‘Which Way Home? A New Approach to Homelessness’

Submission to the Australian Government Green Paper on Homelessness

June 2008

Mental Health Coordinating Council
Rose Cottage
Callan Park
Rozelle NSW 2039

For any further information please contact:

Jenna Bateman
Chief Executive Officer
E: jenna@mhcc.org.au
Tel: (02) 9555 8388 ext 102

Corinne Henderson
Senior Policy Officer
E: corinne@mhcc.org.au
Tel: (02) 9555 8388 ext 101

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Coordinating Council

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About MHCC

MHCC is the state peak body for non-government organisations (NGOs) working for mental health throughout NSW representing the views and interests of over 200 NGOs. Our member organisations specialise in the provision of services and support 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 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 participated in a consultation on 11 June 2008 hosted by the Minister for Housing, Tanya Plibersek, and commend the Government's commitment to addressing the complex issue of homelessness, as evidenced in the Green Paper. We thank the Commonwealth Government for inviting us to respond to the paper, and provide input into discussions for the development of a White Paper on a National new approach to homelessness in Australia.

MHCC have consulted their members and the sector for the purposes of this submission, in which we focus specifically on the experiences of people with mental illness who are at risk 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.

Context

MHCC has long been an advocate for improved services for the homeless and the need for an across government approach that highlights the complex and wide-ranging needs of the homeless, including mental health problems. What must to be emphasised, which is not apparent in the Green Paper, is the leap required to firmly place the homeless in the health agenda.

As MHCC stated back in 2002, the relationship between mental health and homelessness is multifaceted. The evidence is one of multi-dimensional problems that are structural, economic, systemic and clinical.[1] Homelessness is identified in the Green paper as, "one of the most important markers of social exclusion".

In 2007, our platform document Social Inclusion: Its importance to Mental Health, stressed the importance of secure housing which was referred to as follows:

1 Parker S, Limbers L, & McKeon. (2002). *Homelessness and mental illness: Mapping the way home.* The Mental Health Coordinating Council. Sydney, Australia, p.1.

> *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 has this 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. Where housing is stable, it can be taken for granted or not explicitly considered when people think about what supports them.[4]

A deficiency of secure housing forms part of the picture of a fragmented social network, family breakdown and poor community participation. Living alone, in poverty, or being homeless, all have been shown to have a negative effect on mental health. Sadly, these are common outcomes for people discharged from institutions into an unsupportive and alienating society. This leaves people vulnerable to neglect, abuse, homelessness and the 'revolving door syndrome', from where they enter cycles of admission, discharge and re-admission to hospital. Clearly, this is not a conducive context for recovery.[5]

In 1993, the Human Rights and Equal Opportunity Commission (HREOC) stated that, "a lack of appropriate supported accommodation is the most significant obstacle to effective recovery and rehabilitation for people living with mental illness". [6]

People with mental illness need a variety of levels of support. While in the early post-acute stage, 24-hour care may be necessary, but for people in recovery, secure independent accommodation ongoing or as-needed support is more effective in promoting improved mental health. Need also differs according to age, gender, cultural context, and individual circumstances. An additional range of support is necessary for those with co-existing alcohol or other drug problems,[7] [8] and co-morbid intellectual disability.

Poverty and mental illness

The World Health Organisation (WHO) state that best evidence indicates that the relationship between mental ill-health and poverty is inter-related. Poverty increases the risk of mental disorders and visa versa. [9] Common mental disorders are twice as common among people living in poverty. The highest prevalence of mental disorders can be found among people with the low levels of education and the unemployed.

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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 Bateman J & Merton R. (2007), op. cit., p.21.
6 Human Rights and Equal Opportunity Commission (1993). *Human Rights and Mental Illness*. Australian Government Publishing Service, Canberra ('the Burdekin Report').
7 Rickwood D. (2006), op. cit., p. 36.
8 Bateman J & Merton R. (2007), op. cit., p.21.
9 WHO (2007). *Breaking the vicious cycle between mental ill health and poverty.* Geneva.

A lack of employment not only drives people into poverty, but as a consequence these people become at higher risk of developing mental health problems.[10] WHO support the view that supportive community networks and services help protect against the adverse effects of poverty and mental illness.

