Homelessness, Mental Health and Human Rights

Submission to the Senate Select Committee on Mental Health

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1. Executive Summary and Recommendations

1.1 Summary

This submission is made by the PILCH Homeless Persons' Legal Clinic to the Senate Select Committee on Mental Health.

The submission examines and discusses the relationship between homelessness, poverty, discrimination and mental health. The submission also examines and discusses the importance of analysing and addressing these issues in a human rights framework, consistently with Australia's obligations under the *International Covenant on Civil and Political Rights* and the *International Covenant on Economic, Social and Cultural Rights*, to which Australia is a party.

The submission is particularly addressed to Terms of Reference (c), (e), (f), (i), (j), (m), (n) and (o).

A summary of findings and recommendations is set out below.

1.2 Findings

Findings in Relation to Homelessness, Poverty and Mental Health

- On any given night, almost 100,000 people experience homelessness across Australia.
- There are clear causal and consequential links between homelessness, poverty and poor mental health outcomes. Poor mental health can cause, contribute to and exacerbate homelessness and poverty, and homelessness and poverty can cause, contribute to and exacerbate poor mental health. There are also clear correlates between discrimination against people experiencing homelessness or poverty and poor mental health outcomes.
- Identified health-related consequences of homelessness include low self-esteem, social isolation and mental health problems. It is estimated that up to 80 per cent of people experiencing homelessness also experience some form of mental disorder, including mental illness, drug dependency, intellectual disability and acquired brain injury. Homeless people also experience significantly higher rates of death, disability and chronic illness than the general population. Identified chronic mental health issues for people experiencing homelessness include schizophrenia, post-traumatic stress disorder (with up to 93 per cent of homeless people reporting at least one event of extreme trauma in their lives), and depression.
- There is a direct correlation between the period of time that a person experiences homelessness and the worsening of that person's mental health.
- Homeless people have significantly less access to health services than the broader population. Identified barriers to adequate health care for people experiencing homelessness include:

- financial barriers and hardship and associated lack of access to appropriate and affordable health care;
- lack of transportation to medical facilities;
- competing needs – basic subsistence needs in relation to food, accommodation and income take precedence over health care;
- lack of documentation, including proof of identity, medical records and Health Care Cards;
- many homeless people do not have a Medicare Card and very few have health insurance;
- lack of contact details which presents difficulties in maintaining contact and, for example, communicating results;
- reluctance on the part of many homeless people to engage with services due to previous negative experiences;
- lack of insight into illness or assistance to access services – those most in need are those least likely to obtain health care;
- difficulty maintaining appointments, contact or treatment regimes;
- disconnection from supportive social networks;
- difficulties associated with navigating and negotiating a complex service system;
- issues of discrimination, stigma and prejudice; and
- co-morbidity.

- Research and experience demonstrate that improving health outcomes for homeless people requires specifically targeted health care services. These should be delivered together with programs which address the underlying causes of homelessness, including through the provision of housing, income support, employment and training opportunities, primary care, rehabilitation services, counselling and other support services.
- The health care system should ensure that people experiencing homelessness are not discharged on to the street or into accommodation which is likely to damage or detrimentally impact their health or welfare.

Findings in Relation to the Role of Human Rights in Addressing Homelessness and Poverty and Promoting Good Mental Health

- There is a strong correlation between a state's respect for human rights and that state's success in addressing homelessness and poverty and promoting good mental health.
- The promotion of good mental health requires that factors underlying poor mental health outcomes, including homelessness, poverty and discrimination, be identified and addressed through a range of legislative and institutional measures. The international human rights framework provides a useful and

important framework to identify, monitor, assess and address such factors. Poverty and vulnerability to poor mental health can be significantly reduced by governmental implementation of obligations to respect, protect and fulfil human rights.

- Under international human rights law, particularly article 12 of the *International Covenant on Economic, Social and Cultural Rights*, all people have the right to the highest attainable standard of health. This right imposes an obligation on governments to establish conditions, including the adoption of legislative measures, which are designed to ensure that people have the best possible chance for being healthy. These conditions include that people are able to access the full variety of facilities, goods, services and conditions necessary to ensure an individual's mental health. These conditions also include access to appropriate mental health care, safe water, adequate sanitation, an adequate supply of safe food, adequate nutrition, adequate housing, occupational health, a healthy environment and access to health-related information.
- Article 11 of the *International Covenant on Economic, Social and Cultural Rights* provides that all people have the right to adequate housing. Access to adequate housing is a critical determinant of good mental health; people without homes suffer from ill health at much higher rates. Providing, and ensuring access to, adequate housing is both the most effective and cost-efficient prevention and treatment of homelessness and associated ill health.
- A human rights approach to the promotion of good mental health and the reduction of homelessness and poverty requires active and informed participation of people experiencing homelessness in the development, implementation and assessment of health care, housing and poverty reduction strategies. This is also required by article 25 of the *International Covenant on Civil and Political Rights,* article 13(1) of the *International Covenant on Economic, Social and Cultural Rights* and article 2(3) of the *Declaration on the Right to Development*.
- The right to equality and freedom from discrimination is an integral component of the international human rights normative framework and is entrenched in articles 2(1) and 26 of the *International Covenant on Civil and Political Rights* and article 2(2) of the *International Covenant on Economic, Social and Cultural Rights*.
- An adequate income is necessary to ensure an adequate standard of living, facilitate participation in the civil, political, economic, social and cultural aspects of community life, and to facilitate access to the highest attainable standard of mental health. The absence of a guaranteed minimum income, together with the fact that social security payments are generally pegged and paid below the Henderson Poverty Line, is a significant contributor to people either living in or being at risk of poverty, homelessness and poor mental health across Australia. Article 9 of the *International Covenant on Economic, Social and Cultural Rights* enshrines the right of all persons to receive social security necessary to meet basic subsistence needs.

1.3 Recommendations

Recommendations in Relation to the Right to the Highest Attainable Standard of Health

Recognising the human right to the highest attainable standard of health and the links between homelessness and poor mental health, the Australian Government should:

- substantially increase funding to improve the availability and accessibility of targeted, specialist mental health care services for homeless people. These services should be holistic and multi-disciplinary, and coordinated and integrated with housing, income support, employment, training, rehabilitation, counselling and other support services, to achieve positive health and social inclusion outcomes; and
- ensure that people experiencing homelessness are not discharged from mental health care services on to the street or into accommodation which is likely to damage or detrimentally impact their health or welfare.

Recommendations in Relation to the Right to Adequate Housing

Recognising the human right to adequate housing and the links between homelessness and poor mental health, the Australian Government should:

- amend the *Supported Accommodation Assistance Act 1994* (Cth) to enshrine a right of access to crisis accommodation for homeless people;
- increase funding to the Supported Accommodation Assistance Program by 40 per cent to meet demand; and
- develop a National Housing and Taxation Plan that includes strategies to align the supply of affordable housing with demand. The availability of affordable housing, including public housing, should be progressively increased through both direct expenditure and fiscal and taxation policy reforms.

Recommendations in Relation to the Right to Participation

Recognising the human right to participation and the links between the participation of homeless people in policy and service design and delivery and the improvement of mental health:

- federal, state and territory governments should commit to ensuring that people who are homeless or formerly homeless are directly represented on all governmental and departmental reference groups, advisory groups and steering committees that relate to homelessness or to issues that impact on people experiencing homelessness;
- all homelessness assistance services should be required to directly involve people who are homeless or formerly homeless in organisational governance, management, development and operation; and

- through SAAP, federal, state and territory governments should fund and support people who are homeless or formerly homeless to form groups and associations to participate in governmental and sectoral policy development, decision-making processes and service delivery development and operation.

Recommendations in Relation to the Right to Non-Discrimination

Recognising the human right to non-discrimination and the links between homelessness, discrimination and poor mental health:

- federal, state and territory governments should amend anti-discrimination and equal opportunity law to prohibit discrimination on the ground of 'homelessness', 'unemployment' and 'being in receipt of income benefits' and to ensure the availability of redress and effective remedies in respect of such discrimination; and
- the Australian Government should schedule the *International Covenant on Economic, Social and Cultural Rights* to the *Human Rights and Equal Opportunity Commission Act 1986* (Cth). This would empower the Commission to investigate and monitor discrimination against people experiencing homelessness, particularly in relation to the implementation of economic, social and cultural rights that are determinants of good mental health, such as housing and health care.

Recommendations in Relation to the Right to Social Security

Recognising the human right to social security and the links between lack of adequate income, homelessness and poor mental health, the Australian Government should ensure that:

- social security payments are available to all people who experience a loss of income beyond their control or who require income support to ensure realisation of their human right to an adequate standard of living;
- social security payments are increased to levels above the Henderson Poverty Line so that recipients are able to meet their material needs and participate in society. Payments should be sufficient to ensure that recipients can afford adequate housing, health care and an adequate standard of living;
- the breach penalty regime under the *Social Security Act 1991* (Cth) is amended so that people are only penalised if they wilfully and intentionally breach their mutual obligations. Penalties should be no longer than 8 weeks duration, no greater than 25 per cent of income and recoverable on compliance or reasonable steps;
- Centrelink's 'proof of identity' requirements are changed so that homeless people can use a letter from a homelessness assistance service as proof of identity; and
- an integrated package of social security assistance to homeless people is developed that includes access to health care, adequate housing,

employment assistance and personal support to ensure sustainable outcomes.

2. Introduction

2.1 Overview of Submission

This submission is made by the PILCH Homeless Persons' Legal Clinic to the Senate Select Committee on Mental Health.

The PILCH Homeless Persons' Legal Clinic would appreciate the opportunity to supplement this submission with oral evidence at any public hearing.

This submission examines and discusses the relationship between homelessness, poverty, discrimination and mental health. The submission also examines and discusses the importance of analysing and addressing these issues in a human rights framework, consistently with Australia's obligations under the *International Covenant on Civil and Political Rights* and the *International Covenant on Economic, Social and Cultural Rights*.

