3 Rickwood D. (2006). *Pathways of Recovery: Preventing further episodes of mental illness* (monograph). Commonwealth of Australia, p.36.
4 Bateman J & Merton R. (2007). *Social Inclusion: Its importance to Mental Health*. The Mental Health Coordinating Council. Sydney, Australia, p.21.
5 Rickwood D. (2006), op. cit., p. 36.
6 Bateman J & Merton R. (2007), op. cit., p.21.

Poverty and mental illness

A lack of employment not only drives people into poverty, but as a consequence these people are at greater risk of developing mental health problems.[7] The World Health Organisation (WHO) support the view that supportive community networks and services help protect against the adverse effects of poverty and mental illness. [8]

The cycles of poverty and mental illness are clearly described in the diagram below:

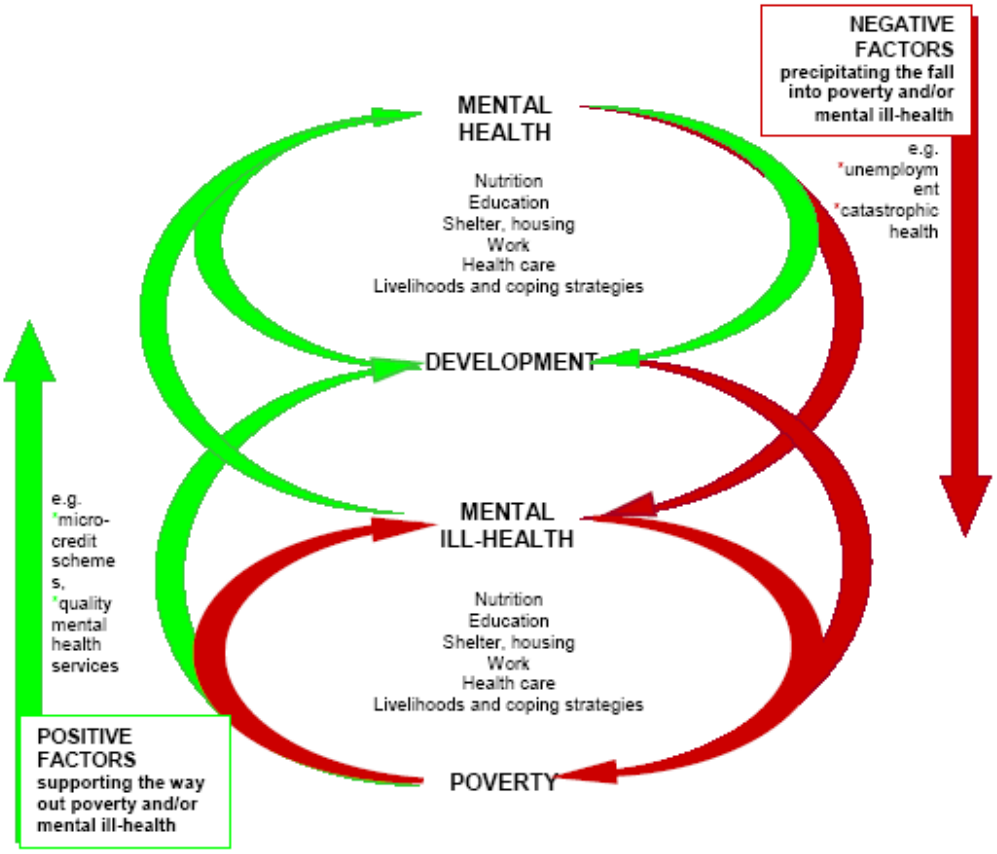

Figure 1: The Cycles and factors linking Mental Health & Development and Mental Ill-Health & Poverty

World Health Organisation (2007). *Breaking the vicious cycle between mental ill health and poverty.* Geneva.

7 Bateman J & Merton R. (2007), op. cit., p.21.
8 WHO (2007). *Breaking the vicious cycle between mental ill health and poverty.* Geneva.

