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Editorial

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Deb Tisorbaris
Chief Executive Officer, Council to Homeless Persons

This special joint edition brings together two significant publications recognising the importance of the issues of mental health, housing and homelessness. *Parity* has a long history of raising the issues and furthering debate in the area of homelessness and *newparadigm* actively pushes the agenda on community mental health and psychosocial rehabilitation.
There is substantial and significant evidence indicating that mental health issues are prominent amongst people who are homeless. In addition, people with mental health problems encounter particular problems in accessing long term secure housing because of stigma, poverty and disability.

Greater acknowledgment and action is required to address mental health, housing and homelessness in the National Mental Health Strategy, the National Homelessness Strategy, COAG’s National Action Plan and other related policy responses at both Commonwealth and State government levels.

A clearer commitment and increased resources are required to enshrine, expand and develop a sophisticated and responsive community based mental health service system. This will allow long-term assistance to be provided and reduce the level of hospitalisation.

CHP and VICSERV support the view that most people experiencing mental illness, including those who are homeless, should receive and have regular access to mental health treatment, support and counselling in community settings rather than in hospitals and large institutions. While there is a need for some provision of hospital-based responses, mental health services should largely be aimed at ensuring that clients can participate as fully as possible in the community. People who are homeless and experiencing a mental illness need specific on-going support to enable them to be part of community life.

The lack of resources and inadequate mental health service system responses particularly affect people who are homeless experiencing a mental illness and who due to their living circumstances face multiple barriers in accessing a range of public and community services and often lack social and family networks.

The narrow and clinical definition of mental health applied by many mental health services combined with high demand, leads to a strict prioritisation of cases and contributes further to people who are homeless experiencing mental illness not receiving treatment and support.

CHP believe that SAAP and homelessness assistance services should be the primary broker or service provider for people who are homeless. Difficulties for people who are homeless are compounded when they are required to navigate other public and non-government service systems. It is for this reason that homelessness assistance services should be funded to provide a specialist mental health response to people who are homeless, enabling an immediate professional assessment and diagnosis and to assist people who are homeless with a mental illness to access and maintain supported accommodation.

Specific service delivery and policy strategies are required to meet the needs of people who are homeless experiencing mental illness. In particular, the needs of young people, people in rural and regional areas and indigenous people.

CHP and VICSERV support recommendations and actions that enshrine the rights of all people to the highest attainable standard of health, to adequate housing, to participate in policy, service design and delivery, to non-discrimination and the right to adequate income.

While some data and information has been collected about people who are homeless experiencing mental illness, more quantitative and qualitative research is required to further improve and develop appropriate service delivery and policy responses.

We are pleased that our organisations could come together to produce this joint publication, which significantly adds to the discussion on mental health, housing and homelessness.
Foreword
Come in the Front Door... Name Please?

By Anne Maree Rogers
Regional Manager, Homelessness, Support and Specialist Programs
Salvation Army EastCare

The Salvation Army EastCare’s Homelessness Support and Specialist Program is pleased to sponsor this edition of Parity and new paradigm.

EastCare is a major human service provider in the Eastern Region. More specifically the homelessness program receives a range of funding through a variety of streams which include SAAP, Alcohol and Drug, NIDS, Disability, PDRS, HACC, Aged Care, Multiple and Complex Needs.

EastCare is a multidisciplinary team of approx 140 staff including social workers, psychologists, nurses, family therapists, trainers, psychiatric nurses, youth workers and other professionals who bring a range of skills, to their day-to-day work.

EastCare’s Hawthorn Project began in 1995 as a community agencies response to the increasing number of consumers who were without support and were living in marginalised accommodation in the City of Boroondara. At this time, and some would say still, the community was struggling to provide support to a range of vulnerable consumers who had been living in institutions and had little experience in navigating their way through the service system.

Homelessness spans structural disadvantage, family and relationship breakdown, sexual abuse, familial and individual characteristics, environmental aspects and policy consequences. Lack of access to affordable housing, issues such a deinstitutionalisation and the inadequate resourcing of alternative community based options all contribute.

Currently some service providers and consumers are still unsure of the level of community acceptance towards those people with a significant mental illness.

With the changing face of the City of Boroondara the once admirable compassion of the local residents has at times been tested.

In the mid 90’s in Hawthorn there were three large boarding houses and fifteen rooming houses providing a total of 391 beds. There were also ten Supported Residential Houses (formerly Special Accommodation Homes), which provided a total of 536 beds. The City of Boroondara, which includes Hawthorn, Kew and Camberwell had a combined total of 614 beds.

Up until 2004 EastCare provided a “drop in” service where people could stop over for a coffee, chat, read the local paper, discuss the days activities, keep staff informed of how life’s dramas had been addressed or how they had escalated. Many of the regulars were people with mental health issues that were needing a helping hand to problem solve a range of difficulties including money, food or accommodation concerns.

Whilst this experience appeared ad hoc and unscripted, the purpose was to engage and assess, to ensure that basic needs were being met and that help was provided if they were not. More importantly everyone knew the names of the regulars and if a period of time went by when they had not been sighted, an outreach visit was conducted to ensure that all was well.

For people with a significant mental illness, who had lived for many years in an institution, now living in the community, the structure of their lives had changed significantly. They no longer had a secure base. People with mental illnesses struggled to find suitable accommodation that will provide them with security and predictability. Even those lucky enough to have family and a strong supportive network could be caught up in the cycle of homelessness which can reoccur over many months some times years, depending on a range of issues.

We know, from our own observations and from the stories that we hear, the experience of being homeless can be one of extreme isolation, coupled with sleep deprivation,
exposure to violence, drug and alcohol misuse, which may lead to an increase in anxiety and depression, loss of self esteem and self worth.

More commonly, this group of consumers fall through the gaps often wondering the streets in constant alert where after they find the local housing service, they may find temporary accommodation, but then, due to the nature of their environment, frequently loose their way. At this time they loose their accommodation and the cycle begins again. At times of relapse their temporary accommodation may not feel like a safe place to be, which leads to sleeping in lane ways, under bridges and therefore exposing themselves to more harm. Research tells us that a concerning number of individuals develop mental health problems after becoming homeless.

As a relationship based service with strong links to clinical mental health, EastCare was often the place where consumers would come when they felt vulnerable and in need of care. Responding to clients that are difficult to engage with, or clients that have been “sleeping rough” or who may or may not have been diagnosed with mental illness, or who even if they have been so diagnosed, then not been taking medication, requires a highly skilled and flexible staff team. In this context, providing a predictable environment with familiar faces was a way to secure trust and establish rapport with the most vulnerable and distressed service user.

Not having a service with a “mental health” identity was also a way of ensuring that consumers would feel comfortable and able to come even when they were obviously unwell, frightened and unable to make decisions. This often led to the staff advocating with the clinical mental health team so that support and treatment could be provided to the consumer in the least restrictive, appropriate confronting way. Individuals were known to the service and patterns of relapse could therefore be predicted and early intervention strategies would be utilised in order to circumvent an episode.

In early 2004 The Department of Human Services Eastern Region called for “Trial of Homelessness Front Door” submissions. This was a response to the growing demand on services and the increased complexity of the needs of the homeless population.

EastCare was successful in becoming the “Front Door” for the Inner East. The organization set about providing an integrated service with an accessible continuum of support and accommodation. The “drop in” function of the service was no longer feasible.

The five “Front Doors” in the Eastern Region set about implementing a Common Homelessness Assistance and Referral Tool (CHART), Integrated Data Collection, Electronic Homelessness Bed Vacancy Register and enhanced IT and Data Collection.

The change in the homelessness service system was now set and the pathways established to provide an integrated service response that was client focused, client centered and client driven.

Since 1995 the rooming houses boarding houses and pension level SRS’s have closed down. It is now estimated that there are only 150 available beds in the City of Boroondara compared to the 614 of the mid 90’s.

Despite this major change the Front Door service averages 1000 contacts per month for accommodation options, rent areas, rent in advance or motel accommodation. The Hawthorn Program received 19 new support referrals in the month of July, the most that has been received, in a one month time frame, for 12 months.

In the last twelve months the number of females who are accessing the front door service has jumped to 54%.

This change is service provision has meant that the most at risk and highest priority consumers have access to the available vacancies for that day.

Change has happened over the last ten years on a number of levels. There are still some staff members at EastCare who remember the early days. Most have embraced the changes and moved forward with a positive attitude.

For those of us in management the challenge might be to make room for both approaches so that those most at risk will be attended too with priority, and the most vulnerable will also be attended to with predictability, patience and most of all familiarity.
Chapter 1: Framing the Discussion of Mental Health and Homelessness
Homeless SAAP Clients with a Mental Health Problem

By Lynda Carney
SAAP National Data Collection Agency
Australian Institute of Health and Welfare

About 1,300 SAAP funded agencies throughout Australia support clients who are experiencing homelessness or who are at risk of becoming homeless. They report data to the National Data Collection Agency, which is based at the Australian Institute of Health and Welfare (AIHW).

This article largely draws upon the bulletin Homeless SAAP clients with mental health and substance use problems 2004–05 (AIHW 2007a). Data relating to mental health will mostly be discussed, as will some reasons for underreporting the incidence of mental illness in the SAAP National Data Collection.

Defining a mental health problem for the National Data Collection

There is no single data item in the SAAP National Data Collection that allows for easy identification of clients with mental health issues. A number of criteria were used in the above mentioned bulletin to determine the SAAP mental health population. These included clients who reported psychiatric illness as a reason for seeking assistance, or who were referred from a psychiatric unit. Clients who needed, were provided with, or were referred to psychological or psychiatric services were also included in the mental health group.

Profile of SAAP clients with a mental health problem

In 2004–05, 11,800 SAAP clients (around 12%) reported a mental health problem. Problematic substance use was reported for 19,400 clients (around 19%), and 4,800 (around 5%) of these two groups reported both problems (comorbidity) during the same support period. Neither problem was reported by 83,500 clients.

Clients who identified as being Aboriginal and/or Torres Strait Islander comprised 9% of the mental health group and 10% of the comorbidity group. In the mental health group, the majority of clients were in the ‘other Australian-born people’ category (76%), and 11% were people born overseas in a predominantly non-English speaking country.

Clients in the mental health group most commonly sought support because of psychiatric illness (in 19% of support periods), followed by domestic violence (14%). Children accompanied by a parent or guardian in only 5% of all support periods associated with mental illness.

Type of SAAP agency attended

Clients in the mental health group mostly attended agencies targeted at single men (30%). Cross targeted agencies provided the second highest amount of support (27%), followed by agencies targeted at young people (18%), then those for women escaping domestic violence (16%). Agencies primarily targeting single women provided a higher proportion of support periods in the mental health group (6%) than in the substance use (4%) group or the ‘neither’ group (3%).

Support to SAAP clients

Generally, the support clients with a mental health problem received was comparable to the majority of SAAP clients. However, they were the most likely to have their need for specialist services remain unmet. In 11% of closed support periods, specialist services were neither provided nor referred when requested, compared to 4% of support periods for SAAP clients without a substance use or mental health problem. For the mental health group, the need for psychological services was unmet in 16% of closed support periods,
psychiatric services were unmet in 13%, and requests for drug and alcohol support or intervention services were also unmet in 13% of closed support periods.

**Circumstances before and after SAAP support**

In 19% of closed support periods, clients with a mental health problem had been accommodated in SAAP or other emergency accommodation immediately before their support period, and in 20% of instances they exited to this type of accommodation, seemingly cycling within the SAAP and emergency housing systems to secure accommodation. Others had been living in a rooming house, hostel, hotel or caravan before 9% and after 10% of closed support periods. In 14% of closed support periods, clients with a mental illness were living in private rental accommodation both before and after support, and 11% reported that they had been living in public or community housing. This proportion increased to 17% after support. Around 11% of cases were for clients who had been living in an institutional setting before support, and clients exited to this type of accommodation in 9% of closed support periods. In 11% of closed support periods, mental health clients had been living in a car, tent, street or squat before support. This decreased to 6% after support.

Prior to support, around 71% of SAAP clients with mental health problems were not actively seeking work, compared to around 65% of the rest of the SAAP population. The disability support pension was their main source of income in around 44% of closed support periods, compared to 34% for the substance use group, and 18% for those in the ‘neither’ group. The circumstances of clients with a mental health or a substance use problem were less favourable than those from the ‘neither’ group, but there was one exception — mental health clients were the least likely to present to a SAAP agency with no source of income (6% compared to 9%). Overall, reported outcomes after SAAP support slightly improved for all groups.

**Length of support and accommodation outcomes**

Clients with mental health problems were generally supported for longer than clients without this problem, with a median length of support of 22 days compared to 7 days for clients who experienced neither a mental illness nor substance use issues.

Longer periods of support were associated with more positive housing outcomes for clients with mental health problems.

Clients who stayed less than one week commonly moved on to SAAP or other emergency housing, but their chances of exiting to private rental, or public or community housing significantly increased with time. Around 47% of clients who had support periods of between 26 and 52 weeks in duration moved on to these types of accommodation. Nevertheless, around 16% of clients with a mental health problem moved on to another SAAP agency or emergency housing after this same extended period of support.

Those able to secure ‘independent’ accommodation may still need additional support to prevent them from returning to SAAP accommodation.

When closed support periods were longer than one week, clients with mental health problems were also far less likely to be living rough upon exiting a SAAP agency. Clients who had less than one week’s support were living in a car, tent, street or squat in 12% of cases, with this figure more than halving to 5% for 1–13 weeks of support.

**Changes to the National Data Collection**

A number of changes have been made to the NDC since the 2004–05 bulletin was released. In 2005–06 the SAAP Core Data Set was introduced and the option of ‘mental health issues’ as a reason for seeking assistance was added to the client form. The collection was also updated to specify whether the client had been living in a psychiatric institution, rather than having come from or exiting to a hospital/psychiatric institution, as was the option in the previous collection. This should allow more specific reporting of mental health in SAAP.

The bulletin reports on SAAP clients (adults or unaccompanied children) but does not include data on accompanying children with mental health problems. The SAAP National Data Collection does not include specific information on mental health issues for accompanying children. For accompanying children, SAAP agencies report on help with behavioural problems, sexual/physical abuse counselling/support, health/medical services, and general counselling and support.

**Why is mental illness underreported in the SAAP National Data Collection?**

A figure of 12% is certainly far less than other estimates of mental illness in the homeless population. For example, a literature review conducted in 2005 concluded ‘that between one quarter and one half of adult homeless persons across western cities are experiencing severe and perhaps chronic mental illness’ (St Vincent’s Mental Health Service & Craze Lateral Solutions 2006).

There are a number of reasons for mental health issues being under reported in the National Data Collection. Firstly, the presenting reasons for seeking assistance are to be recorded from the client’s own perspective, and a mentally ill client might not acknowledge that they have
an illness, or may even seek to conceal it because of the associated social stigma. Secondly, their mental illness may not be the most pressing issue at the time, with only 2% of SAAP clients citing psychiatric illness as their main reason for seeking assistance in 2004–05 (AIHW 2006). The National Data Collection definition states that the presenting reason for seeking assistance question is ‘intended to focus on the reasons the client initially presented to your agency as opposed to the underlying reasons or causes that may have built up over a lifetime’ (AIHW 2005).

Mental health problems can also be identified when requesting specialist services, but many clients do not stay long enough to have their needs fully assessed, or to receive support from mental health services. For example, 37% of the group most likely to have mental health problems, single men aged 25 and over, had closed support periods of 1 day or less (AIHW 2006).

People with mental health problems may also experience difficulty in accessing a SAAP agency. A 2001–02 inquiry by the NSW Ombudsman into improving access to SAAP agencies in NSW reported that over half of ‘the 125 agencies surveyed had eligibility policies that allowed for exclusion on the basis of mental illness’, and documented ‘290 instances where people with a mental illness were denied access to 50 agencies’ (NSW Ombudsman 2004). They cited several reasons, assuming that clients would require extra support, have challenging behaviours, and were concerned that agencies would have difficulty accessing mental health services. If a significant proportion of SAAP agencies do not have the capacity to support clients with a mental illness, and some SAAP clients are reluctant to report a mental health problem, or the support period is too short for them to have their needs recognised, then the SAAP National Data Collection is very likely to significantly underestimate the number of homeless people with mental health problems.

Conclusion
It would seem the most pressing issues for homeless people with mental health problems are the need for access to mental health services, and their continued high dependence on SAAP or emergency accommodation. More extensive reporting of mental illness in the National Data Collection could assist SAAP agencies and their clients by providing better evidence for the need for support by mental health services.

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Mental Health Outcomes Among Clients of Homelessness Programs

By Paul Flatau
Murdoch University

Introduction

The World Health Organisation (WHO) defines health ‘as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’ Translating the thinking behind this definition into the mental health area, mental health is a state of mental and social well-being not simply the occurrence (or absence) of mental health conditions/disorders/illnesses.

The examination of mental health outcomes among homeless people should ideally cover both dimensions. This is the key aim of the present paper, which provides evidence from a Western Australian study of homeless program clients on both the prevalence of mental health conditions and outcomes from the WHO Quality of Life-BREF (Australian version) instrument (see Flatau et al. 2007 for further details).

The homeless programs covered in the study are:

• The Supported Accommodation Assistance Program (SAAP),
• the Supported Housing Assistance Program (SHAP) whose primary goal is to provide tenant support services to those in public housing at risk of eviction and the Private Rental Support and Advocacy Program (PRSAP) program, which does likewise in terms of the private rental market; and,
• transitional support programs for prisoners exiting jail; namely the Transitional Accommodation and Support Service (TASS) and the Community Re-entry Coordination Support Services (Re-entry Link) programs.

Data on the prevalence of mental health conditions and quality of life outcomes comes from the study’s Client Survey. The Client Survey elicits information from adult homelessness program clients (those over 18) on their background, homelessness histories, needs and outcomes. The Client Survey went into the field in May 2006 in Perth and the south-west regions of WA and was administered at 31 services; 18 in the SAAP sector (8 single women and domestic and domestic violence services and 11 single men, families and other services) and 13 in the non-SAAP homelessness prevention service sector. An existing homelessness research project directed at the SAAP youth sector prevented coverage of this sector.

Table 1 provides evidence of the prevalence of mental and physical health conditions among clients of the various programs. The Client Survey asked a series of questions about the client’s mental and physical health. The question regarding mental health was: ‘Does the client currently experience a mental health condition?’ (The Client Survey was completed by members of the research team or by agency caseworkers on the basis of direct responses by clients to relevant questions, case notes and entry assessments.)

The following mental health condition options were presented as options on the survey form:

• Depression (or other depressive disorders),
• bipolar disorders,
• schizophrenia (or other psychotic disorders),
• anxiety disorders (including post-traumatic stress disorders),
• other condition(s), please specify, and
• yes, but no specific diagnosis is available please specify.

The list is open-ended in scope. However, it does not explicitly include drug and alcohol use disorders. A separate question was included on this issue in the Client Survey. The results on the prevalence of mental health conditions should therefore be read as exclusive of such disorders.

Across all program categories, a very high proportion of study participants reported a mental health condition. Around 44 per cent of respondents reported a mental health condition. This rate is many times higher than in the general Australian population. In the 2004–05 ABS National Health Survey, 11 per cent of Australians reported a long-term mental or behavioural problem. In the 1997 National Survey of Mental Health and Wellbeing of Adults, where diagnostic criteria were used to assess mental health conditions in a survey environment, 18 per cent of respondents were assessed as
experiencing a mental health disorder at some time during the twelve months prior to the survey (Australian Bureau of Statistics 2006). However, these national estimates are not directly comparable to those from the Client Survey as alcohol and drug use disorders, following international mental health classification frameworks, as mental health conditions.

The estimates of the prevalence of mental health conditions provided in this study also differ from those in a recent study by the Australian Institute of Health and Welfare (AIHW) of the prevalence of mental health conditions among Supported Accommodation Assistance Program (SAAP) clients (see AIHW 2007). The AIHW study uses the SAAP National Data Collection (NDC) where the occurrence of a mental health condition can only be determined from referral, reason for seeking support and needs/support services information. Using this criteria, around 12 per cent of the SAAP client population ‘reported’ a mental health condition, while 19 per cent ‘reported’ a substance use problem. The relatively low reported incidence of mental health conditions in the SAAP NDC almost certainly reflects the fact that information on mental health conditions in the SAAP data is indirect in nature based on referral, needs and support information; no direct questions are included on whether or not a client experiences a mental health condition.

SAAP-DV and Single Women services sector study participants, exhibit the highest reported incidence of mental health conditions with 60.5 per cent of respondents currently experiencing a mental health condition. Half of all SHAP and PRSAP clients also report experiencing a mental health condition. The lowest reported incidence of mental health conditions was in the SAAP-Single Men services sector, where 29.2 per cent of clients report that they experience a mental health condition.