The submission concludes that Australia's legislative and institutional frameworks for mental health should enshrine the right to the highest attainable standard of health and recognise and respond to the social and economic determinants of health, with particular regard for the special needs of people experiencing homelessness, by respecting, protecting and fulfilling human rights.

2.2 PILCH Homeless Persons' Legal Clinic

The PILCH Homeless Persons' Legal Clinic, a project of the Public Interest Law Clearing House (Vic) Inc, provides free legal services at 9 drop-in centres to people who are homeless or at risk of homelessness. It also undertakes significant community education, public policy advocacy and law reform work.

Since its establishment in 2001, the Clinic has provided legal advice to almost 1500 homeless people across Victoria. These services have been provided by volunteer pro bono lawyers from Allens Arthur Robinson, Baker & McKenzie, Blake Dawson Waldron, Clayton Utz, Mallesons Stephen Jaques, Minter Ellison, the National Australia Bank Legal Department and Phillips Fox.

3. The Links Between Homelessness and Mental Health

3.1 Introduction

Homelessness and poverty are among the most serious socio-economic and health issues confronting Australia and Victoria.

There are strong associations between homelessness, poverty and poor mental health outcomes.

3.2 Homelessness in Australia

On any given night, almost 100,000 people experience homelessness across Australia. This includes over 14,000 people sleeping rough or in squats, more than 14,000 in crisis accommodation or refuges, almost 23,000 in boarding houses, and nearly 49,000 people staying temporarily with friends of relatives. A further 23,000 people across Australia live temporarily in caravan parks.[1]

According to the Australian Institute of Health and Welfare, approximately 153,000 people accessed homelessness assistance services in 2003-04.[2] Despite this, every day, more than 700 people are turned away from homelessness assistance services due to lack of capacity and resources.[3]

The causes of homelessness are complex and varied. However, they are generally acknowledged to include:

- structural causes (such as poverty, unemployment and inadequate supply of affordable housing);[4]
- fiscal, social and public policy causes (such as taxation policy and expenditure on public and community housing, health care, education and vocational training);
- individual causes (such as ill health, mental illness, intellectual disability, substance and alcohol dependency, problem gambling, domestic violence, family fragmentation and severe social dysfunction); and
- cultural causes (such as the provision of culturally inappropriate housing or support services to indigenous communities).[5]

In many cases of homelessness, these causes are intersectional and related.

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[1] Australian Bureau of Statistics, *Counting the Homeless 2001* (2003).

[2] Australian Institute of Health and Welfare, *Homeless People in SAAP: National Data Collection Annual Report 2003-04* (2005) 9.

[3] Australian Institute of Health and Welfare, *Demand for SAAP Assistance by Homeless People 2001-02* (2003).

[4] Following the 2001 Census, the Australian Bureau of Statistics identified unemployment and inadequate income as significant structural factors contributing to and causing homelessness across Australia: Australian Bureau of Statistics, *Counting the Homeless 2001* (2003).

[5] See generally, 'The Changing Face and Causes of Homelessness: Symposium' (2002) 15(9) *Parity*.

In addition to those experiencing homelessness, it is estimated that up to 35 per cent of low income people experience 'housing stress', meaning that their housing costs are so great relative to their income as to jeopardise their ability to meet other basic needs. Almost 10 per cent of low income people experience 'extreme housing stress', meaning that they are required to spend more than 50 per cent of their income on rent to avoid homelessness.[6]

3.3 The Relationship between Homelessness and Poor Mental Health

There are strong associations between homelessness and poor mental health.[7]

Poor mental health is a cause of, a contributor to, and consequence of homelessness.[8] As the US Institute of Medicine states in a report entitled *Homelessness, Health and Human Needs*, there are three types of interactions between homelessness and poor mental health:

1. some mental health problems precede and causally contribute to homelessness;
2. some mental health problems are consequences of homelessness; and
3. homelessness exacerbates and complicates the treatment of many mental health problems.[9]

Each of these interactions is discussed in further detail below.

3.4 Mental Health Problems can Cause Homelessness

There is strong evidence demonstrating that poor mental health can cause homelessness.[10]

For example, poor mental health can cause homelessness by reducing a person's capacity to obtain or maintain employment or an adequate income.[11] Similarly, according to the National Mental Health Working Group, 'mental illness can affect basic abilities to access and sustain a tenancy – including the ability to work through administrative requirement, such as completing application forms' or paying rent

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[6] Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) 123-4.

[7] The terms 'mental illness' and 'poor mental health' are used in this submission to mean 'the existence of a clinically recognisable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions': World Health Organization, *International Classification of Diseases and Related Health Problems* (10th revision, 2002).

[8] Adrienne Lucy, 'South Eastern Sydney Area Health Service Homelessness Health Strategic Plan 2004-09' (2004) 17(8) *Parity* 6.

[9] Institute of Medicine (US), *Homelessness, Health and Human Needs* (1998) 39.

[10] See, for example, S Fleischman and T Farnham, 'Chronic Disease in the Homeless' in D Wood (ed), *Delivering Health Care to Homeless People* (1992). See also Margaret Eberle et al, *Homelessness: Causes and Effects – A Review of the Literature* (2001) 7.

[11] Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) 173.

regularly.[12] Similarly, mental health problems can cause family fragmentation and loss of the social and economic supports necessary to maintain stable housing.

It is also well recognised that severe mental illness can cause both psychosocial and socio-economic decline and also 'inner city drift', all of which may result in homelessness.[13]

3.5 Mental Health Problems are a Consequence of Homelessness

There is also strong evidence establishing that poor mental health is often a consequence of homelessness and can maintain homelessness. Poor mental health is also associated with many correlates of homelessness, including substance abuse and dependency, stress, anxiety and trauma.[14]

Identified health-related consequences of homelessness include low self-esteem, social isolation and mental health problems, particularly schizophrenia and affective disorders such as depression, bipolar depression and post-traumatic stress disorder.[15] It is estimated that up to 80 per cent of people experiencing homelessness also experience some form of mental disorder, including mental illness, drug dependency, intellectual disability and acquired brain injury.[16]

According to recent studies, homeless people also experience significantly higher rates of death, disability and chronic illness than the general population.[17] Identified chronic mental health issues for people experiencing homelessness include schizophrenia, post-traumatic stress disorder (with up to 93 per cent of homeless people reporting at least one event of extreme trauma in their lives), drug dependency and depression.[18] These conditions often combine with other chronic illnesses, such

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[12] National Mental Health Working Group, *Homelessness and Mental Illness: Bridging the Gap – Discussion Paper* (2003) 5.

[13] Correspondence with Dr Julian Freidin, Consultant Psychiatrist, Alfred Hospital Homeless Outreach Psychiatric Service, 10 April 2005. See also Sydney City Mission, Society of St Vincent de Paul Salvation Army, Wesley Mission and the Haymarket Foundation, *Shifting the Deckchairs: Homeless People and Mental health Services in Inner City Sydney* (1997).

[14] Correspondence with Dr Julian Freidin, Consultant Psychiatrist, Alfred Hospital Homeless Outreach Psychiatric Service, 10 April 2005.

[15] Adrienne Lucy, 'South Eastern Sydney Area Health Service Homelessness Health Strategic Plan 2004-09' (2004) 17(8) *Parity* 6, 7; Margaret Eberle et al, *Homelessness: Causes and Effects – A Review of the Literature* (2001) 8.

[16] Colin Robinson, *Down and Out in Sydney* (1998); Peter Ellingsen, '80% of Homeless have Mental Disorder' *The Age* (Melbourne), 19 December 2004; Department of Family and Community Services, *Accommodating Homeless Young People with Mental Health Issues* (1999); Margaret Eberle et al, *Homelessness: Causes and Effects – A Review of the Literature* (2001) 7.

[17] E Harris, P Sainsbury and D Nutbeam (eds), *Perspectives on Health Inequity* (2000); Adrienne Lucy, 'South Eastern Sydney Area Health Service Homelessness Health Strategic Plan 2004-09' (2004) 17(8) *Parity* 6, 7.

[18] Colin Robinson, *Down and Out in Sydney* (1998). See also Colin Robinson, *A Long Road to Recovery: A Social Justice Statement on Mental Health* (2001).

as blood borne viruses (particularly Hepatitis B and C), skin infections, cardiovascular disease, malnutrition, dental decay and tooth loss.[19]

There is also mounting evidence that there is a direct correlation between the period of time that a person experiences homelessness and the worsening of that person's mental health[20] and similarly between a person's mental health and the duration of that person's homelessness, with poor mental health linked to longer periods of homelessness.[21]

3.6 Homelessness Exacerbates and Complicates the Treatment of Many Mental Health Problems

Notwithstanding the particular vulnerability of people experiencing homelessness to poor mental health and ill health generally, homeless people have significantly less access to health services than the broader population.[22] The Senate inquiry into poverty and financial hardship found that homeless people 'miss out on a range of health services'.[23] As one formerly homeless person reports:

> I was assaulted several years ago while having no fixed address. I was admitted to the Accident and Emergency department of a major hospital bruised and battered and with two sprained ankles. There was no avenue for effective after care. Who has ever heard of a hospital admission for sprained ankles! For somebody with a safe and secure home, limited use of both legs can be a major inconvenience. For somebody who has no secure home, limited use of their legs can be a serious threat to their continued well-being.[24]

Identified barriers to adequate health care for people experiencing homelessness include:

- financial barriers and hardship and associated lack of access to appropriate and affordable health care;
- lack of transportation to medical facilities;

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[19] Adrienne Lucy, 'South Eastern Sydney Area Health Service Homelessness Health Strategic Plan 2004-09' (2004) 17(8) *Parity* 6, 7. See also Royal District Nursing Service Homeless Persons Program, *A Framework: Improving Health Outcomes for People Experiencing Homelessness in Victoria* (1999), cited in Department of Human Services, Victoria, *Primary and Acute Health Responses to People Who Are Homeless or at Risk of Homelessness: Information Paper* (2000) 4; Sam Lees, 'Homelessness Health Issues' (2004) 17(8) *Parity* 30, 30.

