



THE ROYAL
AUSTRALIAN AND NEW ZEALAND
COLLEGE OF PSYCHIATRISTS

RANZCP Submission

Which way home? A new approach to Homelessness

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Introduction

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand and has responsibility for the training, examining and awarding of the qualification of Fellowship to medical practitioners. There are approximately 2700 fellows of the RANZCP who account for approximately eighty-five per cent of all practicing psychiatrists in Australia and over fifty per cent of psychiatrists in New Zealand. There are branches of the RANZCP in each state of Australia, the ACT and New Zealand.

The College is pleased to have the opportunity to contribute to a reform process that will reduce the number of people who are homeless together with decreasing the risk of becoming homeless, and improving the outcomes of people who may be or who are at risk of homelessness. The College commends the Government for conducting this review and for recognising that in order to address the incidence of homelessness in Australia requires approaches to:

- (i) reduce the immediate shortfall in services available to and that are readily accessible to homeless people and, critically
- (ii) address the factors that contribute to and perpetuate homelessness.

This submission particularly focuses on **the interaction of homelessness and mental illness** and notes the very strong correlation between these issues. The RANZCP advocates for a mixed approach that increases the system's crisis response capability whilst addressing the mediating factors that increase demands on SAAP and other crisis services. If the design and integration of services reflects a better understanding of the factors that contribute to homelessness, it is likely to reduce the extent to which more complicated and costly interventions are required later on, when problems have often become more acute.

Key considerations

There are no simple remedies to homelessness. This is demonstrated by sustained levels of homelessness remaining distressingly high despite a period of prolonged high employment rates and economic growth. Recognising that homelessness is an issue that spans the responsibilities of each sphere of government and many of the portfolio areas within governments, the RANZCP suggests that the progress on this issue have the explicit oversight of the Prime Minister and Premiers/Chief Ministers, possibly through COAG.

Increasing the availability of crisis and/or more permanent forms of accommodation, with appropriate levels of support, will relieve some of the more obvious symptoms of homelessness however these must be accompanied by strategies that reduce the likelihood of people becoming or remaining homeless. Increasing funding at the crisis intervention end of the service spectrum will ultimately be less effective and more costly (in human, social and economic terms) than an approach that addresses causal factors, focussing on prevention and early intervention strategies that are integrated between Commonwealth, State/Territory, Local Government and community-based service providers.

Discussion

The Green Paper process is timely as the issues will be better dealt with before factors that could exacerbate the risk of homelessness increase. Those drivers include the changing burden of disease, specifically the increasing incidence and burden of mental health, which has implications for the size and service needs of the potential homeless population.

“...23% of the total Australian adult population are affected by one or more mental disorders in any given year” and “that about 14% of children and young people (or 500,000 persons) are affected by mental disorders within any six month period” (various authors cited in Australian Government National Mental Health Report 2007 page 15).

“... the Australian Institute of Health and Welfare reported mental disorders to be the third leading cause of overall disease burden, accounting for 13% of total burden and 27% of total years lost due to disability. Mental disorders rank third after heart disease and cancer as the largest causes of illness-related burden in Australia. However, they represent the largest single cause of disability, accounting for nearly 30% of the burden of non-fatal disease” (Mathers, Vos and Stevenson cited in the Australian Government’s National Mental Health Report 2007 page 16).

Projections also suggest the mental health related disease burden will grow markedly as a proportion of overall disease burden (“Burden of disease and injury in Australia in the new millennium: measuring health loss from diseases, injuries and risk factors” Begg, Vos, Barker, Lopez Medical Journal of Australia; 188(1): 36-40)). Given the correlation between homelessness and mental illness, and the projected increase in mental health disorders, this is likely to increase the risk of homelessness and pressure on crisis services.

Access to homeless services in rural and remote areas also warrants direct and special attention. The lack of services in communities can mean that people move to locations where homeless and related supports exist but are at considerable distance from the communities where they are known and family or other informal care might best be provided. This can add to social dislocation and increase the likelihood of people losing access to income support, coming into contact with the police and justice system and a decline in their health as they lose contact with known health care providers. Further, if services are to be more effective in future, increasing the availability of tailored services to Indigenous Australians and other groups whose needs are not well met by mainstream services is also warranted.

