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SPLA ENQUIRY INTO HOMELESSNESS

Background
The author of this submission once worked as a nurse at Rozelle Psychiatric Hospital, and trained as a psychiatrist at St Vincents Hospital in inner city Sydney before taking up a fellowship at the Maudsley Hospital in south east London, and UCLA in California. He worked for fifteen years in NSW prisons and since 2006 has performed a weekly clinic at the Matthew Talbot Hostel for the homeless in Woolloomooloo. The observations and recommendations in this submission mainly relate to the homelessness faced by people with severe mental illness and other disabling mental disorders.

The current plight of the mentally ill has often been blamed on the closure of beds in the large psychiatric hospitals from the 1980s, which in NSW was attributed to the Richmond Report. In fact, deinstitutionalisation began long before that much maligned report, as Rozelle Hospital (previously known as Callan Park) had around 4000 patients in 1950, about 400 when I worked there as a nurse in 1977, and was down to around 200 by the time the Richmond Report came out in 1983. What the report actually recommended was adequate provision for care of the mentally ill in the community, in particular, the construction of clusters of supported accommodation.

Research suggests that the discharged patients did not on the whole end up in prison, but the prisons now hold a cohort of new patients who might once have been housed in the large hospitals. In effect, our prisons are the new asylums. NSW prisons (our oldest industry) now house between 700 and 1000 people with schizophrenia every night, which compares with 1600 psychiatric beds for the entire state. A large proportion of those patients are released without a secure place to stay. Nearly a third of attenders at our clinic, including those with schizophrenia, are straight out of gaol.(1)

In response to the items in your terms of reference:

1. **The incidence of homelessness in Australia**

About a third of the rough sleepers in Sydney and other large cities have severe mental illness, mainly schizophrenia. Moreover, people with severe mental illness are more likely to be chronically homeless and to sleep in the open for long periods.

2. **Factors affecting the incidence of homelessness, including housing-market factors**

In 1990 there were about 1200 beds in the four large homeless shelters in Sydney – Matthew Talbot, Edward Eager, Foster House and Swanton Lodge. For various reasons, there are now only 300 or so. The difference is basically your rough sleeping population in inner city Sydney on any night, which the annual census shows is between 700 and 800 people. Similarly, in 1990 it was usually possible to obtain a place in a boarding house in which medication and meals might be provided and the resident would still have some money left over for tobacco. Many of those places have been closed down by fire and

other regulations, the market has been slow to replace them and the cost is now often beyond the means of people living on Centrelink payments.

3. The causes of, and contributing factors to, housing overcrowding

Obviously the main reason is supply and demand. There has been chronic underinvestment in public housing, despite housing being one of the most effective forms of welfare. The stock of public housing has remained static in NSW while the population has doubled. The stock is also quite old and often no longer fit for purpose, and the cohort of residents are more and more disabled and dysfunctional. The NSW Housing Department has prioritised the homeless mentally ill, but their tenancies often do not last because less disabled people move in and take over. When the celebrated wordsmith Vincent Greentree died in his Housing Department flat in Woolloomooloo after 30 years of sleeping in the open (https://www.smh.com.au/national/nsw/a-piece-of-woolloomooloo-has-died-passing-of-man-homeless-for-39-years-20181205-p50kcg.html), twelve other people were reported to be sleeping there with him.

4. Opportunities for early intervention and prevention of homelessness

Some preventative measures that might prevent the mentally ill losing tenancy and becoming homeless include:

- Crisis rental assistance
- Involuntary hospital admissions to address co-morbid substance use
- Rapid rehousing of mentally ill prisoners on release
- More flexible transfer arrangements to allow vulnerable tenants to get away from predatory neighbours
- A range of tenancy support, including an expansion of existing programs that have been positively evaluated
- Improved security in housing estates

5. Services to support people who are homeless or at risk of homelessness, including housing assistance, social housing, and specialist homelessness services