[20] See, for example, L J Trevana, D Nutbeam and J M Simpson, 'Asking the Right Questions of Disadvantaged and Homeless Communities: The Role of Housing, Patterns of Illness and Reporting Behaviours in the Measurement of Health Status' (2001) 25(4) *Australian and New Zealand Public Health* 298-304.

[21] Margaret Eberle et al, *Homelessness: Causes and Effects – A Review of the Literature* (2001) 7.

[22] E Harris, P Sainsbury and D Nutbeam (eds), *Perspectives on Health Inequity* (2000).

[23] Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) 174.

[24] Matt Gleeson, 'Obstacles to Surviving Homelessness' (2000) 13(10) *Parity* 7, 7.

- competing needs – basic subsistence needs in relation to food, accommodation and income take precedence over health care;
- lack of documentation;
- many homeless people do not have a Medicare Card and very few have health insurance;
- lack of contact details which presents difficulties in maintaining contact and, for example, communicating results;
- reluctance on the part of many homeless people to engage with services due to previous negative experiences;
- lack of insight into illness or assistance to access services – those most in need are those least likely to obtain health care;
- difficulty maintaining appointments, contact or treatment regimes;
- disconnection from supportive social networks;
- difficulties associated with navigating and negotiating a complex service system;
- issues of discrimination, stigma and prejudice; and
- co-morbidity.[25]

Research and experience demonstrate that improving health outcomes for homeless people requires specifically targeted health care services, delivered together with programs to address underlying causes of homelessness, including in the areas of housing, income support, primary health care, training and employment, protection from discrimination, rehabilitation and reintegration.[26] The consequences of failing to provide adequate treatment, support services and supportive housing for people who are homeless and have mental health issues include 'poor physical health, social dysfunction, inappropriate incarceration, higher crime rates, prolonged homelessness and early death'.[27] Despite this, Australia does not have a national housing strategy, a poverty reduction strategy, a homelessness action plan, a homelessness health strategy, or adequately funded and appropriately targeted health care services for homeless people.

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[25] L Gelberg, L S Linn, R P Usatine and M H Smith, *Health, Homelessness and Poverty: A Study of Clinic Users* (1996) 2325-30; National Mental Health Working Group, *Homelessness and Mental Illness: Bridging the Gap – Discussion Paper* (2003) 5; Margaret Eberle et al, *Homelessness: Causes and Effects – A Review of the Literature* (2001) 16-17. See also Royal District Nursing Service Homeless Persons Program, *It Can Be Done: Health Care for People who are Homeless* (1992), cited in Department of Human Services (Victoria), *Primary and Acute Health Responses to People Who Are Homeless or at Risk of Homelessness: Information Paper* (2000) 3; Correspondence with Dr Julian Freidin, Consultant Psychiatrist, Alfred Hospital Homeless Outreach Psychiatric Service, 10 April 2005.

[26] Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539, 540; Correspondence with Dr Julian Freidin, Consultant Psychiatrist, Alfred Hospital Homeless Outreach Psychiatric Service, 10 April 2005.

[27] National Health Care for the Homeless Council (US), *Addiction, Mental Health and Homelessness: Policy Statement* (2004) 1.

3.7 Poverty and Poor Mental Health

There are similarly strong links between poverty and poor mental health. Socio-economic status is a critical determinant of health status, with lower socio-economic status generally associated with poorer overall health.[28]

Poor mental health plays a central role in creating, exacerbating and perpetuating poverty. Evidence tendered to the Senate inquiry into poverty and financial hardship demonstrated that poor health can cause poverty (by, for example, reducing a person's capacity to engage in employment or education) and maintain poverty (by, for example, requiring a family to sacrifice basic needs to meet health care costs).[29] As one witness to the Senate inquiry testified:

> I have got no health care for my children. I dread every sniffle and cough because I cannot afford to go to the doctor and, if I do go to the doctor, I cannot afford to pay for the prescriptions that they are going to need when I am finished. We may be at the top end of the poverty scale but we are on the downward slide and, if something is not fixed, then that is where we will end up.[30]

Similarly, poverty tends to have a very negative overall impact on mental health. Substantial statistical analysis demonstrates that the most critical determinants of a population's life expectancy, a key indicator of public health, are public expenditure on health care and the success of poverty alleviation strategies, including targeted health care programs for the disadvantaged and social security and safety net arrangements.[31] Despite this, Australia does not have an anti-poverty strategy or a targeted and comprehensive health care program for people experiencing poverty. Further, there is no national program to ensure the conditions necessary for health, including access to adequate housing, nutrition, income support and health and medical services.

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[28] Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) 173; John Glover, Diana Hetzel and Sarah Tennant, 'The Socio-Economic Gradient and Chronic Illness and Associated Risk Factors in Australia' (2004) 1(8) *Australia and New Zealand Health Policy* 1. See generally Chris Reynolds, *Public Health Law in Australia* (1995).

[29] Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) 173.

[30] Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) 174.

[31] Sudhir Anand and Martin Ravallion, 'Human Development in Poor Countries: On the Role of Private Incomes and Public Services' (1993) *Journal of Economic Perspectives* 7; Amartya Sen, *Development as Freedom* (1999) 44-7.

4. Improving Mental Health for People Experiencing Homelessness through the Realisation of Human Rights

4.1 Introduction

Homelessness and poor mental health are both complex and multi-faceted problems that are often caused or exacerbated by, or a consequence of, multiple and inter-related individual and structural deprivations. If the good health of people experiencing homelessness is to be promoted, 'street level' public policy responses and interventions that are flexible, responsive, individualised and holistic need to be joined-up and implemented with structural socio-economic reforms in the areas of housing, health, income support, freedom from discrimination, participation and social inclusion.

The international human rights framework provides a useful structure to effectively promote good mental health, and address the particular mental health needs of people experiencing homelessness and poverty.[32] This is because there is a strong positive correlation between a state's respect for human rights and that state's success in addressing poverty and promoting public health.[33] The *International Covenant on Economic, Social and Cultural Rights* and the *International Covenant on Civil and Political Rights* are particularly pertinent to this discussion given that Australia's ratification of these instruments results in tangible legal obligations on the part of both the Commonwealth and the states with respect to human rights, particularly social and economic rights that impact on mental health.

4.2 The Role of Human Rights in Addressing Homelessness and Promoting Good Mental Health

The international human rights framework provides a useful and important framework to identify, monitor, assess and address the civil, political, economic, social and cultural determinants of poverty and poor mental health. Homelessness and vulnerability to poor mental health can be significantly reduced by governmental implementation of obligations to respect, protect and fulfil human rights.[34] According to former UN High Commissioner for Human Rights, Mary Robinson:

> Respect for human rights, the standards of which are contained in numerous international instruments, is an important tool for protecting health. It is those who are most vulnerable in society — women, children, the poor, persons

[32] See generally, UN Office of the High Commissioner for Human Rights, *Human Rights and Poverty Reduction: A Conceptual Framework* (2004); UN Office of the High Commissioner for Human Rights, *Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies* (2002). See also, World Health Organization, *Mental Health Legislation and Human Rights* (2003).

[33] See generally, Amartya Sen, *Development as Freedom* (1999) 49, 87, 90 and 144.

[34] World Health Organization, *Health and Freedom from Discrimination: WHO's Contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance* (2001) 6. See also B Loff, 'Reconciling Rights with Risk' in Australian Institute of Health Law and Ethics, *Public Health Law: New Perspectives* (1998) 139.

> with disabilities, the internally displaced, migrants and refugees — who are most exposed to the risk factors which cause ill health. Discrimination, inequality, violence and poverty exacerbate their vulnerability.
>
> It is therefore crucial not only to defend the right to health but to ensure that all human rights are respected and that the root economic, social and cultural factors that lead to ill health are addressed.[35]

The international human rights framework also imposes obligations on governments to develop and implement policies that provide all persons with the maximum opportunity to be healthy, including by addressing poverty and homelessness.

The interdependence and indivisibility of the international human rights framework makes it clear that while governments have obligations to respect and protect the right to health — including by preventing, treating and controlling disease and ensuring access to appropriate health care — they also have obligations to ensure the conditions required for fulfilment of good mental health.[36] This requires that they progressively correct conditions that may impede realisation of the right to health — such as poverty and homelessness — as well as ensure that all people can access the goods and services necessary for good mental health, including through realisation of the right to adequate housing, the right to equality and freedom from discrimination, the right to participation and the right to an adequate income or social security.[37] Each of these rights and concomitant obligations are discussed in further detail below.

4.3 The Right to the Highest Attainable Standard of Health

Pursuant to article 12 of the *International Covenant on Economic, Social and Cultural Rights*, all people have the right to the highest attainable standard of physical and mental health.[38]

Content and Scope of the Right to the Highest Attainable Standard of Health

Although the right to health does not necessarily translate as a right to 'be healthy' (the United Nations Committee on Economic, Social and Cultural Rights acknowledges that health is relative to an individual's biological conditions and a state's available resources),[39] the right does impose important substantive obligations

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[35] Mary Robinson, UN High Commissioner for Human Rights, quoted in World Health Organization, *Health and Freedom from Discrimination: WHO's Contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance* (2001) 7.

[36] Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539, 540.

[37] See generally, UN Office of the High Commissioner for Human Rights, *Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies* (2002).

[38] Opened for signature 16 December 1966, 993 UNTS 2 (entered into force generally 3 January 1976 and for Australia 10 March 1976).

[39] Committee on Economic, Social and Cultural Rights, *CESCR General Comment 14*: *The Right to the Highest Attainable Standard of Health*, [9], UN Doc E/C.12/2000/4 (2000).

on Australian governments to establish conditions, designed to ensure that people have the best possible chance of being healthy, including through the adoption of legislative measures.