Changes in mental health policy have led to increases in homelessness, by closing institutions and moving people with severe and chronic illness into unsupported community settings. Mainstreaming, deinstitutionalisation and reducing the number of acute mental health beds were all deliberate policy positions with underlying rationales. However, the impacts of those changes on the ground have generally been to reduce the capacity of the system to deliver mental health services in an effective or

coordinated way. The result has tended to be to fragment services, and to overstretch inadequately provisioned community based infrastructure which was intended, but not equipped adequately, to provide the replacement supports envisaged by policy makers.

The major service gap in mental health community settings that leads to homelessness is the lack of intensive rehabilitation programs, both residential and day programs. The phenomenon described as “from the back wards to the back streets”, suggests the unintended but frequent pathway for people with mental illness, between often marginal and inadequately provisioned acute service settings and the broader community that does not have the service structures and operating systems to support people with mental illness to live safely or rehabilitate in the broader community. Acute inpatient units increasingly discharge people with severe illness into crisis accommodation or “no fixed address”.

Homelessness is a marker of severe illness and therefore of complex needs. For many, especially the longer-term homeless, it is far more than an accommodation or even a housing affordability issue. Increasing the amount of low cost housing will be of benefit to those who are already homeless but will not reduce the number of new people with severe illness from becoming homeless.

Complex needs require complex interventions with integrated long-term services across sectors. For instance:

- Severe mental illness impairs the person’s ability to access and use support programs;
- Homelessness, regardless of cause, leads to mental health and substance use problems;
- Models of housing for homeless people need to include programs to decrease rather than promote the risk of mental health and substance use problems; and
- The link between homelessness and mental illness needs to be approached at all levels including prevention, early intervention, treatment, relapse prevention, rehabilitation and recovery.

Homelessness and mental illness are not the same and are generally treated as distinct issues. Yet there are strong correlations between the two issues and for those who experience both the risks to safety and recovery are greatly heightened. Since the population of homeless people with mental illness in the community fluctuates, it is difficult to quantify. However, there is consistent evidence to support the finding that people who are homeless have a much higher prevalence of mental illness than the general population (St Vincent’s Mental Health Service, May 2005). An individual does not become part of this statistical group and remain there; rather there is a constant movement of people with mental health problems into and out of the homeless population. Nonetheless, it is well understood that people with a mental illness have a much increased risk of homelessness, that the mentally ill are very highly represented among the homeless population and that the circumstances of being homeless itself exacerbates or increases the risk of poor mental health.

Some of the increasing difficulties facing persons with mental illness should be seen as the effects of poverty and social exclusion. Mental health services have limited influence where people are struggling to maintain basic standards of living. Contributing factors include changes in the availability of low cost housing and public housing, increased banking related costs, increased use of short term credit, increased penetration of gambling, increased public and private transport costs, increased availability of illicit substances, charges such as co-payments for medication and the aggressive marketing of new products, especially through “buy now - pay later” schemes. The cost of housing and boarding house closures further contributes to homelessness among the mentally ill.

A major factor in the increasing numbers of homeless people with mental illness is the failure of the mental health system to provide adequate treatment and support to people suffering chronic and

severe illness. More effective servicing in mental health will reduce the incidence of homelessness and pressure on related services, and vice-versa. People with mental health problems require a range of supported accommodation services, preferably permanent housing with a focus on recovery. The lack of these services results in people being discharged from acute hospital settings into short term crisis accommodation and/or to no address at all. This illustrates a systemic issue rather than a criticism of any particular service or mechanism. Providing well integrated services to a population with widely differing and complex needs is inherently difficult and resource intensive. However, the alternative is likely to be a set of interventions that focus on symptomatic rather than causal factors, perpetuates service gaps, cost shifting pressures and ineffective commitment of resources. The call for greater collaboration between all levels of Government, between services at each level of government and with the community sector is welcomed.

Experiences of homelessness and mental illness

It is important to clarify that most mental illness is treatable, as demonstrated by the increasing body of research on evidence-based medicine. The inevitable interaction between mental illness and other social problems facing homeless people causes a spiral of decline. The interaction varies from person to person, so that in some instances mental illness (chronic severe psychotic disorders) leads to homelessness, in some people homelessness leads to mental illness (depression and anxiety disorders); and in other cases another problem, such as substance abuse, leads to both homelessness and mental illness. As a consequence, people who suffer both homelessness and mental illness tend to have severe and complex problems (Jablensky, 2000). They require service systems that are attuned to their specific needs.