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

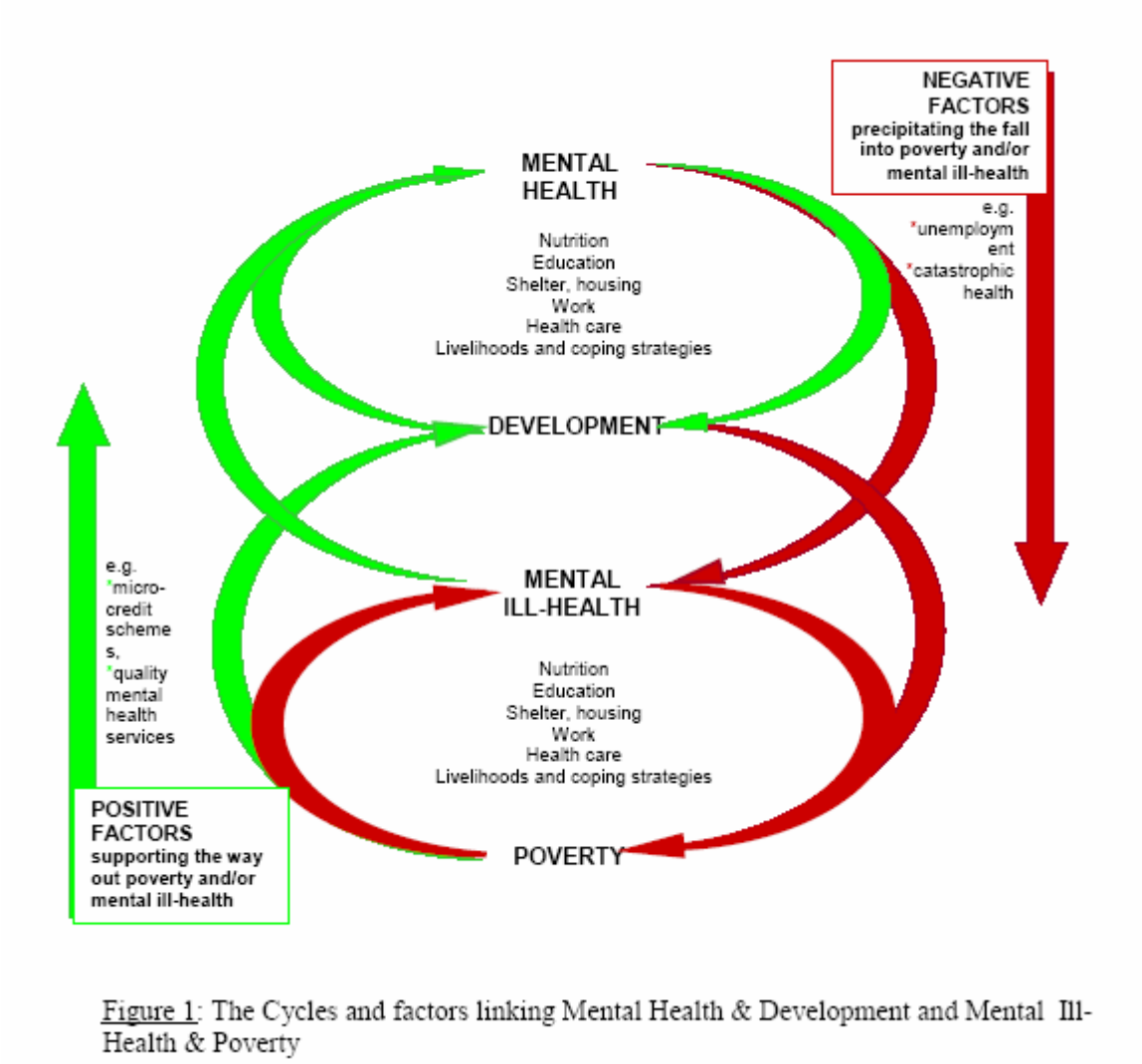

Figure 1: The Cycles and factors linking Mental Health & Development and Mental Ill-Health & Poverty

Youth Homelessness

Youth homelessness in Australia has doubled since 1991. An estimated 37,000 young people aged 12 - 24 are believed to be homeless at any one time, whilst approximately 100,000 young people aged 12 -24 experience homelessness every year, of which around 20% are chronically homeless. It is estimated that 90% of young people who become homeless have their first experience of homelessness when they are aged 15 or younger.[11]

10 Ibid.
11 Chamberlain C & MacKenzie D. (1998). *Youth Homelessness: Early Intervention & Prevention.* Australian Centre for Equity through Education.