According to the Committee, these conditions should mean that people are able to access the full variety of facilities, goods, services and conditions necessary to ensure an individual's health.[40] This includes access to appropriate health care and also access to safe water, adequate sanitation, an adequate supply of safe food, adequate nutrition, adequate housing, occupational health, a healthy environment and access to health-related information.[41] Services must be provided in a culturally appropriate[42] and non-discriminatory manner.[43] Health care services must be particularly targeted and accessible to the poor.[44]

Obligations of Implementation in Relation to the Right to the Highest Attainable Standard of Health

Pursuant to article 2(1) of the *ICESCR*, Australian governments are obliged to take steps, using the maximum available resources, to progressively achieve the full realisation of the right to the highest attainable standard of health. As discussed above, this includes particularly the adoption of legislative measures.

According to the Committee, the steps and measures taken must be 'deliberate', 'concrete' and 'targeted as clearly as possible' towards full realisation of the right to the highest attainable standard of health.[45] Progress towards full realisation of the right is required to be as 'expeditious' and 'effective' as possible and requires that the maximum of available resources be directed towards public health, including by ensuring that the attainment of good mental health is a fiscal and budgetary priority.[46] Further, even while Australian governments are developing and implementing measures for the full realisation of the highest attainable standard of health, they are under an obligation to ensure that certain non-derogable 'core minimum standards' are met, including the provision of basic housing, nutrition and health care for marginalised or disadvantaged people.[47] At a minimum, health care for the poor must

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[40] Committee on Economic, Social and Cultural Rights, *CESCR General Comment 14*: *The Right to the Highest Attainable Standard of Health*, [4], [9], UN Doc E/C.12/2000/4 (2000).

[41] Committee on Economic, Social and Cultural Rights, *CESCR General Comment 14*: *The Right to the Highest Attainable Standard of Health*, [11], UN Doc E/C.12/2000/4 (2000).

[42] Committee on Economic, Social and Cultural Rights, *CESCR General Comment 14*: *The Right to the Highest Attainable Standard of Health*, [12(c)], [27], [37], UN Doc E/C.12/2000/4 (2000).

[43] Committee on Economic, Social and Cultural Rights, *CESCR General Comment 14*: *The Right to the Highest Attainable Standard of Health*, [43(a)], UN Doc E/C.12/2000/4 (2000).

[44] UN Office of the High Commissioner for Human Rights, *Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies* (2002) 22-6 [Guideline 7: Right to Health].

[45] Committee on Economic, Social and Cultural Rights, *General Comment 3: The Nature of States Parties' Obligations*, UN Doc HRI/GEN/1/Rev.5 (2001) 18.

[46] Committee on Economic, Social and Cultural Rights, *General Comment 3: The Nature of States Parties' Obligations*, UN Doc HRI/GEN/1/Rev.5 (2001) 18, [9].

[47] Committee on Economic, Social and Cultural Rights, *General Comment 3: The Nature of States Parties' Obligations*, UN Doc HRI/GEN/1/Rev.5 (2001) 18, [10].

be 'available, accessible, acceptable and of good quality.[48] Australian governments are obliged to 'reduce the financial burden of health care and health protection on the poor, for example by reducing and eliminating user fees for the poor.[49]

Costs of Homelessness for the Health Care System

A number of recent studies have examined the costs of homelessness to the health care system. Research in the United States, Canada and the United Kingdom has consistently demonstrated that:

- on a per capita basis, homeless people are significantly more likely to require medical care and hospitalisation than domiciled people;
- homeless people, on average, require longer hospitalisation and treatment, with the cost of the additional days per stay for mental health patients exceeding $6000 per person; and
- better access to adequate housing would significantly reduce health problems and treatment needs and costs.[50]

Synthesising this research, Professor Paul Starr of Princeton University has commented:

> Failure to deal with a social problem 'upstream' (lack of housing, education, health insurance, substance misuse prevention) leads to added costs for resources 'downstream' (police, prisons, hospital care). The downstream institutions are not only expensive, but also poorly equipped to deal with the underlying social problems. Many people conclude, therefore, that pre-emptively attacking the problems upstream would be both more efficient and more effective, but the pattern stubbornly persists. In the case at hand, we continue paying to put the homeless in hospital beds while not providing them with ordinary beds of their own.[51]

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[48] UN Office of the High Commissioner for Human Rights, *Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies* (2002) 23.

[49] UN Office of the High Commissioner for Human Rights, *Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies* (2002) 26.

[50] Margaret Eberle et al, *Homelessness: Causes and Effects – A Review of the Literature* (2001) 20-2. See also Sharon Salit et al, 'Hospitalization Costs Associated with Homelessness in New York City' (1998) 338(24) *New England Journal of Medicine* 1734; Robert Rosenheck and Catherine Seibyl, 'Homelessness, Health, Service Use and Related Costs' (1998) 36(8) *Medical Care* 1256; Peter Molyneux and John Palmer, *Towards a Strategy for Health and Housing: Cost Drivers and Blocks that Impact on the Public's Health* available at <http://www.vois.org.uk>; Paul Starr, 'The Homeless and the Public Household' (1998) 338(24) *New England Journal of Medicine* 1709; Barbara Dickey et al, 'Housing Costs for Adults who are Mentally Ill and Formerly Homeless' (1997) 24(3) *Journal of Mental Health Administration* 291.

[51] Paul Starr, 'The Homeless and the Public Household' (1998) 338(24) *New England Journal of Medicine* 1709.

Recommendations in Relation to the Right to the Highest Attainable Standard of Health

Recognising the human right to the highest attainable standard of health and the links between homelessness and poor mental health, the Australian Government should:

- substantially increase funding to improve the availability and accessibility of targeted, specialist mental health care services for homeless people. These services should be holistic and multi-disciplinary, and coordinated and integrated with housing, income support, employment, training, rehabilitation, counselling and other support services, to achieve positive health and social inclusion outcomes; and
- ensure that people experiencing homelessness are not discharged from mental health care services on to the street or into accommodation which is likely to damage or detrimentally impact their health or welfare.

4.4 The Right to Adequate Housing and the Promotion of Good Mental Health

Access to adequate housing is a critical determinant of good mental health; 'people without homes suffer from ill health at much higher rates'.[52] As one doctor put it, 'once you find permanent housing for these people you can start to do something medically'.[53]

Providing, and ensuring access to, adequate housing is both the most effective and cost-efficient prevention and treatment of homelessness and associated ill health.[54]

Content and Scope of the Right to Adequate Housing

Pursuant to article 11 of the *ICESCR*, all people have the right to adequate housing, which includes a right to live somewhere in security, peace and dignity.[55]

According to the United Nations Committee on Economic, Social and Cultural Rights, at a minimum, housing must be affordable, accessible to disadvantaged groups, habitable, culturally appropriate, provide occupants with security of tenure and afford access to appropriate services, materials, facilities and infrastructure, including employment, health care, schools and other social facilities. [56]

Obligations of Implementation in Relation to the Right to Adequate Housing

Under article 2(1) of the *ICESCR*, realisation of the right to adequate housing requires that federal, state and territory governments devote the maximum of available

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[52] National Health Care for the Homeless Council (US), *Homelessness and Health: Policy Statement* (2004) 1.

[53] Quoted in Margaret Eberle et al, *Homelessness: Causes and Effects – A Review of the Literature* (2001) 17.

[54] Suzanne Zerger, *Chronic Medical Illness and Homeless Individuals* (2002) 16.

[55] CESCR, *General Comment 4: The Right to Adequate Housing*, UN Doc HRI/GEN/1/Rev.5 (2001) 22.

[56] CESCR, *General Comment 4: The Right to Adequate Housing,* UN Doc HRI/GEN/1/Rev.5 (2001) 22.

resources to progressively ensuring that all people have access to adequate housing. As with implementation of the right to the highest attainable standard of health, this requires 'concrete', 'targeted', 'expeditious' and 'effective' steps, including budgetary prioritisation.[57] Retrogressive measures, such as cuts in expenditure on public housing or homelessness, are permissible only in 'exceptional circumstances', which do not exist in Australia.[58]

Even while Australia is progressing towards full realisation of the right to adequate housing, it is under a 'core obligation' to ensure that certain non-derogable 'minimum essential standards' relating to fundamental human rights are met, including in relation to the provision of housing, nutrition and health care for marginalised or disadvantaged people.[59] In the Clinic's view, in relation to the right to adequate housing, Australia's core obligation is to provide sufficient housing services through the Supported Accommodation Assistance Program (SAAP) to ensure that all homeless people can access crisis accommodation as of right.[60]

Responsibility for Implementation of 'Core Obligations'

We understand that the Australian Government is currently threatening to reduce funding to SAAP in many states, including Victoria unless the state governments increase their own contribution to SAAP. We further understand that, to date, the Victorian Government has refused to commit to such an increase.

In relation to the respective responsibilities of federal and state governments regarding resource allocation and implementation, article 28 of the *ICESCR* expressly provides that, in federations such as Australia, the obligations of the Covenant are binding on the federation as a whole and must extend across all parts of that federation. This means that, in Australia, all branches of government and other public or governmental authorities, at whatever level – national or state – must act to respect, protect and fulfil *ICESCR* rights, including the progressively realisable right to adequate housing and the immediately realisable, non-derogable right to crisis accommodation and homelessness assistance services.[61]

International human rights law, like people experiencing homelessness themselves, is not concerned with which level of government provides housing and crisis

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[57] CESCR, *General Comment 3: The Nature of States Parties' Obligations*, UN Doc HRI/GEN/1/Rev.5 (2001) 18.

[58] CESCR, *General Comment 3: The Nature of States Parties' Obligations*, UN Doc HRI/GEN/1/Rev.5 (2001) 18; CESCR, *Substantive Issues Arising in the Implementation of the International Covenant in Economic, Social and Cultural Rights: Poverty and the International Covenant on Economic, Social and Cultural Rights*, UN Doc E/C.12/2001/10 (2001) 4-5, [15]-[18].