Youth Homelessness

Youth homelessness in Australia has doubled since 1991.[9] Chamberlain and MacKenzie (2003) suggest that homelessness is *"best understood as a process, or series of biographical transitions."* [10] Whilst causality is diverse and complex, particularly relevant is the transition of youth to adult homelessness and the aetiology amongst young homeless people, which may result in a progression to chronicity.[11]

Discharge planning

The Discharge Planning Policy Directive for Adult Mental Health Inpatient Services published in January 2008 [12] presents a structured and standardised process for ensuring safe and successful transition of people with a mental illness from time of admission to hospital to post-discharge. The directive recognises that effective discharge planning must prioritise engagement with other agencies, community service providers and carers. Importantly this must actively involve the consumer in the decision making process regarding their ongoing treatment and care, possibly over extended periods of time and at different levels of need.

Despite policy directives, evidence has identified a need for improved coordination between acute mental health clinical services, community-based services, GPs and carers. High bed pressure is frequently cited as a reason for discharging prematurely, and that this impacts negatively on appropriate and thorough discharge planning, often leading to homelessness. Coordination between government and community agencies is vital to ensure improved outcomes for the long-term stability in the community, and reduction in acute hospitalisation. [13]

SAAP services

MHCC are concerned that as a consequence of funding structures SAAP services have developed into three distinct service silos. Problems are both structural and cultural. If we are really looking at 'families and communities,' we need to explore different funding structures and the potential for housing cooperative models as alternatives. We propose that models must be empowering to enable people who are homeless with mental health and other complex needs to develop the skills they need to live comfortably in the community. This is analogous with models of consumer managed and run mental health services here and overseas, and social cooperatives for example in Trieste, Italy.

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9 Chamberlain C & MacKenzie D. (1998). *Youth Homelessness: Early Intervention & Prevention.* Australian Centre for Equity through Education.
10 Ibid.
11 Ibid.
12 NSW Health. (2008). *Discharge Planning for Adult Mental Health Inpatient Services*. Mandatory Policy Directive PD2008_005. Available: http://www.health.nsw.gov.au/policies/pd/2008/PD2008_005.html
13 Bateman J & Henderson C. (2008). *Submission to the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals.* Mental Health Coordinating Council.

However, since some positive aspects of the SAAP model in Australia are evident, it is unlikely that this model for early intervention will be entirely scrapped.

The Commonwealth Green Paper on Homelessness provided a number of options with regards to SAAP services, under which headings MHCC made the following responses:

Option One - Transform SAAP to build a national homelessness response focused on distinct streams

This option would provide a new national homelessness response which focuses on four streams of support, tailored to particular life events and circumstances:

- *youth*
- *people experiencing or escaping domestic and family violence*
- *single people*
- *families in housing stress*

Current crisis services, including SAAP, would be aligned to the critical areas of employment, health, justice and housing.

Option One covers prevention and early intervention for important target groups but the option fails to acknowledge the needs of those who would not fall specifically under each category or where needs are complex and compounded by mental health problems.

A significant number of people in each category are likely to have mental health problems, whose needs will not be adequately met by general homelessness services. Mental health services need to be part of a total suite of services offered. Mental health related services tend to operate to 'silos' making it hard for people with mental illness navigate the system and receive consistent support. Many consumers fall through the gaps in service delivery or exit the system in frustration.

Pathways to service access for these identified groups would be somewhat different. We suggest that such a model would present difficulties in managing quality service delivery across all sectors. We are also concerned that in this context mental health services are not identified as a 'critical area' for crisis services to be aligned to. The Green Paper recognises the relationship between stable accommodation, clinical and community support to prevent homelessness, but fails to include key mental health services in this Option.

The Option also fails to include people with mental illness as a group at risk of homelessness or already part of the homeless population. It would seem that under this Option, these groups would surely experience social exclusion in all key areas.[14]

There is an urgent need for improved connectedness between different services and access to appropriate services requires greater collaboration between state and federal governments. Without this, any objective for a consumer-oriented and connected mental health system will not be achieved. [15]

14 Robinson C. (2003), op. cit., p.13.
15 The Boston Consulting Group (2006). *Improving Mental Health Outcomes in Victoria: The Next Wave of Reform.* Report to the Government of Victoria, Boston Consulting Group, Melbourne, Victoria. Cited in

Option Two—Improve current SAAP response

Option two would provide extra investment to reform the current crisis accommodation service system to give a greater focus on long-term outcomes.