Chamberlain and MacKenzie (2003) suggest that homelessness is "best understood as a process, or series of biographical transitions." [12] 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. [13]

The National Homelessness Strategy (2000)[14] identified several factors, which have altered the character of homelessness in recent years, several of which closely relate to child sexual and physical abuse, mental illness and substance abuse. [15]

Obstacles to independent living for people with mental illness

The Australian Housing and Urban Research Institute (AHURI) [16] has identified a number of behaviours and symptoms which some people living with mental illness and its related disabilities may experience, which give rise to difficulties in maintaining tenure in accommodation without support, such as:

- inability to perform routine living tasks;
- persistent feelings of high anxiety leading to isolation; fear of panic attacks making it stressful to use public transport, shop or leave home;
- extreme mood swings, from depression and sadness to elation and excitement;
- delusions, such as feelings of persecution, which may cause interaction with other people problematic;
- hallucinations, which can distort the senses, creating fear, confusion and unreal beliefs;
- thought disorder, which may lead to speech becoming difficult to follow;
- aggressive behaviour towards others, arising from fear, unreal thoughts, frustration or influences of substance abuse.

Such presentations may fluctuate. The capacity to function effectively can vary considerably at different times, and may be exacerbated by the co-existence of experiences of isolation, inadequate support, stigma and discrimination.

A lack of understanding of mental illness particularly amongst among neighbours, fuelled by misconceptions and stereotypes, may add to social isolation, and inevitably put a strain on tenancy maintenance. [17]

Discharge Planning

The Discharge Planning Policy Directive for Adult Mental Health Inpatient Services published in January 2008[18] 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.

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12 Ibid.
13 Ibid.
14 Commonwealth Government of Australia. (2000). *National Homelessness Strategy - A Discussion Paper*. Department of Family & Community Affairs. Available: http://www.facs.gov.au/internet/facsinternet.nsf/AboutFaCS/Programs/house-homelessnessstrategy.htm
15 Australian Bureau of Statistics. (2003). *Australian Social Trends: Housing and Homelessness*. Available: www.abs.gov.au/Ausstats/abs@.nsf/0/ddc8dc3787e2d9fcca256e9e0028f91e? OpenDocument
16 O'Brien A, Inglis S, Herbert T & Reynolds A. (2002). *Linkages between housing and support: what is important from the perspective of people living with a mental illness.* Australian Housing and Urban Research Institute (AHURI), Swinburne/ Monash Research Centre / Ecumenical Housing Inc.
17 Bateman J & Merton R. (2007), op. cit., p.21.
18 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

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.[19]

Evidence

Whilst there are frequent calls for greater numbers of institutional beds to manage people with mental health problems, clear benefits have been shown through comparison of supported accommodation in the community with institutional care for consumers in recovery.

The World Health Organization (2003) summarise the findings from a series of studies throughout developed countries, as follows:

- 73 % of studies found significantly better outcomes in functioning and psychosocial adjustment;
- 64% of studies found significant reductions in hospital admissions and re-admissions;
- 64% of studies found significant increase in patient satisfaction.[20]

There is consistent evidence highlighting the importance of stable accommodation and ongoing support in the long-term recovery of people with mental health issues.[21] A Cochrane Review (2006) called for more randomised trials that compare supported housing with other forms of community-based living, [22] although they acknowledge the complexity of such interventions.

Internationally, a growing number of programs show clear and tangible benefits for people receiving quality supported housing in the community. In NSW, significant improvements in clients' quality of life, community participation and mental health have been demonstrated by the Housing and Accommodation Support Initiative (HASI) operational since 2005.

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19 Bateman J & Henderson C. (2008). *Submission to the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals.* Mental Health Coordinating Council.
20 World Health Organization. (2003). *Organization of Services for Mental Health: Mental Health policy and service guidance package.* WHO, p. 46.
21 Browne G & Courtney M. (2005). *Housing, social support and people with schizophrenia: A grounded theory study.* Issues in Mental Health Nursing, 26(3), 311-326; Browne G & Courtney M. (2004). *Measuring the impact of housing on people with schizophrenia.* Nursing Health Science: 6(1):37-44; Freeman A, Malone J, & Hunt G. (2004). *A state-wide survey of high-support services for people with chronic mental illness: Assessment of needs for care, level of functioning and satisfaction.* Australian and New Zealand Journal of Psychiatry, 38:811-18; Rog D. (2004). *The evidence on supported housing.* Psychiatric Rehabilitation Journal, 27(4):334-44; Tsemberis S & Eisenberg R. (2000). *Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities.* Psychiatric Services, 51(4):487-93.
19 Chilvers R, Macdonald G & Hayes A. (2006). *Supported housing for people with severe mental disorders* (Review). The Cochrane Collaboration.
22 Ibid.