[59] CESCR, *General Comment 3: The Nature of States Parties' Obligations*, UN Doc HRI/GEN/1/Rev.5 (2001) 18; CESCR, *Substantive Issues Arising in the Implementation of the International Covenant in Economic, Social and Cultural Rights: Poverty and the International Covenant on Economic, Social and Cultural Rights*, UN Doc E/C.12/2001/10 (2001) 4-5, [15]-[18].

[60] CESCR, *General Comment 3: The Nature of States Parties' Obligations*, UN Doc HRI/GEN/1/Rev.5 (2001) 18.

[61] Human Rights Committee, *General Comment 31: Nature of the General Legal Obligation Imposed on States Parties to the Covenant*, UN Doc CCPR/C/21/Rev.1/Add13, [4] (2004).

accommodation but, far more fundamentally, with ensuring that all people have access to adequate housing and can live in security, peace and dignity.

Current Implementation of 'Core Obligations' and their Impact on Mental Health

Despite these non-derogable core obligations, every night, almost 100,000 people experience homelessness in Australia, including more than 20,000 people in Victoria.[62] Only 1 in 7 of these people find a bed in the homelessness service system.

Funding for SAAP is manifestly inadequate to meet demand. More than 700 homeless people per day are turned away from homelessness services across Australia.[63] It is estimated that, in Victoria alone, over 22,000 people are unable to access homelessness assistance services each year due to lack of capacity and resources. This is despite the fact that Australia has enjoyed sustained levels of high economic growth and development.

Homeless people experiencing mental disorders, particularly co-morbid people experiencing both mental illness and drug or alcohol dependency, are especially susceptible to being unable to access, or being actively excluded from access to, SAAP services.[64] According to a recent report by the NSW Ombudsman, the following homeless client groups find it particularly difficult to access SAAP services:

- people with drug and alcohol disorders (61.0 per cent);
- people with mental illness (53.7 per cent);
- people with intellectual disabilities (33.3 per cent); and
- people with acquired brain injury (19.5 per cent).[65]

Current and proposed funding arrangements, levels and outcomes in relation to SAAP constitute clear violations of Australia's core obligation under articles 2(1) and 11 of the *ICESCR* to ensure that people experiencing homelessness can access homelessness assistance services, particularly crisis accommodation, as of right. This has, and will continue to have, direct and significant detrimental impacts on the mental health of people experiencing homelessness. Pursuant to article 28 of the *ICESCR* and emerging international jurisprudence, both the Australian and state governments are responsible for this violation and its remedy.

According to the Australian Federation of Homelessness Organisations, funding to SAAP must be increased by 40 per cent to meet demand for homelessness

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[62] Chris Chamberlain and David MacKenzie, *Counting the Homeless 2001* (2003).

[63] Australian Institute of Health and Welfare, *Homeless People in SAAP: SAAP National Data Collection Annual Report 2002-03* (2003).

[64] See generally, NSW Ombudsman, *Assisting Homeless People: The Need to Improve their Access to Accommodation and Support Services* (2004). See also S Tsemberis and R F Eisenberg, 'Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities' (2000) 51 *Psychiatry Services – American Psychiatric Association* 487.

[65] Monica Wolf, 'Assisting Homeless People: The Need to Improve their Access to Accommodation and Support Services' (2005) 18(1) *Parity* 25, 26.

assistance services. Such an increase would not only improve accommodation situations for people experiencing homelessness, but would also improve their mental health.[66] Such an increase is also necessary for Australia to discharge its core obligations under international human rights law to ensure that people experiencing homelessness can access crisis accommodation as of right.

The Business Case for Increasing Funding and Access to Adequate Housing

Studies conducted in the US and Canada demonstrate that establishing long-term solutions to homelessness reduces the use of other government services and substantially reduces the total cost to the government. This is because, among other things, the cost of providing social services and health care to, and obtaining positive social and health outcomes for, people experiencing homelessness is considerably higher than for domiciled people.

For example, a Canadian study found that the cost of providing major government health care, criminal justice and social services (excluding housing) to homeless people costs, on average, 33 per cent more than the cost of providing those services to housed people.[67] According to the study, the service and shelter costs of homeless people range from $30,000 to $40,000 per annum per person, while the cost of providing services and supported housing to the same group range from $22,000 to $28,000 per annum per person. A similar study in New York study monitored 4679 homeless people suffering psychiatric disabilities over a seven-year period who were placed in affordable housing and provided with clinical and social support.[68] The study found that placement of a homeless person in supported accommodation resulted in an average reduction in service use of $US16,281 per year. Over 80 per cent of the service reduction occurred in the area of medical and mental health services. According to the cost study, the reduction in service usage overall would pay for an average 95 per cent of the costs of building, operating and providing accommodation and related support services to the homeless.

Recommendations in Relation to the Right to Adequate Housing

Recognising the human right to adequate housing and the links between homelessness and poor mental health, the Australian Government should:

- amend the *Supported Accommodation Assistance Act 1994* (Cth) to enshrine a right of access to crisis accommodation for homeless people;

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[66] C Caton et al, 'Risk Factors for Homelessness Among Schizophrenic Men: A Case-Control Study' (1994) 85 *American Journal of Public Health* 265.

[67] Margaret Eberle et al, *Homelessness: Causes and Effects – The Costs of Homelessness in British Columbia* (2001) 2-3.

[68] Dennis Culhane, Stephen Metraux and Trevor Hadley, 'Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing' (2002) 13(1) *Housing Policy Debate* 107. See also Ted Houghton, *The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals* (2001).

- increase funding to the Supported Accommodation Assistance Program by 40 per cent to meet demand; and
- develop a National Housing and Taxation Plan that includes strategies to align the supply of affordable housing with demand. The availability of affordable housing, including public housing, should be progressively increased through both direct expenditure and fiscal and taxation policy reforms.

4.5 The Right to Participation and the Promotion of Good Mental Health

A human rights approach to the promotion of good mental health and the reduction of homelessness and poverty requires active and informed participation of people experiencing homelessness in the development, implementation and assessment of health care, housing and poverty reduction strategies.[69]

Content and Scope of the Right to Participation

It is a central principle of the international human rights framework that all people have the right, and should have the opportunity without discrimination, to participate in public affairs and, in particular, in decision-making processes that affect them.[70]

The right to active, free and meaningful participation, enshrined in article 25 of the *ICCPR*, article 13(1) of the *ICESCR* and article 2(3) of the *Declaration on the Right to Development*, covers all aspects of public administration, decision-making and policy formulation at international, national, regional and local levels.[71] It requires that strategies be developed, special measures taken and resources dedicated to provide for the consultation and inclusion of individuals and groups who are marginalised or have special needs, such as people experiencing homelessness or poverty, in the development and implementation of public policies and programs.

In addition to being required by international human rights law, the participation of people experiencing homelessness in decision-making and policy formulation processes is both instrumentally and substantively important and intimately linked to meaningful social inclusion and positive mental health.

Instrumentally, the participation of people who are homeless or formerly homeless in the development and implementation of programs to address the housing and health care needs of homeless people can enhance their individual autonomy,

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[69] UN Office of the High Commissioner for Human Rights, *Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies* (2002) 2.

[70] Committee on Economic, Social and Cultural Rights, *Substantive Issues Arising in the Implementation of the International Covenant in Economic, Social and Cultural Rights: Poverty and the International Covenant on Economic, Social and Cultural Rights*, UN Doc E/C.12/2001/10 (2001) 3, [12].

[71] Human Rights Committee, *General Comment 25: Article 25*, UN Doc HRI/GEN/1/Rev.5 (2001) 157.

independence, sense of control, sense of value and self-esteem.[72] As James, a 29 year old homeless man, reports, 'there is nothing worse than not being able to understand or control what is happening to you. We should have the main say, because it's for us, and we know what's really going on'.[73]

Substantively, the meaningful and informed participation of homeless people can enhance programmatic development and improve responses to homelessness by informing governments and service providers about people's needs and the most effective and targeted way to address those needs.[74] According to the Committee on Economic, Social and Cultural Rights, 'a policy or program that is formulated without the active and informed participation of those affected is most unlikely to be effective'.[75] This is an insight shared by people experiencing homelessness themselves. As Anne Gosely, a spokeswoman for the Homeless People's Association, has argued, 'we understand that you think you are doing your best but until such time as you stop and ask the people themselves what their needs are you will keep going around in circles and wasting money that could be put to good use'.[76] In the area of homelessness and mental health, studies demonstrate that consumers are far more likely to 'co-operate' and engage if they have had a role in determining the scope and nature of the service.[77]

Obligations of Implementation in Relation to the Right to Participation

Notwithstanding the important role that people who are homeless or formerly homeless should play in developing and implementing programs and responses to homelessness and poor mental health, together with the instrumental role that such participation could play in social inclusion and alleviation of many of the compounding causes and effects of homelessness and poor mental health, homeless people are not represented or are significantly underrepresented on governmental advisory and reference groups on homelessness, and on the boards and committees of homelessness organisations and assistance services. Further, although the Preamble to the *Supported Accommodation Assistance Act 1994* (Cth) provides that it is essential that homeless people have the opportunity to be involved in the

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[72] Deena Hurwitz, 'Lawyering for Justice and the Inevitability of International Human Rights Clinics' (2003) 28 *Yale Journal of International Law* 505, 516; Andy Blunden, 'Capital Investment' (2004) 14(5) *Eureka Street* 30.

[73] Department of Human Services (Vic), *Charter of Rights and Enhanced Complaints Mechanism: Report on Consumer Consultations* (2004) 13.

[74] Robert A Solomon, 'Representing the Poor and Homeless: A Community-Based Approach' (2000) 19 *St Louis University Public Law Review* 475, 483.