MHCC welcome the suggestion of removing time limits on interventions, so that people get support for as long as they need it

Increasing the amount of crisis accommodation targeted to different population groups to meet unmet demand could significantly improve the situation for homeless people with mental health problems who are frequently turned away.

We support programs encouraging one-stop assistance by putting people directly into long term housing with varying levels of support. Evidence from the USA has shown success with models such as, Pathways to Housing, whose mission is to: *"end homelessness for people who suffer from psychiatric disabilities by providing housing first and giving support and treatment for their recovery and integration into the community".* [16] Pathways provide immediate access to permanent independent apartments without requiring treatment or sobriety as a precondition for housing, as well as clinical and social support tailored to the individual's needs.

We support implementing sector wide reform to standardise best practice approaches, including key support worker methods aimed at independent living and greater economic and social participation. Whilst all people using housing services would benefit from such a reform process, this initiative would particularly benefit people with mental illness who are exceptionally socially excluded.

MHCC support introducing clear inter-governmental and agency accountabilities so that protocols are established at the local level to make it easier for SAAP agencies to interact with other services (so that clients receive a joined-up approach). This accountability would be particularly beneficial to people with co-morbid mental illness and substance abuse issues.

We highlight the necessity to address complex needs of clients with mental illness in developing such a strategy without which many SAAP users will be unable to secure long-term housing. Delivery of generalist homelessness services alone will not meet these requirements.

Under the HASI program, people are placed in long-term housing which supports their level of need. We strongly recommend this as preferable to the short-tem SAAP model of support.

Mental Health Council Australia (2007). *Let's get to work. A National Mental Health Employment Strategy for Australia*, p.33.
16 Pathways for Housing. Available: http://www.pathwaystohousing.org

HASI

Internationally, a growing number of programs show clear and tangible benefits for people receiving quality supported housing in the community. In NSW, HASI has been operational since 2005. The HASI Stage 1 Evaluation Report (2007)[17] identified some significant improvements to clients' quality of life, community participation and mental health.

Option Three — Improve mainstream service response to homelessness and restrict SAAP to responding to crisis interventions

Option three boosts the capacity of mainstream services to respond to homelessness with a particular focus on early intervention and prevention, restricted to short-term and crisis-based interventions.

In relation to mental health programs, fundamental to achieving better outcomes for people at risk of homeless are specialist programs such PHaMS and Day to Day Living in the Community, that enable self referral via the community, GPs or SAAP allowing people with mental health problems to bypass a clinical pathway.

During consultations for the Commonwealth Inquiry into Mental Health Services in Australia (2007) MHCC recommended that COAG:

- review PHAMS referral processes to maintain community access rather than access via clinical services as is occurring in some states
- review tender process to recognise the value of locally based NGOs who may be appropriately placed to offer PHAMS services
- develop the PHAMS program to assist NGOs develop collaborative relationships with clinical teams providing support for NGOs

To ensure the viability of Option Three, governments will need to make a commitment to increased levels of high quality housing options to meet current need. The program will also need to have a broad spectrum of rehabilitation and support services available reflecting differing levels of need both ongoing and sporadic, as a result of episodic mental illness.

We are concerned that Option Three may not cope with the needs of the chronically homeless, and suggest that high need clients may have poor access because of the high cost of long-term, intensive support required.

What happens after short-term crisis interventions have ceased has not been addressed in this option. What of stability thereafter? People might well return to homelessness if housing stock is inadequate, or return in crisis to access short-term alternatives. MHCC support a focus on pathways for transitioning between levels of need if this Option is to be more generally viable.

17 New South Wales Department of Health. (2007). *Housing Accommodation Support Initiative* (HASI). Final Evaluation Report.

For any homelessness strategy to be successful requires that a central focus be placed on the needs of people with mental illness and/ or co-morbid substance abuse problems; who are at risk of becoming homeless; already homeless; and those who are at risk of homelessness or homeless at risk of mental illness and co-morbid substance abuse.

Amongst those in crisis or chronically homeless are significant numbers of people with mental illness and co-morbid substance abuse problems. Programs such as HASI and Pathways overseas are models that MHCC would like to see expanded to include intensive outreach programs for the homeless with mental illness, for people with co-morbid substance abuse and/or intellectual disability. Programs must be flexible and innovative, tailoring service responses to individual need.