Having a mental illness can affect basic abilities to think clearly, engage with others and work through bureaucratic processes. This adds to the difficulty in accessing accommodation services and sustaining tenancy. It can interfere with the ability to work through administrative requirements, such as completing application forms or attending appointments and the capacity for independent living may fluctuate and be unpredictable. When a person is unwell, they may be heavily reliant on others to ensure the availability and coordination of support to gain housing. Without that support it may leave returning to the streets as the only option.

The nature of being homeless leads to behaviours that make accessing standard clinical and social support services difficult. The person is often mobile, moving between different short term crisis accommodation and therefore different catchment areas for services. Living on the streets can be frightening and dangerous, particularly at night, so many try to sleep during the day and be awake and mobile at night, which can further exacerbate the risks of violence and/or coming into contact with the justice system, for example. It can also lead to an attitude of being completely self-reliant and not trusting others, including those who may wish to provide services. Life can become a matter of day to day survival rather than long term planning, with any problem that cannot be immediately resolved being avoided. Consequently there are enormous problems in engaging homeless mentally ill clients who are living on the streets into routine service delivery systems. Even if that does occur, homeless people may have a different picture of their needs than do providers. The individual may believe that meeting basic needs for food or shelter should come first, whereas providers may emphasise mental health or alcohol and other drug services.

The impact of homelessness on the vulnerable young person in our society can have a devastating impact on their mental health. Homelessness in children and adolescents can arise from many sources however are on the rise primarily due to the increased rates of family dysfunction and disintegration especially amongst marginal households. These children and young people subsequently lose the

support and security of family and home at a critical stage in their lives when they are challenged with the stress of seeking an identity and role in society. Developmental interference with educational opportunity and peer support become additional burdens. The trauma of homelessness can exacerbate risk-taking behaviour further endangering emotional wellbeing and leading to the development of co-morbid disorders that may carry over into their adult life.

In order to address these issues it is recommended that service models be funded that integrate both clinical and non-clinical supports, examples include NSW HASI Program, Victorian Housing outreach Service and the US "Housing First" project. Such models allow for flexibility across catchment areas, are able to respond quickly (if not immediately) to crisis and changing needs, and address the person in an individualised, informal and non-stigmatising manner. There are a range of approaches that might be taken to achieve better integration and outcomes for individuals. One approach might be to pool funds (Commonwealth and State) provided for clinical and non-clinical services which might be held by a single coordinating agency (fund-holder) responsible for integrating all components of care.

Alternative approaches could include

- (i) services maintaining separate, independent funding control but reporting to a broadly based steering group with an overarching monitoring and outcome-focussed performance reporting role or
- (ii) service providers that maintain independent operational autonomy and funding, but share a common set of high-level, outcome-focussed performance indicators that increases service accountability for the outcomes of system as much as the specific service.

Response to the Green Paper

The Green Paper is a substantial representation of the extent and complexity of homelessness. The inclusion of the three Options in the paper is helpful as a means of illustrating possible approaches and as a means of drawing out practical responses. Nonetheless, the best approach may include elements of each Option or other approaches not described in the Green Paper. The RANZCP advocates that in progressing this matter, the Government remain open to consider approaches other than the three Options presented.

Principles of a new approach

Addressing the needs of homeless people especially those with mental illness, requires a shift from a simple "health" or "housing" model of care to a more integrated model that addresses the broad range of psychosocial problems alongside the health problems. The service system is currently chaotic involving numerous Federal government agencies, State government agencies, non-government organisations including the charitable sector and volunteer organisations. Targeted mental health services to homeless people must be integrated with housing services, but also need to be linked with primary care, physical health services, rehabilitation services, employment services, financial support services, substance abuse services and the justice system.

An effective model should allow for flexibility across catchment areas, be able to respond quickly to crisis and changing needs, and address the person in an individualised, informal and non-stigmatising manner. The service system needs to understand the impact a mental illness can have on achieving housing stability and recognise the importance of addressing permanent housing needs in stabilising mental illness.

Service systems need to be developed that are assertive in following homeless people across the geographic and structural barriers of standard systems, facilitate engagement and provide integrated outreach supports rather than expecting homeless people to attend an office. There needs to be adequate resourcing to allow provision of time to build relationships and to make appropriate responses to unpredictable fluctuations in needs and capacities. This should be done in a manner that is consistent and respectful of the individual.