[75] Committee on Economic, Social and Cultural Rights, *Substantive Issues Arising in the Implementation of the International Covenant in Economic, Social and Cultural Rights: Poverty and the International Covenant on Economic, Social and Cultural Rights*, UN Doc E/C.12/2001/10 (2001) 3, [12].

[76] Anne Gosely et al, 'Stop and Listen … Don't Assume: Why the Homeless People's Association was Formed' (Beyond the Divide: The 3rd National Homelessness Conference, Brisbane, 6-8 April 2003).

[77] S Tsemberis and R F Eisenberg, 'Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities' (2000) 51 *Psychiatry Services – American Psychiatric Association* 487. See also C P O'Brien and A T McLellan, 'Myths About the Treatment of Addiction' (1996) 347 *Lancet* 237.

development of policies and programs relating to or impacting upon them, no SAAP funds are committed or provided to the establishment or support of homelessness community groups or organising processes.

Recommendations in Relation to the Right to Participation

Recognising the human right to participation and the links between the participation of homeless people in policy and service design and delivery and the improvement of mental health:

- federal, state and territory governments should commit to ensuring that people who are homeless or formerly homeless are directly represented on all governmental and departmental reference groups, advisory groups and steering committees that relate to homelessness or to issues that impact on people experiencing homelessness;
- all homelessness assistance services should be required to directly involve people who are homeless or formerly homeless in organisational governance, management, development and operation; and
- through SAAP, federal, state and territory governments should fund and support people who are homeless or formerly homeless to form groups and associations to participate in governmental and sectoral policy development, decision-making processes and service delivery development and operation.

4.6 The Right to Non-Discrimination and the Promotion of Good Mental Health

There are strong links between discrimination against people experiencing homelessness or poverty and the health status of those groups. According to the World Health Organization:

> The fundamental principles of equality and freedom from discrimination have been identified as key components in all matters concerning health. This includes non-discrimination in access to health facilities, goods and services, paying particular attention to the most vulnerable or marginalised sections of the population.[78]

The World Health Organization considers that 'discrimination violates one of the fundamental principles of human rights and often lies at the root of poor health status'.[79] This view is consistent with an emerging consensus that discrimination and stigmatization are major causal factors of ill health, including higher anxiety,

[78] World Health Organization, *Health and Freedom from Discrimination: WHO's Contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance* (2001) 12.

[79] World Health Organization, *Health and Freedom from Discrimination: WHO's Contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance* (2001) 6.

depression, worsened quality of life, a sense of loss of control and difficulty coping.[80] As St Mary's House of Welcome, a drop-in centre in Fitzroy, Victoria for people experiencing homelessness identifies:

> Our service users include homeless people, people in financial crisis, people who are suffering hardship, people with alcohol, drug and gambling addictions, mentally ill people and others of low social status. They experience discrimination because of their social status, their appearance and their lack of access to amenities and services. The effect of this discrimination can be detrimental to health and well-being, result in further financial hardship, and impact negatively on ability to cope.[81]

Discrimination can exclude people from access to good and services, health care, adequate housing, education and employment, all of which are powerful influences on and determinants of mental health.[82] Discrimination can also increase vulnerability to or magnify poverty, leading to poor mental health.[83] Indeed, according to Jesuit Social Services:

> Discrimination, especially in the areas of private housing, room and caravan rental, and also in health, is both widespread and can result in significant psychological deterioration as well as material deprivation of the recipient. Indeed, consistent discrimination of this nature results in deepening of identification with the marginalised condition so as to make negotiation through their issues more difficult.[84]

Despite the clear correlates between discrimination, poverty and poor mental health outcomes, discrimination against people experiencing homelessness or poverty, including in the provision of health and medical services, is not only widespread in Victoria and at a national level, it remains lawful.[85] At a state level, for example, the *Equal Opportunity Act 1995* (Vic) does not prohibit discrimination on the ground of social status, homelessness, poverty, unemployment or on the basis that a person is a recipient of social security or welfare assistance. Similarly, anti-discrimination legislation at a federal level does not prohibit less favourable treatment on the ground of homelessness or poverty. This lack of legal protection from discrimination causes and contributes to homelessness, poverty and poor mental health outcomes. As

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[80] Lisa Waller, 'Living with Hepatitis C: From Self-Loathing to Advocacy' (2004) 180 *Medical Journal of Australia* 293; S Zickmund, E Y Ho, M Masuda et al, 'They Treated Me Like a Leper: Stigmatization and the Quality of Life of Patients with Hepatitis C' (2003) 18 *Journal of General International Medicine* 835.

[81] Letter from St Mary's House of Welcome to the PILCH Homeless Persons' Legal Clinic dated 20 August 2002.

[82] Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539, 539.

[83] World Health Organization, *Health and Freedom from Discrimination: WHO's Contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance* (2001) 6, 10.

[84] Letter from Jesuit Social Services to PILCH Homeless Persons' Legal Clinic dated 22 August 2002.

[85] Philip Lynch and Bella Stagoll, 'Promoting Equality: Homelessness and Discrimination' (2002) 7 *Deakin Law Review* 295.

discussed below, this lack of legal protection is also a violation of Australia's obligations under international human rights law.

Content and Scope of the Right to Non-Discrimination

The right to equality and freedom from discrimination is an integral component of the international human rights normative framework and is entrenched in both the *ICCPR* and *ICESCR*.[86]

The obligation of all Australian governments to guarantee, by law, equal and effective protection against discrimination is set out in article 26 of the *ICCPR*:

> All persons are equal before the law and are entitled without discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Although 'discrimination' is not defined in the *ICCPR*, the United Nations Human Rights Committee has defined it as:

> … any distinction, exclusion, restriction or preference … which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, by all persons, on an equal footing, of all rights and freedoms.[87]

The norm of non-discrimination is also enshrined in article 2(1) of the *ICCPR* and article 2(2) of *ICESCR* which provide:

> The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

In addition to being enshrined in other international human rights treaties, like the *International Convention on the Elimination of All Forms of Racial Discrimination*, the *International Convention on the Elimination of All Forms of Discrimination Against Women* and the *Convention on the Rights of the Child*, the norm of non-discrimination probably constitutes a peremptory (or non-derogable) principle of customary international law.[88] In the *Namibia Case*, Ammoun J of the International Court of Justice stated:

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[86] Committee on Economic, Social and Cultural Rights, *Substantive Issues Arising in the Implementation of the International Covenant in Economic, Social and Cultural Rights: Poverty and the International Covenant on Economic, Social and Cultural Rights*, UN Doc E/C.12/2001/10 (2001) 3. See also *ICCPR* arts 2(1) and 26 and *ICESCR* art 2(2).

[87] Human Rights Committee, *General Comment 18: Non-Discrimination*, UN Doc HRI/GEN/1/Rev.5 (2001) 136.

[88] See, for example, K Parker and L B Neylon, 'Jus Cogens: Compelling the Law of Human Rights' (1989) 12 *Hastings International and Comparative Law Review* 411, 441-2.

> One right which must be considered a pre-existing binding customary norm which the Universal Declaration of Human Rights codified is the right to equality.[89]

Obligations of Implementation in Relation to the Right to Non-Discrimination

The norm of non-discrimination prohibits unfair, unjust or less favourable treatment in law, in fact, or in the realisation of rights in the political, economic, social, cultural, civil or any other field. It is a norm that is immediately realisable, which means it is not subject to progressive realisation with respect to economic, social and cultural rights. That is, Australian governments have no excuse, in international law, for any discrimination against people experiencing homelessness.

The implementation of the norm of non-discrimination has two key facets in relation to people experiencing homelessness and mental illness.

First, the right to freedom from discrimination imposes an immediate obligation on Australian governments to ensure that their legislation prohibits discrimination against people experiencing homelessness and is itself non-discriminatory. To this end, federal, state and territory equal opportunity and anti-discrimination laws should be amended to prohibit discrimination on the ground of social status, including a person's status of being homeless or at risk of homelessness.

Second, the right imposes a further substantive obligation on governments to take positive steps to address the special needs of people experiencing homelessness and mental illness so as to enable them to realise all of their rights and freedoms.[90] These steps should include legislative, educative, financial, social and administrative measures that are developed and implemented using the maximum of available governmental resources. An important legislative step is that the *ICESCR* be scheduled to the *Human Rights and Equal Opportunity Commission Act 1986* (Cth). This would empower the Commission to investigate and monitor discrimination against people experiencing homelessness, particularly in relation to the implementation of economic, social and cultural rights that are determinants of good mental health, such as housing and health care.[91]

Recommendations in Relation to the Right to Non-Discrimination

Recognising the human right to non-discrimination and the links between homelessness, discrimination and poor mental health:

- federal, state and territory governments should amend anti-discrimination and equal opportunity law to prohibit discrimination on the ground of

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[89] *Namibia Case* [1971] ICJ Rep 16. See also *Barcelona Traction, Light and Power Company Limited Case (Belgium v Spain) Second Phase* [1970] ICJ Rep 3, 34.

[90] Human Rights Committee, *General Comment 18: Non-Discrimination*, UN Doc HRI/GEN/1/Rev.5 (2001) 136.

[91] Committee on Economic, Social and Cultural Rights, *Substantive Issues Arising in the Implementation of the International Covenant in Economic, Social and Cultural Rights: Poverty and the International Covenant on Economic, Social and Cultural Rights*, UN Doc E/C.12/2001/10 (2001) 3, [11].

'homelessness', 'unemployment' and 'being in receipt of income benefits' and to ensure the availability of redress and effective remedies in respect of such discrimination; and

- the Australian Government should schedule the *International Covenant on Economic, Social and Cultural Rights* to the *Human Rights and Equal Opportunity Commission Act 1986* (Cth). This would empower the Commission to investigate and monitor discrimination against people experiencing homelessness, particularly in relation to the implementation of economic, social and cultural rights that are determinants of good mental health, such as housing and health care.