A key to success is that prevention and early intervention focus on the needs of people to maintain secure tenure when becoming unwell, providing them with appropriate clinical and social services so that they do not slip into homelessness.

A sustained approach

As identified in our submission to the Homelessness Green Paper, MHCC supports the need for a multi-sector, sustained approach to community based care. Establishing people in stable accommodation is not a solution on its own:

> *What is needed is a system of accommodation, support, and mental health care with the capacity to form ongoing relationships with clients and to respond to the destructive experiences layered under presenting disadvantage and distress.*[18] [19]

A 2002 Victorian study undertaken with people living with mental illness with successful tenancies, examined the factors that contribute to successful maintenance of tenancy.

The study concluded:

> *It was evident that key supports were vital – from a stable income, to appropriate treatment, to psycho-social rehabilitation. Such supports have helped participants to develop their own readiness to live independently. Support that was tailored to particular individual needs and aspirations, and to the way in which the mental illness manifested was also important.*[20]

Local networks of NGOs are well placed to provide crucial services that meet the needs of consumers and their carers based in the community. [21]

18 Robinson C. (2003). *Understanding iterative homelessness: the case of people with mental disorders*. Australian Housing and Urban Research Institute, UNSW/UWS Research Centre, p. 43.
19 Bateman, J. & Henderson, C. (2008). *Submission to the Homelessness Green Paper.* Mental Health Coordinating Council.
20 Robinson C. (2003), op. cit.
21 O'Brien et al. (2002), op. cit., p. 58.

Housing First

Based on key elements and principles, many different 'Housing First' models have been developed internationally, particularly in the USA. Housing First is not just a 'bricks and mortar' approach, but has been successfully used in outreach programs in the US and in Adelaide, in the 'Street to Home Program'.[22]

In an outreach-focused Housing First model, the emphasis is on supporting clients to access housing as quickly as possible, engaging with them to take up appropriate support services to maintain their housing. A central tenet of the Housing First approach is that social services can enhance individual and family well-being more effectively when people are in their own home (NEAH, 2006:1, cited in Gordon, 2007).[23]

In the US, Housing First interventions have proved to be an effective response even for people with multiple and chronic needs. While the upfront costs of providing access to permanent housing may be greater, the approach has been shown in international studies to reduce the personal and financial costs associated with long term homelessness and repeat episodes of homelessness. [24]

This approach addresses chronic homelessness for individuals and families that encompass a range of sustainable responses - a solution for people who have been homeless for a long period of time (i.e. over twelve months). It is not a preventative or early intervention approach and is generally not suitable for people newly homeless. [25]

The key principle is provision of long term stable housing as a first step, complemented by the coordinated provision of services needed by each individual/family to sustain that housing and manage their often complex needs. Importantly the housing is not contingent on people accepting or complying with support services or being drug free. Compliance with residential tenancy laws is the only requirement.[26] However, for people with mental health problems, there needs to be ongoing follow up to prevent the likelihood of neglect as a consequence of illness, resulting in a deterioration of living conditions and mental and physical health.

Key elements in a Housing First approach include:

> Assessment and Targeting – in-depth initial assessment to ascertain if Housing First is the most appropriate intervention and to determine support requirements.
>
> Permanent Housing – different housing models may be used to provide housing including public or community housing, rental market leasing, sub-leasing and subsidies, purpose built or purpose modified housing, which may include a mix of tenants or be solely for high needs tenants.

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22 Gordon R. (2007), *Homelessness Research Report Stage 2.* Resolve Community Consulting and Black Ink Writing and Consulting for the City of Melbourne.
23 Gordon R. (2007), Homelessness Research Report *Stage 2.* Resolve Community Consulting and Black Ink Writing and Consulting for the City of Melbourne.
24 Ibid.
25 Ibid.
26 Ibid.

Low, Moderate or High Intensity Support Services – to assist tenants to sustain their tenancy and address other issues affecting their economic and social wellbeing and health, for example employment, drug and alcohol or mental health support services (NEAH, 2006). [27]

The Housing First approach (see Figure 2) is different to major homelessness responses in Australia which typically use a 'pathways' approach (see Figure 3), starting with a crisis response (with or without accommodation) through to transitional responses, and on to long term housing.