Depression represents the most common mental health condition experienced by client respondents reporting a mental health condition with 67.1 per cent of those with mental health conditions reporting that they experience this condition. Anxiety disorders (including post-traumatic stress disorder) also represent a major mental health condition particularly in the SAAP-DV and Single Women services category where 47.8 per cent of client respondents report experiencing an anxiety

Table 1 Mental and Physical Health Conditions and Concerns of Alcohol and Drug Use, Wave 1 Client Survey 2006 (per cent)

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<thead>
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<th>SAAP-DV and Single Women</th>
<th>SAAP-Single Men</th>
<th>SAAP-Families &amp; General</th>
<th>SHAP</th>
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<td>- Bipolar disorders</td>
<td>30.4</td>
<td>14.3</td>
<td>0.0</td>
<td>0.0</td>
<td>4.8</td>
<td>0.0</td>
<td>13.2</td>
</tr>
<tr>
<td>- Schizophrenia (or other psychotic disorders)</td>
<td>8.7</td>
<td>14.3</td>
<td>0.0</td>
<td>12.5</td>
<td>9.5</td>
<td>25.0</td>
<td>10.5</td>
</tr>
<tr>
<td>- Anxiety disorders (including post-traumatic stress disorder)</td>
<td>47.8</td>
<td>21.4</td>
<td>50.0</td>
<td>37.5</td>
<td>23.8</td>
<td>0.0</td>
<td>32.9</td>
</tr>
<tr>
<td>- Other conditions</td>
<td>17.4</td>
<td>28.6</td>
<td>0.0</td>
<td>0.0</td>
<td>4.8</td>
<td>25.0</td>
<td>13.2</td>
</tr>
<tr>
<td>Medication and support services (n=74)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Taking medication</td>
<td>69.6</td>
<td>71.4</td>
<td>60.0</td>
<td>85.7</td>
<td>71.4</td>
<td>25.0</td>
<td>68.9</td>
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<tr>
<td>- Receiving support from a mental health service or specialist</td>
<td>47.8</td>
<td>35.7</td>
<td>83.3</td>
<td>50.0</td>
<td>28.6</td>
<td>25.0</td>
<td>42.1</td>
</tr>
<tr>
<td>Long-term physical health condition (n=173)</td>
<td>36.8</td>
<td>31.3</td>
<td>31.6</td>
<td>37.5</td>
<td>25.6</td>
<td>23.1</td>
<td>31.2</td>
</tr>
<tr>
<td>Client expresses concerns about their alcohol/drug use (n=169)</td>
<td>21.6</td>
<td>22.9</td>
<td>10.5</td>
<td>12.5</td>
<td>15.8</td>
<td>54.5</td>
<td>20.7</td>
</tr>
<tr>
<td>Client experiences more than one of: mental health condition, physical health condition, disability and client concerns over alcohol and drug use (n=169)</td>
<td>42.1</td>
<td>31.6</td>
<td>31.6</td>
<td>43.8</td>
<td>35.9</td>
<td>23.1</td>
<td>35.2</td>
</tr>
</tbody>
</table>

Notes: (a) The count of survey respondents who provided non-missing responses to a given item is given by ‘n’.
condition. Of those experiencing a mental health condition, a relatively high proportion, 68.9 per cent, are currently taking medication for their condition, while 42.1 per cent receive support from a mental health service or specialist.

In addition to mental health conditions, the client surveys addressed two further health needs: the prevalence of long-term physical health conditions (examples given in the relevant question include cancer, diabetes, deafness, heart attack) and client concerns of alcohol/drug use.

• Close to a third of all respondents to the Client Survey (3.1.2 per cent) experience a long-term physical health condition with prevalence rates not differing significantly between the various program categories. In a separate study of community centre clients (the Community Centre Survey), 63 per cent of respondents, many of whom are living on the streets, experience a long-term physical health condition.

• Around a fifth of all respondents to the Client Survey (20.7 per cent) expressed concerns about their own alcohol and drug use with the highest rates being evident for TASS and Re-entry Link clients. Fifty four per cent of these clients reported concern about their own alcohol and drug use. Again a higher proportion of the Community Centre Survey’s respondents expressed concerns about their own alcohol and drug use.

• Across all program categories, 35.2 per cent of respondents report more than one of the following: a mental health condition, a long-term physical health condition and client concern over alcohol and drug use. Dual diagnosis is highest for those in the SAAP-DV and Single Women service sector (42.1 per cent of respondents) and the SHAP category of respondents (43.8 per cent).

The second method used in the Client Survey to quantify the level of client needs with respect to mental health conditions was based on a considerably modified version of the Thomson Goodall needs assessment form (Thomson Goodall Associates Pty Ltd 2003). One of the specified needs was mental health issues. Around a fifth of all clients were assessed by caseworkers as requiring intensive and/or ongoing support with mental health issues.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>World Health Organisation Quality of Life (BREF Australian Version), Mean and Median Scores, Wave 1 Client Survey 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall quality of life: How would you rate your quality of life? 1 (very poor) – 5 (very good) (n=145)</td>
<td>Mean 3.4 3.5 3.4 3.3 3.6 2.8 3.4 4.3</td>
</tr>
<tr>
<td>Health satisfaction: How satisfied are you with your health? 1 (very dissatisfied) – 5 (very satisfied) (n=146)</td>
<td>Mean 3.4 3.4 3.4 3.0 3.2 3.3 3.3 3.6</td>
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<tr>
<td>Physical (n=147)</td>
<td>Mean 58.8 67.1 59.7 54.9 61.8 53.9 60.9 80.0</td>
</tr>
<tr>
<td>Psychological (n=147)</td>
<td>Mean 54.8 65.5 50.7 50.0 59.1 54.2 57.5 72.6</td>
</tr>
<tr>
<td>Social relationship (n=142)</td>
<td>Mean 42.7 53.5 56.9 45.6 56.3 39.6 50.0 72.2</td>
</tr>
<tr>
<td>Environment (n=147)</td>
<td>Mean 59.1 60.2 58.1 50.2 58.9 45.8 57.2 74.8</td>
</tr>
</tbody>
</table>

Notes: (a) The count of survey respondents who provided non-missing responses to a given item is given by ‘n’.
The issue of the quality of life outcomes of clients was addressed in the Client Survey using the WHOQoL-BREF (Australian version) instrument. Results are reported in Table 2.

The WHOQoL-BREF (Australian version) comprises two overall quality of life items relating to overall quality of life and health satisfaction and a 24 item instrument. Outcomes from these 24 questions are summarised into four broad domains:

- **Physical**: physical pain, need for medical treatment to function in daily life, energy for every day life, ability to get around physically, sleep, ability to perform daily living activities and capacity for work.
- **Psychological**: enjoyment of life, the extent to which life is seen to be meaningful, the ability to concentrate, acceptance of bodily appearance, satisfaction with one’s self and frequency of negative feelings such as blue mood, despair, anxiety, depression.
- **Social Relationship**: personal relationships, sexual activity and social support.
- **Environment**: based on questions on feelings of safety in daily life, how healthy the respondent’s physical environment is, whether the respondent has enough money to meet needs, availability of relevant information, opportunity for leisure activities, conditions of the respondent’s living place, access to health services and satisfaction with transport options.

The WHOQoL-BREF (Australian version) scores for Client Survey respondents fall generally around 20 per cent below those reported for an Australian norm-based study. It is important to recognise that quality of life readings are being made after clients have received initial support from the program; quality of life outcomes prior to support being provided are likely to be lower. On the basis of other questions in the Client Survey, clients report that the provision of support has had a significant positive effect on their lives. The mean quality of life outcome for homelessness program respondents is 3.4 (out of a possible 5) as compared with 4.3 for the Australian norm group. A much closer fit between the two groups is evident with respect to the question on overall health satisfaction where the Client Survey outcome (3.3) is only 8.3 per cent below the Australian norm outcome of 3.6.

Mean Physical, Psychological and Environmental domain scores for the Client Survey group of respondents lie between 20 and 25 per cent below the Australian norm results. The deficit between the Client Survey outcomes and those for the Australian norm study is greater for the Social Relationship domain where the gap widens to around 30 per cent, suggesting a high level of disconnectedness from others experienced by homelessness program clients.

The results reported in this study indicate that the prevalence of mental health conditions in the homelessness program client population is much higher than that of the Australian community. Many clients of these programs also experience long-term physical health problems and/or substance use problems and exhibit low psychological and social relationship outcomes. The high incidence of mental health conditions suggest that SAAP and other agencies providing support to homeless people or those at risk of homelessness need to be appropriately trained and adequately resourced to meet the needs of their clients and that strong linkages to community-based mental health support networks and clinical supports are developed and maintained. Importantly, the study shows that the prevalence of mental health conditions is not restricted to SAAP sector but is also a feature of the homelessness prevention programs.

**Footnotes**

1. The research on which this paper was based, was produced with an AHURI research grant funded by the Australian Government, the Australian States and Territories and AHURI participating Universities.
3. The Australian norm results are drawn from a Victorian-based study of randomly selected community members weighted by socio-economic status to achieve representativeness of the Australian population (n = 396) (see Melbourne WHOQoL Field Study Centre 2000 p. 24).

**References**


Thomson Goodall Associates Pty Ltd (2003), People who are Assisted by SAAP Services and Require a High Level and Complexity of Service Provision. An Enhanced Assessment and Measurement Framework, Report to the Australian Government Department of Family and Community Services Supported Accommodation Assistance Program, PACSIA, Canberra.
Homelessness in Britain has some significant variances both within the country itself and in comparison with Australia.

The most striking difference is that homelessness strategies are developed and funded by local authorities, which means that in a city like London you can be provided with one type of service on this side of the street and be treated completely differently on the other. I assure you that this does in fact happen. As a consequence, one of the favoured homeless strategies is diversion. This is based on the spurious notion of local connection, which means that if you’re last place of abode was in the borough of Camden (this counts even if you were sleeping rough there) and you slip over the border into the City of Westminster, you will be diverted back to Camden rather than being offered a service.

Similarly, although mental health has increasingly become a major public issue it is still approached in an extremely piecemeal fashion due to the differences between the priorities and resources of local authorities. For homeless people the system is unnecessarily complex with most of the responsibility falling on their shoulders. The sense that if you are homeless and suffer from mental health difficulties is basically your own fault, seems to have greater currency here than I remember was the case in the land of Oz. Although, like the memory of perfect weather, this may be a myth brought on by extended absence.

The first British homeless agency I visited on my study tour in 2001 was The Passage in London. The Passage operates the largest day centre for homeless people in Europe with anywhere between 200 and 300 individuals accessing services daily. What struck me on my first visit was the similarity between the group of (mainly) men using the day centre and the men seeking assistance at The Matthew Talbot in Sydney. The clothes and baggage and general demeanour were the same. Since then I’ve returned on a number of occasions to The Passage and have, in fact, been employed by the organisation to help them re-develop the services they are offering. Part of this work has been to constantly review those participating in the services so as to respond more effectively to any emerging needs.

So who comes to The Passage? As I found with my work in Sydney the age group of the homeless population has steadily decreased over the past 15 to 20 years. The average age at The Passage is early to mid thirties. Very few of the older men or women who used to constitute the streets homeless population are still around, either they have died or they have been successful in obtaining accommodation from the ever-diminishing supply of social housing. It’s worth noting that The Passage has recently discontinued a project aimed at working with those over 55 because there weren’t enough people who needed the service.

Another point of similarity is the fact that only 10 per cent of those coming to The Passage are women. This is because those sleeping rough in London overwhelmingly tend to be men and, as a result of this, their presence dominates the service. In turn this may act as a disincentive for women who may not be actually on the street but living in poor quality and inappropriate accommodation. A group of workers at The Passage are currently examining this phenomenon to see if a greater balance can be achieved.

One of the projects I drew most satisfaction from in my years of work in Australia was convening the steering committee that oversaw the production of Down and Out in Sydney. This well respected and groundbreaking report gave clear evidence that 75 per cent of those using inner city Sydney homeless services either had or had experienced a significant mental
health problem. Those of you familiar with the findings of
that research would also remember the startling percentage
of those interviewed who had suffered from trauma.
Ninety-three per cent had experienced a serious traumatic
event usually involving violence of one kind or another.

Whilst there have been some in-depth studies of mental
health and homelessness in Britain none has been as detailed
as Down and Out in Sydney. As a consequence, and as a
result of my own observations, I doubt the current London
estimates of the percentage of street homeless who have
mental health difficulties. Generally the figure of 35 per
cent is given, but this seems low in the same way that the
notorious street counts that are conducted to ascertain the
numbers sleeping rough in Britain, seem to be artificially low.

The services provided to homeless people experiencing
mental health problems vary considerably. While they
are not completely inadequate, neither could they be
described as comprehensive. Somewhat like the situation,
as I remember it, in Sydney. Too often, appropriate and
timely support fail to materialise. Community mental
health teams are run off their feet and can only attend
in the direst emergencies. Personality disorder? Let's
leave that over here shall we in the too hard dustbin.

Despite a variety of systemic problems like the
aforementioned drying up of social housing, there are some
very good, on the ground projects aimed at those with
mental health problems. The Passage, for example, has been
running an excellent dual diagnosis program bringing together
a range of individual and group activities and therapies but,
wouldn’t you know it, the funding has run out and nobody,
especially not the National Health Service (NHS) seem to
be prioritising funding in this incredibly important area.

Another service that works with The Passage provides
much needed counselling particularly to those experiencing
depression. As is clearly obvious to anyone who has
worked with homeless people, depression and anxiety are
epidemic. And why wouldn’t they be depressed or anxious
given the daily circumstances a homeless person has to
face. This, on top of the often-traumatic events that led to
their homelessness, makes it surprising that more homeless
people don’t choose to give the game away completely.

Counselling, or providing opportunities for people to
have positive and friendly engagement, can do wonders
for anyone’s mental health. Yet it has traditionally, in
Britain at least, been a low priority for homeless services
and the treatment of mental health problems.

Increasingly in my work with homeless people in Britain,
I believe it is this positive and personal engagement

coupled with stimulating and challenging activities that can
do the most to improve a person’s chance of surviving
homelessness and building a new life in an often hostile
environment. I think this is particularly true if mental health
problems are part of the story. To many, this may sound
overly simplistic, but it’s amazing how often this basic,
warm and welcoming engagement can work. Depression
and anxiety, loneliness and lack of confidence need to be
addressed much more effectively than they are currently
being addressed if homelessness is to be eradicated.

Footnote

1. I shouldn’t refer to Britain as one country because it is clearly at least four
countries and probably more depending on where and how you set the
boundaries. I live in Scotland so should no better than to make this mistake.
2. Colin Robinson is a social research consultant and writer based in Edinburgh, Scotland.
He is the author of over 40 reports on social issues in Australia including several well
received and influential social justice statements on behalf of the St Vincent de Paul Society.

By Dr Hellene Gronda
Project Worker, Australian Housing and Urban Research Institute (AHURI)

Case management has been central to homelessness assistance practice in Australia since the early 1990s, when it was adopted as a key strategy to enhance the Supported Accommodation Assistance Program (SAAP). The approach was formally documented in 1997 with the release of the SAAP Case Management Resource Kit.¹

A decade later it is certain that case management ideas and practice have changed, along with the broader social context, so a new research project sets out to identify and disseminate the available evidence on case management for the homelessness sector.

The project, Evidence-Informed Case Management Practice for Homeless Persons Agencies, will provide independent, contemporary and grounded insights from sources including academic research, practitioner interviews and workshops, and agency research and practice literature.

This Victorian project is independently funded through the Helen Macpherson Smith Trust and auspiced by Hanover Welfare Services and AHURI Ltd. It has an Advisory Group of service providers, and a focus on collaborative involvement of the practitioner community. The Brotherhood of St Laurence, St Vincent De Paul, and the Council to Homeless Persons Victoria assisted in the development of the project.

The first part of the project will synthesise existing research evidence about case management practice from the homelessness and allied human service sectors. It will analyse the evidence about what works: why, when, in what circumstances, and for whom.

The second part of the project will develop and test practice-relevant, accessible research outputs and knowledge transfer processes. It will ask: in what form will this information about case management be most useful to workers? The project will provide practitioners with evidence-based strategies to enhance outcomes for clients, and tools to reflect on their own practice.

From a policy and advocacy perspective, a better understanding of the role of case management practice and the required staff skills will be invaluable for contributing to the development of a stronger, sustainable and more effective response to the needs of people experiencing homelessness in our society.

Project timelines: Practitioner Workshops to test the research outputs will be held in May–June 2008. The final report and materials will be completed by September 2008.

For further information, please contact the project worker, Dr Hellene Gronda, Hellene.Gronda@ahuri.edu.au

Footnote
1. FACSIA is currently reviewing the Kit.
Chapter 2: Policy Settings
Towards Inter-Sectoral Support Models in Mental Health

By James Wilson
Executive Officer
Network for Carers, Victoria*

We have recently seen a peak in the attention policy makers have given to planning for mental health services. This is related to:

- The recent Council of Australian Government National Action Plan (COAG NAP) with spending of $1.9 billion, and
- the 2007 Senate Inquiry into Mental Health Services in Australia (the 2007 Senate Inquiry), into, among other things, alignment of this spending with the 3rd National Mental Health Strategy.

The 2006 Senate Report entitled A national approach to mental health — from crisis to community (the crisis to community report) makes it clear that we know how to improve the responsiveness of the mental health system.

This article focuses on the level of alignment and coherence within all of these policy and funding instruments. I argue that the prevalence of homelessness among people with mental health issues is evidence of a failure, a disconnection between what is identified as the desired outcomes in policy frameworks and what actually happens. I argue there is a failure to implement desired outcomes, because doing so would require changes in both thinking and doing.

Reform is not achieved by doing the same thing. It is more about changing the way we think. We seem to have the questions and the answers. However, we don’t fund in response to this knowledge. The level of homelessness among mental health consumers is a key part of the evidence for this proposition.

Some Vision, but Little Action: How Policy Formation has Responded to the Issue of Homelessness in Mental Health

The crisis to community report and the range of submissions to the Senate Select Committee’s Inquiry into Mental Health (the 2005 Senate Inquiry) make it clear that we can identify the structural causes of homelessness among people who have mental health issues.

In 1993, Brian Burdekin in his landmark report on human rights and mental health services stated that:

“The absence of suitable supported accommodation is the single biggest obstacle to recovery and effective rehabilitation.”

This HREOC report was in the context of the human rights of people with a mental illness. If we take the view that a basic human right is wellbeing, providing support can be seen as a crucial human rights response.

The move from a “bed and buildings” approach to mental health, to a model where we focus on recovery and rehabilitation, with the required provision of support, has been a policy driver throughout the 15-year conversation that informed the three plans under the National Mental Health Strategy.

The move to community-based clinical treatment models, which have the (human rights) benefit of actually allowing people to live and recover in their own community, has been the basic concept behind the reform of the mental health sector. In fact, the majority of spending on total mental health services is for services based on this model.

In brief, the move has been from a restrictive environment to an environment that offers the best chance of recovery.

But somewhere between the idea of community based treatment and its connection to supports for recovery and the actual funding of those supports to maximise the effectiveness of community-based treatment, the funders have lost the will to act.

A key support is accommodation. The evidence suggests that 30–80 per cent of homeless community members have a “mental disorder”.

We have seen a variety of state-based innovative models that seek to address the issue of accommodation support including the Housing and Support Initiatives (HASI) in NSW and the Project 300 program in Queensland.
We also know that models of support based on whole-of-government approaches and continuum of care models are a key part of the National Mental Health Strategy Plan.\(^9\)

So if we know all this, why are we not implementing support in a coherent way? If we look at the Council of Australian Governments National Action Plan on Mental Health 2006–2011 (the COAG NAP)\(^1\) we see that accommodation is identified as a required support.\(^1\) It is even referred to in the title of one of the expenditure headings as a key issue in relation to community participation.\(^1\)

But the question is: Where are the actual outcomes we can predict? The COAG NAP focuses on support in a number of programs and appears to align with the matters covered under the crisis to community report and to the aims of the National Mental Health Strategy.

A closer look shows that most of the programs under COAG NAP either respond to the needs of the “severely ill” (a narrow focus) or they are designed to respond to “barriers” to participation. It is difficult to see how this “support” translates into outcomes by giving “access” to services, which in practical terms does not exist, for example, an adequate supply of supported and/or affordable accommodation.

These programs will spend a lot of money to try to link consumers to systems, which themselves have little capacity and are poorly resourced. Part of the answer to this apparent failure of program design is the functional split as to who (Commonwealth or State) provides service systems like mental health and housing (and the implicit aim of each to avoid providing a service they claim the other is supposed to).

But another part of this is an apparent incoherence about what constitutes an outcome that underlies the COAG NAP. A concrete example is stating that the reduction of homelessness among the mentally ill is a “Progress Measure”\(^1\) of the “outcomes” of the NAP. But this related outcome refers to “increasing the ability of people with a mental illness...an increase in access to stable accommodation”. Access to what accommodation?

In practice, increasing accommodation is ignored in preference to focussing on assistance to better “access” to accommodation. So we have a level of incoherence that is difficult to penetrate or analyse.