As referred to in the Green Paper, HASI is an initiative is based on an innovative partnership between NSW Health, the NSW Department of Housing and community sector organisations. It assists people with mental illness who need help with accommodation to participate in community life, maintain tenancies and improve their quality of life.

Providing high-level support for people who are homeless, at risk of homelessness or inappropriately housed, lower-level support for people in public and community housing who may be at risk of losing their accommodation without support, the HASI program provides an integrated support system from housing providers, area mental health services, and accommodation support providers. The support is broad-ranging and tailored to client's individual needs. Assistance is provided in the areas of domestic, emotional, employment, educational, advocacy, social and skill-based support. The HASI Stage 1 Evaluation Report (2007) [23] identified some significant outcomes for participants, including:

- 84 % experienced reduced rates, frequency and duration of hospitalisation—the time spent in hospital emergency departments decreased by 81%;
- 66% of clients reported improved mental health;
- 70 % stayed in the same home for 12 months or longer, and 85% remained with the same housing provider, ensuring that they maintained secure and affordable housing;
- Two thirds of clients had improved psychological functioning, with the average score moving from 38 ("serious impairment") to 65 ("generally functioning pretty well");
- Almost half the clients with a substance use disorder were no longer experiencing substance use problems; and on average, all clients increased their independence in living skills.

The Australian Housing and Urban Research Institute (AHURI) have identified the need for a multi-sector, sustained approach to community based care. Establishing people in stable accommodation is not a solution on its own, citing consumers who have had stable accommodation in the past, before experiencing episodes of homelessness and instability. "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".[24]

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.*[89]

Local networks of NGOs are well placed to provide crucial services that meet the needs of consumers and their carers based in the community. [25]

23 New South Wales Department of Health. (2007). *Housing Accommodation Support Initiative* (HASI). Final Evaluation Report.
24 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.
25 O'Brien et al. (2002), op. cit., p. 58.

Social Inclusion

Research has shown that people with a mental illness are no different than other members of the community. In examining consumers' housing preferences it was found that they value:

- independence and choice;
- convenient location;
- safety and comfort;
- affordability;
- privacy; and
- social opportunity.[26]

> *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.*[27]

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, which gradually increases their ability to live independently. This support requires a network of services responding to an individual's changing needs, and goes beyond the scope of Government's existing health and housing interventions[28] with the exception of the HASI program.

The Green Paper – Comment
Future Directions

Whilst the Green Paper clearly identifies that the primary goal in any homelessness initiative is social inclusion, the key messages in 'Future Directions' do not include one of the most central themes to target - that of the mental health of those at risk of homelessness or who are homeless. In identifying that, contact with crisis response services must offer a gateway into safe accommodation, and pathways to social and economic participation.

There also 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.

Some people with mental health problem shun clinical services. There must be options for alternative pathways, i.e. direct access through community-based organisations.

Targets

Mental health community services together with "mainstream and homelessness-specific services have a role to play in comprehensive homelessness response". Importantly, there needs to be a clear understanding that prevention of people at risk of homelessness needs to be part of the mix.

Targets identified in the Green Paper must also include a decrease in numbers of:

- people discharged from mental health facilities to homelessness;
- homeless people discharged from medical facilities back into homelessness;
- released inmates who become homeless;
- people who are homeless who have been unable to access any services;

26 Ibid.
27 Bateman J & Merton R. (2007), op. cit., p.25.
28 Ibid.

- people with intellectual disability and/ or co-morbid drug and alcohol and/or mental health problems;
- older aged men and women with complex physical and mental health problems

Principles for change

Throughout the Green Paper there is confusion regarding terminology. “Early intervention” is a crisis response, ***not*** prevention, as expressed in ‘Principle 2’. In setting the goal of substantially reducing homelessness, one of the aims should be constructed around providing strategies for prevention.

The focus must be building 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 the 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)[29] 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.

Measurement of improved outcomes for homeless people must include holistic longitudinal evaluation, and cost-benefit analysis must include measuring the cost of homelessness to the community and the individual.