While support services are theoretically linked to these various housing options, in reality, support is often not available due to constraints (including limited funding to meet the overwhelming demand). However, where support is offered, housing is often contingent on the client's acceptance of support services as part of a case management approach.[28]

Figure 2: Housing First Approach

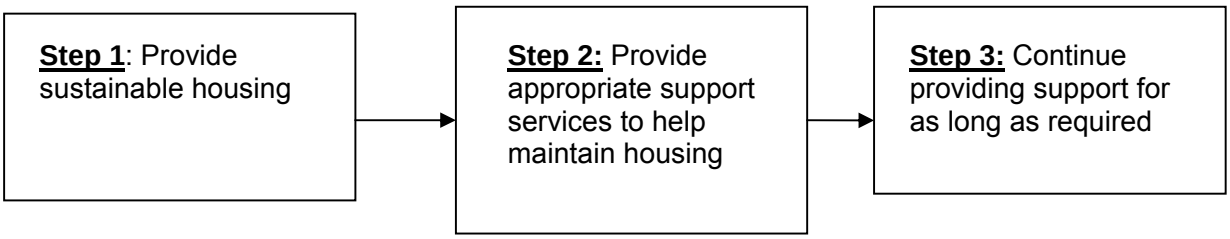
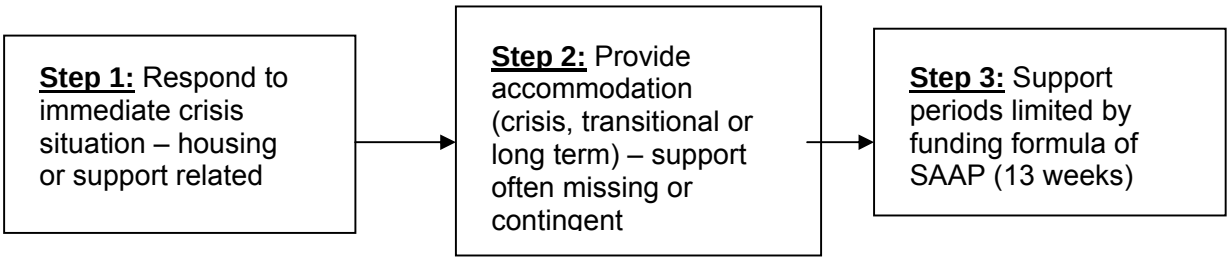


Figure 3: Pathways Approach



Using a Housing First approach, access to long term housing is made as simple as possible with minimal barriers for recognition of the complex and chronic needs of the target group.

27 Ibid
28 Gordon R. (2007), *Homelessness Research Report Stage 2.* Resolve Community Consulting and Black Ink Writing and Consulting for the City of Melbourne.

As evidenced in the research, a socially inclusive model provides supports based on individual needs and should be long term if required. Residents take up supports as they are engaged through assertive processes, when ***they*** are ready. This supportive engagement must take into account monitoring living standards and maintaining mental and physical health. Permanent housing gives residents the stability to address other issues which contribute to and exacerbate their homelessness. [29]

There are two key components to supportive housing:

- The provision of safe and secure rental housing that is affordable to people on very low incomes; that is self-contained accommodation and permanent; with occupancy based on an individual tenancy agreement.

- The provision of support services by staff with appropriate skills and experience, provided either at the same site as the housing or close by, tailored to the needs of individual residents; and that are flexible enough to respond to changing needs over time. The primary purpose of this support is to address the underlying causes of homelessness for each individual, to assist them to sustain stable housing.

MHCC propose that a useful process is to consider some 'core principles and key elements' identified in a Housing First and Supportive Housing program in Melbourne developed after analysing a range of international and Australian examples including some Melbourne examples. [30]

Supportive Housing Principles

1. Housing not contingent on acceptance of support

2. Supportive Housing targeted at individuals with complex and multiple needs who have been homeless for over 12 months

3. Supportive Housing providing long term safe self-contained affordable accommodation.

4. Supportive Housing providing long term housing and support

5. Supportive Housing that includes on or near site support services

6. Access to 24 hour support

29 Ibid.
30 Gordon R. (2007), *Homelessness Research Report Stage 2.* Resolve Community Consulting and Black Ink Writing and Consulting for the City of Melbourne.