**Why Intersectoral Approaches Are Not Taken Up**

The funding barriers are identifiable but difficult to change. The overall issue is history. The mental health sector has been driven, for much of its history, by the medical model. This idea that the problem is essentially a medical one, and therefore the solution is also a medical one, has now been supplanted in mental health discourse by a more holistic view where the consumer’s life, health and relationships are fully considered. But the echo of that earlier culture is reified in the very conversations we have about what we can know and do about mental health issues.

No one is suggesting clinical treatment is not a crucial element in response to mental health issues. However, the continued dominance of the medical model raises a basic question; can we just know health information, or can we know the social and personal dynamics within which consumers live, and respond to them? This includes the relationship between consumers and carers.

The empirical evidence about outcomes for consumers gives us a very detailed picture. Mental health consumers live their lives within a complex of social, medical, economic and even legal issues.\(^6\) Support adds to the effectiveness of clinical treatment in achieving maximum possible reduction in relapse and acute illness and the consequent misery for consumers and carers. One of those most common miseries is homelessness, because illness can mean breakdown, which can mean tenancy and accommodation failure. We know that for many homeless people, a failure to achieve good mental health recovery outcomes is the primary cause of their homelessness.

There is a strong discourse that describes support as a key element in managing mental illness.\(^7\) We need to move provision of support from the periphery to the centre of treatment and recovery models and the programs that revolve around them.

**A Victorian Example: How the Elements of the System Might Fit Together to Achieve Better Outcomes**

Victoria has a mental health budget of around $800 million per annum, with a two-part service system made up of the clinical (including community-based treatment) and the Psychiatric Disability Rehabilitation and Support Services (PDRSS) sectors.

In terms of the clinical sector at least, we have a basic service system philosophy articulated that includes a move to the least restrictive treatment environments. The service system is based on a commitment to (operational) principles including:

- Continuity of care,
- care in the community,
- early intervention, and
- consumer and carer participation and support.\(^18\)

In terms of PDRSS basic principles, there is commitment to
assist consumers to “actively participate in daily life, in personal and social interactions and in community life and activities”.19 This would require that the consumer not be homeless.

So we have good base of ideas from which to work. The question in Victoria is why haven’t we put them together in an integrated service system? One that recognises many consumers have a range needs met. These should be met in coordinated way.

Victoria has developed some effective and innovative models aimed as this integration.20 But as a whole, the parts of the system still don’t quite fit together to meet the needs of consumers. And given that Victoria is arguably the most likely state for this to happen given its investment in infrastructure that can support innovation, this is a grim picture Australia-wide.

We have the elements of an integrated treatment and support system, so why not fulfil our commitment to achieving the outcomes that reduce the impact of illness on consumers and carers?

Victoria goes somewhat against the trend in its COAG NAP response by actually investing in accommodation options via its support for one form of supported accommodation, Supported Residential Services.21 But much focus is still on “access” to accommodation by housing “pathways”. This is only good if accommodation actually exists.

Conclusions

In Victoria, the general policy structures move from service “silos” to “whole of government” approaches, raising the hope of outcomes for an integrated social service planning approach. However, we still need to find the will to do it.

Australia-wide, the 2005 Senate inquiry and the crisis to community report gives us the national approach, capturing and actioning the learning for the National Mental Health strategies.

We have to move the mental health sector away from the outcome inertia in which we appear to be stuck. The answer is not to just do the same things but more of them. The answer is to accept the challenge of achieving those outcomes we have said over and over again, are necessary. How can the failure to do this be acceptable when mental health consumers are dying?

* James Wilson has been community lawyer, homelessness and housing worker, manager and a director of policy development. He is currently Executive Officer of the Network for Carers of people with a mental illness, the peak body for mental health carers in Victoria.

Footnotes

1. The definitional issues around mental illness and broader “scope” issues for policy frameworks are complex issue, see for instance page 5 NMH Strategy 2003–8 Plan, Commonwealth of Australia 2003
2. Perhaps the most effectively structured and cogently argued is the 2005 Submission
A Unique Partnership Approach to Achieve a Cohesive Mental Health — Homelessness Service System

By Susan Curmi
Program Manager
Norwood Association Inc.

Research over the last few years has pointed to the clear connection between mental health and homelessness. Research data has shown that up to 50 per cent of people who are homeless have a mental illness. There is significant discussion whether having a mental illness is a factor in the cause of homelessness, or rather that homelessness itself is the contributing factor to the development of a mental illness.

In 2001–2002, two per cent of clients accessing public mental health services were recorded as having no usual residence and a further eight per cent were in unstable accommodation. However, the actual number is expected to be significantly higher than this as there are a number of people who are homeless as well as having a mental illness who do not engage with mental health services and will not actively seek assistance.

Housing is fundamental to living successfully in the community. For people experiencing the effects of long-term mental illness, appropriate housing can mean the difference between health and mental health deterioration. In general, people with mental illness have a history of difficulties accessing appropriate housing. This may be in part due to mental health and housing services not working in partnership to share their resources and utilise knowledge, skills and competencies to more effectively meet the needs of this complex client group.

If only one of these needs is met, the chances of maintaining appropriate housing and having stable mental health are not likely. For example, if a person’s mental health is being treated and is now stable, but their housing is inappropriate, their mental health will quickly deteriorate again. The situation is the same if housing is stable but the person has mental health issues, which if left untreated, could very quickly result in housing issues and the client to be at risk of homelessness. Once mental health and housing are stable, PDRSS services can provide ongoing support in consultation with other specialist services involved with the client to ensure the development of independent living skills are gained to maintain this optimum level of living.

A number of Government initiatives along with greater resources and specific service responses have been implemented in recent years, directed towards mental health and homelessness. Early in the year, the mid-west catchment area was successful in tendering for some of these additional resources to provide a specific service response, the Pathways Program, and has gone about attempting to address some of the issues identified above with a very unique partnership approach, setting it far apart from other models.

The Pathways Program is supported by nine collaborating agencies and DHS; with Norwood Association the lead agency. This unique partnership is between psychiatric disability rehabilitation and support services (PDRSS), clinical mental health, housing, homelessness and employment service sectors to achieve a cohesive mental health — homelessness service system in the catchment area of Brimbank, Melton and Sunbury. Additional to Norwood Association, the partnership agencies include Western Region Health Centre, North West Mental Health — Mid West Area Mental Health Service, Melbourne Citymission Western, Melton Shire Housing Service, Wombat Housing and Support Service, Salvation Army Social Housing and Support — Western Network, Royal District Nursing Service — Homeless Persons Program and Distinctive Options. Department of Human Services has also provided their support and direction for the partnership group.

The partnership has two broad overarching aims:
1. To work cooperatively to achieve a responsive local service model, which aims to reduce the risk of re-occurring homelessness in the mental health population by breaking the cycle of crises and homelessness (by working actively to achieve localised housing and support options within the Brimbank–Melton catchments) and improve quality of life and community integration for consumers.
2. To build on established partnership arrangements
to develop coordinated pathways, joint interagency protocols and augment system integration between homeless assistance, housing, mental health, employment and other relevant services, such as alcohol and other drug services and family and children services.

To provide a summary of the program, the Links Homeless Pathways Program (LHPP) is a service response to consumers within the Brimbank and Melton communities, which provides pathways for people experiencing mental illness, primary and secondary homelessness and/or who are at risk of homelessness, into stable and appropriate accommodation. The model incorporates an early engagement or ‘in-reach’ approach with the Acute Mental Health Services located at Sunshine Hospital and associated programs within the Mid-West Area Mental Health Services; as well as an assertive ‘outreach’ to locate and support people who are homeless within the community.

The LHPP has been formed by integrating two programs (one existing and one new) administered by Norwood. The existing program is the Links Homeless Outreach Program — funded by DHS — Mental Health Branch. The program has been operational since 2004 and provides an intensive outreach service to assist people who have a mental illness, complex needs and who are homeless or are at risk of homelessness to stabilise their accommodation and improve their health and wellbeing. The new program is the Mental Health Pathways Program — a new innovative partnership program funded by DHS — Housing. This program provides a specific response to people with mental illness who have been admitted to an acute care facility and require specialised assistance and planning to facilitate discharge and create a pathway from homelessness to secure long term housing and support.

Whilst in theory, this unique partnership approach will prove to be most beneficial to consumers in the mid-west region, having each of the various partnership agencies sit at the one table has bought into light a number of challenges. The most significant being the limited knowledge of each sector has of the others — at times it appears we are speaking different languages. The workforce will also have a greater understanding of how agencies operate and the resource constraints imposed on each of the agencies, and allows the agencies to work in a more collaborative and problem-solving manner for better outcomes for each of their shared consumers.

The combined resources of the PDRSS’ clinical mental health, housing, homeless and employment agencies, a holistic approach, as well as integrated and coordinated assessment and care planning processes will make possible effective and sustainable outcomes for the target clients. Assessment and care planning processes incorporate clinical assessment, risk assessment, relationship mapping, housing needs, support needs, exit planning and review agreements, which also reflect the goals and aspirations of the client.

The diverse knowledge and specialties with the different services working together will ensure that consumers will get
the most accurate information, assistance and direction to assist them with their goals and will benefit from the smooth transition between the partnership agencies as their needs and requirements change. For example, a consumer may initially start with clinical services to address mental health issues, then need to be linked in with housing services and PDRSS to find housing and develop independent living skills. They may eventually becoming work-ready and need to be linked in with employment services.

It is also envisioned that via the program, consumers will have improved their mental health situation, have reduced re-admissions into in-patient services and will be linked to services to address ongoing health and wellbeing issues. It is also hoped that consumers will have an improved quality of life and will have access to sustainable, safe, appropriate and affordable housing.

To conclude, this unique partnership approach for the Links Homeless Pathways Program provides an exciting opportunity for the mid-west region in providing an integrated and cohesive mental health-homelessness service system. It is based on a holistic and coordinated approach which will maximise the chances of achieving positive and sustainable outcomes for consumers. I look forward to being involved in and observing the program and partnership evolve, and report on the learnings, challenges, successes and outcomes in the near future.
Let’s Start Again: Recognising the Complex Relationship Between Mental Health and Homelessness

By Simon Smith
Policy and Research Manager
Homelessness Australia

Much of the way we think about the relationship between homelessness and mental health is still captured by preconceived ideas, often ones we don’t realise that we have. If we are going to better respond to the mental health needs of people who are homeless, these preconceptions need to be spelt out and then dismantled.

Many people still see that the major relationship between mental health and homelessness is around deinstitutionalisation. That is, a large proportion of the homeless are adult men, and to some extent women, who would have been accommodated in psychiatric hospitals. Both of the major pieces of research on homelessness and mental health, “Down and Out in Sydney” and “Homelessness in Melbourne” demonstrate why the relationship between mental health and homeless is more complex than this.

I want to take each piece of research in turn. Let me start by saying though that there is a lot of truth to this. According to the findings of “Down and Out”, it is the case that the rate of psychosis amongst people surveyed was dramatically higher than the rate in the broader population. The study found the lifetime prevalence of psychosis was 23% for men and 46% for women, compared to less than x% in the broader community. Lack of community care for people who would have previously been institutionalised, is a critical problem that has been well documented, including in the Senate Select Committee’s report on mental health services in Australia.

However, what “Down and Out” also shows is that people experiencing homelessness have a high prevalence and complex set of mental health issues. The study found that 71% of men and 83% of women met the criteria for at least one disorder in the last 12 months. This is four times higher than the broader community where the 12 month prevalence for mental illness is 18%.

The most common mental illness for men was substance use disorders, primarily alcohol disorders, found in 49% of men surveyed. There were also very high rates of depression and anxiety, with a 12 month prevalence of 22% for each condition. For women the most common mental illnesses were affective disorders, found in almost half (48%) of those surveyed. Major depression was found in 38% of cases and anxiety disorders in 36% of cases.

The complexity of mental health issues for people who are homeless is also reflected by the categories of people that “Down and Out”, by the nature of its design, had to leave out. The study is based on a random sample of people using adult services, so it doesn’t give a sense of the mental health issues for children and youth. Around half of all people experiencing homelessness are under 25 and about 10,000 are under 12. Clearly, understanding the relationship between homelessness and mental health also needs to involve looking at the issues affecting these groups.

We also don’t get a sense from “Down and Out”, the mental health issues for homeless people from indigenous or non-English speaking backgrounds (NESB). Both of these groups make up a large proportion of the homeless population. Indigenous people make up 17%, and those from NESB make up 11% of users of SAAP services.

The preconception about homelessness and mental health being to do with deinstitutionalisation is also challenged by “Homelessness in Melbourne”, which looked at the cause and effect between these two issues. To many people, homelessness is the consequence of people with severe mental illness having difficulty maintaining their independence in the midst of social isolation, and eventually losing their accommodation. The Senate Select Committee heard from “a study on the effects that the closure of institutions has had on homelessness, in which it [was] suggested that authorities failed to recognise the range of services that institutions had provided, including the provision of housing.”
What “Homelessness in Melbourne” found was that causality runs in both directions. Half of all people surveyed who had a mental illness, and two-thirds of all people surveyed that had a substance abuse problem, developed this after they became homeless. In many ways, this is unsurprising because the home provides a range of emotional support. It gives us a sense of safety and security, and provides a basis from which people build relationships and access economic and social opportunities.

By challenging the preconceptions that we have, we can rethink how we go about responding to the mental health needs of people who are experiencing homelessness.

One element of responding to mental health and homelessness will have to involve responding to the need for community-based care. The Mental Health Council of Australia, for example, has called for Community Supported Recovery Services (CSRS). Non-clinical services would work alongside clinical treatment services with the goal of assisting people to live successfully in the community. CSRS would include accommodation options where these were not available.

On the other hand, responding to mental health issues requires the ability for services working with the homeless to identify issues and link clients with clinical services where appropriate.

If we want SAAP to respond to the mental health issues of clients, the program needs more resources. The last SAAP evaluation recommended an increase in base funding of 35–40% to increase the ability of the program to work with clients to achieve independent living.

More resources would enable SAAP to work with clients long enough to realistically identify what their mental health issues are. The median length of support in SAAP in 2005–06 was 6 days. While this is partly influenced by short stays in crisis accommodation, this is an unrealistic period of time for agencies to be able to identify mental health issues in clients.

More resources would enable agencies to build better linkages with non-SAAP services. While “Down and Out” found that as many as three-quarters of all male clients and four in five female clients meet the diagnostic criteria for mental illness, specialist mental health and substance abuse services are only provided in a limited number of SAAP support periods. In 2005–06, psychological and psychiatric services were provided in 3.9% and 1.3% of closed support periods, respectively. Drug and alcohol support/intervention was provided in 6% of cases. Given the findings of “Down and Out”, far higher numbers of SAAP clients might be expected to use these services.

Perhaps fundamentally, if we are going to better respond to the mental health issues of people experiencing homelessness, we need to dismantle our preconceptions. Mental health issues for people experiencing homelessness are not only related to deinstitutionalisation. Research has identified a complex set of mental health issues, which are often caused by the experience of being homeless. Let’s start over again and look at the link between mental health and homelessness differently.

Footnotes
2. Senate 2006, A national approach to mental health — from crisis to community, Senate Printing Unit, Parliament House, p.67
3. Teeson, Hodder and Buhrich 2004, p.164
4. ibid, p.165
5. ibid
6. ibid
7. ibid
8. ibid
11. Senate Select Committee on Mental Health 2006, A national approach to mental health — from crisis to community, Senate Printing Unit, p.67
15. Erebus Consulting Partners 2004, National Evaluation of the Supported Accommodation Assistance Program (SAAP IV), Executive Summary, p.9
16. AIHW 2007, p.3
17. ibid, p.49
Chapter 3: From the Coalface, the Experience of Services
Home Wasn’t Built in a Day: A Homeless Health Outreach Team Success Story

By Emma Martin and Deanna Erskine
On behalf of the Homeless Health Outreach Team
Royal Brisbane and Women’s Hospital Division of Mental Health

A current challenge exists to develop an effective method of mental health service provision for utilisation with the homeless population.

The Homeless Health Outreach Team (HHOT), operating within the Royal Brisbane and Women’s Hospital Division of Mental Health, has been established to provide mental health, drug and alcohol, dual diagnosis and primary health services to the homeless population. The HHOT successfully combines assertive outreach, interagency collaboration and a multidisciplinary team approach to address the numerous and significant barriers to engagement that exist for people experiencing homelessness.

The barriers to engagement for the homeless population are numerous and varied and include the high prevalence of mental illness, trauma, substance use, intellectual and physical disability, ethnic minority and history of incarceration or institutionalisation. These barriers significantly impact people’s ability to access health and support services, and in turn, health and quality of life outcomes are limited. The homeless population of Brisbane faces and fights these barriers on a daily basis and the HHOT have had the privilege of working with many such individuals. We would like to share the story of one client, Tom, who epitomises the struggles of this population and the role of the HHOT in recovery and rediscovery of hope. This is his story.

Tom was well known to the inner city community. He was often seen first thing in the morning wandering around the Botanical Gardens, across the William Jolly Bridge and through the city streets. Tom was always isolated. In the early evenings at peak hour he could often be seen wandering through the crowds in the city centre and would sleep on the steps of the general post office, overlooking Queen Street and Post Office Square.

Tom stood out in a crowd. He was striking in appearance, an indigenous man of large build with thick dreadlocks reaching his waist and a long beard to match. Tom lived in his own reality. He was able to exchange a polite please or thank you but was otherwise consumed with the spirits of the trees, which lived in the parks and in drain pipes. Tom was often seen performing ritual peace blessings on objects and buildings, mumbling to himself often and sometimes yelling at people not present. Tom was unwell, disconnected from society and reality for four years on the inner city streets of Brisbane.

Referral came to the Homeless Health Outreach Team (HHOT) via the gardener at the Botanical Gardens. Tom was pulling up plants and had been seen walking around with roots and leaves hanging from his beard. There had also been complaints of him frightening tourists while yelling at the spirits. For several months HHOT attempted to engage Tom at the early morning food vans with superficial contact made, but little rapport established. Conversation revolved around soccer and Tom’s belief that he was from Scotland. Lengthy discussion at HHOT around how to engage Tom and the role of mental health services ensued.

After obtaining collateral about Tom’s past, it was decided to admit Tom to hospital involuntarily. Tom had been a bus driver for a local school and lived a fully independent lifestyle before becoming unwell several years ago and consequently withdrawing from society. He had a history of schizophrenia which had been treated successfully in the past.

On admission to hospital Tom began receiving treatment for psychosis and at this time, the discovery was made that Tom was in end stage renal failure. Without medical intervention Tom’s prognosis was terminal. After lengthy deliberation and much advocacy on Tom’s behalf, he commenced renal dialysis treatment three times a week. Slowly his mental
and physical health began to improve and having settled in the ward, Tom adapted to sleeping indoors and expressed a wish to no longer be homeless. The next step would involve intensive long-term rehabilitation and medical follow-ups. The question was how to provide this? After lengthy deliberation, a successful outcome was reached with Tom’s admission to the Continuing Care Unit, where he could receive ongoing medical follow-up, rehabilitative group work for independent living and ongoing input from the HHOT.

Although a man of few words, Tom seized the opportunity as a step in his recovery. The first days in his independent living unit brought many changes including a haircut, a shave, a new bed and new clothes, all of which were initiated by Tom. After lopping the dreadlocks he joked he would have to get his balance back now all that hair had gone! Likewise he stated that he would have to get used to sleeping well in the quietness and comfort of a bedroom. He could once again cook, grocery shop and maintain his own place. His mental wellness still continues to improve slowly with ongoing treatment and the team have had the opportunity to get to know Tom’s friendly, easy going nature and calm temperament, without the mask of psychosis.

The final piece in the puzzle of Tom’s transition from homelessness came when he was offered a place on the Queensland Council of Australian Governments (COAG) Mental Health Group housing and support initiative. The move to his new home is pending the location of the most sustainable accommodation available, somewhere with easy access to the hospital for his dialysis treatment and to parkland for walks amongst the trees. The ongoing support package provided through the project will enable Tom to live independently, to continue with the life saving dialysis treatment and to recover his life, which had become lost through years of untreated psychosis and homelessness.

Tom’s journey has involved a huge team of clinicians and specialists. At the centre is a core group of committed clinicians who have followed his journey from the park to the inception of his new home, quality of life and increased wellness. They have advocated, coordinated and problem solved through a labyrinth of challenges. Tom’s journey has incited many ethically based discussions and challenged each treating team at every stage. The journey has also involved intensive input from the mental health inpatient team and specialists, renal dialysis team and specialists, continuing care team, the COAG coordination team, City Police, Brisbane City Council Open Space Liaison Officers, RBWH dieticians, the Guardianship Tribunal, Indigenous Health Workers, specialist occupational therapy consultation, Centrelink and Department of Housing. Tom’s story continues to provide inspiration and strength for members of this collective, as we work to deliver clinical services to the homeless community. Tom is a shining example of what can be achieved by the collaborative spirit of recovery.
A Journey to Social Inclusion (J2SI):
A Service Model that will enable those who are
Entrenched in Homelessness and Socially Excluded to
Find a Place in Society

By Michael Perusco
CEPO Sacred Heart Mission

In 2006, Sacred Heart Mission (SHM) undertook its planning process for the next three years. To inform this work, the Mission sought to obtain a better understanding of the people who use its services. In August 2006, a survey of 319 people was conducted at the Mission to explore the history of their homelessness and the extent of their social inclusion.