I would like to advocate for a particular model of housing for the severely mentally ill who are not in stable tenancy or being supported by family, and that is clusters of purpose built units within a secure perimeter and day staff to direct care and rehabilitative programs. The best example of the model in Australia is the Haven foundation founded by Allan Fels in Melbourne (havenfoundation.org.au). However, a large scale version can be found in Italy, where the radical closure of the large psychiatric hospitals, seen at the time as an example of Italian chaos, has in fact led to the construction of around 30,000 community based places in small clusters. The Italian example has been in effect the adoption of the recommendations of the Richmond Report. A more systematic version in Europe, based on the quality of construction and the integration of mental health care into the service, has been the Y Foundation in Finland (ysaatio.fi), the only European Country to reduce homelessness among the mentally ill.

6. support and services for people at particular risk of homelessness, including

a. women and children affected by family and domestic violence;
b. children and young people;
c. Indigenous Australians;
d. people experiencing repeat homelessness;
e. people exiting institutions and other care arrangements;
f. people aged 55 or older;
g. people living with disability; and
h. people living with mental illness

This submission particularly applies to people with severe mental illness, mainly schizophrenia, who are now often discharged from hospital without secure accommodation, and released from prison without any preparations being made for further treatment. The lack of preparation for discharge results in more rapid return to hospital and prison, and the lack of suitable supported accommodation is one of the main causes of bed block and stress on the mental health system.

7. The suitability of mainstream services for people who are homeless or at risk of homelessness

Mainstream services have failed the homeless mentally ill. In our experience public hospitals show a nihilistic attitude to the care of the chronically homeless. Better to direct funding to services that are genuinely committed to providing long term secure supported accommodation, and not to the large NGOs or to existing government run services.

8. Examples of best-practice approaches in Australia and internationally for preventing and addressing homelessness

There is no one size fits all model of care, and a range of services are needed for the various communities and levels of disability arising from severe mental illness. As well as Haven in Melbourne, Home in Queanbeyan (homeqbn.org) is a good example of a philanthropy led purpose built cluster of housing for the severely mentally ill. Home received grants from the State and Commonwealth to build on a church owned car park. The model proposed by Habilis (habilis.org.au) hopes to go one better, by incorporating visiting psychiatrists and mental health nurses to ensure continuity of care for people who have been chronically homeless and under treated.

9. The adequacy of the collection and publication of housing, homelessness, and housing affordability related data

There is ample data. There are also improved opportunities to perform case linked research through improvements in data provision by MBS and PBS, as well as state based registries and the data linking organisations. The cumbersome procedures for approval and the obstructiveness of some agencies has prevented some research. However, there is no lack of information. What is needed is housing.

10. Governance and funding arrangements in relation to housing and homelessness, particularly as they relate to the responsibility of Local, State, Territory and Federal Governments.

Haven has been able to use capital grants from the Victorian State government for the purchase and construction of units in high need areas. Recurrent funding for those clients is now available through the NDIS, mainly in the form of SIL grants for individual care packages, which in effect pays for staffing of centres. A more secure method is SDA funding for purpose built accommodation to house the more disabled chronically mentally ill. Extending SDA funding and making it a more reliable basis on which to construct housing would help meet the need. Our data suggests the problem is finite, and that about 1000 units would make an enormous difference to the mental health and prison systems in NSW.

The NDIS was not intended for people with mental illness, although people with severe forms of schizophrenia often meet all the criteria.

Yours sincerely

Olav Nielssen

1. Nielssen OB, Stone W, Jones NM, Challis S, Nielssen A, Elliott G, et al. Characteristics of people attending psychiatric clinics in inner Sydney homeless hostels. The Medical journal of Australia. 2018;208(4):169-73.
2. Nielssen O, McGorry P, Castle D, Galletly C. The RANZCP guidelines for Schizophrenia: Why is our practice so far short of our recommendations, and what can we do about it? The Australian and New Zealand journal of psychiatry. 2017:4867417708868.