A mental health focus

The Green Paper outlines a number of strategies which we support in principle, but highlight that in themselves their impact will be limited. Success requires all of the strategies to be put in place and meaningful partnership and collaboration arrangements established across a wide range of services. [30]

MHCC emphasise that mental health needs to be the core focus in working with people at risk of homelessness and the homeless. This is not evidenced in the Green Paper’s strategies or identified elsewhere in reference to for example: the mental health implications for victims of domestic violence; families and individual experiencing extreme financial distress; and people in unsatisfactory and unstable housing. Mental illness and financial instability are issues that require collaborative or ‘joined up’ service delivery models.

Options for a Reformed Service Model

MHCC acknowledge the Options described are not the only options that could be considered, but will respond to each. We are concerned that the Green Paper found it necessary to highlight the limits to ‘taxpayer funds’ prior to making an assessment as to best practice option for the initiative. Considering the monetary estimates and then making a judgement as to where funds could be directed most effectively would be a more positive approach.

29 Australian Bureau of Statistics. (2003). *Australian Social Trends: Housing and Homelessness*. Available: www.abs.gov.au/Ausstats/abs@.nsf/0/ddc8dc3787e2d9fcca256e9e0028f91e?OpenDocument
30 Australian Government. (2008). *Which Way Home? A new approach to homelessness*. Commonwealth of Australia, p.61.

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 at '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.[31]

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. [32]

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

31 Robinson C. (2003), op. cit., p.13.
32 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 Mental Health Council Australia (2007). *Let's get to work. A National Mental Health Employment Strategy for Australia*, p.33.

- MHCC believe that 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.

- MHCC would 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". [33] 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.

- MHCC 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 again 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.

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.

This option is fundamentally a HASI model. It is one that MHCC wholeheartedly support, since it has proved successful for people with mental illness. However, inconsistencies have become apparent in Australia between the States, who have different levels of engagement.

In NSW, under the PHAMS program (a Commonwealth funded program which funds NGOs directly) the NSW Health, Mental Health and Drug and Alcohol Office (MHDAO) have interpreted Care Coordination as a method of referral via clinical services. As a consequence clients cannot have direct access to services via community–based services or a GP. They must be processed through Area Health Services. Consumers must be able to exercise choice as to how they access services.

33 Pathways for Housing. Available: http://www.pathwaystohousing.org

During consultations for the Commonwealth Inquiry into Mental Health Services in Australia (2007) MHCC identified that tender processes for PHAMS and HASI favour larger organisations and exclude smaller NGOs. Smaller organisations need additional resources to provide appropriate services. Some concern was also expressed that Personal Helpers and Mentors Program (PHAMS)[34] in some ways replicates HASI 2, and consumers reported that they need more centre based services to go to and that access is confusing.
MHCC recommended that COAG:

- review PHAMS referral processes to maintain community access rather than access via clinical services
- investigate inconsistencies between service delivery of PHAMS in States and Territories
- tender process 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, Government will need to make a commitment to increased levels of high quality housing options. The program will also need to have a broad spectrum of services available reflecting differing levels of need both ongoing and sporadic, as a result of episodic mental illness. We are concerned that such a model cannot cope with the needs of the chronically homeless, and suggest that programs may avoid high need clients 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 inadequate housing stock is available, or return in crisis to access short-term alternatives. MHCC encourage the Government to focus on pathways for transitioning between levels of need if this Option is to be more generally viable.

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.

34 The PHAMS Program aims to provide increased opportunities for recovery for people who have a severe functional limitation resulting from a severe mental illness by helping them to overcome social isolation and increasing their connections to the community. Available: http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/pham-1

Recommendations

1. 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

2. 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

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

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

5. The Strategy must include increased availability of outreach clinical services

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

7. 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

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

9. 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

10. The Strategy must include ongoing accountability. Initiate outcome evaluation from the perspective of consumers as well as service deliverers must include longitudinal studies

11. 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

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

13. The Strategy must include community awareness programs to address stigma and discrimination

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

17. A National charter should be developed that is a Statement of Rights intended to improve community understanding of homelessness issues, the impact of stigma and discrimination and promoting a rights-based approach to service delivery. The aim being that these stated values become embedded into the legislation.

Conclusion

MHCC applaud the Government for having placed Homelessness as one of the top priorities of the Social Inclusion agenda for their first term of office. We are hopeful that the White Paper developed as a result of the Green Paper consultations will lead to a robust 10 year National Strategy for eradicating Homelessness.

A dynamic strategy will need to adopt a holistic approach to model development and be strongly focused on the link between mental illness and homelessness. This association was made throughout the Green Paper, but not evidenced in the Options proposed, which are somewhat narrowly focused.

MHCC look forward to the outcome of the Government's deliberations.

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