The data showed that 53% of Mission clients had been homeless for more than two years and, based on an earlier survey undertaken, it also emerged that 79% suffered from some form of mental illness and 52% had a substance abuse issue. An analysis of the data gathered on four indicators of social inclusion — access to stable housing, employment, mainstream services and social support networks — also revealed a very high level of social exclusion amongst clients. Of those clients who were currently housed, 61% were still socially excluded and 33% indicated their original reason for being homeless had not been resolved.

The general conclusion that can be drawn from these results is that a significant proportion of SHM’s clients are entrenched in homelessness and excluded from mainstream society. We need to work more effectively with this group and in a way that leads to stable housing and a reconnection with the mainstream community.

The Cost of Homelessness

Chronic homelessness is expensive because those who are trapped in the cycle of homelessness tend to be heavy users of crisis accommodation, hospitals and health services, homelessness assistance agencies, police resources, legal and judicial systems, rehabilitation and correctional facilities and mental health services.

Much time and effort has been spent on understanding the economic costs of homelessness in Australia and overseas. The volume of work undertaken in the USA on the cost of homelessness prompted an article, Million Dollar Murray, in the February 2006 edition of the New Yorker. The story gained worldwide attention and focused on a man, Murray Barr, who was homeless in Reno, Nevada. Over 10 years, Mr Barr was provided with approximately $1 million of services without his homelessness being addressed.

Two recent Australian studies on the subject show that it costs between $30,000 and $35,000 per year to maintain a person in their state of homelessness (Morgan Disney and Associates 2006; City of Sydney Homeless Unit 2006).

This significant, repetitive and fruitless expenditure does little to resolve the homelessness dilemma and is one of the key reasons SHM has sought to develop a service model that creates sustainable outcomes for those who are chronically homeless.

The Homeless Service System

The Mission considers that those who are entrenched in homelessness are not well served by the crisis-oriented homeless service system, which results in a fragmented approach, which is costly and does little to assist people to obtain long term housing and end their entrenchment. The consequence is significant, repetitive and fruitless expenditure in dealing with the problem, rather than an investment in addressing the root causes for the person’s homelessness so as to resolve them at source, once and for all.

Under the current funding regime, which focuses on short-term fixes, many agencies like SHM are unable to invest the necessary resources to assist the homeless in a meaningful way. In limited cases where SHM is able to invest its own resources to work intensively and on a longer term basis, very positive results have been achieved.

Furthermore, people who are chronically homeless are likely
to have personality traits that are dysfunctional as a result of trauma they have experienced. This is compounded by their homelessness — the constant fear, danger and victimisation that can lead people to experience depression, thought disorders, paranoia and anxiety. These are all problems that contribute to a person’s ongoing vulnerability to homelessness.

There are very few opportunities to address these disorders for people who are homeless. The existing mental health services to homelessness, target those with more serious conditions such as schizophrenia and bi-polar. Disorders that are more behavioural and require a therapeutic response tend to go untreated, due to the transience and resistance of the client group, and the resource limitations and fragmentation of the mental health system.

**The Proposed Model: A Journey to Social Inclusion**

The model has four service delivery elements that all work towards the same goals from a different perspective, reinforcing and building on the outcomes achieved in each of the other areas. The result for participants is social inclusion and an end to their chronic homelessness.

In addition, the workers providing each of the components, including the professionals delivering the therapeutic responses, constantly work together to understand the most effective way in which to work with individual participants and to achieve the best outcomes.

**Element 1: Intensive Assistance and Coordination**

Each participant will be allocated a key worker (the worker to participant ratio is 1 to 4) who will provide intensive support and coordinate the full response provided to that participant. The key worker is also the client’s “significant other” during the trial, being available for intensive practical and emotional support for the equivalent of one day per week.

**Element 2: Therapeutic Intervention**

The Therapeutic Intervention will primarily involve one-on-one sessions with psychologists or counsellors and may also involve group work. It will focus on resolving the underlying causes of homelessness, the trauma experienced prior to and during their homelessness and the stigma associated with an individual’s identification with the homelessness sub-culture.

**Element 3: Building Up and Developing Skills (BUDS)**

BUDS will equip participants with the life skills — such as interpersonal skills, numeracy and literacy, practical living skills, assertiveness, house tenancy skills and job readiness — via a program of group work and one-on-one sessions. Participants will also develop their own social networks within the mainstream and connection to the community by involvement in recreational activities and participation in volunteer work, job-readiness training and/or employment.

**Element 4: Linkages into Existing Services**

Participants will be able to access existing SHM services and SHM’s relationships with specialist providers to meet their health, housing, mental health and drug and alcohol needs. A coordinated response between programs will be required to ensure consistent and seamless service provision and crisis intervention, if these circumstances were to arise.

The model recognises and encompasses the important connection between how people become homeless and what subsequently happens to them, including how they respond to homelessness, how long they remain homeless and how they get out and stay out of homelessness.

In this way, J2SI will address both the symptoms (e.g. addictions, mental health) created by the homelessness experience and the underlying causes that led to the homelessness experience (e.g. trauma, family breakdown).

The Intensive Assistance and Therapeutic Intervention will provide the focus and time necessary to undertake an in-depth analysis of a person’s biographical history. This will improve both the worker’s and participant’s understanding of the underlying causal factors of the participant’s homelessness, identify the “triggers” in their life that lead to periods of homelessness and provide an insight into the methods that can be adopted to mitigate the risk of this re-occurring.

Achieving sustainable change in the lives of people who are chronically homeless, requires strategies to address deep seated behavioural patterns, beliefs, values and a sense of identity that serves to keep the person trapped and entrenched in homelessness.

Personal growth and learning is at the forefront of the J2SI model. The long term and intensive nature of the support allows the key worker to develop the relationship and rapport required to challenge these behaviours. The key worker will coach the participant through the process of reflection and evaluation and eventually, of developing new behavioural and cognitive patterns.

The Therapeutic Intervention will also play a critical role in the development of these new patterns and the Building Up and Developing Skills (BUDS) component will provide the opportunity to develop the communication and interpersonal skills to support them.

The fundamental strengths of the model are as follows:

1. It is focused on addressing the casual factors of a person’s homelessness that often relates to unresolved trauma.
2. It works to dissociate a person from the homeless
sub-culture in a way that addresses the routines and behaviours they have developed and replaces the stigmatised identity with a more positive self-image.

3. It provides a mental health response that treats physiological disorders as well as behavioural disorders.

4. It provides opportunities to build and practice interpersonal and life skills in a safe environment over a long period of time.

5. It focuses on creating a sense of belonging outside of the homeless sub-culture and equips people with the skills and opportunities to build alternative social networks.

The Pilot

SHM is proposing to trial the J2SI model with participants who will be drawn from its existing client base and have demonstrated a willingness to engage with services. The objectives of the pilot are three-fold:

1. To trial the J2SI Model with 40 participants in order to provide detailed feedback on the model through action research,

2. to demonstrate to the government and the community that an effectively resourced program can create sustainable pathways out of chronic homelessness and thereby reduce the numbers of people who are homeless, and

3. to persuade the government to commit funding to the model on an on-going basis.

The budget for the three-year pilot is $3.7 million, which represents an investment in each participant of $29,979 per annum or $89,937 over the three-years.

This is an unprecedented level of investment in this group of people. The Mission considers that the investment into J2SI is well worthwhile however, not only in terms of the mitigation of avoidable human suffering, but also in terms of the broader economic benefits which will flow from reduced expenditure associated with the interminable bandaid solutions offered to those who are entrenched in homelessness. Most importantly, this investment will help this group lead more meaningful and connected lives and enable them to reap the benefits that other citizens derive from being part of the community.

The Mission is excited about the benefits of J2SI for both its clients and the community, as it provides the opportunity to effectively tackle a persistent social issue that has so far proven intractable by working within the current paradigm.
The Doutta Galla Community Health Service: Program Experiences

By Andrew Shakespeare
(Arion Coordinator)
and Cameron North
(HOPS Case Manager)

Doutta Galla Community Health Service is the leading provider of community health services for the inner west of metropolitan Melbourne, operating in the municipalities of Melbourne and Moonee Valley. In addition to a comprehensive range of allied health, counselling and dental services, Doutta Galla is the major provider of Psychiatric Disability Rehabilitation and Support Services for the inner west.

This suite of programs, provided to people who have experienced a mental illness, include Outreach, Day Programs and a range of Accommodation service types. Two DGCHS PDRSS programs in particular, have worked extensively with clients who have experienced histories of both homelessness and mental illness. These are the Arion Program and the Intensive Home-Based Outreach Program.

The Arion Program — Background

Arion is an eight-bed Step Up/Step Down program located in Flemington, Melbourne. The program’s principle aim is to assist with the prevention of, and recovery from, acute relapse. Clients of Arion can currently stay a maximum of six months with the program. The program also aims to assist with relapse prevention through ensuring that appropriate linkages with community services are in place prior to exiting from the program.

Arion is a partnership between DGCHS and the Inner West Area Mental Health Service. Arion was initially established as a Hospital Admissions Risk Program, and began admitting clients in April 2004. Arion was initially established solely as a Step Down unit. The express aims of the program at this time were to assist with the easing of bed pressure at the Royal Melbourne Hospital — both in the Emergency Department and Acute Ward. A Step Up component was introduced in November 2004; Step Up is open to clients of three teams of the IWAMHS: the Mobile Support and Treatment Team, the Continuing Care Team and the Homeless Outreach Psychiatric Service.

Arion and HOPS

The partnership between the IWAMHS and Arion has seen the fostering of effective working relationships and communication between clinical and PDRSS programs. The Arion clinician, whilst having primary responsibility for clinical liaison on behalf of the service and residents, is also a staff member of the IWAMHS. All decisions regarding the referral, assessment, admission and exit of Arion clients are the joint responsibility of the Arion Clinician and Coordinator/Team Leader.

One of the most significant partnerships has been between Arion and the HOPS team. The IWAMHS HOPS team works within a catchment that contains two of the three largest crisis accommodation shelters in Melbourne. The catchment also contains the Central Business District of Melbourne and surrounding suburbs of Carlton, Parkville, West Melbourne and North Melbourne. This area has the highest population of itinerant, homeless and shelterless people in Victoria, many of whom experience mental health problems. Case managers with the IWAMHS HOPS program most typically employ an assertive outreach approach in their work, meaning that clients are often assessed in a homeless setting. If clients are subsequently diagnosed as in need of acute care, they are admitted to the acute psychiatric ward of RMH, where treatment is either commenced or reviewed. Appropriate accommodation is then sought for post-discharge clinical treatment, recovery and psychosocial rehabilitation.

Prior to the commencement of the Arion program, often the only option for clients with a history of homelessness was a discharge from the ward to one of the major crisis accommodation shelters in the catchment area. These shelters provide a service to a wide range of people, including a significant number who experience enduring substance use issues, financial and social difficulties. Environments such as these, whilst being an invaluable part of the service system,
can prove to be difficult environments for clients who are entering the post-acute recovery phase. This particularly applies to clients whose experience of chronic psychosis can make them vulnerable in a potentially volatile setting.

The prevalent diagnosis for HOPS clients who have been admitted to Arion remains schizophrenia, 87% of clients to date have schizophrenia as their primary diagnosis. Arion figures also show that drug and alcohol issues — often highly prevalent amongst the homeless population — have been a current issue for only 23% of Arion/HOPS clients. More typically, the experience of chronic and untreated or intermittently treated psychosis has been identified as the primary cause of homelessness for these shared clients. All too often, a discharge to crisis accommodation has resulted in clients either being lost to clinical care, or re-admitted to the acute ward within a comparatively short time frame.

Program Results

The development of the Arion program has created an alternative pathway for HOPS clients to more appropriate long-term housing options and treatment. Many HOPS clients have been admitted to Arion’s six-month stream, in order to achieve the best possible outcome for clients within this time frame. These outcomes have included linking clients in with a range of services, including supported accommodation, day programs, allied health care and a range of other community services.

Figure 1 depicts the range of services Arion/HOPS clients have been referred to whilst resident at Arion (Apr 04–Jul 07).

Initially, all clients coming to Arion were to have a pre-planned exit point. This was to avoid the possibility of a lack of throughput for Arion beds, which would significantly impact on the program’s stated aim of easing bed pressure at RMH. After some months of operation it became apparent that this policy meant that some RMH inpatients, otherwise assessed as suitable for Arion, could not be discharged from the ward to the program, due to the lack of an exit address. After consultation with clinical stakeholders, a ‘no exit’ bed was introduced into the program. This enabled inpatients with a history of homelessness, and without a suitable exit point, to leave the acute setting and be admitted to Arion’s six-month stream. This service change was made with the agreement that a case manager must be currently engaged with the client, and would actively work with Arion support staff to identify an appropriate exit point from the program. The ‘no exit’ bed feature of the program was introduced in late 2004, and has resulted in close working relationships between the services, and positive outcomes for clients.

Figure 2 indicates the range of accommodation types that Arion/HOPS clients have been exited to from the program. ‘Unknown’ represents clients who have chosen to exit the program to an unknown destination; ‘RMH’ represents the 7% of Arion/HOPS clients who have had to be readmitted directly to RMH from Arion.

Acute Results

(Please note: All Acute Results data shown pertains to clients discharged from Arion between April 2004 and July 2006.)

At the conclusion of the first 12 months of operation, collection and analysis of information on acute admissions and length of stay began at Arion. The aim was to examine the effectiveness of the program’s aims, in terms of reducing the incidence of acute relapse and lengths of hospital stay. Acute data was collected for the 12 months prior to Arion admission, and 12 months after Arion discharge. Figures obtained are applicable not only to
RMH acute admissions, but the clinical service system as a whole. The collection of data from a two-year-period has proved to be both illuminating and encouraging, in terms of outcomes for clients and the clinical service system.

Figure 4 illustrates an overall reduction of 68% in acute admissions for Arion/HOPS clients.

Figure 4: HOPs: Acute admissions — overall results

A significant number of HOPS clients have occupied designated long-term beds at Arion. A number of clients who entered the service for a short-term stay were moved to the six-month maximum stream when both staff and clients were able to determine that a better outcome would be achieved if the client was to move to a different accommodation type than originally planned. Achieving an outcome of this nature, more often than not, requires more than a short-term stay. This is mainly due to the challenge of finding appropriate accommodation, and waiting times for admission to suitable services. Acute outcomes for clients in this category have been significant.

Figure 6 illustrates a 94% reduction in acute bed days for Arion/HOPS clients who were with the service for between 29 days and six months. A comparison between Figures 5 and 6 illustrates that Arion/HOPS clients in long-term Arion beds have experienced longer acute stays prior to Arion admission than those clients who have occupied short-term Arion beds.

Figure 6: HOPs: Acute bed days pre and post Arion (Arion stay of 29 days to six months)

Acute bed day results for clients with the service for 28 days or less are currently showing a 63% reduction. Whilst this, too, is a positive result, it is clear that the opportunities afforded by a possible six-month maximum stay — including referral to a range of community services and exit to appropriate accommodation — have resulted in positive outcomes for a client group who are often prone to frequent acute relapses and re-hospitalisation.

Conclusion

Much of the information presented in this article is quantitative in nature. The collection of quantitative data is important in terms of services being able to clearly demonstrate outcomes, both for clients and the service system. This is particularly important when a new type of program is introduced into the service system. The purpose of this article has been to demonstrate that partnerships between clinical and PDRS services can result in positive and measurable outcomes for clients. The Arion program, since the consolidation of the Step Up and Step Down components, has aimed to alleviate the pressures on clinical services through providing a non-clinical space for recovery from acute episodes, and to provide a service to those for whom an Arion admission in a Step Up capacity may prevent an acute relapse and subsequent hospital admission. Clearly, the outcomes detailed demonstrate that Arion, in partnership with the HOPS team and clients of both services, is achieving its stated aims.
The Intensive Home-Based Outreach Program

By Wendy Marven
Intensive Home Based Outreach Worker
and Jon Martin Inner West Outreach Coordinator

The Intensive Home Based Outreach Program is one of the Mental Health and Complex Needs programs provided by DGCHS. The program is specifically designed to offer a pathway out of homelessness for people who have mental illness and complex needs.

IHOP offers flexible, intensive, and individually tailored outreach support for clients; the program also offers access to IHOP-specific transitional housing for the duration of time with the program. The support provided assists people to secure long-term housing and has the overall aim of assisting with an improvement in health and well being.

IHOP is for adults who experience an enduring psychiatric disability or who have a history of involvement with mental health services. Clients who come into the program are currently homeless or have a history of homelessness, and have been assessed as being eligible for public housing. Eligibility for public housing is for the purpose of moving clients from IHOP transitional housing to ongoing accommodation. The person will often have a range of complex needs that have yet to be met, and must be open to entering into an ongoing support plan.

One person's pathway to “a place to call home”

The Case Study

At the time of referral to the IHOP program, S had recently arrived in Victoria after living a transient lifestyle across several states. He was, at the time of referral, living in an Inner West homeless shelter for men. Following the initial few weeks of working with S, staff were able to ascertain that S felt he had many issues that he wished would “just go away”. He wanted to be rid of his concerns but felt that he needed support to enable this to happen. S had thought for some time that moving from state to state would help, but found his concerns persisted. This resulted in S experiencing ongoing mental health issues, which had remained largely untreated — mainly due to the inconsistency in clinical support. S also had many outstanding warrants, and expressed a fear that the law would catch up with him, and that he may be subsequently jailed.

After many discussions with S, and through assisting S to make numerous interstate calls, it was established that his legal issues could not be dealt with in Victoria. Interstate authorities informed S that he would need to travel back to NSW, and would be required to present in person to a police station. Staff gave S time to consider this situation, and whether or not he felt he could act upon this advice without support. After some consideration, S decided he wanted to face his legal issues, but would need support from staff to do so.

Arrangements were made for two IHOP workers to travel with S to NSW, with the intention of presenting at a police station, as advised. The trip was made, and S did present to a police station in Sydney, in the company of the support workers. S was subsequently remanded, and went before the court later that day. During this, and subsequent court appearances, the magistrate expressed his appreciation at the lengths the IHOP Program had gone to in order to support S. S was placed on a Community Based Order, and the Magistrate encouraged him to continue to accept the support of the IHOP program upon his return to Victoria.

Resolving this legal matter relieved a major anxiety in S’s life: The fear of being arrested and jailed. Having this issue resolved then allowed S to address other issues in his life. Firstly, S accepted support from the IHOP program in seeking legal advice around the possibility of re-engaging with his family. As a result he was reunited with his five children, all of whom were living in NSW. Contact was initially conducted by phone; at a later time S was able to visit his younger children in NSW. S's eldest child subsequently came to visit him in Victoria. S was also able to reconnect with his mother and one of his sisters.

The IHOP team to the Inner West Area Mental Health Service referred S. This enabled him to access consistent
treatment for his mental health needs, initially through the Homeless Outreach Psychiatric Service. After a period of in-home clinical treatment, S was assessed as no longer needing an intensive level of clinical support, and was subsequently transferred from HOPS to the IWAMHS Continuing Care Team. S continued to attend regular appointments at the IWAMHS, and was later discharged from CCT to his local GP for ongoing clinical treatment.

Due to his stability in the program, S was able to consider returning to work. Consequently, he secured some casual shifts in a profession in which he had some previous experience. After a period of casual employment, S was able to secure full-time work, which he has maintained. S also began to pursue his interest in singing and writing songs, and was involved in the production of a CD with a local Community Group. S was also supported to see a financial counsellor, in order to address outstanding debts and arrange repayment plans.

Whilst living in transitional housing with the IHOP program, S made a decision to remain in Victoria. The IHOP team assisted S with an Office of Housing application, with the hope that this would secure him permanent, affordable accommodation. After a waiting period, S received an offer of permanent housing through the Office of Housing, which meant that his time in the IHOP transitional housing program was coming to an end. S was referred to the general Outreach Program within DGCHS for less intensive, ongoing community support.

After a further period of personal achievement and stability, S made the decision, in conjunction with his outreach support worker, to discontinue his outreach support. S expressed that he felt that his outstanding issues and concerns had been addressed, and that he would be able to make the move to living without ongoing support. At the point of exit from the program, S was invited to contact the service at any time in the future should he wish to re-engage with support. S has subsequently been in intermittent contact, mainly to express his thanks, and to say that he feels he is travelling well in his life.

How this was achieved
The outcomes with S were achieved by working in partnership with S and other services accessed by him during his time with the program. A strong commitment from the management team allowed the best and most flexible service to be provided to S, in order to assist him in fulfilling his personal goals. The IWAMHS also offered tailored grading in treatment, by initially providing in-home treatment through the HOPS team, a subsequent shift to CCT and clinic attendance, and finally a transfer to a local GP. Assistance with accommodation issues was also of primary importance, as it assisted S in moving out of homelessness — at first with access to transitional housing, and with the subsequent securing of permanent housing through the application lodged with the program’s assistance.