4.7 The Right to Social Security and the Promotion of Good Mental Health

According to Amartya Sen, Nobel Prize Winner for Economics, 'inadequate income is a strong predisposing condition for an impoverished life'.[92] An adequate income is necessary to ensure an adequate standard of living, facilitate participation in the civil, political, economic, social and cultural aspects of community life, and to facilitate access to the highest attainable standard of mental health.

The absence of a guaranteed minimum income, together with the fact that social security payments are generally pegged and paid below the Henderson Poverty Line, is a significant contributor to people either living in or being at risk of poverty, homelessness and poor mental health across Australia. For example, in September 2004, inclusive of housing costs, the Poverty Line for a single unemployed adult person or young person living independently was $317.61 per week. The base rate of Newstart Allowance for such a person was $194.60 (or 61 per cent of the Poverty Line), rising to $242.30 if the person also received the highest payable rate of Rent Assistance (or 76 per cent of the Poverty Line). Similarly, for a single parent with two children, the Poverty Line was $433.46 per week while the base rate of income support available was $232.10 (or 54 per cent of the Poverty Line), rising to $461.70 (or 107 per cent of the Poverty Line) with Family Tax Benefit A and B and the highest payable rate of Rent Assistance.[93]

Having regard to the above, for many people, particularly homeless people, access to appropriate health care services is simply unaffordable.

Content and Scope of the Right to Social Security

Access to a secure and adequate income is necessary to ensure a dignified human existence and good mental health. Recognising this, article 9 of the *ICESCR* provides that all people have the right to social security.

Although international human rights law does not prescribe social security payment levels, it does stipulate that benefits must not be reduced below a minimum threshold.

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[92] Amartya Sen, *Development as Freedom* (1999) 87.

[93] See generally, Melbourne Institute of Applied Economic and Social Research, *Poverty Lines: Australia* (September Quarter 2004).

Social security must be sufficient to ensure a dignified human existence and to meet people's needs, particularly in relation to housing and health. A person's needs vary based on factors including housing status, age, health, cultural background, family responsibilities, and other factors.

Obligations of Implementation in Relation to the Right to Social Security

Lack of access to an adequate income is a major causal and prolonging factor of homelessness and poor mental health. Social security availability and payment levels must meet the special needs for assistance and other expenses often associated with homelessness and mental illness.[94]

Australia's social security regime, administered by Centrelink under the *Social Security Act 1991* (Cth), does not meet human rights standards. For example:

- not all people who require social security are able to access it, including newly arrived migrants (many of whom become homeless), people unable to provide adequate proof of identity, and homeless people unable to satisfy mutual obligation requirements;
- the level of income support paid is inadequate to meet needs or guarantee a dignified human life;[95] and
- the breach penalty regime can result in a loss of income beyond a person's control and to an extent that violates the right to an adequate living standard.

The difficulties faced by homeless people in obtaining and maintaining social security payments, together with the inadequate levels of such payments, breach the right to social security and contribute significantly to poor mental health outcomes.

Recommendations in relation to the Right to Social Security

Recognising the human right to social security and the links between lack of adequate income, homelessness and poor mental health, the Australian Government should ensure that:

- social security payments are available to all people who experience a loss of income beyond their control or who require income support to ensure realisation of their human right to an adequate standard of living;
- social security payments are increased to levels above the Henderson Poverty Line so that recipients are able to meet their material needs and participate in society. Payments should be sufficient to ensure that recipients can afford adequate housing, health care and an adequate standard of living;

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[94] Committee on Economic, Social and Cultural Rights, *General Comment 5: Persons with Disabilities*, UN Doc HRI/GEN/1/Rev.5 (2001) 28.

[95] More than 83 per cent of people accessing homelessness assistance services in 2002 received a social security payment, indicating that such payments are inadequate to access or maintain housing: Australian Institute of Health and Welfare, *Demand for SAAP Assistance by Homeless People 2001-02* (2002).

- the breach penalty regime under the *Social Security Act 1991* (Cth) is amended so that people are only penalised if they wilfully and intentionally breach their mutual obligations. Penalties should be no longer than 8 weeks duration, no greater than 25 per cent of income and recoverable on compliance or reasonable steps;
- Centrelink's 'proof of identity' requirements are changed so that homeless people can use a letter from a homelessness assistance service as proof of identity; and
- an integrated package of social security assistance to homeless people is developed that includes access to health care, adequate housing, employment assistance and personal support to ensure sustainable outcomes.

5. Other Measures to Improve the Mental Health of People Experiencing Homelessness

5.1 Introduction

This Part examines a range of further issues that should be considered to address the issues of poor mental health, poverty and homelessness.

In particular, it discusses:

- the overrepresentation of people with a mental illness who are homeless in the criminal justice system (Term of Reference (j));
- the accountability and proficiency of agencies, such as housing, employment, law enforcement and general health services, in dealing with people who are homeless and have a mental illness (Term of Reference (m));
- the adequacy of mental health research and data collection (Terms of Reference (n) and (o)); and
- the importance of a national poverty reduction strategy in relation to coordinating services and improving outcomes at all levels of government through a joined-up approach.

5.2 Homelessness, Mental Illness and Access to Justice – Term of Reference (j)

> I've been homeless and in and out of court for most of my life.[96]

Homeless people with mental illness are disproportionately represented in the criminal justice system and the rate of recidivism amongst homeless offenders is high.[97] Often, the problems associated with homelessness and mental illness are further entrenched rather than addressed by the criminal justice system. There are a range of particular issues and difficulties that mentally ill homeless people face when they are required to attend court. Failure to take into consideration a defendant's homelessness and mental illness can result in an unfair and unjust outcome for the defendant.

In the past decade there has been a growth, both in Australia and overseas, of specialist and problem solving courts (including homeless persons' courts) that aim to facilitate access to justice for marginalised and disadvantaged groups through the application of 'therapeutic jurisprudence' and problem solving court approaches.[98] Therapeutic jurisprudence aims to link misdemeanour adjudication with social service intervention and use the coercive power of the law to address the complex causes of

[96] Focus group participant, Flagstaff Crisis Accommodation, 5 July 2004 quoted in Beth Midgley, *Improving the Administration of Justice for Homeless People in the Court Process: Report of the Homeless Persons' Court Project* (2004) 4.

[97] Jelena Popovic, 'Homelessness and the Law: A View from the Bench' (2004) 17(1) *Parity* 53, 53.

[98] Arie Freiberg, 'Therapeutic Jurisprudence in Australia: Paradigm Shift or Pragmatic Incrementalism?' (2002) 20(2) *Law in Context* 6.

'offending behaviour'.[99] Commentators have identified that there are good reasons for the introduction of problem solving courts in Australia 'both systemically and for dealing with particular problems (such as mental illness, drug abuse, homelessness and street offences).'[100] In particular, early intervention strategies and problem solving court approaches can generate significant cost savings, both within the criminal justice system and in relation to the provision of health services and welfare support,[101] particularly where they are implemented within the existing structures of the criminal justice and welfare systems.[102]

In 2004, the PILCH Homeless Persons' Legal Clinic undertook a law reform project entitled the 'Homeless Persons' Court Project'. The objective of the Project was to undertake research and consultation in order to identify the difficulties that homeless people face in the court process and to examine a range of options to address those difficulties, including the possibility of a specialist list or court for people experiencing homelessness and mental illness. The Project aimed to ensure that the particular needs of homeless people within the criminal justice system are appropriately identified and addressed by the Victorian Department of Justice in its implementation of problem solving court strategies within the Magistrates' Court.

A key finding of the Project was that at least 75 per cent of participants received fines and charges in relation to behaviour that was a direct consequence of their homeless or mentally ill status, including: fines in relation to begging, drinking in public and other public space offences; activities caused by extreme poverty, such as travelling on public transport without a valid ticket or shoplifting food and other necessities; and activities relating to one of the underlying causes of homelessness, such as drug or alcohol dependency. This is consistent with studies in the US and Canada which have found a strong relationship and association between homelessness, mental illness and low-level crime.[103] Participants felt strongly that they were unfairly targeted by the law itself and that the activities that they were forced to undertake as

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[99] David Wexler, 'Robes and Rehabilitation: How Judges Can Help Offenders "Make Good"' (2001) *Spring Court Review* 18, 27; Arie Freiberg, 'Problem-Oriented Courts: Innovative Solutions to Intractable Problems' (Speech delivered at the Australian Institute of Judicial Administration Magistrates' Conference, 20–21 July 2001, Melbourne, Australia) 13–14 available at <http://www.aija.org.au/Mag01/FREIBERG.pdf>.

[100] Andrew Phelan, 'Solving Human Problems or Deciding Cases? Judicial Innovation in New York and Its Relevance to Australia: Part III' (2004) 13 *Journal of Judicial Administration* 244, 258. See also Tamara Walsh, *From Park Bench to Court Bench: Developing a Response to Breaches of Public Space Law by Marginalised People* (2004) 86.

[101] Arie Freiberg, 'Problem-Oriented Courts: Innovative Solutions to Intractable Problems' (Speech delivered at the Australian Institute of Judicial Administration Magistrates' Conference, 20–21 July 2001, Melbourne Australia) 13–14 available at <http://www.aija.org.au/Mag01/FREIBERG.pdf>.

[102] Consultation with Mark Crosby, Associate Professor, Melbourne Business School quoted in Beth Midgley, *Improving the Administration of Justice for Homeless People in the Court Process: Report of the Homeless Persons' Court Project* (2004).