Supportive Housing Key Elements

1. On-Site Support Using Assertive Engagement

   The support services required in Housing First/Supportive Housing are different to SAAP support services in that they are long term and are not looking to move clients on after a short/medium term intervention. Supports should include intensive case management; assertive engagement; personal support with tasks of everyday living; and linking to other specialist services. An assertive engagement approach is required as acceptance of support is not mandatory.

2. Quality, Affordable, Long Term Housing

   Providing high quality housing in which tenants feel at home and can take pride in is a key component of Supportive Housing. The quality of housing should be comparable with local community standards.

   The cost of housing needs to be affordable and set at a maximum of 30% of income to allow for purchase of food, utilities and other needs such as transport and recreational costs. As emphasised previously the housing needs to be available for as long as the tenant needs it, provided that tenants continue to meet all tenancy requirements.

3. Security

   Security is a critical issue for maintaining a safe environment for people with complex needs who are often physically and emotionally vulnerable. Security is even more critical when there is a low barrier for housing access.

   Security is important for keeping out those people who may prey on residents, minimising criminal activities and maximising resident well-being for people who have often experienced violence in the past. Twenty-four hour access to support also provides an immediate on-call response after hours.

4. Community Connectedness

   An on-site community connectedness/social participation program would be beneficial in a Supportive Housing model targeting people with high needs who have been homeless for long periods of time. Community connectedness and social participation both within housing projects and externally are vital aspects of life which can increase individual health and wellbeing and build residents' capacity to address their own health and wellbeing needs.

5. Employment

> Employment as meaningful activity and as a means of sustaining pathways out of homelessness was raised emphatically by people experiencing homelessness in the City of Melbourne research. Research has shown that employment is critical to exiting homelessness and achieving individual life goals.[31]

Supportive housing is one strategy to end homelessness. It needs to be complemented by a range of other strategies to effectively tackle homelessness including:

- Strong preventative measures to deal with causes of homelessness and prevent people from becoming homeless initially;
- Increasing the number of assertive outreach workers across the state using a socially inclusive Housing First approach;
- Strengthening the existing service system through adequate resourcing and improved service coordination;
- Improving data collection, particularly for primary and chronic homelessness to firstly establish a benchmark and then to collect evidence of service system outcomes.

Stringent evaluation processes must be embedded into Housing First programs as they were in the USA. One agency reported that having been in operation for two and a half years that results for participating families were extremely positive. Clients enter housing very quickly, with over 70% getting into permanent housing in less than one month. Clients also have high housing retention rates, with every family still in housing at the end of the 12-month program. A majority of clients report at one year that they are keeping a monthly budget, they have saved money, and that their financial situation has improved. Similar results were reported across different locations. [32]

Social Inclusion

Research has shown that people with a mental illness are no different than other members of the community.

> *People with mental illness also value practical skills development, material aid and emotional support to help them to achieve independence, especially when they have fluctuating periods of illness and/or disability.*[33]

The link between support and sustainable housing is often absent from housing delivery service models. What is required is the help that reinforces and assists people to cope with the challenges of daily living, gradually increasing their ability to live independently. This support requires a network of services responding to an individual's changing needs.[34]

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[31] Bateman, J. & Henderson, C. (2008). *Submission to the Homelessness Green Paper.* Mental Health Coordinating Council.

32 The National Alliance to End Homelessness(2006). *Santa Clara County Housing First Initiative Year Two Report: Evaluation Brief.* Available: http://www.endhomelessness.org/back/HousingFirstEvaluationReport.pdf

33 Bateman J & Merton R. (2007), op. cit., p.25.

34 Ibid.

If the primary goal in any homelessness initiative is social inclusion, one of the key objectives needs to be the mental health of those at risk of homelessness or who are homeless. In identifying those at risk, contact with crisis response services must offer a gateway into safe accommodation, and pathways to social and economic participation.

There needs to be an umbrella strategy that includes provision of services for those people who may as yet be undiagnosed as having mental health problems who are at risk; and options for alternative pathways, i.e. direct access through community-based organisations. Mental health community services together with "mainstream and homelessness-specific services have a role to play in comprehensive homelessness response".[35]

Principles for change

The focus must be to build human capacity to maximise everyone's potential for social and economic participation. This can only be achieved if the needs of homeless people and those at risk of homelessness are built into a holistic service delivery system. This must include priority housing lists (accompanied by support systems) drawn up by the collaborative efforts of responsive government and community services across all sectors.