Support workers with the IHOP program have developed a team strategy in their approach to working with clients. They have endeavoured to introduce all clients to the Mental Health & Complex Needs management team and other program staff in order to encourage familiarity with all parts of the service. This strategy enables the support worker to promote the program as a comprehensive service, and means that clients do not feel that they are totally reliant on individual workers. This strategy also allows client needs to be promptly met by any member of the team, and has been fruitful when Key Support Workers have been unavailable — for example, during times of annual leave.

Conclusion
This experience has demonstrated that effective partnerships between clinical and non-clinical services are vital in securing the best possible outcomes for clients. Equally importantly, partnerships and communication between different programs within a service can result in a gradual move through different levels of support and care, depending on what assistance is required at any given time. Clearly, in the case of S, the flexibility and support offered not only by the IHOP program, but the DGCHS mental health programs as a whole, and the local area mental health service has meant that S has made a significant shift in his life. He has indeed, moved from a history of homelessness to “a place to call home”.

Acronyms included in the two previous articles
DGCHS: Doutta Galla Community Health Service
PDRSS: Psychiatric Disability Rehabilitation & Support Services
IWAMHS: Inner West Area Mental Health Service
HOPS: Homeless Outreach Psychiatric Service
RMH: Royal Melbourne Hospital
GP: General Practitioner
CCU: Community Care Unit
IHOP: Intensive Home-Based Outreach Program
Challenges in Responding to Complex Psychosocial Patient-Need in a Bio-Medical Model

By Nicole Hill, David Brophy, James Gullifer, ALERT, St Vincent’s Hospital Melbourne

‘Mental health’ is referred to broadly in literature as encompassing drug and alcohol related problems and issues associated with homelessness. For patients who are acutely psychiatrically unwell, treatment by the emergency psychiatric triage service and area mental health team is warranted. However the majority of patients present, however, with issues that are assessed as not requiring acute psychiatric service. Such issues include drug and alcohol issues, homelessness, personality disorders, depression and anxiety or commonly, a combination of these factors.

A small, yet significant number of patients contributing to the volume in Emergency Departments are the group of patients who frequently present to Emergency Departments with non-urgent needs. Several studies have revealed that this small cohort of Emergency patients are responsible for a disproportionate number of Emergency Department visits and associated costs (Blank et al, 2005, p.139). These studies suggest that frequent users of Emergency Departments are likely to have complex psychosocial issues including alcohol abuse and psychiatric illness (Blank et al, 2005).

St Vincent’s Hospital Melbourne (SVHM) has the highest number of mental health related presentations of any acute Victorian Hospital, recording 10.6 per cent of all SVHM Emergency Department presentations having been triaged as mental health or substance-related problems (St Vincent’s Health Service, 2003). Alcohol intoxication is a specific and increasing area of concern, accounting for 488 of the mental health presentations to SVHM Emergency Department in 2001–02, and 300 presentations to the Royal Melbourne Hospital’s Emergency Department in the same year for the same presenting problem. According to the Department of Health and Community statistics, each presentation with alcohol intoxication costs the Emergency Department $222.00 (Hancock, 2001, p.14).

Patients presenting within this mental health-related cohort are likely to have poor physical health and other co-morbidities, however evidence suggests that the presence of co-morbid medical and mental health issues are likely to remain untreated, sometimes even undiagnosed (Laine et al, 2005). Despite this high service usage, the care received may be fragmented and disjointed (Andersen et al, 2003, p.849), and commonly other health needs may be neglected. As a result, healthcare for this cohort of patients is usually disorganised, and medical care is sought often when crises emerge and urgent treatment is required (Laine et al, 2005, p986).

The Assessment Liaison and Early Referral Team (ALERT) clinicians strive to address this very real issue. ALERT was established at St Vincent’s Hospital in 2001, as part of the Hospital Admission Risk Program (HARP) initiative to improve health outcomes and reduce demand on the Emergency Department. (Department of Human Services, 2004). ALERT is a multidisciplinary care coordination service, aimed at providing assessment and intervention to patients presenting to the Emergency Department with complex psychosocial and medical needs.

Policy Context

The Hospital Demand Management (HDM) Strategy was established in October 2000, as a four-year funding strategy to address the increasing demand and deterioration in access to acute public hospital services (Department of Human Services, 2001a). A significant initiative to emerge from the HDM Strategy in 2001–02 has been the allocation of $150 million for the Hospital Admission Risk Program (HARP) to improve health outcomes and reduce the avoidable use of Hospitals (Department of Human Services, 2004). HARP permits the opportunity for acute, primary care and community agencies to work collaboratively to improve outcomes for clients (St Vincent’s Health Service, Issue 1). The objectives of HARP Chronic Disease Management are to improve patient outcomes by providing integrated and seamless care within and across Hospital and community sectors (Department of Human Services, 2001b). ALERT is one of three HARP programs operating at St Vincent’s Hospital.
How Does ALERT Operate?

ALERT aims to achieve better health outcomes for patients whilst simultaneously reducing preventable use of the Emergency Department and inpatient services, if and when this is appropriate. By identifying patients whose needs might be more appropriately met in the community, ALERT proactively manages patient’s health needs, linking patients in to appropriate referral pathways and fostering stronger care planning for individuals across the acute and community sectors.

ALERT is an interdisciplinary care coordination service, aimed at providing assessment and intervention to patients presenting to the Emergency Department with complex psychosocial and medical needs. It is comprised of clinicians of varying disciplines including nursing, social work, occupational therapy, nutrition, physiotherapy and administration.

ALERT provides assessment and risk screening in the Emergency Department, completes early referrals and provides targeted care coordination and community outreach to patients who present with one or more issues in the areas of substance use, homelessness, ageing, disability, chronic illness and mental health.

Figure 1. illustrates a summary and comparison of the primary presenting issues for ALERT involvement in patients presenting to Emergency who were assessed by ALERT clinicians between January and June 2007.

ALERT has developed strong working relationships with key community health providers in the local Fitzroy area. These include:

- General Practitioners,
- Police,
- Centrelink,
- Crisis Accommodation,
- boarding and rooming houses,
- Ministry of Housing officers,
- supported residential services,
- Aged Care Assessment Team,
- aged residential care facilities, and
- other HARP programs targeting chronic illness and aged care.

ALERT — An innovative response in service provision and care coordination

Analysis of clinical patient data from ALERT has demonstrated a favourable and significant impact on reductions in the number of admissions, average length of stay in hospital, and the number of Emergency Department presentations. Patients affected by mental health-related co-morbidities continue to be resource intensive and challenging, and the numbers of patients presenting with these problems to Emergency Departments across metropolitan Melbourne are increasing.

Substantial research evidence has focused on the demographic and psychosocial characteristics of frequent users of Emergency Departments, and concluded frequent Emergency Department utilisation is associated with social isolation, deteriorating health, disability, chronic illness, psychiatric illness, violence, alcohol and other drug-related issues, homelessness, and lower socio-economic status (Blank et al 2005; Dent et al 2003; Harris et al 2001). A focus on increasing utilisation based on a purely quantitative measure of the number of Emergency presentations fails to acknowledge the complexity of these underlying reasons for presentation and the factors influencing the Emergency Department use. The other side of the coin is that many primary health services have often unintended barriers to access either due to their hours of operation, reliance on appointment times, wait lists or a person having financial means, whereas Emergency Departments have the potential to be an open door, “one stop shop”. ALERT clinicians strive to enhance the existing provision of Emergency care, by establishing closer links between ALERT staff, Emergency mental health clinicians, psychiatric triage, addiction medicine staff, medical and nursing staff, and primary care agencies.

Care coordination provides for staff to have a flexible response to the increasing number of patients with complex needs presenting to Emergency Departments, particularly with homelessness, mental health and substance use problems.
(Department of Human Services 2002). Based in the hospital acute setting, ALERT care coordinators seek to improve the interface between the health care system and community service system, linking patients with appropriate services to support the management of their health and psychosocial needs (Weiss 1998). Research conducted across three Emergency Departments on the most frequent presenters (Phillips 2006) who had been recruited for care coordination by ALERT, showed that in post recruitment there was a measurable increase in patient connections to community supports in areas of housing, health and welfare.

ALERT staff provide outreach care coordination for patients identified as having substance use, homelessness, chronic illness, ageing, disability and/or mental health issues. Often with this client group there needs to be an initial engagement and trust developed before they can be linked to community services. Simply making a referral and relying on the person to follow through may not be sufficient. In this instance, ALERT staff provide a flexible outreach service to ensure a safe and effective discharge from the Emergency Department, facilitating referrals to and engagement with community services and thereby reducing the need for re-presentation to Emergency Department for assistance.

**Challenges in Clinical Practice**

Patients targeted by ALERT have complex psychosocial care needs, and literature clearly demonstrates the resource intensity required by this population. Research evidence further indicates that the provision of flexible and coordinated service delivery can impact positively on mental health problems, reduce drug and alcohol consumption and prevent homelessness (Kendall 2004; Weiss 1998). In reality, the capacity of clinicians to respond effectively to complex psychosocial needs in an acute environment such as an Emergency Department remains challenging.

An additional significant challenge for clinicians is to respond psychosocially to patients presenting in what is predominately a medically-oriented model. The biophysical orientation of physicians concerned primarily with health-oriented outcomes, as compared with the psychosocial focus of ALERT clinicians, fosters an environment where advocacy on behalf of patients becomes a crucial role for ALERT when facilitating discharges and setting treatment goals.

Inter-hospital communication will also develop more awareness of the beneficial impact that co-operative strategies can play. More efficient networking of ideas can also minimise the feelings of isolation amongst clinicians who are often dealing with long-standing issues in a narrow window of time. As mental illness, homelessness and substance abuse exists without borders, it is a realistic challenge for future health care delivery to reflect this in its application.

A major objective and motivation of ALERT is to address issues of service fragmentation with improved clinical outcomes for this complex patient cohort. The challenges in achieving this include appropriate engagement and rapport building with clients, appropriate clinical management, and care planning that is shared with other relevant services to ensure longer-term sustainability. It is intended that ALERT’s innovation will continue to make significant contributions to knowledge of how to best manage complex patients, through linkage with primary care agencies, more effectively avoiding the preventable use of the Emergency Department, whilst simultaneously improving health and quality of life.

References in full are available at the parity
Web address www.chp.org.au/parity/
The Experience of a Psychiatric Disability Specific Housing Service

By Sharlene Bennett
Whirrakee Coordinator, St Lukes, Bendigo, Victoria

St Lukes is a social work agency providing diverse human services throughout north central Victoria and parts of southern NSW using a client centered strengths-based philosophy. The Recovery Focused Mental Health Service can offer a range of programs including flexible home-based outreach and intensive home-based outreach, psychosocial rehabilitation group programs, assistance to families and carers, education about mental health issues and accommodation and housing support. Whirrakee (the St Lukes mental health team in Bendigo) provides a psychiatric disability specific Supported Accommodation Assistance Program (SAAP) service to clients diagnosed with serious mental illness.

History
In 1987 St Lukes opened up a day program for clients experiencing mental illness. The activities were based on the belief that recovery from mental illness was possible and should be supported. It became apparent fairly quickly that many of the clients were experiencing, or were at risk of homelessness, particularly those leaving psychiatric units, with little or no support. Managers of the service at that time began to lobby, the then Department of Community Services for funding for a psychiatric specific SAAP service. They argued that many generic services were ill equipped and resourced to support clients with complex needs.

In 1989 the Department of Community Services said that if St Lukes and partner agencies (psychiatric services) could come up with psychiatric service dollars from the Office of Psychiatric Services, they would match it with SAAP funding. This was pursued and a 1.0 EFT position was introduced and the Whirrakee Housing and Support Service was developed. Initially the program provided intensive support for clients living in a four bedroom transitional property. As the clients’ needs changed and they left transitional housing, St Lukes moved to offering an outreach model of support. At this time Whirrakee Housing and Support and the day program were quite distinctly separate programs. In 1999 St Lukes moved to an integrated model and the name Whirrakee was used to identify the new integrated service.

Move to Integrated Model
Currently Whirrakee operates using an integrated service delivery model. This means that all staff work across all the Whirrakee programs including home-based outreach (HBO), intensive home-based outreach (IHBO), SAAP, Assertive Outreach (A/O) and the day program. Clients can move through the programs according to needs and support levels and can stay with an allocated key worker. It also means staff are skilled up and have knowledge of all different program areas.

VHS/Mental Health Pathways Program
In 2002 St Lukes submitted an application for funding through the Victorian Homelessness Strategy (VHS). The aim was to provide an integrated service approach for the prevention of people with a mental illness being discharged into homelessness. The general idea was for the services to work together on discharge planning and prevent the occurrence of homelessness and hospital readmissions. The application was successful and St Lukes was involved in the pilot program. This has since been rolled out across the state of Victoria and is now known as the Mental Health Pathways program.

Locally it works by a St Lukes worker meeting with the social worker on the psychiatric ward weekly and identifying patients who may be experiencing or who are at risk of homelessness. Discharge is then planned between the workers and the client according to accommodation options and the goals of the client. There is brokerage attached to this program that is designed to increase the options for clients coming through the program. The pilot program also came with a crisis unit and nine transitional units, which are still in use today. A typical client might be identified on the ward as experiencing homelessness, move in to the crisis unit upon discharge with the support of a worker who will explore housing pathways and assist to navigate the complex housing system. They may then go into transitional housing and be allocated a worker to support them to obtain and maintain long term housing and work on the rehabilitation process.
Benefits of a Psychiatric Disability Specific Housing Service

There are many benefits to having an integrated service model that includes a psychiatric disability specific SAAP service. The different programs come with different resources. By having an integrated model it means workers can be creative about accessing resources for clients from different programs. This ultimately benefits the client as they can potentially access items/services that may be otherwise unavailable to them if they were linked to a generic SAAP service. Having said this, St Lukes community services senior staff have been in discussion about how we can make these resources available to other SAAP services. Some ideas that have been put forward include assisting via secondary consultation, and allowing other SAAP services to apply to St Lukes to access mental health brokerage for eligible clients.

Whirrakee has a crisis unit and nine transitional properties attached to the program specifically for clients experiencing mental illness. This resource is invaluable as it means that there is greater access to accommodation for clients and comes with support as well. There is also brokerage that can be used for emergency accommodation in the instance that there is nothing else available at any given time. All housing clients are allocated a worker who would support them to find and maintain long term, stable housing as well as work on other aspects of a person’s recovery.

Whirrakee also has nomination rights on a number of Office of Housing (OoH) properties through the Housing and Support Program (HASP). This provides an additional resource to the service and for clients with ongoing support needs. Currently the relationship with the OoH is quite good and properties are replaced in a timely fashion when clients move on from the program.

All workers who work within Whirrakee are skilled and have specific knowledge around mental health issues and its impacts. They are also aware of the impact of homelessness on people regardless of whether or not they have a mental illness. By having an understanding of the issues faced by people who are not only homeless but who are also experiencing mental illness, workers are equipped to respond in a timely and appropriate manner. St Lukes is also very involved with the local accommodation network LOMA (Loddon Mallee Accommodation Network) and keep up to date with new developments in the homelessness sector.

Staff have the capacity to build rapport and lasting relationships with clients due to the ongoing and type of role we play. By working from a client-centered perspective, clients take more of an active role in their recovery and future directions. Often a SAAP client is linked in to more than one of our programs and this allows them to build community and social connections. Workers can be flexible in their responses to clients and service can be targeted to the clients’ changing needs. They can move in and out of programs as the needs and support levels change. The integrated model means that they can stay with the same worker as they move through programs and are not changing on a regular basis. This has an enormous impact on clients as they do not have to retell their story to different workers and they can truly build rapport and trust with their worker.

By having a key worker relationship it also allows workers to recognise early warning signs and symptoms that a client may be becoming unwell and respond accordingly. Relapse plans would be done with the client and possible actions agreed upon. The level of support could also be increased during this time. By having that flexibility in the level of support, some clients can avoid hospital admissions as they are getting timely intervention and appropriate support when they need it.

The service has already established service links and relationships with other services including the local area mental health service and works collaboratively with case managers or other support workers in the client’s life. By working together it can result in positive outcomes for the client.

Whirrakee workers also have links with a number of generic services that they link clients in to. This can help break down the stigma of mental illness and does not pigeon hole clients to mental health services only. Most of our programs are run in local community venues and workers encourage clients to become involved in local groups.

Challenges

Some of the challenges that we face as a service are experienced across the whole homelessness and housing sector, including the lack of long-term housing options for many of our clients. Many who have been quite transient, lack rental references, which can make obtaining private rental next to impossible. The current cost of private rental also makes it difficult for clients. One of the things St Lukes has been looking at with its brokerage dollars is to provide ‘top up rent’ for clients entering the private rental market. This would have a limit in that the plan would be for the client to gradually start increasing the contribution they make, as a budget is worked out. We are hoping that it might give clients that extra help to break through the private rental market.
Public housing is also an issue. With the current bottleneck, it is very difficult for clients to gain a public housing property. Often when they do, the offers that they are given are not appropriate and could be seen to be detrimental to their mental health. Housing estates where violence is rife is not a good environment for someone who suffers from severe anxiety for example. Often clients who enter our service may not fit segment one criteria or be able to enter the private rental market. This is challenging for workers as transitional housing has time frames. Where do people go after that? We often use our HASP program and properties as a means to address this, however we do not always have vacancies in that program.

As a way to maximise our resources, all of our transitional properties are two-bedroom share properties. The benefit of this is that we are able to provide support to double the amount of clients, however it does raise some challenges. Some clients do not like the idea of sharing with a stranger and would prefer other forms of accommodation such as caravans. There is often little choice for clients as to where they live as it can often depend on what is available at the time they need accommodation. While workers do their best to match tenants who would get along, it is not always possible and there is often conflict and issues between clients in transitional units. Clients often need extra support in learning skills to maintain a house, particularly those who have been transient for long periods of time. This can lead to further issues between tenants about the state and cleanliness of the property.

On a broader level there is often a lot of stigma that goes along with being a mental health client or person experiencing homelessness. When our crisis unit is full, there are often few options for a client in need of accommodation. Workers are often knocked back from other accommodation providers (such as caravan parks and motels) when they identify as being from a welfare agency. Whilst this has been identified as an issue it is very difficult to get around as many will not even accept a cheque from our agency to pay for accommodation. Whirralkee has been very lucky in that we have a couple of providers in town that are very supportive of our agency and clients and are more than willing to provide support to our clients. As a sector we need to do more to address this issue and raise awareness in the community.

Other challenges we experience include the time it takes for many of our properties to come back on line after being cleaned or getting maintenance. Whilst they are off line it puts pressure on other resources and it can be quite unsettling for a client who is in our crisis unit for example, and we keep telling them they have a unit when it has its maintenance completed but this keeps getting extended out. At a local level there are actions being taken to address this.

In conclusion, from a worker’s perspective, I believe that working within an integrated model that contains a psychiatric disability specific housing service, leads to greater outcomes for clients. Workers are skilled up in a variety of programs and are supported by the model to be flexible and creative in working towards future goals with clients. Having that mental health specific knowledge is invaluable in working with the client group as well as an understanding of the impacts of homelessness. In all I think it leads to successful relationships with clients and better general outcomes.
CLIENT STORY: J

James* came to our service in late December one year after being told by the local housing provider that we could assist people suffering from mental illness. Upon doing an assessment with James the worker identified significant risk issues (James had talked of feeling suicidal and had recently self harmed), and placed him into crisis accommodation at a local motel. The crisis assessment team was phoned and James was assessed and follow up was arranged.

During his two day stay a St Lukes worker visited with James on a daily basis, and got to know him and what his needs were. He also determined his housing history. James had recently had a relationship breakdown and was unable to return to his previous housing. Before this he had been in and out of SAAP services across Victoria but never stayed in the one area long enough to be linked in with support agencies. He also had quite a number of hospital admissions. He had previously rented privately a number of years ago, had lived in three different caravan parks, had stayed on friends’ couches and had been sleeping rough for the last few weeks. James was later placed in the crisis unit and a key worker was assigned.

James and his key worker began exploring what goals James had for the future and strategies for achieving them. They included finding a house, getting a job, making some friends and eventually having access with his two young children. James was linked in to the St Lukes group programs where he met quite a few people. He was also referred by Centrelink to the Salvation Army where he received support via the Personal Support Program (PSP). They helped him to get together a resume that he and his worker later dropped around to a number of different places. He also joined a wood work group at the Salvation Army site. During this time James was assigned a case manager and was put on some medication. His mental health later stabilised. With support, he also organised to start having supervised access with his children. Child protection has now closed the file and James and his ex partner have an access arrangement in place that both parties are happy with.

Over the course of this work the St Lukes worker also assisted James to complete a segment one application with the Office of Housing. Recently James was offered a one-bedroom property that he accepted and is now living happily in stable accommodation. He has not had a hospital admission in six months and is looking ahead to finding work in the near future. James is still linked in with Whirrakee at the moment but is currently working on an exit plan with his worker as is gradually increasing his level of independence as his support needs decrease.