The provision of mental health and health services also need to extend beyond the illness to include providing a broad array of services, linkages and connections to appropriate support systems which include:

- Earlier, more considered and detailed discharge planning (especially from acute settings);
- The development of coordinated crisis plans and interventions; and
- Collaborative case management to assist individuals with a mental illness integrate into their communities and decrease the potential for homelessness.

Goals and Targets

The College believes the issue of homelessness is more than just providing a home and that the proposed targets should primarily focus on addressing the causes of homelessness not just the effects. Specifically within the context of those with a mental illness who may be at risk of becoming homeless or who are already homeless, the most important principles that require immediate and long-term interventions include the focus on prevention and social inclusion especially during significant transition and interface points in peoples' life where the risk of homelessness is exacerbated.

The College believes that all targets should aim to end if not significantly reduce the rates of homelessness and should be based on overarching principles of social justice and prevention. The following proposed targets are both measurable and should be attainable in the short term with ongoing improvement expected over the long term:

1. A decrease in the number of people with a mental illness who enter and then subsequently re-enter the homeless service system;
2. A decrease in the number of people with a mental illness (and those in general) that are discharged from the hospital system into primary, secondary and tertiary homelessness;
3. Provide increased treatment supports for and monitoring of people with a mental illness that cycle through the mental health system and end up being homeless;
4. A decrease in the number of homeless people with a mental illness appearing in other systems such as the justice system; and
5. A decrease in the number of people with a mental illness and in general those who receive a disability or related pension being "breached" for non-compliance by Centrelink and losing their income for a defined period.
6. An increase in housing retention, increased uptake of mental health services and reduced drug and alcohol use of people with a mental illness (over 1 year, over 5 years, over 10 years).

These targets relate to interventions and transitions that are known, practical and quantifiable and, if measured, ought to build the evidence base required to link outcomes to some of the key factors that contribute to them.

Research priorities

Studies reveal that if community psychiatric services or primary health care services are accessible (see references section), homeless people will both use and gain benefit from clinical treatment and clinical support services'. It is apparent homeless people with mental illness are economically and socially marginalised and current strategies do not prevent or remediate the situation. Despite increased funding, it is evident that the old system of dealing with homelessness e.g. shelters, soup kitchens, transitional housing programs, have not worked and the number of homeless has grown.

Research funding should be increased substantially and tailored to develop a greater understanding of the causes of homelessness and the identification of long term solutions to the problem. This would, in turn, lead to more effective and efficient service interventions. Specifically, research into the links between homelessness and mental health could focus on:

1. Mental health service patterns and changes over the past decade to identify correlations and determine whether these changes have affected rates of mental illness within the homeless population, and/or the rate of homelessness of those with a mental illness;
2. How the extension of mental health interventions can/has prevented homelessness or assists those with a mental illness moving out of homelessness;
3. The degree to which homelessness causes mental illness e.g. exposure to and abuse of drugs and alcohol, exposure to and experience of violence and sexual abuse, effects on physical health, depression etc;
4. The degree to which homelessness and mental illness facilitate social exclusion and effect on long-term outcomes e.g. employment, justice issues, treatment outcomes etc; and
5. The cost of prevention of homelessness versus the ongoing costs of intervention and compares a range of illness (mental health and physical health).
6. The effect rapid placement in permanent housing with ongoing access to support services has on housing retention rates, the uptake of mental health services and the rates of drug and alcohol use of people with a mental illness (over 1 year, over 5 years, over 10 years).

Furthermore, given the level of current and potential resourcing to deal with homelessness, including direct services and through access/interaction with other service systems (e.g. income support, health, justice etc), detailed modelling that comprehends the scope and projects possible cost implications (short and long term) would seem warranted. This modelling could potentially be undertaken or supported by the Commonwealth Treasury and consider a similar timeframe to that of the Intergenerational Reports.

A reformed homelessness service model

Homelessness will only be reduced by providing permanent housing with ongoing access to appropriate support services that aim to reduce demand for and reliance on short term interventions such as crisis accommodation. These services must target improvements in the delivery of relevant and appropriate supports during the transition and interface points within and between the primary health, mental health and community and welfare sectors. Although meaningful interventions will always be required, more investment in the prevention of homelessness needs to occur if the flow on to chronic illness is to also be reduced and should not be the sole responsibility of service providers.