[103] See generally, Margaret Eberle et al, *Homelessness: Causes and Effects – The Costs of Homelessness in British Columbia* (2001) 37.

a result of being homeless should not be criminal offences. As one focus group participant commented, 'some things just shouldn't be a crime anyway'.[104]

Indeed, it is widely recognised that homeless and mentally ill people are disproportionately impacted by laws regulating the public space as well as by the enforcement of those laws.[105] In Victoria, for example, the act of begging is a criminal offence under the *Vagrancy Act 1966* s 1(d) and the *Transport (Passengers and Rail Freight) Regulations 1994* (Vic) s 325(d). 'Loitering' is also a criminal offence under ss 7(1)(f), 7(1)(i) and 7(2) of the *Vagrancy Act 1966* (Vic). Other public space regulations, which criminalise behaviours such as sleeping, bathing, lying, drinking or storing belongings in public space,[106] impact on homeless people on the grounds of their housing status and the necessary location of their conduct.

In all focus groups and interviews conducted for the Project, participants and interviewees spoke of being targeted by law enforcement officers, particularly police officers and public transport ticket inspectors. They said that homeless people are more likely to attract attention from law enforcement officers, more likely to be fined or charged in relation to their behaviour in public spaces, and more likely to be treated with impunity in the course of this process. It was agreed that 'people in suits don't get picked on',[107] but people who are homeless attract attention because of their appearance and the activities that they are forced to undertake in public due to their lack of stable and secure housing.

The Project examined and made recommendations in relation to the experience of homeless and mentally ill people through all stages of the criminal justice system, including at the time of the alleged offence, before the court date, in the obtaining of bail, at the court hearing, in the sentencing process, and in the rehabilitation, release and reintegration processes. The Report and recommendations are available at <http://www.pilch.org.au>. Key recommendations include that:

> Recommendation 3: The Department of Justice and the Department of Human Services should consider the employment of a specialised Homelessness Coordinator within the Magistrates' Court to:
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> - act as a liaison between the court and defendants experiencing homelessness;
> - provide non-legal support and guidance to homeless people before, during and after the court process; and

[104] Focus group participant, St Mary's House of Welcome, 4 August 2004 quoted in Beth Midgley, *Improving the Administration of Justice for Homeless People in the Court Process: Report of the Homeless Persons' Court Project* (2004).

[105] See, for example, Tamara Walsh, '*In*equality before the Law: Legal Issues Confronting People who are Homeless' (2004) 17(1) *Parity* 38, 40; Philip Lynch, 'Begging for Change: Homelessness and the Law' (2002) 26 *Melbourne University Law Review* 690.

[106] See *Summary Offences Act 1966* (Vic), the *Vagrancy Act 1966* (Vic) and numerous Local Laws (such as the City of Melbourne Activities Local Law 1999) made under the *Local Government Act 1989* (Vic).

[107] Focus group participant, The Big Issue, 6 July 2004 quoted in Beth Midgley, *Improving the Administration of Justice for Homeless People in the Court Process: Report of the Homeless Persons' Court Project* (2004).

- assist homeless people to access services (by providing appropriate referrals), including accommodation, health, welfare and other support services.

Recommendation 4: The Department of Justice should fund a specialist list as part of the Magistrates' Court, which could:

- be flexible with regard to the circumstances and particular needs of homeless defendants;
- outreach to appropriate welfare agencies and crisis accommodation facilities;
- be administered by appropriately trained judicial officers and court staff;
- apply the principles of therapeutic jurisprudence and administer a range of diversionary strategies and alternative sentencing options.

The Report clearly demonstrates the need, in Australia, for what Margaret Eberle has referred to in the Canadian context as:

> Stronger links between the mental health system and the legal system to get mentally ill offenders the help they need rather than warehousing them in the prison system. Corrections and mental health personnel need to work together in an effort to reduce the revolving door cycle of admissions to both jail and mental health facilities. Given that many homeless adults have an overwhelming set of social, mental health, criminal, alcohol and drug problems, an effective solution will need to combine the efforts of socio-economic, housing, mental health, and drug and alcohol addiction service providers.[108]

5.3 Commissioner for Homelessness and Mental Health – Term of Reference (m)

Under the current federal, state and territory homelessness and mental health frameworks, there is no independent investigatory or complaints resolution body in relation to matters of homelessness and mental health.

It is axiomatic to monitoring and ensuring the proficiency and accountability of agencies with respect to the promotion and protection of mental health and the resolution of homelessness that Australian governments coordinate to establish a Commissioner for Homelessness under the *Supported Accommodation Assistance Act 1994* (Cth), with the power to, among other things:

- consider, investigate, monitor, analyse and report on the social and economic determinants of mental health, including poverty, homelessness and discrimination;
- consider, investigate, monitor, analyse and report on programs directed towards improvement of the social and economic determinants of mental

[108] Margaret Eberle et al, *Homelessness: Causes and Effects – The Costs of Homelessness in British Columbia* (2001) 42 (citations omitted).

health, including programs directed to addressing poverty, homelessness and discrimination;

- enhance programs directed towards improvement of the social and economic determinants of mental health by publication and dissemination of information and practical strategies identified by the Commissioner;
- regularly report to the federal, state and territory Ministers for Health and Housing;
- produce an annual report on the work and deliberations of the Commissioner and make recommendations for systemic change required to improve social and economic determinants of mental health and address issues of homelessness, poverty and discrimination;
- educate the community about matters of homelessness and mental health, including the right to the highest attainable standard of health and social and economic determinants of health such as homelessness, poverty and discrimination;
- initiate and undertake investigations and inquiries regarding matters of homelessness and mental health and the extent to which the right to the highest attainable standard of health and the right to adequate housing is protected, respected and fulfilled;
- receive and consider complaints regarding matters of homelessness and mental health, including in relation to the extent to which the rights to adequate housing and the highest attainable standard of health are protected, respected and fulfilled;
- make determinations regarding complaints about matters of homelessness and mental health; and
- make and enforce such orders as are necessary to improve or enhance positive housing and mental health outcomes.

These proposed powers and functions are substantially similar to those conferred on the New South Wales Community Services Commission in respect of community services, which has recently been amalgamated with the New South Wales Ombudsman.

5.4 Mental Health Research and Data Collection– Terms of Reference (n) and (o)

The collection and effective dissemination of accurate and extensive mental health information is necessary for a range of purposes, including identification of the nature, extent and causes of ill mental health and the determinants of good health and ill health, the development and implementation of policies and programs to improve mental health, and so on.

Significant research has demonstrated that while most public health efforts are intended to benefit the poor and vulnerable, ‘a strategic approach is necessary to overcome the tendency for people experiencing poverty to benefit too little from even

the best-intentioned public health programs'.[109] In this respect, the World Health Organization considers that,

> at a minimum, this requires ongoing monitoring of social inequalities in health, receipt of health care, health care financing, and allocation of health care resources, with built-in mechanisms for translating findings into actions that fill the gaps.[110]

In relation to the collection, use and dissemination of health information, the World Health Organization recommends that:

> Routine assessment of potential health implications for different social groups should become standard practice in the design, implementation and evaluation of all development policies … Routinely collected data on health, health care and other health determinants that are monitored overall should also be disaggregated into more and less socially advantaged groups by factors such as wealth, gender and race/ethnicity that reflect poverty and social disadvantage.
>
> …
>
> Quantitative data should be routinely supplemented by qualitative information from the poor and disadvantaged and their advocates describing unmet need, perceptions of service quality, and obstacles to receiving recommended services in any sector influencing health.[111]

In light of the above, the Clinic considers that further mental health research and data collection and analysis should have particular regard to:

- social and economic determinants of mental health;
- the relationship between financial and social disadvantage and mental health;
- the relationship between discrimination and mental health;
- systemic mental health disparities between social and economic groups and the causes of such disparities;
- allocation of mental health care resources as between social and economic groups;
- access to mental health care, including obstacles and barriers to accessing mental health care, for people experiencing financial or social disadvantage; and
- the relationship between mental health and human rights, including the right to adequate housing, the right to an adequate income or social security, the

[109] Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539, 541; Paula Braveman and E Tarimo, *Screening in Primary Health Care* (1994).

[110] Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539, 541.

[111] Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539, 542.

right to equality and freedom from discrimination, the right to privacy, the right to participation, the right to education, and the right to dignity and respect.[112]

5.5 Anti-Poverty Strategy and Unit – Term of Reference (c)

As discussed throughout this submission, there is a very strong correlation between homelessness, poverty and poor mental health on the one hand, and the alleviation of poverty, investment in targeted mental health care for the poor and homeless and improved mental health on the other hand.

Despite this, Australia does not have an anti-poverty strategy or a poverty reduction strategy. Although homelessness and poor mental health are complex, multi-faceted problems that require coordinated, holistic, joined-up responses, there is no national program to ensure the conditions necessary for good mental health, including access as of right to adequate housing, nutrition, income support and health care and medical services.

Consistent with the recommendations of the Senate Community Affairs References Committee made pursuant to the inquiry into poverty and financial hardship, and the *Draft Guidelines on Poverty Reduction* developed by the UN Office of the High Commissioner for Human Rights, the Clinic considers that the Australian Government should develop a comprehensive anti-poverty strategy that involves:

- holding an initial summit of state and local governments, the welfare sector, unions, the business sector, community groups, income support customers and relevant experts in the field to highlight the importance of the issue and agree on a timetable for action;
- a commitment to achieve a whole of government approach. That is, coordinated action across policy areas such as employment, health, education, income support, community services, housing and other relevant areas to reduce poverty and poverty of opportunity; and
- a consultation period of not longer than 12 months.[113]

The Clinic also considers that a statutory authority or unit reporting directly to the Prime Minister should be established with responsibility for developing, implementing and monitoring a national anti-poverty strategy and that this entity should:

- establish benchmarks and targets to measure progress against a series of anti-poverty objectives;
- report regularly to the Parliament on progress against the strategy; and

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[112] UN Office of the High Commissioner for Human Rights, *Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies* (2002) 22-6 [Guideline 7: Right to Health]. See generally Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539.

[113] Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) 434 [Recommendation 94]. See also UN Office of the High Commissioner for Human Rights, *Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies* (2002).

- undertake or commission research into a range of poverty-reduction measures.[114]

[114] Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) 434 [Recommendation 95].