*Name has been changed to protect the identity of the client
Chapter 4: The Importance of Housing
Stable Housing: The Foundation of Improved Mental Health
Findings from the Housing and Accommodation Support Initiative (HASI)

By Kristy Muir and Karen Fisher*
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People with mental illness are at risk of experiencing unstable housing and homelessness. Deinstitutionalisation resulted in a shift from institutional to community living, but it did not ensure stabilised housing for people with mental illness. Individual housing support programs aim to provide stable, affordable housing for people with mental illness.

This paper examines the Housing and Accommodation Support Initiative (HASI), a NSW based program that aims to support people with high levels of psychiatric disability to stabilise their housing, improve their mental health and increase their community participation. It uses findings from a two-year evaluation of HASI by the Social Policy Research Centre, UNSW, to understand how the program is assisting people to acquire and stay in their own homes in the community.

Introduction
People with mental illness are at risk of experiencing unstable housing or homelessness. Deinstitutionalisation resulted in a shift from institutional to community living, but it did not ensure stabilised housing for people with mental illness. Individual housing support programs aim to provide stable, affordable housing for people with mental illness.

Recent developments in support for people with mental illness focus on local, community-based, coordinated services that provide treatment at home and focus on both symptoms and disabilities. For such a system to work, stable housing is critical.

In the 1990s and early 2000s, mental health services in the US and UK started to offer individualised supported housing options. These options aimed to assist people with mental illness to live in stable, affordable and safe housing. In Australia, many accommodation-based programs for people with mental illness continue to follow a transitional model of supported housing. There are numerous programs, which offer psychosocial accommodation support, but these rarely also include the provision of housing.

HASI is one NSW based program that offers both housing and psychosocial accommodation support. This paper describes the HASI model and examines the impact of the program on housing stability for people with high levels of psychiatric disability.

HASI Model
HASI is a partnership between the NSW Department of Health, NSW DoH and non-government organisations (NGOs). The program, funded by NSW Health and DoH, aims to assist people with mental health problems and disorders requiring accommodation (disability) support to participate in the community, maintain successful tenancies, improve quality of life and most importantly to assist in the recovery from mental illness.
There are a number of HASI stages. This paper only examines HASI Stage One, which the Social Policy Research Centre, UNSW, was commissioned to evaluate. HASI Stage One was established over 2002/2003 and supports more than 100 people with complex mental health problems living in nine locations that fall within six NSW Area Health Services.

The program has a psychosocial rehabilitation focus and uses a coordinated approach between housing providers, Area Mental Health Services (AMHS) and NGOs. The Department of Housing provides participants with permanent social housing; NGOs offer long-term accommodation and community support to enable independent living and access to community services; AMHS case managers provide active mental health case management.

**Housing Component of the Model**

On joining the program, each HASI Stage One participant is provided with their own unit, townhouse, villa or stand-alone house. These properties are provided through and managed by the Office of Community Housing (OCH) or DoH in each area. The housing providers work closely with NGO accommodation support personnel on issues such as locating appropriate accommodation, property maintenance, rental arrears, neighbour relationships and property related problem solving.

**HASI Stage One Participants**

During the evaluation, HASI Stage One participants were most likely to be men (67.3 per cent) with a primary diagnosis of schizophrenia (74.3 per cent) and a secondary diagnosis (64.3 per cent). They have histories of long-term hospitalisation, unstable tenancies and poor rental histories, minimal living skills, low levels of occupational, social and psychological functioning, limited social networks, and some have spent time in prison.

Prior to joining HASI, the majority of participants experienced unstable housing. At least one in ten were in very vulnerable housing situations (living in boarding houses, refuge or crisis accommodation, cars, tents, parks, squats, or in other temporary housing). Almost one-third were living in hospital. Even where participants were living with family, this was often unstable, unsuitable and unsustainable.

**Evaluation Methodology**

HASI was evaluated over a two-year period with three data collection stages in each of the nine locations. The evaluation measured tenancy stability, mental health and community participation outcomes for participants, along with service delivery and processes and partnership issues. This included 633 interviews and surveys (during 2005 and 2006) with participants, housing providers, AMHS and NGO personnel, family members, consumer advocates and people involved in the governance of the program. Data was also collected from housing providers regarding tenancy details, NSW Health's hospital admission and clinical assessment records and through a participant information database.

**Tenancy Results**

HASI enabled the sustaining of successful tenancies for the majority of people participating in the program. As Table 1 shows, by the end of the evaluation, 70 per cent of participants remained in the same property they were first housed in (as part of the HASI program). Furthermore, 85 per cent remained with the same housing provider (even if some had left the program). Therefore most people established positive rental histories while in the program. With appropriate support from housing providers, NGOs and AMHS case managers, the majority of participants had no rental arrears, amiable relationships with their neighbours and maintained a sound level of property care.

**Table 1: Sustained Tenancy (Entry to Phase 3, n=105) (15)**

<table>
<thead>
<tr>
<th>Explanation</th>
<th>HASI participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustained tenancy</td>
<td>70%</td>
</tr>
<tr>
<td>Remained in same home (12 months or more)</td>
<td></td>
</tr>
<tr>
<td>Remained with housing provider in or out of HASI</td>
<td>85%</td>
</tr>
<tr>
<td>Rental arrears</td>
<td>83%</td>
</tr>
<tr>
<td>Proportion of tenants without rental arrears</td>
<td></td>
</tr>
<tr>
<td>Relations with neighbours</td>
<td>70%</td>
</tr>
<tr>
<td>Proportion of tenants with no complaints from neighbours throughout the program</td>
<td></td>
</tr>
<tr>
<td>Satisfaction with tenancy</td>
<td>94%</td>
</tr>
<tr>
<td>Self-reported participant satisfaction measured with a Likert scale</td>
<td></td>
</tr>
<tr>
<td>Property care</td>
<td></td>
</tr>
<tr>
<td>Housing provider managers reported property care</td>
<td></td>
</tr>
<tr>
<td>by the majority of HASI participants were equal to or better than general tenants</td>
<td></td>
</tr>
</tbody>
</table>

**Housing Lessons From HASI**

The majority of HASI participants achieved housing stability because of significant investment in social housing (DoH), ongoing, individualised accommodation support (NGO personnel), and clinical case management (AMHS). There were, however, numerous other important factors that assisted HASI participants to maintain stable, safe, affordable housing.

Housing providers and NGO personnel strived to match...
available accommodation to individual need and choice (and if initial housing did not match requirements, people were relocated). The type of housing is an important consideration. For example, the chance of conflict with neighbours was increased when noisy people were located in units. Standalone houses were unsustainable for other people because of the added responsibility of ground maintenance. These problems were lessened for HASI participants by matching property types to individuals, and also by ongoing, targeted supports and strategies (such as subsidised gardeners).

Where the accommodation is located, in terms of the social setting at the block, street and suburb levels is also important. Accessibility to family, friends, services and resources, such as shopping facilities, doctors and hospitals, increased the likelihood of a successful tenancy and other positive outcomes. The few HASI participants (6 per cent) who were not satisfied with their homes, were disgruntled with poor access to services and facilities, social problems in their block, street or area (such as drug and alcohol problems and anti-social behaviour) and/or felt geographically too far from family and social networks.

How properties are arranged and managed also affect individual tenancies. Capital owned properties (those owned by housing providers) offer more stability, than head-lease properties (owned privately and rented through OCH or DoH), because the latter can be sold at any time. Capital properties also provide flexibility in terms of the frequency and standard of property inspections, but they limit accommodation choice. Contrarily, head-lease properties enable greater choice and flexibility in regard to matching an appropriate property to an individual.

While there were considerable debates among AMHS and NGO interviewees and in the literature around the benefits and disadvantages of clustered or grouped, accommodation for people with mental illness,14 the evaluation found this could be successful under certain conditions. Where the cluster of homes was kept to a minimum of tenants (three or four) and where the tenant mix was carefully considered, it helped to build supportive, social relationships between people. However, too many people with mental illness and/or an inappropriate mix of individuals in a clustered setting could stigmatise people and hinder independent, integrated community living.

The sustainability of tenancies not only reflects appropriate choices in terms of housing type and location, but also ongoing support from housing providers and NGO accommodation support personnel. Property care is sound because NGO personnel work with HASI participants to improve, build or sustain living skills. Rental payments are consistent with the aid of NGO personnel providing budgeting support, coupled with the use of Centre Pay.17 In addition, most NGO personnel and housing providers work in partnership to prevent, intervene and/or solve tenancy problems.

Throughout the evaluation, problems persisted for a minority of HASI participants in relation to neighbour complaints, co-tenancy and exploitation. Complaints made against the 30 per cent of HASI participants were all in relation to property care (damage or maintenance issues) and nuisance or annoyance (such as noise levels, substance use and disruptive ‘uninvited guests’). Greater transparency around tenancy problems between housing providers and NGO accommodation support personnel may further prevent some neighbour complaints and property care issues. Unsurprisingly, participants housed in areas of high disadvantage with prevalent anti-social behaviour were most vulnerable to exploitation.

Co-tenancy was difficult for some people because the HASI Stage One model excludes shared leases. It was also problematic when informal co-tenancy arrangements resulted in exploitation and threatened tenancy instability. While some tenancy problems occurred for a minority of HASI participants, property retention rates are testimony to the effectiveness of the program in providing people with mental illness and high levels of psychiatric disability with secure, stable accommodation. HASI has worked well both as a reactive program, for people with poor rental histories and those living in unstable accommodation, and as an interventionist program, for people who were unsustainably depending on family or friends for somewhere to live.

Conclusion

People with mental illness are at risk of experiencing unstable housing or homelessness. Individualised accommodation support programs aim to assist people with mental illness to not only improve their mental health, but also acquire or maintain stable housing. HASI, a NSW Health and DoH program, has demonstrated that people with high levels of psychiatric disability can be successfully supported to live independently in stable housing. At the end of a two-year evaluation, 70 per cent of HASI participants remained in the same home they first moved into as part of the program. This was possible because of permanent social housing, intensive NGO support and active mental health case management. The tenancy findings from the HASI evaluation can inform policy that attempts to address housing stability for people with high levels of psychiatric disability.

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* Kristy Muir is a Research Fellow and the Evaluations Manager at the Social Policy Research Centre (SPRC), University of New South Wales (UNSW); Karen Fisher is a Senior Research Fellow at SPRC, UNSW. We would like to acknowledge Ann Dadich, David Abello, Alan Morris and Michael Bleasdale, who also worked on the evaluation.
Footnotes

8. As defined in the 2002 NSW Health Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders. 'accommodation support' is a component of disability support that specifically assists an individual to maintain their role functioning, skills and independence in relation to their accommodation.
11. These include the Greater Western, Hunter/New England, Northern Sydney/Central Coast, South Eastern Sydney/ Illawarra, Sydney South West and Sydney West Area Health Services.
12. The majority of homes have two-bedrooms. At the end of the evaluation 52 per cent were in a unit or an apartment, 32 per cent in a townhouse, villa or duplex and 8 per cent in a house.
13. From here on, HASI Stage One will be referred to as HASI.
15. ibid.
17. An automatic rent payment system where rent is electronically directed from Centre Link payments straight to the housing provider. This is a voluntary system that can be suspended at any time.
The Importance of Housing for People with Serious Mental Illness

Tom Meehan*, Terry Stedman and Samantha Robertson
Service Evaluation and Research (The Park), Centre for Mental Health

The reform of stand-alone psychiatric hospitals has been underway in Australia since the early 1980s. The reform agenda called for the downsizing and closure of psychiatric hospitals and the transfer of services and resources away from institutions towards community-based alternatives. In Queensland, a significant component of mental health reform has focused on the resettlement of people with long-term mental illness that resided in the three psychiatric hospitals in that State.

A number of strategies were initiated to promote the resettlement process. One of these became known as ‘Project 300’ and was established in 1995 with the aim of relocating 300 people with long-standing mental illness back to their community of origin or choice. Each person returning to the community received a package of care consisting of case management services, stable housing and disability/lifestyle support services in keeping with their needs. This paper argues that in addition to good case management, people with severe problems require stable housing and disability support.

Literature Review

The downsizing of state hospitals and the shift to community care for people with mental illness brought into focus the issue of how best to accommodate and support people with serious mental illness once they had moved to the community. The importance of housing and its contribution to one’s well-being cannot be overstated (Carling, 1995). A living situation that feels like a ‘home’ is a primary source of stability and security in the lives of all people — those with and without a mental illness. Indeed, much time and effort is spent in establishing and maintaining one’s preferred living space (ie. home) in the community.

Research findings from a number of studies suggest that environmental factors are better predictors of outcomes than patient variables, and that a low-stress environment that neither overwhelms nor under-stimulates the individual can favourably alter the course of serious mental illness (Rosenfield, 1990; Baker and Douglas, 1990). Indeed, when housing and psychiatric care are considered, housing appears to be a better predictor of success (ie. of not being hospitalised) than the existence of mental health services (Rosenfield, 1990). Baker & Douglas (1990) found that patients who remained in adequate and appropriate housing (as assessed by case managers) improved, while those in poor housing remained the same or deteriorated in their level of functioning. Similarly, patients who moved from poor quality housing to better housing improved in their global functioning. The authors concluded that the quality of housing had a clear impact on the outcomes for people with mental illness.

Mental health has learnt a lot from its previous mistakes and a dramatic change has occurred in the way that housing for people with mental illness is now conceptualised. Under the old paradigm, emphasis was on getting people a place to live and this was frequently linked to treatment and external control by mental health professionals and others. Within the new thinking, we strive to provide a normal housing that is controlled by the individual. Ridgway and Zipple (1990) describe the changing approaches to the provision of housing in North America.

<table>
<thead>
<tr>
<th>Old Thinking</th>
<th>New Thinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential treatment setting</td>
<td>A home</td>
</tr>
<tr>
<td>Staff control</td>
<td>Client control</td>
</tr>
<tr>
<td>Grouping by disability</td>
<td>Social integration</td>
</tr>
<tr>
<td>Learning in transitory/</td>
<td>Learning in permanent settings</td>
</tr>
<tr>
<td>preparatory settings</td>
<td></td>
</tr>
<tr>
<td>Standard service</td>
<td>Individualised service</td>
</tr>
<tr>
<td>Least restrictive environment</td>
<td>Most facilitative</td>
</tr>
<tr>
<td>(independence)</td>
<td>environment (supports)</td>
</tr>
</tbody>
</table>
It is now clear that consumers prefer to live in independent, integrated housing either living with friends, partners or alone. Consumers also tend to prefer not to live with other people with a psychiatric illness and prefer support, which is provided on a 24-hour basis, but available when the consumer requires it rather than when a health worker decides they should have it (Tanzman 1993; O’Brien and Peady, 1988). In addition, consumers want to feel part of their neighbourhood and to be integrated within the local community — they simply want the same as everyone else!

Consumer control over their housing and power relationships with treatment/support staff has also been identified. Control in decision making appears to be directly related to subjective quality of life and level of independence (McCarthy and Nelson, 1991). These findings can best be understood in terms of the empowerment theory. When individuals have control over decision making and participate actively in their settings, they experience control, personal growth and well being.

‘Project 300’

Project 300 was a Queensland Government initiative, which was designed to assist 300 people with psychiatric disability to move from institutional care to ‘normal’ living/accommodation options in the community of their choice. The project was somewhat unique in that it involved a partnership arrangement between the three Government Departments of Public Works and Housing, Family Services, and Health. Each client leaving hospital was provided with a ‘package’ of services consisting of accommodation, disability support services, and mental health services in keeping with their individual needs.

Housing Within ‘Project 300’

Individuals discharged from the institutions were provided with priority housing and they were encouraged to inspect a range of housing options before making a final decision. Some 76 per cent of clients reported that they had been directly involved in selecting their accommodation. All of the clients who responded, appreciated the opportunity to be involved and claimed that it reduced the stress of leaving hospital when they had some knowledge of where they were going to live in the future.

Non-involvement in the selection of accommodation occurred when the chosen accommodation was not within driving distance of the hospital involved. For example, clients who moved from Wolston Park Hospital (Brisbane) to North Queensland did not have the opportunity to view accommodation options prior to leaving hospital. However, they were happy that efforts had been made to meet their needs and the majority (82 per cent) were satisfied with the accommodation provided (when interviewed at six months post-discharge).

Accommodation was not provided free of charge and consumers were required to pay approximately 25 per cent of their income for their accommodation. Public housing in Queensland does not usually include furnishings. Thus, an ‘Establishment Grant’ of $5,000 was made available to each client to purchase household items essential to their daily life, comfort and safety. This process was empowering for clients as it enabled them to choose the goods they wanted for their new home. While most people spent the grant buying white goods, one man spent the grant on setting up a worm farm while another spent the whole grant on a leather lounge. He outlined that ‘now I have a comfortable chair… I could never find a decent chair to sit on in the hospital in the 20 years that I spent there’.

The grant could also be used to reconnect electricity and provide a telephone. Having a telephone was considered important by the people who were discharged as described by one of the individuals,

‘That’s my safety line there on that little table. I can talk to anyone I want anywhere in the world. I can even call my case manager and have a chat when I want to. I can go without most things but not my phone’.

Every effort was made by the Housing Department to provide accommodation in the locality selected by the client and to use normal housing. ‘Normal’ in the sense that it consisted of that, which was available on the open-housing market and is not necessarily affiliated with mental health programs or systems.

The majority of people demanded accommodation with at least two bedrooms. Some used the second bedroom to accommodate family members when they came to visit while others used the second bedroom as an art studio or for hobbies. Having an outside area as part of their accommodation was also considered important. However it is clear that such an area should have adequate privacy. As a consequence of their illness, many consumers feel restless at times and like to pace but are mindful of being observed by neighbours.

Disability Support Within ‘Project 300’

It is becoming increasingly recognised that people with psychiatric disability require intensive, flexible support over long periods of time. Support services are often essential in compensating for the lack of a family network or reducing the burden of care placed on carers. Support agencies work in collaboration with mainstream mental health services and tend to target people at the most severe end of the spectrum. They assist people to navigate the maze of mainstream social
and disability services by linking people to community-based recreation and vocational services. The focus of their work is on practical assistance with budgeting, personal hygiene, building social networks, promoting links to family/friends, providing psychological support, advocacy and advice (Harrington-Godley et al., 1988; Mak and Gow, 1996). Support workers provide a sense of psychological assurance for people with severe disability — they are available at weekends and out-of-hours when health professionals are not available.

Each individual entering the Project 300 program was assessed by a team of health professionals and disability support staff to determine the level of support required. On average, people received 24 hours of support each week when they left hospital. However, there was wide variation within this and while some individuals received only 1 hour of support, others received over 150 hours of support per week.

The majority of project 300 clients felt that their support workers were more attuned to their everyday needs and they found them to be credible helpers with whom they developed easy rapport.

‘My support workers help me with my problems if I get upset about something, and help me out the best way they can. Someone to talk to if I’m upset, I always talk to them’.

Many saw their support workers as paid friends that provide a degree of social support. This in itself is an important factor since lack of social support has been found to be associated with rehospitalisation (Mak & Gow, 1996; Clarkson et al., 1999) and increased contact with the criminal justice system (Caton et al., 1993).

**Summary**

The provision of appropriate and affordable accommodation was considered by those interviewed to be one of the most important components in the success of Project 300. While it is clear that housing has a physical component (i.e., an identified building), it also provides people with a sense of identity and asylum from the outside world. The quality of housing had been found in previous studies to impact on the rehabilitation, functioning, and quality of life of people with mental illness (Nelson et al., 1995; Baker and Douglas, 1990; Rosenfield, 1990). The provision of housing for people with mental illness is currently undergoing a paradigm shift, with three essential principles now increasingly recognised: Consumer choice (Ridgway, 1988), normal integrated housing (Hogan and Carling, 1992), and flexible, integrated support (Carling, 1990). These principles have formed the basis of the provision of housing within the Project 300 model and are closely related to the principles outlined in the National Mental Health Policy (1992).

It is likely that the high levels of satisfaction arise from having consumers involved in the selection of the accommodation prior to moving to the community. Carling (1993) found that those consumers who had no involvement in the selection of their accommodation experienced more problems than those who voluntarily entered the program. A greater proportion made suicide attempts and experienced self-neglect, and a higher proportion were re-hospitalised in that study.

Mental health professionals have an important role to play in the promotion of greater collaboration between health services and other agencies, both at a formal and informal level. Similar initiatives around the world have recognised the importance of housing for people with mental illness, and that the establishment of intersectoral links is a key element in the overall provision of quality care. For instance, in the UK, collaboration between the National Housing Federation and the Mental Health Foundation led to the development of the ‘Housing, Care and Support Code of Conduct’. This code forms part of a guide to good practice for managers of voluntary sector housing provision who are dealing with people with mental illness on a daily basis.

Optimal community integration for people with mental illness requires more than appropriate psychiatric care. Adequate disability support and suitable housing are also critical factors in the successful social integration and recovery of people with chronic mental illness.