When reviewing the proposed options, the College draws the Government's attention to the needs of homeless people living in rural settings as these people have even less resources than homeless people in cities, and therefore need special attention. In addition to this, appropriate services should also be developed for Aboriginal and Torres Strait Islander Australians who may have particular support needs and for whom more tailored services may be needed in order to be effective. Similar arguments may also apply for those from Culturally and Linguistically Diverse (CALD) backgrounds.

As stated earlier, no single Option as described in the Green Paper will address the issue fully and a more balanced and integrated approach is required.

Option One

The College does not support this Option as it places little emphasis on preventing homelessness or stemming the demand for crisis services. Option one may offer some improvement in coordination and performance but continues a segmented approach to service provision on a limited categorical basis. This approach does not reflect the multiple characteristics and needs of homeless people nor appear to emphasise the causes of homelessness.

The College feels that although the four identified target populations are of particular importance and are heavily represented in the homeless population, it is critical that the Government does not limit interventions solely to these groups and that other equally important and disadvantaged populations such as those with a mental illness or substance abuse problem, Indigenous Australians, the elderly and those in rural and remote areas, also receive dedicated interventions to meet their specific needs. For many of these groups the lack of tailored or local services leads to further displacement from potential support networks (including family or other informal care networks), increased transience and reduced service access, consistency and effectiveness. Care would also need to be taken to recognise that many people have multiple risk factors and that an overly simplified targeting mechanism will mean that people with multiple or complex needs miss out entirely while others who are able to access the system receive only partial responses to their overall care needs.

The Option as outlined risks creating or re-creating stricter silos of practice and places an additional burden on already over stretched service systems. No mention is made of the integration of services systems and appears to only cater for last minute interventions, inevitably requiring the person to be homeless in order to access services and supports, which is not a preferred outcome. The classification of homeless people into these broad groupings also does not allow scope for those with more complex needs such as those with a mental illness as previously identified.

Options two and three

The College proposes that an amalgam of Options two and three will provide a longer-term solution to the problem of homelessness and will enable more appropriate collaboration and integration with other mainstream services. However in order for this approach to be successful, the College believes that the option must be driven and have high-level oversight by Federal and State jurisdictions, meaning that the Prime Minister and Premiers should have oversight (through CAOG) and commit to being responsible for achieving change. This oversight is required in order to ensure shared responsibility for addressing this crucial issue.

The College supports the removal of time limits on access to interventions however feels that further investment in the SAAP program reinforces reliance on short term solutions where evidence suggests

that rapid placement in permanent housing with ongoing access to support services increases housing retention and the decrease of psychosocial problems (Housing first - USA). Australians should aim to no longer rely on public housing authorities building or buying houses; we should be looking to other innovative programs around Australia and the world that prevent the reliance on short term interventions and focus on prevention.

As previously highlighted, the development of improved data collection systems that are based on the proposed targets in this paper is a sound investment in the reduction of homelessness in the future. However, funding based on incentives further perpetuates the perception by some consumers that current initiatives focus on service provider needs and survival, and not necessarily on the survival needs of the homeless person. The proposal of increased subsidies, although a useful short term intervention, does not address the causes of homelessness nor long-term options for those identified target groups.

The College supports the investment in nationally implemented integrated service delivery models such as the HASI initiative, which focus on all facets of life and functioning, and that provides long term individualised supports.

Concluding remarks

Whatever Option or variation is chosen, ultimately it will be important to manage the risk that operationalising reform, in collaboration with myriad agencies and people, does not lead to the same trap where identifying distinct accountabilities and 'manageable' components leads to splintered service provision. A joint funding initiative across mental health, general health and addictions is a good starting model in establishing integrated and appropriate treatment services. In addition to this the identified targeted outreach services between hospitals and the non-government sector are good models to replicate nationally. This is achievable if there are shared and explicit accountabilities tied to the overall targets, goals and research priorities.

The RANZCP is committed to working with Government and governing mental health bodies in addressing the crisis of homelessness and mental illness.

For more information or to schedule a meeting to discuss any of the areas raised in this paper please contact:

Sarah Gafforini

Manager, Policy and Practice Standards

Royal Australian and New Zealand College of Psychiatrists

309 La Trobe Street Melbourne VIC 3000

Ph: + 613 9601 4964 Fax: + 613 9642 5652

Email: sarah.gafforini@ranzcp.org

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