Research, data collection and outcome measurement

It is widely acknowledged by service providers such as SAAP that census figures used to measure homelessness such as ABS, Australian Social Trends: Housing and Homelessness (2003)[36] hardly reflect the real extent of the problem of homelessness. People who are chronically homeless move around a great deal, characteristically have given up trying to access services and are generally off the radar for data collection purposes. We agree that a vital component of any strategy development is meaningful data collection.

Almost no research has been conducted into models of care coordination for people with mental health problems. A key aspect to moving towards the establishment of best practice is developing tools for measuring improved outcomes for homeless people, including holistic longitudinal evaluation, and cost-benefit analysis - measuring the cost of homelessness to the community and the individual.

One of the major stumbling blocks for the homelessness sector is role delineation and looking at health professionals' roles, and what they are in the homelessness sphere. Recent examples of where the area is starting to be investigated, is in research conducted by Geoff Waghorn in Qld. His work encompasses holistic evaluation that comes from a population health framework.

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35 Ibid.

36 Australian Bureau of Statistics. (2003). *Australian Social Trends: Housing and Homelessness*. Available: www.abs.gov.au/Ausstats/abs@.nsf/0/ddc8dc3787e2d9fcca256e9e0028f91e?OpenDocument

Dr Waghorn leads a program of research into the functional recovery of people with mental illness and psychiatric disabilities, looking at the social and economic marginalisation associated with mental illness, and improving the longer-term outcomes achieved by vocational and other non-treatment services. He has begun to look at role delineation in the sector and at who is providing what. MHCC suggest that this area needs to be part of the evaluative process in any strategic framework for homelessness in NSW.

A mental health focus

MHCC emphasise that mental health needs to be the core focus in working with people at risk of homelessness and the homeless. Success requires all strategies to be put in place with meaningful partnership and collaboration arrangements established across a wide range of services. [37] Mental illness and financial instability are issues that require collaborative and 'joined up' service delivery models.

Data collection

The People with Mental Health Disorders and Cognitive Disabilities in the Criminal Justice System Research Project (ARC Linkage Project, UNSW) clearly highlights the incongruence between systems dealing with people with mental health disorders. The absence of shared data means that pathways through the system cannot be identified. Thus individual and system interactions are obscure. This project, still in progress, is identifying the growing over-representation of people with mental health disorders in Australia's criminal justice systems of significant concern to the CJS, other human service agencies and advocacy groups.

The project involves a protocol developed through an innovative liaison between the School of Social Work at UNSW and eight criminal justice and human service agencies in NSW, which enables the creation of a linked dataset of criminal justice and human service records. The project has identified the critical issues in identifying and mapping the data needed and available to trace such pathways and interactions.
The project has highlighted current barriers to accessing such information, with a particular focus on the intersections of privacy requirements with considerations of the public good. [38]

This project evidence highlights the importance of assessing the accuracy of information/ data collected before identifying what interagency actions for improved coordination is put into place and how KPIs will be measured. A system baseline needs to be established from which plans can be developed, together with implementation to support the plans and future plan development. We strongly recommend that the working group discuss the evidence collected from this research with Dr Baldry & Dr Dowse at UNSW.

37 Australian Government. (2008). *Which Way Home? A new approach to homelessness*. Commonwealth of Australia, p.61.
38 Baldry,E. & Dowse, L. (2006). *People with Mental Health Disorders in the Criminal Justice System: Innovative Approaches To Exploring Criminal Justice Life Course and Agency Interactions.* UNSW, School of Social Work, Sydney.

Conclusion

A dynamic strategic framework needs to support a recovery orientated holistic approach to model development and to strongly focus on the close relationship between mental illness and homelessness.

MHCC applaud the NSW Government for placing Homelessness as a priority issue for NSW. We are encouraged and hope that the state consultation process together will the development of the Commonwealth White Paper will result in a robust strategic framework for eradicating Homelessness with achievable strategic directions and measurable outcomes.

MHCC look forward to the outcome of the Government's deliberations. For further information on this submission, please contact Corinne Henderson at corinne@mhcc.org.au or T: 9555 8388 ext 101.

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