**References**


* Tom Meehan, Director, Service Evaluation and Research (The Park) and Senior Lecturer (University of Queensland) can be contacted at Thomas_Meehan@health.qld.gov.au
After the Institution: What Next?

By Meg Carter
Research Fellow, Institute for Social Research, Swinburne University of Technology

Can people who have had long stays in psychiatric institutions be supported to live independently in the community? This article reports on a study that considers programs providing this support in two Australian cities. When psychiatric hospitals close, people residing in them need housing. Many also need support to enable them to live independently in the community. Since the inception of the National Mental Health Strategy in 1992 various models of support and housing have been developed for this group. This article discusses a research project being undertaken by the Institute for Social Research at Swinburne University of Technology in Melbourne that considers one of these models.

The project is called ‘Out of the Institution’. It looks at outcomes from a model of housing and support that has been implemented in Victoria, and at the recent implementation of similar model in South Australia. The study takes as its starting point a model delivered in the northern suburbs of Melbourne since 1995 by NEAMI, a psychosocial rehabilitation support agency, in partnership with Supported Housing Limited, which is a specialist housing management agency.

The model has three components. The first is housing. Clients live in their own homes, either alone or in pairs. Most properties are provided through the Victorian Office of Housing. Clients have security of tenure, and tenancy management is provided by Supported Housing Limited.

The second component is clinical support. This is provided by community-based mental health services, through Mobile Support Teams or community mental health services.

The third is psychosocial rehabilitation support, which is provided by NEAMI. A NEAMI worker provides support for clients in areas the client identifies as a priority. This may include things like cooking, shopping, cleaning, budgeting, using public transport, and getting involved with work, education and other community activities. Support will vary in intensity as clients’ needs change, and it continues for as long as the client feels they need it.

Variations on this model have been delivered by a number of agencies in Victoria and other states, for similar client groups. Examples include the Housing and Accommodation Support Initiative in New South Wales, the Independent Living Program in West Australia, and Project 300 in Queensland. These models of housing and support are of particular interest to policymakers in settings like South Australia, where stand-alone psychiatric hospitals remain at the centre of the mental health service system.

The ‘Out of the Institution’ project asks: ‘Does the model implemented in Victoria by NEAMI and Supported Housing Limited work?’ And: ‘Is it transferable to other settings?’ For the ‘Does it work?’ question, we want to find out:
- Where the model is effective, what are the critical factors that make it work?
- Where it is not effective, what are the critical factors that make it fail?
- How could the model work better?

For the ‘Is it transferable?’ question, we want to find out:
- What are the critical factors that enable or impede implementation?

The study uses qualitative methods. It looks at client experiences through semi-structured face-to-face interviews with clients, and with their psychosocial rehabilitation support workers. Where clients give permission we seek input also from their clinical workers and family members. The South Australian component of the study includes a follow-up twelve months after the initial interviews, to see how clients’ circumstances have changed.

The program implemented in South Australia is called ‘Returning Home’. Initiated in 2005, it is based on a model of support similar to that delivered in Victoria by NEAMI and Supported Housing Limited. Support under the program is available to inpatients of extended-care wards of Glenside hospital in Adelaide, who have been assessed as able to live in the community if appropriate services were in place. Under this model psychosocial rehabilitation support is provided by three non-government organisations: NEAMI,
Richmond Fellowship and Life Without Barriers. Clinical support is provided by community-based mental health services, and housing mostly through Housing SA.

‘Returning Home’ is similar to the model implemented in Victoria by NEAMI and Supported Housing Limited, but it is not the same. One task for the research is to identify critical differences between ‘Returning Home’ and the Victorian model that influence effectiveness in achieving outcomes for clients.

So far we have collected a huge amount of data, and are in the process of doing analysis. In Victoria, of the twenty-eight people who moved from psychiatric institutions into the ‘NEAMI Community Housing Program’ in 1995, eighteen remain with the program. Of the ten clients who are no longer in contact with NEAMI, some have moved to other areas and receive support from other agencies, and the whereabouts of others is not known. Of the eighteen clients who are still with NEAMI, eleven agreed to participate in the research. I have interviewed these eleven clients and their psychosocial rehabilitation support workers, and where possible, sought input from clinical staff and family members.

In South Australia I have interviewed twenty-five clients and their psychosocial rehabilitation support workers, and where clients gave permission I have sought input from clinical staff and family members. Of the twenty-five clients interviewed, thirteen had been discharged and were living in their own homes, and twelve were in the process of ‘transition’ from Glenside. We have also done a survey of clinical staff working in Glenside, and conducted interviews with staff working in management roles in clinical, housing and psychosocial rehabilitation support agencies in South Australia and Victoria.

Our initial analysis indicates some broad answers to our research questions. For the ‘Does the model work?’ question, the evidence in Victoria shows that the model has been effective in enabling some people with significant and ongoing disabilities associated with mental illness to sustain tenancies over a period of twelve years.

There are clearly sampling issues here, as the people I have interviewed in Victoria are those who have been successfully supported by NEAMI and Supported Housing Limited. But we have seen people who after having spent half a lifetime in hospital, have been able to live in the community with ongoing support. So yes, for some people, it has worked.

In relation to housing, key factors in the success of the model include the location and type of properties, managing issues around sharing or living alone, a commitment to providing ongoing tenure, arrangements for automatic payment of rent, and practices around tenancy management.

Around psychosocial rehabilitation support, key factors revolve around the nature of workers’ engagement with the client. Significant aspects include the intended duration of support, flexibility in its intensity and approach, the skills of support workers, the resources available to them, and the quality of their working relationships with other providers.

Our findings are similar to those reported in other studies. For example, evaluations of the Housing and Accommodation Support Initiative in New South Wales and Project 300 in Queensland found similar models successful in enabling clients to sustain tenancies. Muir et al. (2007) found, over their two-year longitudinal study, that 85 per cent of clients supported through Housing and Accommodation Support Initiative maintained their tenancies over this period. Meehan et al. (2007) found that over a seven year period, 82 per cent of clients in Project 300 remained in the community.

As we complete analysis of our data we will be able to say more about the critical factors for effectiveness of support in enabling clients to sustain tenancies, in the programs delivered in Victoria and South Australia.

In relation to the ‘Is the model transferable to other settings?’ question, the answer seems to be that effectiveness of implementation depends to some degree on context. Victoria and South Australia are very different from each other in relation to policy and service delivery around mental health. How these differences affect the transferability of the Victorian model of housing and support to the setting of South Australia will be another focus of our analysis.

So, can people who have had long stays in psychiatric institutions be supported to live independently in the community? Our findings show that under the model of housing and support delivered in Victoria by NEAMI and Supported Housing Limited, former long-stay patients have succeeded in living independently in the community over the long term. Comparable models implemented in New South Wales and Queensland have shown similar outcomes.

The ‘Out of the Institution’ project is still the early stages of data analysis, but at this point two findings are clear. For some people, the model does work. Its effectiveness in different settings is significantly shaped by the context in which implementation occurs.

For acknowledgements and footnotes for this article, see page 60
“Where Do You Go When Your Last Resort Has Closed?”

By Ann Smith (Operational Manager) and Tom Styli (Team Leader — Specialist Programs)
Salvation Army EastCare

The closure of Willow House (boarding house in inner east, Melbourne) earlier this month has caused workers to reflect on where clients with chronic mental health issues go, when other options are exhausted.

When Willow House was operational it was often the only option available in terms of housing for individuals who have been discharged from mental health services or released from corrective services. A typical resident of Willow might have had chronic mental health, drug and alcohol and legal issues. Unfortunately for many, the remaining rooming houses are the only option for those being discharged. Most of these individuals are on a Disability or Newstart allowance. The income is inadequate to meet the needs to maintain the accommodation and general cost of living expenses. There is little left after they have paid for the box that is considered a room. Often an individual shares a bathroom with six to ten other people, a kitchen which may only have a functioning sink and no cooking facilities. Storage of food is always a dilemma. Does one risk the food being taken by other tenants in the shared fridge or risk the health issues associated with inappropriate storage of food in their room? As a consequence, many individuals live off fast food, which is not only a financial burden but also a health issue for them.

Previously many of these individuals, who once would have felt safe and secure as they lived within the walls of the old psychiatric institutions, after a brief stay in the in-patient ward of a public hospital are now trying to recover in the community. Hospital Case Mix Funding and short-term hospital stays do not seem to marry up with the limited resources available in the community, even though there is much planning and collaboration around trying to provide seamless service delivery.

Currently many of the referrals we receive from the inpatient unit are for individuals who need help for primary homelessness. Many individuals are having extended stays in the inpatient unit primarily, not because of any specific therapeutic value, but rather that they cannot be discharged into homelessness. Recently a referred individual hospital admission was extended by an additional 2 weeks purely because he had nowhere to go and the concern was he would decompensate again quite quickly if accommodation was not sorted out prior to discharge.

Should these individuals desire to live in private rental, they frequently experience difficulties in obtaining and/or maintaining private rental either due to presentation and behavioural issues, inability or reluctance to pay for their accommodation and/or discrimination by real estate agents. Even if they were able to access the private rental system without discrimination, the boom in the rental market has placed this option way beyond their financial means. For example, where previously individuals were able to access a bedsit in the private rental market within the City of Boroondara for $80.00 per week, this has now risen to at least $160.00 per week, separate to utilities. The Centrelink benefits have not risen in line with the cost of living. For those on DSP benefits of approximately $300.00 per week, this is more than half their income. For those on Newstart it is considerably more. Financial counsellors would advise people that accommodation costs should not exceed one third of their income if they are going to be able to maintain it.

The alternative option for low-income people with multiple issues is to consider public housing. Anyone working in the field will understand and appreciate the difficulties associated with accessing public housing. In spite of the housing being targeted to those most in need, the level of public housing stock available is unable to meet the demand that exists.
within the community. Separate to this, the process of applying for public housing under the recurrent homelessness category is dependent upon people being in crisis managed housing or transitional housing, both of which are in short supply and have limited tenure. Bureaucracy works well if you have a base to work from. What do you do if you have no letterbox to receive your offer of housing?

Many of the people we work with are struck off the public housing list because of their primary homelessness and an inability to contact them. Others have a letter sent to them while they are in the inpatient unit (often as involuntary patients) and an offer of housing is sent to them, but as they are unaware of it, it is viewed as a rejection due to lack of response. Then if they are lucky to get a property there are a lot of other issues around referrals, setting up new bank accounts, links into new chemist, GPs, dentist, mental health provider let alone where the local supermarket is. As simple statements, it all appears to be non-daunting, but imagine you are doing all this while trying to come to terms with your diagnosis of paranoid schizophrenia or bi-polar with paranoid features. A recent example of this was a client who was nearly struck of the list as they were in the hospital when their offer of public housing came through. In the process of moving they had a lapse and were required to be admitted into hospital. Now it is close to 4 months since the move and the alternative support agency is only now able to commence working with the individual.

Within the Specialist Programs of Salvation Army EastCare we have the added benefit of having a very limited number of quarantined transitional housing properties that are connected to EastCare Housing. The benefit of having the two services within the same building allows for easier collaboration, speedier response in resolving issues, increased awareness of both programs and generally better working relationships. This co-location of programs enhances information sharing (e.g. when properties are being taken back by the owner), advocacy and negotiation for clients, exploration of strategies to resolve issues before they become problems and generally a shared value in that accommodation is primary to all of us in maintaining our physical, mental, emotional and social health.

More recently, even contending with the limited quarantined properties we have access to, that exceeds the number of clients, we have landlords who are terminating their ‘head leases’ with the Department of Human Services, which further reduces the stock of properties that are available for individuals and families. Again, while the policy may say priority is for people with mental illness to access public housing, what does one do when there is no property for them to access?

In the event that individuals gain public housing, the difficulty then arises as to how they will maintain this accommodation without the necessary supports. While it is policy for the Office of Housing to insist that individuals moving into public housing have support workers in place, the reality is that there are limited resources for this to occur, and an ongoing demand for workers to meet their targets in terms of throughput. Permanent ongoing support is rarely an option. At best, support is a short-term measure used to stabilise someone in their accommodation, and perhaps the opportunities to re-link should issues re-emerge sometime down the track. Even with these supports in place, frequently individuals end up back into the cycle of homelessness, often to the rooming house environment that contributed to their mental illness in the first place.

With the ongoing closures of rooming/boarding houses, the increased demand in the community, the sky rocketing rental costs and the limited public housing, combined with the increase of individuals presenting with multiple and complex needs in the community, the Government and the community sector need to find some answers and do so quickly. With deinstitutionalisation and the aforementioned issues, we are further marginalising the already disenfranchised and vulnerable within the community. If not addressed, we may end up like the U.S.A. with cardboard boxes becoming the norm.

From After the Institution: What Next?

Acknowledgements

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Footnotes

1. NEAMI started life as an advocacy group, the ‘North Eastern Alliance for the Mentally Ill’. It is now known by the acronym, NEAMI. See http://www.NEAMI.org.au/. For information about Supported Housing Limited see http://www.shl.org.au/.
2. People who receive support under this model are known as patients when they are in hospital, as consumers by psycho-social rehabilitation support agencies, and as tenants by housing providers. To reflect their status as people for whom this suite of services is provided, I refer to such people as clients.
3. For elaboration of the role of a support worker see Wismann, D., (2003) Psychosocial Rehabilitation: working with people with a psychiatric disability. To be a Keyworker New Paradigm Press, Melbourne
Chapter 5: Giving Voice
Nothing Worse Than Being Alone: A Case Study

Interviewee: Jennifer Riley
and written by Melinda Soos
Regina Coeli Community Inc.

When Jennifer stood up to receive her gifts, quiet swelled across the filled tables and those standing in the doorway. The bright red butterfly that adorned her hair bobbed as she spoke, sparkling in the light. “Thank you so much. It’s been almost a year since I came here,” she began. She continued with a catch in her voice that it hadn’t been easy, but she’d made a lot of friends and appreciated their support and the presents. She smiled disarmingly throughout the applause, and shyly as her peers lauded her. She was well liked, fun, and had contributed to the Community since her arrival.

It was birthday night at Regina Coeli Community in North Melbourne, celebrated once a month. Inclusively it encouraged all residents and past residents to participate. It was a time of commemoration not only of the passing of another year, but of the achievements made within it.

Jennifer entered the Community in December 2006 after being referred by the psychiatric unit at Royal Melbourne Hospital. One evening Jennifer had arrived on her brother’s doorstep, asking to stay. She had nowhere else to go. Her brother, like her parents, had been at their wits’ end with what to do. Since Jennifer left the family home aged eighteen, they had witnessed her gradual decline into drug-induced paranoia, amotivation and seclusion that may have exacerbated an underlying mental illness. Feeling it was beyond them to help, they turned to the Royal Melbourne Hospital. There Jennifer was diagnosed with schizophrenia.

Jennifer is gently-spoken. She considers her words before she speaks, often witty but always worldly-wise. She recalls growing up essentially alone with her continually arguing parents. Her two brothers were a decade older than her and weren’t always around to support her. Her mother, who had been diagnosed with breast cancer just after Jennifer’s birth, was paranoid, particularly about her husband’s whereabouts. There was very little affection in the home. It was an unhappy time.

When Jennifer was ten-years-old, her mother died. It had been a protracted, hospital-based death, after which Jennifer “went into shock.” She didn’t miss her mother until she was older, when she mourned what could have been and missing “the transition from being a mum to being a friend.”

Her father re-married some years later. It was hard for Jennifer to accept that he and his new wife got on so well. One day, she saw her step-mother taking down pictures of her mother. She remembers thinking, “What? Where’s the home gone?”

Jennifer rebelled. While her family had always considered her fairly uncommunicative and thankless, she became even more so, abusing their efforts. Although Jennifer could see their frustration, she didn’t seem to be able to do anything to change her behaviour. “I wasn’t a confident teenager,” she says. “I didn’t have very high self-esteem, but I made good friends at high school.” She changed schools twice in primary school and thrice during high school. “Maybe all this moving around contributed…through instability,” she considers. She enjoyed school, particularly music and sports; the encouragement of a sports teacher has remained with her, contributing to her current interest in becoming a fitness instructor.

After finishing high school, Jennifer had had “enough of school” and went into full-time work at KFC where she enjoyed the atmosphere. Shortly afterwards, she moved in with a friend, got her driver’s licence and bought a car. “I loved the high life,” she says. She roller-skated, camped and clubbed, looked forward to her free time. “I could do whatever I wanted, be whatever I wanted. My time out, my fun.”

Wanting a change, she left KFC after eighteen months to work in horticulture. She liked working outdoors and the work made her feel good about herself. She was placed into training courses, mastered a four-wheel-drive and studied plant life. Jennifer drank alcohol only on weekends with friends, but the occasional cannabis use became more regular. Over three years, she became dependent on it and with it, became apathetic. She went into work “feeling good, but I would wonder what I was doing, if it was the
right thing." She started sleeping in, and autumn turned to winter “all the more reason not to get out of bed.” Eventually, she stopped going to work and turned her phone off. She felt guilty about work; her manager left messages with her father wanting an explanation, and for Jennifer to know they would welcome her back any time, as KFC had. She continued smoking cannabis until she “didn’t wake up.”

The more Jennifer smoked, the more she felt her problems would go away. She describes her problems as “just coping with day-to-day life: rent, keeping the car on the road, putting food in the cupboards, buying drugs and alcohol. Smoking was the easy way out.” She would smoke after dinner, wake in the night to smoke more, and would wake stoned by morning. “My body clock was out of whack,” she says.

As the years passed, her stable friendship group fragmented. However, Jennifer maintained a relatively secure relationship with her partner, with whom she lived. She embarked on a series of casual factory-line and gardening jobs. It was hard to know what to expect from the new jobs. She didn’t commit to anything she didn’t like. If she’d had a bad day, she went home to smoke. Although she wondered about using “chemical drugs,” her partner ensured they weren’t available to her.

Jennifer moved to the Mornington Peninsula to be closer to her parents after she split with her partner. It was a time of emotional upheaval. “I had memories of him in my head,” she remembers. “I dreamed of what could have been.” Her parents knew she was using drugs and although they didn’t encourage her to stay under their roof, they eventually bought her the caravan she was living in. “They didn’t really know what to do with me,” she says. Her brothers were interstate and overseas at the time. She went on Centrelink benefits and continued living alone, smoking. “I was never really paranoid, but in the caravan park I became so paranoid I didn’t want to leave the caravan park to use the toilet block.”

She became friendly with others in the caravan park including a young mother and an older man, “a father figure,” with whom she cooked and talked. She also met a man on her first weekend in the caravan park who, that weekend, held up the local Chinese to get money for his next fix. While he was in jail for two and a half years, Jennifer kept up correspondence with him. “Being with him gave me confidence,” she says. She found work for a couple of days a week as a cleaner and took on a hospitality job that led her to work as a kitchen hand in Tasmania for eighteen months. It was a good experience, and her parents encouraged her to stay there because she was doing really well.

She returned to the caravan park, however, anticipating her friend’s release from prison. She stuck up for him, although her parents thought she was mad. Angry that nobody supported their relationship, she started smashing up the caravan. She moved in with her partner, but the relationship didn’t last long. Again, alone and stressed, returned to smoking cannabis.

“I had a warped idea that no-one would let me work full-time if I didn’t get out of the caravan park and have a normal local address,” Jennifer says. She found a room in a house with a mother and son as landlords. The son became her partner for nearly two years. When they broke up, Jennifer sought out someone who she felt could help her. That was when she went to her brother and asked to move in. After years of her abuse towards her family, and feeling her attitude to life, self, and standard of living was below normal, her brother told her he would take her to hospital for help.

Jennifer spent three months at Royal Melbourne Hospital, feeling as though she didn’t need to be there. She was cared for with three regular meals a day, but didn’t fully understand what was going on. “I’m still in the dark about my diagnosis,” Jennifer says. “People with schizophrenia have hallucinations and stuff, but I never did. The doctors didn’t really explain what it meant and why it happened.” She also described bad side effects and a “cloudy mind” from the medication administered. “It took a lot of nagging to get them to change it.” The caseworkers and support workers were helpful and interactive, “but you learned more from the other patients. You didn’t feel alone.” Jennifer became an outpatient and from the half-way house was transferred to Regina Coeli Community. She still keeps in touch with two of the patients and feels she can go back to the caseworkers and “say g’day.”

At Regina Coeli, Jennifer felt “a bit far out in this big old house. You even have to raise your washing using pulleys,” she laughs. “It became common knowledge about respecting others and you had to learn the house rules. It’s been an experience getting to know the other residents and the reasons why they’ve been living here for such a long time. It can be a good thing to have company sometimes. There’s nothing worse than being all by myself.”

Jennifer keeps her weekly meetings with the community case workers, as well as the monthly psychiatry out-patient sessions. Stable and content for now, she involves herself in the community chores and activities from daytrips to singing, which she finds therapeutic. Although her relationship with her family is still distant and her brothers both have families of their own, Jennifer feels more able to be affectionate towards them and looking back, wishes she’d taken advantage of their help. She can see now how her behaviour affects others and is more deliberate about her actions.

Jennifer remains positive about the future. “I feel more
confident and strong,” she says with a smile. “I know that if a problem comes up, instead of ignoring it until it gets worse, I have to face it.” She is determined she won’t take the easy way out by using drugs again. “I know I’ve changed since leaving home, and my time here at Regina is a bit memorial. I was brought up a Catholic, and so is this place.” It’s made her think about how she was a child and how far she has come since then.

Jennifer is still pursuing her interest in becoming a fitness instructor; she contemplates she could use the new skill to put something back into the community down the track. She feels she has benefited from the community’s support and is ready to move on, but will return for birthday nights to keep part of the community. Judging from the words of her fellow residents, Jennifer will be missed. Aged twenty-seven, articulate, happier and more insightful, Jennifer is like the beautiful butterfly dancing in her hair, poised for flight and as she says, “ready to tackle to world outside.”
Piter’s Story

Interviewed by new paradigm Editor, Matt Clear and new paradigm Editorial Assistant, Kristie Lennon

Recently diagnosed with psychosis and depression, 23-year-old Piter, a Prahran Mission participant for over seven years, speaks openly about his experiences of living on the streets of Melbourne from the age of six.

‘I know what it’s like to be homeless; I’ve been there done that. I was in foster care from the age of one. For a while I was abused by a couple of my foster parents, that’s why I was on the streets. I just wanted to leave. I had to go on the streets. I don’t know how I managed to survive on the streets because I had nowhere to go. I had no Centrelink benefits. I had nothing.

I don’t fear anything because I’ve been brought up to be fearless. I know I’m a strong person; I’m straight up with people. I don’t like it, but I’ve been brought up fighting. I’ve been brought up around abuse and I’ve been brought up with guns being pulled out at me. I was street fighting for money, I was doing burglars and I was stealing food. I lived on the streets in St Kilda, South Yarra, Toorak and Footscray for about six years.

I had to sleep at train stations at night time and I survived on two hours’ sleep a day. I always slept where people could see me, so if anything happened, there would be witnesses. Eventually after about two or three years, I started getting an eye for squats that were vacant. I made them into my own little home. I used to stay at the main train stations, tram terminals and disused buildings. There used to be an old tram terminal down by the Yarra River; I stayed there for a while, but that’s no longer there. That was the only place that had electricity in it. I was lucky. Then I stayed at the old Empire theatres for four months. It wasn’t really like a squat, it was more like a home. It had a microwave, it had gas, it had electricity and it had a bed for me to sleep on.

I was in the drug scene as well; I hung out with drug dealers a lot. I’ve been chroming since I was 10. I stopped using heroin, speed, ice and pills about five years ago but now I just chrome, which I’m doing something about. When I was 10-years-old I was doing 10–15 cans a day. I’ve cut down a lot since then.

I do have a slight anger problem. Just recently I was diagnosed with psychosis and depression. I knew I had depression for a while, probably since I was about 10. I only got officially diagnosed with it two weeks ago, so it was a shock. But I’m not going on medication for this. I’d rather just suffer. Medication will just stuff me up. I don’t even go on painkillers anymore. Medication just makes me too drowsy, it just makes me not want to do anything. I refuse to touch any medication or I’ll miss out on things I want to do.

I like to keep myself occupied, keep off the chrome. I do want to sort myself out. I’m in transitional housing at the moment but it’s hell. I was alright for a while but there have been arguments and punch-ons there. People are breaking into my place and I’m sick of it cause it ends in hospital and I don’t want to go down that road anymore. But that’s the only way I know how to survive. I live by myself. I don’t even use the word ‘friends’, I don’t use the word ‘acquaintances’, they’re just people I know or people I’ve seen. I’ve always been by myself.

I put in a segment one, which is for reoccurring homelessness and this pushes me up the list for housing commission but I called the housing commissioners yesterday and they said it got cancelled, so I’m back onto the general waiting list. Now I have to appeal against the housing commission to get back up to the segment one. With transitional housing, you’re only supposed to stay in the one place for 18 months, but if I don’t have a place at the end of the 18 months and if they kick me out, I’ve got nowhere to go.
The government don’t care. They only want their money. They don’t care about people who live on the streets. If I had a lot of money, I’d build shelters and stuff like that. But the government really need to just get off their arses and help the homeless.

I’ve been coming to Prahran Mission since February 2000. I get support here but I don’t ask for much of it. I’m too independent. I do music group every Thursday and I’m also going to Young Person’s Group at Revolver on Fridays. I’m also doing art and poetry. I like music and that’s why I do music group. It’s good practice for me because I’m hoping that sometime in the future I can start a band or something. It gives me a bit more experience and improves my singing voice and my bongo playing. Up until about a month ago, I hadn’t touched the bongos for about eight years and in the last month I’ve been playing them again.

My goals in life are to get off the chrome, to run my own restaurant as a chef, or to own a restaurant and become a youth worker. I want to live up in the country and do cooking and I think Second Storey [a Prahran Mission program] will help me through.

To all the homeless people out there, I would say focus on the positive things you have done in your life. Look at me, see how far I’ve come from the age of six and take that as inspiration. I’d also like to say to everybody that there is support out there. You might not think there’s support but there is. You just have to find it so you’re able to do the stuff you want to do, even if it’s just staying out of jail, which is one of my biggest achievements!'
No Limits PDRSS & VicHealth
Promoting Mental Health and Wellbeing Through Constructive Engagement

Coordinated and Written by James McCracken
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No Limits PDRSS, St Mary’s House of Welcome, Melbourne.

My Favourite Place photography project was initially set out to promote mental health wellbeing through developing skills and interests in photography. Through this, it was hoped to promote confidence and create a sense of inclusiveness and facilitate participation within the group and the broader community. The grant received for the project is the first that St Mary’s House of Welcome has received from VicHealth. The project was also supported by the City of Yarra.

The project was conceived by David Ring, a social worker at St Mary’s House of Welcome, as a constructive means of engagement with those whose lives are often engaged through deficiencies. An essential aim of the project was to teach people from marginalised backgrounds and those with a mental illness the skills required to be a photographer. This was done through a 13 week course, co-ordinated by James McCracken and Lara Denes, running from the 4th of July through until the 20th of September, 2006.

The group was facilitated by Georgia Metaxas, a professional photographer and social documenter. Twelve individuals formed the core of the group, and enthusiastically attended the 13 week course. During this time, participants were taught many essential photography skills; from using an SLR camera, through to framing and exhibiting work. The group also visited many photographic galleries, including the Australian Centre for the Moving Image (ACMI) and the National Gallery of Victoria. Furthermore, the group was constantly exposed to the previously exhibited work of Georgia Metaxas.

During the course, the group was approached by Colors Magazine, an international photographic journal, and asked to exhibit at the Colors Notebook exhibition at the Pompidou Centre, Paris, in October, 2006. The exhibition was aimed at celebrating the freedom of speech. This was done through the distribution of blank Colors journals which were then filled with photographs taken by the participants, as well as artwork and prose. This great work and fantastic opportunity was documented by Martin Flanagan ‘Note the names…. faceless, anonymous; now almost famous’ (The Age, 5/8).

An exhibition of 36 images resulting from the course, entitled My Favourite Place was exhibited at the Richmond Town Hall from the 3rd of October until the 27th of September, 2006. The exhibition was launched on the 10th of October (World Mental Health Day), by Dr Ruth Vine, director of Mental Health at the Department of Human Services. After this, the images toured various cafes and public venues around the City of Yarra, in order to promote mental health wellbeing, and inclusiveness within the City of Yarra. Eventually the exhibition returned and has been mounted in the dining room at St Mary’s House of Welcome, as a reminder of the amazing journey that 12 individuals and their cameras went on.

My Favourite Place was an incredibly successful project for all those involved. The project was awarded best health promotion project primarily promoting mental health and wellbeing with budgets under $15,000. Many of the participants also developed a passion for photography that they have continued to pursue. The staff involved in the project observed vast changes in the self esteem and self-confidence of many of the participants. Individuals who at the beginning were distant and disengaging primarily due to lack of confidence, were, by the end, talkative, participating, engaging, actively asking questions and were seeking ways in which to sustain the project beyond its specified period. An individual who frequently attends St Mary’s intoxicated and was thought he wouldn’t last in the group, attended all sessions sober, committed and met all deadlines that were set out for the participants. The individual has since began to engage in volunteer work in the kitchen at St Mary’s and is seldom intoxicated.
The success of *My Favourite Place* lead to St Mary’s House of Welcome receiving a second, and significantly larger grant from VicHealth. The digital media project PsycheTube aimed to impart individuals with 21st century skills necessary to challenge the digital divide, which prevents individuals acquiring employment and maintain their position in the poverty cycle.

Also conceived by David Ring, PsycheTube aimed to teach 12 individuals who regularly experience marginalisation, resulting from homelessness and mental illness, how to use computers for them to tell their story using a variety of digital mediums. It was hoped that through this, the individuals would be able to use these skills to challenge their circumstances. Beginning on the 6th of March, 2007 and running for 13 weeks, the participants (many of whom had participated in *My Favourite Place*) were taught digital photography by Georgia Metaxas; and literacy writing and digital media skills through a partnership established with the Council of Adult Education (CAE).

During this time the group travelled regularly into the CAE and engaged with the classroom and education system, something many of the participants had not done since their diagnosis. Throughout the course of the project, the participants self-esteem and self-confidence increased noticeably, as did their confidence and skills at engaging not only with one another, but with previously unknown teachers. This development in social skills was perhaps most evident in the group having a very social and conversant mid-morning coffee on DeGraves St during the course of the project.

At the conclusion of the 13 week period, each person had composed a digital story, using two types of digital media, that they had not used before. After a celebratory lunch with all involved, all work was handed over to ‘The Works’ and our IT consultant, Adam Weisser, for a few minor adjustments before being posted on the internet.

The PsycheTube webpage was launched on the 28th of June, at the Fitzroy Town Hall by the Hon. Lindsay Tanner, MP and Mr Todd Harper, CEO of VicHealth. PsycheTube furthered the success of *My Favourite Place* by offering marginalised access to equipment to develop the skills required to challenge their circumstances in a constructive, engaging and fun environment.

The success by which PsycheTube will be measured by, is the five participants from the project who are continuing their education with the CAE next semester, without any involvement from the PDRSS. As is already well documented, education and access to it can offer these individuals a very real and permanent chance of overcoming their disability, and moving out of the poverty cycle. These are very positive outcomes by which we measure the success of our projects.
**Mental Health, Housing and the Problem of Supply**

By Ben Ilsley  
Policy and Research Officer  
Psychiatric Disability Services of Victoria (VICSERV)

Regardless of how homelessness and mental illness are defined, people with mental health problems are over represented in the homeless population.

In many ways, the causality between the two issues is complex. Studies show that having a mental illness makes it more likely that someone will become homeless (Jablensky) but also that being homeless makes it more likely that one will develop a mental health problem (Chamberlain, Johnson and Theobald). Mental illness is also likely to affect the duration of homelessness. This all makes intuitive sense: having a mental illness means that one is more likely to be unemployed and in poverty, both of which are detrimental to maintaining secure housing. Having a mental illness also means that you are more likely to encounter discrimination from landlords or neighbours. It may mean that your behaviour is less acceptable to others in the community at times or that your skills in organising your finances are inconsistent. Many people with mental illness have experienced family breakdown, a known risk factor for homelessness. Conversely, it is easy to understand that the lack of safe and secure housing can lead to anxiety, abuse and social isolation which can adversely affect mental health.

What is different for people for people with mental health problems accessing and maintaining housing?

People with mental health problems can have particular difficulties in accessing housing. The vast majority of this group are unemployed or on low incomes and so are less likely to own their own home than other population groups. Similarly they are likely to find it difficult to afford accommodation in the private rental market, particularly in inner city areas. Affordability problems are particularly acute when looking for single accommodation. In this increasingly competitive commercial environment, people with mental health problems are also vulnerable to discrimination from real estate agents and landlords. For accommodation to be suitable, it must be near to mental health and support services, which are often concentrated in inner city areas. People are less likely than the general population to drive or own a car so are limited further to areas with good public transport links.

The inaffordability of the private sector frequently means that people with mental health problems are limited to living in public housing or community housing. Public housing is targeted towards people with a history of recurring homelessness and/or mental health problems but is not without its drawbacks and critics. Waiting lists are lengthy and choice is limited. Public housing is often located on areas of high density where the concentration of people with complex needs is not helpful for recovery from mental illness. Furthermore, there are concerns that targeting policies have lead to the increasing stigmatisation of this housing type. Community housing can be planned to avoid these problems, but is also in limited supply. Other issues regarding community housing will be addressed shortly.

There are also risk factors relevant to the retention of housing. Mental illness is often episodic which means that someone’s mental health status and situation in regard to employment, behaviour or ability to cope can fluctuate. This issue is described within the paper, *The 21st Century Housing Careers of Persons with a Disability* (A. Beer and D. Faulkner, 2007). The social isolation caused by mental illness can also mean that personal supports are limited. Illness may have caused psychiatric disability, which can impact on important life skills such as financial management, payment of bills and so on (Reynolds 2001).

The Case for Addressing this Issue

Housing is a human rights issue, as identified in the Brian
Burdekin report on Human Rights and Mental Illness (HREOC, 1993). Homeless people with psychiatric disability are among the most vulnerable of groups in our community. Stable housing is a lynchpin of social inclusion: it is difficult to hold down a job without a home or participate in the community in any meaningful way. There are further compelling arguments on therapeutic, systemic and economic grounds.

We know that for people with mental health problems, the existence of secure housing is, in fact, a better predictor of someone’s mental health than whether that person is involved with mental health services (Rosenfield, 1990, Baker and Douglas, 1990). If people are given secure housing, their mental health improves. Similarly, if early effective treatment is provided, people with mental health problems are less likely to become homeless (Herrman et al, 1998).

The 2006 report, Improving Mental Health Outcomes in Victoria: The Next Wave of Reform (Boston Consulting Group) identifies that Victoria’s mental health system has significant problems in terms of a lack of access for people requiring services. Part of this problem is that of “blocked beds”, that is, parts of the acute hospital system cannot be accessed by others because there are people “stuck” in the mental health system, frequently because they would lack appropriate housing or support if they were discharged. This is a problem for the person “stuck” in an unnecessarily restrictive hospital environment, for people who need the system but cannot access it, and also for the taxpayer. It costs the public purse well over $400.00 a day to treat someone in an acute inpatient hospital. The combination of mental illness and homelessness can incur considerable further financial cost for the state: homeless services, treatment for physical health problems, possible criminal justice involvement amongst others. One of the report’s recommendations is that the government invests in additional new stable housing and housing assistance for people with mental illnesses.

Deinstitutionalisation

There is some evidence that the prevalence of severe mental illness amongst the Australian homeless population has increased since the 1980’s (DoHA, 2005). It may be natural to reflect here on the fact that Victoria’s large psychiatric institutions used to provide, amongst other things, housing for the mentally ill, and indeed this may have been a therapeutic intervention of sorts. We no longer have these institutions and the mental health care component of the old asylums has indeed this may have been a therapeutic intervention of sorts. We no longer have these institutions and the mental health care component of the old asylums has been moved to the community. It is easy to posit that, while the clinical care component of the old asylums has to some extent been delivered, the safe, long term housing and support elements have not. While this line of discussion is beyond the scope of this article, it is worth pointing out that national and international studies suggest that it is not the long-term patients of psychiatric institutions who became homeless, but rather people who had no history of hospitalisation or a history of short stays in hospital. Another relevant counter to a call to reopen institutions is that programs that provide long-term housing in the community with flexible support, such as the HASP in Victoria, HASI in NSW or Project 300 in Qld, have all demonstrated success for people with psychiatric disabilities (O’Brien et al, 2002, Abdello et al., 2006).

A Way Forward

As mentioned above, there are successful and evaluated existing programs across Australia that offer housing and support to people with mental illness. Although there are some local differences, they have the following components in common:

1. Long term housing e.g. through public or community housing.
2. Supportive landlord eg community housing provider, which is separate from the support provider.
3. Clinical support.
4. Psychosocial or disability support.

An essential feature of the design of these programs is that they are integrated so that all the components work together to meet the varying needs of the resident. Choice of housing by the person with mental illness is also important, as is flexibility of support.

These have all been evaluated to some extent and have been shown to be successful in a number of domains such as the maintenance of housing and the reduction in readmission to acute mental health services. Important learnings have also been documented, which could be used to improve future implementation or expansion.

Given that these models have been shown to meet the needs of people with mental illness, it might seem that we have arrived at a solution: an immediate and extensive expansion to these programs, possibly with some minor changes. There are also other existing programs, such as Pathways, which aim produce better co-ordination between mental health and homeless services. However, the larger problem is not so much one of how to deliver programs or of what model to use, but is more one of supply of both housing and support. The Housing and Support Program (HASP) in Victoria, instituted in the 1990’s, has largely lost its identity and has not been sustained because housing stock has not been replaced as residents have recovered from mental illness and so no longer needed support. This problem of supply is largely a political and economic one rather than of practice or models.

Affordable Housing, the Commonwealth and the State

Australia is deep in an affordable housing crisis (Disney,
2007), as currently described throughout the media. Many people in the mainstream population are experiencing housing stress. The issue is a highly complex, systemic one and solutions, as advocated by the Australian Alliance for Affordable Housing, are necessarily multifaceted and beyond the scope of this paper. However, given the additional barriers faced by people with mental health problems, it follows that this group will be particularly disadvantaged in such a competitive environment. It is a consequence of this complexity that both Commonwealth and State governments have roles to play if any progress to be achieved. Commonwealth funding for public housing delivered through the Commonwealth State Housing Agreement has decreased significantly over recent years (Bleasdale, 2007). A report released by the Australian Housing and Urban Research Institute (Bleasdale 2007) also points to a lack of clear data that allows an understanding of current or levels of unmet need. This context may have influenced the Victorian state government to embark on a series of policies to ensure that community housing organisations deliver housing in economically sustainable ways. This means that housing providers must be able to demonstrate that their housing stock will grow without additional funds. Joseph Connellan (2005, 2006) has highlighted a number of possible negative implications of this policy direction for people with disabilities. Organisations will be encouraged to house people who can pay more rent to support growth and this is likely to exclude people on very low incomes such as that provided by the Disability Support Pension. This approach would seem to undermine the ethos and core mission of community housing. The 2007–08 Victorian State budget provided an additional $300 million for community housing. None of this money has been targeted or allocated to particular groups other than to people on “low incomes”.

Opportunities

The Council of Australian Governments (COAG) National Action Plan on Mental Health 2006–11 includes $1.8 billion additional spending by the Commonwealth. Some of the plan’s emphasis is on participation in the community and employment, including accommodation. However, there is no funding allocated within this spending towards the actual provision of housing, in spite of this being an essential prerequisite for recovery from mental illness. Victoria’s government is currently developing a new Mental Health Strategy for reform. The early signs are that the approach will also involve some ideas around social inclusion and a “whole of government” approach. It is vital that this includes a mental health housing strategy and that progress is made in developing sustainable models of providing supply of appropriate housing and support for people with mental illness.

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Rosenfeld, Baker and Douglas
Rhonda is an artist and musician and has produced a number of little books similar to Cat Wars. If you would like to purchase some of Rhonda’s work, please make contact with her at rhondaplaysbanjo@yahoo.com.au.
Psychiatric Disability Services of Victoria (VICSERV) Inc. Membership Application Form

Name ________________________________________________________________

Organisation __________________________________________________________

Street Address ______________________________________________________________________

Suburb ___________________________ Postcode ______________

Country ____________________________________________________________________________

Email ______________________________________________________________________________

Telephone ___________________________ Fax _____________________________________________

Type of Membership applied for

☐ Ordinary (full) ☐ Associate ☐ Individual

Is your organisation psychiatric specific support ☐ Yes ☐ No

If yes, what type(s)?

☐ Day Program ☐ Home-based Outreach ☐ Respite Care

☐ Mutual Support and/or Self help ☐ Residential Rehabilitation ☐ Statewide (describe)

Please describe any other services your organisation provides _________________________________

The funding level of your organisation (for billing and statistical purposes) ________________________

The above named organisation (or individual) hereby applies for membership of Psychiatric Disability Services of Victoria (VICSERV) and nominates the above-named person as the contact person for all correspondence. Upon acceptance of this application, Psychiatric Disability Services of Victoria (VICSERV) is authorised to insert the name of this organisation (or individual) in the register of members of the incorporated association. We hereby agree to abide by the Rules of Psychiatric Disability Services of Victoria (VICSERV)

Signed Official Representative _______________________________________________________

Name ________________________________________________________________

Position __________________________________________________________________________

Upon approval of the application by the VICSERV Committee of Management, you will be invoiced for the membership fees due.

If an organisation, please supply a copy of your last Annual Report, and a Statement of Purposes, or other information about your service.

Please mail completed form to:
Membership
Psychiatric Disability Services of Victoria (VICSERV)
Level 2, 22 Horne Street,
Elsternwick Victoria 3185 Australia

Or
Please fax completed form to:
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